STRATEGIC CORPORATE RESPONSIBILITY ORIENTATION FOR SUSTAINABLE GLOBAL HEALTH GOVERNANCE: PHARMACEUTICAL VALUE CO-PROTECTION IN TRANSITIONING ECONOMIES

Frederick Ameyaw Ahen

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Turun kauppakorkeakoulu
Turku School of Economics

Custos: Assistant Professor Peter Zettinig
Turku School of Economics

Supervisors: Assistant Professor Peter Zettinig
Turku School of Economics

Professor Niina Nummela
Turku School of Economics

Pre-examiners: Professor Kevin Ibeh
Birbeck University of London

Professor Tuomo Takala
University of Jyväskylä

Opponent: Professor Kevin Ibeh
Birbeck University of London

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ABSTRACT

This is an interdisciplinary inquiry into the strategic corporate responsibility (SCR) of the major actors in global health governance. These actors include pharmaceutical MNCs, health-oriented international NGOs, global governors (e.g. World Health Organization), and national governments. Value destruction through the proliferation of pharmaceutical counterfeits is used as a lens to offer empirical insights into how the above actors influence, and are influenced by, national and global institutions to integrate corporate responsibility (CR) into corporate strategy to shape global health outcomes. Additionally, the study problematizes how the actors' governance approaches lead to (un)sustainable value co-creation/co-protection with and for consumers in transitioning economies. Ghana's national–global interconnectedness is used as a proxy for the transitioning economies of West, East, Central and Southern (WECS) Africa.

Two major arguments are advanced in this study. First, the notion of CR is not an 'it' as reified in extant literature but is only an empty rhetoric, unless the process is embedded in the day-to-day strategic-ethical behavior of an organization to create institutionally and contextually relevant value in the long term. Second, it follows that there cannot be responsible value co-creation without values-based value co-protection; the two are inextricably intertwined (Article 1). Through multiple approaches and semi-structured interviews (N=62) across sectors, I investigated the institutional foundations of value co-creation through cross-sector social interactions (CSSIs) and global health diplomacy (GHD). Following the interpretivist tradition through a fieldwork, this qualitative study contributes to the neo-institutional theory. I draw attention away from seeing CR as pertaining to businesses only by meaningfully reframing the CR concept differently from the mainstream CR discourse which ignores the non-business actors such as governments. More prominently, I reorient attention from organization-centeredness (resource-based view) to a consumer/patient-centered perspective for value co-creation/co-protection.

The study develops a ***value parliament*** as a metaphor to explain how the decision makers' application of rational technologies in model-based decision making conflicts with emotions (which avoid decision paralysis), beliefs, identities and political allegiances to swing the pendulum in favour of the dominant group of decision makers. The study argues that value creation will only come about through the central role of strategic ethical leadership and values-

based managerial entrepreneurship (Article 2), pockets of excellence emerging from inefficient cross-sector interactions (Article 3), and institutional responsibility on the part of transitioning economies and international organizations through collaborative investments in patient-centered global health instead of organization-centeredness (Article 4). Additionally, the institutional path dependence of global health governance results in a five-fold paradox in emerging economies of Africa: (i) complex formal bureaucratic structures/high institutional void and lack of enforcement mechanisms for consumer co-protection; (ii) relatively stable political institutions/weak public health systems; (iii) resource abundance/high dependency on donors; (iv) high economic growth/weak structural determinants of health; (v) increase in non-communicable diseases/lack of political will to enact radical change in the institutional path dependence of GHD.

In synthesis, the study develops the theory of the ultimate preference for non-optimal solutions in global health governance. Here, values and micropolitics, power asymmetry, corporate irresponsibility and institutional path dependence are the explanatory variables of this theory. Thus, for any given set of global health solutions for creating value (maximum health benefits), a range of market and institutional possibilities always exist. Nevertheless, deliberately quick fixes (representing the foreign policy and economic interests of the core region) are preferred over sustainable options. The major reason for these includes the prioritization of survival (organizational/institutional preservation) through resource seeking, incentive seeking, market seeking and legitimacy/status and relevance seeking rather than value co-creation for the consumer or the patient. This allows actors to maintain the status quo and the attendant incentive structures—leading to weak governance structures that undermine the sustainability and institutionalization of global health as a major concern. The theory explains why medico-techno-scientific products remain geopolitical commodities via which powerful actors leverage competitive advantage, allowing them to maintain the path dependence of global health outcomes in transitioning economies of WECS Africa. The main conclusion of the study challenges the conventional view by arguing that the global health governance deficit stems from the path dependence of market and institutional mechanisms and not the high cost of innovations and investments in ameliorating global health or mitigating global health risks as previously thought.

KEYWORDS: anti-counterfeit cross-sector interactions, ethics, institutional change, global health diplomacy, patient safety, strategic corporate responsibility, sustainability, value co-creation, value co-protection, WECS Africa

TIIVISTELMÄ

Tämän monitieteisen tutkimuksen aiheena on maailmanlaajuisen terveyshallinnon keskeisten toimijoiden strateginen yritysvastuu. Näitä päätoimijoita ovat monikansalliset lääkeyritykset, terveyskysymyksiin keskittyneet kansainväliset kansalaisjärjestöt, maailmanlaajuisesti merkitsevät toimijat (esim. Maailman terveysjärjestö WHO) sekä kansalliset hallitukset. Tässä tutkimuksessa tarkastellaan miten nämä toimijat vaikuttavat kansallisiin ja maailmanlaajuisiin instituutioihin (ja vastavuoroisesti instituutiot toimijoihin) pyrkiessään edistämään terveyttä maailmassa. Erityisenä tarkastelun kohteena on yritysten yhteiskuntavastuun yhdistyminen niiden strategiaan ja tätä analysoidaan lääkeväärennösten lisääntymisen aiheuttaman arvon tuhoutumisen kautta. Lisäksi tutkimuksessa problematisoidaan, kuinka näiden toimijoiden hallintotavat johtavat kestämättömään tai kestävään arvon luomiseen ja -suojeluun yhdessä kuluttajien kanssa ja kuluttajien hyväksi kehittyvissä talousmaissa. Ghanan kansallista ja maailmanlaajuista verkostoituneisuutta käytetään edustamaan läntisen, itäisen, keskisen ja eteläisen Afrikan kehittyviä talousmaita.

Tutkimusprosessin aikana rakentuu sen kaksi pääargumenttia. Ensinnäkin, yritysvastuu on vain tyhjää retoriikkaa, ellei se ole olennainen osa organisaation jokapäiväistä strategis-eettistä käyttäytymistä institutionaalisesti ja kontekstuaalisesti relevantin arvon luomisessa pitkällä aikavälillä. Toiseksi, tästä seuraa, ettei arvon yhteisluomista (co-creation) voi olla ilman arvoperusteista arvon suojelua (co-protection); näitä ei voi erottaa toisistaan (Julkaisu 1). Useita lähestymistapoja käyttäen ja eri alojen asiantuntijoitten puolistrukturoitujen haastattelujen (N=62) avulla selvitettiin arvon yhteisluomisen institutionaalisia perusteita sektorien välisen sosiaalisen vuorovaikutuksen ja maailmanlaajuisen terveysdiplomatian kautta. Tutkimus kääntää huomion pois perinteisestä näkemyksestä, jossa yritysvastuu kuuluu vain yrityksille, muotoilemalla yritysvastuun käsitteen uudelleen aikaisemmasta poikkeavalla tavalla ja siirtää tarkastelun painopisteen organisaatiokeskeisyydestä kuluttaja/potilaskeskeiseen näkemykseen arvon yhteisluomisessa ja -suojelussa.

Tutkimuksessa kehitetään metafora arvoparlamentista, joka kuvaa kuinka käsitys päättäjien rationaalisesta päätöksenteosta on ristiriidassa niiden tunteiden, uskomusten, identiteettien ja poliittisten sidonnaisuuksien kanssa, jotka usein kääntävät päätöksenteon heilurin hallitsevan ryhmän eduksi. Se osoittaa, että arvon luominen on mahdollista vain strategis-eettisen johtajuuden ja arvoperusteisen yrittäjyyden keskeisen roolin (Julkaisu 2); sektorien välisen vuo-

rovaikutuksen synnyttämien osaamiskeskittymien (Julkaisu 3); sekä kehittyvien talousmaiden ja kansainvälisten järjestöjen institutionaalisen vastuun kautta. Tätä vastuuta tulee toteuttaa potilas-, ei organisaatio, -keskeisesti yhteisillä investoinneilla (Julkaisu 4).

Vaikka monikansalliset lääkeyritykset pysyvät tärkeinä mahdollisina liittolaisina maailmanlaajuisessa terveyshallinnossa, niiden 'ylhäältä alas' toteuttama harkinnanvarainen yhteiskuntavastuu ei edusta aitoa yritysvastuuta vaan tietoista legitimaatiotaktiikkaa. Samoin hybridiorganisaatioiden ja hallitusten satunnaiset interventiot lisäävät maailman terveyshallinnon puutteita. Voidaankin todeta, että terveyshallinnon institutionaalinen polkuriippuvuus aiheuttaa viisi keskeistä haastetta Afrikan kasvavissa talousmaissa: (i) monimutkaiset viralliset byrokratiarakenteet yhdistyvät suureen institutionaalisen tyhjiöön ja puuttuvat toimeenpanomekanismit eivät edistä kuluttajien yhteissuojelemista; (ii) suhteellisen vakaat poliittiset instituutiot yhdistyvät heikkoihin kansanterveysjärjestelmiin; (iii) suuret luonnonvarat yhdistyvät korkeaan riippuvuuteen; (iv) suuri talouskasvu yhdistyy heikkoihin rakenteellisiin terveyttä määrääviin tekijöihin ja (v) kroonisten sairauksien lisääntyminen yhdistyy poliittisen tahdon puutteeseen maailmanlaajuisen terveysdiplomatian polkuriippuvuuden muuttamiseksi.

Tutkimus tarjoaa myös yhden selityksen siitä, miksi maailmanlaajuisessa terveyshallinnossa usein päädytään ei-optimaalisiin ratkaisuihin. Arvot, mikropolitiikka, vallan epäsymmetria, yritysten vastuuttomuus ja institutionaalinen polkuriippuvuus ovat tämän teorian selittäviä tekijöitä. Maailmanlaajuiset terveyskysymykset tarjoavat aina mahdollisuuden arvon luomiseen sekä markkinoiden että instituutioiden näkökulmasta. Päätöksentekijät suosivat kuitenkin tietoisesti nopeita ratkaisuja kestävien vaihtoehtojen sijasta. Eräs pääasiallisista syistä tällaisiin ratkaisuihin on eloonjäämisen priorisointi (organisaation tai instituution säilyttäminen) resurssihakuisuuden, kannustinhakuisuuden, markkinahakuisuuden ja laillisuus-/statushakuisuuden sekä relevanssihakuisuuden kautta sen sijaan, että arvon yhteisluomista kuluttajan tai potilaan hyväksi pidettäisiin tärkeimpänä. Vallitseva tilanne edistää status quon säilyttämistä ja tukee siihen liittyviä eturakenteita. Tämä puolestaan johtaa heikkoihin hallintorakenteisiin, jotka vähättelevät kestävää kehitystä ja estävät pitämästä maailmanlaajuisia terveyskysymyksiä ykkösprioriteettina. Teoria selittää, miksi lääketieteellis-teknologiset tuotteet pysyvät geopoliittisina hyödykkeinä, joiden kautta voimakkaat toimijat saavuttavat kilpailuedun ja pystyvät säilyttämään globaalin terveyden hallinnon polkuriippuvaisena läntisen, itäisen, keskisen ja eteläisen Afrikan kehittyvissä talouksissa. Tutkimuksen tärkein johtopäätös haastaakin perinteisen näkemyksen perustellen, että maailmanlaajuisen terveyshallinnon puutteet johtuvat markkina- ja institutionaalisten mekanismien polkuriippuvuudesta eivätkä innovaatioiden ja maailmanlaajuisen tervey-

den edistämiseen tähtäävien investointien tai maailmanlaajuisten terveysriskien pienentämisen korkeasta hinnasta, kuten aiemmin on ajateltu.

Lyhyesti sanottuna tutkimus ehdottaa muutosta läntisen, itäisen, keskisen ja eteläisen Afrikan kansanterveysjärjestelmän institutionaaliseen perustaan siten, että hallitusten, kansalaisjärjestöjen sekä lääketeollisuuden vuosikymmenien aikana vakiinnuttamasta yritysvastuuttomuudesta ja organisaatiokeskeisistä lähestymistavoista voidaan siirtyä kuluttajakeskeisiin lähestymistapoihin. Tämän muutoksen tulee uudelleen ohjata yritysten strategista yritysvastuuta siten, että se ottaa osakkaat mukaan arvon yhteisluomiseen ja arvon yhteissuojeluun. Tämä tapahtuu paikallisten lääkkeellis-teknis-tieteellisten innovaatioiden kautta, joissa voimaannuttavat lähestymistavat on laitettu etusijalle.

AVAINSANAT: lääkeväärennösten vastainen sektorien välinen vuorovaikutus, etiikka, institutionaalinen muutos, maailmanlaajuinen terveysdiplomatia, potilasturvallisuus, strateginen yritysvastuu, kestävä kehitys, arvon yhteisluominen, arvon yhteissuojelu

SOLI DEO GLORIA

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Dedicated to my Outi Salo-Ahen, PhD. Thanks for existing!

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> *No weapon formed against you shall prosper, and every tongue which rises against you in judgment you shall condemn. This is the heritage of the servants of the LORD, and their righteousness is from Me, says the LORD (Isaiah 54:17).*

Turku, 7th of May, 2015

Frederick Ahen

ABBREVIATIONS

BOP	Bottom of Pyramid
CDC	Centers for Disease Control and Prevention (USA)
CEO	Chief Executive Officer
CEPS	Customs Excise and Preventive Service (Ghana)
CFP	Corporate Financial Performance
cGLP	Current Good Laboratory Practice
cGMP	Current Good Manufacturing Practice
COO	Chief Operating Officer
CR	Corporate Responsibility
CSR	Corporate Social Responsibility
CSSIs	Cross-sector social interactions
ECOWAS	Economic Community of West African States
EMA	European Medicines Agency
EU	European Union
FDA	Food and Drug Administration (USA)
FDA-GH	Food and Drugs Authority (Ghana)
GDP	Gross Domestic Product
GHD	Global Health Diplomacy
GNP	Gross National Product
HoCSO	Health-Oriented Civil Society Organizations
FDI	Foreign Direct Investment
IMF	International Monetary Fund
INTERPOL	International Criminal Police Organization
IGO	Intergovernmental Organization
INGO	International Non-Governmental Organization
IO	International Organization
MDGs	The United Nations Millennium Development Goals
MNC	Multinational Company
MoH	Ministry of Health (Ghana)
OECD	Organization for Economic Cooperation and Development
PSGH	Pharmaceutical Society of Ghana
PSI	Pharmaceutical Security Institute
R&D	Research and Development
SARS	Severe Acute Respiratory Syndrome

SCR	Strategic Corporate Responsibility
SDGs	The United Nations Sustainable Development Goals
SME	Small-and-Medium-Scaled Enterprise
TNC	Transnational Corporation
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children and Education Fund
USAID	United States Agency for International Development
USP	United States Pharmacopeial Convention
WB	World Bank
WECS Africa	West, East, Central and Southern Africa
WHO	World Health Organization
WTO	World Trade Organization

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PART I: INTRODUCTORY ESSAY

1 INTRODUCTION

> *Medicine is a social science, and politics is nothing else but medicine on a large scale*. (Rudolf Virchow 1848, in his weekly medical newspaper Die Medizinische Reform, 2; cited in Sigerist 1941, 93)

1.1 Background

Global health is profoundly marked by persistent structural inequalities (Ahen 2015a; Marmot 2005; Ruger 2006). This is clearly an intractable socio-economic and political problem especially in the global South. But what has international business got to do with global health governance? Everything. In fact, these two fields have evolved dialectically and in interdependence rather than as separate spheres. This may not be immediately noticeable. However, global health governance gave birth to international business within the context of Europe-West Africa and beyond. How? The discovery of quinine initiated the Western imperial adventure that had hitherto been stalled due to the ability of little mosquitoes to kill millions of people, including four Popes (Shah 2010) and even the most powerful armies, by transmitting the dangerous parasite *Plasmodium falciparum* through their sting. International business within the above context became less perilous[1] only when this major epidemiological issue was solved—at least in part. That is, when a preventive medicine for malaria ('bad air') was found, it allowed European merchants trading access to the continent (Rocco 2003). Then the proselytizing mission of *Christianity*, the *commerce* of everything (including humans), and the *civilizing mission* (now replaced by international development and humanitarian interventions) through conquest of the 'others' ensued (Jackson, Louw, Zhao, Boojihawon & Fang 2014; King 2002; Nkomazana 1998). As King (2002, 780) writes: "*Colonial public health was part of a larger 'civilizing mission', in which modern medical science would drive out primitive traditional thera-*

[1] Trade in gold and other rich minerals (from the Gold Coast and Guinea) has flourished over several millennia. The pre-industrial trade between Africa and Europe, especially with the Portuguese, allowed gold to be transported from West Africa through the Sahara (trans-Saharan caravans) as early as 1444 (Cipolla 2002).

peutics, freeing backward societies from the grip of irrationality and legitimating colonialism as an ultimately humanitarian project".

That was then, but even today epidemiological questions such as Ebola and SARS (Severe Acute Respiratory Syndrome) threaten the movement of goods and services and other international business operations. Consider this, too: Hajer (2003), writing on the expansiveness of global policy making and emerging fundamental changes, offers an interesting illustration to explain how even the discovery of a new plant becomes an issue that trespasses national sovereignties and engages multiple actors. The conflict always lies within the health of populations and capitalists' profits. The World Trade Organisation's agreement on Trade-Related Aspects of Intellectual Property Rights (the WTO/TRIPS agreement) raises an important question about the finding of any plant-based active ingredient. Would the major actors consider such a medicament as an invention as the West 'suggests', or can it be labelled a discovery as the South 'argues'? These are not mere semantic games because inventions receive protection under patent law, discoveries do not. Two issues of institutional nature are raised here by Hajer (*ibid.*). First, the established notion of sovereignty is now challenged in this decision making process that involves pharmaceutical multinational companies (MNCs), nation states and supranational organizations and local people. Second, the question of who decides which actors become the legitimate protagonists in such a legal, socio-political and ethical conflict becomes increasingly complex in global health governance and international business. The state of global health and international business strategies today is therefore a product of the history, geography, epidemiology, geopolitics, economics and institutions surrounding all of them (Sachs 2006; Shah 2010; Wainwright 2008).

For Fidler (2007), *"governance refers to the efforts societies make to organize and exercise political power in response to the challenges and opportunities they face"*, bearing in mind that at both local and global levels *"governance involves susbstantive goals and the mechanisms designed to achieve them"* (Hill 2011, 595). Global health governance presents a significant array of complex medico-techno-scientific, political and managerial challenges that affect health security as a global public good (Buchan & Grimalda 2011) on one hand and responsible international strategy on the other. Currently, these problems are exacerbated by the emergence of medical product counterfeiting, especially in transitioning economies (Barnes 2007; Bate 2008; Liang 2008; Satchwell 2004; Shepherd 2010; Yankus 2006). The magnitude of this global threat represents an egregious form of value destruction (Ahen & Zettinig 2011) with vast socio-political, ethical, economic, security, and public health implications. There is, however, a dearth of interdisciplinary studies (in business and society) aimed at providing an informed basis for responsible strate-

gies for mitigating the phenomenon of drug counterfeiting and sustainable policies for institutional change in global health governance. In an ideal world, such changes would affect the structural determinants of health, while contributing to the improvement of global health in general. For the pharmaceutical industry, this would serve as a legitimation process and as a risk management mechanism towards value co-creation (Grönroos 2008; Prahalad & Ramaswamy 2004) and value co-protection, for example the protection of intellectual property rights and the safety of consumers (Ahen & Zettinig 2011).

On a practical level, however, resolving drug counterfeiting demands a responsible aggregation of input from a multiplicity of actors in the pharmaceutical industry and beyond, namely: business and non-business actors, patient-safety organizations, state and non-state actors, donors and consumers. This implies that the use of non-market strategies (Doh, Lawton & Rajwani 2012) for dispute settlements, stakeholder engagement (Freeman 1984), and cooperation and competition (co-opetition) (Afuah 2000) is fundamental to any forward-looking approach. Thus, it would be an oversimplification to assume that in matters of global health, either firms or governments or some other stakeholders were solely responsible for anything. At first glance this seems surprising since the provision of healthcare is a public good. Nevertheless, within the context of the issue at hand, private business and non-business actors are deeply entrenched in this sector (Gates & Gates 2014). This delineates a shift from the sole creation to co-creation of value (Austin & Seitanidi 2012). In the same vein, both theoretical and empirical arguments cannot be reduced to the pharmaceutical firms or market-actors only. Firms may have what Grayson and Nelson (2013) refer to as corporate responsibility (CR) alliances, coalitions or multi-stakeholder platforms between such actors as businesses, non-governmental organizations (NGOs) or governments for scaling up and solving big socio-economic and environmental problems. Such a model also holds true in the world of pharmaceutical innovation and commercialization where regulatory institutions, governments and multilateral organizations play a major role in fighting global counterfeiting (Mackey & Liang 2011). The outcomes of such collaborative initiatives (by this complex set of interrelated actors) are very much dependent on the institutional context and the political will of the major actors with political power. That is, the actors represent an adaptive system—"*not a cluster of unrelated activities but a system; not a simple system but a complex one, and not a static, unchanging set of arrangements but a complex adaptive system"* (Rosenau 2003, cited in Hill 2011, 594–595).

Further, the responsibilities of global health actors are not clearly delineated. This is because their identities have convincingly undergone a series of evolutionary transformations over the past decades as NGOs are shifting their traditional roles towards marketization via business models (Eikenberry &

Kluver 2004). Corporations are also venturing into social entrepreneurship and cross-sector social interactions (CSSIs) with NGOs and governments (Seitanidi & Crane 2009; Selsky & Parker 2005; Vaillancourt Rosenau 1999), and governments are in public-private-collective NGO partnerships (Austin 2010; Vurro, Dacin & Perrini 2010) in order to collaboratively co-create value, especially in the health sector (Nwaka & Ridley 2003). Moreover, in engaging other actors in a world of rapidly changing institutions, firms now employ what Doh et al. (2012) refer to as non-market strategies. This in part is a reflection of an evolutionary metamorphosis of the different organizations as they adapt to their environments and new socio-economic, regulatory, institutional, technological and ethical demands (Ahen & Zettinig 2013; Geels 2002).

The study is situated within the under-researched context of criminal network activities in international business where value destruction pervades (Ahen & Zettinig 2011; Roberts & Dörrenbächer 2012). In the pharmaceutical sector, typical examples of value destruction due to such criminal activities include infringement on the intellectual property rights of firms, infiltration of supply chains with dangerous or below-standard active pharmaceutical ingredients (Barnes 2007), loss of taxes to governments, and health hazards for consumers. The scale of all this and the impact on global health and international business is very controversial and too great to determine with exactness (Liang 2008; Yankus 2006; Zimmerman 2011). For example, big pharmaceutical MNCs and patent-holder lobby groups have the tendency to characterize legitimate generic drugs (produced outside of patents or after patents' expiration) as counterfeit in order to suggest that the loss of market share is due to counterfeits (Reynolds & McKee 2010). Additionally, some illegitimate and to some extent legitimate organizations produce and commercialize counterfeit and substandard drugs (Park 2011). IB and global health have always had an inextricably intertwined but complicated nexus in their pursuit of wealth and health (Fidler, Drager & Lee 2009) and both are affected by foreign policy (Labonté & Gagnon 2010).

In this study, I appropriate the term 'entrepreneurial managers' from Augier and Teece (2009) to be the central locus of decisions and therefore the focus of the study. In fact, entrepreneurial managers neither refer to small-and-medium-scaled enterprises (SMEs) nor MNCs but to all decision makers/ managers who are involved in allocating resources for change. Here, both entrepreneurial managers in SMEs, MNCs or NGOs are defined by their ability to see (in turbulence) emerging threats and opportunities and use business or non-business solutions as agents of social change. The study therefore applies to both SMEs and MNCs as business actors and governments and NGOs as non-business actors.

Why the acronym WECS Africa? For technical reasons explained below I use the term 'transitioning economies/institutions of West, East, Central and Southern (WECS) Africa' (my brainchild, already presented in 2012 in the University of Aalborg, Denmark) instead of 'developing' or 'emerging economies' of Sub-Saharan Africa (SSA). First, the term 'transitioning economies' is preferred over 'developing' or 'emerging economies' because it accentuates the on-going structural reforms and changes in the institutional underpinnings of the WECS African countries (see e.g. Radelet 2010). Second, the use of the term 'Sub-Saharan Africa' is problematic (Sharples, Jones & Martin 2014) because it brings up a host of apocalyptic images of backwardness, death, disease and desperation. It is therefore not a business-friendly word. It must also be recognized that 'Sub-Saharan' is an adjective that qualifies the noun 'Africa' whereas WECS is an abbreviation of four cardinal locations in the continent. The former lumps all the 48 countries together as a region whereas the latter is a recognition of the already existing geopolitical configurations and regional trading blocks in Africa. Moreover, North Africa is in fact in the Sahara region whereas one can hardly see the link between Ghana or the Congo and the Sahara. In addition, the four 'WECSern' regions have similar (but not exactly the same) epidemiological profiles unlike the North that has the influence of the Mediterranean and the Saharan climate (WHO 2013). Sub-Saharan Africa Business Environment Report (SABER) also uses a very similar regional configuration to accentuate the economic and geopolitical differences whilst recognizing the single nation-states' institutional heterogeneity (Spring, Rolfe & Parent 2011) (see Figure 1).

The change from SSA to WECS is important because the aggregation of economic data from the region and lumping countries together clouds and confuses rather than illuminates us about the diversity and institutional heterogeneity of the regions and the countries therein. For example, although all Africa is frequently lumped together, it is the most institutionally diverse of all the continents, with over a thousand languages (Connolly 2014), diverse histories and cultures as well different levels of economic development and levels of global economic integration. Further, there is a serious problem with the premise that, perhaps, geography, history, ethnicity and culture are justifiable reasons for putting over 48 countries together. That leads to a false conclusion. The outcome is a one-size-fits-all approach in global health governance—which has done little to help. Although these countries were under colonialism they emancipated differently and are therefore at different stages of development and institutional maturity.

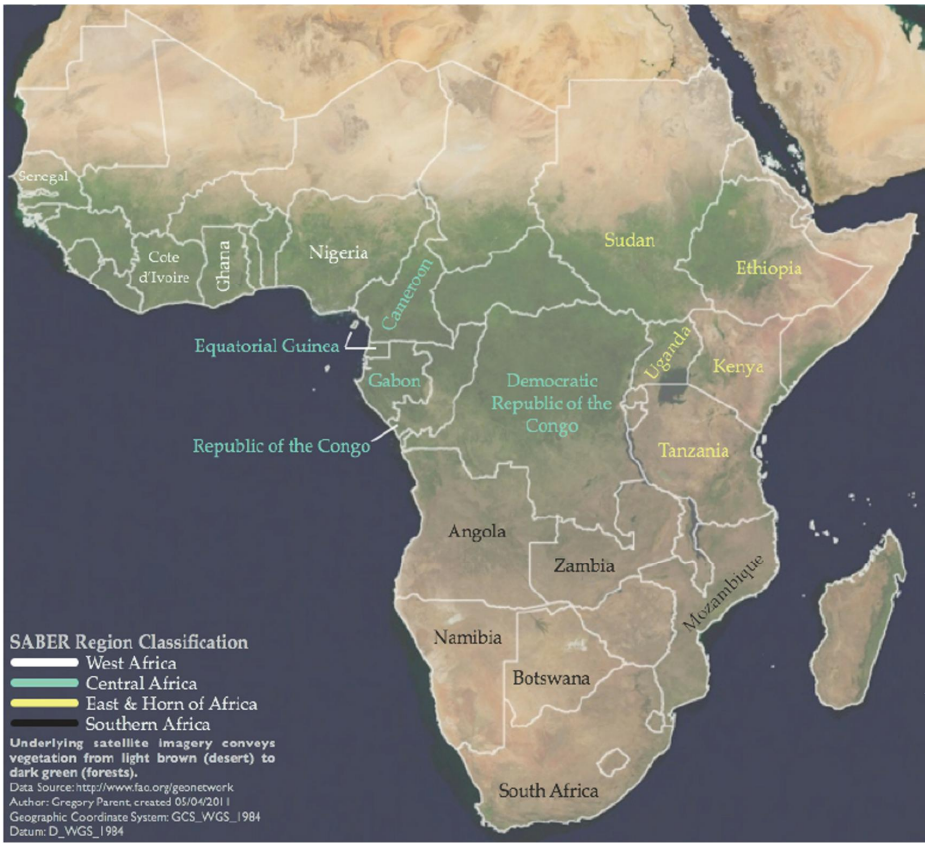

Figure 1 West, East, Central and Southern (WECS) African regional trading blocks as depicted by Spring et al. (2011).

Why then do the transitioning economies of the WECS African region matter? What can we learn from the region and why is it a suitable context for this study? It is important to recognize two contrasting but perfectly harmonious views: Even though global health is about improving health worldwide, it is the periphery, especially Africa and the rest of the South that are the main focus. On the other hand, even though WECS Africa's integration into global commerce is well documented (Radelet 2010), it is the least studied region in international business (IB) and in the natural sciences. On a more general level, apart from the need to investigate CR and the major actors who are deeply involved in the governance of counterfeit problems in this region, the context of WECS Africa is extremely important because there is a dearth of literature at the intersection of global health and IB that deals with the region. This has resulted in the fact that it has the least cumulative number of research output both in natural sciences (Nordling 2013), though now with an average increase greater than in any other region (Irikefe et al. 2011), and social science re-

search. In the latter scientific field, most reports describe Africa in apocalyptic and pejorative ways (Egri & Ralston 2008; Jackson et al. 2014). This designed oversight of interesting contemporary questions pertaining to sustainable development and international business have been highlighted in the works of Jackson (2004), Jackson et al. (2014), Kolk and Lenfant (2010), Kolk and Van Tulder (2010), Spring et al. (2011) and Visser (2006). As Jackson (2004, 8) notes, *"Africa has been excluded for too long from serious academic study, and from international management programs. I have even been warned that spending too much time focusing on management in Africa could 'seriously damage my career.'"*

Nevertheless, the fact that WECS Africa has not been studied is not enough a reason for it to be studied. There are many more convincing arguments in support of why this neglect is neither fruitful nor justifiable. One, there is the need to draw insights from the region which, since time immemorial, has been contributing both natural, intellectual and cultural resources to the world through trade and migration (Cipolla 2002)—from the oldest university in Timbuktu where the rest of the world came to learn, and from the Egyptian, Sudanese, Ghanaian, Songhaian and other empires' connection with the rest of the world, to slave trade and current international exchanges (Boahen, Ajayi & Tidy 1986; Harris 1998; Niane 1984; Oliver 1977). Two, combining the phenomenon of global health and counterfeit trade as an institutional lens offers us the opportunity to revive the interdisciplinary roots of IB research that is placed squarely within the business and society discourse.

Three, there are interesting socio-economic, political and health issues happening across the continent which must not be kept from the rest of the world (Radelet 2010; Spring et al. 2011). Four, without studying about this new, old region, we will only become speculative in theorizing about it and offer false statements that are either exaggerated or depreciatory and not grounded in the scientific method but based on clichés. Five, it is intellectually restrictive to concentrate only on the triad and a few emerging economies just because that is what some 'gatekeepers' are interested in. Six, Egri and Ralston (2008, 325) could not be more crisp and profound when they argue that *"it is particularly troubling that there has been relatively little on-the-ground CR research in countries where the need for CR is most pressing due to greater poverty, environmental degradation, and institutional governance issues."* This brings me to the seventh point that some African scholars are complicit in neither writing about the continent nor doing it right when they do, in that they seek to be approved by others through conformity with clichés. Meriläinen, Tienari, Thomas and Davies (2008) refer to this kind of behavior from the periphery as self-marginalization to gain acceptance.

Finally, and for our purpose, the context of WECS Africa makes analysis of global health even more interesting. Even though Africa is inhabited by only 11% of the world's population, it carries 25% of the global disease burden. Furthermore, it has only 3% of the globe's healthcare professionals (due to brain drain) and its public health budget represents only a meagre 1% of the global health budget (IFC 2008; Pamba 2014) despite being resource rich. But who controls the value chain of the resources (Bougrine 2006)? Additionally, the '90-10 rule' still pervades: that is, only 10% of the R&D expenditure by the pharmaceutical industry is allocated to the underprivileged in transitioning economies of WECS Africa (Stiglitz & Jayadev 2010) and other Southern economies. Below in Table 1 is a list of major global health challenges in transitioning economies of WECS Africa as compared with the respective situation in the advanced countries.

Table 1 Distinguishing features of global health inequity: major challenges in transitioning institutions of WECS Africa and advanced economies[2]

Major global health challenge	**Gravity of the challenge**	
	Transitioning economies	**Advanced Economies**
The proliferation of counterfeit medicines and the uncoordinated efforts to combat the menace	High	Moderate
Financial, opportunity, and informational cost barriers to healthcare (Janes, Chuluundorj, Hilliard, Rak & Janchiv 2006)	High	Low
Lack of access beyond primary healthcare	High	Low
"Shrinking budgetary resources, increasing demand for health services, and rising healthcare costs as the primary factors driving the sub-region's health financing reform agenda" (Sekwat 2002).	High	High
"Vaccines, access to safe water, efforts to encourage breastfeeding – such were the strategies that dominated public health efforts" (Kim, Rhatigan, Jain, Weintraub & Porter 2010, 181). Attention has now shifted from prevention to treatment (*ibid.*).	High	Low
Worsening social determinants of health	High	Moderate
Access to infrastructure and healthcare professionals	Low	High
Self-sufficiency in providing for healthcare needs	Low	High
Political participation in health reforms	Extremely low	High

[2] I thank Professor Sten-Olof Hansén for the idea of this taxonomy.

WECS Africa's contradictions are intriguing. Whilst there are 358 million people living with 1.75 cents a day, there are 16 Africans joining the billionares of the world (Sebhat 2014). That, however, leaves over 600 million people as middle class according to the African Development Bank. With rising incomes, global integration and information technology transforming banking and economic transactions, the continent is not as cash-strapped as previously reported (Radelet 2010). This makes the setting an interesting business case. This study is not making the case for aid and philanthropy but pharmaceutical investments in Africa. It is at present the place with the highest return on investment in the entire developing world (Dörr, Lund & Roxburgh 2010). Chinese investments, irrespective of what critics have to say, are boosting the infrastructure that is much needed for local investments and foreign direct investments (FDIs) (Brautigam 2010; Moyo 2009).

Against the backdrop of the above introduction, *this article-based dissertation seeks to problematize why and how business and non-business actors in the pharmaceutical industry influence and are influenced by national and global institutions in successfully co-creating and co-protecting value for consumers in transitioning economies of WECS Africa.* Here, an integrative role of actors and distributed governance structures that span the boundaries of many sectors and countries (Vurro et al. 2010) are central to the present study in IB and related fields. Since the international aspects of counterfeit drug control and regulatory systems are more important than national ones (Abraham & Reed 2001; Labonté & Gagnon 2010), *this study seeks to explain how the pharmaceutical industry (with related stakeholders) influences institutions through strategic corporate responsibility (SCR) and global health diplomacy (GHD)*. More specifically, it is a search for deeper insights into how institutions and power asymmetry shape, enable and constrain organizations' and agents' proactive and reactive responses to emerging health threats via SCR orientation towards value co-creation and co-protection for and with consumers. Here, SCR orientation refers to the ethical posture and the dominant content of the organization's focus and scope that determine how capabilities are employed and allocated for institutionally and contextually acceptable behavior which in turn defines the raison d'etre of the organization in the long term.

Two major arguments are advanced in this study. First, CR is only an empty rhetoric or a myth-infused vogue that withers with speed unless the process is embedded in the day-to-day strategic-ethical behavior of an organization to create institutionally and contextually relevant value in the long term. As Rushworth Kidder brilliantly puts it in his book, 'How good people make tough choices', ethics is "*obedience to the unenforceable"* (cited in Mohin 2012, 2). *Ethics* also refers to a set of moral standards by which society in general regulates the behavior of natural and legal persons, to distinguish be-

tween what is acceptable and what is not (Flew 1984). For Wines (2008, 487) ethics refers to "*the cognitive, analytical, systematic and reflective application of moral principles to complex, conflicting or unclear situations [or dilemma]"* (emphasis added). Second, it follows that there cannot be value co-creation without values-based value co-protection; the two are inextricably intertwined. Additionally, the study investigates the co-evolutionary dynamics of GHD and the interactive roles and strategic responsibilities of global health actors (Ählström & Sjöström 2005) and supranational organizations (Cantwell, Dunning & Lundan 2010; Teegen, Doh & Vachani 2004). These co-evolutionary patterns facilitate the translation of specific conceptual targets such as global health and CR into mechanisms for co-creating value and inducing institutional and market changes in the WECS African context.

1.2 Motivation for the study

In general, IB research has a dominance of managerially-oriented studies. In its narrow (highly focused) compartment that seeks to contribute to managerial practice, it sometimes shows disdain for non-typical IB research as almost irrelevant and non-rigorous if such research strongly engages society, ethics and sustainability issues. Concerning this deficiency, Buckley and Casson (2003; cited in Meyer 2004, 261) caution with a serious tone:

> *Although political debates continue to rage over globalization, academic research has become increasingly divorced from the political, social and economic issues involved. Most international business scholars, it appears, would rather influence the boardroom than the office of the president or prime minister. It certainly pays better, and appeals to people with narrow ethical horizons.*

Following the above, prominent IB scholars have in recent years strongly argued about the importance of IB's link with supranational organizations who are the major players in the global economy. To remain relevant, IB scholars must offer useful insights about global issues in our quest to raise the profile of the IB field (see Collinson, Doz, Kostova, Liesch & Roth 2013). On the firm–NGO–government nexus in the pharmaceutical sector, there cannot be any better context than transitioning economies, wherein lie all the big and interesting questions. As Liesch, Håkanson, McGaughey, Middleton and Cretchley (2011, 38) astutely argue:

> *For example, organized international terrorism has altered the way in which international firms approach their international business operations, but has the field, through JIBS [Journal of International Business Studies], embraced research in this area? Similarly, is the field effectively addressing the likely social, political and economic effects of global climate change on the activities, success and possible failure of international firms?*

Research in IB has so far missed the opportunity to incorporate the study of certain contemporary issues into its focus, especially within the WECS African context. Reversing this trend in IB and management research could create connections between theory building, problem-centered enquiries, and critical research on issues of strategy (Vaara & Tienari 2004) and CR. For example, southern voices and contexts are even missing or ignored in mainstream management research (Alcadipani, Khan, Gantman & Nkomo 2012).

This dissertation was not solely written because it fulfills the academic requirement to obtain a PhD. At the end of this I expect to be the PhD whose knowledge within this substantive domain will effectively contribute to the engineering of innovative choices for change in global health governance. Since this is a report on a heavy investment of resources in an essential subject that must be investigated, I expect the publications to make theoretical contributions and my recommendations to create avenues that will affect policy now and in the medium and long terms; thus, fulfilling both criteria of rigor and relevance. One day, during the course of my fieldwork, after I was offered a seat in the office of the Director for Traditional Medicines at the Ministry of Health (MoH) in Accra, he quickly engaged me in a serious conversation in a stern tone that I had not anticipated:

> *Every year we receive lots of people who say they are doing PhDs. They ask for interviews or data of some sort. A lot of them have graduated but we don't know what they are doing to help. Are you one of them?*

My answer was a resounding:

> *No, as much as I believe in seeking knowledge for its own sake, I have an agenda for change. I know that this is required in this context (Ghana). And it is my responsibility, too. I am studying this to equip myself with the required knowledge and to acquire 'a license' to influence change through research publications and direct engagement with policy makers and other influencers.*

This is all because the precarious equilibrium of global health crisis in the so-called developing world makes it an interesting domain for intellectual inquiry. That is also because the sustainability of global health or the lack of it can be measured in lives lost or lives saved and the general productivity and socio-economic development of a nation. Most importantly, the thesis has something to say that is of importance to the interdisciplinary worlds of global health, political economy and IB and beyond, with the aim of fostering intra-tribal conversations in academia. This is done not under the pretense of false neutrality and in an unengaging way but in a critical manner that is novel and is of socio-economic and global health relevance (Alvesson 2013). For Alvesson (2013, 80), *"to have something [meaningful] to say would then mean communicating something original and of interest to the working/organizational life of an audience outside that of the usual, ie like-minded people in one's own [disciplinary] subtribe."* As Leedy and Ormrod (2005, 4) argue, all research starts with a problem and 'curiosity is the germinal seed'. An 'enlightened acknowledgment' of the need to choose a socially relevant area of research (Phillips & Pugh 1994) was the major factor that drew me towards global health as a domain of study. This pragmatic and purpose-driven pursuit also led to the abandonment of less pressing questions for more relevant and viable or scientifically rigorous ones, meant for an interdisciplinary audience and for engaging society. This is because within socio-economic research, it is very easy to start 'majoring on minors' by following the crowd in enquiring about fashionable but trivial issues instead of the burning issues (big societal questions) that allow us to both theorize and at the same time actively participate in business and society's most important conversations in order 'to influence them' (Corley & Gioia 2011). This is what Ahen and Zettinig (2015b) refer to as burning questions. Colquitt and George (2011) refer to such issues as big societal problems and the mathematician David Hilbert refers to such problems as 'grand challenges' which require novel solutions in science and technologies to fix them in a way *"that have the potential to capture the public imagination"* (U.S. Office of Science and Technology Policy 2014) .

This entails sensibility to emerging trends and making sense of the shocks and cues they offer. This approach is based on what Corley and Gioia (2011) refer to as *prescienc*e. Theoretical prescience can be defined as *"the process of discerning or anticipating what we need to know and, equally important, of influencing the intellectual framing and dialogue about what we need to know"* (p. 23) to enlighten both academic and reflective practitioner domains.

Colquitt and George (2011) argue that significance, novelty, curiosity, scope, and actionability are five useful criteria for choosing research topics. Thus for this study, apart from the above criteria, the most pressing issues

must cause the researcher to question conventional assumptions (exposing their flaws) and demand immediate intervention through innovative theories and recommendations. But one must be proactive, after all, to effectively affect contemporary social-economic and global health discourse. Major issues are urgent, burning and pertain to the sustainability of environmental, health, socio-economic and some political matters with broad implications (Ahen & Zettinig 2015b). These essential theoretical and empirical questions, according to Meyer (2004) and Roberts and Dörrenbächer (2012), are among the major trajectories of future IB research that clearly need attention. Of all the concerns about the sustainability of global health, the most important dimension we are ultimately trying to save or sustain is the human population and the spread of health risks across borders in the era of globalization. Science and globalization affect global health policy (Drori, Meyer, Ramirez & Schofer 2003), which in turn affects international business (Labonté & Gagnon 2010). Everything concerning the international nature of human health is therefore worthy of a deeper analysis in terms of its nature, causes and 'the causes of the causes' (Krech 2012, 279), as well as all the market and regulatory institutions surrounding them. Different actors have the responsibility to make this happen.

The concept of corporate [social] responsibility, C[S]R, transcends the compartments of several disciplines including law, economics, political science, international relations, macro-sociology, IB and management studies, global health, and anthropology. This immediately explains why there are different theoretical lenses and ontological and epistemological variations in the way the notion is conceptualized. This dissertation is a conscious attempt to intellectually break free from what Frederick (1998) refers to as the 'CSR trap' by problematizing some of the fundamental assumptions, especially those that seek to generalize CSR issues without the minimum understanding of the socio-political, economic and historical intricacies of the WECS African context.

In $CSR_{1\text{-}3}$ the concept is more about everyone knowing the right answers about what firms ought to do and researchers offering normative prescriptions: in CSR_1, their moral obligations; in CSR_2, corporate responsiveness; in CSR_3, acting with integrity and moral rectitude. For Frederick (1998), this way of theorizing has lost steam since little else is emerging out of these considerations. In part this is probably due to the silo knowledge it produces which has little or no connection to major global problems or emerging ones, especially to those of a medico-techno-scientific nature. Perhaps in a more revolutionary sense, Frederick (*ibid.*) proposes a Kuhnian approach (Kuhn 1970) by arguing that there is an urgent need for a paradigm shift due to inadequacies in CSR theorizing, especially when the traditional problems (for our purposes) such as affordability and accessibility of drugs are giving way to new emerging inter-

national problems of more complex and sophisticated, technical, socio-economic, and political nature. Such problems include terrorism, environmental problems, and a network of sophisticated criminals employing technologies and underground grey markets to ply their trade in counterfeits. All these are also entrenched in human values and meaning to life (Scott 2014). For Reynolds and McKee (2010), criminal activities in international business are a *"neglected contributor to avoidable ill health"* that has a direct effect on global movement of factors. This clearly shows that research from the CR perspective has much to contribute to and gain from a cross-disciplinary, interdisciplinary, or multidisciplinary work (Frederick 1998), especially where it keeps abreast of contemporary issues of global nature (Roberts & Dörrenbächer 2012). Research of this type however is scant. Hence, any analysis that focuses on only one actor misses out on a deeper understanding of underlying explanations especially in the pharmaceutical sector.

This study is important because it touches directly on an aspect of our modern human experience that is going through a wave of medico-techno-scientific and ethical transformation. As a personal responsibility, it would be a disservice to the academic community and society as a whole not to consider the purpose of the different healthcare actors in improving global health through field studies. This is because field studies help to obtain deeper insights that will be applied to induce change, rather than being part of the 'methodolatry', for the sake of gathering facts just to participate in the institutionalization of irrelevance (Bennis & O'Toole 2005). For our purpose, and in agreement with Shim, Bodeker and Burford (2011, 770), *"medicine as a social institution, involves cultural as well as technological aspects; it is a global—or increasingly globalizing—institution. Inquiries on medical transformation, therefore, invite a cultural-institutional perspective in both local and global contexts."* This type of interdisciplinary inquiry has the potential of answering Frederick's (1998) call and offering a meaningful contribution to enrich both CR and IB research, especially where we seek to contribute to the neo-institutional theory (NIT) and value co-creation.

Beyond the above general premises, the following reasons encapsulate why this particular study is worth pursuing:

(i) Basic research makes theoretical contributions to global health by advancing knowledge in internationally related CR, co-creation/co-protection issues, the NIT (DiMaggio & Powell 1983; Meyer & Rowan 1977; Scott 2001), and the resource-based view (Barney 1991; Wernerfelt 1984).

(ii) Unresolved issues in the substantive domain of strategy and GHD have an interdisciplinary nature with the possibility of reaching a

wider academic, industrial and public policy-oriented audience. They belong to the broader domain of sustainable global health, environmental and economic dynamics where domestic and international understanding and pursuit of CR are a central part of current debates (Peng & Pleggenkuhle-Miles 2009).

(iii) There is now an emergence of research that contributes to sustainable development in the African context (see e.g. Bardy, Massaro & Rubens 2013). The context for this research is novel in that there is no known research in IB that looks at this subject from the WECS African context. A rare case is Buabeng (2010) in the field of social pharmacy. The WECS African context is a relevant feature which will produce new insights and deeper understanding for an emerging market frontier with strong potential (Macdonald 2011a; 2011b).

(iv) Finally, the results of the study provide an immediate application for managers, policy makers, health-oriented civil society organizations (hoCSOs) and multilateral organizations. An interdisciplinary insight into the role of global and national healthcare organizations and the power asymmetry between global governors and national CSOs will help explain the dynamics of various intractable global problems, such as the governance of the proliferation of counterfeits, with the NIT (Clegg 2006; 2010).

In summary, the main motivation for this study is that of basic research that fills theoretical, contextual, and interdisciplinary gaps and clarifies confusions on CR and value co-creation as they pertain to global health. It problematizes extant knowledge on one hand and on the other it curiously ventures into an unconventional research context that has for the most part been neglected in the mainstream management and IB research.

1.3 An interdisciplinary research approach in international business and global health

The constant focus on rigor rather than relevance removes researchers from reality "*which is socially and politically constructed rather than objectively determined*" (Aharoni 2013, 17). More specifically, broad-brush generalization-seeking studies sacrifice details through indiscriminate methodological shortcuts. This study avoids such an error by studying the socio-cultural and institutional reality of global health governance. This interdisciplinary study is mostly based on qualitative data. Evidence of the interdisciplinary nature of this study is found in (i) the substantive domain—global health; (ii) the refer-

ence list of literature from diverse fields; and (iii) the triangulated sources of data for the empirical work. There are no hard and fast rules for studying the extremely complex nature of institutions in the context of global health. Therefore, the underlying concepts and constructs such as power, CR, value co-creation and institutional arrangements such as CSSIs and GHD are studied from the interdisciplinary perspectives using multiple methods at different stages of the study. The questions that are posed about institutions and the object or subjects of the study determine the appropriate methods for the research endeavor. IB research has since its inception embraced several methodological and disciplinary orientations, as William Dymsza puts it: *"The…underlying methodology should be a matter of indifference and…should be dictated by the nature of the task assumed by the author"* (Dymsza & Vambery 1979, 7). Thus, interdisciplinary and multidisciplinary scholarship is woven into the rich tapestry of IB research (Liesch et al. 2011).

A multidisciplinary (multi, meaning many) approach differs slightly from an interdisciplinary (inter, among) approach. The former comprises several successive research endeavors conducted separately, without a conscious attempt to fuse them by synthesizing their connectedness and the new knowledge they can create (Cantwell & Brannen 2011; Cheng, Henisz, Roth & Swaminathan 2009). In other words, multidisciplinary research is additive by nature since little attempt at mutual integration is made. The opposite is true for interdisciplinary research, as is the case in this study. Nonetheless, some experts use these two terminologies interchangeably (e.g. Dymsza 1984).

A study about Big Pharma's strategies (whose contents and processes are characteristically informed by science and technology) and their interface with socio-economic and institutional actors (governments and international organizations) within the context of transitioning economies is by nature very complex. First, there are several epistemic linkages which make the strategic and political processes of firms, NGOs, multilateral institutions and host governments difficult to explain without recourse to the synthesis and integration of multiple theoretical frameworks from other disciplines. Hence, a single theoretical lens will hardly yield any intellectually pragmatic value. Second, such intellectual pursuits have been advocated by prominent scholars in the past and most recently (2013) by Cheng, Birkinshaw, Lessard and Thomas in their call for papers on a special issue, specifically on interdisciplinary research, in the Journal of International Business. In addition, several academics have emphasized the potential to sustain and create linkages between the health sciences and social and economic sciences (see e.g. Lethbridge 2011; Rosenfield 1992).

Therefore, recourse to a multi-/interdisciplinary approach is neither a stylistic nor a trivial enterprise. It is a serious search for higher impact, across-the-board relevance and rigor through methodological triangulation (also called cross-validation) and theoretical cross-fertilization (Lethbridge 2011). Such a process helps to draw inferences from other studies in ways that allow for generalizable applications. That is because the convergence of several levels of complementarities creates synergies worth exploiting in search of convincing explanations, and offering rich details and generalizable conclusions (Coviello & Jones 2004; Shadish 1995).

Although an interdisciplinary approach is a useful methodological strategy, it is not without practical challenges. This is true especially when the project is not a collaborative work (though that is no less challenging). That notwithstanding, the conceptual and methodological integration (Stokols et al. 2003) helps to advance theory whilst offering policy recommendations for social use. As Bello and Kostova (2012, 539) put it, this helps to *"identify overlooked antecedents and consequences, reveal various ambiguities, and issues which have been inadequately addressed."* The result is a coherent and insightful conclusion that makes a meaningful contribution. For this study, I take a cue from Nobel Prize winner Douglas North's (North 1990) style of inquiry (albeit nowhere near his contribution). He pursued an integrative research approach in which the socio-political and economic analysis of the co-evolution of institutional change and economic performance and their legal implications formed the basis of the work. This study also builds on recent contributions on the co-evolution of corporate strategies and institutions (Lewin & Kim 2004; Peng, Wang & Jiang 2008).

Following Denzin (1978), an interdisciplinary research may apply two main approaches: (i) theory triangulation or (ii) theory amalgamation. In the first case, the researcher makes use of one underlying theory as a 'lens' through which a phenomenon is investigated. In the second approach, the researcher focuses on relevant concepts and premises from different theories and combines them into a single framework, which is then used in the investigation of the substantive domain. Consequently, the various diverging perspectives are synchronized to allow for conclusions to be drawn. I employed the second approach, given the cross-cutting and intertwined nature of sustainable global health governance, value creation and institutions in the diverse disciplines that were combined for the study.

1.4 The structure of the thesis

This thesis comprises four sections: (i) the introductory part (Chapters 1-5), (ii) the methodological part (Chapter 6), followed by (iii) the results and discussion (Chapters 7-9), and (iv) the research articles. After the introduction (Chapter 1), Chapter 2 sets out the research context and central research questions as well as details the interdisciplinary positioning of the study. Chapter 3 analyzes the orientation of SCR in value co-creation with the emphasis on the foci and loci of strategic decision making. Chapter 4 conceptualizes value and values as applied in global health. Chapter 5 analyzes the role of global health actors in extant literature. Chapter 6 outlines the philosophical considerations underpinning the theoretical and conceptual choices in the study as well as contains the research design and the methodological choices for the research articles. Chapter 7 pulls together all these articles in conclusions and discussions in a mutually reinforcing manner. Chapter 8 contains the empirical evidence from the pilot research project that was conducted in the early stage of the study: the case of the LaGray Chemical Company in Ghana. Chapter 9 outlines the policy and managerial implications as well as the theoretical contribution and suggestions for future research.

2 RESEARCH CONTEXT AND CONCEPTS

In this chapter I provide the definition of the major concepts used in the study. Additionally, I present the arguments that motivate the study, lay out the existing gaps in the extant literature on CR and problematize the governance of global health in transitioning economies. This is followed by the central research question, the objectives and the interdisciplinary positioning of the study.

2.1 Definitions of concepts

For this study, the *corporation* is defined as "*a fictitious legal person that is endowed with many of the functions of a human being. It can possess property, it can incur debts, it can sue and be sued and it can be criminally prosecuted, fined, and in theory, dissolved by the federal government*" (Chandler & Werther Jr. 2014, 250). Although corporations have neither souls nor bodies and can do as they deem fit, they are governed by humans. They can therefore be held accountable for irresponsible behavior. Given the centrality of human agency, then, CR cannot be restricted only to profit-making organizations but also to non-profit-making organizations who employ either political or social logics (i.e. governments or NGOs, respectively).

Porter (2010, 2477) defines *value in healthcare* as *"the health outcomes achieved per dollar spent."* He further argues that only when this becomes the overarching goal can all the actors in the healthcare system be united around the consumer. Further, with the improvement of value come benefits for all: patients, payers, providers, etc.—leading to sustainable health.

> *Value should always be defined around the customer, and in a well-functioning healthcare system, the creation of value for patients should determine the rewards for all other actors in the system. Since value depends on results, not inputs, value in healthcare is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge. Nor is value measured by the process of care used; process measurement and improvement are important tactics but are no substitutes for measuring outcomes and costs.* (Porter 2010, 2477)

In this study, *value co-protection* is defined as actual values-based behaviors (responsible strategies), involving collaborative processes, aimed at minimizing the probability and magnitude of undesirable health outcomes, and simultaneously increasing the probability and extent of desirable health outcomes within certain time, space and institutional contexts.

2.1.1 From traditional CSR, strategic CSR, corporate responsibility and responsibilization to strategic corporate responsibility orientation

Before introducing the main thrust of the concept of SCR orientation and the supporting thesis, I will first make some clarifications on traditional concepts such as social embeddedness, CR and CSR as used in the extant literature. The rationale for this is to shed light on the novelty, conceptual relevance and most importantly the distinctiveness of SCR orientation from the other CR-related concepts.

First, *social embeddedness* refers to a firm's involvement in economic and political processes and networks of non-market actors in its operational milieu (Badry 2009), through non-market strategies in the quest to effectively manage legitimacy (Suchman 1995). In contrast to the operationalization by the Industrial Marketing and Purchasing Group, this social embeddedness transcends the purely business network of the buyer–seller dyadic relationship (Forsgren, Holm & Johanson 2005) and encompasses an involvement and sensitivity to the prevailing local non-market institutional problems (Gifford, Kestler & Anand 2010; Reimann, Ehrgott, Kaufmann & Carter 2012), such as the counterfeiting of pharmaceuticals.

Second, *CSR, or traditional CSR* as used in this thesis, however, refers to the socio-ethical, economic and discretionary responsibility of the firm as in Carroll's (1979) often-cited classic work. This definition then includes philanthropy and public relations and what firms ought to give back to society. The *broader term CR*, now in common use, leaves out the 'S' (social) and is not a mere semantic simplification but an attempt to see the firm/organization as part of society and that its socio-economic, ethical and environmental actions must be in congruence with society's expectations (see for example Rivoli & Waddock 2011; Sundar 2013). *SCR orientation*, on the other hand, goes beyond the 'shared value' *strategic CSR* hypothesis (Porter & Kramer 2011) to argue that firms should not only create value when it makes business sense. Rather, on the basis of deontological ethics (Bowie 1999; Kant 1964; Lin-Hi & Müller 2013) value creation must simultaneously seek to protect value in all of the day-to-day actions of the firm in the socio-economic, political, environmental and ethical arena. This is achieved by seeking innovative ways to

solve global problems and by *'avoiding public bad'* now and in the long term—that is, by aiming at sustainability (Lin-Hi & Müller 2013). The underlying premise for SCR orientation is that the instrumental or strategic posture of the firm is not in any way divorced from the firm/organization's ethical foundations. Thus, SCR orientation eschews the needless dichotomy between ethics and strategy but embraces a harmonious synthesis of the two, leading to responsible actions for sustainable outcomes. The reason for SCR orientation is fundamental to what the concept does and what it seeks to achieve in defining what the organization is. As Stephens and Cobb (1999, 22) posit: *"To ignore the normative component risks facilitating change without serious consideration of its ethical bases and ramifications; to ignore the technical component risks failing to facilitate change altogether."* Nielsen (2003, cited by Tsoukas and Knudsen, 2003, p. 27) stretches the above notion further by arguing that *"just as it is not possible to have an organizational form without an at least implicit ethical or normative foundation, it is also not possible to actualize social ethics without an organizational form [and all organizations require strategy]"* (emphasis added).

SCR orientation is broadly defined as a proactive integration of CR into strategy through the employment of dynamic capabilities (Eisenhardt & Martin 2000; Zollo & Winter 2002) to innovatively create and protect value that is historically, institutionally and contextually relevant (Ahen & Zettinig 2013; 2015a). Here, SCR orientation is not meant to explain only the responsibility of the firm (MNCs and SMEs) to both create and capture value, but also the responsible role (moral, ethical, economic, and social obligations) (Carroll 1979; 1991) of all non-market actors: governments, multilateral or hybrid organizational bargaining models (global governors), and NGOs. For this study, I also include criminal (fundamentally irresponsible) organizations whose business models are intrinsically unethical: that is, they produce solely negative externalities as long as their actions result in profits (Ahen & Zettinig 2011). Their illegal behaviors are, however, no different from organizational crime when viewed from the instrumental CSR perspective (Gond, Palazzo & Basu 2009).

In contextualizing SCR orientation in global health, this study follows Koplan et al. (2009) and Beaglehole and Bonita (2010) in operationalizing *global health* as an interdisciplinary area of basic and applied study and research for global institutional arrangements aimed at improving and sustaining the structural determinants of health. *Global health governance* (aimed at ensuring health for all) here includes the institutional (regulative and normative), political (agenda setting, decision making) and medico-techno-scientific processes for guaranteeing the safety of medications, rational use of drugs, and

international value chain protection from counterfeits by multiple and traditionally unrelated socio-economic and political actors.

2.1.2 Global health and global health diplomacy

> *International health becomes global health when the causes or consequences of a health issue circumvent, undermine or are oblivious to the territorial boundaries of states and, thus, beyond the capacity of states to address effectively through state institutions alone* (Lee, Fustukian & Buse 2002, 5).

Global health has been defined as *"an area of study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide"* (Koplan et al. 2009, 1995). The nature of this domain, given the definition above, means it is not confined to any specific discipline. Beaglehole and Bonita (2010) define global health as *"collaborative transnational research and action for promoting health for all"*; in other words, cross-sectorial collaboration among many nations for research initiatives to provide a scientific basis for policy prescription towards actions that aim at improving the overall equity in health. They further argue that *"global health is concerned with all strategies for health improvement, whether population-wide or individually based healthcare actions, and across all sectors, not just the health sector"*. Whilst some authors make a distinction between global health and public health, Fried et al. (2010) argue that there is no need for such a dichotomy given the centrality of the socio-economic, political and environmental determinants of health (Krech 2012).

Global health as a foreign policy issue that affects international business is also called global health diplomacy (GHD). GHD refers to *"the process by which state and non-state actors engage to position health issues more prominently in foreign policy decision-making"* (Labonté & Gagnon 2010, 1). GHD is structured into six policy domains: *security, development, global public goods, trade (international business), human rights, and ethical reasoning* (Labonté & Gagnon 2010). In a slightly different way, Stuckler and McKee (2008) present global health policy in five metaphors: (i) as a foreign policy (e.g. trade governance and economic development); (ii) as a security issue (fighting counterfeits, bioterrorism and drug resistance); (iii) as a charity (fighting poverty in paradoxically resource-rich countries); (iv) as an investment (maximizing economic development); (v) as a public health issue (maximizing health effect and reducing global disease burden). None of the above categories, however, is mutually exclusive. Ordeix-Rigo and Duarte (2009)

refer to this process as corporate diplomacy, while Hillman (2003) calls these relationships, aimed at acquiring and managing legitimacy in international business (Suchman 1995), strategic political management. For Oliver and Holzinger (2008) these firm–government–stakeholder interfaces (Maguire & Hardy 2006) are referred to as corporate political strategy. Aharoni (2013, 18), on his part, defines 'political strategy' as when managers concentrate on "*getting benefits from the government rather than on getting competitive advantages in the marketplace.*" This also shows how businesses attempt to use their corporate political power as organized interest groups especially in weaker institutions to achieve their aims. Organizations/firms are in turn affected by both governments and other context-specific factors (Aharoni 2013).

Oliver and Holzinger (2008) postulate that the efficacy of a political strategy is a function of the firms' dynamic political management capabilities. They propose four firm-level strategies which are employed in the effective management of the socio-economic environment of the firm: proactive, defensive, anticipatory and reactive. These, they explain, are how specific dynamic political capabilities are employed. The above major lines of explanations are further delineated into two main sub-domains: (i) who are these international organizations (IOs), and (ii) are their specific roles directly or indirectly connected to global health in transitioning economies?

Major health-oriented non-market actors within business–government–NGO interactions now feature international institutions and global governors. The archetypical examples of such actors include the International Monetary Fund (IMF), the United States Pharmacopeial Convention (USP), the World Bank (WB), the World Health Organization (WHO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United States Agency for International Development (USAID), the World Trade Organization (WTO), Centers for Disease Control and Prevention (CDC; Atlanta, USA), and the Food and Drug Administration (FDA; USA). They are formal actors in the bargaining model where non-market strategies are currently prevalent (Doh et al. 2012; Prakash 2002; Ramamurti 2001). Muldoon (2005) refers to these types of non-market strategies as corporate diplomacy. Baron (1995) refers to them as integrative strategies, comprising market and non-market decision situations of firms (i.e. negotiation, dialogues, and collaboration), international NGOs (INGOs), governments and multilateral organizations. The non-market strategies are adopted by firms in managing relations with states and other non-market actors. This is also because global health and its attendant problems are situated within public good discourses (where the state is a public sector payer), making the firm–government–NGO nexus a natural pattern of engagement in the firms' co-evolution with its environment. In global health within the context of transitioning economies, there is a thin

line between global governors, hoCSOs, and national governments. For example, hospitals and the dispensaries of the Christian Association of Ghana are the major healthcare providers of the Ghanaian population, especially in rural areas (Buabeng 2010; SPS Strengthening Pharmaceutical Systems Program. 2012).

At this juncture, it is apt to define sustainability which is one of the central concepts of this study. Classically, *sustainable development* has been defined as development that *"meets the needs of the present without compromising the ability of future generations to meet their own needs"* (Brundtland 1987, 16). These needs fundamentally include environmental, climatic, energy, education and health needs. Furthermore, s*ustainability* refers to:

> *The design of human and industrial systems to ensure that humankind's use of natural resources and cycles does not lead to diminished quality of life due to either losses in further economic opportunities or to adverse impacts on social conditions, human health and the environment* (Mihelcic et al. 2003, 5315).

For this study, I operationalize *sustainable global health governance* as a complex set of market, institutional and medico-techno-scientific mechanisms aimed at creating, coordinating, improving and sustaining (long term) the structural determinants of health worldwide through public, private and multilateral politics, research, regulations and decisions.

2.1.3 Transitioning economies of West, East, Central and Southern Africa

There is no generally accepted definition for developing or emerging economies and *"it is fair to say that the world has changed so much that the terms 'developing countries' and 'developed countries' have outlived their usefulness"* (Gates & Gates 2014, 6). The differences in definitions are due to the many socio-economic and institutional factors that are taken into consideration by the classifying bodies. Economic and governance differences between countries with low or middle levels of gross national product (GNP) per capita are the main criteria. This rapidly transitioning category of low and middle level GNP includes most countries in Africa, Asia, Latin America and the Caribbean (WB 2011). The developing/emerging economies of Africa are drug markets with a mainly small and not fully developed drug industry of their own. They have a population consisting of a combination of higher income, lower-middle income, and vulnerable low-income segments [i.e., compressed effect of development (Ahen 2015a; Whittaker, Zhu, Sturgeon, Tsai & Okita

2010)]. That notwithstanding, such economies in Africa especially have high growth potentials, growing GNP per capita (Bandyopadhyay 2001; Nwankwo 2012), and governments that are swiftly dismantling trade distortion policies to allow for an increased volume of trade in all sectors of their economies (Begg, Fischer & Dornbusch 2005; Hoskisson, Eden, Lau & Wright 2000). For Hoskisson et al. (2000, 249):

> *Emerging economies are low-income, rapid-growth countries using economic liberalization as their primary engine of growth. They fall into two groups: developing countries in Asia, Latin America, Africa, and the Middle East and transition economies in the former Soviet Union and China.*

That is to suggest that developing and transition economies are part of the domain of emerging economies. From a global health perspective, Fan and Liang (2012, 34) postulate that *"emerging markets refer to countries with rapidly growing but still developing economies with growth in variety of sectors including health and medical care."*

To put pharmaceutical business operations in developing/emerging countries into perspective, I propose an operational definition for these economies. In this study, the fundamental reason for using the term *transitioning economies*, instead of concepts such as emerging, developing, or transition economies, is that these economies are undergoing a period of rapid structural transitioning into democratic governance-based models and seeing continuous reforms in their market and institutional underpinnings (Ahen 2012; Radelet 2010). This is characterized by a metamorphosis from the 'outsiderness' into a very steady and rapid integration in the global market and institutional arena. The above fundamental institutional changes are the prerequisites for sustainable economic development and not economic growth per se (Easterly 2006; Rodrik 2008). Therefore, no other label will sufficiently explain the transmutation of these economies into contemporary governance and institutional maturity in their quest to adapt to an increasingly dynamic and turbulent world economic system.

Thus, within the limits of this conceptualization, the WECS African markets qualify as transitioning economies given their rapid economic growth and the accompanying institutional changes. For example, the demographic map of the world has now been completely redrawn, with Africa being the youngest continent on the planet as opposed to the aging populations in the West and Japan. Life expectancy in Africa has risen significantly from a mere 41 to 57 (or to 61 without disease epidemics) (Gates & Gates 2014). According to the IMF's most recent World Economic Outlook the African economies in general

are experiencing a steady growth (IMF 2015). Moreover, in recent years the number of African MNCs has increased significantly (Ibeh 2013). This also means that the growing middle class, with exponentially rising incomes is demanding quality pharmaceutical products. Nevertheless, Africa still has a very high disease burden compared to the other regions in the world (IFC 2008). This presents a myriad of paradoxes worth investigating from an institutional perspective.

2.2 Problematization: beyond gap spotting

It is argued that simply spotting a theoretical gap is not sufficient for advancing our understanding of underlying issues in research (Alvesson & Sandberg 2011; Sandberg & Alvesson 2011). This is especially true in global health issues where the dilemma lies in values and ethical questions on one hand and strategic and technological issues on the other. Simply spotting a gap hardly questions the fundamental assumptions of extant theories but rather subscribes to them by only incrementally revising and reinforcing their basic premises instead of challenging the existing truth claims. As Kilduff argues *"the route to good theory leads not through gaps in the literature but through an engagement with problems in the world"* (Kilduff 2006, 252). In the same vein, Karran (2009, 20) argues that *"knowledge is created by challenging [with counterarguments or evidence], rather than accepting, orthodox ideas and beliefs, which means that because of the nature of their work, academics are more naturally lead into conflict with governments and other seats of authority."* Therefore, a better strategy for coming up with interesting theories (Davis 1971) is by way of problematization (Sandberg & Alvesson 2011). An example of this is Banerjee (2011), who problematizes the new repressive ways of management by dispossession. Foucault (1985, 9) postulates that problematization actually concerns *"an endeavour to know how and to what extent it might be possible to think differently, instead of what is already known"*, thus disruptively questioning and shedding new light on conventions, in a step towards deinstitutionalizing them and replacing them with innovative ways (Sandberg & Alvesson 2011). The potential inconvenience with problematization, despite its inherent ability to offer interesting perspectives, is that it challenges the *status quo* and the study in question is hard to sell even if it is presented in well-polished, accessible writing.

In keeping with Kilduff (2006), I did what Sandberg and Alvesson (2011) call 'confusion spotting'. I identified an epistemic fault line (Donaldson 2012) in extant literature in which strategy seems to have been separated from socio-ethical (normative) reasoning in the firm's socio-economic and political inter-

face. Correcting such a fault in strategic management and global health research, therefore, requires an interdisciplinary approach. This was the way the foundational Article 1 was framed, through economic philosophical analysis (Sen 1988) and a critical perspective on CR research. Consistent with the Foucauldian strategy, Article 1 not only critiques but also proposes innovative value co-creation as an alternative pathway.

Consistent with Article 1, Article 2 explains how sustainable global health presents an emerging new form of competition in the pharmaceutical industry. This requires a developmental orientation towards answering the questions of sustainable health in the transitioning economies of WECS Africa. Contexts of time, place and the ethical leaning of the entrepreneurial manager then become the central focus. Here, the study problematizes the macro-level analysis of organizational change that ignores the central role of the entrepreneurial manager.

Article 3 explores how complexity and institutional disorientation are managed in pharmaceutical anti-counterfeiting CSSIs. It problematizes the national–global linkages of healthcare organizations and the taken-for-granted nature of institutional logics that create barriers to the optimal functioning of inter-organizational relations in mitigating counterfeits.

Finally, Article 4 is an inquiry into the structural role of the major global health actors in GHD. It problematizes the role of these actors and how the institutionalization of certain behaviors has led to path-dependent outcomes in global health. The overall process of problematization in the study is shown in Figure 2.

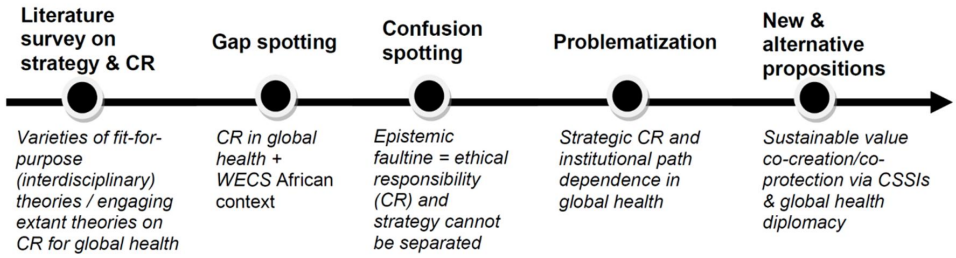

Figure 2 The overall process of problematization of CR, institutions and global health.

2.3 Central research question, objectives and delimitations

The central research question of this study is formally articulated as follows:

Why and how do business and non-business actors in the pharmaceutical sector influence and are influenced by national and global institutions in successfully co-creating and co-protecting value for consumers in transitioning economies of WECS Africa?

The above question is answered through the following four objectives in the corresponding articles:

1. To integrate CR doctrine into corporate strategy with an emphasis on value co-creation and institutional contexts (Article 1).

2. To explain the central role of entrepreneurial managers in strategic organizational renewal and co-evolution of pharmaceutical firms with the institutional environment in ensuring sustainable global health (Article 2).

3. To explain how differences in institutional logics increase the complexity in managing inter-organizational anti-counterfeiting initiatives and account for their ineffectiveness in transitioning economies (Article 3).

4. To investigate why and how path dependence and power asymmetry in the strategic political management of global health influences institutional change in consumer protection against pharmaceutical counterfeiting in transitioning economies (Article 4).

It is always important to define the scope and boundaries of any study (*delimitations*) (Leedy & Ormrod 2005). Despite the interdisciplinary nature of the study, I will restrict myself to the strategic corporate responsibility of business and non-business actors in global health and their national global linkages. Here, I use Ghana's national global linkages as a proxy for understanding global health. The data and theory are set within the boundaries of the pharmaceutical industry and in the context of WECS Africa although the findings are expected to be of significance to the global South as a whole.

2.4 The interdisciplinary positioning of the study

This study connects IB to organization studies, political economy, macrosociology, international relations, global health and ethics. The global anti-counterfeiting initiatives are used as a lens to gain insights into the complex

problem of multi-actor governance in global health. The role of institutional change, power asymmetry and value co-creation in transitioning economies in the context of WECS Africa are central to the analysis. Figure 3 shows the interdisciplinary positioning as well as the theoretical and investigative lenses as used in the study.

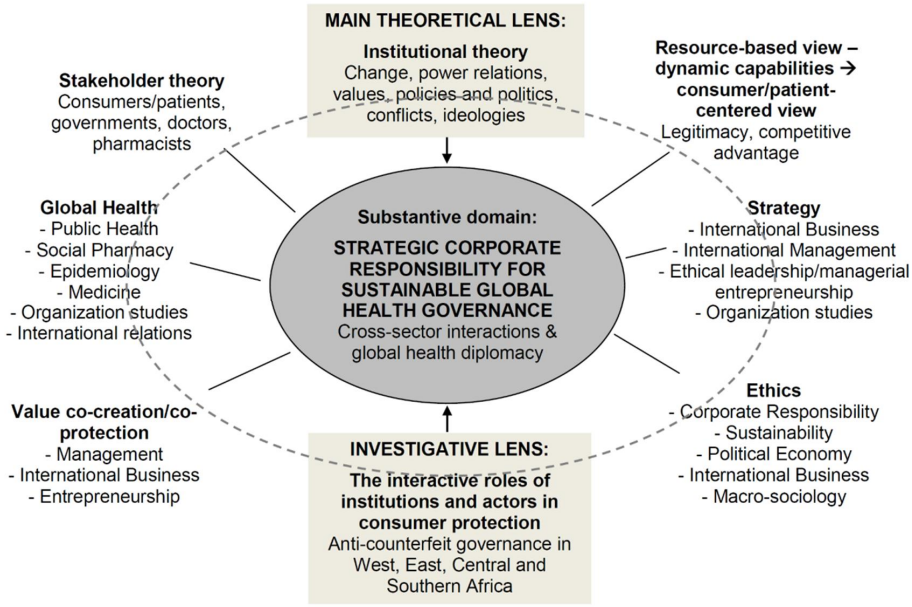

Figure 3 The interdisciplinary positioning of the study. The dashed line indicates the interrelations between the various disciplines and their theoretical foundations.

2.4.1 International business

To suggest that questions of CR and global health contextualized in transitioning economies are characteristically international is probably an unnecessary repetition, but still a crucial point worth making. Moreover, the present study is placed squarely within an interdisciplinary domain since it cuts across diverse theoretical lenses. The above considerations lead us to seek an epistemological consensus on common concerns if relevant theories could be developed without losing sight of the fundamental principles of IB, where CR is a major contemporary issue and a source of major concern for sustainable global health.

First, broadly speaking, the research question is based on the theory that competitive advantage or the lack of it is a determinant factor of the success or

failure of the international firms (Galbreath 2009; Peng 2004; Porter 1990). This leverage should be built on legitimacy, among other variables, that engages stakeholders responsibly (Freeman 1984; Smith 2011). Second, in spite of the negative historical antecedents, there seems to be a promising shift towards a CR-guided philosophy in pharmaceutical MNCs as a result of mimetic isomorphism (DiMaggio & Powell 1983), even though CR practices are in some cases completely detached from the strategy (Galbreath 2009). Third, the above question and objectives subscribe to Peng's (2004) prescription, in response to Buckley's (2002) provocative question about what the big question in IB is and whether the field is getting out of steam. In response, Peng (2004, 99) argued that 'continuity, novelty and scope' should characterize IB research revolving around the question: *"what determines the international success and failure of firms?"* (*ibid.*, p. 106). Here again, the firm-centeredness of IB scholarship is evident despite the increasingly changing role of the firm. I extend this vision for our purpose to the firm–NGO–government interaction to co-create value. The above question, though differently framed, is essentially about how CR from the institutional perspective can be a determinant factor of an organization's success in its value creation process for the society that sustains it. Fourth, the central research question has that 'novel' element in that it is contemporary in nature and welcomes new disciplinary interests and methodological strategies as well as alternative explanations. In essence, how do the answers to these questions help? Or, put differently, what is their value for transitioning economies and the cooperative value creation of global health actors?

Whilst Peng's (2004) response about the success of the international firm sounds interesting and thought-provoking, it does not point out where—the operational milieu (in which institutional context)—when—the temporal dimension (at which historical point)—and in what industry. His objective seems obvious: the provocative question is still open for researchers to answer. What exactly does the firm produce or which service does it offer internationally? Is it arms, tobacco, extractives, pharmaceuticals, computer chips or potato chips? What are the ethical implications and what is the value it creates with and for the society in which it operates? Linking the above reflections to the value co-creation discourse in IB means that it is not only multinational firms' success but also multinational organizations' success in general. This ushers IB into a complex interdisciplinary domain.

I argue that the IB field ceases to be interesting if major socio-ethical issues and the negative externalities produced by firms are not addressed instead of the *"pursuit of making corporations more efficient and profitable"* as Profes-

sor Prakash Sethi recently argued when chastising IB scholars.[3] There are many unexplored issues. However, from its inception, the IB field has developed and gained relevance due to the geographical dispersion of MNCs and the gradual inclusion of international scholars outside the USA who contribute to this area. In fact, early editors of JIBS, for example, sought contributions from fields such as macro-sociology, anthropology, political science and economics. and imported methodologies and concepts to enrich the field. This indicates the interdisciplinary nature of IB in describing and explaining the home country/host country operations of a firm (Liesch et al. 2011). Approaches which go beyond the boundaries of disciplines to accommodate policy makers and managers are needed to find common solutions, make common problem definitions and devise methods to solve them in ways that are congruent with scientific canons and responsive to social expectations. Hence, questions pertaining to cross-border commercial investments or global health threats and specific cultural, cognitive and regulatory differences (Scott 2001) are fundamental to the analysis of global health governance. Such institutional pillars shape the nature of a firm's operations.

It follows that situating CR research in the context of pharmaceutical MNCs and global health governance with non-business actors towards value co-creation/co-protection in IB is an intellectually viable pursuit. The quest to broaden the 'narrow vision', as Sullivan (1998) puts it, and to allow for innovative linkages (Sullivan & Daniels 2008) of multiple paradigms (Kuhn 1970) will offer brighter, more hopeful future grounds for the IB field to thrive (Terpstra 1973). This is because such an approach will help bridge the macro-level analysis with micro- and meso-level analysis in order to shed light on complex issues in global business, especially in the pharmaceutical industry within the virgin contexts such as WECS Africa.

2.4.2 Institutional theory and the neo-institutional perspective

Institutions are diverse; therefore, context matters in any meaningful analysis of economic agents and organizations acting in international business. For further insights into how differences in institutional environments affect economic and social outcomes, see Aguilera and Jackson (2003), Hall and Soskice (2001), Husted and Allen (2006), North (1990), Oliver (1996), Scott, Ruef, Mendel and Caronna (2000), and Scott (2001). There are several perspectives of institutions when studying international business and non-business organizations. There is the micro-perspective (Ostrom 1990; Zucker 1977; 1988),

[3] Prof. Prakash Sethi: Reflections on the AIB annual meeting in Istanbul, July 3-6, 2013

and the transaction cost and evolutionary economics perspective (mainly Williamson 1975). I will somewhat confine myself to the macro-perspective of institutions since the issue under consideration is a global phenomenon. Generally, institutional analysis comprises three major paradigms, namely: (i) rational choice, and (ii) organizational and (iii) historical institutions. For further discussions on this, see Campbell (2006; 2007) and Scott (2014).

Following Scott (2014), I offer reasons why institutional theory merits special attention, especially in the study of CR and global health. Institutional theory is a 'fit-for-purpose' framework for studying and posing provocative questions about the way organizations behave and work, inside and in relation to the outside world. This framework helps to unravel issues pertaining to the reasons why moral obligations are either pursued or ignored by organizations, considering the role of individual actors in enacting strategies. Further, according to Scott (2014), this institutional framework also helps to connect the micro- and the macro-levels of social structures whilst linking the past and the contemporary, and acting as a tool for understanding the probable future (Bell 2003). Most importantly for our purpose, institutional theory connects multiple fields in the socio-economic sciences, allowing for a rich interdisciplinary study and understanding of social phenomena. Such interesting fields include global health and CR pursued by diverse IOs.

For the early theorists of institutions, such as Philip Selznick (1948), in their basic form, institutions are products of organizations. By distinction, Selznick (1948, 25) argues that organizations are the *"structural expression of rational action."* In a more detailed analysis of Selznick's work, Scott (2014, 24) articulates an organization as a *"mechanistic instrument designed to achieve specific goals."* He further describes organizations as adaptive, organic systems whose configurations are shaped by the social characteristics of the individuals constituting it and the pressures from the wider environment in which it is embedded. These mechanisms that are created to achieve specific outcomes are, in diverse degrees and over time, transmuted into institutions. The process termed 'institutionalization' is therefore constrained by the context, historical framing, preference functions, values, and the vested interests of agenda-shaping individuals—all hinging on the unanticipated outcomes or consequences of purposive social action. Essentially, to institutionalize therefore is *"to infuse with value well beyond the mechanistic and technical process of organizational routines"* (Scott 2014, 24).

Old institutional economics (OIE) (Commons 1931) and new institutional economics (NIE) (Meyer & Rowan 1977) are the products of dissatisfaction with the orthodox micro-economics, which is less concerned with the basic role of institutions (Coase 1988; Groenewegen, Spithoven & Van den Berg 2010; Scott 2001; 2014). As Groenewegen et al. (2010, 367) paraphrase, OIE

assumes that *"firms are just production functions in a sea of market transactions."* Thus, neo-classical economics ascribe no specific role to institutions, thereby risking becoming an 'animal theory', as Coase (1988) puts it. This is because humans and snakes, octopuses and monkeys all have preferences aimed at maximizing their utility. Mainstream economics consists of formalized doctrines which ignore the socio-cultural cognitive and normative basis for all human interactions in the real world (Scott 2001). The OIE founders include such pioneering intellectuals as Commons (1931; 1934) whereas the NIE founders include Coase (1937; 1960), North (1990) and Williamson (1975). However, they all built on the shoulders of other preceding intellectual insights. Thus, the evolutionary track of the institutionalization of institutional theory (Tolbert & Zucker 1996) has its genesis in the early works of social science (e.g. Weber 1924, 1968) and addresses issues pertaining to conflict and change (Scott 2005), which are the two major constants in socio-economic interactions. The works of Elinor Ostrom, for example, emphasize context, institutional complexity and the need for an evolutionary learning approach to the changing nature of institutions (Frischmann 2013), which is very much applicable in the global health discourse (public good). A closer look into the distinct nature of Ostrom's works, however, demonstrates that they do not fall clearly within the OIE or NIT, especially when they espouse governance systems of the commons.

On the spontaneous appearance of institutions, how they dissipate and are replaced, the seminal work of Oliver (1992) on deinstitutionalization presents a comprehensive account. More to the roots, the foundations of all institutions always go back to the actors' historical, socio-cultural and philosophical tribes and belief systems—institutional logics (see Friedland & Alford 1991; Meyer & Rowan 1977; Thornton & Ocasio 2008).

This section discusses the institution-based perspective, as used in the international business strategy of the firm (Peng et al. 2008), to understand how responsible strategies are enacted in governing big questions such as global health. Institutions are diverse in different nations and regions due to the socio-political and cultural environments which shape them (Ahen 2012; Hall & Soskice 2001). These evolutionary mutations of institutions are defined as the *"fundamental and comprehensive changes introduced to the formal and informal rules of the game that affect organizations as players"* (Peng 2003, 275). Scott's (2001, 48) definition of institutions is employed in this work, *"cultural-cognitive [institutional logics], normative [type of actors and organizational models] and regulative elements that together with associated activities and resources, provide stability and meaning to life."* Thus, institutions are the rules of the game of a society or the humanly desired constraints that structure the interactions of the members of a society. They consist of formal

rules (e.g. common law as used in most commonwealth countries) and informal systems such as norms, traditions and values of human behavior, deriving from the local culture of self-imposed guidelines for conduct and the enforcement characteristics (North 1990; Scott 2001). Organizations are rather the players of the game (e.g. education, law enforcement, etc.). The terminologies are sometimes used interchangeably since the gap between the state apparatuses such as the courts, law enforcement agencies and organizations is blurred. Nevertheless, institutions are different from organizations (Scott 2014). On NIT and strategy in emerging economies, Doh et al. (2012, 1) argue that *"the integration of institutional and strategic perspectives provides a logical path for the continued development of non-market strategy research going forward."* This is because firms need to adapt their strategies to these new contexts while investing in new business models in their interaction with non-market actors, such as governments and NGOs.

This study is positioned to make a theoretical contribution to CR at the micro- and meso- (the organizational) levels of analysis, and to the NIT at the structural level. The NIT captures these three dimensions comprehensively in terms of the way institutions serve as behavioral templates, cognitive scripts, and constrain the actions of managers and policy makers in different institutional contexts (DiMaggio & Powell 1983; Meyer & Rowan 1977; Scott 2001). Certainly, the entire dimensions above have a historical pattern since there is always a path dependency under the favorable conditions of increasing returns (Augier & Teece 2008; Teece, Pisano & Shuen 1997). This approach also helps to explain how pharmaceutical firms react to social and political pressures in transitioning economies in their quest for legitimacy and institutional acceptance, while co-creating value competitively.

Argumentation for using the NIT. Instead of the stakeholder theory (Donaldson & Preston 1995; Freeman 1984), I build on and integrate NIT into the GHD discourse given the limited explanatory power of the stakeholder theory. More to the point, not all stakeholder issues are public issues and not all public issues are stakeholder issues (Clarkson 1995). For example, Kantanen (2007) in her study of Finnish universities and stakeholder dialogue argues that universities have the responsibility to offer high quality education to students while fulfilling contracts with the Ministry of Education. She, however, questions the appropriate use of CR thinking in the public sector if not through the stakeholder empowerment and dialogue. In the present study, however, the CR concept finds home both in the public sector and in the third sector (NGOs). This is because of their blurred roles and sometimes strong collaboration with firms in providing health outcomes, not only for a small group of individuals with a direct or indirect stake, but for a larger population. This means that unlike individual universities, as in Kantanen's study, the

concept of CR can be extended to the education sector as a whole. First, this is because education is a public good. Second, education involves policies and public resource allocation. Third, education is not limited in scope as a stakeholder issue. The same logic holds for the health sector. Thus, CR applies to all organizations whose roles evoke public interest. The issue at stake is a global public health issue because it has public policy implications and therefore it evokes legislative/regulatory attention. This is why the NIT applies here for the analysis at the structural level. Further, stakeholder theory does not fit well within the wider framework of analysis when the pharmaceutical firms and global health organizational discourse are central to the complex questions of value creation at multiple structural levels. That notwithstanding, at some level of analysis, stakeholder theory has been used to enrich the study.

Additionally, an alternative way of theorizing and articulating major contemporary global concerns, using the institutional lens where power and ideology shape discourses, is long overdue (Jack, Calás, Nkomo & Peltonen 2008). Here, this is achieved by questioning, challenging and explaining new issues in new institutional contexts. In the light of the above, the NIT becomes an extremely useful lens for connecting theory and empirical realities, especially in turbulent times such as these when power and agency in institutional analysis matter (Clegg 2006; 2010).

The NIT has strong explanatory power to unlock multiple levels of truth structures and facilitate interpretation of socio-economic phenomena, while keeping abreast of contemporary dynamics and how change is initiated, implemented, resisted and punctuated by key events. The institutional theory, seen from both economic and sociological perspectives, helps to capture the rules of the international business game in the context of the pharmaceutical industry. It helps to unravel the available incentive structures for the actions of a firm and its relationships with other economic and non-economic agents (North 1990; Peng 2003).

While attention has been paid to CR in firms, little is known about the institutional matrix which constrains or enables certain strategic outcomes. Current research on CSR in pharmaceutical firms operating in transitioning economies lends itself to a new form of intellectually stimulating and robust theorizing in the NIT (Aguilera & Jackson 2003; Campbell 2006; Matten & Moon 2008). The institutional perspective becomes increasingly important due to the systemic regulatory and normative dynamics and market turbulence across the globe. Hoskisson et al. (2000) underscore the importance of the institutional theory in the study of firms' operations in developing economies. They also recommend agency theory, transaction cost economics and, finally, the resource-based view, although they say little on the deficiencies of these theories

when ethical questions and CR, corporate culture and firm–host-government relations are raised (Scott et al. 2000; Thornton 2002).

Moreover, the present study emphasizes the role of the entrepreneurial managers and the dynamic capabilities in different institutional contexts (see Article 2). I employ different aspects of the definitions of Eisenhardt and Martin (2000) and Teece and Pisano (1994) to provide an initial point of departure for the analysis of the interface of a firm's capabilities and institutions as well as the institutional logics (Thornton 2002) which inform the values-based managerial decisions and actions in the pharmaceutical sector. For Aguilera and Jackson (2003), institutions shape the ways in which organizations respond to day-to-day social and environmental issues. Organizations are therefore political actors, as Scherer and Palazzo (2007) assert, especially in transitioning economies where there may be some institutional deficiency. Such institutional voids, in turn, constitute real challenges as well as opportunities for actualizing CR within various regulatory (formal governmental legislature and the extent of their enforcement) and normative contexts (industry rules of the game) (Ahen 2012). The discussions that follow demonstrate how CR is enacted in diverse institutions and sectors by economic agents and social actors.

2.4.3 Research in the corporate responsibility field

For Aharoni (2013, 18) strategy *"is not about gaining competitive advantage in an industry but about creating a monopoly in a well-defined niche…strategy is about being an outlier and being unique—not about being part of the herd"*. This is a business-centric perspective of strategy. For Johnson and Scholes (1993, 10), strategy refers to *"the direction and scope of an organisation over the long term which achieves advantage for the organisation through its configuration of resources within a changing environment to meet the needs of markets and to fulfil stakeholder expectations."* From the latter definition, stakeholders are important for strategy implementation; yet, most of the time for many organizations only the stockholders are the main focus—thus, the organizations relegate their responsibilities towards other stakeholders as the least important thing. Nevertheless, that is part of a strategy aimed at focusing on the bottom line of the organization—profits. Moreover, not all strategies are responsibly enacted, but every CR action is strategic in nature.

The relevant question is: is there any CR action that is not strategic? The answer is a resounding 'no', for no firm is a 'Mother Theresa'. Traditional CSR is either an offensive strategy to gain reputation or a defensive strategy to

avoid losing face, as Vogel (2005) argues, in a world where legitimacy matters and in some cases amounts to a competitive advantage. Organizations, for-profit or not-for-profit, need legitimacy both in the industry and in the operational milieu. Where regulatory institutions are strong, negative externalities are minimal and firms compete in doing the right thing to avoid the extra cost of sanctions and loss of reputation (Ahen & Zettinig 2013). Simple generic strategies such as product differentiation, product uniqueness due to contextual relevance, research and development (R&D) spending (innovation), and relative quality of products (Chandler & Werther Jr. 2014; Porter 1990) can now be relabeled as CSR practices even though they are normal corporate behaviors. Strategy involves three things: (i) systematic planning that involves human values, choices and trade-offs; (ii) employing resources of principals or the entrepreneur; (iii) seeking some favorable outcomes, not only now but also in the long-term future (Hayek 1945), to satisfy multiple stakeholders (Freeman 1984). With this definition in mind then, all organizations pursue intelligence (March 2006) or strategy, whether they are NGOs, governmental organizations or firms. Therefore, they have socio-economic, political, environmental and ethical responsibilities (Carroll 1991).

CSR is not an 'it' as has been reified by scholars. Rather, we are referring to human behavior on a daily basis that defines an organization's nexus and impact with other organizations and society as a whole. One area where CR and strategy are inextricably intertwined is the pharmaceutical industry (the supply side), and by extension the healthcare sector as a whole. I do not argue that strategy plus CSR equals SCR as do Chandler and Werther Jr. (2014). Rather, strategy is either responsibly pursued both in industry and society, or irresponsibly pursued as a human behavior towards attaining certain outcomes (Ahen & Zettinig 2013; 2015a).

Different conceptions of CR. There are several conceptions of C[S]R. The concept has been shifting between stylistic, conceptual, deceptive, distorted, simplistic and unnecessarily complex explanations. Some authors distinguish between the strategic and political CR (Baur & Palazzo 2011; Baur & Schmitz 2012). Where authors simply offer labels of CR as either political or strategic, citing Milton Friedman (1970), they hardly define what strategy is and how it is entrenched in corporate ir/responsibility or vice-versa. Nevertheless, in agreement with Porter and Kramer (2006, 80), strategic C[S]R is a *"source of opportunity, innovation, and competitive advantage."* This 'harmonistic world-view' (Baur & Schmitz 2012; Ulrich 2008, 402) does not see any controversy between CR and strategy but assumes that it is commonsensical for thriving businesses to honor their social contract (Donaldson & Dunfee 1994) by creating shared value (Porter & Kramer 2011). Value co-creation/co-

protection (Ahen & Zettinig 2011) and value capturing are therefore at the heart of this discourse of strategy and responsibility.

Secchi (2007) offers a taxonomy of CSR theories. He argues that there is the utilitarian group of theories, where the firm exists for the maximization of its utility and where questions of positive and negative corporate externalities and associated social costs become part of the analysis. Further, in the managerial category of theories, challenges in managing a responsible behavior are confronted, based on the internal credo, core beliefs, vision, mission and strategies of managers. Using systems thinking, the perception of managers with political power plays a decisive role in framing what matters and where resources must be expended (Maon, Lindgreen & Swaen 2008). Motives for CR may differ internationally. Kuada and Hinson (2012), in comparing the motives and drivers of CSR in Ghanaian local and international firms, found that CSR in foreign firms is guided by the need to conform to legal instructions, whilst the local firms are guided by discretionary and social motives. This suggests that the local firms tend to meet the social expectation that the wealthy should help the less privileged. Finally, the relational theories are centered on the firm's interface with the constituents in its environment. This latter is not very different from the stakeholder theory (Freeman 1984).

The political conception of C[S]R focuses on the power of MNCs in their operational environments, especially in emerging economies and how firms employ this power to influence socio-economic and political agendas (Scherer & Palazzo 2007; Scherer, Palazzo & Baumann 2006; Walsh, Weber & Margolis 2003; Wettstein 2009). As Bonardi (2011, 249) puts it:

> *In political markets, suppliers of public policies (e.g. politicians and bureaucrats) will not benefit from competition among demanders in the same way that actors in economic markets will benefit. In effect, a critical dimension of competition in economic markets is to foster differentiation, especially through innovation.*

Where does all this lead us?

> *The most valuable benefits that firms or interest groups can provide to policy-makers, in the context of political market competition, are not differentiated products but rather relatively homogeneous sources of support. Quantity or volume might therefore be more important in political markets than differentiation or innovation [in markets].* (*ibid.*)

Furthermore, questions and theory building in CR have thus far failed to recognize and incorporate emerging socio-economic view points and natural

sciences into the discourse of their problem domains, even when there are considerable linkages that may lead to better and more profound understanding of underlying issues.

Another premise according to Frederick (1998) is that ethical philosophers' near chauvinistic zeal towards 'non-contextualist abstraction' dwells very much on issues of human conditions of the past centuries, although the problems at stake have evolved significantly. In addition, Frederick argues that much of this discourse in CR has more or less been antagonistic to business in the form of preaching what ought to be done by businesses. This has not been of great relevance to managers and policy makers or scientists since such prescriptions involve a cycle of 'normative referencing' (implying the continuous invocation of ethical responsibility) (Baron 2001; Mitnick 1993) that needs to be merged with the positive CR, especially when pharmaceutical firms and government face a daunting task of re-evaluating measures, policies and strategies with the sustainability of all these in mind. What is important here is that much of the responsibility is always shifted to the firm, even though there is inherent human opportunism in organizations (whether they are business or socially oriented, or hybrid) that can conduct them towards irresponsible or socially unethical actions. This in part is the reason for the failure of aid money for healthcare and other development work (Bougrine 2006; Rashid 2006; Williamson 2010). This leads us to the question of responsibilization.

2.4.4 Corporate responsibility or responsibilization?

Fleming and Jones (2012) argue that "*CSR never really began*" (p. 1) in the first place since neo-liberal capitalism actually favors those it has been favoring—by privileging the rich, at the expense of the 'others', the politically powerless and marginalized in society—irrespective of the socio-economic and environmental consequences (Banerjee 2007; Fleming, Roberts & Garsten 2013). Firms achieve this through the neo-liberal economic apparatus and ideology by making corporate misbehavior almost invisible to any radical stance, alternative (Prasad & Holzinger 2013; Shamir 2004), or antithesis (Fleming & Jones 2012; Prasad 2013). Consider the following illustration. In recent years there have been public debates which tend to suggest that consumers are solely responsible for the protection of sensitive data on their computers. Can the same logic hold for the healthcare sector? I will start this section with a typical contemporary health problem. Who is responsible for the medical condition of obesity? Is it the government, the media, the fast-food companies, or the patient? Irrespective of one's political view, a more pragmatic explanation will lead us away from pinpointing any actor as being solely responsible. All the

above actors do have a responsibility when we analyze the phenomenon through the framework of the structural determinants of health (Krech 2012). A complex web of factors such as genes, the climate, the socio-cultural, economic, political, environmental, and relational circumstances of an individual defines his/her health status in general. However, within the context of obesity, many policy prescriptions have been given that hardly fix the problem. Such prescriptions (‘*dos and don’ts*’ for consumers: exercise more, eat healthily, etc.) assume that the patient/consumer is responsible for his/her health problems and this mostly relieves the corporations from their responsibility. Whilst these are useful demand-side recommendations, they hardly deal with the foundations of this problem of obesity. But what are the foundations of this problem? A recent article by De Vogli, Kouvonen and Gimeno (2014) argues that deregulation has led to significant market concentration of food and drink companies who now operate mostly in oligopolies with enormous political power to lobby and swerve regulations to change them. They offer mostly over-processed foods which led the authors to conclude in their extensive study that countries with highly deregulated markets have a population with much higher body mass.

We now move from CSR to a higher level of abstraction by deconstructing the concept of responsibilization (Shamir 2008), which seems more appropriate to cover all the business and non-business actors and the current order CR governance as applied in this study. The gist of Shamir’s (2008) contribution is that the blurred nature of markets and politics is due to the moralization of markets and the marketization of politics by way of a new order of private markets of authorities. Shamir (2008) (citing Radin 1996; Strange 1996) argues that by the principles of neo-liberal economics, all state and non-state organizations within the sectors of health, education and security operate like corporations, as if they were implanted in a competitive market environment. On the other hand, managers seek social welfare for their constituents and are engulfed in moral matters where nation states once had a major role. These are subtle mutations but institutionally significant announcements of the changes that follow.

For Winston (2002) and Shamir (2004; 2008), the explanation for the moralization of markets lies in the enormous pressure from consumers (Kozinets & Handelman 2004), stakeholders (Campbell 2007), civil society and the NGOs for corporations to behave ethically or to display ethical responsibility (Carroll 1979; Frederick 1998) and act as civic corporations (Zadek 2001). Moreover, the neo-liberal state has, to a large extent, retreated from its moral and welfare functions, leaving it for market actors to participate in such political processes. In essence, the state is losing control of its sovereignty and bargaining power (Sassen 1996) in this era of liberalism (Ruggie 1982). Hymer

(1960/1976) already analyzed this when he studied the transnational corporation's relationship with the nation state. The process of moralization is not only an economic doctrine but an intrinsic part of the 'neo-liberal epistemology' (Shamir 2008), which is characterized by complexity, trickle-down ideals, incoherence and contradictions, and whose pervasive nature defines modern global market economies. This neo-liberal economics is also unchanging in its practices of commodification of hitherto non-commercial products, capital accumulation and profit maximization logic (Bougrine 2006), based on performative intents of business enterprises. As a classic feature, liberalism constantly keeps government interventions away while depending on government to ensure its sustainability in the era of globalization (Sklair 2002). However, it seeks to promote its own government of self-regulation through CSR (Gond, Kang & Moon 2011). For example, Hamm (2010) shows the number of millionaire congressmen who are essentially put into politics to do the biddings of corporate bodies through lobbying.

Responsibilization, therefore, is a horizontal flat-world, non-hierarchical and meta-regulatory form of self-governance and voluntary assumption of responsibility through moral agency. This entails the reconfiguration of markets into moral entities (with the infusion of a 'corporate conscience') and nation states and civil society into marketized entities, based on the logic of economic rationality and 'markets of authorities' (Shamir 2008). What this teaches is that in contemporary times, responsibility has been turned into merely complying with rules and regulations based on one's moral motivations. *"As a technique of governance, responsibilization is therefore fundamentally premised on the construction of moral agency as the necessary ontological condition for ensuring an entrepreneurial disposition in the case of individuals and socio-moral authority in the case of institutions"* (Shamir 2008, 7). This suggests a gradual dissipation of deontological ethics towards the institutionalization of teleological ethics (consequentialist ethics), analyzed through CSR that is based on what the expected gains may bring about by economic calculus, or through the logic of cost-benefit analysis.

In the same vein, Boltanski and Chiapello (2006) argue that today's employees are independent entrepreneurs with the full responsibility to advance their career (the perfection of their human capital) and its apposite investment based on private initiatives. This, they argue, is the new spirit of capitalism, away from the Fordist hierarchical structures to a new network-based organizational form that takes its stressful toll on the employee: *"A successful career now depends on the responsibilized employee: a creative and innovative person who nurtures his or her own 'employability' on the basis of his or her entrepreneurial and networking skills"* (Boltanski & Chiapello 2006, cited in Shamir 2008, 8).

Based on Boltanski and Chiapello's (2006) studies, I now draw on the logical series of lessons for both theory building and practical application. It can be immediately inferred that the consumer now represents an independent set of market preferences (Coase 1988), not a human being. It alone is responsible for its sustainable health, irrespective of the structural determinants of health and other corporate externalities. Again, irrespective of one's healthy lifestyle the onus is on the responsibilized customer (the patient with obesity) to make choices and acquire resources that improve health whilst acting entrepreneurially to seek health-enhancing opportunities and bracing every risk. The consumer can therefore no longer expect a major contribution from the government or the pharmaceutical firm – unless it is a client for profits in a system of marketized politics and moralized market which is based on economic rationality and moral agency (Shamir 2008).

Essentially, Shamir (2008) argues that the corporate reframing of traditional CSR includes commodification process in which the expected gains from market opportunities remain the overarching drive for CSR. CSR is then a camouflage for deregulation and for irresponsibility. In essence, corporations shape the CSR field through a process of de-radicalization in an effort to undermine any change that will affect their profit maximization intents. The mechanism for achieving this is through the coopting and supporting of business friendly NGOs. CSR can then be seen as an archetypical tool of the neoliberal capitalist system's ability to deflate criticisms, weaken any countervailing power and reinvent itself by finding new moral justification for its survival (Boltanski & Chiapello 2006; Fleming et al. 2013; Shamir 2008). In sum, responsibilization is a process through which firms de-radicalize CSR whilst trying to free themselves from regulations.

Contrastingly, Gond et al. (2011) present a different typology of the CSR–government nexus. In challenging the critical perspectives on CR by Shamir (2008), Banerjee (2007), etc., they offer five configurations of CSR (p. 647):

(i) CSR as self-government: firms' discretion without state's coordination or intervention, for example philanthropy.
(ii) CSR as facilitated by government: government intervention through incentives, for example public procurements with some CSR requirements (ex poste).
(iii) CSR as a partnership with government: the state and corporations merge resources to achieve some social good.
(iv) CSR as mandated by government: the state regulates CSR actions by corporations, such as laws on environmental reporting (ex-ante).
(v) CSR as a form of government where there is an institutional void or political power vacuum. This is consistent with the varieties of capitalism (Hall & Soskice 2001) and national business systems (Whitley 2007)

perspectives in how they differ from each other and how they determine the CR regime.

In conclusion, these seemingly innocuous discourses should not be treated as either puns or footnotes. They have enormous effects on the outcomes of the structural determinants of health, especially in transitioning economies where governments leave their privileged positions and core responsibilities to provide public goods in the hands of private authorities. These private authorities will be the object of a deeper analysis in the subsequent chapters.

3 STRATEGIC CORPORATE RESPONSIBILITY ORIENTATION FOR SUSTAINABLE GLOBAL HEALTH

> *I don't subscribe to the notion that companies exist to create value strictly for their shareholders. I think they are there to create value for the customers. We need to reorient how we think about capitalism. Anyone who's willing to postpone the long-term strategies to make the short-term numbers is in route to going out of business.* (Professor William George, Harvard University, 2013[4])

This chapter presents the main thesis of the study. For the purpose of this study, the above quotation does not only apply to businesses but non-business actors as well. This is because their decision makers seek the same thing: the maximization of the organizations' utility, their survival and associated incentives and those of the owners. *Why and how do business and non-business actors integrate CR doctrine into corporate/organisational strategy with an emphasis on value co-creation and institutional context of consumers in transitioning economies of WECS Africa?* With reference to the above research question, this chapter analyzes what SCR orientation towards value co-creation is. Kuada and Hinson (2012) argue that unless economic development can be converted into social change that is beneficial to the underprivileged, it cannot be described as development-oriented. In the same vein, it is postulated that since the private sector (pharmaceutical MNCs and SMEs) and governments as well as hybrids and NGOs are hugely implicated in the global health, unless the SCR orientation drives socially beneficial change in the form of value co-creation/co-protection in WECS Africa, such a process cannot be described as a genuine SCR orientation either. Therefore, in what follows, the consumer and his/her sustainable environment and general wellbeing (value for the consumer) are the central *focus* (orientation); whereas the managerial decision-making and policy-making setting (in the context of market, hierarchies, and networks with non-market actors) is the *locus* (see Articles 1 and 2).

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[4] Bill George on rethinking capitalism. Interview by Rik Kirkland. McKinsey&Company. Available at: http://www.mckinsey.com/Insights/Leading_in_the_21st_century/Bill_George_on_rethinking_capitalism?cid=other-eml-alt-mip-mck-oth-1312

Two nuanced sets of arguments are advanced in this study (sections 3.1. and 3.2, respectively). These two arguments along with the NIT constitute the central tenet of my thesis and they also serve as the fundamental theoretical point of departure in the order delineated below.

Creating maximum social value. First, SCR orientation refers to the fact that SCR operations are directed by a firm or organization's core competencies and the values-based leadership of the upper echelon towards socio-economic, political, environmental or health issues of interest. The SCR orientation regards the scope and direction of an organization's actions and its relationship with a social problem based on its capabilities and sector. Here, SCR orientation is not restricted to business organizations but also collective (social) systems since their decisions and actions have the potential to create or destroy value given the blurred nature of business and non-business actors in global health governance. In contrast, the SCR orientation is a forward-looking means of survival in this information age of numerous institutional and sustainability pressures/threats and highly aware consumers, who are no longer easily outmaneuvered by the gimmicks of savvy business people. For example, whilst Davis' (2010) typology of CSR refers to a form of (i) risk management, (ii) cost, and (iii) value creation, SCR orientation is neither a form of risk management in the traditional sense, nor can it be treated as a cost. It is rather risk prevention as an investment, an aggregate of proactive corporate actions that employ resources innovatively and efficiently in order to create socially desirable value competitively.

Future orientation. Second, historically, how society organizes itself to produce, distribute and consume resources has always included an ethical component as to what there is, and how it ought to be; thus positive and normative economics (Sen 1988). While such views diverged, they are now converging (Elms, Brammer, Harris & Phillips 2010) given the global dynamics such as globalization, deregulation, and digitalization consisting of global awareness and active networking via the use of information technology (Downes & Mui 1998). Thus, whereas social responsibility is uni-dimensional (i.e. determining what firms ought to do for society without reciprocating gain), SCR orientation is pluri-dimensional with a past, present and a sustainable future outlook in the multiplicity of functions. Hence, the concept of SCR orientation is used to accentuate the prospective nature of strategy and stake-player impact. It represents the present undesirable socio-economic and political situation: how to identify possibilities and the preferable futures that can be influenced through change management. Every strategy leads or guides to a potential future outcome and so does the way in which stake-players can affect the strategy.

Putting the 'lasts' first. Third, in this consumer-centric study (not firm-centric study founded on the resource-based view), SCR orientation means that, among all the stakeholders, organizations (market and non-market actors) 'put the last (patients) first', to borrow from Murtaza (2012). In this case, Agle, Mitchell and Sonnenfeld's (1999) most salient attributes of stakeholders (power, legitimacy, and urgency) may not be totally satisfactory criteria for who receives attention. The conditions of the mostly economically challenged and socially alienated composition of each population may be legitimate and urgent but that legitimacy and urgency hinges on whether or not they are recognized and taken seriously by the organizations before actions can be taken. The conditions of millions of patients at the bottom of pyramid (BOP) actually render them socially and economically powerless, and in most cases politically as well. This lack of influence means that they are at the mercy of those who make decisions on their behalf. For poor communities outside urban areas, without an ethical push, they will remain outsiders since NGOs prefer to spend where they will be visible in order to quickly qualify for the next cash donation. Accountability for operations is therefore for satisfying their overseas donors (the dominant stakeholders) and not those whose welfare they are there to improve (the weak stakeholders) (Assad & Goddard 2010).

The next sections explain the foci (the objectives of SCR decisions) and the loci (the centers of decision making) of SCR orientation. The words 'foci' (plural of focus) and 'loci' (plural of locus) are neither nice play of words nor should they create any ambiguity, just like data (plural for datum). The plural form 'foci' respects the idea that based on the organizational capabilities, attention may be oriented towards a number of different objects or socio-economic, political and health-related issues. In the same way, the plural form 'loci' is preferred to accentuate the multiplicity of market, non-market, government and hybrid platforms upon which SCR centers of decision are built.

3.1 The foci of SCR orientation

SCR orientation as a non-market strategy. Non-market strategies are mechanisms for attaining legitimacy. Legitimacy is achieved when the behavior of organizations does not deviate from the socio-institutional expectations or prevailing institutional logics. First, it is argued that the concept of CR in the pharmaceutical industry, and by extension in global health governance, only represents an artificial façade unless the responsibility of the business and non-business actors is fully integrated into their day-to-day activities and strategy implementation process through value co-creation with all relevant stakeholders (Ahen & Zettinig 2013). Such a value co-creation process is not based

on ordinary capabilities. Instead, it is based on the first order dynamic capabilities (Winter 2003) which are consumer-oriented as well as environmentally and institutionally sensitive, rather than producer-oriented (firm-centered) (see Article 1). The underlying rationale for integrating CR into corporate strategy is for the entrepreneurial manager to identify, sense and seize emergent opportunities (Augier & Teece 2008). This is achieved by meeting the current and future latent needs of society through a proactive and ethical co-creation of value (Austin 2010) with and for the society in which the firm is socially embedded. This is what I refer to as strategic CR orientation or SCR orientation without the 'S'—'social'—in a more updated version of the vague, traditional CSR (Rivoli & Waddock 2011; Sundar 2013). The traditional CSR concept is in principle a pleonasm, given that all corporate actions by NGOs, firms or governmental agencies by nature affect and are affected by society and its environment. The orientation of the firm also indicates its position or strategic and political stance on specific socio-economic, political, and environmental or health issues. This in turn determines how it configures resources, makes strategic decisions, and operates, proactively or reactively, alone or through cooperative investments based on dynamic capabilities (Augier & Teece 2009; Eisenhardt & Martin 2000; Winter 2003; Zollo & Winter 2002).

Moreover, pharmaceutical MNCs, SMEs, contract research organizations, wholesale and distributors, researchers, and Ministries of Health all exist just because of the consumer/patient. The decisions and interventions by governments and other non-market actors directly affect the consumer. This is why the analysis of the responsibilities of all these socio-economic actors is essential for a fuller understanding of the institutions that shape their actions and how these actors also shape the institutions. Thus, these actors are the means through which, as Djelic and Quack (2003) put it, globalization as a dual process of both institutional change and building of institutions happens.

SCR orientation as a prerequisite for innovation and competitive advantage. SCR orientation positions an organization within an ecology to gain competitive advantage through innovative processes that meet the complex needs of consumers and also represent a source of new opportunities (Porter & Kramer 2011). Understanding these opportunities requires managerial entrepreneurship (Augier & Teece 2008) that employs the first order dynamic capabilities rather than ordinary resources (Winter 2003) (see Article 2). WECS Africa presents enormous international business opportunities but only for innovators. This will partly define firms' international success. More than ever before, a great part of the African population has access to medicines. Nevertheless, this access is from both legitimate and illicit supply chains. There are global power shifts in science, technology, and social orders for the co-

protection against counterfeits but this is not very much the case of WECS Africa, although there are some exceptions. At the same time:

> *Africa is the world's richest continent in terms of natural resources, with half of the world's gold, most of the world's diamonds and chromium, 90 per cent of the cobalt, 40 per cent of the world's potential hydroelectric power, 65 per cent of the manganese, millions of acres of untilled farmland, as well as other natural resources.* (Klutse 2014)

Despite this great wealth, apart from South Africa which produces over 75% of its internal market demand of medicines (Nordling 2013), the remaining small economies are dependent on several sources: importations, local manufacturers, the Global Fund, private donors such as churches, mission organizations (Buabeng 2010; SPS Strengthening Pharmaceutical Systems Program. 2012) and private mega-organizations such as the Bill and Melinda Gates Foundation (Gates & Gates 2014). Further, in the WECS African context, outside of South Africa, there is not a traditionally recognized fertile ground for complex techno-scientific R&D of medicaments by big pharmaceutical firms (Macdonald 2011b). Managerial entrepreneurship in pharmaceutical MNCs is suggested as the way forward to capturing these new markets (Jerven 2013; Radelet 2010; Roxburgh et al. 2010).

SCR orientation as a foundation for legitimacy through consumer co-protection. Analysts often neglect the fact that not only should essential drugs be made available through the shared responsibility of healthcare actors but such value propositions must also be co-protected from counterfeiters and irresponsible actors within the industry (Ahen & Zettinig 2011). The consumer protection agenda (Hanson 2008) is not the sole responsibility of the firm (intellectual property protection) but of all the actors within the economic sphere, namely: governments, INGOs, multilateral organizations and consumers themselves.

Value destruction does not only occur as an exogenous dimension of the value chain of essential medicines. Within the industry itself, there are several behaviors that are detrimental to value creation. For example, there are firms that bypass the regulatory bodies, such as EMA in Europe and the FDA in the US, to collude with unscrupulous doctors to reach consumers with unapproved medicines (Goldacre 2012). Besides other unethical practices that adversely affect patients, some firms also disregard medical Hippocratic ethic by, for instance, using unwitting patients as guinea pigs for clinical trials in transitioning economies without any voluntary informed consents (Emanuel & Miller 2001). All these value destruction activities are mainly possible due to the

weakness of the institutional context (Meyer 2008) as well as the power of market concentration of pharmaceutical corporations.

Solving ethical concerns promotes the organization's social acceptability. Every organization, irrespective of its fundamental purpose, has a responsibility towards stakeholders and society in general (Freeman 1984). That explains why CR cannot apply to businesses only because all organizations require legitimacy for their existence. Legitimacy can be achieved by modifying the organization's behavior to adapt to the emergent needs of society.

In summary, SCR orientation, through the configuration of dynamic capabilities, towards consumer protection is a means to achieve legitimacy. This is achieved in various ways: for example, by developing technologies for serialization and tracking and tracing, or by producing affordable generic drugs and collaboratively co-creating value with the other actors.

3.2 The loci of SCR orientation

SCR orientation via ethical leadership/managerial entrepreneurship for value co-protection. As previously argued in section 3.1, the concept of SCR orientation is meaningless unless the responsibility of the actors is fully integrated into their organizational routines to co-create value. It follows logically in the second argument that there cannot be any form of value co-creation without ethically responsible strategies geared towards value co-protection. This, however, must be relevant to time and context and attuned to current and future institutional and market expectations (Ahen & Zettinig 2013). Questions pertaining to the purpose of the firm in a global business and political environment, and how it can be both efficient and ethical, demand much deeper analysis that cannot be oversimplified and reduced to only numbers:

> *In business research, however, the things routinely ignored by academics on the grounds that they cannot be measured—most human factors and all matters relating to judgment, ethics, and morality—are exactly what make the difference between good business decisions and bad ones.* (Bennis & O'Toole 2005, 98)

Regulations and international standards matter but they are not sufficient. An ethical commitment as a core value is required to move actors into action on global health issues. Ethical questions begin where legal prescriptions, such as current Good Manufacturing Practice (cGMP), current Good Laboratory Practice (cGLP), industry standards or codes of conduct, end. By implication, a proactive initiative towards value co-protection and ethical concerns in drug

production on one hand, and responsible product distribution and value co-creation on the other, are the two sides of the same coin.

It is argued that value co-protection is essential because of the existence of value destruction. Value must be safeguarded, conserved or protected if its continual existence is to be guaranteed. This consideration stems from the fact that within the whole economic gamut of the pharmaceutical sector, there are value destruction activities such as the sale of counterfeits and other unethical practices (Angell 2004b; Barnes 2006; Goldacre 2012; Petryna & Kleinman 2006; Welch, Schwartz & Woloshin 2007). Undesirable behaviors do not happen in a vacuum. This is due to the opportunism of irresponsible actors who take advantage of market and governance failures, information asymmetry, and regulatory institutional lapses (e.g. lack of proper law enforcement and quality control mechanisms). Thus, ethically responsible leadership is a core dimension of SCR in ensuring value co-protection.

SCR orientation as a catalyst for institutional change via global health diplomacy and cross-sector social interactions. Cross-sectorial collaboration (Austin & Seitanidi 2012) towards value co-creation activates a change in institutional fields via the creation of 'proto-institutions' (Lawrence, Hardy & Phillips 2002, 281) and organizational learning that allows for the emergence of new practices. This in turn affects the rules of the game (North 1990) within global health governance. It also permits the diffusion of new social technologies, which were once organization-specific, into unique forms of technologies that allow adaption to the changing environment.

Within the context of WECS Africa, however, the problem is about the nature of GHD and the fundamental role of power wielded by industry and global governors (Stiglitz 2002) in shaping the dynamics of strategic public health outcomes. Although no global government exists, powerful global institutions such as the WTO, IMF, WHO and UNESCO play a hegemonic role as governors in determining the outcomes of globalization and associated socio-economic and political processes (Stiglitz 2002). This means that in global health issues most WECS African countries privilege global domination over national sovereignty in their health agenda (Fidler & Gostin 2006). This in most cases takes care of all complex issues but not the consumer, ignoring the 'voices of the governed' (Banerjee 2011). Further, the WTO TRIPS agreement has had a serious impact on the accessibility to medicines in transitioning economies (Chen, Nie, Yao & Shi 2013). This issue, however, has been covered in detail elsewhere; see for example, ('t Hoen 2002; Fellmeth 2004; Mwalimu 2002; Smith, Correa & Oh 2009; Sykes 2002).

CSSIs and GHD that aim at new institutional rearrangements will then lead to the required changes in the rules of the game. SCR represents a co-evolutionary and path-dependent progress of global health actors. The actors'

adaptation therefore becomes essential for their survival. Thus, the future of business, society and healthcare conducts us to the fundamental institutional changes that, more or less organically, reflect the 'Geist der Zeit' of how actors think and respond to most of the intractable problems within the global health domain. Cross-sectorial collaborative strategies in public health based on SCR are therefore at the heart of changing institutions and adapting to emergent changes (Cantwell et al. 2010).

3.3 Concluding synthesis of the loci and foci of SCR orientation

In sum, this chapter establishes the main thesis of the dissertation by emphasizing the foci and the loci of the SCR orientation. It is first argued that the concept of SCR orientation is meaningless unless the responsibility of the actors is fully integrated into their daily organizational routines to co-create value with and for the consumer. It follows logically in the second argument that there cannot be any form of value co-creation without ethically responsible strategies geared towards value co-protection within the boundaries of the pharmaceutical industry and in the context of WECS Africa.

The Figure 4 below describes the structure of SCR orientation based on the above arguments. The major elements of the structure are the institutional foundations and the loci and the foci of the SCR orientation which lead to sustainable institutional change in global health.

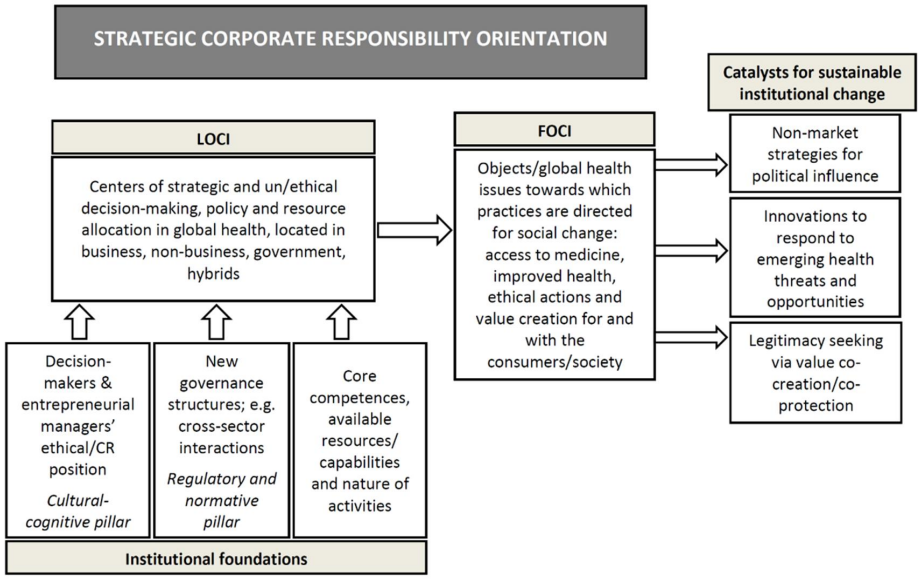

Figure 4 The structure of the loci and foci of strategic corporate responsibility orientation.

The next chapter reviews the literature on the definition of value as used in various disciplines. Further, the final part of the chapter theorizes about value co-creation/co-protection in global health based on insights on the field studies.

4 THE NATURE OF VALUE AND VALUES

> *Just as there are different formal and informal rules that govern economic exchanges, there are also different hierarchies of value, based on the location of those exchanges. [Therefore] the meanings of what a thing is worth becomes encased in where the thing was produced, or rather in the collective stories told about and the symbols singularly attached to the place of production.* (Wherry 2013, 185)

Values and value are among the central concepts of this study. For the sake of consistency, I will refer again to the main research question:

> *Why and how do business and non-business actors in the pharmaceutical sector influence and are influenced by national and global institutions in successfully co-creating and co-protecting value for consumers in transitioning economies of WECS Africa?*

This chapter examines the conceptual uses of the terms *value* and *values* in disciplines relevant for this study. This is a quest to draw a clear line between what value means as applied in global health and as used elsewhere. I also analyze the crucial role of human values which constrain decisions on how capabilities are organized to create or destroy value. Finally, I examine the empirical insights drawn from the field study about value and its co-creation and theorize about responsible value co-creation/value co-protection within the context of the pharmaceutical industry (thus, supply-side issues), and by extension the global health domain. A central analytical question guiding the following analysis of the concept of value was: What are the incongruences in extant literature about value from the perspectives of pharmaceutical industry and global health?

4.1 What is value?

"Why is the same object produced in one place valued more highly than its functional equivalent produced elsewhere" (Wherry 2013, 183)*?* In the same vein, one could ask why some health products and services are more highly demanded and more highly quoted in price than others. For our purposes, we

can further interrogate why giving access to medicines to certain populations of lower socio-economic conditions in certain geographical areas is more difficult to attach value to. *"These questions of value allow social scientists to consider how valuation differences undergird economic inequality and how values must be transformed in order to better serve the disadvantaged"* (Wherry 2013, 183), especially the low-income households in transitioning economies.

In common usage, (consumer) values refer to deep-seated beliefs that serve as criteria which guide preferences and judgments, while value refers to the resultant trade-offs, benefit or worth attributed to a product or service (Holbrook 1994; Nozick 1989; O'Shaughnessy & O'Shaughnessy 2003; Rokeach 1971). Existing definitions of value seem to attribute the concept more frequently to monetary value (e.g. Yadav & Monroe 1993) and as a feature of a core product (Doyle 2000; Zeithaml 1988). Despite its great theoretical and practical relevance in all socio-economic analyses, there is no consensus on the meaning attached to value (Lindgreen & Wynstra 2005; Miles 1961). Place, time and context are plausible explanations for this. This relevance of the concept sometimes brings into debate how the term is appropriated and used by groups, organizations and individual actors within the economic sphere (Lindgreen & Wynstra 2005; Parolini 1999). In fact in healthcare, Michael Porter (2010, 2477) argues that some professional care providers see value as a code word for cost cutting whilst others may see it as some abstract word. Nonetheless, value is neither cost cutting nor a superficial concept but rather concrete health outcomes for patients. Notwithstanding the differences in definitions of value, there are some universal points of convergence.

Value-added activities are a refinement of activity-based management, which is about reducing costs and improving process (Weygandt, Kimmel & Kieso 2004, 154). Value-added activities increase the worth of a product or a service to customers through manufacturing or performing a service. Examples of value-added manufacturing processes include design, assembly and packaging. Examples of value-added service include surgery or training. Non-value-added activities are products or service-related activities that augment cost or increase time spent on a product or service without increasing its market value. Examples include repairs of machines, building maintenance, and inspections. For services, examples include book-keeping, reception, advertising, cleaning and computer repairs (*ibid*., 155).

The *value chain* refers to all activities associated with providing a product or service (e.g. manufacturing, R&D, acquisition of raw materials, production, sales/marketing, delivery to customers). The process is long and involves several actors, which Parolini (1999) refers to as the value net. That long process is what Kaplinsky (2000, 121) describes as:

> *the full range of activities which are required to bring a product or service from conception, through the different phases of production (involving a combination of physical transformation and the input of various producer services), to delivery to final consumers, and final disposal after use.*

For analyzing firm-level value creation processes, the value chain framework (Porter 1985) is now the accepted currency in understanding the logic of firms' competitiveness, weakness and strengths (Parolini 1999; Stabell & Fjeldstad 1998). The value chain analysis is therefore a technique for structuring the firm into strategically pertinent activities to understand how these activities affect cost and the value creation process. Whilst the value creation logic in the value chain in itself can be applicable in all industries, how the specific activities lead to competitive advantage depends on the industry (Porter 1985).

In sum, there are myriad uses of the concept of value in various disciplines. For example in business valuation, Pratt, Reilly and Schweihs (2000, 28) mention *"fair value, true value, investment value, intrinsic value, fundamental value, insurance value, book value, use value, collateral value, ad volorem value"*. However, I will not delve into the subtleties of all the uses of the concept of value but instead I synthesize and problematize its applicability in the context of global health. Within the context of SCR orientation and global health, and for our purpose of putting the 'last' (patient) first (Murtaza 2012), I analyze value from the point of view of the consumer, the raison d'être of all economic activities, before evaluating value from the perspective of the firm or an organization. Thus, in global health, I operationalize the creation of maximum *social value* in the pharmaceutical sector as the process and outcome of socio-economic activities (e.g. R&D, social marketing) that delivers the highest benefits to the patient (see Stiglitz & Jayadev 2010).

4.1.1 Building blocks of responsible value co-creation

Cantwell et al. (2010, 569) view that *"Value creation consists of the production and distribution of goods and services, involving the exploitation (and augmentation) of ownership specific advantages related to resources, capabilities and markets."* Cantwell et al. (2010) definition is clearly firm-centered and neglects a fundamental part of the value creation process—the conception—compared to Kaplinsky's definition of the value chain (see paragraph 4.1). The consumer is not even included, let alone the environmental impact of disposal and how it is responsibly done. But it does offer a clue about the dynamic capabilities which are a requirement for all forms of innovation, looking

into the future. Without principle-based decision rules to guide how actors have to create and protect value, global health cannot be made sustainable.

Wenstøp and Myrmel (2006) offer three taxonomies of value. They maintain that (i) *created value* is the value that stakeholders (including shareholders) have come together (with their contribution) to produce and this actually represents the very essence of the organization's existence. The distribution of this value is the outcome of decisions and negotiations. (ii) The *protected values* are neither negotiable nor can they be compromised or violated. This is because they represent the ethical behavior that needs to be protected through established rules, normative and regulatory standards, and certifications within a context and time. Such values include health, safety and environment. (iii) *Core values* are those values that define the organizational character which in turn dictates and shapes the behavior of actors. The core values include commitment, trustworthiness, responsibility and accountability which for the CSSIs in the pharmaceutical industry are fundamental, if value can be co-created with the patient in the first place. All the three types of values are essential. Value co-creation should not be oversimplified as synonymous with collaborative activities. Rather, a gestalt switch is proposed from the simple definition to include value co-protection and the core values.

4.1.2 Intrinsic and instrumental value

From the perspective of business valuation, *intrinsic value*, also called fundamental value, is not the same as investment value. Rather, *"it represents an analytical judgment of value based on perceived characteristics inherent in an investment not tempered by characteristics peculiar to any one investor, but rather tempered by how these perceived characteristics are interpreted by one analyst versus another"* (Pratt et al. 2000, 31). Thus, intrinsic value is what a security analyst (after fundamental analysis) will consider as the appropriate or true value of a stock or an investment (Pratt et al. 2000). In consumer psychology, however, Nozick (1989) maintains that emotions respond to things that involve values, meaning that emotional arousals of consumers are a guide to their values or psychological replica of values – or intrinsic value (O'Shaughnessy & O'Shaughnessy 2003). These are things that have value in themselves or are *"of inherent value – that is anything that brings unity into diversity to provide internal coherence"* (p. 47). The problem with this definition, beyond its mere description, is how to measure intrinsic value or how that value translates into consumer value (O'Shaughnessy & O'Shaughnessy 2003). The obvious philosophical question is: why should intrinsic value be measured and by what criteria can that be done? For our purposes on global

health, I take a cue from Nozick (1989), by arguing that good health, or happiness, have intrinsic value in themselves "*since the different elements in each of them form an integrated and united whole"* (*ibid.*, 47). Intrinsic value, therefore, is a universal category of all things good and meaningful 'in and of themselves'.

By contrast, *instrumental value* is anything that serves as a means to an end. That means instrumental or extrinsic value does not have an infinite value but only serves as an instrument towards achieving or fulfilling the ultimate—intrinsic—value. In this way, consumers do not buy products (Drucker 1974; Penrose 1959) but they buy a service and that service is aimed at providing the ultimate (happiness, good health, etc.). There is an endless philosophical debate about these two words as the foundations for arguing about whether or not certain policies or actions are acceptable both in business and in the social world. In Table 2 I offer a collection of meanings attributed to value in various disciplines.

Table 2 Examples of conceptualizations of value in relevant disciplines

Discipline	Meaning of value	Author	Characterization
Global Health	The creation of maximum social value in the pharmaceutical sector as the process and outcome of socio-economic activities (e.g. R&D) that delivers the highest benefits/service to patients especially those from low-income households.	Stiglitz and Jayadev (2010)	R&D and innovation of medicines to create affordable, high-quality access to low-income patients
Public Health	Value in healthcare is defined as *"the health outcomes achieved per dollar spent."*	Porter (2010, 2477)	Emphasis on measurable outcomes and costs rather than process—is the patient cured and at what cost?
//	*"Fundamentally, value is what is gained for a given cost. Definitions of value should consider how care improves patients' overall health, their quality of life, their experience of care, and the overall health of the public."*	O'Kane et al. (2012, 3)	Curtailing waste by rallying all healthcare stakeholders around the value creation processes to achieve optimal outcomes
Micro-Economics	Based on the demand curve of a good, both gross benefit and consumer surplus can be determined. The latter is measured by the net benefit (value) that consumers receive.	Parolini (1999)	The difference between the utility of a good/service and the reduction in the sum that the consumer has available to spend on other products
Strategy	Net value for the consumers is equivalent to consumer surplus.	Parolini (1999, 112)	Value created by the value creating system is equivalent to the difference between the benefits received from the good and the costs-per unit, times quantity.
Strategic Management	Value is the amount consumers are willing to pay for the offers of a firm.	Porter (1985)	From the firm-centric perspective, profitability hinges on the lower cost of production and the higher value for customers—generic strategy

Discipline	Meaning of value	Author	Characterization
//	Creating competitive advantage by making offerings that the buyers perceive as of superior value to those of competitors.	Doyle (2000)	Perceived value (e.g. functionality aesthetics, brand) consists of the benefits/utility minus the price and associated costs of ownership
Consumer Psychology	Humans' system of values (key concerns) structures the relative importance of products and services and the subsequent choices and trade-offs	Ekman (1992), Elliott (1997), O'Shaughnessy (1987), O'Shaughnessy and O'Shaughnessy (2003)	Emotional responses lead to appraisal and clear demarcation of which things matter and which do not. Values are expressed as value judgments and announce an individual's ethical position.
Organization studies	Value is created relationally between businesses and NGOs or businesses and governments or between all of these three categories.	Austin (2010), Austin and Seitanidi (2012), Waddock (1991), Selsky and Parker (2005)	Greater value (creating solutions to complex problems) is created in cross-sector interactions which could not be created by a single organization.
Finance/ Managerial Accounting	*"Value is usually measured by the trading price of the company's stock and the potential selling price of the company"* (p. 5)	Pratt et al. (2000)	Stock value or value of an investment
Marketing (general)	Placing importance on alliances, networks and other long-term relationships are argued to be inherently valuable.	Ghosh (1998), Gummesson (1996)	Emphasis on the inherent value of relationships for value's own sake
Service and Relationship Marketing	Marketing is seen as exchanges in a continuum and value is created relationally rather than 'transactionally'.	Coviello and Brodie (1998), Coviello, Brodie and Munro (1997), Grönroos (1991; 1996; 1997; 2000), Gummesson (1996), Sheth and Parvatiyar (1995), Sheth, Sisodia and Sharma (2000)	Firm-customer relationship central to value creation, with emphasis on value creation, dialogue, trust and quality relationship.
Philosophy and Ethics	Intrinsic value (value as an end in itself) and extrinsic value as an instrument towards an intrinsic end	O'Shaughnessy and O'Shaughnessy (2003)	Money as a classic example of means (instrumental) and happiness as an end in itself (intrinsically valuable)

Put together, studies on value are inconclusive about its meaning. Even in the same discipline there is no single, straightforward conceptualization of the word 'value' (however, the case is simpler for the word 'values').

4.2 Synthesis of the multidisciplinary conceptualization of value

In different contexts, at different times and among different goods and services, value is conceptualized differently by different scholars (Pratt et al. 2000). One thing has, however, remained constant—the evolutionary change in its meaning which always reflects the values of the people in context. In fact, Prahalad and Krishnan (Prahalad & Krishnan 2008, 24) have argued that *"value is shifting from products to solutions to experiences."* Further, members of each epistemic community may conceptualize value in a way that is a generally acceptable to them, whilst at the same time being aware of the conceptual dissonance with other disciplines. These 'essential tensions', to use the words of Kuhn (1977), are more than needed to keep the interesting conversation about value alive in an innovative way. For example, in finance and accounting shareholder value is easily understood as more dividends. Economics places emphasis on the cost of producing value (that is firm-centric) and on increasing shareholder value, while marketing seems to look more at how to satisfy the consumer value as the way to let that (creation of shareholder value) come about. This also includes paying attention to business actors: suppliers, financiers, intermediaries and all those who affect mostly the brand and reputation of the firm. Whereas strategic management used to emphasize a competitive advantage (e.g. Porter 1985), general management leans towards ethics and political issues and appears to be concerned with the overall day-to-day practices of the firm and its socio-economic and political impact on society at large. This, in fact, is the CR and sustainability research sphere. It is complex to define and account for responsibility since it increases with the corresponding increasing number of players or stakeholders (Freeman 1984; Freeman & Velamuri 2006). This is where governments, NGOs and civil society become essential in answering political, marketing and management issues as the firm becomes more and more embedded in society.

There is a gradual shift in the conceptualization of value beyond instant utility (benefits for consumers and high dividends for shareholders from high profits), as proposed in economics, to long-term relational activity towards sustainability of the value creation processes and outcomes on the organization's external environment. This suggests that in making value propositions to consumers (Grönroos 2008) and creating value for shareholders, externalities should be accounted for. This is because all organizations require legiti-

macy for survival in the twenty-first century of fierce non-price competition. For example, even in related fields, such as public health and global health, Porter's (1985) and Stiglitz' (2011) definitions are not totally in disagreement. Whilst Stiglitz is interested in attaching importance to the process and outcome and intrinsic value of access to medicines to provide healthcare for both economic and ethical reasons, Porter seems to point to the outcome and the cost involved in providing healthcare. Both, however, see the central role of the patient. Further, there is a growing consensus on placing value on relationships with stakeholders (Freeman 1984), especially the consumer. Following Grönroos (1990, 138), relationship marketing "*is to establish, maintain, and enhance relationships with customers and other* partners, *at a profit, so that the objectives of the parties involved are met. This is achieved by a mutual exchange and fulfillment of promises."* The central role of the consumer is also gradually re-emerging as a source of new ideas for innovation and engagement with society (Cox & Mowatt 2004). At the business and society interface, matters get analytically interesting, especially where 'social issues in marketing', 'marketing and social policy' and the health of consumers become central issues. This is because of their plurality, conflictual, and highly controversial nature. Above all, how marketing and international business impact and are impacted by socio-political issues (Shapiro & Heslop 1982) leads to complex decisions that must be made based on values and social expectations.

4.2.1 Complex decisions and values-based leadership

There is little contestation over the fact that value always has at least two connotations: a negative value or a positive value, depending on the context, place and time. This is what raises the question about value protection. When value protection is done in a relationship with other partners, I refer to this as *value co-protection.* Here, both the intrinsic and extrinsic value of the processes of achieving sustainable health are safe-guarded to prevent loss of worth or decrease in value. Nevertheless, mitigating value destruction and protecting value requires values-based leadership as a moderating factor. This brings us to organizational values (Mintzberg, Ahlstrand & Lampel 2005; O'Toole 2008; Trevino & Brown 2004; Viinamäki 2009) where the role of values-based leadership is seen as a prerequisite for creating and protecting value (see Article 2).

Values-based leadership concerns spearheading decisions and actions that are based on fundamental moral principles or values. These include ethical practices such as socio-economic and political responsibility, integrity, accountability or transparency. (Reilly & Ehlinger 2007; Viinamäki 2009). It is

the central role of values that triggers the need for SCR orientation towards the latent need of consumers based on which dynamic capabilities are marshaled towards fulfilling such needs and wants—products/services offered through the market (Kotler 2000).

In terms of the economic value of consumers to business firms, while customer retention in general is perceived as a competitive weapon (Dawkins & Reichheld 1990), it has also been argued that some consumers hold a much superior net value in comparison with others (Lindgreen & Wynstra 2005). This is because customers do not come with equal purchasing power (Hallberg 1995). This implies that value is destroyed when less profitable consumers are retained instead of focusing on what Hammond and Ehrenberg (1995) refer to as heavy buyers. But treating non-profitable (non-loyal) customers as value destroyers tends to treat humans (consumers) as only mechanisms for achieving profits (instrumental value), not as people with intrinsic value in themselves. This is the same as arguing that poorer patients in a hospital are not our business but the rich only, or that R&D for pharmaceuticals should be made only for those who are in the high-income brackets. Consider for example a case in which the firm produces medicines for an individual who suffers from high cholesterol (a life-time need) and a child who needs a short course of antibiotics for a bacterial infection. It makes economic sense to prioritize the higher value cholesterol patient whilst neglecting the low-value patient who needs antibiotics. Here, this inaction constitutes an indirect form of value destruction, a result of the unethical posture of decision makers.

Further, ethical leanings of decision makers are always implicit or unwritten rules that guide decisions (Muir Gray 2004). In accounting for the similarities between clinical decisions and policy, Muir Gray (2004, 988) argues that *"decisions are based on evidence but are not made by evidence."* Further, in both clinical and policy decisions evidence alone does not lead to decisions but the values of the context are fundamental. First, the clinician has to evaluate the evidence whilst explaining the implications to the patient in terms of harms and benefit and the current health conditions of the patient. Examples could also be found in policy making. That is, the decision maker has to evaluate the context-specific values and needs of the population in order to allocate resources. The ethical dilemma lies in the deontological ethics (always do what is right) and the utilitarian ethics (the end justifies the means). Should resources be allocated for patients with rare diseases or only for those with common illness, especially when the cost associated with creating value in the former is higher? From the viewpoint of utilitarian ethics, lower economic value can clearly be assigned to the former. On the other hand, seen from the perspective of distributive justice and fairness:

> *Investment may be made in rare diseases, even though the cost per patient treated, and therefore the value assigned to a beneficial outcome for a patient with a rare disease, becomes, by this process, higher than the value ascribed to the same outcome for someone with a common condition* (*ibid.*, p. 988).

This argument is valid for drugs for neglected diseases. It is evident that the created value is always a function of the values of the value creator—the values-based leader (managers and policy makers). Figure 5 outlines a framework for how scientific evidence contrasts with values-based decisions in pharmaceutical value chains. Such decisions determine whether value is destroyed or created. It is argued that not only corporate irresponsibility on the part of managers and policy makers constitute material and intentional destruction of value, but indifference (doing nothing about value creation) in itself constitutes 'silent complicity' (Wettstein 2010) to undermine global health. This is important especially in the pharmaceutical industry where every step involves value judgments and ethical practices with the potential to affect stakeholders and most importantly the patient.

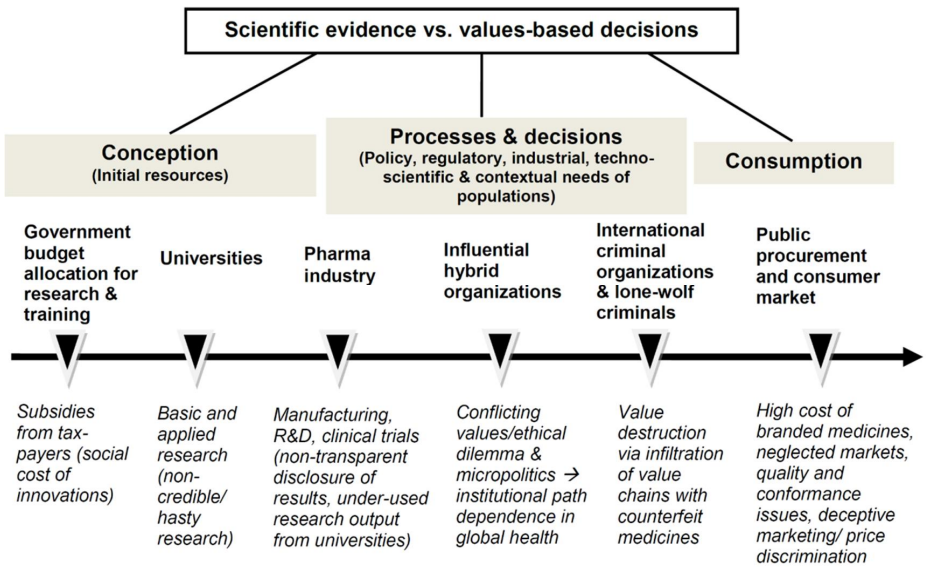

Figure 5 Values and value destruction in pharmaceutical chains.

4.2.2 Dominant values in global health domain

Consistency is essential. Therefore, I have argued throughout this study that policy and regulations are either value creating or value destroying activities

since they are akin to strategic planning for the allocation and configuration of resources with desirable or undesirable consequences on the consumer. Even in the face of major evidence for any decision making (policy or strategy), values rule (Muir Gray 2004). What then are the dominant values that shape global health policy making?

In the West, according to Benatar, Lister and Thacker (2010, 144), the dominant values are embodied as *"individualism and respect for human rights, economic liberalism, corporate managerialism, a narrow focus on scientific rather than social solutions to health problems, and an oversimplified, linear approach to health problems."* In this elegant conceptualization, it is inferred that political and economic rights are prioritized over social rights, which include access to health as an inalienable right (Benatar et al. 2010; Falk 1999; Farmer 2003). Of course, this is not all black and white since the Nordic countries with Evangelical Lutheran values seem to lean towards social-welfare capitalism where priority is given to the value of human health over economic value. From the perspective of global health governance, within transitioning economies where there are institutional voids or weaker institutions (Hajer 2000), non-state actors such as the IMF and MNCs thrive on these neoliberal managerialist values. That is, they can avoid accountability and CR given their ability to accumulate power and affect regulatory decisions and agenda setting (Arts 2003) through their corporate political activities (Mantere, Pajunen & Lamberg 2009). They are freed from regulatory measures that make them accountable (Sukhdev 2012), whilst their rights are prioritized over citizens as a result of international agreements such as the WTO TRIPS (Benatar et al. 2010). As Kinderman (2012) put it, corporations demand to be freed so that they can be responsible!

What encapsulates the values that dictate public health strategy and policy making in most transitioning economies of WECS Africa? From the existing literature and empirical insights drawn from my fieldwork, these values can be put together as: a co-existence of cultural collectivism, economic individualism, respect for human rights on books (written in fine jargon), a mixture of liberal, coordinated and crony capitalism (with huge informal markets), and vestiges of structural adjustment programs, forced trade liberalization and privatization, and a mixture of scientific and social solutions to an ever-increasing disease burden. The public health systems of WECS African economies are highly dependent on donors, NGOs and multilateral institutions and are also characterized to a large extent by wastes, corruption and a lack of innovation. Thus, global health within the context of transitioning economies of WECS Africa is notoriously complex and increasingly contradictory. Successful outcomes are therefore based on the institutional logics (values and belief systems) of those who frame the formal institutional structures through policy

and planning and international negotiations or GHD. The market values that insist on managerialism have now even led to the marketization and corporatization of hospitals where profits are privileged over care (Benatar et al. 2010; Gawande 2009). In this vein, citizens are seen as customers rather than important co-creators of value without whom there would not be any need for such organizations or their policies. The mantra is that for all economic activities in healthcare, there must be a business case (Porter & Kramer 2011).

The values that privilege dependence on scientific solutions, although essential, sometimes undervalue the importance of social solutions. This leads to excessive wastes in taxpayers' money allocated for research. On the supply side, this increases setbacks and deterrence to innovation that creates value. The abundance of 'me-too' drugs with patent protection makes matters worse. They are made only to enjoy rents from the markets and hence have significant undesirable social consequences, such as the lack of access to medicines for under-resourced nations. Patents especially in their exclusivity prevent the spread of knowledge and hence new innovations since only those with the rights and monopoly can utilize them. The R&D system as it stands encourages market distortion. For example, physicians who participate in trials are more likely to prescribe such medicines and patients who also take part are likely to use the medicine already introduced to them even though the adverse effects of the medicines have not been revealed to them (Goldacre 2012; Stiglitz & Jayadev 2010). Further, deception in pharmaceutical marketing for profit purposes is a common phenomenon (Goldacre 2012).

It is abundantly clear that value destruction is pervasive along the value chain from conception to consumption of all medical and pharmaceutical activities. Currently, there is a general trend towards making use of *valuation* (of everything) as a political instrument and as an institutionalized rule of the game. The problem with economic valuation from the instrumental values perspective is the misguided attempt at measuring the immeasurable and quantifying the unquantifiable. For example, the valuation instruments in sciences include university rankings and journal impact factors which are clearly not absolute measures of quality of single articles, authors or journals. In biomedical sciences this can have an enormous impact on how value is created or destroyed through drug R&D and clinical trials (Schatz 2014). Schatz (2014), citing recent studies, has argued that at least two-thirds of all biomedical research cannot be reproduced, which entails a huge waste of time and money, as well as a disturbing drop in the success rate of clinical Phase II trials. Moreover, to the detriment of all inhabitants on earth, there is convincing evidence that the majority of research findings in biomedical research may be false (Ioannidis 2005) and fake papers are now exposing the weaknesses of our current peer-review system (Grens 2013; Schroter et al. 2008). Currently,

many pharmaceutical companies cannot trust and use academic research as a basis for developing new drugs without verifying their authenticity in-house or through external contract labs (Schatz 2014). 'Publish or perish', group bias that grows among different scientific networks, hasty research, questionable statistics and, of course, the economic interests of researchers all lead to increasing fraud (Schatz 2014). Also, there are many values-based issues related to publications on drug targets (Prinz, Schlange & Asadullah 2011) and it is for these reasons that many are calling for the need to raise standards for preclinical cancer research (for example, Begley & Ellis 2012). The problem is, would this call be so loud if the matter was about medicines for transitioning economies?

4.2.3 Values and the behavioral foundations of value creation

There is a conspicuous absence of patient-focused global health governance within the context of transitioning economies. This brings us to the behavioral foundations of value creation and value destruction which Augier and Teece (2009) point out in their work on dynamic capabilities and Kahneman, Knetsch and Thaler (1986a; 1986b) have long grappled with in explaining fairness and other principal assumptions in economic theory. Nielsen (2003) has also dealt with this in his treatise on varieties and dynamics of constrained optimization. The problem with the firm as a person is that it has no emotion whatsoever to speak of, and precious little empathy, the type of human understanding that will respond to other people's sentiments apart from profits. These behavioral factors closely mirror sociopathic behavior (Mantere et al. 2009). The first Hippocratic Oath of Medicine is "first do no harm." How do we reconcile this oath to the lack of access to medicines (Stiglitz & Jayadev 2010)? Just like the arms, pharmaceutical products cannot always be regarded in absolute terms as commercial private commodities given their direct impact on massive numbers of human populations (Osuji & Umahi 2012). How can a cigarette company score so high on the Dow Jones Sustainability Index while being referred to as a corporate citizen (Chandler & Werther Jr. 2014)? The globalization of the principle of humanity, as enshrined in the 2009 Global Economic Ethic Manifesto, argues for a change where the under-served and disadvantaged consumer is reintegrated as a matter of justice through closeness to local situations.

Then again, how can sociopaths seek the good of society? Psychopaths without empathy or ethical leaning are rationalist by nature and intrinsically paternalistic and make their way to the top decision-making levels as Chief Executive Officers (CEOs) and policy makers (Bakan 2004; dos Santos 2014;

Mantere et al. 2009; Ronson 2011). They achieve their aims by flouting rules of decorum as long as it favors them. Sociopathic behavior is more adept as a necessary condition for capitalism and to competition. Sociopaths among CEOs are four times larger a group than in the normal society (dos Santos 2014). Sociopaths feel no remorse after destroying the environment, testing drugs on people without informed consent or making huge numbers of employees redundant whilst euphemistically calling it restructuring or rationalizing. This means economic capital, fame and self-seeking reign supreme compared to human, environmental or social capital. Such decision-makers see a world in which strategy is enacted as a battlefield operation (Ghoshal & Westney 2005; Mantere et al. 2009).

Notwithstanding all of the above, there is no suggestion that all who flout common sense rules of care are sociopaths. Fear of the future may pollute values. Philosopher Professor Helen Longino of Stanford University argues that the fear of future and the fear of having no security for one's family, besides situational and environmental factors, is the major explanatory variable for deviant and delinquent behavior (personal communication).

4.2.4 The value parliament

Scholars of choice have postulated that *"in the case of collective decision making there is the problem of conflicting objectives representing the values of different participants"* (March 1978, 589). In order to better understand the complicated, inconsistent and ever-changing preferences and actions in global health, a model would be needed. As a metaphor, the governance of value co-creation/co-protection in global health is viewed as a political process that is embedded in a virtual parliament whose values dictate the successes and failures in global health, especially and for our purpose, in the transitioning economies of WECS Africa. Like a pendulum, the direction to which the parliament swings (thus, the political view of those in power on the left or right) offers immediate cues about certain predictable outcomes or policy and governance orientation. This implies multiple levels of conflictual approaches and goal ambiguities. The model (a simplified representation of reality) of value parliament (see Figure 6) explains who global health (personified) is and not what it does. The value parliament represents a logical clarification of the reason for the existential contradictions and the failures in global health.

The literature on values in global health shows the motivations for studying values and thus, what authors seem to be prioritizing—the consumer or the organization, or a managerial motivation or another variation of it. On the basis of this I identify six representative theoretical value orientations. First,

there are the two extremes: (i) firm-centric/conservative and (ii) consumer-centric value creation perspectives. The former stresses the resource-based view and how to acquire, manage and capture value (profits). The latter, on the other hand, places much emphasis on people; that is, they emphasize a 'people-based view'. Then there are the (iii) center right—leaning more towards firms than consumers; the (iv) center left—leaning more towards consumers than firms; and also (v) the independent group—the consumers who represent value in themselves, although not recognized as such by right and center right. Finally, there are (vi) the global health governors who, however, set priorities based on a wide range of factors: the power asymmetry and the values of decision-makers, available resources and geopolitical agenda and foreign policy (Feldbaum, Lee & Michaud 2010), besides other factors such as external influences.

The right wing/conservative see the firm/hospital or healthcare giver and health insurance companies as operating to create value for shareholders through higher sales. Here, healthcare is not viewed so much as a public good but an instrument for making profits; thus, a privilege for those who can afford. The 90-10 rule is an example of this: most pharmaceutical R&D has traditionally been for the 'diseases of the rich' whilst only 10% is geared towards the diseases of under-resourced households (Stiglitz & Jayadev 2010). It follows that *"in business, the goal is economic value as measured by sustained profitability"* (Kim et al. 2010, 183). But as McGahan and Keusch (2010) argue, value in economics and by extension strategy can be wildly different from value in a global health advocacy perspective. McGahan and Keusch (2010) build on the simple empirical reality that whilst there are medicines and technologies for preventing diseases, the low-income households still receive the least. The answer may be found in how the market system assigns value to health with an ever-diminishing ethical content of ensuring equitable access. Economics builds on the principle of efficiency, not equity. For Posner (2003), efficiency can be described as effective trade-offs and decisions for the purposeful utilization of resources in ways that reduce wastes and costs in order to achieve the maximum social benefit in any socio-economic activity. The problem is how to reconcile equity and efficiency.

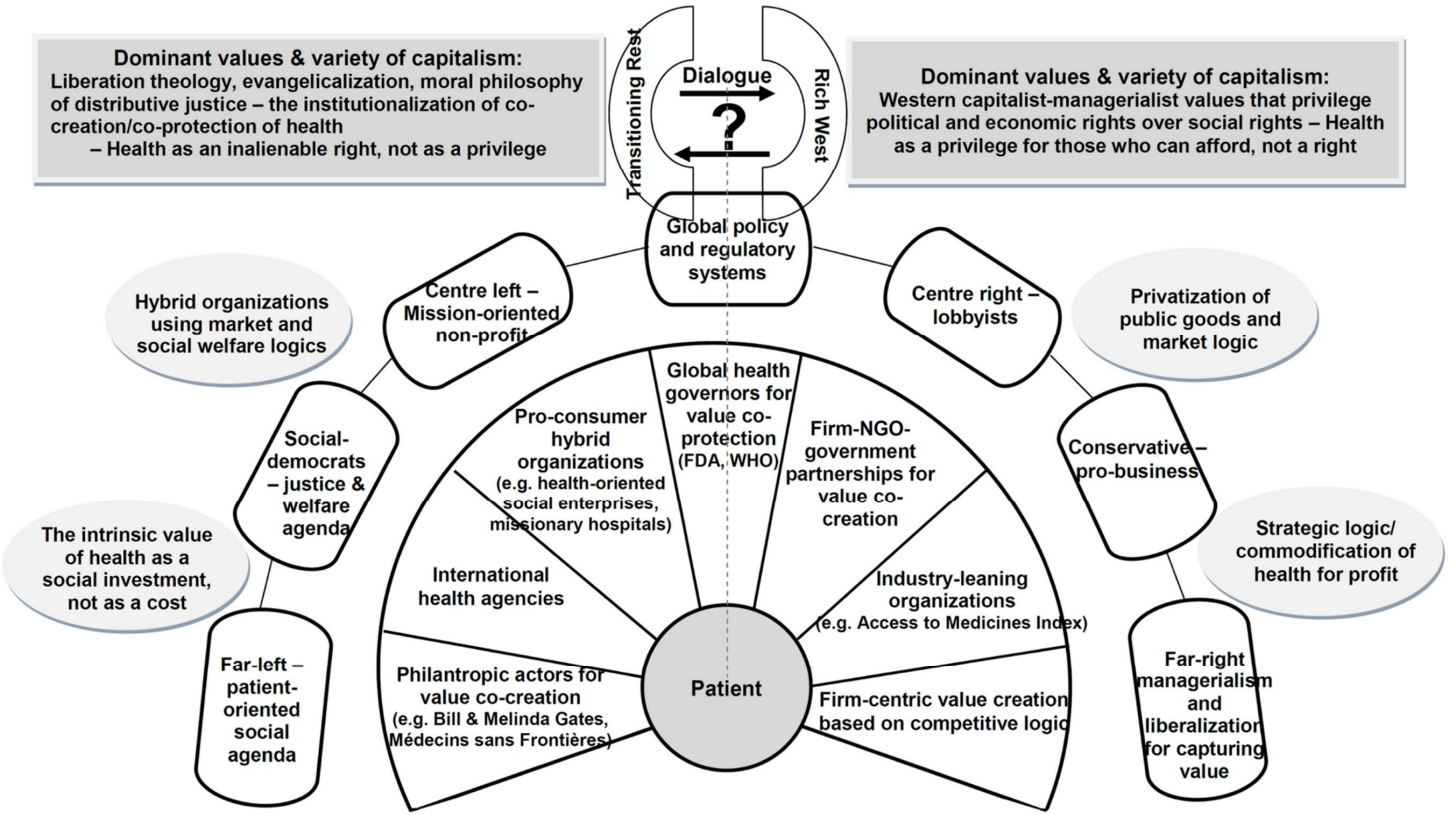

Figure 6 The Value Parliament of global health.

Another example of the right-wing view is the neo-liberal governance approach in which public hospitals are being morphed into business firms in the name of efficiency and the managerialist approach of the new public management (also in university governance) (Frølich 2005). Whatever CR action or ethical behavior they pursue is only a tactic aimed at achieving corporate goals or to dodge criticisms and avoid negative reputation which may eventually affect their brand—and legitimacy (Hanlon & Fleming 2009). Here, the patients or consumers in general are mechanisms for creating that value. This is the raison d'être of the firm (Friedman 1970). There is an overwhelming criticism of this traditional view. For example David Pitt-Watson (2014) argues that:

> *You should treat people as if they have value in themselves. In business it is easy to think of people as mechanisms by which you can achieve things. I don't think that works well. Yet we are all guilty of doing that.*

On the other hand, the far-left group (including consumer safety organizations, philanthropic groups and professional NGOs such as Médicins Sans Frontières) permanently on the consumer/patient side argues that consumer-centrism helps to identify the unfulfilled latent needs of consumers. Here, the consumer is the priority. Consumer-centrism conceptualizes value from the consumer perspective and, thus, automatically represents value for the consumers and therefore value for the firm or the organization. For example, Zeithaml (1988, 13) in defining value clearly from the consumer-centric perspective states: (a) value is low price (b) value is whatever I want in a product (c) value is the quality I get for the price I pay, and (d) value is what I get for what I give. Consumer-centric organizations seek to meet these socio-psychological and material (products and services) needs.

The center left represents organizations and government agencies that seek to respond to consumer needs through philanthropy or low-cost offerings, whilst the center right caters mainly for firm interests in the quest for legitimacy by making offerings for consumers. In an overwhelming swing of the value pendulum, the prioritization of the consumers (the value creators) seems to be garnering great force through quality relationships with them (Grönroos 2008) through an understanding of their daily lives (Heinonen et al. 2010; Vargo & Lusch 2004). That is not to suggest that consumers suddenly have the power to change anything. It is still the organizations that have to make this happen and this is possible only when the preference for values guides organizations within an institutional context.

4.2.5 Values and decisions in global health

The idea that values are at the heart of the nature and outcomes of global health policies as well as the degree of institutional commitment is well documented (Stewart, Keusch & Kleinman 2010). The centrality of values as the foundation for creating value in global health has gained considerable attention (Benatar et al. 2010; Janes et al. 2006; Kim et al. 2010; McGahan & Keusch 2010; Stewart et al. 2010; Yang, Farmer & McGahan 2010). It is a well-known fact that Halfdan Mahler's Scandinavian origin, including his training as a medical doctor as well as the years spent in India with the underprivileged, shaped his social values and this led to his intense efforts in championing the Alma Ata Declaration that defined the 'Health for All by the Year 2000' strategy (see e.g. Stewart et al. 2010). This is consistent with the 'ubuntu' concept which is based on African humanistic values, premised on the equity/social justice as well as harmony and the inherent value of the human being, in and of himself, but not as a means to an end (Mbigi 1997). This contradistinguishes from certain Western instrumental perspectives of value.

Yang et al. (2010) attribute the failure to achieve sustainable global health to the plurality of values among the recipients of the global health programs and donors. More prominently, Yang et al. (2010) and Benatar et al. (2010) argue that three fundamental reasons underpin this failure in transitioning economies: (i) a vertical or top-down approach rather than a combination of bottom-up and top-down approaches to combat disease burden; (ii) conventional disease control approaches which underestimate the socio-cultural, economic and environmental determinants of health; and lastly (iii) the exponential increase in inequity in access to healthcare. Large-scale scientific solutions that lack a broader outlook, the lack of consistent funding and the narrow focus on the control of diseases are among the factors that impede sustainable global health (Benatar et al. 2010; Stewart et al. 2010; Yang et al. 2010). Whilst all the above authors present an excellent overview of the problem at stake, there is little that is said about the institutions in transitioning economies and the values of decision makers therein.

The idea of the value parliament builds on the supposition that value creation, value destruction or value capture are organizational-level political choices that are based on ideologies, values and resources and the behavioral foundations of employing dynamic capabilities in strategic management terms (Augier & Teece 2008). The fundamental assumption in this analytical framework is that values frame what type of value is created, destroyed or captured within an institutional context and for whom (Baumol 1996; Scott 2014). For our purpose, in values-based leadership seen as a social relational activity, all *"healthcare organizations are conceived as moral agents"* (Gallagher &

Goodstein 2002, 438) who must uphold institutional values. In seeking to co-create or co-protect value, the organizational ethics (embodiment of values), which are characterized by integrity, responsibility and choice, are the foundational pillars (Gallagher & Goodstein 2002) for a mutual co-existence with society. In Selznick's 'Moral Commonwealth' he argues that

> *When we view an 'organization as an institution,' we may be mainly concerned with the values it embodies, from the standpoint of the people whose lives it touches as well as that of the larger community. Insofar as it is 'infused with value,' the organization is likely to claim and be granted respect [legitimacy] and concern. At the same time, to be an effective participant in the moral order, it must be competent, intentional and accountable* (Selznick 1992, 239; cited in Gallagher and Goodstein 2002, 438).

For example, creating shared value (Porter & Kramer 2011) is the buzzword for the business case for CSR. Others refer to it as 'doing well by doing good' (Falck & Heblich 2007). Still, this concept rests on the instrumental premise of utilitarian ethics which ignores the moral agency of organizations (Mantere et al. 2009). There is a huge publicity about the increasing cadre of Big Pharma beginning to embrace the markets in transitioning economies. This is because there is an increasing number of 'diseases of the rich', such as cardiovascular diseases, affecting the poor (Porter & Kramer 2011). Non-communicable diseases are now the highest cause of death in transitioning economies. On the surface, it appears that Big Pharma engages the poor for their sake (the intrinsic value in them). The evidence, however, suggests something else; firms do not offer access to medicines because it is right but because it is becoming increasingly profitable to use CR activities to market themselves (Banerjee 2007; Hanlon & Fleming 2009) especially across Africa where there is a robustly emerging middle class (Gates & Gates 2014; Radelet 2010) and the market is available (IMS-Health 2012; Kermeliotis & Porter 2013). Household incomes are rising, poverty is decreasing and the potential for profits is high. It would therefore be naïve for the firm that once neglected these markets to just internationalize without a human face in order to gain legitimacy for their operations.

4.3 Theorizing about value co-creation/co-protection in global health

On the basis of the insights derived from the fieldwork of this research and the literature on value, this section theorizes about the strategically responsible

governance of value co-creation, value co-protection, value capturing and value production in transitioning economies within the context of global health. Following Whetten (1989) on what constitutes a theoretical contribution, I explain the building blocks that make up value co-creation. Context matters and the context of national–global linkages of value co-protection and the diverse institutional orders that shape outcomes add to the novelty that takes us beyond conventions. This, in fact, is what Davis (1971) refers to as an interesting contribution. A complete theory according to Dubin (1978) must consist of four basic features:

1. **What?** – This refers to the building blocks or variables. A construct is defined as *"an abstract form of concept which cannot be directly or indirectly observed but can be inferred by observable events"* (Meredith 1993, 5) (example: core competence) and a concept defined as *"a bundle of meanings or characteristics associated with certain events, objects, or conditions and used for representation"* (*ibid.*) (examples: cold, symposium chair). *Concepts are "universal classifications that we develop from our observation of individual instances of something"* (Greetham 2008, 9). There are two main criteria for evaluating this: the comprehensiveness and parsimony, leading us to conclude that the most important variables have not been neglected or that the irrelevant factors have not been included. Nevertheless, some space should be given to error so that with time there can be the possibility to refine the theory.
2. **Why?** Questions the underlying socio-economic and political rationale for specifically referring to certain factors and the justification for their relationships. 'What' and 'how' offer the explanatory basis, while 'why' explains.
3. **How?** The set of identified factors related to each other.
4. **Who-Where-When?** This combination of elements refers to the actors (individual or collective), the context (Ghana), and the time. These elements help to derive meaning from the phenomenon being described and explained. From the contextualist outlook, meaning is derived from the context (Gergen 1982; Whetten 1989).

On the basis of the above, value co-creation is defined as: a values-based bargaining model of collaborative efforts between multiple actors in co-generating desirable outcomes for and by the consumer. It essentially includes the procedures of interpretations of all the maximum socio-economic benefits through services, products or technologies for the mitigation of undesirable

outcomes (value co-protection). The key terms in the definition are detailed as follows:

- *Values-based*: without moral principles underpinning the day-to-day operations the generation of social benefits will hardly come about.
- *Desirable outcomes* refer to all maximum socio-psychological, economic, political, environmental, ethical and health results.
- *Undesirable outcomes* refer to the lost, untapped or underused opportunities, unprotected resources (e.g. intellectual property, consumer safety), and unformed or unharnessed alliances to produce unique value that increases mutual gains.

Thus, value co-creation is an economic investment based on sociological catalysts in a dynamic relationship, sometimes underpinned by binding provisions for safeguarding the value propositions. The ultimate goal of such a process is to satisfy the different mutual expectations of global health actors through value appropriation within the economic sphere with the firm/organization as the nucleus. It follows that the potential value to be captured (shared or appropriated) through diverse forms of competition by actors plays a fundamental role in determining the level of actors' commitment (Afuah 2000) and how power is played within the game. Afuah (2000) refers to these coopetitors as the firm's vast network of cooperation. This consists of financiers, suppliers, customers, industry rivals and complementors as well as other non-market actors and institutions with whom the focal organization makes cooperative investments to create maximum socio-economic benefits (value) and competes to appropriate these outcomes.

The major components of value co-creation in the pharmaceutical sector in the context of transitioning economies are theorized as follows:

1. **What?** Nature of value: Principally, value consists of unique pharmaceutical products and technologies for cure and diagnostics, services, and the socio-economic (profits and reputation), political and environmental relevance. *"I think value can be defined by geographical points; for example, meeting unmet medical needs, providing high customer value or offering safe and quality medicines to users in the WECS African context where lifesaving medicines are more essential than lifestyle medicines"* (Director/Eli Lilly, interview in Washington DC). *"This is how I see it: maintaining the protection of high quality standards and ensuring accessibility is what value constitutes"* (Director of global anti-counterfeiting/Eli Lilly, interview in Washington DC). *"Value for me is the untainted integrity of a service or a product; I mean it [prod-*

uct/service] must be genuine in its integrity" (President of the Partnership for Safe Medicines, interview in Washington DC).

2. **Why?** Rationale:
    - Value co-creation is a pragmatic quest for optimal level of efficiency now and in the future through decisions and trade-offs (Posner 2003). This is, however achieved through a combination of SCR as proposed earlier. For example, creating outputs such as track-and-trace detection technologies requires highly technical core competencies. The initial endowment of each firm or organization may not be sufficient. Therefore, the necessity to cooperate becomes the obvious trajectory towards success.
    - Value co-creation is explained by the quest for legitimacy (Kostova & Zaheer 1999; Turcan, Marinova & Rana 2012) through partnerships (Suchman 1995) and as a measure to reduce adversarial interactions between firms and CSOs (Baur & Palazzo 2011). Thus, legitimacy is gained by proactively responding to stakeholder pressures through dialogue and relationships.
    - Search for synergy: The need to aggregate diverse inputs—what one organization can do, two or more organizations can do better in a unique way.
    - Value co-creation can also be explained as a reflection of evolutionary dynamics. The evolution of major global health problems and their sheer magnitude naturally demand the aggregation of political, industrial, economical and technical inputs to offer durable solutions—sustainability.
    - Finally, value co-creation is now essential because consumers have become innovators or a salient part of the process of innovation (Bogers, Afuah & Bastian 2010). Their involvement in value co-creation is therefore indispensable. Additionally, technological changes, globalization, market turbulence and institutional pressures are the main drivers of co-creation bargaining models.
3. **How?** *Modus operandi*: via technical innovations (new commercially viable products and services), socio-economic political processes and the combination of traditionally unrelated capabilities aimed at adapting to emerging turbulence with speed and across a diverse geographical area while limiting the chances of failure. Within the broader scope of creating value, non-market actors such as churches and health-oriented NGOs play the role of intermediation between governments and firms (Austin 2010).

4. **Who?** Value co-creation in the pharmaceutical sector involves diverse actors, or what Rod and Paliwoda (2003) refer to as multi-sector actors. Austin (2010) refers to cross-sector social partnerships as consisting of firms, governments, NGOs and multilateral institutions. The consumer is the source of knowledge, experience and feedback (e.g. recommendations and warnings about the quality of the product) (see the model on responsible value co-creation in Article 1). As Austin (2010, 15) argues, *"to the extent that sustainable cross sector alliances emerge, then institutional social capital has been created."* Partnerships can also involve coopetiting actors such as the focal organization, government and other rivals (Afuah 2000).
5. **Where?** Where value co-creation is pursued depends on the identification of the latent needs of either a community of place or a community of interest (opportunity). This, however, should match with the entrepreneurial drive of the organization (risk).
6. **When?** The time for value co-creation comes into focus once the need for consumer-centered sustainable innovations becomes the central agenda. The initial condition can either be a period of turbulence or stability.

An important overall conclusion is that one cannot protect value unless it is first created, and one cannot sustain value unless it is protected in the long term. It follows in a logical cause and effect reasoning that only human values (cultural-cognitive and normative institutions) prompt the need to protect value so that it can be captured not only now but also in the future (sustainable global health). Can this happen without the co-responsibility of all actors along the value chain? This is a question that can only be logically answered in one direction: no. Therefore, the elements of value co-protection are:

- Sustainability: safeguarding the present value for future use;
- Preservation: avoiding waste, destruction and negligence that will then affect the value to be conserved or the cooperative investment in the future;
- Innovative anticipation: proactive adaptation to emerging challenges that will affect future value;
- Local–global linkage: value co-protection that does not destroy the distal value in order to protect the proximal, or vice versa;
- Stakeholder engagement: recognizes organizational responsibility as well as endogenous and exogenous inputs from related actors in providing versatile institutional conditions for long-term protection of value;

contextually relevant to moral ethical and socio-psychological considerations and demands.

4.4 Conclusions on the analysis of value and values in global health

How do values facilitate value creation under conditions of complex dilemmas which create a need for entrepreneurial behaviour that aims at fixing a social problem through the operations of an illegal enterprise? Will driving without a license be justifiable for taking a severely sick person to the hospital because it will create value for the patient (saving the life)? While the study can hardly do justice to this complex phenomenon of pharmaceutical counterfeits, it attempts to capture the full spectrum of my field experience. At present, my research does not fully provide exact answers to some of the questions about values and value creation in global health. For example, what if the drugs on sale to patients are knock-offs (i.e. products sold at affordable prices which are equally efficacious and of high quality as those produced by legitimate pharmaceutical companies but manufactured by illegitimate, unlicensed or underground lone-wolf or smaller businesses)? Clearly, the means is deficient but the end is about saving lives. This is especially true for the Ghanaian local herbal manufacturers who still operate mainly in the informal herbal sector. Formalization of a business enterprise is costly and painfully slow across Africa. The initial capital to start a business with all the associated regulations is extremely difficult to procure (Lartey & Graham 2007). The Ghanaian hospitals are not always the first best options. In the minds of consumers, herbal medicines are orthodox, just as the imported Western medicines, or are even considered the first best choice in most cases.

Sustainable global health may be the defining ethos of our time but whether or not policy makers, strategists or advocates care about this is very much dependent on values which are shaped by prevailing institutional logics, situational, environmental and social conditions (Muir Gray 2004; Thuraisingham & Lehmacher 2013). The belief systems, worldviews and other individual proclivities are fundamental elements that shape decisions leading to a systemic change. All actions by major actors in global health are clearly a function of values, shaped by worldviews.

Until ethical behavior is legislated to check those who flout rules, opportunism and neglect of the greater social good will always produce pernicious outcomes. The disharmony of values of the policy makers and strategists will also make for unpredictable outcomes. Globally, a consensus is developing about the needs of those who are too under-privileged to fully participate in global health value co-creation. Following Stewart et al. (2010), the pertinent ques-

tion is: how is value created and measured? Who creates value of health and for whom?

Furthermore, value is clearly a central issue in all socio-economic interactions but is seen and appreciated differently in different disciplines. While many have for long focused on product value, there is however an emerging consensus that value is created within relationship and that the quality and commitment that comes with nurturing relationships between socio-economic actors is more crucial than ever (Grönroos 2000; Ravald & Grönroos 1996). The paradigm shift is clear: the firm no longer stands for a provider of goods and services but one that designs or makes value propositions of a 'system of activities' (Lindgreen & Wynstra 2005, 738) *"within which customers can create their own value"* (Wikström 1996, 360). Value co-creation then takes place in a relationship, and more: especially in global health it takes place in CSSIs and other ecologies of engagement. This is what Austin and Seitanidi (2012) refer to as a shift from sole creation to co-creation. There are diverse configurations of collaborative co-creation: for example, the dyadic relationships between businesses, business and consumers, or business and NGOs. In the next chapter, I focus on the roles and responsibilities of major global actors in co-creating value in global health.

5 ECOSYSTEMS OF ENGAGEMENT IN GLOBAL HEALTH

This chapter examines the responsibilities (the combined efforts) of the major actors in creating value in global health, otherwise referred to as ecologies of engagement: pharmaceutical MNCs, NGOs and other non-market actors. The role of governments is also analyzed alongside the major actors (Figure 7). The chapter further develops a taxonomy of non-market global health actors.

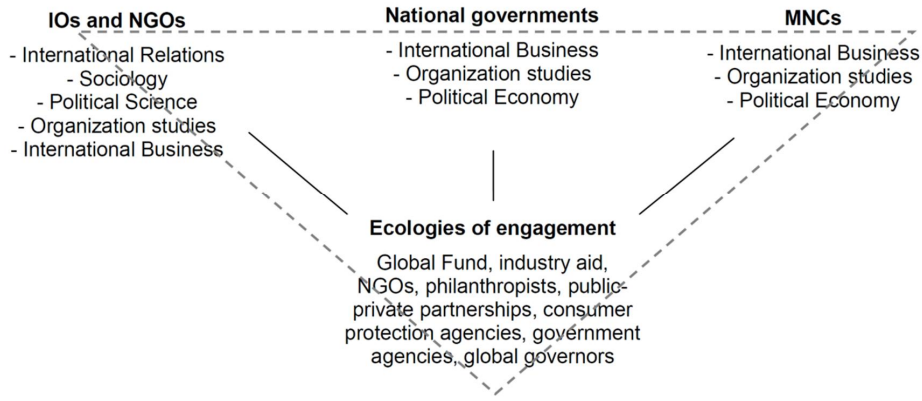

Figure 7 The interactive roles of institutions and actors in consumer protection in global health governance. The dashed line indicates the connection between the actors and the related disciplines.

5.1 Ecosystems of engagement in global health value co-creation

In the late 1990s, numerous initiatives challenged the pharmaceutical industry and redefined international CSSIs to solve public health problems with positive outcomes. Jeffrey Sachs refers to these as ‘ecosystems of engagement’ (Green 2013). Within these ecosystems, or the sphere of socio-economic and political responsibility for production, provision of services, and governance of global healthcare, the roles of individual and collective actors are no longer mutually exclusive. Four major forms of collaborations are evident in global health: (i) business–NGO, (ii) government–NGO, (iii) government–donor (multilateral organizations), and (iv) business–government–NGO or public-

private partnerships (PPPs). Some non-business international actors operate autonomously or on behalf of governments (Schemeil 2013).

The roles of NGOs in governance and value creation in diverse sectors are well researched (Teegen et al. 2004). Current research suggests that in the context of global health, there is a dwindling boundary, or in some cases there are no clear-cut boundaries, between hoCSOs (NGOs), IOs, intergovernmental organizations (IGOs), businesses (MNCs and SMEs), and the public sector in transitioning economies (CPIAWG 2011; Feldbaum et al. 2010; Okuonzi & Macrae 1995). This is explained by economically developed countries' global foreign policy, geopolitics and trade relations with transitioning economies (Feldbaum et al. 2010; King 2002; Labonté & Gagnon 2010). For the multilateral financial institutions and governments, global health issues, such as counterfeit medicines, are regarded as a security threat to economic development, human rights, international business, and global health as a public good. The afore-mentioned are intrinsically intertwined (Labonté & Gagnon 2010). Further, there is now a changing role for all the diverse organizations. The big organizations in the non-profit sector (also called charity or voluntary sector) are being governed like corporations (Jegers 2009). Their sizes and the adoption of business management approaches make them resemble firms. Evidence of this is witnessed by the fast pace at which these organizations are going through a process of 'marketization' (Eikenberry & Kluver 2004).

Moreover, at the industry front, pharmaceutical firms now pursue a form of social entrepreneurship (Baron 2007) under social pressure to make access to medicines possible in transitioning economies (BBC 2013). This is, however, a strategy for seeking legitimacy (March 2006; Suchman 1995). For the firm, questions of legitimacy or practices that do not deviate from institutional expectations through SCR orientation (Ahen & Zettinig 2013) are fundamental in their international business operations.

Firms, however, play significant political roles in transitioning economies (Palazzo 2011; Scherer & Palazzo 2011). In general, they exert much influence on governments and nations through political lobbying (Bakan 2004; Banerjee 2007; Epstein 1969) and the use of mass media and internet technologies. They sway public opinion on major global issues using public relations and political activism (Dunlap & McCright 2011). As Susan George (2014, 15) argues:

> *It's not just their size, their enormous wealth and assets that make TNCs [transnational corporations], dangerous to democracy. It's also their concentration, their capacity to influence, and often infiltrate, governments and their ability to act as a genuine international social class in order to defend their commercial interests against the common good.*

All these factors profoundly shape public policy and the very nature of society (Barley 2010; Sukhdev 2012). In global health in particular, the pharmaceutical industry remains a very powerful political player (Abraham 2002; Abraham & Reed 2001). As with all corporations, employing their political resources becomes imperative when facing rivals, governments and other forms of pressures (Bonardi 2011; Wei 2006). This is how they protect their actions and conducts from being questioned (Meyer & Rowan 1977) in the quest for survival and sustained competitive advantage (Porter 1990).

An emerging theme in global health is how big pharmaceutical companies team up with NGOs and governments to provide access to drugs for some essential diseases through R&D. These are commonly featured in international news. For example: *"Britain's biggest drug manufacturer GlaxoSmithKline has launched a new partnership with Save the Children to develop medicines to tackle child mortality in Africa"* (BBC 2013). Also, governments now engage in PPPs to co-produce essential public health goods (Nwaka & Ridley 2003; Osborne 2000). In what follows, the roles of the major actors in global health are discussed in detail, starting with the pharmaceutical industry.

For Hearn and Pace (2006, 55) there have been enormous shifts in value creation activities towards what they conceptualize as 'value-creating ecologies'. These shifts in thinking or paradigms are reflected in the changes from:

1. *thinking about consumers to thinking about co-creators of value;*
2. *thinking about value chains to thinking about value networks;*
3. *thinking about product value to thinking about network value;*
4. *thinking about simple co-operation or competition to thinking about complex co-opetition; and*
5. *thinking about individual firm strategy to thinking about strategy in relation to the value ecology as a whole.* (*ibid.*)

First, a distinction must be made between the value chain and the supply chain. Concerning the concept 'supply chain', as Sahay (2003, 76) argues, the traditional focus of firms has been on the *"flows within the organization or flows over which the organization has direct control."* Conversely, Hearn and Pace (2006) argue that supply chain per se describes the process of mere distribution, denoting a cost that requires minimization, whereas for the value chain, each phase of the process is a value adding activity that needs to be optimized and maximized (see also Parolini 1999; Porter 1985; Walters & Lancaster 2000). Further, Hearn and Pace (2006) argue that the value chain metaphor has several weaknesses when applied to the digital industry.

In a similar vein, I argue that most of Hearn and Pace's (2006) arguments are also applicable to value co-creation in global health. For example, whereas

the value chain denotes linearity in a process where one stage ushers into another, this is not the way things work in the global health domain. Thus, the mechanistic, straightforward metaphor immediately clarifies but also has the limitation of obscuring the complex dynamics which is revealed only after a nuanced analysis. Further, the value chain process, when applied to global health, ignores the fact that the process is both competitive and cooperative (as well as antagonistic and criminal actors), especially where there are countless stakeholders pulling in different directions. Additionally, it simplifies the notion of value as if value is embodied only in the product (medicine) while ignoring the environment (determinant of health) and other external relationships to the systems. Finally, the value chain isolates from other systems that impact the creation of value in the first place. This is why several authors have resorted to other nomenclatures than the value chain. Stabell and Fjeldstad (1998) use the concepts 'value shop' and 'value network' to denote value creation occurring at the firm level. Sawhney and Prandelli (2000) use 'communities of creation' to describe how to manage innovations in turbulence. Hearn and Pace (2006) use the term 'value ecology'. Moore (1998) coined the term 'business ecosystem' to clarify the nature of long-term mutual dependence between organizations, or as Hearn and Pace (2006, 56) put it, an extended system of mutually supportive organizations. Seuring (2004) uses the term 'industrial ecology' to describe how groups of firms supportively manage and coordinate information flow from raw materials to finished products and to final waste disposal in their quest to achieve sustainability. This is very close to Kaplinsky's (2000) definition of the value chain. For Hearn and Pace (2006), "*another term for ecology is the 'web of life' and another term for web is network. Therefore, implicit in the value ecology model is a dynamic, multi-directional cluster of networks.*"

Using the 'ecosystems/ecologies of engagement' metaphor to describe the complex and interrelated process of value creation in global health has the following implications:

i. It captures the fundamental notion of the interdependence of business and non-business actors and governments.
ii. It points out the emergence of a new phenomenon as the product of redirection from sole creation to co-creation, which Prahalad and Ramaswamy (2004) argue as the very essence of value. This also denotes a shift from firm-centeredness to consumer-centeredness. Here, society is challenging the traditional firm-centric logic of value creation and value capture which marketing has inherited from micro-economics; that is, the customer is the co-producer and co-creator at any given point, time and place of the value chain.

iii. It suggests that the consumer needs to take the center stage and must be prioritized in global health policy (see e.g. the United Nations Millennium Development Goals, MDGs).
iv. This leads us to emphasize the complex socio-economic, political and ethical nature of the distinct organizational forms competing and cooperating in order to align their goals with the emergent demands of the consumer. It is expected that this will allow them to gain legitimacy in a new global health order.
v. The engagement to co-create value emphasizes the co-evolution of the multiple sectors from antagonism to partnership.

5.2 Big Pharma – clusters of techno-scientific and political capabilities

Cantwell et al. (2010, 569) refer to the MNC *"as a coordinated system or network of cross-border value-creating activities, some of which are carried out within the hierarchy of the firm, and some of which are carried out through informal social ties or contractual relationships*." This definition reinforces the idea of strong collaboration outside the pure business arena. They further postulate that "*an MNC is not defined solely by the extent of the foreign production facilities it owns, but by the sum total of all of its value-creating activities over which it has a significant influence*" (*ibid.*).

Beyond the above general background, the pharmaceutical MNCs (also called Big Pharma) are large science and technology-based firms creating and capturing value in several different geographical areas. They can simply be referred to as knowledge-based industries (Bruche 2011; Pisano 2006). Their functions may generally include R&D, innovation, production, and commercialization of pharmaceutical products and services (Gambardella 1995; Pisano 2006). In particular, their activities have the goal of discovery and development of medicines for the purpose of curing (therapeutic purposes), prevention (prophylactic purposes) and diagnostics of medical pathologies. Hospital and medical technologies are also often integrated into their operations (Granlund & Lukka 2009; Hermans, Kulvik & Ylä-Anttila 2005; Sklair 2002). Following Smith (2013) on a more technical level, however, pharmaceutical MNCs can be defined as 'clusters of capabilities' with an evolving know-how to configure resources that allow them to invent medical products, acquire regulatory approval, and to meet different current and emergent consumer needs and preferences in diverse consumer segments internationally. Most importantly, in the context of anti-counterfeiting initiatives, they engage in the serialization, drug pedigree processes, product identification, and manufactur-

ing and commercialization of track-and-trace technologies and information capturing devices.[5]

What is unique about pharmaceutical firms, which makes them relatively different from other industries (even though they may demonstrate speedy evolutionary patterns that are similar to other advanced technology industries), is the stringent and complex regulatory framework under which they operate. In addition, the lengthy and complex process of R&D (Gambardella 1995) and the heavy financial investments in preclinical tests on animals and clinical trials on human subjects (Stiglitz & Jayadev 2010) as well as the ethical questions accompanying all these are peculiar to pharmaceutical firms. The two latter points are the most sensitive and controversial issues in the whole drug development process (Emanuel, Wendler, Killen & Grady 2004).

The forms of market in which pharmaceutical MNCs operate are mostly oligopolistic. This means that traditional firms are huge and have superior production power, the advantage of economies of scale due to size, sophisticated distribution channels, better links and access to exogenous pool of financial resources for market expansion, in-house R&D departments or collaboration with institutions such as universities, and the ability to attract experts or very highly skilled labor for innovative technical and market operations internationally (Gambardella 1995; Krugman & Obstfeld 2005). The result of this is an entry barrier sealed with huge capital outlay, cumulative techno-scientific innovations, and large-scale market coverage of over US$ 800 billion by 2009 figures (Bruche 2011) and US$ 1.3 billion according to Schoonveld (2015). Big Pharma's possession of huge intellectual property rights as an entry barrier makes them a fortress industry, mainly centered in the triad: US/Canada, Europe and Japan (see Table 3).

A few firms from India and China position themselves mainly in the generic production industry to serve transitioning economies (*ibid.*). However, according to Lembit Rago, Head of Regulation of Medicines and other Health Technologies at the WHO: *"Eighty percent of all active pharmaceutical ingredients are manufactured in India and China"* (Osterath 2014). Given the sizes and resources of Big Pharma, their extensive bargaining power vis-à-vis host governments in transitioning economies is almost uncontrollable (Ghauri & Buckley 2002) as with all multinationals operating in weaker institutions (Ahen 2012; Hymer 1960/1976; Ietto-Gillies 2002). By contrast, local pharmaceutical firms in transitioning economies have serious resource limitations and that leads to the continual use of ordinary capabilities. This, however, does not lead to any significant improvements or competitive advantage and

[5] www.GS1US.org

may explain why pharmaceutical MNCs have their home countries mostly in the triad.

5.2.1 Controversies about Big Pharma

In the pharmaceutical industry *the process is the product*, and in the process there are many players (stakeholders). The past couple of decades have witnessed a significant increase in conflicts of interest between Big Pharma and their atypically numerous influential stakeholders, mainly: regulators, NGOs, governments, and consumer organizations (Goldacre 2012; Mullin 2009; Nwaka & Ridley 2003; Schipper & Weyzig 2008; Smith 2008). Freeman (1984) refers to stakeholders as individuals and/or organizations [private and

Table 3 Top 20 pharmaceutical companies in 2013[6]

Rank	Company	Location	Revenues[7] 2013 Sales	Revenues[5] 2013 R&D
1	Johnson & Johnson	USA	67.22	8.18
2	Novartis	Switzerland	57.92	9.85
3	Roche	Switzerland	52.52	9.76
4	Pfizer	USA	51.58	6.67
5	Sanofi	France	45.40	6.57
6	Merck & Co.	USA	44.03	7.50
7	GlaxoSmithKline	UK	43.93	6.50
8	Bayer	Germany	40.16	4.39
9	Fresenius	Germany	28.01	0.48
10	AstraZeneca	UK	25.71	4.82
11	Eli Lilly	USA	23.11	5.53
12	Abbott	USA	21.84	1.45
13	Boehringer Ingelheim	Germany	20.97	3.77
14	Teva	Israel	20.31	1.43
15	Abbvie	USA	18.79	2.85
16	Amgen	USA	18.68	4.08
17	Takeda	Japan	16.41	3.14
18	Bristol-Myers Squibb	USA	16.38	3.73
19	Novo Nordisk	Denmark	15.43	2.15
20	Baxter	USA	15.26	1.25

public, internal and external] who affect and are also affected by the firm. Post, Preston and Sachs (2002, 8) propose that "*the stakeholders in a firm are individuals and constituencies that contribute, either voluntarily or involun-*

[6] Source: Current Partnering, 2014; www.currentpartnering.com
[7] US$ billions

tarily, to its wealth-creating capacity and activities, and who are therefore its potential beneficiaries and/or risk bearers." What about externalities? What these stakeholders advocate for is a bigger responsibility of the firm, which in large part appears to have been ignored and brought into dispute (Banerjee 2007; Bowen 1953; Campbell 2006; Carroll 1991; Clarkson 1995; Davis 1960; Donaldson & Preston 1995; Frederick 1960; Vogel 2005). There are, of course, others who hold the opposite view, such as Friedman (1970).

This impasse has intensified the already heightened tensions and drawn significant attention from academia, practitioners and policy makers concerning how to deliver value to the consumer (Gambardella 1995; Jain, Weintraub, Rhatigan, Porter & Kim 2008; Kim et al. 2010; Porter & Teisberg 2006; Schipper & Weyzig 2008; Sklair 2002). Current mainstream IB management literature on this issue is comparatively sparse and mostly limited to Western markets and a few transitioning economies (but less so in the healthcare and law literature) (Buabeng 2010; Mackey & Liang 2011; 2012; 2013). Precious little systematic attempt through empirical studies has been made to theorize about the institutions of transitioning economies where new drug markets are now being discovered (IMS-Health 2012; Macdonald 2011a; 2011b). Further, little has been done to explain what constitutes CR and whether the contextual demands of transitioning economies have any significant effects on corporate strategy orientation and collaborative initiatives to counter value destruction activities such as counterfeits and in what institutional context.

The resultant trend is the high temptation to take a crusading view of Big Pharma in support of public outcry for more responsible corporate practices in clinical drug testing, pricing and provision of quality drugs in transitioning economies (e.g. Barnes 2006; 2007; Petryna 2007; Schmidt 2005). Nevertheless, emerging information technologies have meant that access to medicines can no longer be understood in the traditional sense. The means of access now include the Internet (Class 2012), which is also a source of threat to consumers due to the abundance of counterfeits with global reach. With regards to access to medicines, scholars usually take two approaches of analysis. (i) The governmental model emphasizes the responsibility of institutions (e.g. Stiglitz 2006; Stiglitz & Jayadev 2010). (ii) The corporate perspective (Osuji & Umahi 2012) emphasizes the vital role of firms in ensuring access to medicines in developing nations, where pricing, patent-driven practices, and unethical arguments are the factors that explain the causes of low access to medicines. Both approaches are, however, required if value co-creation can be possible in the complex domain of global counterfeiting where multiple stakeholders must be factored into the equation.

5.2.2 Big Pharma and stakeholder issues in transitioning economies of WECS Africa

The pharmaceutical industry is 'the most important industry' in the world (Smith 2013) alongside the food industry for human preservation. However, its evolution is marked by increasing conflicts, some even unprecedented. It is also the most heavily regulated industry. This may be due to the fact that externalities produced by this industry cannot be easily safeguarded only by market mechanisms (Katsikas 2011). The regulations are also due to the direct impact of the sector on public health concerns. Although the exact costs incurred in drug development remain a mystery—it is estimated at US$ 600–800 million (462–616 million Euros)—and the average time for developing a new drug is 10–12 years (Gehrke 2012). *Public Citizen* (2001), a US consumer advocacy organization maintains that the actual cost incurred in drug development is at most US$ 110 million. The gargantuan difference lies in the calculation of the opportunity cost of over US$ 100 million per annum during the process of drug development (Gehrke 2012). This explains the strategic importance of the industry in monetary terms.

Principal among the Big Pharma–stakeholder conflict generators in transitioning economies is the demand for quality drugs at affordable prices on one hand (product issues), and the need to ensure drug quality and efficacy while protecting trial subjects in transitioning economies on the other (people issues). Besides the problem of affordability lies the big question of a basic health infrastructure in transitioning economies (modern logistics, efficient supply systems and pharmacies) and qualified healthcare personnel to manage and disburse drugs (doctors, pharmacists, nurses) (Gehrke 2012; Yang et al. 2010). Further, the fundamental question of structural determinants of health must be addressed as a shared institutional responsibility that encompasses markets, ethical and political levels to stem the tide of causes of diseases in the first place (Hill 2011; Schrecker 2012).

Third, central to these questions is the need for companies to survive by making profits or capturing value while being able to reduce costs (principal–agent issues) (Emanuel, Wendler & Grady 2000; Jensen & Meckling 1976; Santoro & Gorrie 2005; Schipper & Weyzig 2008). For example, the British pharmaceutical giant AstraZeneca announced in January 2014 that it was renouncing R&D for malaria, tuberculosis and neglected tropical diseases. They will rather be focusing on drugs for the affluent: cancer, diabetes, and high blood pressure (Balasegaram 2014). Balasegaram (2014) argues that taxpayers pay twice for medicines because R&D is heavily subsidized by governments with taxpayers' money. On a global scale, more than 40% of all R&D is paid by public and philanthropic organizations and the figure can be double for

some neglected diseases. Concrete examples of financial support for pharmaceutical research include *"taxpayers' money…disbursed at universities or…tax deductions the companies receive for their research"* (Gehrke 2012). Patients then have to again pay the high price of accessing patented medicines whose production they have already subsidized. This instrumental approach of purely for-profit business is only embraced by those who receive the direct financial benefits—the shareholders.

The fourth problem concerns MNCs' process of transitioning to capture emerging markets in transitioning economies. Essentially, the current stock of resources/capabilities and products is mostly designed to serve Western and some emerging markets but not institutionally diverse business environments such as WECS Africa. This latter problem is motivated by the fact that the market potential and favorable institutional conditions in WECS Africa are self-evident (Meyer 2004). However, the existing business models (Casadesus-Masanell & Ricart 2011; Chesbrough 2010) and capabilities (technologies and organizational systems) of MNCs are not shaped towards capturing such markets (i.e. the problem of transition) or meeting the emerging opportunities and challenges. This explains the slow pace of internationalization in that region.

Fifth, critics point to a trend of deceptive marketing in the pharmaceutical industry despite the presence of strong regulatory measures. Such violations include undisclosed adverse effects of medicines, omission of risk information, and the misrepresentation of certain medicines as being of superior value although the evidence may suggest only a modicum of such clinical experience (Myslinski Tipton, Bharadwaj & Robertson 2009). Doctors, pharmacists, regulators and other stakeholders within the supply chain are cited as complicit (Goldacre 2012). In fact, there is still controversy as to whether the industry spends more on marketing and advertising than on R&D given the limited number of new blockbuster medicines (Angell 2004a; Myslinski Tipton et al. 2009).

Sixth, there are concerns about the firms' concentration on the overproduction of drugs for perceived diseases in advanced countries whilst neglecting the most needed drugs for the cure of tropical diseases such as malaria and tuberculosis (Braithwaite & Drahos 2000; MSF 2001; Nwaka & Ridley 2003). Although much research is conducted on such diseases in various universities, a few companies pay attention to the development of drugs against them (Gambardella 1995; Jarvis 2009), thus increasing the lack of access to medicines (Osuji & Umahi 2012). The result of this 'negligence' or 'irresponsibility' is the deaths of millions of people (Barnes 2007; Jarvis 2009; Schipper & Weyzig 2008). According to Balasegaram (2014), the CEO of the German pharmaceutical company Bayer, Marijn Dekkers' comments on one

of the company's cancer drugs *"sum up everything that is wrong with the pharmaceutical R&D industry today[:]… Bayer 'didn't develop this product for the Indian market; we developed it for Western patients who could afford it.'"* Peter Frost, the former vice president for Pfizer, explaining the nature of Big Pharma's reluctance to engage low-income consumers, argues that:

> *There is a very big fear that they [drug companies] will ruin their own business model, and I think it's understandable. Drug companies are not there to protect the Third World. They are there to make money. Pure and simple. That's it* (Gray 2013).

In defense, however, there are mainly instrumental reasons for this neglect of markets in the transitioning economies. The top blockbuster drugs are positioned for 'diseases of the rich' such as depression, hypertension, peptic ulcers, obesity and cholesterol reduction. Further, the aging populations of Western Europe, Japan and the USA provide an immediate domestic market for pharmaceutical industries (DiMasi, Hansen, Grabowski & Lasagna 1991). This makes internationalization and a strong presence in the transitioning economies of WECS Africa less urgent. This has drawn significant pressure from diverse groups of influential stakeholders in demand for greater CR on the part of Big Pharma.

Thus, we are led to the seventh problem. The reason for these stakeholder demands is unpretentious; the vacuum is now being filled by sophisticated networks of counterfeiters who offer dangerous versions of such essential drugs to consumers. This vacuum is the result of institutional voids which Rodrigues[8] (2013) refers to as gaps that arise from a fast economic growth on one hand and a slow pace of development of the socio-political and regulatory institutional structures on the other. Initially, drug safety and efficacy were the main questions being pursued by stakeholders but public pressure mounted since the 1990s to push for affordable prices both in the Western countries and in transitioning economies (DiMasi et al. 1991). Questions pertaining to counterfeits have now resurfaced as a massive global problem (Mackey & Liang 2011; Shepherd 2010). The single most important impact of counterfeits is the increasing rate of mortality and morbidity (Kelesidis, Kelesidis, Rafailidis & Falagas 2007). In fact, according to Bright Simons (2013), the inventor of mPedigree (a device for detecting counterfeit medicines), *"worldwide, counterfeit drugs and pharmaceuticals kill up to 2,000 people daily."* Moreover,

[8] Rodrigues, Suzana (2013) 'Understanding the environments of emerging markets: the social costs of institutional voids'. Farewell speech at the Erasmus University of Rotterdam, the Netherlands on the 13th of June 2013. Abstract available at: http://www.erim.eur.nl/events/detail/3063-understanding_the_environments_of_emerging_markets_the_social_costs_of_institutional_voids/

counterfeits contribute to huge financial losses for patients, their families and healthcare systems. Their effect on the intellectual property rights of responsible manufacturers and sellers of safe, quality and evidence-based pharmaceuticals is equally great.

Moreover, the effects from inaccurate active ingredients, counterfeit and substandard drugs do not only complicate matters at the individual patient level, they also cause drug resistance and hence loss of medicine efficacy. In transitioning economies, drug resistance is a particularly big scourge when it comes to antibiotics (Reardon 2014). These in turn lead to the loss of confidence in national and local healthcare systems, clinicians and other healthcare workers. The presence of counterfeits means that the enormous financial resources committed into R&D of new therapeutic and prophylactic treatments, optimizing existing formulas, conducting clinical trials, manufacturing medicines, and introducing new regulatory measures become a waste (Newton, Green & Fernández 2010). Besides which, counterfeit drugs create massive political, and security problems that deserve greater attention from researchers, policy makers and professionals. Interestingly, "*the Russian Mafiya, Mexican gangs, Chinese triads and Colombian drug cartels have all moved into this form of income generation [international counterfeit drug trade], a shift that has been attributed to the pressure exerted by the American war on drugs"* (Reynolds & McKee 2010; Yankus 2006).

Figure 8 demonstrates what constitutes CR dilemmas for the pharmaceutical firm in its relationship with stakeholders and collaborators pushing in different directions. Further, it reveals the complexity of the practical question regarding how firms incorporate the conflicting CR demands of various stakeholders, including groups with vested interests, into their strategy and how these demands are met simultaneously. By epistemic fault line I refer to the artificial compartmentalization of ethics and strategy, which are the two sides of the same coin. They both reside in the mind of entrepreneurs, managers, politicians, policy makers and academics. One is used to cover the other. On one side of the continuum are conflicts with various regulatory agencies for medical ethics and drug security. On the other side are conflicts related to corporate ethics (Buller & McEvoy 2000).

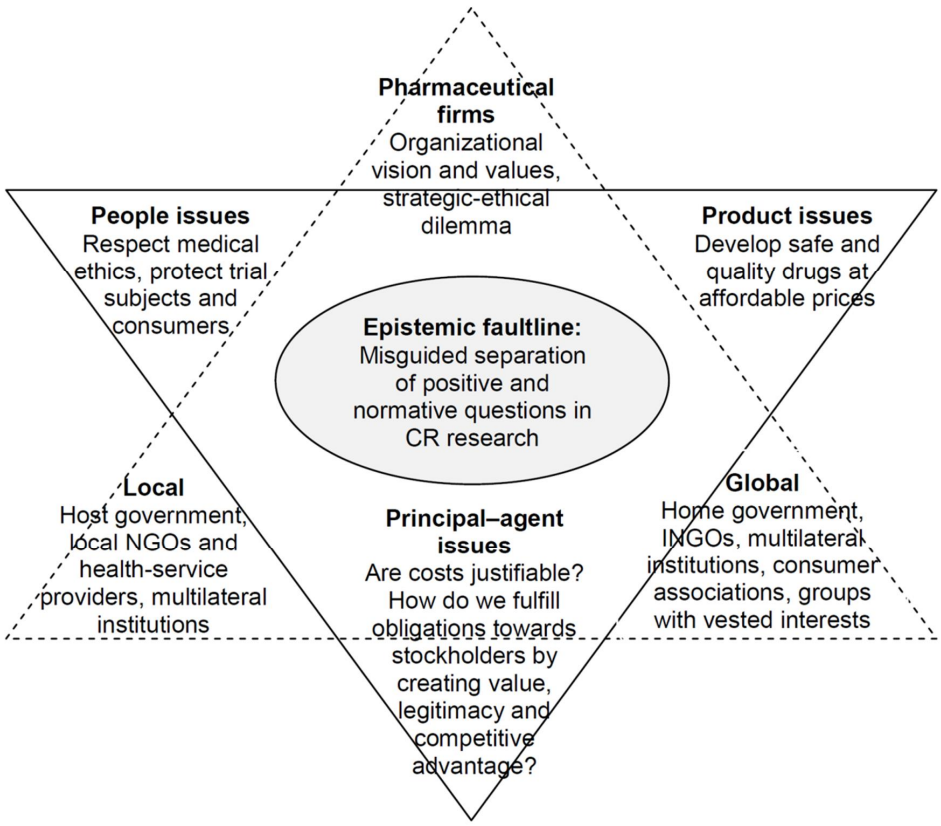

Figure 8 Triangle of pressures: issues (solid triangle) and actors (dashed triangle).

The process of drug R&D through the different trial phases prior to approval requires extraordinary capital outlay (Gambardella 1995; Nwaka & Ridley 2003). The challenge for management is to calculate the unforeseeable outcome and to balance this with the high degree of scrutiny both at home and in host countries. To ascertain the efficacy, safety and quality of drugs as evidence-based medicine (Park & Grayson 2008), drugs must always be tested on animals as well go through trials on human subjects to gain the approval of institutions such as the European Medicines Agency (EMA) and in the United States the FDA, although this may not always yield the most desirable results (Emanuel et al. 2000). At this juncture, the relevant question is: should the potential value of any of these clinical tests and trials justify the sometimes dangerous means by which they are conducted (May 1997)? At the same time numerous NGOs and institutions strictly monitor the process and outcome of such trials while the host country governments in transitioning economies are also ‘vigilant’, not only about the quality but how affordable the drugs are. This triangle of pressures on the firm becomes complicated because the firm’s

reputation, which in turn affects its performance, is at stake when the question of counterfeit is introduced (Payne, Ballantyne & Christopher 2005).

5.3 NGOs as political players in global health

Structurally, NGOs are configured in all forms of shapes and sizes: local, regional, international and even global ones. Their size (in terms of geographical reach) is certainly determined by their resource base and positions within a network. In terms of governance, some are managed through bureaucratic processes like huge multinationals whilst others are managed like sole proprietorships or a mixture of volunteers from communities and hired professionals. In terms of funding, some depend on donations and foundations whilst others barely survive. In contrast, there are mega IOs which receive finances doled out to them to execute certain development aid programs (see Lewis & Kanji 2009). Ideologically they pursue different ends; some are religious whilst others have political agendas.

For NGOs to survive they need to operate efficiently and obtain real demonstrable results. This means they tend to operate where they can be visible. This is why they are also criticized for having an urban bias because they tend to concentrate resources where their visibility will increase whilst neglecting the far-flung areas where help may be most needed. This allows them to report some purported impact to ensure the continuity of funding for their programs (Galway, Corbett & Zeng 2012). This is a complex issue to unravel given that although they are non-profit, voluntary, and aim to provide some public social services, they remain rational open systems (Scott 1981) which set agendas and pursue certain expected outcomes. Sustaining their existence is certainly one of them—leading them to act strategically.

However, without NGOs, big or small, some vulnerable groups and their human rights will be denied a voice in society. This is the generality of issues but I will now restrict my focus to global health actors (e.g. health-oriented IOs) since they hold significant political power. As Hayek (1945) argues in his post-war treatise on the use of knowledge in society, for solving societies' problems, attention needs to be paid to local human and physical resources with sensitivity to the institutions. The grand theories on how global health inequities in accessibility to essential drugs, caused by market and policy failures (Reich 2000), must be solved ignore local solutions whilst employing the first best mindset (Rodrik 2008).

For Ählström and Sjöström (2005), generally CSOs can be divided into Preservers, Protesters, Modifiers and Scrutinizers. These labels are self-explanatory. Of these categories however, the Preservers are the only ones

who strategically partner with businesses to mutually achieve bottom lines. The others may have differing agendas which may not even qualify them in normative terms as NGOs. The latter three intrinsically maintain their independence. While Ählström and Sjöström (2005) argue that businesses should tread carefully with the latter three, it may also be counter-argued that a responsible business need not hold mistrust for NGOs if there is nothing dubious about their operations. The NGOs that mainly seek social justice and equity are scrutinizers, whose usefulness in society is to serve as checks and balances that allow for accountability. In their absence, where then will be the open dialogue and communication representing the voices of society? However, firms can productively engage such NGOs through partnerships to co-create and capture value (Austin 2010; Hamel, Doz & Prahalad 1989; Ingram & Roberts 2000).

The shifting roles of the global health actors demonstrate adaptation to society's emergent institutional and market changes through knowledge exchange, resource combination, and the quest for sources of efficiency, legitimacy and mutuality of interests (Kraatz 1998). The relationship between business, hoCSOs and governments has multiple objectives of co-production, co-creation, co-protection and delivery of public services (Pestoff & Brandsen 2008). Such CSSIs can, for example, provide security and manage systemic risks, such as counterfeit drugs affecting global health. Examples of health-related consumer protection (anti-counterfeiting) CSSIs include the International Alliance of Patients' Organizations[9] based in London and the Partnership for Safe Medicines[10] based in Washington, DC. Their localization emphasizes the historically unchanged nature of assistance, flowing from the North to the South. Nevertheless, these two organizations and numerous others bring together several hundreds of NGOs that may otherwise be fragmented and would not garner enough countervailing power to bring about change (Galbraith 1952).

5.3.1 Complexity of classifying NGOs

Vakil (1997, 2060) defines NGOs as self-governing, private, not-for-profit organizations that are geared towards improving the quality of life of disadvantaged people. This definition seems perfect for analyzing health-oriented NGOs. For Barr, Fafchamps and Owens (2005) NGOs exist for three major reasons: (i) to provide social services due to government failures (Rose-

[9] http://www.patientsorganizations.org/
[10] http://www.safemedicines.org/

Ackerman 1986); (ii) to serve as promoters for building social capital; and (iii) to advocate for or represent the voiceless and marginalized communities of place and communities of interest (Osuji & Umahi 2012). According to Rose-Ackerman (1986), four major reasons may explain the existence of NGOs: they are a response to (i) government failure or (ii) information asymmetries and transaction costs in business sector. (iii) They are spearheaded by entrepreneurs who in furtherance of private agendas employ the non-profit as a mechanism for self-interest, or (iv) they are a result of competitive interactions between non-profit organizations offering very similar substitutes. For economists who study NGOs, the non-profit sector is a service provider while others see NGOs as political institutions organized to exert influence on governments and corporations.

Anna Vakil (1997) attempted to build a taxonomy of NGOs based on two descriptors: essential and contingent. According to the author there have been many ways of classifying INGOs; one recurrent factor in this process is what Vakil, citing Tandon (1991), refers to as opaqueness, in the sense of non-transparent behavior of some international development NGOs. Such NGOs are characterized by secretiveness in decision making and resistance to evaluative measures by partners from the developing countries and host governments. Their hidden objectives tend to suggest a more sinister agenda. Besides, their tendency to universalize their values through induced development, employing Western organizational models that ignore local initiatives, shows a replay of the form of a civilizing mission, the strength of their bargaining power and, hence, the need to be subjected to scrutiny.

Elliott (1987, 57-59) offers a general taxonomy of NGOs based on their position or orientation on the socio-economic development. The three classes, or a combination of them, define NGOs since they may focus their orientation on more than one area, given their core competences or contextual exigencies. Elliott suggests that NGOs can be characterized as welfare-oriented, development-oriented and empowerment-oriented. A welfare-oriented NGO *"delivers services to specific groups."* A development-oriented NGO offers *"support of development projects which have as their ultimate goal improvement in the capacity of a community to provide for its own basic needs."* An empowerment-oriented NGO understands *"poverty as the result of political processes and is therefore committed to enabling communities to enter those processes"* (p. 58). The context, interest and resources involved in how things get done are however important and very much dependent on the institutional environment. For our purpose, health-oriented NGOs seem to embody all three characteristics.

The above definitions demonstrate that the diversity, complexity and the skyrocketing numbers of NGOs makes it difficult to classify them or to make

generalizations about them through empirical studies; and more so in global health without a proper context or clearly defined boundaries. For this reason, the context of IOs and INGOs will not be stretched any further from the territory of global health in the analysis that follows.

5.3.2 The role of international organizations and international NGOs in global health

Principally, the literature about IOs and INGOs falls within the sphere of international relations and political science as well as administrative science disciplines, but less so with IB. In recent years, however, nomenclatures such as TNCs, NGOs, IOs, and IGOs are now being addressed in the same literature. This explains the increasingly strong interrelations and blurring spaces of operation of these business and non-business actors. That further demonstrates the evolutionary nature of business and non-business affairs with global scope and the major actors involved.

In an excellent review, Gonzalez-Perez (2013, 51) for example, presents a definition of transnational actors as *"those actors who are not direct representatives of the state but potentially operate in the international sphere."* This definition is problematic since (i) it ignores the extent to which these actors are indirectly used as a proxy for the representation of the state's interests across borders; (ii) it ignores the transnational actors that are directly representing major powerful nations in international affairs within the context of global health and food security. USAID is a typical example. Further, (iii) it ignores the fact that almost all transnational actors are political actors; Big Pharma is an example (Abraham 2002). What can the alternative definition be? Transnational actors can then be defined as international actors (that are privately or publicly controlled) whose influences are backed in some way by home governments, either to directly or indirectly represent themselves and their home states' interests. Whilst Gonzalez-Perez' definition is a good first step, it does not totally analyze the fact that Western corporations differ from non-Western corporations in their operations. Western corporations tend to want to be free from any government control (neo-liberal agenda that seeks voluntary governance) whilst corporations from, for example, China have a very strong nexus with the home government.

Riddelle (2007, cited in Lewis & Kanji 2009) estimates that in 2004 INGOs were responsible for administering US$ 23 billion of foreign aid money; equaling one third of the total. This shows their importance and shifting roles especially when the aid money was used to be channeled mostly through governments prior to the 1980s (Lewis & Kanji 2009). The reason for this is that

there is what Galway et al. (2012) call an untested assumption that INGOs are less corrupt and more efficient than governments in managing developing aid money in transitioning economies. *"NGOs are implementers, catalysts and partners in development"* (Lewis & Kanji 2009, 22). For Baur and Palazzo (2011) INGOs are legitimate partners of corporations.

Nevertheless, there is also strong criticism of IOs and INGOs. Amongst which is the fact that they are seen as attempting to erode the centrality of the state, by advancing neo-liberal economic agenda through alternative development practices and the privatization of even social services (Galway et al. 2012; Lewis & Kanji 2009). The neo-liberal agenda centers on individualism and flexible managerialism that is certainly incongruent with community-based livelihoods and open markets. Such an agenda pits big multinational corporations against infant industries in transitioning economies. What's more, the neo-liberal agenda was backed by the IMF and the World Bank to impose structural adjustment programs on these economies as a precondition for accessing loans (Easterly 2006; Lewis & Kanji 2009; Sachs 2006; Stiglitz 2006). The structural adjustment programs meant a significant decrease in government expenditure in sensitive area such as education, healthcare, infrastructure, and innovation (Hilson 2005; Sachs 2006; Todaro 1989). In some cases the economies were almost run and policies dictated by the IMF and the World Bank (Sachs 2006).

The models pursued by INGOs provide institutional templates for the design of organizational structures: *"the positions, policies, programs, and procedures of modern organizations"* (Meyer & Rowan 1977, 343). This is what earns them social legitimacy, allowing them to resist efforts to change in order to prolong their lifespan. Nevertheless, INGOs, small or big, are powerful 'carriers' of institutions (Scott 2003), transporting and transplanting logics, cultural commodities and worldviews across the world of healthcare (Article 3).

5.3.3 Corporate irresponsibility in the voluntary sector

The existence of NGOs is shaped by myriad factors; for example, by their constant need for funding from donor agencies, businesses and now from Western governments which channel official aid through them (Barr et al. 2005; Pratt, Adams & Warren 2009). The fierce competition for the financial support (Mowles 2007) increases NGOs' need for visibility. In addition, it is problematic to strike a balance between the socio-ethical raison d'être of NGOs as moral agents pursuing social justice and development on one hand, and their need for financial resources for survival as they organize their opera-

tions with increasing stakeholder scrutiny on the other (Ossewaarde, Nijhof & Heyse 2008). Apart from funding their activities and satisfying their stakeholders (Lewis 2003), NGOs need to pay their professional staff in salaried positions. These individuals are no 'Mother Theresas' but seek to build their careers within this sector. This is where questions of irresponsibility appear in the form of abuses and the lack of accountability, just as it happens in the private sector. Ossewaarde et al. (2008) argue this with examples of abuses from the post-tsunami humanitarian intervention in 2004/2005. Moreover, critics argue that some NGO managers are highly trained professionals who may initiate projects, not necessarily because they care, but because they want to eke out a (sometimes) luxurious living by appropriating to themselves disproportionate sizes of resources meant for socially beneficial projects (Platteau & Gaspart 2003). As Platteau and Gaspart (2003, 1688) put it:

> *Witness to it [the abuses] is the rapid multiplication of national [and international] NGOs that are created at the initiative of educated unemployed individuals, politicians, or state employees who may have been laid off as a result of structural adjustment measures. These people, acting as 'development brokers', have been quick to understand that the creation of an NGO has become one of the best means of procuring funds from the international community.*

More to the above, there are countless chilling examples of irresponsible NGOs, also called 'briefcase NGOs' (Gathigah 2014) because they only exist on paper. For example, they grow at 400 organizations per year in Kenya, all in the name of helping the poor but only as a means to use the poor as an excuse for acquiring riches in millions of dollars. *"Most NGOs here are owned by individuals who 'have perfected dependency on donor aid as a cash cow for their survival'. They also use slums as money-minting machine"* (*ibid.*).

Additional critical perspectives on the role of NGOs can be found under the themes of:

- Shady innerworkings, accountability and transparency (Assad & Goddard 2010; Ebrahim 2003a; Murtaza 2012).
- Downwards accountability and resource control (Fowler 1985)
- Pitfalls in self-regulation, government regulation, donor monitoring and community participation (Burger 2012)
- Inclusive aid and power relations (Groves & Hinton 2004; Holcombe, Nawaz, Kamwendo & Ba 2004; Tembo 2004)
- Technocracy (Blue 2005): tyranny of experts (Easterly 2014)
- Corporatization (Dichter 1999; Mowles 2007; Pratt et al. 2009).

- Tension in NGOs' moral imperatives and financial needs (Barr et al. 2005; Edwards & Hulme 1996; Keevers, Treleaven & Sykes 2008; Lewis 2003; 2007)
- Values contestation, marketization (commercialization) and professionalization in NGOs (Mowles 2007; Weisbrod 1998).
- Internal governance (Barr et al. 2005; Ebrahim 2003b; Platteau & Gaspart 2003)
- Capacity building (Tembo 2004, etc.)

Notwithstanding the above arguments, it must be recognized that there are countless well-meaning faith-based and non-faith-based NGOs, especially in the health sector. Further, the community-oriented and bottom-up managerial approach of NGOs allows them to co-create value with and for socio-economically challenged populations (Fowler 2000; Vakil 1997) and build the capacity of under-resourced communities (local empowerment) (Tembo 2004). This earns them the moral and political legitimacy as socially oriented (Tvedt 2006), unlike business corporations whose survival depends on the accumulation of profits (Bougrine 2006). On the surface, these two creatures (businesses and NGOs) may be living on two different planets in the way they pursue general wealth creation and provide services (Mowles 2007). While businesses need to seek and defend their legitimacy (Atack 1999; Meyer & Rowan 1977; Suchman 1995), NGOs seem to be born with it since they are predicated on the sanctimonious rhetoric of being the normatively righteous ones due to their philanthropic color. Like their business siblings, they pursue strategy and must continue to ride on the wheels of constant cash inflows, which in most cases become the challenge that creates tensions with their social missions. Therefore, deep down, both are simply organizations by nature. This makes them susceptible to analysis in SCR in terms of the exercise of micro-political power and human opportunism. In fact, organizational reputation of NGOs in proper governance, integrity and operational efficiency are fundamental for acquiring the next funding. This means that abuse by a few tarnishes the image of many. Thus, eliminating irresponsibility is of a crucial concern (Barr et al. 2005; Edwards & Hulme 1995).

This research project started with the assumption that SCR should be about Big Pharma doing more—beyond the legal requirements. It has, however, become increasingly clear that firms, NGOs, by and large, and governments should in most cases be scrutinized for the same reasons: accountability and responsibility in transitioning economies where the institutions are not strong enough to serve as checks and balances. This is because they wield resources and authority and because the individuals at the helm of affairs pursue the same thing: profit maximization, self-interest and political gains. Barr et al.

(2005, 659) argue the difficulty in assessing the operations of NGOs as follows:

> *Apart from outright diversion of funds, misappropriation can take place through perks, inflated salaries, or unwarranted per diems, and be much harder to detect as a result. Identifying inappropriate behavior is made even more problematic when the organization does not hold proper records and accounts, in which case it is difficult to distinguish dishonest behavior from incompetence.*

This, however, is not to suggest that INGOs are not needed. Most parts of emerging WECS Africa depend on their inputs for a huge part of their healthcare needs. They are therefore indispensable, especially in remote rural areas.

5.4 Taxonomy of non-market global health actors

Instead of merely offering a long list of different types of NGOs, I present a classification of actors who are directly or indirectly involved in the health issues of transitioning economies of WECS Africa. IOs and INGOs are similar creatures in that they are non-profits that operate in the same universe, in spite of their legal and political differences. ***IOs*** are complex hybrids because *"they combine components that come from local, national, regional and transactional recipes for survival and performance…[they are] made up of public agencies, private firms, third sector associations, and expert, activist, or lobbying interest groups"* (Schemeil 2013, 219). Some IOs are IGOs, or as Schemeil (2013, 219) puts it, they are *"transnational public bureaucracies operating on behalf of governments."* In contrast, NGOs are rather private and partially collective organizations whose scope is mostly within the realm of advocacy. Most of the IOs and IGOs were established in the aftermath of WWII with particular mandates in post-war Europe (Feldbaum et al. 2010; Lewis & Kanji 2009). They have, however, lived to this day (Schemeil 2013). For example, UNESCO was established for sponsoring new school programs whilst the United Nations High Commissioner for Refugees (UNHCR) was established to settle refugees, ensuring food and security for poorer regions. In essence, IOs and IGOs exist to provide some global public good in a particular time and context. Nevertheless, they always find ways to reinvent themselves even when their mandates have expired. It is noteworthy that at present most of their relevance, activities and legitimacy to operate are found in the devel-

oping parts of the South-East Asia, Latin America and Africa because of their centrality to health and development programs (Lewis & Kanji 2009).

IOs must continuously adapt to the evolutionary dynamics of issues in the global arena in order to remain relevant and survive through resistance, adaptation, expansion and networking (Schemeil 2013). For Schemeil (2013), three major reasons explain the ability of IOs to resist over time: (i) they do not succumb to any attempt to regulate, close them down, or merge them with similar organizations; (ii) they are innovative in order to adapt through new norms, institutional orders and new clients; (iii) they survive by extending their roles and controlling overlaps through global networks of interdependence with other IOs. In addition, IOs need certain characteristics to remain successful: they need to be (i) dualistic by combining the technical with political; (ii) adaptive by converting slack into innovation; (iii) organic and ambidextrous by setting new challenges whilst pursuing current ones (Schemeil 2013, 219).

For example, Brown, Cueto and Fee (2006) suggest that global health as a concept came to replace international health as a result of the diminishing importance of the WHO. This was due to major historical-institutional and political mutations at the global level that saw the dominant position of the WHO erode and was therefore forced to forge new alliance to regain influence. Much of these organizational crises occurred between 1948 and 1998, with dwindling financial resources and major geopolitical changes with new players leading to the weakening of the WHO's dominant status. Brown et al. (2006) argue that as a result of these changes the WHO adopted the strategy of survival by reconfiguring itself into the position of a global leader, planner and coordinator of global health affairs as is currently evident.

In a more detailed account, ***IGOs*** are groups with the agenda to manage relationships between nations. Their memberships consist of nation-states whose decision making procedures require consensus seeking among its members (Gonzalez-Perez 2013) on diverse socio-economic, political, environmental, security and diplomatic interests. Willets (2001, cited in Gonzalez-Perez 2013) categorizes IGOs into the following:

(i) Global IGOs; the classical example with a truly global reach is the UN and its various branches such as the WHO and the WTO, and importantly for our purpose, the INTERPOL, UNESCO, and UNHCR.
(ii) Regional IGOs; for example, the Economic Community of West African States (ECOWAS) and the European Union (EU).
(iii) IGOs with differing requirements for membership; e.g. the Organization for Economic Cooperation and Development (OECD).
(iv) Financial IGOs or multilateral donor agencies such as the World Bank and the IMF.

Of the global IGOs, the WTO particularly is a non-health-oriented IGO but with direct effect on health outcomes (due to the TRIPS agreement which is strongly influenced by Big Pharma). The WTO collects and disseminates international trade information whilst standing as a negotiating platform for multilateral trade agreements which have been criticized for favoring rich countries. Further, the financial IGOs play a major role in defining value creation outcomes in global health. They were established as result of high profile meetings between several rich and politically powerful countries (principally, Japan, USA, and the Great Britain) in 1944 in Bretton Woods, New Hampshire, USA (Gómez & Atun 2013). Criticisms against these major global governors include the lack of transparency and broad representation at the level of board governance, lack of accountability, and total immunity from any form of reprimand. Additionally, critics argue, mismanagement and misdirected policies land transitioning economies in real economic and social backwardness instead of economic progress. In essence, to maintain their legitimacy, these institutions' governance requires a heavy dose of democratization (Stiglitz 2006). What is important to note is that these are just financial corporations like any other except that they have a strong political influence with global reach. Therefore, profitability is their major goal and not a just world with improved global health. Following the Bretton Woods model, but with quite distinct operational governance structures, are other regional multilateral institutions such as the African Development Bank, the Asian Development Bank, and the Inter-American Development Bank.

The post-millennium multilaterals (proto-institutions) are organizations established in the new millennium. Lawrence et al. (2002) refer to theses as proto-institutions, namely: the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization (GAVI), established in 2000 and 2002, respectively. There are also ***public-private partnerships (PPPs)*** and ***philanthropic*** global health ***initiatives*** (e.g. Bill and Melinda Gates Foundation) that have by far demonstrated the most excellent results in direct impact on vulnerable populations (Gates & Gates 2014).

Following Higgott, Underhill and Bieler (2000) and Lewis and Kanji (2009), NGOs fall into two broad categories of social/civic and state-sponsored types. Under these two major classifications are: INGOs; MANGOs, manipulated NGOs; QUANGOs, quasi-autonomous NGOs; BONGOs, business-oriented NGOs; GONGOs, governmentally organized NGOs; and GRINGOs, government-regulated and initiated NGOs. For our purpose, ***hoNGOs—health-oriented NGOs***—and ***roNGOs—religiously oriented NGOs***—are the most important in the context of transitioning economies.

As it is in all sectors, the pharmaceutical field also has an ***industry support organization*** with a global scope to protect their interests. The International

Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH)[11] guidelines in transitioning economies require extremely high technological capabilities. The assessments of such capabilities are not always based on scientific evidence or criteria (Timmermans 2004). The ICH creates barriers for SMEs of generics in transitioning economies.

Finally, it is worth mentioning the general taxonomy of non-state actors in global governance developed by Arts (2003). In addition to the categories of NGOs, IGOs, and TNCs (which are already defined above), his classification includes two additional groups of actors, namely: ***epistemic communities***, i.e. the global network of academics, and ***non-legitimate actors***. In the pharmaceutical sector, the last category represents value destroyers, such as terrorist groups, the mafia and international counterfeit drug cartels with sophisticated global networks. A summary of the major non-state influencers in global health and their characteristics is shown in Table 4.

[11] http://www.ich.org/

Table 4 Major influential non-state organizations in global health

Type of organization	Core characteristics	Examples	Mandates to global health	Major CR orientation in emerging Africa
Big Pharma (TNCs)	Global reach.	AstraZeneca GlaxoSmithKline Pfizer Novartis Access to Medicines Index	Provide evidence-based prophylaxes, medicines, and diagnostics.	Offering access to medicines through Global Fund.
Global IGOs	At the helm of global health diplomacy.	WHO, WTO (TRIPS), INTERPOL	Global health surveillance and governance.	Eradication of global poverty and governance of MDGs by addressing 'causes of causes' of ill health and promoting health as a human right.
Multilateral financial institutions (financial IGOs)	Unchallenged global governors; too big, too powerful; representing interests of the elites.	International Monetary Fund, World Bank, followed by the Asian Development Bank, Inter-American Development Bank, African Development Bank	Financial policy mandates, major aid giver and donor status to promote development in general and health in particular.	Policy directions, research, finance and information on global health. Major champions of MDGs in collaboration with governments.
Proto-institutions (post-millennium multilaterals)	Broad stakeholder engagement, collaborative and grassroots oriented, broad representation and transparency.	Global Fund Global Alliance for Vaccine and Immunization (GAVI): an international alliance of public and private sector organizations for mass vaccination in developing nations	Incorporating private foundations, non-state actors and civil society in health-related decision making processes (to create value); curing non-communicable and communicable diseases.	Direct and collaborative implementation of health matters with grassroots stakeholders; governance systems that encourage inclusiveness and are mostly contextually useful.

Public-private partnerships and philanthropic initiatives	Big Pharma and NGOs or governments collaborating to achieve faster and more efficient synergistic results.	The PATH Malaria Vaccine Initiative (MVI); initial funding from the Bill and Melinda Gates Foundation; partnering e.g. with Glaxo-SmithKline	On specific initiative with a time line, for example to develop vaccines.	Global reach to the most vulnerable populations.
Health-oriented NGOs (hoNGOs) and religiously oriented NGOs (roNGOs)	They are local, regional or international and among the oldest humanitarian and church-based organizations mainly from the West. Mostly pushed by ethical concerns.	Médicins Sans Frontières (MSF), Oxfam International, Catholic Relief Agency, Christian Aid, Save the Children, Caritas	Humanitarian activities including healthcare and grassroots involvement of vulnerable populations.	Allocating resources through direct presence in developing countries to solve hard hit populations; incorporating MDGs[a] into operations.
Industry support organizations	Self-regulation and common strategies for defense and reputation protection.	International Conference on Harmonization of Technical requirements for the registration of pharmaceutical products	Global pharmaceutical product standardization.	Protection of the industry within the triad (US/Canada, Japan, EU) and setting standards globally.
Epistemic communities & influential policy think tanks	National and global in nature; comprising scholars who define concepts in global health and carry out both basic and applied research on health-related subjects.	European Federation for Medicinal Chemistry (EFMC) American Association of Pharmaceutical Scientists (AAPS)	Creating science, embarking on evidence-based studies that affect policy.	Influence medico-socio-ethical discourses on e.g. quality of medicines, drug testing, patient safety.
Non-legitimate actors	Nationally, regionally and globally connected.	The Mafia Counterfeit drug cartels Destructive local entrepreneurs	Value destruction through the infiltration of the value chain with fake, substandard or spurious drugs.	Irresponsible, unethical and criminal activities that undermine global health agenda by taking advantage of institutional lapses and control mechanisms.

[a]MDGs, the United Nations Millennium Development Goals

In conclusion, the question posed was how do these global health actors influence and are influenced by national–global institutions to co-create value for consumer in transitioning economies? As seen from above, there is little local content in global health value co-creation in transitioning economies. Much of what is done is the result of actions by the ecosystems of engagement, thus, the initiatives by the actors described above. The path dependency of this is very consistent in this study. Building on Arts' (2003) work, these actors influence institutions through the three faces of power: (i) decisional power, in terms of influencing policies and politics in global health; (ii) discursive power, linked to these actors' ability to define and redefine the nature of global health discourses, their scope and their direction within any institutional context; and (iii) regulatory power. Those with regulatory power (such as the WHO and the WTO) directly affect the processes and outcomes of consumer value co-creation in tangible terms. Essentially, they represent the supranational organizations that set the international standards and the rules of the game in global health. Big Pharma and governments in the triad especially influence the global health institutions through resource endowments. These resources are in the form of superior medico-techno-scientific innovations that allow them to have both comparative advantage and decision making power (see Article 4).

Beyond the theoretical chapters, I now move to the methodological part of the thesis. Here, I discuss the meta-theoretical analysis used in the first two foundational articles and the field work that investigates the role of the major global health actors discussed above in line with the research questions.

6 RESEARCH METHODOLOGY

> *In some instances those (statistical methods) methods are useful, necessary, and enlightening. But because they are at arm's length from actual practice, they often fail to reflect the way business works in real life. When applied to business—essentially a human activity in which judgments are made with messy, incomplete, and incoherent data—statistical and methodological wizardry can blind rather than illuminate.* (Bennis & O'Toole 2005, 361)

This chapter discusses the interdisciplinary research strategy of the study. It includes the methodological choices for the articles, description of the data collection and analysis, a chronological account of the research process as well as the evaluation of the study. The first part of the chapter seeks to philosophically explain the scientific reasons for the methodological choices and their validity. It is a quest for a coherent examination of the philosophical basis undergirding valid scientific explanation and what may not pass for such.

6.1 Philosophical underpinnings

> *The idea of progress in science is a myth, therefore, in the sense that the more we know, the more we realize we don't know. We progress toward an ever greater knowledge of our own ignorance.* (Kilduff & Mehra 1997, 466)

Fundamental questions about the nature of scientific justification or confirmation remain deeply entrenched in the discourses of philosophy of science (Cole 1983; Curd & Cover 1998; Kitcher 2001; Longino 1990). On scientific theories and explanation, Hempel (1965; 1966) provides an early analysis. More prominently, what passes as valid scientific knowledge remains disputable and is still susceptible to analysis.

In principle, questions of the philosophy of science are categorized into two major perspectives: (i) philosophical questions related to a particular field of study, including questions related to the methodological issues (e.g. philosophy of mathematics, or philosophy of economics); (ii) philosophical questions pertaining to science or, more generally, the general philosophy of science (e.g. the problem of demarcation between science and pseudo-science). With

regards to whether an argument or a substantive domain is scientific draws mainly on the latter, whereas a demonstration of one's understanding of the philosophical underpinnings of her/his research methodologies belongs to the former.[12]

In the present work, analyses into SCR orientation, GHD, CSSIs and value co-creation have dimensions that are clearly susceptible to critical reflection: i.e. institutions, human rights, security, and ethical reasoning (Inoue & Drori 2006; King 2002; Labonté & Gagnon 2010). These dimensions are, however, not mutually exclusive. Moreover, global health discourses pale into meaninglessness if the normative aspects of value creation are not critically evaluated. They are more complex than just numbers. Additionally, a Doctor of Philosophy degree in IB is not complete without a firm grasp of the relevant philosophical foundations pertaining to the choice of method for the collection and analysis of empirical material as well as their valid interpretation and social use. Furthermore, a study that employs mainly qualitative research methodologies offers a leeway to explain their scientific value, i.e. following the acceptable canons of the scientific method recognized by the epistemic community. This also entails arguing what valid science is and is not.

Whether knowledge is sought through applied, basic or technologically oriented research or through some inquiry into the metaphysical, each of the domains, paths and orientations are likely to produce potentially useful answers to research questions. However, none is sure to produce scientifically perfect conclusions given the role of humans in the process (Brinberg & McGrath 1985). This section philosophizes what valid knowledge constitutes and whether the degree of our ignorance is made known by the acquisition of more knowledge (Kilduff & Mehra 1997; Longino 1990). Here I seek to demonstrate why the philosophy of science matters in understanding the nature of valid knowledge, its acquisition and use in solving the intractable problems of society, such as global health issues.

Given humans' limited cognition and diverse mental models and preferences, what we value as science on the basis of a confirmatory theory in turn affects the explanatory theory about the justification for what may pass for valid scientific knowledge. On the basis of subjectivity and resource constraints in the formulation of research questions and evaluation of evidence, one can claim that scientific truth is a social construction with a temporal dimension and contested space rather than a discovery independent of human intervention. As Helen Longino (1990, 212) elegantly puts it: *"Knowledge is always knowledge in a situation, from a certain point of view. It is, therefore,*

[12] I thank Marko Ahteensuu for discussions on this.

both incomplete and perspectival. Objectivity is the recognition of the local, mediated, situated and partial character of one's knowledge." This is not to suggest that individual knowledge is not limited but the subjection of theories and hypothesis under the scrutiny of various critiques makes objectivity possible. Knowledge is therefore produced through social process but individually claimed.

What distinguishes scientific knowledge from pseudoscientific claims? In order to distinguish science from pseudoscience some basic definition is required, although this is a difficult task. For Kuhn (1970) scientists in pursuing normal science must commit to routine puzzle-solving instead of innovative thinking. Popper (1959), however, held a contra-position because he saw puzzle-solving as a simplistic, dangerous pathway for scientific progress and human civilization. This is because it encourages the neglect of critical thinking. The absence of confrontation and critical thinking can also be a form of ignorance given the inherent parochialism and self-interest. He suggests that scientists are revolutionaries and not puzzle-solvers whose bold conjectures are controlled by criticisms (Kilduff & Mehra 1997; Longino 1990). This study subscribes to the latter perspective.

Another demarcating attribute of science is falsification, but that is also problematic since theories are not capable of strict falsification (Thagard 1993). Further, the verifiability of science has two major problems; never has verifiability been stated in any precise and plausible way that can exclude metaphysics without excluding science as well (metaphysics, according to the Encyclopedia Britannica refers to the philosophical study aimed at determining the nature, structure and principles of things in the way that they are in reality). The principle is therefore unverifiable (Thagard 2012). Following Thagard (1998; 2012), Derksen (1993) and Hansson (1996) scientific explanations basically rely on mechanistic approaches (e.g. hypothesis formation, making predictions and performing experiments), though not a strict definition, whereas pseudoscience does not. Progress in science comes about through the development of more powerful explanatory theories about novel facts over a long time. This distinguishes real science from pseudoscience which is usually dogmatic, idiosyncratic and hence stagnant. That notwithstanding, while scientists may argue that they use correlational thinking (which applies statistical methods to find patterns within a phenomenon), which pseudoscience clearly does not, correlation does not always mean causation (Leedy & Ormrod 2005). Nonetheless, science evaluates alternative theories whereas practitioners of pseudoscience do not. *"Science uses simple theories that have broad explanatory power, whereas pseudoscience uses theories that require many extra hypotheses for particular explanations"* (Thagard 2012). In essence, pseudoscience is a non-scientific endeavor (inva-

lid science) that claims to be scientific, just like astrology and graphology. However, the fact that something is pseudoscientific does not mean it is utter nonsense. It just does not follow the scientific canons.

Scientific conclusions are, however, socially constructed (Latour & Woolgar 1979). Thus, human interests have always played a fundamental role in scientific conclusions (Longino 1990). What counts as significant truth according to Kitcher (2001) is not free from human values. Since scientific evidence may be inadequate, decisions about what to believe are crucially impacted by socio-political and ideological factors. Kitcher (2001) further argues that scientific research goals are shaped by past projects and accomplishments which also evolve through the theoretical interests and certainly the competencies of the agents. Further, even the two fundamentally important contexts of knowledge production are certainly affected, namely: (i) decision, the planning and formulation of the research endeavor; and (ii) the evaluation of the evidence for conclusions.

Through social processes, we may draw conclusions based on the existence of some evidence whether or not it is selective. If we stand by the idea that merely having evidence of some kind represents a justification for scientific theories, we then subscribe to the school of thought that holds that scientific conclusions represent an objective reality. On the other hand, if we hold the idea that evidence itself is adequate scientific truth without subjectivity and human values, then science is certainly not a social construct. Human agency plays a major role in constructing scientific facts through informal communications, manipulations, agreements and disputing and consensus seeking (Latour & Woolgar 1979; Longino 1990). The role of humans in global warming is one such debate.

Valid scientific knowledge (not pseudoscience) advances our understanding by increasing our awareness about our level of ignorance (Kilduff & Mehra 1997) in the quest to search for more knowledge by asking the right questions. Nothing is settled as yet. To wit, the more you know, the more you know you don't know—Aristotle is now a cliché. If science is ever progressing, then we are far from concluding that we already know, but instead we actually progress towards the knowledge of our own ignorance, as Kilduff and Mehra (1997) claim.

What is the philosophical meaning that can be ascribed to valid scientific knowledge in IB? Knowledge produced in the IB field must as a matter of principle follow the scientific method whilst retaining the internationality of the issue being studied as well as its usefulness to society. The current philosophical conjuncture raises interesting questions for reflection and further analysis on what knowledge consists of, especially in the building of valid theories and their use in advancing our understanding of existing and emerg-

ing socio-ethical and techno-scientific phenomena. More generally, theories refer to a set of interrelated variables, definitions and propositions that present a systematic outlook of a natural phenomenon in order to explain it (Hussey & Hussey 1997). Here, the NIT and the resource-based view, and by extension the dynamic capabilities view, were useful to offer explanations in matters of global health. Whilst different research traditions and their epistemological and ontological orientations may have an enormous impact on how knowledge is produced and disseminated, as well as on the discourses around it, on global health inequity there seems to be a general consensus. There is just one problem: how to move forward with a lasting or sustainable solution through appropriate methods.

It can be concluded that if science is about the discovery and social construction of social and natural phenomena, then our attempt to search and discover the unknown will always reveal how much we did not know. If how much we did not know represents our level of ignorance, then there is no such thing as scientific progress, in that we only find out how much we did not know. On the other hand, it can be argued that if our research efforts are meant to discover new things then we can also agree that on the basis of knowing more than we knew before we have progressed towards an ever greater knowledge than what we possessed before, both about our ignorance and about what might hitherto not have been discovered. That notwithstanding, such knowledge may also include paradigm shifts, false assumptions and misinterpretations, which may affect the outcome of scientific findings. On that basis, we are still in the process of exploration, verification, confirmation and constant explanation of what we already thought we knew. The next section discusses the interdisciplinary research design.

6.2 Interdisciplinary research design

Following Zikmund, Babin, Carr and Griffin (2009), I define a research design as a master plan specifying the methods and procedures for collecting and analyzing the relevant data. In this section I clarify how I worked my way through the interdisciplinary research design. The first major point is that a socio-economic, techno-scientific phenomenon, such as CR questions pertaining to value co-protection of pharmaceuticals, is not a static issue but rather dynamic. This stems from the fact that it is in continuous organic evolution and adaptation to market and institutional changes. To study this, a holistic view was required in which all the major salient dimensions were evidenced.

I followed a multi-stage process for dynamic research design offered by Coviello and Jones (2004). This process allows for the integration of both pos-

itivist and interpretivist approaches. However, in my case, I did not apply both qualitative and quantitative methods since the research question required a qualitative approach to identify the emergent categories. Quantitative data were used to back up claims where necessary. Nevertheless, the design process also proved to be useful in this inductive 'interpretivist-only' approach where multiple qualitative methods were used.

First and foremost I identified what Coviello and Jones (2004) referred to as flexible core concepts in the disciplines connected with this study (see section 4.3) and used them as a basis to construct a general dynamic model of GHD and CSSIs in the pharmaceutical sector for value co-creation. Second, I formulated the argument that there cannot be any value co-creation without value protection. This led to the identification of value co-protection and SCR evidence in the governance of global pharmaceuticals in transitioning economies. From here, the most important components of the anti-counterfeiting governance—that is, power asymmetry and path dependence (in GHD) and institutional logics and management of complexity (in anti-counterfeiting CSSIs)—were operationalized, critiqued/decomposed, and reconstructed from all the intersecting disciplinary views using the NIT as the pivot (central theoretical point of departure) around which all the other theoretical perspectives revolved. Thirdly, all 'fit-for-purpose' empirical evidence (interviews and documents) of governance of anti-counterfeiting initiatives and their national–global linkages were triangulated and analyzed from across Europe, USA, and Ghana as a proxy for WECS Africa.

The last stage in this research design process was generalization, which in the present study was not the generalization in the positivist (law-like) sense but theoretical generalization in the sense of the extendibility of the conclusions to other fields (Leedy & Ormrod 2005). The positivist method yields coarse-grained results that allow for generalizability from data that are statistically significant (Coviello & Jones 2004). In this dissertation however, it is the 'fine-grained' method that remains the overarching aim. Such a fine-grained method "*captures nuance, context, and rich understanding"* (Harrigan 1983; cited in Coviello & Jones 2004, 500) of the global phenomenon of counterfeits and its relevance to managers and policy makers.

Here, I offer more details about how I implemented the four research stages suggested by Coviello and Jones (2004):

1. *Construction:* This entailed establishing and employing the contemporary set of relevant theories, conceptual frameworks, and methodological designs that were used to study global health and counterfeits in particular. In this process, I also searched the extant literature and em-

pirical evidence for who is involved, why and how, and what the differences are in the contexts in which they occur.

2. *Deconstruction:* This second phase involved separating categories and investigating them from an interdisciplinary perspective. This helped to understand in depth where matters stand and the dynamics of their evolution within the complex and multifaceted terrain. From the social constructionist perspective, and as Remenyi, Williams, Money and Swartz (1998, 35) put it, there is the need to study *"the details of the situation to understand the reality or perhaps a reality working behind them."* For this reason I gathered a wide range of empirical data on how the questions about anti-counterfeit governance and value co-protection are agreed upon (socially perceived) by experts as representing the reality.
3. *Reconstruction:* This in essence refers to the interpretation stage where discourse analysis was used to interpret events and outcomes, their processes, critical incidents and the actors involved in creating both endogenous and exogenous conditions that define the success or failure in anti-counterfeiting initiatives globally.
4. *Generalization*: I finally sought common patterns from all the factual evidence and counter-facts and their interpretations to draw conclusions that were supported by evidence to serve as novel insight while making theoretical generalizations.

6.3 Methodological choices

In this section, I explain the methodological choices and philosophical underpinnings in terms of research strategy, data collection strategies, methods for the analysis of evidence and trustworthiness of the different articles of the dissertation. The whole process started with the economic philosophical analysis (Sen 1988) and meta-theoretical analysis (Tsoukas & Knudsen 2003) for the foundation (Articles 1 and 2). This was followed by fieldwork which employed discourse analysis for analyzing the data (Articles 3 and 4).

6.3.1 Why a qualitative research design?

Gareth Morgan and Linda Smircich (1980) argued for the alignment of ontological, epistemological, and methodological approaches in qualitative research whilst at the same time ensuring that the phenomenon under investigation really demands qualitative research. Here, I explain why no other method

is more appropriate than a qualitative study as a scientific method in studying institutions as has been done by pioneers such as Elinor Ostrom (1990) in studying the evolution of institutions for collectively ensuring the sustainability of the commons.

Global health is a common pool resource whose complexity and surrounding institutions cannot be oversimplified in purely statistical analysis. In general, the use of qualitative studies allows the researcher to gain deeper insights into complex phenomena where a survey or any quantitative analysis would miss the opportunity to delve into the important details (stories behind the stories). Quantitative research, within the context of the issue at stake, would miss the opportunity to stumble over surprises and capture nuances. Qualitative research allows for the elaboration of the specificity of the national–global context of place, time and subject of global health as necessary conditions for theory building. Therefore, this study is not a confirmatory or a theory testing study; it is not measuring anything but inquiring into how cross-sector actors behave in changing institutions and are in turn changed by institutions within global health. It is a theory building exercise of an old and matured problem at a critical juncture in its evolution.

For some, qualitative research is used by those who are not well versed in the use of statistical tools; thus, it may not be universally accepted as a scientific process since rigor is mostly equated with quantifiable hard data. Some academics argue that using qualitative methods is an undesirable currency for career advancement (Marschan-Piekkari & Welch 2004). However, these are not legitimate criticisms given how easy it is to use databases of available data with lots of analysis software at hand in the twenty-first century. Moreover, whichever software is used, either for qualitative or quantitative study, interpretation is required to convince audiences—based on data that is not selective, false or misleading. Fieldwork is costly, time consuming and a complex process. Yet, it is a real empirical work that equips us with a deeper understanding of issues and increases our stock of knowledge. Criticisms of qualitative study are manifold but they fail the test here since the substantive domain under investigation actually determines which methods are appropriate (Leedy & Ormrod 2005; Morgan & Smircich 1980; Saunders, Lewis & Thornhill 2009).

6.3.2 Methods used for the articles

The foundation articles for this thesis employed meta-theoretical analysis and economic philosophical analysis of extant works. This then formed the basis for the field studies. Engaging extant theories is important for filling gaps in

the literature and generating proper research questions. Given the conceptual nature of Articles 1 and 2, their intellectual value highly depends on the creative synthesis and engagement with the relevant literature (Lee & Greenley 2009; Starkey & Madan 2001). The complexity of the substantive domain of CR in the context of global health warrants the use of different methodological approaches at different stages of the research. This is because of the multilayered, overlapping as well as the interdisciplinary nature of the responsibilities of the varieties of actors in value co-creation/co-protection.

There are several approaches for studying CR and strategy of the international firm or organization. Typical IB scholars mostly avoid broader business–society issues or issues of globalization (Buckley & Casson 2003). Those issues are relegated to sociologists and philosophers while IB scholars mostly adopt the well-established positivist approaches and avoid critical stances and postmodern methodologies (Vaara & Tienari 2004). The substantive domain and the research context both help to frame the research question. The type of method chosen for the study therefore depended very much on the research question posed in Article 1. More prominently, beyond gap spotting in the literature, the study problematized existing notions of CR and strategy, leading to a more refined way of asking theoretically relevant research questions (Sandberg & Alvesson 2011) that yield strong explanatory power (Whetten 1989) and whose contributions are of strong practical implications (Van de Ven 1989) to global health in the context of transitioning economies (Mackey & Liang 2013).

Article 1 combines economic philosophical analysis and meta-theoretical analysis to engage the extant literature on the critical perspectives on CR in order to understand the state of the art of research in this domain. Thus, this approach clearly belongs to what Alvesson and Willmott (1992) refer to as critical management studies. From this perspective, Fleming and Jones (2012) employ a critical framework to argue that essentially, the invocation of the concept of CR is persistently and strategically pursued as a means by which corporations legitimize their statuses and economic interests. In fact, Browne and Nuttall (2013) also fault traditional CSR for having failed both business and society given its lack of engagement with broader stakeholder issues.

Critical management studies refers to *"a branch of management theory that critiques our intellectual and social practices, questions the 'natural order' of institutional arrangements, and engages in actions that support challenges to prevailing systems of domination"* (Cunliffe, Forray & Knights 2002, 489). Thus, far removed from the profiteering imperative that seems to explain the existence of the firm (decreasing transaction costs and maximizing profits) , this study seeks to shed light on the myriad shortcomings of contemporary capitalism and the externalities it produces, thereby bringing about a radical

change that will result in socio-economic, political and environmental equity. In essence, it is not just criticism *per se* but a provision of an alternative pathway for explaining the exploitative and unsustainable but taken-for-granted approaches in studying organizations. For Fournier and Grey (2000), critical management studies does not seek to only encourage firms' performance (performative intent) or the instrumental rationality of the capitalist market (Shamir 2008). Rather, it seeks to introduce into managerial practice a *"discursive nexus between knowledge and power as it manifests in the workplace and, from there, to illuminate how socio-economic systems of inequality and exploitation are engendered in such settings"* (Prasad & Mills 2010, 230) and promoted by numerous consulting agencies (Shamir 2005).

Historically, critical management has its roots in critical theory. Critical theory is almost a century old and originates from the Institute for Social Research established in 1923 in Frankfurt am Main, Germany. This 'Frankfurt School' drew inspiration from neo-Marxist and social theories. The institute was closed down by the Nazis during WWII and reopened only in 1950 (McLean 2006). This shows that the institute was useful for society as it managed to create nervousness in an oppressive system. The importance of critical theory lies in the fact that not everything can be subjected to prediction and calculation (Alvesson & Sköldberg 2000; McLean 2006). Essentially, critical management is not about mere criticism at all. The practice is about reflexive, intellectually sound reasoning and action aimed at creating foundations for fundamental transformations (emancipation) in a dynamic and sustainable society to increase well-being for all. What then does this critique involve? First, it aims at resuscitating taken-for-granted issues that are important to society. Second, it seeks to identify systems of social injustice and point out alternative solutions through an enlightened sense of responsibility to social action. Clearly, it is the intellectually sound, open-ended arguments that challenge a 'final solution' to any problem (McLean 2006). It involves a refusal to passively accept and reproduce existing forms of knowledge articulations. Instead, it is a forward-looking approach in creating knowledge that is valuable not only to some but all groups in society, especially the marginalized groups who in this case lack access to medicines—leading them to patronize counterfeit drugs.

Article 2 also follows meta-theoretical analysis with illustrative cases on how dynamic capabilities and the central role of the managerial entrepreneur influences innovations in the pharmaceutical sector. Top management's/top policy makers' commitment, their strategic scope and direction, mission, vision and values statements and ethical leadership are the foundations for enacting CR (Chandler & Werther Jr. 2014). Meta-theoretical analysis is an analytical approach whereby theories themselves become the unit of creative synthesis to reveal which theories combined have the strongest explanatory pow-

er. The resource-based view and by extension dynamic capabilities together with the NIT were chosen since they had strong explanatory power within the context of global health. The economic philosophical analysis combined with the theories above helped to trace the historical and institutional linkages between what is optimized and what is constrained by different organizations at different historical junctures. The above approach is similar to that of Geels (2002), who builds on Nelson and Winter's (1982) treatise 'An Evolutionary Theory of Economic Change'. Thus, Article 2 can also be seen as an 'appreciative theory' building process since it is informed by multiple theoretical lenses which helped in strengthening arguments with illustrative cases from the pharmaceutical sector.

Articles 3 and 4 are based on qualitative field studies. Multiple approaches were used in gathering the empirical data. The data from semi-structured interviews, participant observations, field notes, documents and literature from professional agencies were then subjected to discourse analysis. A discursive approach has proved useful in humanistic disciplines (Vaara & Tienari 2004). This makes it worth adopting in IB research. It is clearly the most appropriate for an investigation of this nature (see for example Maguire & Hardy 2006). For example, it helps to reveal nuances and the stories behind stories of a complex phenomenon. It increases the possibility of understanding and theorizing about the institutional logics that underpin the use of certain discourses which have hitherto been taken for granted. The rationale for using this discourse approach within the interpretive tradition (Creswell 2009; Maxwell 1996; Stake 1995) was to have a deeper understanding and appreciation of the issues under investigation as a process of *"inductive generation of explanatory theory"* (Locke, Silverman & Spirduso 1998, 140) from the experiences and perceptual positions of the interviewees (Locke et al. 1998). Interpreting the data from the fieldwork through discourse analysis essentially allowed me to have such comprehensive insights.

In this process, I targeted questions that first sought to prompt the interviewees to describe the phenomenon of counterfeits as they see it locally and globally. Most of these interviews were conducted in Ghana and in Washington, DC, and also via phone and email from Finland, with global experts on the phenomenon. Overall, 62 interviews (ranging from ca. 5 to 110 minutes) were conducted during the fieldwork (see Appendices 1 and 2 for the details about the interviewees and the questions asked). The process ended when there was obvious data saturation.

Using global pharmaceutical counterfeiting as a lens to study how business and non-business actors influence and are influenced by institutions, I inquired about the role of the interviewees' organizations, strategies and/or responsibilities in mitigating the phenomenon and with whose collaboration. I also

inquired why they thought issues pertaining to value co-creation with the diverse sectors are not successful or how they managed to make progress in mitigating counterfeiting. My objective was to probe what their interests were, how they perceived and approached the issue of power asymmetry and institutional path dependence, and how they managed to offer viable solutions either through R&D, technology, or new policies, depending on the organization in question (Levin 2005). Moreover, through the interview questions I aimed at establishing the enabling and inhibiting institutional logics and how they render CSSIs effective or ineffective, respectively. In most interview settings, I did not specifically mention CR or value co-creation but rather asked what is of most value to them and their consumers and how they sought to co-create and co-protect value in their capacity and why. I also brought up questions to find out how firms are dealing with the vestiges of their past actions, old systems and business models to gain legitimacy. The questions were therefore modified to suit the participants in industry, policy making, advocacy or multilateral organizations. Clearly, one size could hardly fit all. Additionally, in Article 4 the use of historical institutionalism (Steinmo 2008) helped to understand the path dependence of GHD from the historical and current empirical setting.

6.4 Data collection and analysis

Within the naturalistic and interpretive tradition of qualitative research (Eriksson & Kovalainen 2008; Fisher 2010; Hammersley & Atkinson 2005; Leedy & Ormrod 2005) this study sought willing respondents who were deemed knowledgeable enough to answer key questions about the role of their organizations and the interaction of the same with other organizations in ensuring consumer safety. For Article 3 interviews were the main approach to acquiring data from three principal entities in the empirical setting of Ghana:

- CEOs and functional managers of the LaGray Chemical Company
- Health policy makers from the Ministry of Health (MoH; both procurement and traditional and alternative medicines divisions), and the WHO.
- Experts from universities, the Pharmacy Council of Ghana, the Pharmaceutical Society of Ghana (PSGH), Ghana Statistical Service, the Food and Drugs Authority (FDA-GH), INTERPOL, the Customs Excise and Preventive Service (CEPS), Ghana Standards Authority, and the Ghana Malaria Control Programme.

In addition, academics and experts from industry and policy-making bodies were interviewed in Europe and the USA. For the sake of robust data triangulation, unpublished internal documents were collected from the above organizations and their web-sites were also consulted for data acquisition. Following desk research in 2009, the pilot field study started in March 2010 and after changes were made to the research protocol, follow-up data collections were conducted in August 2011, January-February 2012 and November 2012. Data from 49 semi-structured interviews, conducted between May 2009–November 2012, were used for this article (see Appendix 1).

Mostly the same semi-structured interviews (see Appendix 2) and other data collected during the fieldwork that were used in Article 3 were also used in Article 4. Specifically, data from 51 semi-structured interviews, conducted between May 2009–June 2014, were used for this article (see Appendix 1).

The following were the recurrent interview questions which were modified for each interview session:

(i) For global actors: How would you describe your changing role in global health in emerging Africa?
(ii) For national actors: What difficulties do you encounter in collaborating with international organizations in mitigating counterfeits?

In Ghana, the interviewed organizations (respondents) were treated as cases and the data consisted of interviews, documents (published and unpublished), focus group interviews, as well as information received in written form via email exchanges and other freely available information, which Silverman (2001) refers to as naturally occurring data. This naturally occurring data included newspaper articles, expert pieces (op-ed) from magazines and international media sources. For Article 4, policy-related documents were collected from open sources, for example websites and the archival databases of the International Alliance of Patients' Organizations, the Partnership for Safe Medicines, and the Pharmaceutical Security Institute.[13] These big organizations with large global networks offer a thorough overview of IOs directly or indirectly involved in consumer protection. Additionally, a critical study for insights was conducted on the Counterfeit Pharmaceutical Inter-Agency Working Group's report to the Vice President of the USA (CPIAWG 2011). Finally, search engines such as PubMed and Scopus were consulted using query words including 'global health', 'global health diplomacy', 'counterfeit medi-

[13] http://www.psi-inc.org

cines/pharmaceuticals', 'Africa + pharmaceuticals', and 'institutions' for relevant articles on global health which were purposively selected.

These forms of data together with primary data (text, talk and observations) were grouped, thematized and codified to identify and reveal emergent categories. The theoretical approach was to see the fit between the observed, text and talk. Based on an inductive approach, analysis of the major themes that were drawn from the primary data included iteration with literature. The data were divided under the overarching themes of GHD (mainly looking at the vocabularies of motives, national–global linkages and the institutional path-dependence using pharmaceutical counterfeiting as a lens) and CSSIs (mainly about developing categories regarding how various organizations collaborate to protect value [consumer safety] or how the divergence of institutional logics leads to breakdown in following on agendas). Such a process allowed me to design conceptual frameworks and theorize whilst interpreting data and drawing conclusions. Dyer and Wilkins (1991) argue that better stories help to generate theory rather than better constructs in a rebuttal to Eisenhardt (1991). Nevertheless, the constructs (e.g. value co-creation, pharmaceutical counterfeiting, and sustainable global health) were needed to build the story. The interpretive process meant pruning the overall data for relevance, looking for disconnects, inconsistencies and contradictions (counterarguments from data).

6.5 Taking stock: a chronological account of the methodological design and research process

The year 2009: This qualitative research started in 2009 with the presentation of the research proposal and exploration of literature. In the meantime much time was spent studying (analyzing and critiquing) other PhD works to familiarize myself with both qualitative and quantitative work at an advanced level. This helped me in reasoning clearly about which approach should be applied once the research question and phenomenon for investigation had been definitively identified and fine-tuned. This period also included postgraduate courses in IB and research methods whilst presenting the research plan in doctoral colloquia. The process also required an extensive literature review on CR and ethics-related constructs aimed at understanding the pharmaceutical industry within the context of transitioning economies of WECS Africa. Towards the end of 2009 it was settled that the study would be about strategies and CR practices of pharmaceutical firms—the focus. The issue was to understand how the problem of access to medicines is mitigated through strategic CR actions. I therefore established contacts with a Ghanaian pharmaceutical SME whilst preparing a research protocol for pharmaceutical MNCs to compare

how CR happens in practice in both transitioning economies and advanced economies. The MNCs that I contacted via email consistently gave no response, even after several attempts. Where there was a response, I was asked to 'consult the websites' which was not how I intended to triangulate my data. The quest for alternatives became necessary; I had to turn swiftly to a back-up plan: to focus on the case study agreed upon in Ghana as a proxy for the whole WECS Africa using a stakeholder approach as the theoretical lens.

My initial idea was to determine the presence of CR in strategy by using proxies such as formal documentation of CSR activities, an established business unit that liaises between the firm and stakeholders, some process of structuring the stakeholder engagement (Freeman 1984), as well as a clear mention of CSR in the corporate vision and mission (Galbreath 2009) as are often seen on corporate websites. I discovered during the data collection that these are necessary but not exhaustive simply because they belong to only the communication aspects of CR but do not truly explain how responsible strategic decisions are implemented towards value co-creation in any way. Further, such rhetorics state intentions but do not demonstrate how the responsible strategies are enacted or who is behind such decision-making processes and what their motivations are for the subsequent execution. A firm's suggestion of what it intends to do does not translate into the implementation based on strategic processes for an outcome that has direct bearings on society. This notion was reinforced whilst studying the literature that questioned the integrity of some public relations announcements on corporate web pages. Relying solely on such data is the easy way of doing research (Starbuck 2010). Instead, I wanted to study the actual process of enacting CR.

Previous methods used in the study of CSR have been predominantly in the form of reputation surveys, content analysis of disclosure documents, accounting-style auditing procedures aimed mostly at measuring "Corporate Financial Performance" and its relationship with CSR (Geva 2008). A plethora of studies used inconsistent methods besides linking Corporate Financial Performance and CSR as a yardstick for measuring good CSR practices. Nevertheless, these approaches have always yielded mixed results (Husted & Allen 2006) because, depending on who is conducting the study, responsibility is either skewed towards financial performance or the motivation behind corporate actions (Geva 2008). Influencing this view in part has been Carroll's (1991) pyramid of CSR. In her work, Carroll puts in the order of importance economic responsibilities (to make profits) before legal, ethical and philanthropic responsibilities. Clearly, however, in the pharmaceutical industry every step is highly regulated and entails a chain of ethical responsibilities which cannot be ignored because of their strategic nature and constant interaction with diverse groups who are also concerned with normative questions.

The Nordic tradition in studying CR and sustainability has mainly been a qualitative approach where case studies have played a dominant role. The quest for deeper understanding of real-life phenomena (Yin 2009) and social relevance of rigorous empirical research has been the underlying rationale for such an approach. In the spirit of the Nordic approach, a qualitative empirical field study to this stakeholder management and cooperative value creation was therefore warranted. This is because it takes the most pressing factors into consideration using different forms of data to offer deeper understanding. Schipper and Weyzig (2008), for example, used multiple case studies which proved to be highly effective in digging deep into the issue of "Ethics for drug testing in low and middle-income countries". However, this study, among others that I have reviewed was conducted in Europe. This means that they reveal little or nothing about the extremely different institutional environments in which firms operate in the emerging WECS Africa. The present study therefore moves a step beyond the European regulatory institutional environment, thus to an unchartered territory, emphasizing the potential originality of the study.

The year 2010: It was during this early case study (in March 2010) that the idea of SCR occurred to me and it was reinforced and corroborated by the emerging evidence during the investigation. My idea of SCR differs from Porter and Kramer's (2006) idea of strategic CSR, which is about a win-win game or the business case for CSR (see also Falck & Heblich 2007). In fact, the business idea of the case SME was to create value in the form of efficacious high-quality drugs for the patients without access or who could not afford costly branded drugs. This was a development-oriented CR agenda to help people. Nevertheless, given the enormous financial constraints the firm faced, it was not going to be sustainable without profitability. Here, it must be noted that profiteering was not the raison d'être for the existence of the firm but managerial entrepreneurship that saw a need that can be fulfilled whilst making gains (profits). The opposite is true for MNCs or equity firms (Goldacre 2012; Gray 2013).

The major problems faced by the local pharmaceutical industry in Ghana became evident. In transitioning economies of Africa, the major players in ensuring value creation through CR practices are not only firms but the government and international multilateral agencies or IOs and NGOs. The case study brought great insights. Nevertheless, it became evident that there was a much larger issue lurking behind it. The lack of access to medicine was breeding a new problem—pharmaceutical counterfeits were flooding the markets—affecting the local firms, the national healthcare agenda, and most importantly the consumer. Institutions matter (North 1990)—this is not a cliché because

really they do matter. And within these institutions there are major organizations playing the game according to conflicting rules. The research quickly turned to ask the question about how these actors influence and are influenced by institutions, using the global pharmaceutical counterfeiting as a lens. This was not a complete change of the research but a broadening in scope and depth in the hope that it would make a much better contribution (theoretically and empirically) than the single, though interesting, case study.

The case study, however, yielded interesting results which were reported in the European International Business Academy conference in Bucharest in 2011. The findings were later divided into two foci. The first was published as a teaching case study focusing on relationship marketing (Ahen 2013) whilst the other is a forthcoming book chapter focusing on how strategic ethical leadership leads to development-oriented CR practices (Ahen 2015b). These two publications were, however, not included in this dissertation. A short summary of the insights from the case study is reported in this thesis in Chapter 8. With inspiration from the grounded theory approach (Glaser & Strauss 2009)—deriving (mid-range) theory from empirical data—the contribution of the case study is that it forms the foundation of the whole research project that led to the redirection of the original research agenda whilst increasing understanding of CR practices in an SME. The most important feature of this redirection of the research agenda was to bring the international and global nature of my study to fruition. This was not quite the case with the original idea of a single case study.

The years 2011–2012: Building on the foundations of the insights from the data from the case study, I continued data collection based on the changes to the research protocol. The changes went beyond firms to include other global health actors, to inquire about their roles in global health with respect to transitioning economies. The field study then took me to Ghana twice, in 2011 and 2012, for a one-month period each with the support of travel grants from various sources as previously acknowledged. In Ghana I spent time visiting (and re-visiting) various institutions. During the data collection process some respondents allowed me to tape-record their answers whilst others wanted to remain anonymous. The data collection process could simply be defined as extremely difficult, especially with my haste in getting things done while time flew and with changes in appointments notwithstanding earlier agreements and scheduled plans.

In 2011, 2012 (and 2013) I attended the Partnership for Safe Medicines Interchange in Washington, DC (mostly combined with academic conferences) where global actors on patient safety converge for a full one-day presentation of results and insights. Taking advantage of the supportive and friendly envi-

ronment I interviewed and exchanged information with global representatives of various institutions whilst learning from their experiences. Afterwards I collected policy documents and these experts' presentations by email. This process could simply be called participant observation or to some extent an action research (Eriksson & Kovalainen 2008). At international conferences I also took advantage of the acquaintance of professors in good moods to speak about the research, during which they offered insights about the phenomenon. All this while, I kept writing and updating articles for publication. Essentially, I did not have breaks between data collection and writing for publication. In the meanwhile, I kept polishing my writing expertise by reviewing multiple conference papers and journal articles. I also attended follow-up doctoral colloquia where I made presentations and received feedback.

The years 2013–2014: In this period, I spent time finding an overriding theme to effectively encapsulate the research question whilst designing how best the articles fit together in my portfolio of articles for the dissertation. At the same time, I was writing the introductory part of the thesis, mainly focusing on the major interdisciplinary contributions that can be put together to shed light on the phenomenon of global health focusing on GHD and CSSIs for value co-creation/co-protection.

6.6 Evaluation of the study

To start with the evaluation, I address one crucial criticism common with interdisciplinary studies, which is that they draw on multiple concepts, theories and disciplines but may not sufficiently use them effectively. In rebuttal and in regards to this study, experts from different fields who have had a preview of this study acknowledge that they are able to understand the concepts, even those that are not traditionally used in their disciplines. Further, they appreciate the methodological approaches and the depth of analysis in answering the research question. Finally, they can easily familiarize themselves with the relevance and the interdisciplinary nature of their field. Essentially, interdisciplinary research is not a misguided conflation of theories; rather the chosen theories are being used as analytical means towards an explanatory end in order to offer a scientific basis for the way forward after critically engaging with the CSR literature and challenging the existing notions of SCR orientation as it pertains to sustainable global health. The individual articles have also been presented at conferences (as competitive papers) after double-blind peer reviews. They were later revised and submitted to journals for double-blind peer reviews and subsequent multiple revisions. This is the only way to expose the

study to scrutiny in order to guarantee rigor and the highest quality of academic work. In a nutshell, if policy makers, academics and professionals can appreciate the familiarity and theoretical robustness of the study as well as the conclusions, then the objective of the study has been achieved.

Given the merits, transparency and trustworthiness of the data sources, the data used in this study represent a recognizable 'authority of evidence' and the process of their analysis and interpretation have systematically followed the acceptable research canons to ensure validity. Validity and the systematic sequence of research phases are the fundamental elements of an investigation that characterize its acceptability. This is well documented. Nevertheless, one can still assess possible contradictions as far as fundamental axiological (governing criteria of judgments) and epistemological (the philosophical view as to the way of acquiring knowledge, and the validity and scope of knowledge) stances are concerned. To start with, validity is explained as the extent to which the methods and approaches used in acquiring knowledge meaningfully reduce our level of uncertainty about the research outcome (Brinberg & McGrath 1985; Phillips & Pugh 1994) (Figure 9). Hussey and Hussey (1997) define validity as the extent to which research findings accurately reflect or represent reality and increase confidence. Validity is about using the appropriate approaches to research to arrive at findings so that they can stand the test of scientific scrutiny (Brinberg & McGrath 1985). Validity cannot be obtained by loyally following a list of strategies and procedures. It should be tied to the research process from conception, through data collection, analysis, conclusions and reporting. The present study sought to carefully follow this process to fulfill these criteria. The criteria for defining the originality of a PhD thesis are based on the work of Phillips (1992).

Finally, since there are no known conventions for reporting interdisciplinary research in a new substantive domain, journal editors find it difficult to locate reviewers who are interdisciplinary-oriented. This study also finds that despite numerous suggestions for the need for interdisciplinary studies in academia, there are not many who actually do it.

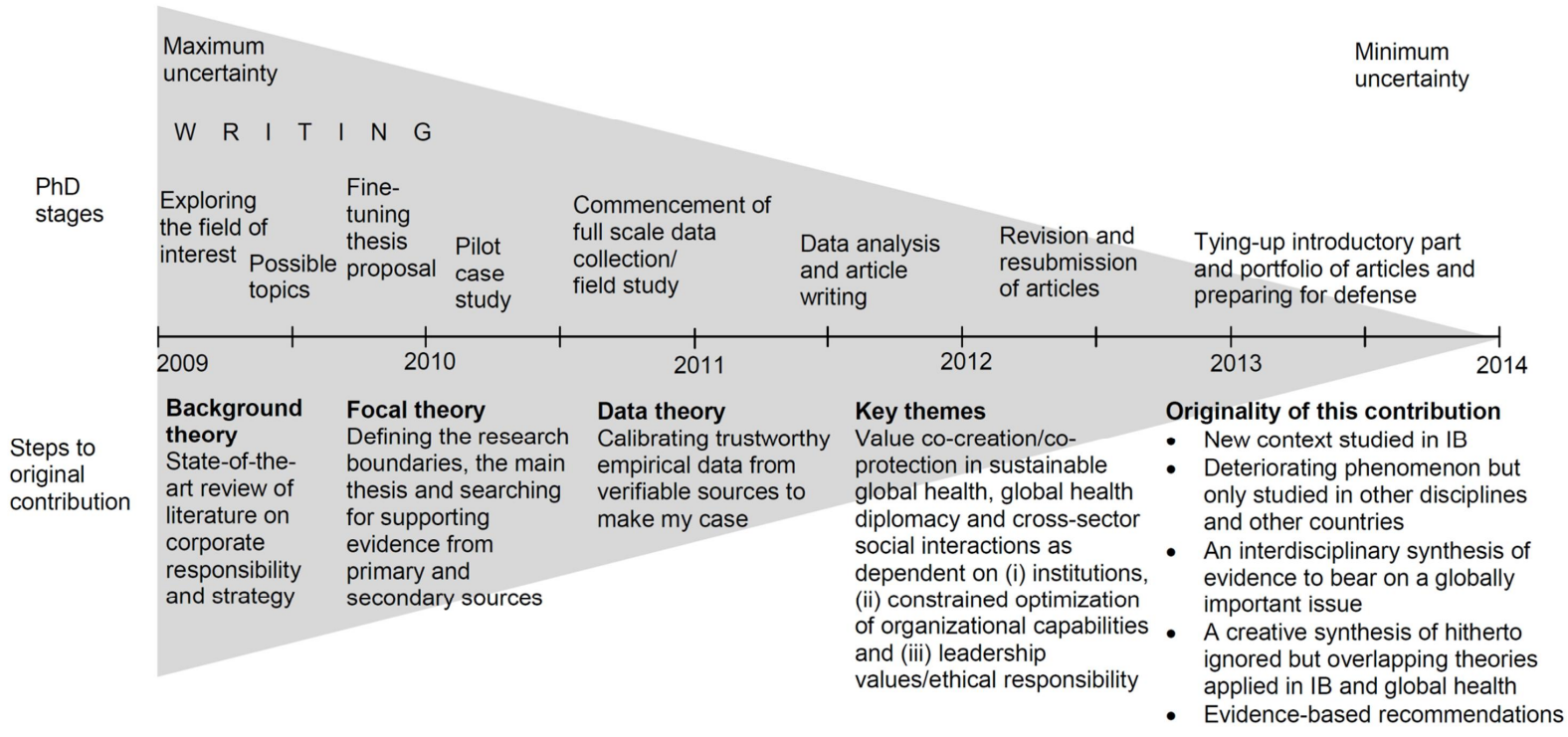

Figure 9 The PhD process as the progressive reduction of uncertainty. Adapted from Phillips and Pugh (1994, 84).

While reliability, internal validity, generalizability/external validity and objectivity are measures for ascertaining the acceptability of any quantitative study as to whether it meets the basic scientific canons, some argue that the case may be different for qualitative research and that *trustworthiness* is the major issue to be considered in a qualitative study (Sinkovics & Ghauri 2008). Simply put, trustworthiness is about the dependability of the qualitative research findings. It is about asking: (i) how the findings may be wrong; (ii) how the findings will stand up to scrutiny; or (iii) how they match with data or facts on the ground (Leedy & Ormrod 2005). In other terms, the trustworthiness of a qualitative study can be evaluated by the criteria of confirmability, dependability, credibility and transferability. First, the criterion of *confirmability* (parallel to objectivity in a quantitative study) (Ghauri 2004) suggests that the researcher arrives at conclusions not based on his/her own subjective views. Rather, such analysis and conclusions are solely based on the data provided by the social actors (interviewees) that are also verifiable in order to stand the test of scrutiny. In this study, personal assumptions do not form part of the data analysis and nor do they influence the interpretation. All assertions are therefore backed by theory or empirical evidence. My personal biases were kept in check throughout the process so as to maintain the academic integrity of the research. In this regard, the portfolio of articles for this dissertation received criticism and recommendations from the experts in this field within the academic community—initially in international conferences and subsequently through the double-blind peer-review process. This helped to test the conceptual, theoretical and methodological soundness of the study and how meaningfully it actually partakes in the conversation of global health, CR and value co-creation within diverse institutions.

Second, *dependability* (parallel of reliability) is the criteria for measuring quality, consistency and level of cautiousness that leaves no untraceable element in the process. Thus, every minute detail which helps substantiate the findings should be available for verification. This means the data were collected from a wide array of credible respondents in international conferences across Europe, the Interchange of Partnership for Safe Medicines in Washington, DC, and diverse organizations in Ghana. The documents and emails, Power Point presentations and other correspondence between me and the respondents are readily available for verification but with the express permission of the interviewees. Where permission was given for recording, the interviews are still available for re-analysis.

Third, *credibility* (parallel to internal validity) (Miles & Huberman 1994) refers to whether the research makes sense and has those elements which are capable of convincing its readers that the conclusions are grounded in demonstrable empirical evidence. In this thesis, research ethics are observed

throughout to make sure that the study is not only using the scientific method, but also ethical questions are taken seriously. The empirical data were triangulated from various sources to offer counter-arguments and inputs that either support or bring into dispute certain issues in order to ensure that the findings can be trusted. In doing so, the data were sourced only from well-established organizations that are currently active in the phenomenon under investigation. Extensive descriptions of the research design were done in detail so as to increase consistency and the logical flow of thoughts. The mostly iterative nature of the study (i.e. moving back and forth between data and theory) allowed for the removal of ambiguities in the analysis and presentations. Efforts were made to ensure that ensuing judgments and conclusions are based on the data.

Fourth, *transferability* (parallel to external validity) takes into account how the qualitative research findings can be generalizable to other contexts with similar characteristics. It should be emphasized, however, that generalization is not the reason for all research. Certain studies need to be performed in their own right due to their uniqueness and, second, because of their newness or how poorly the story is understood (Dyer & Wilkins 1991). In such a situation, generalization is neither the main objective nor is it relevant since the study aims at understanding a phenomenon or a situation in-depth, which is more feasible in case studies (Punch 2005). In this study, targets of generalization were defined. This refers to an attempt to maximize the fit between the study and what actually occurs more broadly in reality in the transitioning economies' markets for pharmaceutical products. To generalize is therefore an attempt to find out what is not, what is, but what may also be (Kvale 1996). The objective was to draw analytic generalizations (Firestone 1993) beyond the empirical setting in the light of SCR for value co-creation in dynamic institutional contexts. This was achieved through a systematic application of the following steps: (i) analyzing the logical fit between the triangulated data and the extent to which they answer the research questions; (ii) validating the results with a deeply reflected judgment of the questions. Finally, (iii) meanings were drawn from the various complex puzzles in order to demonstrate not just what happens in GHD and pharmaceutical CSSIs but also how they come about in the first place. In the end, however, the conceptual, methodological, and empirical domains of the studies were incorporated into a coherent whole in order to achieve analytical generalizations extendable to industrial sectors of similar characteristics. The findings of this study can confidently be transferred to the food industry. This is because its products (both packaged and fresh food) are consumed directly and have an immediate and direct impact on human health. Moreover, food is a basic necessity and is therefore inelastic to price/demand: the degree to which its demand varies with changes in price. The final step was to report what firms/policy makers do not know or do (Kvale 1996) in

articles dealing with various aspects of the research questions while deriving new questions for further research. Using Ghana as a proxy, the conclusions and the recommendations are expected to apply in the WECS African regional context, despite the institutional heterogeneity.

6.7 Ethical Considerations

To preserve the academic integrity of the final report of this investigation, I have strictly followed the 2012 guidelines for responsible research as proposed by the Finnish Advisory Board on Research Integrity (Tutkimuseettinen neuvottelukunta, TENK). This means that the choice of the subject of the investigation, social relevance, and the respect for the academic canons that must be followed in reporting have all been rigorously followed and approved by supervisors and the committee for doctoral studies.

In order to ensure the highest level of transparency, most of the names of the organizations where the studies were conducted are revealed. However, the identities of the interviewees are not revealed except where the subjects have explicitly agreed (for example by signing an informed consent). Where the key informants requested the preservation of their anonymity, their names were not reported in the study. Finally, although I made every effort to analyze and report my data with absolute objectivity and integrity, I also admit that '*errare humanum est*'. Reminded of my limitations, I take full responsibility for any unintended errors since I am in a constant process of discovering how much I do not know. In the next chapter, I summarize the main features of the four articles included in the dissertation.

7 PORTFOLIO OF ARTICLES

Starting from economic philosophical analysis and meta-theoretical analysis (Articles 1 and 2), this study sought to answer questions that are not only answerable through the collection and analysis of empirical data but instead through recourse to scientific reasoning and logic and other well-established theoretical evidence (Curd & Cover 1998). Proceeding from these theoretical foundations, I embarked on more data collection after the pilot study (synopsis in Chapter 8) and those are reported in Articles 3 and 4 on CSSIs and GHD, respectively. In these two articles for which data were collected concurrently, I use the global pharmaceutical counterfeit crisis as a lens to gain insight into how cross-sector social interactions and GHD are used in mitigating value destruction. More prominently, the institutional framework in the pharmaceutical sector in transitioning economies of WECS Africa was probed through fieldwork and analyzed through a discursive approach.

The portfolio of articles can be sub-divided into four levels to form a coherent storyline of their conceptual linkages (Figure 10).

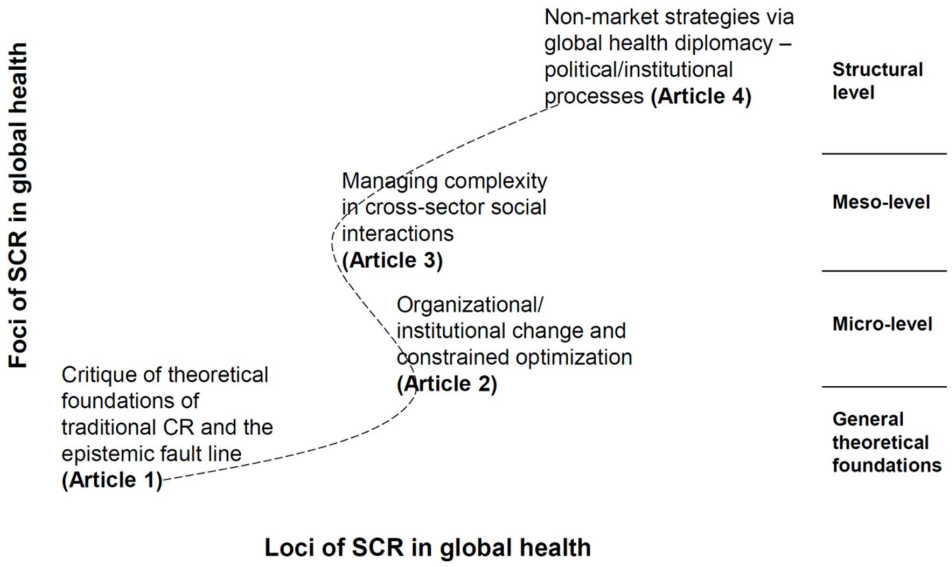

Figure 10 Conceptual linkages of the portfolio of articles. Foci of SCR orientation: Institutional change—from organization centric to consumer focus via sustainable innovations, value creation and value co-protection; Loci of SCR orientation: General and micro-ethical foundations of SCR and global health governance.

The first article forms the general theoretical foundation and arguments for the project on SCR and value co-creation. The second article explains the micro-ethical foundations in enacting sustainable health. The third article is at the meso-level where organizations seek to aggregate resources to protect value while managing the complexity that accompanies the differences in institutional logics among partnering organizations. The final article conducts a macro-level analysis of global health by probing the role of global actors, and institutional path dependence and power asymmetry in global health. Below, I offer flag posts for how the first article logically connects to the subsequent articles and the major conclusions therein.

The portfolio of articles included in this thesis is summarized in Table 5. The dissertation concludes with managerial and policy recommendations for enacting institutional change and response to institutional pressures via value co-creation and value co-protection as an institutional responsibility of actors.

Table 5 Portfolio of articles for the doctoral thesis

Features & processes	***Article 1***	***Article 2***	***Article 3***	***Article 4***
Authors	Frederick Ahen & Peter Zettinig	Frederick Ahen	Frederick Ahen	Frederick Ahen
Research purpose	Economic philosophical analysis through critical perspectives on traditional CSR doctrine	Studies how strategic organizational renewal becomes prerequisite for the organic resilience and co-evolution of pharmaceutical firms with their dynamic environment	Enquires into the management of complex institutional logics undergirding pharmaceutical anti-counterfeiting partnerships for patient safety	Examines the role of business, non-business and adaptive hybrid organizational forms in determining how GHD influences institutional change in the securitization of global health
Approach	Meta-theoretical analysis/ Economic philosophical analysis	Meta-theoretical analysis/Economic philosophical analysis and illustrative cases.	Empirical field studies, critical discourse analysis on the management of complexity.	Multi-level approach: field studies, discourse analysis, historical institutionalism
Theoretical emphasis	Resource-based view, new institutional theory and ethics	Dynamic capabilities, organizational change and institutional theory	Institutional logics	Global institutions, governance and power
Context	Global	Transitioning economies, globalization	Transitioning economies	Global and transitioning economies
Substantive domain	Sustainability, CR and value co-creation	Ethics, dynamic capabilities and (pharmaceutical) organizational change	Cross-sector social interactions for patient safety	Global health governance and pharmaceutical anti-counterfeiting
Data	Literature on strategy and conceptual design	Appreciative theory building based on literature review and illustrative cases from the pharmaceutical industry	Field study, participant observation, ethnographic study, focus group	Field study, literature review, participant observation, focus groups

Features & processes	***Article 1***	***Article 2***	***Article 3***	***Article 4***
Analysis & interpretation	Inductively building theories with the strongest explanatory power; unit of analysis: CR	Creative synthesis of extant theories and examining rival explanations; systematic combining with empirical illustrations	Discourse analysis based on deductive and inductive reasoning	Discourse analysis based on deductive and inductive reasoning, historical institutionalism
Contribution to progress in IB and global health domains	(i) Challenges existing conception of CSR (ii) Offers insights into the central role of institutions in determining ir/responsible behavior	(i) Increases our understanding on the massive role played by the micro-political power and ethical posture of entrepreneurial managers in optimizing resources (dynamic capabilities) to adapt to change in the pharmaceutical industry (ii) Emphasizes the importance of context, time and prevailing institutions	Delineates the challenges that lie within organized anarchies and explains how pockets of excellence emerge out of chaotic and multiple institutional logics in anti-counterfeiting cross-sector interactions	(i) An interdisciplinary study that problematizes national–global linkages, local healthcare governance paralysis, the global axis of power and its path dependence (ii) Synthesizes insights from fieldwork to develop a theory of ultimate preference for non-optimal solutions

7.1 Article 1: Critical perspective on traditional CSR

Article 1 is a conceptual paper co-authored with Peter Zettinig. It forms the theoretical foundation for this dissertation project. We employed meta-theoretical and economic philosophical analyses in critiquing the underlying epistemological and ontological standpoints of traditional C[S]R and its accompanying confusions, the centerpieces of which ignore value co-creation opportunities and sustainability. The study goes beyond the usual gap spotting by problematizing extant works on traditional C[S]R while challenging the needless dichotomy between CR and strategy. We argue that the two concepts are in fact, the two sides of the same coin. The paper integrates CR doctrine into corporate strategy by analyzing the silent opposite of responsibility through juxtaposition with corporate irresponsibility and other unethical practices. Here, the institutional theory, resource-based view and the concept of

value co-creation were used. The study provides a theoretical and empirical basis for the proposition that the bridge between CR and corporate irresponsibility is the integration of strategic decisions into ethically-oriented corporate practices towards sustainable value co-creation. Further, we examined the historical, cultural and international institutional context within which organizational culture becomes either saturated with deviance or directed towards positive social changes via socio-economic and technological innovations. By introducing the concept of SCR and explaining the elements that constitute SCR orientation, the study examines contemporary trends which have led to the institutionalization of sustainability questions through a descriptive schematic diagram and a theoretical framework. The schematic diagram offers the historical co-evolution of firms' strategies, dominant global issues, historically critical incidents and institutional changes that shaped CR. The theoretical framework explains the processes of sustainable value co-creation. We demonstrate how SCR orientation leads to sustained competitive advantage and legitimacy by explaining how value co-creation/value co-protection must become a new trajectory of managerial thought on the crossroads of strategy and international CR. Thus, this represents a paradigm shift in actualizing concrete CR, based on 'deliberate and emergent strategy making' (Ahen & Zettinig 2013; Mintzberg & Waters 1985).

Finally, the position (major argument) of this study is consistent with the Kantian deontological ethics. That is, *"the time is always right to do what is right"* whether or not it is profitable for the firm, to use the words of Martin Luther King Jr. SCR orientation is therefore a consistent proactive responsiveness through decisions and substantive resource combination to meet stakeplayers' current and potential demands and expectations in a manner which is not detached but incorporated into corporate strategy in order to achieve long-term corporate goals. Simply put, SCR orientation refers to practices that are socially desirable beyond legal requirements and a firm's narrow interest of profit maximization and power. The conclusions suggest that although traditional CSR is touted as a noble concept, much of what some corporations publicize in the name of CSR is in sharp contrast with what they demonstrate in different empirical contexts. Conducive normative and regulatory structures will therefore be required to serve as enablers of SCR since they either provide incentives for 'beyond-conformance' firms to build brands and attain the expected legitimacy or punish deviant firms. MNCs and IOs, especially those operating in transitioning economies are neither criminal bands nor terrorist groups inspired by hate and sinister ideologies to destroy value in society. They are represented by economic agents with souls. Nevertheless, they resemble value destroyers when their strategies do not embody the SCR orientation towards sustainability.

The paper contributes to the debate on CR, global sustainability, and the role of firms in society. It brings clarity to the conceptual confusions and fills a theoretical gap through a novel conceptualization of SCR. Here, consumer orientation and environmental as well as institutional orientation rather than producer orientation form the basis of the analysis on value co-creation. Beyond the general framing of the context of SCR and the orientation of firms' resources towards value co-creation and value co-protection, the next step (Article 2) introduces the micro-foundations of SCR for an organizational change that will accommodate emerging changes in a co-evolutionary manner.

7.2 Article 2: Meta-theoretical analysis of constrained optimization

Context matters. Therefore, Article 2, a technical research paper, explains how sustainable global health presents an emerging new form of competition in the pharmaceutical sector. The socio-political and functional pressures require strategic organizational renewal for the organic resilience and co-evolution of pharmaceutical firms with their environment. Contexts of time, place and the ethical leaning of the entrepreneurial manager were emphasized. The article problematizes the macro-level analysis of organizational change that ignores the central role of the entrepreneurial manager. Following Richard Nielsen's (2003) concept of constrained optimization, this article builds on the resource-based view and by extension dynamic capabilities view to explain how responsible optimization is enacted in the pharmaceutical industry in various institutions at various historical junctures. As in Article 1, I employed a meta-theoretical analysis. A wider framework was developed to allow for a comprehensive and nuanced reinterpretation of the NIT and the resource-based view. In focus was the practical utility and relevance of such theories within transitioning economies where pharmaceutical firms respond to market and institutional changes. Two major arguments were presented in this article:

1. Market turbulence and institutional dynamics (Berger & Luckmann 1966; DiMaggio & Powell 1983; Scott 2014) now affect managerial decisions in ways that turn solely-profit-oriented SMEs and MNCs' leaders into entrepreneurial managers (Augier & Teece 2009; Dimov 2007; Penrose 1959; Winter 2003).
2. In spite of the high levels of strategic-ethical dilemmas, simultaneous pursuit of ethics and efficiency by entrepreneurial managers is possible through transition where existing capabilities are reconfigured through new business models.

The study used a combination of theories along with illustrative cases that are easily available as naturally occurring data. The analysis suggests that organizational renewal is dependent on the combination of ethically constrained managerial choices as well as entropic institutional pressures that allow firms to successfully adapt to their dynamic environment within time and space. This is achieved through legitimization and sustained competitive advantage, the result of innovation and contextually relevant differentiated value propositions. The novelty in this paper is the framework it provides for analyzing the massive role played by the micro-political power of managers and how the goals they pursue become fundamental to what the organization becomes as it coevolves with the turbulent era of emergent health needs.

After the two foundational articles, the project transitioned into empirical fieldwork that built on the argument that responsible value co-creation requires value co-protection by multiple actors. This is due to value destruction caused by criminal organizations and organizational crime (Gond et al. 2009) as well as the abundance of irresponsibility on the part of the non-business actors in the pharmaceutical sector.

7.3 Article 3: Empirical field study on governance of anti-counterfeiting CSSIs

In Article 3, I studied how complexity and institutional disorientation are managed in pharmaceutical anti-counterfeiting CSSIs. The article employs an ethnographic field study to explore the anti-counterfeiting CSSIs of Ghana and their global interconnectedness. This article problematizes the national–global linkages of healthcare organizations and the taken-for-granted nature of institutional logics that create barriers to the optimal functioning of inter-organizational relations in mitigating counterfeits. The objective was to develop an explanatory theory that associates particular variables with the social interaction between healthcare organizations.

Within the framework of anti-counterfeiting CSSIs, it was theorized that the performance outcomes of such interactions are a reflection of the maturity and dynamism of the formal and informal institutional structures in the contexts in which they evolve. It was argued that a breakdown in institutional orders produces chaos. Even in the same field, parallel institutional logics have the potential to produce anarchy. Nevertheless, articulating institutional logics is complex due to their taken-for-granted nature and fragmented decision locations. Findings suggest that complexity in CSSIs leads to organized anarchy (Cohen, March & Olsen 1972), which in turn erodes efficiency and synergy gains from CSSIs. This is akin to deliberate value destruction since such con-

ditions make CSSIs a self-defeating concept and hence counterproductive. The ineffectiveness of CSSIs derives from the chaotic nature of organizing, a product of the institutional incoherence, misfit and disorientation that run parallel to well-functioning institutions in the same context. CSSIs do not change institutional logics but the emerging mutations in the institutional logics at the micro-level may help advance and facilitate the agendas of selected 'pockets of excellence'. This meso-level analysis then evolved into the structural level of analysis where the path dependence of global health was studied in the field as described below.

7.4 Article 4: Multi-level analysis on path dependence of global health

Article 4 is an inquiry into the structural role of MNCs, governments, and adaptive hybrid IOs in GHD. It problematizes the role of these major global health actors. The study demonstrates how GHD, through power and politics, influences institutional change in consumer protection against pharmaceutical counterfeiting in transitioning economies. More specifically, it examines the power asymmetry between global governors and MNCs on one hand and national governments and local NGOs on the other. The study further investigates how such power imbalance affects weaker institutions in transitioning economies in various degrees. The article offers a condensed account of the institutional path dependency of GHD and the national–global context of policies in the pharmaceutical industry.

The complexity of this subject required multiple approaches to answer the research question: field studies combined with the examination of relevant naturally occurring data on global health (Silverman 2001).

Understanding contemporary global health is extremely difficult and almost impossible without recourse to its historical path. Therefore, in analyzing the data in iteration with the literature I used historical institutionalism which is an approach with an orientation towards understanding how institutions shape political behavior in the real world (Steinmo 2008).

This study finds that the outcomes in anti-counterfeiting interventions are path dependent or that they follow a trajectory which fits a familiar pattern of power asymmetry. Additionally, the power of actors in global health governance lies not only in how resource owners influence others, but also in the consequences of the periphery's passivity and voluntary renunciation of responsibility and sovereignty, leading to the periphery's inability to produce massive independent outcomes. The axis of power for the securitization of global health is constructed around the economic influence, medico-techno-scientific innovation, and geopolitical status of cartel-like super-rich actors.

These strategic geopolitical commodities are centralized in the core region and dispensed in the periphery. Thus, the cooperation and collaborations between the core and the periphery are not founded on the same political and philosophical premises or footing.

Put together, the study develops the theory of the ultimate preference for non-optimal solutions in global health governance. Thus, values and micropolitics, power asymmetry, corporate irresponsibility and institutional path dependence are the explanatory variables of this theory. For any given set of global health solutions for creating value, a range of market and institutional possibilities always exist. Nevertheless, quick or too slow fixes are preferred over sustainable options. This allows actors to maintain the status quo and the attendant incentive structures—leading to weak governance structures that undermine the sustainability and institutionalization of global health as a major concern. This explains why medico-techno-scientific products remain geopolitical commodities via which powerful actors leverage competitive advantage, allowing them to maintain the path dependence of global health outcomes in transitioning economies.

The study further reveals that hybrid organizations, NGOs and firms seek relevance/legitimacy. Moreover, MNCs engage in market seeking and together all these actors seek the status quo maintenance. This maintains a five-fold paradox: (i) relatively stable political institutions/weak public health systems; (ii) resource abundance/high dependency on donors; (iii) complex formal bureaucratic structures/high institutional void and lack of enforcement mechanisms for consumer co-protection; (iv) high economic growth/weak structural determinants of health that defines the high disease burden; and (v) increase in emergent non-communicable diseases (e.g. cardiovascular problems), global health risks and crises (counterfeit medicines, Ebola)/lack of political will to enact change. The crucial reason for these paradoxes is the lack of SCR orientation towards sustainable global health governance in the context of WECS Africa. The conspicuous absence of SCR orientation as seen in the theory of the ultimate preference for non-optimal solutions in global health governance then explains the current global health governance conundrum. The handling of the current outbreak of Ebola in West Africa is a litmus test that can also predict how future outbreaks will be handled.

The next chapter reflects on the lessons drawn from the pilot study of the LaGray Chemical Company.

8 REFLECTIONS ON THE STRATEGIC CORPORATE RESPONSIBILITY ORIENTATION FROM THE PILOT CASE

> *The notion of sustainability can only be effective if it is firmly integrated into organizational and management systems. We have therefore created structures to promote sustainable business activities—from planning to implementation* (BASF, Ludwigshaven, Germany).[14]

This chapter contains the synthesis of the pilot research project that was conducted in the early stage of the study: the case of a local Ghanaian pharmaceutical firm, the LaGray Chemical Company. Interviews and participant observations from this company were used in all the articles included in this dissertation. Additionally, this case was reported from the perspective of network-based marketing in a recent international peer-reviewed book (Ahen 2013). Furthermore, there is a forthcoming book chapter (based on LaGray) on how strategic ethical leadership in the pharmaceutical industry affects sustainable development (Ahen 2015b).

8.1 Strategy and ethics: the false dichotomy

Besides a limited few, strategy-oriented management scholars often take an instrumental approach when analyzing firms' external operations with little else to say about the values and ethical decisions of managers. That aspect has always tended to be labeled as business ethics as if that were divorced from strategy. Whilst strategy and ethics diverted, they are now reconverging (Elms et al. 2010). In order to avoid a repeat of such analytical flaws, we set off with an empirical illustration from the pharmaceutical industry. For example, meeting a particular therapeutic need with the discovery of one promising compound out of a meticulous screening of tens of thousands of them (Gambardella 1995; Nwaka & Ridley 2003) or choosing to produce certain generics to address a target population in themselves constitute a premeditated ethical responsibility. That ethical stance is inherently part and parcel of strat-

[14] Management and Instruments for Sustainability. Available at: www.basf.com.

egy and never detached. This is carried out throughout the different stages and phases of drug design with a huge capital outlay. At no point of the drug production stage do ethical issues become secondary. In other words, there is a chain of ethical responsibilities and interactions (co-operation and confrontations), with various economic and socio-political actors, through the different processes. Astley and Fombrun (1983) refer to such an interaction as 'collective strategy' in reputation building to earn legitimacy for the drug being produced. From the research and design of medicaments until they are supplied to the shelves of pharmacies, the mission is to provide what is optimum (highest satisfaction or value) for consumers, better than competitors, with the least adverse effects and with optimal pharmacokinetic properties (excellent absorption, distribution, metabolism and excretion profile). This chain of activities at the same time should be competitive (premium characteristics sold at a premium price) and represent the best value proposition with which the consumer and the firm create value (Freeman & Velamuri 2006; Grönroos 2008; Porter 1985).

Whether the firm manages to produce evidence-based medicaments (which depends on tests on animals and humans) or falsifies the trial, gets approval and sells deadly drugs is not only an ethical question but certainly strategic as well because strategy and ethics are both conceived in the organizational mind ex-ante the actual operations. This is due to the ramifications of such actions on the firm's current performance as well as future reputational survival (costs on reputational risk management) as it seeks legitimacy. This is what Prahalad & Ramaswamy (2004) refer to as co-creating value with your customers. We agree with Lee (2008) that just staying within the laws is an indispensable but not a sufficient condition to qualify as a responsible enterprise. This statement cannot be truer in the pharmaceutical industry.

Based on this scientifically objective analysis, we question how the complex and intertwined ethical and regulatory framework within which medical research and commercial business operates can be detached from the corporate strategy of any given firm. Moreover, if corporate strategy is directly linked to the external operational environment of the firm (Porter 1985), then how can it be detached from the CR of the firm? Any disintegration of the two concepts can be tactically possible for short-term gains but that would be strategically deficient with dire consequences for the firm's competitive advantage whilst destroying value for society. Formalized long-term CR commitments by which actions can be judged and matched are now the way forward in strategy implementation, as shown at the chemical company BASF (Germany). As an illustration, when patients go to a pharmacy to purchase medicines, they are neither interested in how much alms the producing company gives to

communities nor are they interested in places where they are made, but rather, they seek better prices and quality drugs that address their bottom lines.

8.2 The case of the LaGray Chemical Company (Ghana)

The LaGray Chemical Company is an indigenous Ghanaian company established by two medicinal chemists who have over three decades of experience in drug development in the USA. Interestingly, it is the only firm in WECS Africa (outside South Africa) that has the capacity to manufacture drugs from molecules to finished products. It is an extremely important case for this study because the mission of this company is to manufacture quality but affordable drugs in response to the high demand for medicines against tropical diseases. Further, its vision is to internationalize across WECS Africa. For LaGray, contributing to the economic development of Africa through the provision of affordable medicines is an ethical responsibility.

Governance structure matters in organizations for actualizing SCR in any institutional context. This means governance structure affects an SME differently from an MNC. The LaGray case showed that functional activities are interlinked because production, R&D, marketing, and purchasing divisions are coordinated processes in a medium-scale pharmaceutical firm so that value for the consumer can be guaranteed. This makes ethical and strategic questions inextricably linked to leadership and governance structure. The organizational culture and the founders' position in social networks were determinant factors in creating institutional legitimacy as an ethical and sustainable business entity. Despite the superior power of MNCs, what emerged from the study is that it is possible for small firms to compete with bigger firms in weaker institutional settings by doing responsible business that fills gaps left by Big Pharma. Characteristically, this gap depends on the extensive knowledge of the local institutional logics and the consumer psychology of drug purchasing and the cognitive closeness of the organizational leaders.

This important link supports my thesis of SCR orientation as being part and parcel of the day-to-day activities of the SME and its relation towards stakeholders. In MNCs the production activities are geographically more dispersed, so they are more difficult to control. The environment picks winners and this is what creates the competitive advantage, even in competition with big firms. The more favorable an institutional environment is, the greater the chance of survival and competitiveness of a small pharmaceutical firm. This means LaGray's survival cannot be predicted in a less favorable environment outside Ghana, at least in the founding stage. In the absence of supportive and appropriate institutional environment, smaller pharmaceutical firms are only able to

survive mainly due to the ingenuity and resilience of their values-based leaders. Nevertheless, big multinational firms may have their way in focusing on profit maximization while making CR only a label through philanthropy on one hand and ignoring SCR in the development of their dynamic capabilities on the other. The presence of stakeholders consisting of big organizations per se does not affect managerial decisions in making issues of CR strategic in SMEs. Rather, the strength of the constituents and their links with home governments, NGOs and supra-national organizations such as the WHO affect how firms respond with their internal resources.

The evidence from this study shows that institutions can undermine or promote responsible value co-creation. The advancement of local pharmaceutical firms is systematically undermined in the WECS African countries while the opposite is true for the Western countries. The LaGray Chemical Company even after satisfying all the requirements for obtaining the WHO prequalification still has not received any proper response. Essentially, this prequalification would allow the firm to take part in the competitive bids and to increase its market share and expand, but this is not happening. There is also very little financial support from the local and international financial institutions and the government. This means that pharmaceutical MNCs also lack financial power. Power is therefore the ability of one actor to systematically disempower others by centralizing knowledge forms, financial input, means of production and political strength. This is how the path dependence of dependency is perpetuated (see Article 4).

8.3 Dimensions of SCR orientation

What is the key difference between CSR, strategic CSR and SCR we propose without the 'social'? Among the most constantly evoked arguments of CSR are the moral obligation of firms as 'corporate citizens', questions of sustainability, reputation and the social license to operate (Porter & Kramer, 2006). Put together, they all make good sense but are fraught with ambiguities, incommensurability and shortsightedness in terms of practicability. They do little to answer the question of how the firm can continue to create value with and for society while maintaining a sustained competitive advantage.

The logic of SCR is where both implicit and explicit ethical responsibilities are fully embedded in the socio-economic, political and environmental strategy to cooperatively create value (new innovations of social benefit) based on emerging industry standards (**structural dimension**). This proactive innovation '*based on competence*' by sensing emerging opportunities and challenges (**dynamic capability and innovation dimension)** characteristically creates a

sustained competitive advantage (**strategic dimension**). This moves the above valuable conceptualizations from a mere theoretical expression to 'enactable' policies because the firm becomes constantly innovative in its value protection orientation (**value creation and quality management)**. Such a long-term perspective determines the success of the firm while creating wealth for the society in which it is embedded. In essence, SCR is inherently proactive, reactively relational, and it is the result of interlinked resources, activities and strategic stakeholders with reciprocity of interests for cooperative value co-protection (**value co-protection and customer orientation dimension)**. This is still insufficient unless coupled with responsible leadership (**strategic and values-based leadership**) (Orlitzky, Siegel & Waldman 2011) and its complex psychodynamic structure (in big firms) and sustainable innovations that are congruent with the prevailing institutional environment as a catalyst for value co-creation. Adaptation to the post-millennium forces and the SCR dimensions towards sustainability are the prerequisites for acquiring institutional legitimacy (**institutional dimension)**. On the basis of the above, it can be conjectured that: *SCR is a predictor of higher performance and adaptability to future contingencies. The greater the firm's embeddedness in SCR towards sustainability, the higher its sustained competitive advantage and potential to achieve both market and institutional legitimacy*. We employ these seven dimensions of SCR by Ahen and Zettinig (2013) in this case company (Table 6).

While multinationals may have the economies of scale to produce and sell at lower costs, LaGray's strategy helps it to overcome its limitations. This strategy is embodied in the firm's operational effectiveness: that is, performing comparable tasks better than its rivals (Porter 1996). The operational effectiveness is achieved through LaGray's core competencies and other resources such as techno-scientific expertise, responsible leadership, organizational, ethical and relational inputs which cut costs heavily for a firm in a not-so-favorable financial environment. In addition, since operational effectiveness is not sufficient to create a competitive advantage, Porter (1996) again alludes to strategic positioning which involves performing different activities from rivals or comparable tasks with different operational procedures. LaGray's very existence is built on ethical performance at the strategic, operational and managerial levels. This is different from a mere ethical label. Rather, with the objective of building a brand, the consumer is essentially the 'definer' of quality and an active value creator, not a passive customer who engages in episodic exchanges. During the interviews, the CEO and other employees constantly referred to the consumer as patients. They probably see a different world than a pure marketer would see. This means the firm–consumer relationship is based on bonds and ties and the consumer represents the pivot around which every value creating decision is made. In other words, the firm positions itself

in the minds of stakeholders as the quintessential consumers' firm for quality and responsible corporate practices. This resonates extremely well in collectivist contexts such as West Africa and is therefore able to create a perceived high value for the firm's products where a premium is paid. It was found that SCR does not necessarily attract support from the host government, influential NGOs, or institutions. Nevertheless, it attracts support from suppliers, local NGOs and influential personalities and other stakeholders in society to promote a business which they find very much in line with their developmental agenda.

8.4 Revisiting the empirical evidence from the pilot study

Strategic ethical leadership leads to sustainable social impact. This consists of real leaders and their agents ethically co-creating value with end-users. While the enormity of the crisis of neglected diseases seems to be beyond the scope of pharmaceutical SME's leadership, my analysis suggests the contrary. Thus, as I compared the extant literature with empirical data, I particularly noticed, consistent with Petrick and Quinn (2001), that the long-term success of a business hinges on the ability of strategic ethical leaders to operate responsibly and ethically, as also epitomized in the works of Donaldson and Preston (1995), Frederick (1998), Freeman and Velamuri (2006), Maak and Pless (2006a; 2006b) and Bird, Smucker and Velasquez (2009). I postulate that ethical leadership is then the new way for pharmaceutical SMEs to compete effectively and win in markets that are almost entirely dominated by the multinational pharmaceutical companies. I discovered through this investigation that it is possible to defeat the 'strong man' (MNC) by identifying his weak point. For example, Big Pharma generally neglects certain ethical responsibilities in transitioning economies where there is a perceived lack of market. Pharmaceutical SMEs then take on such responsibilities by taking advantage of the in-depth knowledge of local healthcare conditions to create institutional legitimacy. This brings us to the strategic dimension of leadership and its knowledge component. Thus, the creation of competitive advantage is made possible when the indigenous leadership has the knowledge component of the local needs. As Meyer and Kirby (2010, 41) argue, "*many types of externality that used to be minor have grown too large to ignore. Simply put, commercial activity has reached a planetary scale.*" It appears that some big companies still do not see this trend but that is where small firms take advantage because positive externalities matter and leaders who embrace such a notion will use it as a winning formula.

Table 6 The dimensions of SCR orientation in the LaGray Chemical company

Specification	Description	Empirical examples
Cognitive dimension and values-based leadership	All the employees have backgrounds in pharmaceutical sciences irrespective of their current function. This basic cognitive frame and shared value without any space for divergence creates the harmonious teams for reaching goals while the productive use of political power of decision makers rests on the CEO. Together there is a constant increase in the social, psychological and intellectual capitals that spur innovation.	Mostly Ghanaian and Indian scientists with shared educational background and both native and Western cultural awareness.
Structural dimension	The CEO and Chief Operating Officer (COO) have an extensive network in industry, academia and even in the political arena. This social capital based on trust creates the legitimacy.	CEO and COO are important members of professional associations with political role in spear-heading national health agendas in West Africa.
Dynamic capability dimension	Consists of alliances across the globe plus scientific expertise and decades of experience in both academia and industry; these are configured into new capabilities to meet the context-specific drug needs for capturing emerging opportunities via managerial entrepreneurship.	Local universities, Howard University (USA), suppliers in India, Government of Ghana, Ghana Pharmaceutical Association.
Opportunity seeking and consumer orientation dimension	The opportunity consists of the health issues which are turned into problems worth solving. Thus, innovative products that meet the needs of patients for which a premium price is paid.	Deeper understanding of the patient, not as a consumer but as a patient. Strong ties with local doctors.
Institutional legitimacy	Knowledge about the cultural, regulatory and normative circumstances creates the added momentum to explore what contributes to the national developmental agenda. Institutions also refer to the internal governance structures of the firm.	Strategy implementation embedded in ethical responsibility leads to differentiation that facilitates branding.
Strategic dimension	Available resources (innovation via competence and unique leadership styles) are well defined and allocated and are contingent to the successful achievement of the firm's long-term goals.	Achieving the WHO pre-qualification and subsequently becoming a world leader in the production of drugs for neglected diseases.
Value co-creation dimension	The ultimate goal of the combination of all the above is to offer the best service or value proposition through collaboration with stakeholders.	Drugs with multiple solutions. Specific cocktails for malaria and other infectious diseases.

Multiple levels of analysis were conducted, namely: the strategic management level, the organizational level and the business operational environment level. Each level comprises individuals or collective units in the firm who are all linked to the external environment. The vision, mission and overall strategic direction that are embedded in an ethical content remained the overriding issue: What remains of a firm if everything it possesses can be sent offshore? It is its reputational and relational assets which are unique and cannot be replicated by rivals. The relational assets of the firm demonstrate that the possession of tangible capabilities is a crucial but not a sufficient condition for value creation aimed at survival and higher performance. An analytical probe of the data implies that the unique managerial styles in which novel ideas from personnel are encouraged and an organizational culture (Barney 1986) in which externalization and learning takes place are the key strengths towards overall adaptability and higher performance. As stated above, LaGray's key strength lies in its organizational capabilities, such as its strategic ethical leadership, and the core competencies, which consist of the unique skills and in-house knowledge of functional teams that are working together and are fully aware of the strategic direction of the entire company.

SCR is a winning modus operandi for a firm competing against well-established multinational rivals in a fundamentally uncertain international business environment via enhanced and responsible differentiation based on visionary innovations. On the other hand, the study reveals how, to some extent, issues of ethical responsibility neglected by big businesses provide new opportunities for SMEs in the quest for institutional legitimacy. This is a paradigm shift and a confirmation of the changing role of firms from self-seeking capital accumulators to political actors and value co-creators.

Entrepreneurial firms or SMEs differ very much from MNCs. Their problems are manifold but they have more strategic agility and swift decision making power. The institutional analyses are different but so are the levels of analysis which in an MNC could be labeled as an embedded case study because of the multiple layers of analysis. While SCR in a big organization depends mostly on resources and competence, in a small organization it depends on political will, values-based leadership and innovation based on competence.

8.5 SCR for sustainable health?

Pharmaceutical small-scaled businesses and Big Pharma have a socio-ethical responsibility to invest emergent health solutions if they seek legitimacy as civil corporations (Wilmot 2000; Zadek 2007). The neglect of the WECS African BOP market by Big Pharma is what Wettstein (2010) refers to as *silent*

complicity of those with political authority who ignore responsibility. It is a moral imperative that firms respond to this long overdue call to do their part in what is a human right and justice issue beyond legal constraints (Wettstein 2009). The attitude of 'if they cannot pay then we will not produce' also reinforces the notion that R&D should be undertaken only when the expected market return is positive (Stiglitz & Jayadev 2010).

Nevertheless, apart from the ethical rationale for doing business with low-income market segments (Hahn 2009), the conditions for the neglect are rapidly changing. Local production offers enormous advantages: proximity to market and local distribution channels, new learning opportunities about the latent needs of local consumers, and the possibility for innovative diversification through the offering of contextually relevant versions of life-saving medicines at cheaper prices in large volumes (Macdonald 2011a; 2011b). Industry-wise, this will increase positive spillovers which will be beneficial to other budding local firms. This is articulated in many works, see for example Lehoux, Williams-Jones, Miller, Urbach and Tailliez (2008), Oudshoorn and Pinch (2003), Shah and Robinson (2007), and Shah, Robinson and AlShawi (2009). In fact, industry experts agree with the challenges local industries face. When they were asked what the three biggest problems the pharmaceutical firms face are, the answers were identical among all interviewees. For example:

> *Lack of access to long-term finance – There are of course special commercial loans but the cost of capital is usually very high. The second thing is the lack of procurement market. For example, anti-malarial drugs have a huge market but are provided by the Global Fund. A related problem is the lack of facilities and land for production. A pharmaceutical manufacturing must as a requirement be far from any firm or production that has the potential to cause contamination. The third point I want to make is that although the world is becoming very globalized and there is the need to open up one's market, I would say there is a lack of protection for the pharmaceutical industrial base in Ghana. That however, requires a strong political commitment.* (Executive secretary of the Pharmaceutical Manufacturers Association of Ghana)

The major conclusion from the LaGray case is that with strong managerial entrepreneurship coupled with SCR, value can be created for society, at least in the short run. Nevertheless, without the institutional support for scaling up, it is not quite predictable how sustainable this can be for an SME.

9 DISCUSSION AND CONCLUSIONS

> *To most economists [and by extension business and marketing experts] the consumer is not a human being but a consistent set of preferences…We have consumers without humanity, firms without organization and even exchange without markets.* (Coase 1988, 3)

The present and future of the safety of consumers matter, and the strategic ethical responsibility of the firm and other non-business actors in ensuring this is crucial for sustainable global health. Even more important are the institutions which shape the global health actors and in turn are shaped by them. From the global health perspective, where the patient is treated just as a consumer or another market actor (in a mere exchange), health as an ethical question and a fundamental human right is breached by those who put only efficiency before social ethics. The result is the discontent that breeds a lack of trust towards Big Pharma (and other actors along the value chain). Nonetheless, the industry remains an important ally in achieving global health sustainability. This is why the overarching objective of the present inquiry was to determine *how business and non-business actors in the pharmaceutical sector influence and are influenced by national and global institutions in responsibly co-creating and co-protecting value for consumers in transitioning economies.*

This study began with an evolutionary bridge that transitions from firm-centeredness (and broadly, organization-centeredness) to a shared form of capitalism and collaborative governance as ways of creating and capturing value in global health. The study re-orients attention from firm-centeredness (resource-based view) to people-centeredness (a relational perspective) and that is where my idea of value co-creation/co-protection with and for consumers gains prominence in producing sustainable global health outcomes. Re-orienting attention from the resource-based view and by extension the dynamic capabilities view means that the resource-based view is used only as a backdrop while the focus is on new concepts.

Here, the indispensable role of non-business actors is emphasized. The first article being a critical perspective on the CR literature sheds light on the need for a fresh look at value creation as a way forward to the C[S]R discourse. The second article in a more technical way offers important lessons on ways to proactively respond and adapt to the turbulent changes through the optimization of dynamic capabilities and ethical leadership as well as managerial en-

trepreneurship. The last two articles arguably provide the most revealing empirical insights about the nature of value co-creation in modern healthcare governance in the context of global consumer protection through CSSIs and GHD in transitioning economies of WECS Africa. The study contributes to the NIT with a particular focus on the emergent turbulent scenarios of the pharmaceutical market. Clearly, the highly likely surprises brought about by these scenarios cannot be ignored. An intellectual endeavor to address them is therefore imperative.

9.1 Conclusions based on theoretical findings

SCR orientation is a fundamental determinant of value creating outcomes of organizations and their associated stakeholders. A major conclusion from this study is that the global governance of consumer protection initiatives does not yield optimal results in the face of new threats such as counterfeit medicines. This lack of success can be attributed to a lack of correspondingly strong national governance and institutional structures to match the global efforts—essentially, the persistence of institutional voids. Ensuring sustainable global health is not the sole responsibility of the firm, NGOs, or global governors, but it is a cooperative investment (Lin-Hi 2008) for value co-protection and co-creation. I refer to this structure of the changing responsibility of the global health governance actors as co-evolutionary since it is characterized by enormous speed, contemporaneity, inclusivism and scale in keeping with the spirit of the times—the urgent need for the sustainability of global health.

What really is the responsibility, purpose or role of a firm in mitigating value destruction? Another way of posing this question is to ask what must a firm do to survive in its embeddedness in society? And if it does not do that, whose business is it to do it? Firms have basic responsibilities towards their internal stakeholders (stockholders and employees, financiers and suppliers) and external stakeholders (consumers and civil society). Nevertheless, beyond this ordinary behavior of satisfying stakeholders and abiding by the rules, firms have to act ethically. This is not an ‘ought’ but a ‘must’ in order to gain legitimacy, given the crucial nature of non-price competition. Internally, in order to ensure their survival, they have to defend and protect their intellectual properties and core assets (mostly tacit knowledge and skills). Since this ordinary behavior does not offer any competitive advantage, the only way to earn super-profits is to be innovative by offering value propositions that are of higher value to the consumer and other relevant actors. This can only be achieved through dynamic capabilities and not ordinary resources. Survival, therefore, depends on proactive offerings that allow the firm to earn legitimacy by re-

sponding to market and institutional demands. This allows the firm to thrive while not impeding others from making a living. This way of reasoning can also be extended to all health-oriented organizations.

In ensuring their survival, the responsibility of pharmaceutical MNCs was found to be a highly controversial question given their egregious deviations from the institutional expectations. However, this is not a sweeping generalization of all pharmaceutical firms at all times. This suggests that Big Pharma remains an indispensable actor in creating global public health goods. From problems related to drug testing, over-diagnosis, unneeded diagnosis, manufacture and sale of diseases (Goldacre 2012), or pricing mechanisms and R&D in transitioning economies (Class 2012) there exists a great deal of public mistrust of the pharmaceutical industry, and especially the associated global governors such as the World Bank, IMF, WHO, and United Nations Children and Education Fund (UNICEF) (Cohen 2006; Goldacre 2012). This is due to the sheer level of deception of the general public and even the regulatory bodies such as the FDA and EMA (Angell 2004b; Petryna & Kleinman 2006). But misconduct is not peculiar to Big Pharma. All corporate bodies produce some negative form of externality. What makes it so bad or socio-ethically unacceptable in the case of Big Pharma is because of the direct effects on human health. For this study, looking at CR from the instrumental perspective, organizational crime or irresponsibility is the same as acts conducted by unethical and criminal organizations. Nevertheless, from a juridical point of view crime should be distinguished from unethical practices. It is not for this thesis to argue what ought to have been done (in the sense of being polemical) but to make suggestions on the basis of the findings about what concerted efforts will constitute a new form of governance to reverse the decades of value destruction. This will help redirect attention towards the institutions which will serve as fertile grounds for sustainable global health, consumer co-protection and accessibility to evidence-based medicines.

9.2 Conclusions from the empirical findings on cross-sector social interactions and global health diplomacy

Within the multilateral and cross-sector bargaining models, global health solutions and interventions—that is, all medico-techno-scientific resources—are important strategic geopolitical commodities that only reconfigure themselves over time in different historical periods. The competitive and comparative advantages remain almost permanently with the centers of power, as suggested in Article 4. Within this path-dependent condition, sustainable health in transitioning economies is unlikely to be achieved by only examining how power

imbalance shapes this process. Attention must also be paid to how transitioning economies renounce their responsibility and why they have come to be complacent with the public health debacle. Whilst the powerful see themselves as entitled to offer help and in the position to steer the way things work, the recipients (in Ghana in particular and WECS Africa in general) of health products, services and decisions have neither demonstrated resistance nor offered an alternative solution. The recipients' abundant local endowments still remain underutilized. For example, R&D in the herbal medicine sector is far from developed and the budgets for scientific research in universities are woefully behind the threshold for a serious public health agenda. Thus, transitioning economies' inability to consolidate efforts and resources to address healthcare challenges bottom-up has resulted in a perennial form of dependence on global actors. This explains the type of national–global linkages between WECS Africa in particular and the global north. The opposite is also true where institutional logics, which guide the actions of individuals with political power, are oriented towards irresponsible strategy making or encouragement of regulatory lapses.

The pragmatic approaches through SCR orientation succeed because the value to be captured in the form of legitimacy and improved global health is high, given the global pressures and the dominant prescription as to how value must be sought in a rapidly changing environment (Teece et al. 1997). It is not quite clear how efficient this is going to be in the short term. Nevertheless, in the long term, through commitment, continuity and creativity in innovative and imitative capabilities, firms can offer novel pharmaceutical products and consumer protection technologies through new methods of production and new sources of supply (Augier & Teece 2009). Through managerial entrepreneurship and ad-hoc problem solving, innovation is arrived at in a fast-paced manner to serve the untapped niches (Winter 2003) of the WECS African market. The aggregation of medico-techno-scientific and political resources from diverse actors allows for consensus, legitimacy and contextually relevant value propositions. This, in fact, will help to dissipate even the fundamental institutional inertia that has resisted change for far too long. In summary, the study suggests that pragmatic approaches via value co-creation/co-protection lead to efficient results both for the firm, its partners and the society in which the firm operates. Nevertheless, this rarely comes about given the power asymmetry (resource endowment, historical antecedents of institutional path dependence) between MNCs and global governors on one hand and governments of transitioning economies on the other.

The initial conditions are premised on the fact that all the actors within the multilateral GHD and CSSIs are not on the same footing (power asymmetry) although they all seek the same thing (value/advantage) with their actions.

How then can their distinctive roles be characterized when that role (responsibility and accountability) depends on the value they seek to create, capture and appropriate? Three important levels of value co-creation analysis were considered:

1. The market level (Big Pharma): Employment of medico-techno-scientific innovations to meet the latent needs of the consumers in transitioning economies.
2. The civil society level: Consumers/NGOs seek value in terms of consumer safety, gate keeping, access to affordable high quality drugs and protection from unapproved or substandard drugs, grey market agents and counterfeiters. Here, consumers are no longer passive but actively involved.
3. The government/multilateral organization (political) level: Value consists of provision of health as a public good and the global securitization of healthcare where multilateral organizations play a major role.

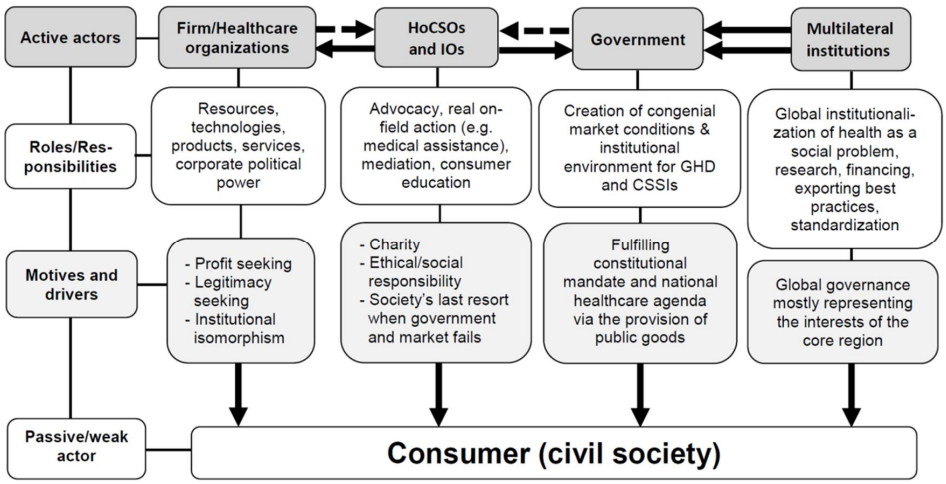

Figure 11 Drivers and motives of actors in global health diplomacy (GHD) and cross-sector social interactions (CSSIs) for consumer protection.

The roles and responsibilities as well as the major drivers and motives of the global health actors are explained in Figure 11. As shown in the figure, all the major actors affect the consumer directly (vertical arrows). However, the consumer is constantly marginalized despite his/her central importance in the global health discourses. There is therefore the need to empower consumers through education and their active participation in the political process of pub-

lic health.[15] In the light of the evidence from this study I argue that responsible value co-creation/co-protection that is consumer-centered is a viable way forward. The horizontal arrows denote the power relations between the global actors; the dotted arrows show the minimal level of influence whilst the solid arrows show the maximum level of influence. The organizations with the maximum influence create the institutions which frame the outcome of global health. Although all the actors have responsibilities, the major influencers have the greatest power to induce change. The ever evolving nature of CR has offered several contested formulations and epistemological positions by both academics and practitioners. In their parallel pursuits, however, sustainability seems to have been placed at the apex of all other political leanings irrespective of the sector. It is concluded in this study that sustainable value co-creation/co-protection with the consumer at the center is still the Holy Grail that actors seek in the pharmaceutical and health sector. Institutions will then change or remain the same in response to actors' understanding of this one very matchless concept—value.

9.3 So what? Synthesis of the theoretical and empirical contributions

Finally, it is apt at this juncture to probe where the above story line leads us. Beyond the description, explanation and synthesis of the extant literature and the factual presentation of the empirical material in the articles, a crucial question is: how does this study enrich and advance our understanding of IB and related fields in general, and the substantive domains of CR and value co-creation as well as the institutions of global health practice in particular? This section highlights the main theoretical and empirical contributions of the study to IB scholarship and beyond. As Barley (Barley 2006, 18) argues, *"rather than forge full-fledged theories, interesting 'theoretical' [and empirical] papers generally propose new models or metaphors that let us either see what we didn't see before or see in a new light what we thought we already understood."* This study achieves that with the proposition of the global health value parliament.

The present inquiry has linkages with several disciplines and non-market strategies are the new normal when it comes to global health sustainability. However, it will consume too much space to delve into the myriad theoretical dimensions. That notwithstanding, this study synthesizes the works of giants upon whose shoulders new ideas are being generated (Hagger 2012). Based on empirical evidence and appropriate methodological approaches, this study rep-

[15] I thank Professor Sten-Olof Hansén for discussions on this.

resents an attempt to fill both theoretical and contextual gaps in NIT and CR literature in the little known context of WECS Africa. The major point to note is that the entropic institutional pressures and the political power of both business and non-business actors shape all outcomes of national–global interactions in value co-creation and influencing institutions. Here the literature seems to point to the importance of micro-political strategies or behaviors (Buckley 1996; Dörrenbächer & Geppert 2006).

First, the study challenges some of the reductionist theoretical platforms upon which the traditional CSR thought has been pushed forward over the course of 60 years, since its initial formalization by Bowen (1953). Principally, the study problematizes the needless dichotomy between ethics and strategy in the context of the pharmaceutical industry and by extension global health. The study suggests that irresponsibility and a pattern of indifference abounds among all global health actors. That is why the discourse on CR in global health only makes sense when the responsibilities of all the actors are studied comprehensively.

Second, CR as an open concept is not bounded by any 'logical necessity' to have a fixed meaning, given the historical and contextual boundaries and the institutional and temporal dimensions which shape its meaning. More formally, if strategy is only about instrumentalism as in the utilitarian view, then objective socio-ethical questions in managerial decisions towards economic, environmental and political responsibilities are irrelevant or do not even exist. Objective socio-ethical questions actually form the basis for sound and institutionally acceptable managerial decision making that leads to organizational legitimacy. Therefore, SCR orientation exists because it is actually the only foundation for legitimate actions (through value co-creation) in any market and institutional context. In essence, SCR orientation stands in sharp contrasts to the traditional C[S]R rhetoric or the strategic CSR (with elements of both traditional CSR and SCR). In SCR orientation, through value co-creation, the consumer and his sustainable environment are the central focus while the managerial decision setting is the locus (see Articles 1 and 2). The SCR orientation is not just social responsibility but only and always a strategy to arrive at the desired outcomes of the firm or an organization. That outcome is achieved by both transforming organizational resources and offering value propositions to meet the needs of society. The means depend on how institutions model the behavior of organizations or how organizations model themselves in adaptation to the institutions. We can safely refer to SCR orientation as an ecology of behaviors by organizations aimed at survival within a sustainable socio-economic and political environment.

Third, the definitional, contextual and conceptual differences of C[S]R cannot mainly be attributed to the embryonic stage of the research field as

Orlitzky, Siegel and Waldman (2011) suggest. Rather, the confusion lies in the analytical negligence of the time, the sector in question, and the geographical context in which CR and its associated terminologies are constructed. In fact, Dahlsrud (2008) makes similar arguments. It is important to emphasize that CR as a concept is not a paradigm; it has never been. Neither is it a theory. We are only referring to organizational practices whose mutation is dependent on time, sector, context and the degree of socio-political pressure. This is what forces the organizational practices such as CR to co-evolve with contemporary articulations of what responsibility must be.

Fourth, this study did not find the myriad conceptualizations of CR as problematic. Firms in different ecosystems, varieties of capitalism (Hall & Soskice 2001), or national business systems (Whitley 2007) make CR mean what they want the concept to mean, and that is always shaped by the institutional acceptance or rejection or gradual dissipation of certain organizational practices (Oliver 1992). These institutions also constrain the interests of actors which, Scott (2014) suggests, require more study. Further, the political nature of CR also plays an important role in its conceptualization (Palazzo 2011). Concepts such as corporate responsiveness, corporate citizenship, and corporate stakeholder relations have specific meanings but we also understand that tobacco and arms companies cannot be citizens (Chandler & Werther Jr. 2014)—or can they? There are epistemological and ontological differences in the way researchers view and interpret the world. It is natural that differences exist in the ways of understanding CR. That, however, is not to suggest that all CR conceptions are correct. Corporate-sponsored research will certainly camouflage the concept with sporadic good deeds and a mixture of 'green washing'. Nevertheless, true CR analysis that seeks to enlighten society by advancing our current understanding in general and the academic community in particular takes a critical perspective where value co-creation is central to all socio-economic analysis, both for the firm and the society in which it is embedded. Asking whether CR is profitable from an instrumentalist view equates asking the wrong question that seeks to suggest whether innovation and co-evolution with market and institutional changes allows for long-term survival and success. That is, the proposed SCR orientation is not about cost-benefit analysis but rather about the long-run sustainability of the organization and its social impact.

Fifth, the argument that CR has no common definition is partly necessary and partly unnecessary. It is necessary because it allows for a single framework with which to work. It will create a more generalized understanding. On the other hand, it is unnecessary because it is a dynamic concept constrained and enabled by institutions and contextual circumstances. A fixed meaning is therefore unhelpful because it will require the standardization of organization-

al actions everywhere. On one hand, this will call for standardization of ethical practices. On the other hand, it will not foster innovative differentiation which serves local needs.

Finally, some have argued that the concept of CSR was initiated by Sheldon (1924; in Wang 2011) and more recently by Bowen's (1953) publication *of the social responsibilities of the business man*. This claim however presents various elements of arbitrariness. First, CSR consciousness emanating from values of societies and the organisations embedded in them has been around since time immemorial. Every epoch or historical juncture has therefore presented different types of challenges for society. Due to evolution and the need for constant adaptation, the nature of commercial and non-commercial actors in business and society issues has also undergone mutations.

9.3.1 Values and the future of governance: bridging global health inequities

Disciplinary-centered and oversimplified definitions hardly outline the variegated complexity of values. Philosophizing or deep reflection on values frees the mind from dogma, unfounded assumptions, retrogressive traditions and destructive fads in ways that allow us to inquire about the world. It is clearly an intellectual preparation for a deeper, challenging inquiry that questions existing answers and emerging questions through independent judgment, creativity and healthy skepticism (Roth 2014). A critical perspective aims at drawing inspiration from an intellectually creative tension that allows for a rigorous analysis and evidence based judgment and justifiable logic rather than a mere fudge of complaints. Here, economic philosophical analysis, which seeks to answer questions that are not easily answered with the data, draws upon the synthesis of the thinking of many a scholar to make sense of the complex world of SCR orientation and global health actors. This is interdisciplinary because the answers to the questions are clearly not found in one field. In fact, Fontrodona and Melé (2002) propose philosophy or reason as a basis for management practice and research.

Current research sheds more light on two paradigmatic poles: (i) the business research that builds mostly on economics and instrumental reasoning, which Melé (2003) refers to as *economistic*, and (ii) the camp that leans towards the intrinsic human value or the supreme sanctity of dignity, which Pirson and Lawrence (2010) capture as *humanistic*. In the latter, the human being, his/her dignity (Hodson 2001; Rosen 2012), his/her instrinsic value and the justice and fairness due him/her becomes the focus instead of economic value creation (Sen 2001). The respect for his/her values and needs and inalienable rights (including health) (Meyer & Parent 1992) are the grounds

for moral reasoning and practice (Kant 1964) and the responsible business relations with society. The world is going through a crisis of moral decadence and there is an emerging consensus to balance the two camps and, in fact, to allow the people and the planet to prevail over profits through a new form of moral consciousness, which Rifkin (2009) refers to as *empathethic civilization*. This may explain the emergent paradigms of dialogue and cooperation, which in a sense is a discomfort to those who have benefited from this system thus far. Nevertheless, the change must come. This is what Senge, Smith, Kruschwitz, Laur and Schley (2010) see as a *necessary revolution* in the quest to create a sustainable world where everyone benefits. This is where value co-protection has relevance.

On global inequities including global health, even IB scholars recognize, *"that [in the international operations of MNCs] even where efficiency gains led to overall welfare improvement, the distribution of these gains between home and host countries could be most unequal"* (Buckley & Casson 2009, 1568). To this, Meyer (2004) encourages scholars to become particularly interested about the negative and positive spillovers of FDIs and the societal impact of international firms on their stakeholders, whilst being mindful of ethical, environmental and socio-political responsibility as well as transparency and accountability questions.

9.3.2 Insights and contributions from the interdisciplinary perspective

Here, I revisit the multiple disciplines in which the findings of the study are entrenched. I pinpoint the overall contribution of the study in how it (i) changes existing knowledge, (ii) contributes novel insights or (iii) challenges existing paradigms (Bansal & Corley 2011) from an interdisciplinary perspective. Finally, I demonstrate in which ways the findings complement each other.

The unique feature of this study is that it is uncommon to have a study that really engages a wide range of audiences in an interdisciplinary conversation on global health. These findings are naturally targeted at a broad intellectual audience in the above-mentioned disciplines but also to all health-related policy makers and advocates in the NGOs. Some theories are used in multiple disciplines, and so are the concepts/methods developed in other disciplines now freely appropriated and applied in other disciplines, given their fit-for-purpose and interdisciplinary nature, as well as the phenomenon they investigate—global health. For example, NIT has sociological origins (e.g. DiMaggio & Powell 1983; Meyer & Rowan 1977; Scott 2001) but is appropriated and used in fields such as IB and international management, global health, and public health, whereas the stakeholder theory (initially used by ethicists such as

Freeman (1984) and originally defined by the Stanford Research Institute (SRI) (Freeman & Reed 1983; SRI 1963)), is used freely by all disciplines in the socio-economic and public health sciences. Ethics from moral philosophy is used in medicine, pharmaceutical studies and, in fact, in all subjects, as a foundational consideration for any research or intellectual contribution that creates social benefits for society. In Table 7, I divide the disciplines into groups of four according to the articles, whilst analyzing the singular and interdisciplinary contributions of each article.

What then are the benefits of an interdisciplinary study? First, this process of integrating diverse frameworks, concepts and methodological approaches has the advantage of reducing a one-sided view of research problems while aiding a balanced scientific argumentation within the complex whole of global health. Second, as Dunning (1989) argues, such an investigative approach has greater predictive and explanatory power than when a mono-disciplinary approach is employed. Third, the rationale behind this line of thought is that an interdisciplinary approach removes parochialism and widens the research scope while helping to find theories that can explore deeper and explain better. That is, it extends and enriches the research agenda under consideration (Ramamurti 2001). Fourth, fusing ideas and previously contrasting assumptions helps to further new understanding which will hardly be possible in a mono-disciplinary approach. Fifth, in essence this way of doing research corresponds to an innovative enrichment of the investigative process which seeks to broaden the readership and scholarship bases by revitalizing worn-out and quasi-out-of-steam domains creatively. Above all, it increases the ability of the product (new knowledge and structures of truth) to gain applicability across disciplines. Moreover, it offers greater latitude and immense practical managerial usage while informing policy. Finally, and for our purpose, such an approach allows extending the nexus between global health and social and economic sciences (Aboelela et al. 2007; Rosenfield 1992). The flipside is that such a process is costly, time consuming, and requires highly concentrated efforts and versatility.

Table 7 Synthesis of the interdisciplinary contribution of the articles in the thesis to sustainable global health governance

Major disciplines	**Main theory**	**Type of contribution:** ** Changes existing knowledge or challenges an existing approach/paradigm* *** Offers novel insights or advances contextually relevant issues in global health*
Article 1		
International Business & Management, Political Economy, International Marketing	International strategy, ethics, CR, sustainability	* Challenges the false dichotomy between ethics and strategy ** Offers novel insight in terms of value co-protection which is inextricably intertwined with value co-creation especially in the pharmaceutical sector where the *process is the outcome*. This is the first time a conceptualization of value centralizes values and value co-protection aimed at sustainability.
Article 2		
Ethics, Public Health, Social Pharmacy, Epidemiology, Medicine, Global Health	Organizational change for sustainable health, new institutional theory, resource-based view and by extension the dynamic capabilities	** The co-evolution of business and non-business organizations and the ensuing change is moderated by the centrality of values-based leadership. Constrained optimization of dynamic capabilities is ethically and institutionally impacted by the 'Geist der Zeit' (sustainability consciousness) and geography of emergent health issues.
Article 3		
Organization Studies, International Management, Macro-sociology	Institutional logics	** Unravels how complex mental maps of organizational leaders in CSSIs lead to goal ambiguities and eventually organized anarchies producing poor outcomes.
Article 4		
International Relations, Sociology, Political Science, Political Economy, Organization Studies, International Business	Institutional path dependence and power asymmetry	* Whereas existing studies accept and only build on the local–global relations as a constant, this study radically challenges and changes existing approaches in national–global governance of health. Findings now suggest that sustainability does not only depend on mere bottom-up approaches but disruptive bottom-up approaches. ** Offers novel insights into the possible futures of sustainable global health that are dependent on a conscious change in values

9.3.3 Synthesis of the contribution

Based on theoretical prescience (Corley & Gioia 2011) and from managerial, clinical and technical standpoints, seeing global health inequity (Janes et al. 2006) not as a permanent constraint but a solvable socio-economic issue makes it a viable interdisciplinary area of research. The critical nature of the study and the fieldwork approach also demonstrates the intrinsically valuable contribution of this study since the major actors are also seen as possible partners in responsibly co-creating and co-protecting value. Research that contributes to intellectual advancements in its field and beyond, as well as to the socio-economic and political progress, can be said to be of value. Most importantly, this research constitutes a timely conversation that brings a whole range of actors to the same table to have an intellectual discourse about one of the most intractable problems of our time—global health inequity and the proliferation of counterfeit medicines. Outside the healthcare disciplines, studies on values in global health are very limited and tend to take a managerialist approach.

This study contributes to the extant corpus of literature: first, from an interdisciplinary perspective on the ethics and behavioral aspects of organizational practices in the area SCR orientation, and second, from a novel/or unexplored context of transitioning WECS Africa. The study has also evidenced the centrality of ethics in value co-creation and value capture by emphasizing the importance of organizational values as central but constrained by ethical consideration within an institutional context—the varieties of capitalism—and within a particular timeframe. The organizations are therefore *"responsible for the moral identity"* (Weaver 2006, cited in Mantere et al. 2009, 127) and are thus not only responsible for actions (what they do) but also who they are (what they stand for and why they exist), especially within the scope of their corporate political activities in achieving their interests (Mantere et al. 2009; Solomon 2003). The above implies that the twenty-first century of sustainability re-unites all the actors around the consumer as the source of value.

Furthermore, the study ventures into a new phenomenon: global drug counterfeiting, whilst conceptualizing value from the perspective of the consumer and other stakeholders who value value-protection as inextricably intertwined with value creation. To the best of my knowledge this is the first interdisciplinary study that addresses value co-creation and value co-protection as one and the same. Most importantly, the major theories—NIT, CR, ethics, and the dynamic capabilities view—are used to inform each other in order to better explain the phenomenon. Through the critique and problematization of literature on traditional CSR, this study builds on the robustly re-emerging literature on critical perspectives on CR by offering fresh empirical input and seriously

needed critique that advances knowledge of previously ignored contexts. This is, however, a stepping-stone into a much complex substantive domain which will certainly require further study.

Four major themes run through this thesis: SCR orientation, sustainable global health governance, value co-creation/co-protection, and transitioning economies. The interdisciplinary outlook provides an interesting understanding of how global health can be studied in the above disciplines without alienating the target audience due to conceptual dissonance or epistemological differences. The nature of the phenomenon under investigation made this possible. IB, international management, political economy, international relations, and epidemiology show the commonality of cross-country exchange and the relationship with public health, social pharmacy and medicine. They are, in turn, all impacted by power asymmetry between the North and South (unidimensional flow of resources, decisional influence and regulatory actions as well as other technologies of governance from North to South) (See Article 4). This power asymmetry explains how the technologies of governance are galvanized in advanced countries and some transitioning economies to engage geopolitically with WECS African economies that are under-resourced in medico-techno-scientific terms.

The above points are important because global health, international commerce, sustainable economic development, political risks and geopolitics are all directly intertwined determinants of public health and related foreign policies (Feldbaum et al. 2010; King 2002; Labonté & Gagnon 2010). Whilst international strategy is mostly applied to the study of how firms internationalize and operate transnationally, this theory is equally applicable when it comes to IOs and INGOs although in mono-disciplines, such as IB and international marketing, MNCs are the major subjects of study. Whilst resource seeking, market seeking or knowledge seeking may explain internationalization and the search for competitive advantage, the resource-based view and by extension dynamic capabilities leads us to the understanding of how managerial entrepreneurs employ resources to identify and take advantage of emerging opportunities and to gain legitimacy where stakeholder expectations and pressures keep mounting. In order to ensure ethically responsible corporate strategies that fulfill the normative, cultural-cognitive and regulatory demands, ecologies of engagement are required to co-create value in order to gain legitimacy and sustained competitive advantage. The relational dimension of business and non-business actors in this study is therefore emphasized.

9.4 To whom is this relevant? Managerial and policy implications

In emphasizing the concerns raised by Bennis and O'Toole (2005), Corley and Gioia (2011, 22) suggest that scholars delimit *"the scope of our studies only to those variables we can easily measure, producing a kind of 'methodolatry' that harbors the paradoxical possibility of blinding rather than illuminating things that really matter"*. Going by the negative accounts about the pharmaceutical industry's organizational conduct (e.g. Goldacre 2012; Welch et al. 2007), do we still need the pharmaceutical industry? To ask such a question is to totally miss the point of critical perspectives on the pharmaceutical industry/global health as a 'rationalized open system' (Scott 1987) 'pursuing intelligence' (March 2006) that may either lead to outcomes deviating significantly from institutional expectations (Suchman 1995) or meeting the stakeholder demands (Freeman 1984). Additionally, such questions also demonstrate a profound misunderstanding of the nature of science as the 'community of organized [healthy] skepticism' in Professor William Richard Scott's[16] words. On the contrary, employing a logical synthesis of contrasting views in problematizing global health, a balanced inquiry into certain patterns of organizational behavior that results in massive negative outcomes on society can be constructively addressed. Such a constructive engagement with other critical perspectives serves to limit the power of certain actors whilst questioning the status quo. Further, it is conjectured that this may facilitate the gradual dissipation of the institutionalized practices that allow such patterns of behavior to prevail whilst introducing new rules into the game (North 1990). The responsible pursuit of such an organized skepticism will create a dialectical space aimed at sustainable global health outcomes.

This dissertation is both theoretical and applied (Bergh 2003; Van de Ven 1989). As Cuervo-Cazurra, Caligiuri, Andersson and Brannen (2013, 286) argue, IB is an applied field where we strive to communicate the results of our findings not only to a *"narrow set of people."* Rather, we make serious efforts to reach out to managers (in firms and health-oriented IOs as well as local organizations), policy makers, activists and, of course, a larger epistemic community beyond the IB field. This is very important especially in matters of global health which involve multiple actors and competencies as well as complex and contrasting views. Therefore, the relevance of this study (Flyvbjerg 2002) is to advance critical theories whose logic will be placed in practice to produce real life empirical changes. From this perspective, what then will be

[16] Scott, W. Richard (2004) Institutional theory: contributing to a theoretical research program. A chapter prepared for: Great minds in management: the process of theory development, ed. by Ken G. Smith – Michael A. Hitt, Oxford, UK: Oxford University Press. Available at: http://www.icos.groups.si.umich.edu/Institutional%20Theory%20Oxford04.pdf.

the alternative for manufacturing drugs and vaccines, inventing drug security technologies or investing into the R&D of new therapeutics for the ever-increasing global population whose healthcare needs and emerging pathologies are exponentially rising? We will have to think about the problem in a radically different manner.

9.4.1 Implications for policy makers in international organizations and governments

> *Può capitare che minime differenze nelle condizioni iniziali producano enormi differenze negli esiti finali. [It can happen that minimal differences in the initial conditions can produce enormous difference in the final outcome.]* (Henri Poincaré, cited by Bianucci 2013, my translation)

Although this study is not about the stability of the solar system or the chaos theorem, it is proposed that minimum, bottom-up value co-protection by business and non-business actors beyond the regulatory exigencies will be the path towards sustainability. This means that a clear definition of what each actor has to offer must be on the table. Without this, whoever controls the medico-techno-scientific resources will always dictate the rules of the game. Nevertheless, top-down, ad-hoc interventions by global actors such as the WHO during epidemiological outbreaks is clearly welcome to manage crises in the short term. Making such top-down policies permanent is, however, destructive since they create dependency and incompetence on the part of the local health actors (e.g. MoH, local NGOs and universities) in the transitioning economies of Africa. I share the sentiment of Woodson (1933) in arguing that:

> *History shows that it does not matter who is in power or what revolutionary forces take over the government, those who have not learned to do for themselves and have to depend solely on others never obtain any more rights or privileges in the end than they had in the beginning.*

Proper representation of transitioning economies of WECS Africa in top decision making levels is a necessary step. Value co-creation can empirically be defined in part as a load and risk-sharing or mutual bearing of responsibilities when sole creation of value is unsustainable, no matter how interesting it may be. In this, the maximum input of all is required based on competence. Increase in passivity will yield illegitimacy, while unlimited ethical commitment is deemed natural in the twenty-first century to avoid value destruction. This is where the CSSIs and GHD are required to make positive changes in

global health. The role of local and INGOs through private politics is essential in the pharmaceutical industry. Here campaigns by activists can influence change towards the responsible production and distribution or market practices of a corporation (Baron 2001).

The following contains perhaps the most serious recommendation and warning based on evidence from this study. The WECS African governments must, as a matter of urgency, take major responsibility in co-creating and co-protecting value within their national healthcare systems. Even when they lack the technologies and scientific know-how, there is absolutely no need to reinvent the wheel. Existing healthcare models/pharmaceutical production models from India and Taiwan are worth emulating (Kettler & Modi 2001; Shih, Lew-Ting, Chang & Kuo 2008). Further, altering the institutional logics and public perception about the dangers of counterfeit drug manufacturing and consumption through appropriate policies will have a significant local impact. Moreover, ensuring integrity among the security personnel charged with the responsibility of enforcement and consumer safety will be a good start. Furthermore, governments in transitioning economies must keep abreast of the emerging changes in the global health sector in terms of technological innovations whilst taking responsibility in abandoning the dependency mentality. To ensure concrete and positive outcomes in this direction, urgent investments in the biotechnology and pharmaceutical research applying local human and natural resources is deemed desirable for optimal results. More specifically, studies and research in pharmacognosy (the study of medicines sourced from natural organisms) is a tested opportunity for solving the intractable public health problems. This will mitigate the spread of counterfeits whilst reducing the disease burden.

The 2013 Africa Progress Report[17] revealed that five mineral deals cost the Democratic Republic of the Congo an estimated US$ 1.36 billion, by undervaluing assets for sale to corrupt anonymous shell companies who connive with the corrupt bureaucrats. According to the report, this amount is more than double Congo's combined annual budgets of health and education. This estimate is only for Congo, meaning that it is the harbinger of a widespread corruption by unnamed, socio-ethically irresponsible bureaucrats, companies and businessmen.

Until now, there are three significant points that policy makers, governments and firms have not taken seriously. One, in healthcare, international policies and regulations are more important than national ones because of the structural, techno-scientific power asymmetry between the advanced and the transitioning economies. Hence, the core region must be considerate in using

[17] Available at http://www.africaprogresspanel.org/en/

their political power when promoting their economic and foreign policy agenda. Global health issues are a threat to all. What is required therefore is cooperation on a level that will with time allow for the transitioning economies to become independent and relevant actors in GHD.

Two, whether or not there is progress and real success in changing the dynamics of issues of patient safety through value co-creation/co-protection, there will be the need for equilibrium in strong local actions and powerful global response. Here, consumers should be given incentives for using pedigree technologies to check whether the drug they purchased is fake or authentic. This is how cooperation and collaboration can work effectively.

Three, there is the big issue of recognition (see Article 4). Recognizing all global health players (especially Big Pharma and NGOs) removes the problem of attribution of responsibility. The WECS African governments should recognize and incentivize all actors who are at the forefront in making cooperative investments to mitigate counterfeiting activities.

Four, dependency must be discontinued. Properly managed aid—aid money that has transparency and accountability as its main characteristics—should be encouraged as a temporary measure as Gates and Gates (2014, 11) suggests:

> *The U.S. government spends more than twice as much on farm subsidies as on health aid. It spends more than 60 times as much on the military. The next time someone tells you we can trim the budget by cutting aid, I hope you will ask whether it will come at the cost of more people dying*.

To ensure cooperation on equal footing, certain structural deficiencies in global policies must be addressed. This is because they have a direct effect on the structural determinants of health, again following Gates and Gates (2014, 9): *"Wealthy countries also need to make policy changes, like opening their markets and cutting agricultural subsidies, and poor countries need to spend more on health and development for their own people."*

Engineering of innovative choices for change: Some prescriptive directions. In what follows, I seize this opportunity to offer policy recommendations on ten general concerns based on empirical observations during the years of research on this subject.

1. **Institutions as foundations:** In the next sections, I discuss how institutions can form the foundation for building the local pharmaceutical industry to solve the problem of lack of access to medicines that leads to the problem of drug counterfeiting. Market and institutional solutions are therefore required to generate efficiency and create high value for consumers. Health problems in

transitioning economies are far worse than in developed economies (CSDH 2008). Global health affects international business and trade policy (Feldbaum et al. 2010). Firstly, the obvious explanation is not only the income discrepancy but the institutions of the industrially less developed countries (Acemoglu & Robinson 2012). These neither seriously support science and medical/pharmaceutical research nor input significant financial resources into local science and innovation industries (AUC 2012; Lartey & Graham 2007). Limited access but increasing purchasing power has three immediate implications. One, patients will always buy what they find, and when they do not find what they need, they resort to counterfeits and fakes sold by street peddlers (MyJoyOnline 2013). Two, since patients have limited choices, scrutinizing what they buy is not routine and this results in dire consequences for their health. This explains the proliferation of counterfeits. Three, a large majority of these poor consumers are vulnerable to the potential risks of purchasing unregistered drugs and they have no idea about non-evidence-based drugs. The presence of pharmaceutical businesses to increase the accessibility of drugs solves one big problem—patient safety. This makes the role of local associations and INGOs indispensable in ensuring that the rights to access healthcare and affordable quality drugs are guaranteed while protecting vulnerable consumers from rogue sellers determined on profiteering.

A counter argument, however, is that policies of international NGOs and intergovernmental organizations who finance health agendas are not bad in themselves but their application represents a potential threat to national sovereignty and makes accountability and transparency more complex to administer (Okuonzi & Macrae 1995). This is not to suggest that benign actions by organizations as they were have been a disguise for something else. While agencies can be scrutinized for accountability and transparency in the UK or the USA, this is obviously difficult in contexts where there are institutional lapses (Acemoglu & Robinson 2012). For example, expenditures on malaria aid programs by agencies have not always been transparent due to wasteful spending in overpayment to consultants (Easterly 2008; Schubert 2007).

2. **Collaboration for value creation:** The temptation to easily take an advocacy role is always very high given the very nature of counterfeit trade on human health. Nevertheless, partnerships with the industry suggest interesting results leading to effective global health rather than an adversarial and acrimonious relationship which in reality solves a slightly different problem. Such a situation does not allow justice to take its course through the regulatory bodies, leading to an enormous waste of time and resources on a media circus. In the past two decades, PPPs have been seen as alternative development options in the areas of health and, more generally, educational infrastructure (Mijiyawa 2013) and more specifically in the pharmaceutical industry (Nwaka & Ridley

2003). Between 1996 and 2006 there were 289 such PPP projects in WECS Africa alone, estimated at US$ 40.7 billion. This figure, according to Mijiyawa (2013), is much higher than in other regions in the developing world. However, the effectiveness of such PPPs has varied according to the strength of the local institutions. Therefore, strengthening the institutions is a fundamental step.

3. **Attracting FDIs in the pharmaceutical sector:** It is argued that heavy FDIs in the health sector are needed in transitioning economies but they must be thoughtfully negotiated to yield the maximum social value. Using the case of Spain to analyze the net benefits of FDIs, a pertinent question by foreign entrants is whether or not FDIs have any effect whatsoever on local industries. Jin, García, and Salomon (2013) mention several possible challenges, such as whether the presence of FDIs crowds out local pharmaceutical innovation and the development of local experts' technical skills, or whether they serve as a form of short-term incentive for local firms to compete. Competition here can be on different levels. Probably, it may be less related to technological know-how but more to market and distribution channels. They also argue that FDIs may lead to foreign firms pushing local firms to less knowledge-intensive niches and their higher remuneration may poach local highly skilled would-be entrepreneurs, thereby starving local industry of the highly skilled R&D experts which is a precondition for local innovation. A counter argument is the mobility of labor which can also be tapped from the diaspora. Incentives to local firms by government will offer more attractive conditions for local entrepreneurship to thrive. Jin et al. (2013) argue therefore that FDIs may improve the overall factor and labor productivity but not innovation. The lesson for WECS Africa, depending on the institutions, may be to prioritize production in the short term but encourage innovation, especially in the pharmaceutical industry, in the long run.

   Taking advantage of economies of scale would also mean the ability to cover large segments of the market with authentic drugs and thereby directly turning consumers off from the counterfeit versions. This has two important implications: indirectly protecting the firms from intellectual property rights infringement and at the same time ensuring consumer safety. This is not to suggest that there are no challenges. There are challenges in doing business in WECS Africa, but they vary according to the strength of the institutional structures. This is why the role of governance is fundamental. There are more general concerns that inhibit the flow of FDIs in the health sector, such as the lack of or poor infrastructure, quality transportation systems, water, sanitation, electric power and a high-skilled labor force (Mijiyawa 2013). Nevertheless, location choice, partnerships with local industries and NGOs, and mobility of

the labor force could be solutions to some of these challenges which are changing rapidly.

In addition, there is a rational explanation for why policy makers in the higher educational sector need to take decisions on medical and pharmaceutical sciences seriously. Investments in this field will benefit the highly vulnerable demographic composition of the society (especially women and children). This is perhaps the most sobering lesson that must be kept at the forefront of all initiatives; 'health is wealth' because it presupposes that healthy living humans are the bedrock for socio-economic productivity and sustainable development (Sachs & Malaney 2002). It has been too long since any African university (apart from the ancient Timbuktu) became a center of excellence or was featured in any global ranking (faulty as they may be). Nonetheless, the African scholars excel elsewhere when they are provided with the right environment to engage in meaningful scientific enquiries.

Recruiting talents both from home and the diaspora, retaining them with incentives, communicating results, and connecting research centers and individuals with stellar performances with interested NGOs and philanthropists to finance research will be an alternative that will start a new era of scientific breakthroughs. Thinking outside the box and seeking alternative sources of finance will be the first step towards both autonomy (in the sense of academic freedom) and gradual deinstitutionalization of solely government-funded and government-controlled research that is stuck in bureaucracy, delays and inefficiency. Even minimal changes in the institutional logics about how to excel with limited resources will change things and yield results that millions of dollars cannot provide. The realization that the locals are the ones they have been waiting for to bring results through scientific contribution in Africa and beyond will stop the repetitive error of dependency and administrative paralysis. Responsibility towards accountability with a few available laboratory apparatus, informal friendships for information sharing (when there is no money for scientific conferences) and South–South cooperation that promotes new ideas, replacement of essential stock of equipment and instruments with new ones, one at the time, will go a long way.

4. **Lofty promises vs. real actions:** Annual budgets and policy statements are mostly full of lofty promises and pro-poor ideas but there is always a deafening silence after elections. Instead, concrete actions are needed to enact real changes in public health. But how? First, there is the need to close the financial leakages in the system through proper tax collection and transparent accountability on how money (from natural resources, taxes and donors) earmarked for healthcare is spent. This means no value creating activity in the health sector should be left in the hands of individuals who lack the integrity to ensure the improvement of healthcare administration in general. This will

require the introduction of punitive and monitoring measures through the institutionalization of legal proceedings against those who cause harm (destroy value) in the healthcare sector. On the other hand, there will be the need to promote competent and committed public health actors (individuals and teams) through empowerment and support.

5. **University–industry collaboration:** There is a huge disconnect between university research and industry across Africa. R&D collaborations and the institutionalization of internships as a compulsory part of university studies would allow budding scientists to have first-hand experience in how the real world of science, technology and their commercialization works.
6. **Complacency:** Health as a basic human need is a serious matter. In fact, taking public health as a pun threatens the very existence of an entire population. Slow execution of projects, the lack of transparency and inept leadership in effectuating interventions negatively affect efficiency, effectiveness and accountability. Instead, health-related policy issues and projects must be prioritized and expedited without going through multiple bureaucratic processes that delay, destroy and eliminate the trust (which is anyway minimal) of the general population in the public health praxis. This is how millions of people with low incomes in developing economies have their life expectancies shortened as a result of their constantly deteriorating structural determinants of health. When people seek healthcare from questionable informal praxes and counterfeit drug dealers on the streets, it is mostly a direct consequence of the lack of trust for public health in general.
7. **Managing care:** 'Prevention is better than cure' is not a complex form of cutting-edge rocket science. Governments, as a matter of urgency, must work on managing care through improvements in the socio-economic determinants of health rather than managing cure that is donor-driven. This means that general hygiene, access to good quality water and food, and common-sense day-to-day management of the environment should be institutionalized through public education as every citizen's ordinary responsibility and prioritized as community based. See also proposal number 10 below.
8. **Retention of health professionals:** Healthcare workers should be retained. The MDGs and the proposed post-2015 Sustainable Development Goals (SDGs) do not make any sense without a massive local content and institutional contribution at the national level. The ever-growing population in Ghana, and WECS Africa as a whole, requires foresight in the healthcare systems. Nevertheless, if the finanza-medico-techno-scientific resources are mostly imported, the national public health systems will not have a future. Retaining talents in the long term requires investment to increase incentives for healthcare professionals. Junior doctors who receive no pay are essentially being forced to migrate to where they will be needed (MyJoyOnline 2014).

9. **Improving public health infrastructure:** Had there been sufficient state-of-the-art health infrastracture across WECS Africa, there would not be so many rich patients traveling abroad in the search of medical treatment. The outbreak of Ebola in Sierra Leone, Guinea and Liberia exposed the inadequacy and vulnerability of the existing health infrastructure. There is an urgent need to boost the human resource capacity building in the health sector. Meeting this need is expected to: (i) provide coverage for the different compositions of the populations whilst contributing positively to the local economies; (ii) encourage decision-makers and other wealthy people to make use of the available health 'praxes' whatever their current state may be; (iii) expose the policy makers and investors to the reality in order to help them understand the vulnerable state of the healthcare infrastructure that the rest of the population is forced to cope with. In essence, such exposure will help the policy makers to take responsibility for the situation. This will serve as the foundation for health equity, aimed at bridging global health inequality.
10. **A 'Sankofa' values approach to social innovations:** a return to the past or 'the world until yesterday' in Jared Diamondian (Diamond 2012) terms (see the Sankofa bird, an Adinkra symbol of the Akans from Ghana in Figure 12).

Figure 12 Sankofa bird.[18] In Akan language sankofa means "reach back and get it". It is symbolized by a bird that reaches backwards to take an egg off its back.

Before I offer any further explanations about the Sankofa values approach in persuing sustainable global health in WECS Africa, I need to address an important caveat. The return to the past is not a naïve, blind, and uncritical valor-

[18] Image source: http://diaryofanegress.com/2013/06/07/sankofa-an-african-collective-company/

ization of ‘just anything African’ approach. The idea of Sankofa is undergirded by sound wisdom and values-based collective initiative that is community-oriented (‘ubuntu’ = ‘I am because we are’). That means learning from the corrections of the errors of the past that have derailed the medico-techno-scientific progress in health care while upholding and advancing the progress made thus far. The requirement here is to enforce existing laws and regulations governing socio-economic factors that directly or indirectly affect health. Moreover, there must be a serious effort that is aimed at deinstitutionalizing some of the normative systems that obstruct progress in public health.

My idea of the Sankofa concept in community health is based on the following two tenets: (i) “Don’t get sick!” (translate: prevention is always the best cure) and (ii) “Use what you have to get what you don’t have.” The first tenet is a prevention-centered logic as opposed to the cure logic which is mostly what modern capitalism proposes in order to sell more medicines. Social innovations are required to fix the deficient social determinants of health from the grass roots with limited resources but high rate of success. This must be based on the value co-protection approach where the population is educated to participate in the political processes that affect health decisions and day-to-day management of social determinants of health—mainly political, environmental and economic factors. The sankofa approach would also include removing wastes and inefficiencies in public health management and making changes in lifestyles and consumption patterns in order to achieve sustainable health.

The second tenet is founded on the premise that public health must not over-rely on donor-driven resources. Donors should offer aid only as a supplement and in emergency situations. Here, the African governments must reposition themselves as strong bargainers in international trade in order to deinstitutionalize the path dependence of international trade-distortion policies. Moreover, a return to traditional medicine along with modern allopathic medicine would serve as a mechanism for pushing drug research agenda forward in WECS Africa to meet the emerging healthcare needs. Experts believe that the next breakthrough in drug development could easily come from active ingredients extracted from plants and the usage of rational drug development processes to innovate medicines in cost-effective ways (Addae-Mensah, Fakorede, Holtel & Nwaka 2011). Further, there is the need to implement and finance the existing projects rather than to reinvent the wheel. For example, this study found that the *“strategy for the formal institutionalization of plant-based medicine services, medical herbalism and complementary medicine”* in Ghana by the traditional and alternative medicine directorate lacks adequate financial support. CSSIs of all stakeholders would be required in a collective action through investments in R&D for traditional medicines. This will create the possibility for frugal, disruptive or incremental innovations.

9.4.2 Implications for managers: enacting institutional change

> *Big business depends entirely on the patronage of those who buy its products: [even] the biggest enterprise loses its power and its influence when it loses its customers (Ludwig von Mises 2006, 4).*

Big Pharma operates in a closely aligned area of public health which is extremely sensitive and emotions-laden (Bhanji & Oxley 2013). When Big Pharma ventures into the public choice domain, the motives behind its corporate citizenship or CR actions open themselves up for suspicion and sometimes fierce antagonism. This is not quite the case of all pharmaceutical MNCs in the transitioning economies of Africa. They are rather pressed to do more for ethical reasons. Managing alliances between NGOs and firms is by nature a complex agenda (Austin 2000; Jamali & Keshishian 2009), especially within the domain of CR in developing nations (Austin 1990). However, finding a common ground with supportive NGOs is almost a panacea for earning legitimacy (Bhanji & Oxley 2013), which is an important reputational asset for foreign operations in a sensitive area. Generally, for MNCs the liability of foreignness is a big problem, but so is the liability of privateness. Zaheer (1995, 343) refers to the liability of foreignness as the *"additional cost a firm operating in a market overseas incurs that a local firm would not."* This is rooted in IB theories (Hymer 1960/1976; Ietto-Gillies 2002) but context and sector matters in making any claims. The difficulties or disadvantages encountered by private commercial enterprises when they participate in producing public goods (i.e. the liability of privateness) are what Bhanji and Oxley (2013, 293) define as the *"additional costs that a corporation investing in public goods incurs that a [comparable] third-sector organization would not incur."*

Reducing the difficulties faced by firms is a bit reductive when questions of legitimacy are in play. However, these problems may simply be called the complex institutional challenges. Bhanji and Oxley (2013) concede, however, that there are certain determinants of liability of privateness which differ significantly across sectors and institutional contexts. As is the experience in the pharmaceutical industry, there is more natural cohesion with governments and the third-sector through co-investments than, say, the oil industry or other extractive industries. They also attribute this difference to socio-economic fundamentals, and of course, the fact that healthcare products and services for our purpose *"have the nature of a public good"* (Bhanji & Oxley 2013, 293). This also means that firms like GlaxoSmithKline or Abbot will enjoy a much lower liability of privateness due to the cumulative experience in dealing with governments through PPPs, and NGOs in co-creating value or public goods. That

is explained by the institutionalized acceptance of their long-standing efforts, which in turn earns them legitimacy.

But what is the purpose of the firm? Then again, which firm? An oil company building schools in the Niger Delta where there is so much oil spill and territorial disputes with stakeholders only creates more suspicion. Rather, they should make the oil deals transparent and avoid spilling oil into the environment. And if that happens, they must expend resources on cleaning while compensating locals whose livelihoods are affected. Tax evasion and backroom deals must be avoided. All this, however, is not CR; it is ordinary behavior. When individuals in developing nations pay taxes they do not announce it in the newspapers. So why should firms? Corporate governance failures have meant the loss of trust in business but the right business models (through stakeholder engagement) will help win social trust in the transitioning economies of WECS Africa.

The preoccupation that some analysts have about the pharmaceutical industry is clearly genuine, others are simply misguided. For the managers of a firm, what happens when the cost of traditional CSR (in the sense of philanthropy) becomes unsustainable? The solution is not found in the later stage of the value chain but rather rooted in the proactive innovations which meet efficiency and socio-ethical concerns at the same time to create competitive advantage—the SCR orientation. The sharing of responsibilities (rights, obligations and accountability) between all major global health actors at different levels means that the old arguments that push all responsibility exclusively on MNCs lead to unrealistic expectations that will probably never be met because Big Pharma is a science and innovation-based business, not a philanthropic organization. Such expectations have also proven inconsistent with the complexity of the emerging turbulence (opportunities and challenges) in the global health arena. That notwithstanding, matters concerning issues such as drug testing must be dealt with as a matter of ethics where the law ends.

On the other hand, MNCs' strategies should be patient-centered but they should also involve sensitizing the consumers through social marketing (Andreasen 1994) to be proactive about the social determinants of health and lifestyle changes. Firms must adhere to the national legal prescriptions and international regulations on cGMP and cGLP, although the laws are not self-enforcing. Ethical questions pertaining to drug testing without the consent of vulnerable patients should be an expired topic that we should not deal with again in the twenty-first century. The regulatory apparatus must be essentially modified to meet the emerging challenges. This is where matters square up when all the actors within the strategic and political processes play a significant part in value co-creation and value co-protection.

The study has implications and ready-to-use evidence-based policy recommendations for pharmaceutical SMEs in the advanced countries. Further, international development cooperation of the Ministries of Foreign Affairs can tap into the emergent opportunities in the new market frontiers of WECS Africa. Moreover, the development of new technologies for fighting counterfeits provides opportunities for pharmaceutical technology firms. The operational relevance of this research for international firms in the science and innovation sector lies in the better understanding of the empirical realities in the drug markets of WECS Africa. Discovering the potential business opportunities in transitioning economies will pave the way for the firms' internationalization through the SCR orientation and the optimization of their dynamic capabilities. This will help capture emerging opportunities with novel technologies and cheaper but quality drugs. Regulators will then be able to formulate informed policies based on objective facts in ways that will facilitate and boost trade in these new marketing frontiers.

9.5 Limitations of the study

The discussion on the limitations of this study focuses mainly on the empirical part. As with all research endeavors, ensuring accuracy and robustness of all accessible data is the ultimate goal. However, the latter goal was not achieved to my satisfaction given the opaqueness of the industry as well as the time factor and the lack of resources. First, the research context is a complex terrain. Therefore, it was not possible to acquire all the intended data that was planned in the initial research protocol. For example, I sought three forms of data: (i) statistical data on the number of individuals or organizations that had been arrested and prosecuted because of counterfeit medicines in Ghana; (ii) the volume of confiscated counterfeit drugs from the ports of entry and the market; (iii) the volume of financial and logistical support in the past years that could be directly attributed to fighting the counterfeits. I did not find any of the above. This also shows what Shanta Devarajan (2013) refers to as 'Africa's statistical tragedy'. On the other hand, on multiple occasions I contacted several pharmaceutical MNCs for data on initiatives and strategies on doing business in the context of WECS Africa. However, I did not receive any response except directly from some managers that I happened to meet in Washington, DC. Similar stories of other researches who could not obtain data from Big Pharma also abound. This could be the reason why both the substantive domain and the research context have hitherto been avoided by many researchers.

This experience is what led me to conclude that the pharmaceutical industry is also part of the open mystery of fortress organizations. From here on, I developed alternative ways of answering the questions, which led to an even more comprehensive investigation involving cross-sector organizations. All known and also newly created innovative approaches, within the limits of the available resources and time, were used to get to the bottom of the research questions. This helped to overcome the difficulties in acquiring empirical data in clearly challenging research contexts.

Although a valid process of triangulating empirical material was followed whilst answering the questions of social desirability bias, the obvious caveat is that it is extremely difficult to acquire supporting quantitative data from 'inside', making this an exploratory study rather than a conclusive one. Given the institutional heterogeneity, Ghana is only partly representative of all WECS Africa but only indicative of the structural similarities for comparison. Moreover, this is an extremely sensitive sector in which the participants did not want to be identified in any way. In most cases I was not given permission to tape record interviews but only to take notes. Although the interviewees were top national or global experts at the forefront of the fight against pharmaceutical counterfeits they did not fully answer all of my questions. That notwithstanding, this whole research project leaves out several unanswered questions that require more extensive future research to establish what exactly the responsibility is of all the global health actors within various institutions.

The current study is socio-ethical, economic and political in nature, and draws on different disciplines. At first glance this appears to be both the strength and weakness of the study—when trying to contribute to various disciplines simultaneously. One may argue that the impact on all the disciplines would be rather rather weak, compared to a study which focuses on one field and contributes strongly to that. This argument is weak and misleading if one recognizes the fact that unlike specialist scientific disciplines, such as astrophysics, the very nature of global health has interdisciplinarity built into its DNA. What makes the domain interdisciplinary is that the mention of its basic theories, concepts and methodological approaches echoes immediately among scientists (researchers), economists, policy makers (government agencies), health professionals (clinicians), NGOs (e.g. Médicins Sans Frontières) and industry (pharmaceutical SME and MNCs). Abstractions such as global warming, environmental sustainability, and economic development are examples of other such naturally interdisciplinary themes. The pragmatic flexibility of these themes allows for the application of various methodological approaches in understanding them. Ahen and Zettinig (2015b), categorize these questions as existential, burning, manufactured and neglected issues. This means that global health and SCR orientation are not silo subject areas that speak in a

highly-focused manner to a minority community distanced in its own world. Moreover, the word contribution or impact must be defined. Is it a contribution that is an unnecessary addition to a sub-field or one that interacts with other fields and has a broader socio-economic and scientific impact? The latter is always preferred in the twenty-first century (Alvesson 2013; Statler 2014).

9.6 Agenda for future research

Future research will follow five lines of probing. The first concerns the institutional logics undergirding individual and group decision making in counterfeit drug purchase. Understanding such logics may help to explain the 'hows and whys' of the demand and supply of counterfeits and the different roles played by industry, hoCSOs and governments. Along the same lines of probing, another research area is to understand the institutional logics and the psychology behind the demand and supply of counterfeits in advanced and emerging markets of Finland/the USA and Ghana, respectively. It will also seek to understand how institutions breed destructive type of entrepreneurships (counterfeit drug production) (Hall & Soskice 2001), and what the role of hoCSOs, professional bodies and the pharmaceutical sector is in combating or encouraging the phenomenon. The relevance of such an investigation is to place the consumer at center stage from the bystander position. Whilst attention is usually paid to regulatory issues, the role of hoCSOs, intellectual property infringement or protection of the pharmaceutical industry, no systematic study has so far been conducted to understand the institutional antecedents that foster both group and individual influences on purchasing behavior. Further, analyses that take into consideration both demand and supply-side factors are also lacking. Cross-nationally, however, a major target for policy intervention is the consumer—the very source of demand, although hitherto overlooked.

Second, global health inequity and inequality is at the heart of all this research. Value co-protection as an essential dimension of value co-creation is still under-researched or at least does not feature in current research at all. These are fruitful areas worth investigating.

Third, there is a clear and direct nexus between environmental governance and global health governance. This is because environmental governance policies affect the structural determinants of health especially in transitioning economies. Further, environmental governance affects health directly in more complex ways. Non-mitigation of deforestation, desertification and questions of sanitation among a host of other factors affect human health everywhere. For example, in a recent issue of Science, Mercedes Pascual and collaborators (Siraj et al. 2014) issued a warning on the increasing risk of malaria even in

mountainous places (of higher altitude) previously seen as at lower risk because of their coolness. The study attributes this to global warming; the elevated temperatures are a safe haven for the malaria spreading mosquitoes. Cold weather is the real enemy of this species of malaria transmitting agents. In 2012, according to the WHO, 207 million cases of malaria were registered and among these, 627,000 mortalities. The majority of these cases were reported in Africa and South America. Future research will therefore seek to unravel the complex nexus between health and environmental governance at a much deeper level. The overarching determinant of any successful governance is clearly the institutional environment which either constrains or enables positive and sustainable results in the long run. *"Malaria is a disease of poverty, and given ample resources, control will remove all pre-intervention determinants of the disease, including climate"* (Bouma, Baeza, terVeen & Pascual 2011, 421). The role of institutions in successful environmental governance and global health governance will therefore be an exciting area to pursue. This line of inquiry will also be considered in the future.

Fourth, how can CSSIs in the pharmaceutical sector use both institutional and market approaches to spur innovations that maximize the social value created for the WECS African consumers? One line of inquiry would be the development of the herbal medicines industry side-by-side with the Western allopathic medicine, and another, the development of pharmaceutical SMEs in WECS Africa which have so far received little input in terms of funding and institutional support. It has been argued that pandemics are a huge health threat to the global population. What is the role of SMEs in the development of novel medical technologies that are adaptable to emerging countries?

Fifth, there appears to be at least three major types of organizational strategy: (i) destructive, (ii) productive and (iii) the 'fence-sitting' type which is only changed by institutional pressure. Research on different sectors and the nature of their CR governance systems will help explain whether the type of international operations of firms makes them more predisposed to irresponsible behavior. Future research could also be directed towards understanding how firms in different industries influence each other to embark on new standards of SCR orientation and how such actions are shaped by the institutions.

Finally, the following questions could also lead to interesting investigations: What is next in global health in the aftermath of MDGs? Which technologies, policies and resources are needed and how are they to be organized to yield the maximum social benefits in transitioning economies when implementing the post-2015 SDGs?

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APPENDIX 1: INTERVIEWEES

Table A1 Sources of interview data for PhD thesis: sample of interviewees by gender, age, years of experience, sector and expertise

ID code of the interviewee/ focus group	Type of data (Place, date, etc.)	Gender	Age range	Name of organization	Informant's position & field of expertise	Entire duration of interview in minutes	Years of experience in the field	Induction from critical emphasis
Industry (MNCs, SMEs) (Subtotal: 15)								
1 [a, b]	Face-to-face interview (Madison Hotel, Washington DC; 02/10/12)	Male	36-40	Eli Lilly & Co	Associate Director	53	3-5	Issues on what constitutes value and how the firm helps protect value
2 [a, b]	Face-to-face interview (Recorded at Madison Hotel, Washington DC; 02/10/12)	Female	31-35	Eli Lilly & Co	Advisor/Director of Global Anti-Counterfeiting	77	3-5	How is the firm protecting consumer value in Africa?
3 [a]	Informal conversation (Turku, May 2010)	Female	31-35	Agendia, Amsterdam	Industry expert for Diagnostics and Devices provider in Amsterdam	38	5-10	How does the industry respond to regulatory demands?
4 [a]	Email communications (07/01/11)	Female	undisclosed	BASF, Germany	Secretary at the Sustainability Centre of BASF	na[c]	undisclosed	Sustainable production of chemical products, development-oriented initiatives
5 [a]	Face-to-face interview (EIBA conference, Bucharest, 09/12/2011)	Male	> 60	Chemical industry (Germany)	Manager/CR and sustainability issues	ca. 40	> 10	Ethical issues surrounding consumer protection

ID code of the interviewee/ focus group	Type of data (Place, date, etc.)	Gender	Age range	Name of organization	Informant's position & field of expertise	Entire duration of interview in minutes	Years of experience in the field	Induction from critical emphasis
6 [a]	Phone interview (June 2014)	Male	undisclosed	Pharma-ceutical Manufacturers Association of Ghana	Executive secretary	ca. 20 min	undisclosed	Challenges of the pharma industry in Ghana
7 [a, b]	Face-to-face interview (LaGray Chemical Company, Nsawam; March 2010)	Male	undisclosed	LaGray Chemical Company	CEO	109	> 10	SCR, value for the consumer, challenges of pharmaceutical SMEs in Ghana
8 [a, b]	Face-to-face interview and presentation (LaGray Chemical Company, Accra; March 2010, August 2011)	Male	36-40	LaGray Chemical Company	Business development manager	97 + 45 Total: 142	5-10	CR and relationship marketing, consumer value protection
9 [a, b]	Face-to-face interview and subsequent email exchanges (LaGray Chemical Company, Nsawam; March 2010)	Male	undisclosed	LaGray Chemical Company	R&D manager	36	5-10	Science, technology and fixing problems of access to medicines, innovations
10-12 [a, b]	Company Tour – participant observation, interviews (LaGray Chemical Company, Nsawam; March 2010)	3 males	undisclosed	LaGray Chemical Company	- Chief environmental safety officer - 2 technicians	107	3-5	Quality assurance
13-15 [a , b]	Joint face-to-face interview and discussions including presentations (LaGray Chemical Company, Nsawam; March 2010)	1 male, 2 females	undisclosed	LaGray Chemical Company	- Chief production manager - Assistant production manager - HR manager	ca. 100	> 10 5-10 5-10	CR, meeting consumer needs, product portfolio

ID code of the interviewee/ focus group	Type of data (Place, date, etc.)	Gender	Age range	Name of organization	Informant's position & field of expertise	Entire duration of interview in minutes	Years of experience in the field	Induction from critical emphasis
Academia (Subtotal: 8)								
16 [a, b]	Face-to-face interview (Korlebu hospital, Accra; 13/02/12)	Male	46-50	University of Ghana, Medical School	University Professor - pharmacovigilance, patient safety	ca. 20	> 10	Lack of coherence in the fight against counterfeit drugs
17 [a, b]	Face-to-face interview (Kwame Nkrumah University of Science and Technology, 17/01/12)	Male	41-45	Kwame Nkrumah University of Science and Technology	Senior Lecturer - expert in anti-malarial markets	47	> 10	Incoherent understanding of the magnitude of the counterfeit problem
18 [a, b]	Face-to-face interview and informal discussions (University of Aalborg, Denmark, 30/05/12-01/06/12)	Male	36-40	Kwame Nkrumah University of Science and Technology	University Lecturer in the School of Business/Legal Practitioner	30+17+23 Total: 70	> 10	Strategies and challenges of pharmaceutical SMEs in Ghana
19 [a]	Face-to-face interviews (in years 2010 and 2012)	Male	46-50	Rotterdam School of Business	University Professor with consulting connection to Access to Medicines Index	41 + 17 Total: 58	> 10	The problem of transition
20 [a]	Informal conversation (March 2011)	Male	41-45	University of Eastern Finland	University Professor in Drug Design	80	> 10	Access to medicines, consumer protection
21 [b]	Face-to-face interview (Willard Hotel, Washington DC, 27/09/12)	Male	> 60	Texas University	University Professor and President of PSM	17	> 10	How value is protected for the consumer
22 [a, b]	Face-to-face interview (National Press Club, Washington DC, 28/09/12)	Male	46-50	California Institute of Health	Professor/Medical doctor	34	> 10	FDA standardization programs
23 [a]	Face-to-face interview (National Press Club, Washington DC, 28/09/12)	Male	undisclosed	California Institute of Health	Assistant Professor	ca. 15	5-10	The role of stakeholders in fighting counterfeits

ID code of the interviewee/ focus group	Type of data (Place, date, etc.)	Gender	Age range	Name of organization	Informant's position & field of expertise	Entire duration of interview in minutes	Years of experience in the field	Induction from critical emphasis
NGO/CSO/Professional organizations (Subtotal: 16)								
24 [a, b]	Video clip and news items and phone interview (03/03/2012)	Female	undisclosed	MyJoyNews	Journalist	ca. 20	3-5	The nature of pharmaceutical counterfeiting in Ghana
25	Face-to-face interview (Ghana News Agency, Accra, November 2012)	Male	undisclosed	Ghana News Agency	Personnel	12	undisclosed	The problem of counterfeit drugs in Ghana
26-27 [a, b]	Face-to-face interview (National Press Club, Washington DC; October 2011)	2 males	undisclosed	- International Alliance of Patients' Organizations (UK) - PSM India	- Patient safety expert - President of the PSM India	ca. 20	3-5 > 10	How to create and co-protect value with and for consumers
28 [a, b]	Face-to-face interview + presentation slides by email (National Press Club, Washington DC; 28/09/12)	Male	61-65	US Pharmacopeial Convention, Compedia Science	Vice president	7	3-5	Harnessing emerging technologies to track counterfeits
29 [a]	Face-to-face interview (Knight Conference Center, the Newseum, Washington DC; 24/10/13)	Male	undisclosed	US Pharmacopeial Convention	Vice president of the Global Health Impact Programs and Promoting the Quality of Medicines program	ca. 40	> 10	Capacity building, stringent quality controls, surveillance technologies
30 [b]	Face-to-face interview (Willard Hotel, Washington DC; 27/09/12)	Male	56-60	Canadian International Pharmacy Association (CIPA)	President and general manager	22	3-5	The role of the NGO in consumer protection
31 [a, b]	Face-to-face interview (Willard Hotel, Washington DC; 27/09/12)	Male	> 65	Partnership for Safe Medicines (PSM)	Professor (consumer protection) and President of PSM	15	5-10	A short debate on the role of PSM

ID code of the interviewee/ focus group	Type of data (Place, date, etc.)	Gender	Age range	Name of organization	Informant's position & field of expertise	Entire duration of interview in minutes	Years of experience in the field	Induction from critical emphasis
32 [a]	Face-to-face interview (National Press Club, Washington DC; 28/09/12)	Male	51-55	International Law Info/FDA	International lawyer, former FDA director/principal agent	31	9	Harnessing the transparency of data exchange, accountability for data deficits, leveraging computerization
33 [b]	Face-to-face interview (National Press Club, Washington DC; 28/09/12)	Male	56-60	Pharmaceutical Security Institute (PSI) (USA)	CEO of PSI	6	> 10	The role of Big Pharma in combating counterfeits
34 [a, b]	Face-to-face interview and informal discussions (Office of Pharmaceutical Society of Ghana, Accra, 26/01/12, November 2012)	Male	undisclosed	Pharmaceutical Society of Ghana (PSGH)	President of PSGH	ca. 40	> 10	The role of institutions in combating counterfeit drugs in Ghana (emphasis on weak legal framework)
35 [a, b]	Face-to-face interview and informal discussions (Office of Pharmaceutical Society of Ghana, Accra, 26/01/12, November 2012)	Male	undisclosed	Pharmaceutical Society of Ghana (PSGH)	General secretary of PSGH	ca. 20	5-10	The fundamental role of pharmacists in combating counterfeit drugs
36 [a]	Email exchange (05/03/12)	Female	undisclosed	undisclosed	Consumer advocate in Washington DC	na	5-10	The current state of drug counterfeiting around the world
37 [b]	Face-to-face interview (Office of Pharmacy Council, Accra, 20/02/12)	Male	51-55	Ghana Pharmacy Council	Registrar and CEO	65	> 10	The role of various statutory organizations in mitigating counterfeits
38 [b]	Face-to-face interview (Office of Pharmacy Council, Accra, 23/01/12)	Male	46-50	Ghana Pharmacy Council	Manager (policy, planning, monitoring and evaluation)	63	> 10	General situation of drug counterfeiting and the role of health professionals in Ghana

ID code of the interviewee/ focus group	Type of data (Place, date, etc.)	Gender	Age range	Name of organization	Informant's position & field of expertise	Entire duration of interview in minutes	Years of experience in the field	Induction from critical emphasis
39 [b]	Face-to-face interview (Local Pharmacy, Accra, August 2011)	Male	undisclosed	Local Pharmacy	Pharmacist	25	> 10	Pharmaceutical counterfeiting situation in Ghana
Ghana government (Subtotal: 20)								
40 [a, b]	Face-to-face interview (Headquarters of the Ministry of Health, Accra; 20/01/12)	Male	51-55	Ministry of Health	Director responsible for herbal and alternative medicine	43	5-10	The difficulty in controlling and monitoring the manufacturing of herbal medicines
41 [a, b]	Face-to-face interview (Headquarters of the Ministry of Health, Accra; 19/01/12)	Female	41-45	Ministry of Health	Head of procurement	37	> 10	Procurement of medicines
42 [a, b]	Face-to-face interview (Headquarters of the Ministry of Health, Accra; January 2012)	Female	46-50	Ministry of Health	Director of Pharmaceutical Services	39	> 10	The role of the different organizations in combating counterfeits
43 [a, b]	Face-to-face interview (Headquarters of the Ministry of Health, Accra; 02/02/2012)	Male	51-55	Traditional Medicines Practice Council/ Ministry of Health	Registrar	34	5-10	Need for regular information dissemination platform; financing of the traditional medicine sector to fill the gap in access to medicines
44 [a, b]	Face-to-face interview + unpublished documents (FDA-GH headquarters, Accra; 18/01/12)	Male	undisclosed	Food and Drugs Authority, Ghana (FDA-GH)	Head of FDA-GH	7	> 10	The current situation of drug counterfeiting in Ghana
45-51 [a, b]	Face-to-face interview FDA-GH focus group (FDA-GH headquarters, Accra; 18/01/12)	9 males (2 listed below individually)	30-56	FDA-GH	Post-market surveillance team	90	3-10	Constraints on enforcement, collaboration with other organizations

ID code of the interviewee/ focus group	Type of data (Place, date, etc.)	Gender	Age range	Name of organization	Informant's position & field of expertise	Entire duration of interview in minutes	Years of experience in the field	Induction from critical emphasis
52 [a, b]	Face-to-face interview + unpublished documents (FDA-GH headquarters, Accra; 18/01/12)	Male	46-50	FDA-GH	Head of drug post-market surveillance team	60	5-10	The central role of FDA-GH in combating counterfeiters
53 [a, b]	Face-to-face interview + unpublished documents (FDA-GH headquarters, Accra; 19/01/12)	Male	undisclosed	FDA-GH	Member of the post-market surveillance team	35	3-5	Constraints in collaborating with other organizations
54 [b]	Face-to-face interview (Customs Headquarters, Accra; 11/01/12)	Male	31-35	Customs Excise and Preventive service	Assistant collector	41	3-5	The role of the customs department in mitigating pharmaceutical counterfeits
55 [b]	Face-to-face interview + internal documents (Ghana Standards Authority headquarters, Accra; 19/01/12)	Male	56-60	Ghana Standards Authority	Director in charge of drugs and cosmetics analysis	ca. 36	> 10	Control of quality of imported medicines
56 [b]	Face-to-face interview (Ghana Standards Authority headquarters, Accra; 19/01/12)	Male	undisclosed	Ghana Standards Authority	Director level	ca. 35	> 10	Control of quality of imported medicines
57 [a, b]	Face-to-face interview (Headquarters of the Ghana Statistical Service, Accra; twice in August 2011)	Male	undisclosed	Ghana Statistical Service	Statistician	35 + 20 Total: 55	5-10	The problem with data collection in Ghana; challenges of the pharma industry in Ghana
58 [a, b]	Face-to-face interview (Headquarters of the Ghana Statistical Service, Accra; twice in January 2012)	Male	36-40	Ghana Statistical Service	Assistant statistician	17 + 21 Total: 38	5-10	The problem with data collection in Ghana

ID code of the interviewee/ focus group	Type of data (Place, date, etc.)	Gender	Age range	Name of organization	Informant's position & field of expertise	Entire duration of interview in minutes	Years of experience in the field	Induction from critical emphasis
59 [b]	Face-to-face interview (National Malaria Control Centre, Accra, Ghana; 23/01/12)	Male	46-50	Ghana Malaria Control Programme	Programme officer (overseer and a member of the advisory board on malaria control)	37	5-10	Inconsistent support for access to medicines
Multilateral institutions (Subtotal: 3)								
60 [a, b]	Face-to-face interview (Police Headquarters, Accra; 20/01/12)	Male	36-40	INTERPOL	Inspector (conducts major operations sponsored by the INTERPOL headquarters)	57	> 10	Nature of counterfeiters
61 [a]	Face-to-face interview (WHO Headquarters, Accra; February 2012)	Female	undisclosed	WHO	Public health expert	ca. 75	undisclosed	The role of WHO in public health in Ghana
62 [a]	Face-to-face interview (on the aeroplane and at the airport in Washington DC; 21/10/2013)	Female	undisclosed	The Global Fund	Expert, manager	ca. 25 min	undisclosed	The current economic crisis and the role of the Global Fund

[a]Data used in Article 4; [b]data used in Article 3; [c]not applicable.

APPENDIX 2: INTERVIEW QUESTIONS

Some of the central questions used in the semi-structured interviews are reported here. They were modified in each case to suit the interviewee.

1) How would you describe the main sources of counterfeit drugs on the Ghanaian market?
2) Whose job it is to protect consumers?
3) How would you describe your organizations' role in the anti-counterfeiting CSSIs? Is it based on single initiatives or common strategies with other organizations?
4) Who are your main partners? Local/international/supranational?
5) What are the main challenges you face in your partnerships?
6) How do you measure the impact of anti-counterfeit initiatives? Short-term/medium-term/long-term?
7) What are the challenges you face when measuring the impact of your strategies?
8) Are there any known tools for measuring the impact of your anti-counterfeiting initiatives and how do they work?
9) How successful have you been so far in your collaborative efforts?
10) Why have the anti-counterfeiting partnerships not been so successful? Are there differences that need to be resolved among the partners? If so, what are they?

PART II: ARTICLES

Article 1: Ahen, Frederick – Zettinig, Peter (2015) Critical perspectives on strategic CSR: what is sustainable value co-creation? *Critical Perspectives on International Business*, Vol. 11 (1), 92-109.

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Critical perspectives on strategic CSR: what is sustainable value co-creation orientation?

Frederick Ahen and Peter Zettinig
Department of Marketing and International Business, Turku School of Economics, University of Turku, Turku, Finland

Abstract

Purpose – This purpose of this paper is to integrate corporate responsibility (CR) doctrine into corporate strategy by problematizing existing notions of traditional corporate social responsibility. We provide a theoretical and empirical basis for the proposition that the bridge between CR and corporate irresponsibility is the embeddedness of strategic decisions in ethically oriented corporate practices toward sustainable value co-creation.

Design/methodology/approach – Analysis was performed by meta-theoretical and economic philosophical approaches. The contemporary trends which have led to the institutionalization of sustainability questions, are explained. Special attention is paid to the historical, cultural and the international institutional context within which organizational culture becomes saturated with deviance.

Findings – The main thrust is that competitive advantage, legitimacy for survival and success of the international firm in the 21st century hinges on innovative value co-creation that meets sustainability pressures and institutional expectations.

Research limitations/implications – The research approach opens itself to debate. No generalizability claims are made but the propositions and conceptual framework seek to direct the CR discourse to engage seriously with cooperative investments for sustainable value creation.

Originality/value – This paper contributes to the debate on CR, global sustainability and the role of international firms in society. It offers clarity in the confusion and fills a theoretical gap through a novel conceptualization of strategic corporate responsibility. Here, consumer, environmental and institutional orientation rather than producer orientation form the basis of analysis on value co-creation.

Keywords International business, Corporate strategy, Cooperative investment, Corporate responsibility, Institutional dynamics, Value co-creation

Paper type Conceptual paper

Introduction

The concept of value creation is central to all socio-economic analysis. How value is created, captured, protected, destroyed or appropriated by organizations and society at

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large, as well as the regulatory and normative institutions governing all the above, is what the Nobel Prize winner Ostrom (1990) referred to as common pool resource (CPR). The global economic crisis, the sky-rocketing number of organizations commercializing counterfeit drugs through legitimate supply chains, global warming, environmental pollution and degradation, which in large part are the results of corporate malpractices and negative externalities, have not reduced corporate irresponsibility in the smallest measure. Corporate irresponsibility and unethical practices pervade the culture of many organizations (Banerjee, 2007; de Jong, 2011). Armstrong (1977, p. 185) defines socially irresponsible corporate behavior as: "a decision to accept an alternative that is thought by the decision makers to be inferior to another alternative when the effects upon all parties are considered". For our purposes, ethical responsibility refers to "the cognitive, analytical, systematic and reflective application of moral principles to complex, conflicting or unclear situations [of dilemma]" (emphasis added; Wines, 2008, p. 487).

At least seven salient characteristics of today's corporation remain unchanged despite the aforementioned intractable global problems. First, there is a relentless and greedy pursuit of expansion, which is explained by the efficiency and economies of scale (Sukhdev, 2012). Second, top management's hypocrisy, unethical leadership and excessive expenditure on deceptive advertising have prompted consumer and stakeholder concerns (Wagner *et al.*, 2009). Third, active lobbying and inappropriate use of corporate political power (Scherer and Palazzo, 2007) in developing economies, with weaker regulatory regimes, have led to human right abuses and dispossession of lands and natural resources from indigenous groups (Banerjee, 2007; de Jong, 2011). Fourth, there is an unlimited leverage by companies, which has led to excessive arbitrage of factors (e.g. land, labor and raw-materials) at lowest cost possible where the firm's pursuit of profits, power, influence and capital accumulation through bribery and corruption are now the major focus, leading to systemic risks (Bakan, 2004; Sukhdev, 2012). Fifth, as Vogel (2005) argues, corporations employ a defensive corporate responsibility (CR) strategy to ward off competitive disadvantage and offensive CR strategies to seek competitive advantage (Porter, 1985) when the payoff is higher.

The implications of all these manipulative and unethical practices to society and its environment are vast as they obstruct the global efforts toward socio-economic and environmental sustainability of our CPR. That notwithstanding, modern mega-corporations still thrive on the scandalous disasters of their actions whilst purporting to pursue what they impenitently call corporate social responsibility (CSR). This is not to suggest that there are no pockets of excellence in different varieties and contexts of capitalism. For example, the oldest and still operating corporation Stora Kopparberg mine, charted in 1337 in Sweden, is still alive because it sought long-term survival, i.e. sustainability, rather than quick-profit-seeking behavior camouflaged in traditional CSR (Sukhdev, 2012). Even in weaker institutional regimes, the LaGray Chemical Company (Ghana) through excellence in innovation provides access to essential drugs for the African population in accordance with its ethical and sustainability vision (see www.lagray.com). However, given the magnitude of the problem at stake, there is a case to be made against traditional CSR and how the concept as espoused fundamentally deviates from how it is enacted.

This raises a sixth point. Is CSR a myth, given the ethical roots of the current economic crisis (Devinney, 2009; Donaldson, 2012a)? In fact, Frooman (1999) argues that in the absence of firm-stakeholder conflicts, there would not be any demand for CR in the

first place. Seventh, outside the European Union (EU) and the USA, where there is much noise and unlimited proliferation of CSR certifications, some scholars suggest that CSR is an euphemism for exporting cultural commodities to developing economies and a pretext for advancing the agenda of political and economic imperialism (Jamali and Sidani, 2011; Khan and Lund-Thomsen, 2011). By implication, all seven major questions are the same fundamental problems under different guises. Such notions that are still labeled CSR are bereft of substance and worthy of disapproval both in theory and practice (Hanlon and Fleming, 2009).

The overarching purpose of this article is to integrate CR doctrine into corporate strategy (CS). Here, value co-creation for the firm and the society, in which the firm is embedded, represents both the means and the end for wealth creation that is sensitive to the prevailing institutions (Prahalad and Ramaswamy, 2004). It aims to provide a theoretical basis for the proposition that the bridge between CR and corporate irresponsibility is the integration of ethical ideals into strategic actions where the consumers and their environment are central to management thinking. In this article, we present various arguments in support of what we perceive as an extremely narrow view of traditional CSR in the extant literature and managerial practice. Clearly, the noble concept of CSR is not incorrect but it is incomplete for contemporary use; or at least it has been irresponsibly misused, distorted and discredited in ways that create ambiguity about its meaning and practical relevance to society. This prompts the question: Is CSR just noble fiction, an overblown rhetoric hyped by media power or a useless cost to a soulless and conscienceless business as Friedman (1970) and Levitt (1958) argued? Or is it an active and integral part of CS for value co-creation in the era of globalization, constrained by questions of sustainability and dynamic changes in regulatory institutions and demand-side market dynamism? We refer to *sustainable value co-creation* as the strategic alliances among the firm, consumers, business and non-business players in ethically, responsibly and innovatively creating socio-economic and environmental gains from our CPR through cooperative investments today – without jeopardizing the future generation's ability to do the same. This view gains credibility among a host of recent scholarly works attempting to integrate CR and strategy as the embodiment of an innovative and forward-looking paradigm shift, which is expected to promote concrete socially desirable actions and value co-creation (Galbreath, 2008; Elms *et al.*, 2010; Katsoulakos and Katsoulakos, 2007; Karnani, 2012; Laszlo and Zhexembayeva, 2011; Lin-Hi, 2008; Louche *et al.*, 2010; Margolis and Walsh, 2003; Porter and Kramer, 2011; Vogel, 2005; Zadek, 2004).

The fallacy of traditional CSR

The existence of a genuine CSR without being embedded in strategy is challenged (Laszlo and Zhexembayeva, 2011; Porter and Kramer, 2006). Sethi (1975, p. 58, cited in Lin-Hi, 2008) argues that "the phrase corporate social responsibility has been used in so many different contexts that it has lost its meaning". To suggest that CSR as hitherto employed by corporations is a great distortion, is a gross understatement. CSR and its use are not just superficial and distractive by nature but they also cloud the intended core message of responsibility of the firm in society, which is expected to be embodied in strategy and aligned with value creating operations. Traditional CSR, then, is a confusing cliché which cheats consumers and society at large.

For these reasons, we introduce the concept of strategic corporate responsibility (SCR) in substitution of traditional CSR. The latter is overly narrow, passive and a disguise for causing harm. Hence it creates the impression of a cost to the firm rather than an investment for itself and society. Further, traditional CSR does not offer any Hayekian explanation of strategizing even though that is what firms do – every CSR initiative involves the allocation of resources within the constraints of the prevailing institutions. SCR practices enhance higher performance and reciprocal value creation for the firm and society (Husted and Allen, 2007) whilst advancing the cause of sustainability (Sukhdev, 2012). By contrast, traditional CSR (despite its originally noble intentions) now lacks substance and remains nothing more than a fashionable concept on corporate web-pages. Some scholars even argue that it is cosmetic, unrealistic and merely a gimmick for public relations (PR) purposes unless it is aligned with strategy (Bakan, 2004; Karnani, 2012; Porter and Kramer, 2006).

Justification for the article

Joel Bakan in his ground-breaking book, *The Corporation* (2004), presents mega-firms as pathologically psychopathic – totally disconnected from their moral compass and hard-wired into the covetous pursuit of profits. That corporations do all the above is now well documented, so why produce this article? First, there are theoretical, socio-political and scientific reasons on the basis of which a new trajectory of SCR based on value co-creation can be pursued to move international business (IB) research into new territories (Roberts and Dörrenbächer, 2012). As Katsoulakos and Katsoulakos (2007, p. 356) argue, it is widely recognized that CSR and corporate sustainability as business practices remain isolated from mainstream strategy and therefore, mainstreaming has become the key challenge for the CR movement. Second, we indicate an epistemic fault-line which separates the normative considerations from the positive in some analyses (Donaldson, 2012b). However, in SCR we explain the importance of the normative as informing the positive and how both to a large extent are self-reinforcing. As Ghoshal (2004) argues, "bad management theories are destroying good management practices". By emphasizing the role of academics to engage with good theories through a critical perspective on CR, we highlight and allow the emergence of theories with strong explanatory power and a better understanding of SCR. Only then can managers, policy makers and society as a whole benefit. We agree with Kilduff and Mehra that:

> […] from a post-modernist perspective, there is no reason to limit enquiry to a few paths marked out by any one particular elite, and it is undesirable for researchers to pursue the obvious at the expense of the unusual [emerging themes which challenge conventional notions with healthy skepticism; emphasis added] (Kilduff and Mehra, 1997, pp. 461-462).

The confusion in conceptualizing CSR lies in the specific context in which it is socially constructed with its surrounding biases and not the substance in its definition *per se* (Dahlsrud, 2006). This means the research agenda must move from mere conceptual dissonance to a meaningful construction of applicable theoretical models with international contexts and institutions in mind. In fact, Sanders (2012) advocates the redirection of international CSR research from rule-based to institutions and agency, considering the conflictual nature of globalization especially when the triad/OECD countries are compared with developing economies. Thus, the conceptualization of CSR entails an ethical dimension that demands breadth and depth wider and deeper than what we do know now. This is the gap in extant literature that we seek to fill in terms of

value co-created with international stakeholders when day-to-day ethical responsibility is fused into strategy and into the deliberate planning and implementation processes (Mintzberg and Waters, 1982).

Theoretical perspectives

Definition of concepts

To increase the coherence in this theory building exercise, the key concepts are defined. CR has been variously defined and yet the plethora of conceptualizations does not include strategy. However, by *strategy*, we are referring to the firm's day-to-day substantive actions through resource combination and allocation that produces long-term consequences for the firm and its stakeholders. Stakeholders are referred to as *stake-players* here to accentuate their active nature and to differentiate them from passive stakeholders if we adopt the service-dominant logic (Grönroos, 2008). Stake-players both pressurize and offer inputs for organizational learning and strategic renewal (i.e. redesigning and refreshing organizational culture, internal institutions and technologies to keep abreast of emerging market and technological, social and environmental changes; Crossan and Berdrow, 2003). *Innovation* is operationalized as creatively transformed, useful and commercially viable resources through technological and scientific applications – whether they are exploitative or explorative by nature (March, 1991) or of frugal type that meets sustainability and institutional expectations. *Value* is seen as optimal service ("perceived worthiness") and satisfaction for the consumer and society at large, which in turn creates value (e.g. return on investments, reputation and legitimacy) for the firm and its network context of players, e.g. stakeholders, financiers, government, suppliers, non-governmental organizations and their environment. Therefore, value is not meant to connote only financial rents for owners, which agency theory holds to be the only responsibility of agents (Jensen and Meckling, 1976).

Value co-creation. A clear distinction should be made between human values and value (e.g. benefit, utility, profits or value in the instrumentalist view). Here, the main strand of literature points to the service-dominant logic (Grönroos, 2008; Vargo and Lusch, 2004) and value co-creation (Prahalad and Ramaswamy, 2004) perspectives to demonstrate that the consumer is ultimately the only value creator because he is the source of revenue to the organization and the firm (which makes value propositions) gets opportunities to co-create value through relationships. In the demand-side analysis of value co-creation (Pitelis, 2009; Priem *et al.*, 2012; Sawhney *et al.*, 2005), it is the consumer who signals the firm about the existence of an opportunity for technological innovation. Pitelis (2009) differentiates between value creation, which is spurred by consumers' willingness-to-pay due to "perceived worthiness", and value capture, being a derivative of market structure and firm's resource base:

> Too much focus on value capture today may undermine long-term success, too much focus on value creation may deprive an organization of the means to compete and thus keep creating value. Hence, an ambidexterity is encouraged (Pitelis, 2009, p. 1,119).

Drucker (1974, p. 84) argues that:

> […] the customer never buys a product. By definition the customer buys the satisfaction of a want. He buys value. Yet the manufacturer, by definition, cannot produce value. He can only make and sell products.

by using tangible resources and core competencies, which Constantin and Lusch (1994) refer to as *operand* (physical resources) and *operant* resources (e.g. dynamic capabilities) given their unique inimitable (or costly to imitate) nature. Zimmerman (1951) and Penrose (1959) subscribed earlier to the firm's resources as being inputs. Penrose (1959) in particular views products that consumers buy as nothing more than the services the products provide. The service-dominant reasoning, then, denotes a gestalt shift from the firm-centered resource-based view (Barney, 1991), which sees the firm as mostly producing and making exchanges, toward a relationship-based marketing for value co-creation. The international firm's operations then become a social activity which involves values that require moral decisions and obligations on the part of entrepreneurial managers to be ethically responsible. Responsibility does not create strategy but defines the boundaries and conditions for strategy's successful and institutionally acceptable implementation.

CR in perspective

The landscape of CR has been thoroughly explored (Carroll, 1979, 1991; Frederick, 1960, 1998; Garriga and Melé, 2004; Matten and Crane, 2005; Secchi, 2007; Waddock, 2003) in terms of its historicity (Bowen, 1953) and contemporary trends, conceptualization and infinite taxonomies as well as CSR and firm performance (Waddock and Graves, 1997). CR has been variously defined. Nevertheless, the fundamental meaning seems to overwhelmingly point to firms' practices that are acceptable as long as they do not deviate from social expectations on legality, legitimacy, health and environmental safety and human rights (Katsoulakos and Katsoulakos, 2007).

In mapping out the fuzzy contours of CSR theories, Garriga and Melé (2004) offer four main dimensions. *First*, in the *instrumental theories* the firm only stands for profit maximization, leading Matten and Crane (2005) to conclude that self-interest is what motivates strategic CSR. For Margolis and Walsh (2003, p. 282), no fundamental principle guides organizations to pursue CSR simply because "it is the right thing to do". Here, "doing good" is conditioned by profitable outcomes. Opportunism and other irresponsible practices persist due to structural incentives available to firms (Orlizky *et al.*, 2011) especially in the absence of institutional checks and balances (Campbell, 2007; Sanders, 2012). Rooted in Pierre Bourdieu's theory of social practice, van Aaken *et al.* (2013, p. 349) argue that at the micro-level, pro-social activities represent "social practices that individual managers employ in their efforts to attain social power". *Second*, the *political theories* explain how corporate power is irresponsibly used in international contexts (Scherer and Palazzo, 2007; Sanders, 2012). *Third*, Garriga and Melé argue that some corporations meet the expectations of society in what is referred to as *integrative theories* given the firms' dependency on society for survival (Donaldson and Dunfee, 1999). *Fourth*, *ethical theories* are about the ethical responsibility of corporations toward society.

There is no general consensus on how CSR can be integrated into CS (Katsoulakos and Katsoulakos, 2007; Orlizky *et al.*, 2011). CSR is, thus, viewed as one of the most contested concepts (Fleming *et al.*, 2013; Lin-Hi, 2008). First, every corporate action is performed with and in cooperation with a vast network of both internal and external stakeholders and their environment. Second, every decision and action then must consider such relationships if it is to reach long-term goals. It follows logically that, separating strategic actions from responsible daily practices becomes an analytically

faulty way of explicating the concept of responsibility. CR is either inherently strategic or just tactical for short-term gains. The tactical route as the ultimate vision of the entrepreneurial manager is rendered incomplete with the introduction of SCR upon which long-term success depends.

SCR in context

Strategy is defined as "a pattern in a stream of decisions" with emphasis on what organizational leaders plan (strategize) with the intention to act upon and what is actually realized or implemented (Mintzberg and Waters, 1982, 1998). Oliver (1991) offers five strategies by which firms respond to their institutional environment: *acquiescence* (complying by imitating model organizations), *compromise*, *avoidance* (strategies for avoiding compliance), *defiance* (resistance to institutional pressure), *manipulation* ("the purposeful opportunistic attempts to co-opt, influence, or control the environment"; Oliver, 1991, p. 157). Harnessing Hayek's (1945) definition, planning (strategy) refers to a complex set of interrelated decisions about the allocation of available resources. In fact, all economic activity is in this sense planning. The resource-based view finds relevance in four ways: what is allocated; who allocates it; how it ought to be allocated and with what consequence. Further, CSR does not offer any Hayekian explanation of strategizing even though that is what firms do. By leaving out "social" and broadening the scope toward CR in general, the concept adequately accommodates a firm's socio-ethical, institutional and sustainability obligations toward the internal and external environments. Responsibility will then denote all actions, decisions, implicit and explicit with direct or indirect effect on legal and natural persons with whom a company relates. This is not a mere semantic difference. Rather, it represents a transition into an epoch of centralizing the ethically responsible role of managers as inseparable from corporate practices. This answers the philosophical question of whose business it is to act responsibly and toward whom? While only one step away from referring to such organizational practices as SCR, Collins and Porras (1994, p. 4) imply that firms "by nature are woven into the very fabric of society". It is therefore "tautologous" to repeat the "social" when referring to CR as organizational practices. This is also explained by what Donaldson and Dunfee (1999) refer to as the firm's implicit social contract with the larger society of which it is an integral part. It follows that the importance of the discourse still lies within the social license-to-operate, thus, legitimacy (Lin-Hi, 2008), defined as the "generalized perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed system of norms, values, beliefs, and definitions" (Suchman, 1995, p. 574).

We argue that there is no clear-cut dichotomy between CS and CR. They are the two faces of the same coin. Thus, either strategies are inherently responsible or they are irresponsible (all or nothing). Therefore, SCR should not be construed as the amalgamation of two distinct concepts, i.e. CR + CS = SCR, but rather, the full embeddedness of strategies into socio-institutional and sustainability obligations. As a distinction, responsible firms pursue sustainability while deviant firms only aim to maximize their utility with neither a sense of responsibility nor the need for legitimacy. In essence, irresponsibility is the product of a managerial mindset that misses the opportunity to meet market and institutional expectations.

Zadek (2004), citing several empirical examples, describes the five stages of CR as follows. The *defensive stage* is where there is a mixture of deviance and denial, which is

then handled by a legal team or the communications team dealing with PR. The *compliance stage* involves reactionary compliance with some newly established corporate codes in ways that are visible to the complaining constituents. This is clearly seen as a cost of doing business and creating value for the firm in the strictest sense of the word because it mitigates the cost of litigation. The *managerial stage* is where managers begin to realize the superficiality of compliance and public communication apparatus and therefore begin to take serious responsibility for corporate actions. The *strategic stage* is where the firm begins a new set of practices based on proactive response by aligning responsible practices with its strategies aimed at gaining competitive advantage. The *civil stage* is where the optimal and most socially desirable targets are achieved. Here, the firm promotes collective action by addressing socio-economic, political and environmental questions not as a cost of gaining competitive advantage but as a part and parcel of the society it invests in and cooperates with for mutual gains. The link between the strategic and civil stages is blurred and it is here that an open dialogue for learning and innovation aimed at value co-creation exists.

Design

We employ a *meta*-theoretical (Tsoukas and Knudsen, 2003) and economic philosophical analysis (Becker, 2006; Earl, 2001; Sen, 1977, 1988). By the first, we mean that theory itself becomes the main unit of analysis as we attempt to make sense of its conceptual utility and practical relevance to both the social and business worlds, simultaneously. In this way, we reflect critically on and engage constructively with the extant literature on CR and the conceptual proposition of the current understanding of CR. Further, such a process helps us to probe the extent to which the extant literature matches with the contemporary empirical realities. Moreover, the iteration between theories allows for flexibility in abandoning theories with the least explanatory power.

Further, justifications for our recourse to economic philosophical analysis are: one, classically, it is the generally acceptable approach to answer fundamentally complex socio-economic questions [Sen, 1977; see also Adam Smith, *Theory of Moral Sentiments* (1759) and *An Inquiry into the Wealth of Nations* (1776)]. Two, epistemologically, this approach is appreciated because certain questions cannot be answered by scientists through the collection of more data. Three, such critical reflection cannot be done in a vacuum. It entails engagement with influential contributions in a meaningful conversation that leads to key theoretical and practical implications. The limitation is that this approach lacks paradigmatic consensus across disciplines and opens itself to debate among the positivists. Further, the paper does not involve systematic collection and analysis of data, which would be outside its scope.

The economic philosophical analysis with a critical perspective on international CSR contributes to strategic management and international business literature. The aim is to contribute to the new institutional theory (NIT; DiMaggio and Powell, 1983; Scott, 2001; Williamson, 2000). Intersecting the above are the resource-based view and value co-creation. The NIT along with transaction-cost and resource-based view is at the forefront of IB research since its explanatory power has now re-emerged as a fundamental theoretical foundation for inquiries into the strategies of multinational companies operating in emerging economies where institutions are undergoing dynamic changes (Peng *et al.*, 2008). These theoretical lenses are selected to mutually reinforce each other and depicted as the quintessential scope of the broad and yet

overlapping areas of strategy and ethics, firms' resources and their interface with society constrained by institutional dynamics. Such civic engagement is what Lin-Hi (2008) describes as an "investment in social cooperation for mutual advantage".

Firms cannot pursue SCR without the obligation to avoid harm or value destruction. This school of thought subscribes to the "do no harm" universal principle, which is anchored in and inspired by the Kantian tradition of "categorical imperative" (deontological ethics) (Kant, 1964). Although we do not delve into all the subtleties of this Kantian philosophy, which deviates significantly from the utilitarian ethics perspective, we join contemporary ethicists in extending it to "doing good" and "avoiding bad" (corporate irresponsibility) simultaneously (Lin-Hi and Müller, 2013); thus, to a proactive effort to reduce public bad (Orlizky *et al.*, 2011). Bowie (1999), building on the Kantian school offers three formulations of hypernorms of Kant's categorical imperatives:

(1) economic interactions falling short of categorical imperatives are not morally permissible;

(2) it is imperative to have respect for the human person as an end and not a means; and

(3) the moral community formulation emphasizes work place democracy.

Critics mainly attack the Kantian school's universalizability and rigidity in local transposition since they represent Western perspectives. That notwithstanding, they serve as an indispensable guide to ethical behavior.

If the above is a reliable logical guide, then strategy cannot exist without ethical responsibility or vice versa as both the means and an end for sustainable value co-creation. Thus, SCR is not what firms are doing but what firms are in "the process of becoming" in an evolutionary sense, constrained by the prevailing institutions that demand that value is not only co-created for society but is co-protected as a moral duty (avoid value destruction) (Ahen and Zettinig, 2011; Lin-Hi and Müller, 2013). SCR, in this sense, embodies the duty for firms to take "ownership of the externalities they generate" (Crouch, 2006, p. 1,534) beyond the economic, legal, ethical and discretionary (philanthropic) responsibilities as in Carroll's (1979, 1991) typologies.

Results and discussion

How we got here

CSR has a history, and that significant part can hardly be ignored in any useful analysis. The concept has had multiple meanings at different historical junctures and the corporation has always played a central role especially in the past 150 years (Sukhdev, 2012). For Sukhdev (2012) 1820-1920 marked the definition of today's corporation. "These hundred years also freed the corporation from social purpose and established the primacy of profits as the corporation's raison d'etre" (2012, p. 6). The proposition of SCR at this point in its evolutionary course is not meant to remove the firm but to align its goals with those of the society for co-created and shared value (Porter and Kramer, 2011). Figure 1 is a simplified representation of the historical evolution of the trajectory of CSR in the post-World War II (WWII) era (as denoted with the dotted arrows) starting from the bellicose coexistence of capitalism and communism to the present age of neo-liberal capitalism side by side the institutionalization of sustainability issues. In each decade, different struggles were witnessed and CSR was reconfigured in meaning

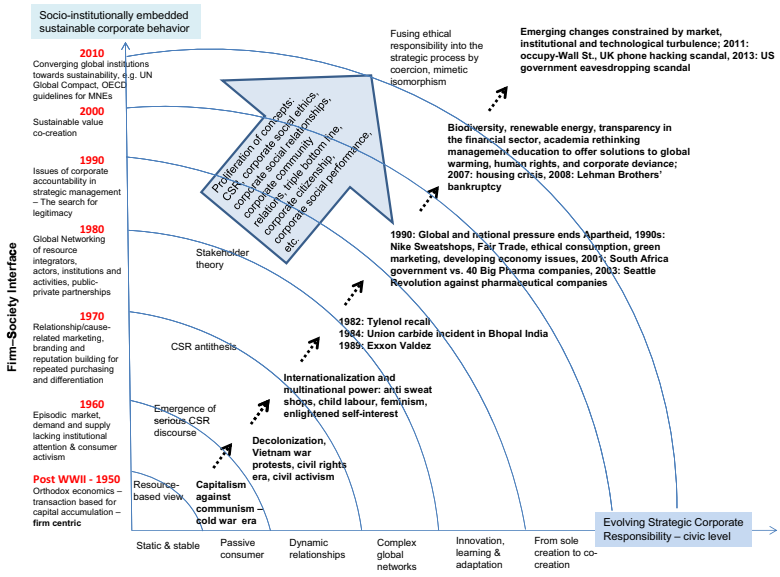

Figure 1.
The historical change process from CSR to SCR; "Towards sustainable value co-creation: Chronicle of path dependence"

Source: Storbacka (2009)

and the level of urgency. The horizontal axis depicts the relational evolution from stable/passive consumers to the emergence of co-creation. The vertical axis shows how each decade framed society's interface with business until the 21st century. The big arrow shows the different labels of CR under business ethics. In the aftermath of WWII, basic consumer needs were in short supply. The scarcity that led to high demand for goods meant that the externalities produced within the economic sphere were not major issues to society and governments any more than the satisfaction of their demand. The sales-transaction approach of orthodox economics applied to production and commercialization worked perfectly. Globally, such a view is shifting since the ultimate preferable future is the institutionalization of global sustainability as depicted in Figure 1.

What is SCR and how does it differ from traditional CSR

To avoid confusion, we distinguish SCR without the second "S" from strategic corporate "social" responsibility (SCSR; Davis, 2010) since the latter still carries with it notions of traditional CSR (such as philanthropy and PR) which has little to do with competence-based innovation and the creation of a long-term competitive advantage within a complex and evolving institutional context. Traditional CSR is a subset of the larger domain of CR. The difference is that SCSR is a transitioning stage from CSR toward SCR, which in essence, is a fully integrated concept as explained below. Therefore, the SCR process involves innovative value co-creation that engages civil

society through the maximization of human, natural, financial and social capitals; a move from producer orientation to consumer, environmental and institutional orientation (view Figure 2). SCR envisages emerging social questions as problems worth solving; it creates new opportunities for value co-creation in response to institutional and contextual needs and is referred to as sustainable value co-creation orientation.

The SCR is defined as the consistent, proactive adaptation process of integrating institutionally acceptable day-to-day behavior into dynamic capabilities, governance and operational systems at all levels. The goal is to co-create superior and contextually relevant value propositions innovatively and sustainably. All levels refer to business level, corporate level and collective level; thus alliances and cooperation via relationships (Porter, 1996). This includes designing and institutionalizing core values at the technical, managerial and structural levels with the aim of matching the external institutional dynamics with the firm's dynamic capabilities. SCR denotes the direction and scope of the firm through the identification of core competencies that coevolve with the market and institutional needs.

What SCR is not

SCR extends the "do no harm" principle by adding "create and protect value". Simply doing no harm constitutes value destruction since the indifference neither decreases nor increases value creation – it is deemed an ordinary behavior. The opportunity cost associated with doing nothing inherently constitutes value destruction. Hence, SCR is not about conformance but rather about performance beyond the required regulations (Drucker, 1974; Lee, 2008; Matten and Crane, 2005). SCR is not a public display of benevolence as a cover up. Rather, it is the renewal of the organizational mind to innovate. Corporations and charitable organizations are two distinct creatures and their

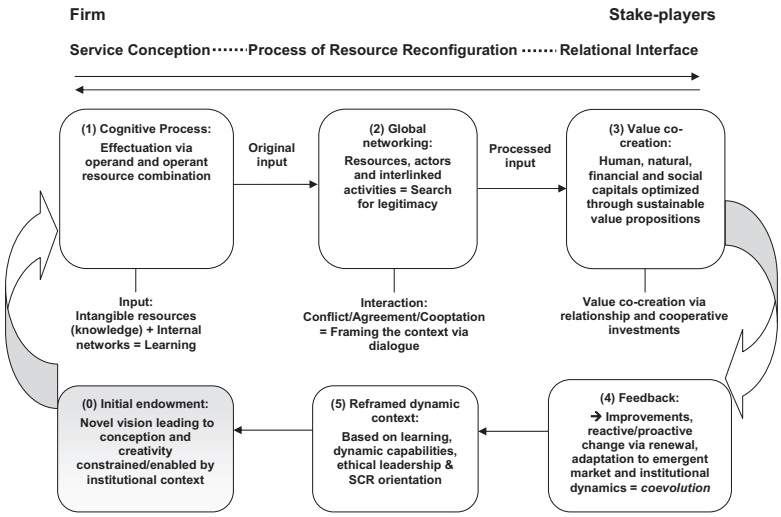

Figure 2.
A six-phase analytical model of SCR cycle for demand-side value co-creation

roles must not be conflated here except when there is an alliance. Between the application of resources and value creation are questions of legitimacy and legality but abiding by the rules does not qualify as SCR. In some weak institutions, no innovation is required to conform to new regulatory requirements. In the EU, for example, regulations are being standardized to allow conformity by all organizations. However, at other times new regulations impose urgency for innovation and only the most innovative firms can effectuate changes that lead to sustained competitive advantage. Major corporations such as Badische Anilin- und Soda-Fabrik (BASF) and Infosys are typical examples of such proactive social and environmental initiatives embedded in technologies.

Toward value co-creation: conceptualizing SCR

To maintain competitive advantage, legitimacy matters due to the current trend toward non-price competition. Thus, responsibility entails the process by which society's resources (knowledge, information, ideas and tangible resources) are systematically and innovatively organized to offer superior value propositions to meet contextual and inter-temporal need. Since SCR is a dynamic concept, how does feedback from stakeholders reshape SCR in co-creating value innovatively? We now present a six-phase (from 0 to 5) analytical model of the SCR cycle (Figure 2).

The learning processes of exploitation and exploration (March, 1991) include learning by doing, learning by experience and learning by interactions as the spatial order for building social networks (Geels, 2002). The strategic interaction of the firm and a network of business and non-business actors creates the basis for learning and adaptation to market, institutional, technological and environmental change. The model in Figure 2 helps to explain the SCR cycle of adaptation and sustainability. In a complex global business context, we view SCR as a chain of responsible decisions, an interlinking of activities and legitimately acquired and sustainably configured resources. Responsibility is characterized as the intent to commit to offer value propositions through learning and proactive actions for the betterment or changing of products or service quality (Phase 0). At its inception to co-create value, SCR does not include any form of physical interaction between the firm and the consumer. It starts directly at Stage 4 and 5 of strategic and civil phases of CR for collective actions for mutual gains (Zadek, 2004; Lin-Hi, 2008) or shared value (Porter and Kramer, 2011). The interaction is only a cognitive process (1). That explains why SCR is inherently of service as the ultimate reason for firm-stakeholder relational embeddedness (2) (Grönroos, 2008). This means that any act defined as irresponsible on the part of economic actors is premeditated, strategically planned and involves resource allocation. This leads us to *P1*:

P1. Superior value propositions for the consumer constitute value for the firm which in turn allows for new innovations leading to sustained legitimacy and competitive advantage.

One value co-creation process (3) ushers in a new process through new knowledge from feedback (4). The feedback loop of ideas and pressures is in the form of novel innovative inputs for learning, compromise and visibly reactive modifications, improvements or new creative ways of offering value propositions. On the basis of the above model, we argue that:

P2. Innovative value co-creation in day-to-day practices and learning occurs through feedback from consumers, institutions, strategic stakeholders and even competitors leading to a coevolution of preferences and sustainable techno-scientific solutions.

At the core of this stage is an ethically proactive leadership and governance structure that reframes (5) the dynamic institutional context of the firm's network and absorptive capacity in response to the feedback; i.e. re-igniting another cognitive process of strategic-ethical decisions to offer value propositions bundled in a chain of responsibilities for mutual benefit (back to 0). Here, there is an economic and political space for voice and accountability. The firm only serves as the initiator and nucleus for organizing the process of value co-creation as it searches for new opportunities. This leads us to the temporal dimension of responsibility as having an invisible cognitive past, a current physical process, an aspiration among players in the present and a vision to affect the potential, preferable future. SCR therefore equals sustainable value co-creation. We formally argue with *P3* that:

P3. Voluntary governance of SCR works under ethical leadership and the appropriate institutional environment and can also innovatively create competitive advantage where formal institutional structures are weak but informal institutional structures are strong.

Conclusions and managerial implications

This paper answers the question what is sustainable value co-creation orientation? It seeks to guide policy by challenging managerial wisdom on the needless dichotomy between ethical responsibility and strategy. Harnessing the contribution of Rasche and Behnam (2009, p. 243), "there are still many unanswered questions and probably even more unquestioned answers" about the insensitivity of the modern corporation toward social ills. We underscore the importance of recognizing corporate malpractices as an institutional and strategic problem that is central to the CR discourse internationally. Notwithstanding the numerous conceptual confusions and tautologies about CR, sustainability and organizational strategy, the presence or the lack of strategy-making that is embedded in CR (Laszlo and Zhexembayeva, 2011) directly affects consumers and their environment. We argue that SCR, organizational strategy or value co-creation leads us nowhere without a long-term focus – sustainability. Profit making *per se* is not unethical. Attaining such objectives at the expense of stakeholders or in ways that make society worse-off now and in the future constitutes corporate irresponsibility.

The managerial contribution consists of the notion that the socio-cultural and historical contexts of international business matter. Therefore, awareness of these will help the international firm to co-create the needed value with stake-players through communication channels and direct engagement toward cooperative investment for mutual gain in international operations. Strategies must respond to institutional needs to gain legitimacy through differentiation and create value with and for society while mitigating negative externalities and seeking to proactively respond to emerging opportunities and challenges.

Our approach in theorizing is neither a trivial enterprise nor a simplistic stylizing of existing CR concepts. We advance a new conceptualization of SCR; this consists of the cognitive processes and actual changes in behavior of a firm that aims at attaining

sustainability. This is pragmatic, phenomenon-driven and context-bound. Strategic operations and managerial direction entail partnerships with other resource integrators for value co-creation. Hence, SCR is a mechanism for coevolving with global environment. Sustainable value co-creation also entails protecting operations against value destroyers such as the drug counterfeit industry. This will also be on our next research agenda after studying how the relationship structure of organizations' resource integrators affects value co-creation.

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About the authors

Frederick Ahen is a doctoral researcher at the University of Turku, Finland. Frederick's main research interests include strategic corporate responsibility, global sustainability, global health diplomacy and strategic political management in the pharmaceutical industry within the institutions of emerging economies. Frederick Ahen is the corresponding author and can be contacted at: Frederick.Ahen@utu.fi

Peter Zettinig is currently University Research Fellow at the University of Turku in Finland. His research interests revolve around change happening to internationally active organizations with special emphasis on multi-level implications of change and in context of sustainability in the widest sense.

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Ethically constrained optimization of dynamic capabilities: towards sustainable global health

Frederick Ahen

Ethically constrained optimization of dynamic capabilities: towards sustainable global health

Frederick Ahen

Frederick Ahen is a Doctoral Researcher based at Department of Marketing and International Business, Turku School of Economics, University of Turku, Turku, Finland.

Abstract

Purpose – *This study aims to explain how sustainable global health presents an emerging new form of competition and socio-political and functional pressure for which strategic organizational renewal is a prerequisite for the organic resilience and co-evolution of pharmaceutical firms with their environment.*

Design/methodology/approach – *Through a meta-theoretical analysis in which theories themselves become the unit of creative synthesis, a wider framework is developed to allow a comprehensive and nuanced reinterpretation of the neo-institutional theory and the resource-based view. In focus is the practical utility and relevance of such theories within emerging economies where pharmaceutical firms respond to market and institutional changes.*

Findings – *The imperative for organizational change is very much dependent on the combination of ethically constrained managerial choices as well as entropic institutional pressures that allow firms to successfully adapt to their dynamic environment. This is achieved through legitimization and sustained competitive advantage, the results of innovation and contextually relevant differentiated value propositions.*

Social implications – *Contrary to popular perceptions, recent developments demonstrate that the simultaneous pursuit of efficiency and ethical preferences is possible, irrespective of the institutional matrix within which change occurs. Managers should, therefore, tap into the niche opportunities offered by favorable entropic pressures.*

Originality/value – *The novelty in this paper is the framework it provides for analyzing the massive role played by the micro-political power of managers and how the goals they pursue become fundamental to what the organization becomes as it coevolves with the turbulent era of emergent health needs.*

Keywords *Corporate responsibility, Pharmaceutical industry, Dynamic capabilities, Constrained optimization, Institutional matrix, Strategic renewal*

Paper type *Conceptual paper*

Introduction

The pursuit of efficiency and profitability does not preclude the introduction of innovative and disruptive business models. Nor is it a reason to disregard product re-engineering embedded in ethical preferences to help organizations keep abreast of emergent scenarios constrained by critical issues. In fact, the evolutionary dynamics of the business environment (Baum and Singh, 1994) and organizations' actions as adaptive systems (March, 2006) need to be consistent with the managerial decisions to deploy resources that are specifically in tune with the times and shaped to respond to current and future opportunities and challenges. Simply put, the ethical and sustainability questions are back in the board room in search of strategic solutions to the changing global business environment backed by strong institutional arrangements. Here, global consumers' demand for corporate responsibility (CR) and the need for ethical response and sustainable technological revolution (Campbell, 2007) seem to constrain how firms seize opportunities, capture value and strategize via resource configuration (Ambrosini and Bowman, 2009; Augier and Teece, 2009; Teece *et al.*, 1997; Winter, 2003; Zollo and Winter, 2002 to meet the new demands that are skewed toward emerging markets as well as

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markets at the bottom of the pyramid (Yunus, 2010). The present contribution provides theoretical, technical and managerial insights into how pharmaceutical firms proactively transition to offer contextually relevant and differentiated value propositions to emerging economies.

Following Nielsen (2003), the main premise of this conceptual contribution is that organizations as social arrangements (with a shared purpose and interest) and ethics (as moral principles that are praiseworthy because they are socially desirable) are two concepts that are inextricably bound. Their inseparability is explained by their relevance, time and the socioeconomic context where they are constructed to make sense. Drawing heavily on the works of Adam Smith, *Theory of Moral Sentiments* (1759) and *An Inquiry Into the Wealth of Nations* (1776), all on ethics and organizations, Nielsen compellingly articulates his thesis that just as:

> It may not be possible to have an operational organizational theory without an at least implicit ethical or normative foundation, it is also not possible to actualize social ethics without an organizational form (2003, p. 476).

Ethics and strategy are, therefore, not at variance. They are mutually reinforcing.

Different organizations may optimize different factors, processes and innovations, taking into account the contextual and temporal dimensions of the organizational life cycle as well as the ethical posture of the leaders. These leaders or agents (purposive actors) are not only influenced by the external institutions but also enact change that influences existing institutions and acceptable forms of innovations in search of legitimacy (McGaughey, 2012) and sustained competitive advantage (Porter, 1985). The increasing phenomenon of organizational search for legitimacy, power and influence through their role as political actors is explained by the neo-institutional theory and CR in the works of Campbell (2007) and Scherer and Palazzo (2007). By interpretation, this is what Nielsen means by constrained optimization. Optimization may be geared toward, for example, shareholder value, legitimacy, power or family wealth under certain constraints (such as environmental sustainability, sustainable healthcare or individual greed). Again, tradeoffs on these issues are based on the individual proclivities and values of the ethical manager. The gap between what is constrained and what is optimized strikingly differs under different institutional environments or societies and types of organizations over time. The transition process poses great challenges for organizations and the societies which sustain them. For Adam Smith (1759, in Nielsen, 2003), business owners should pursue self-interest that does not hurt other constituents but rather increases their welfare. Is it possible then for pharmaceutical firms to simultaneously pursue efficiency and ethics aimed at creating general welfare through the optimization of dynamic capabilities? For Eisenhardt and Martin (2000), such capabilities refer to strategic decisions, the architecture of novel products and services and innovative forms of collaboration.

The purpose of this theory-building exercise is to explore two common theories in current strategic management and how these theories may be consolidated to explain strategic renewal in pharmaceutical multinational companies (MNCs) toward sustainable global health in the context of emerging economies. Against this backdrop, the study seeks to develop a wider framework that allows a complex but comprehensive and nuanced reinterpretation of the theories and their practical application within varieties of institutional contexts where firms respond to change. Through a *meta*-theoretical analysis of the neo-institutional theory (DiMaggio and Powell, 1983; Meyer and Rowan, 1977) and the resource-based view (RBV) (Barney, 1991; Wernerfelt, 1984) and by extension of dynamic capabilities perspective (Augier and Teece, 2008; Eisenhardt and Martin, 2000; Zollo and Winter, 2002), two major arguments are presented here:

1. Market turbulence and institutional dynamics (Berger and Luckmann, 1966; DiMaggio and Powell, 1983; Scott, 2001) now affect managerial decisions in ways that turn solely

profit-oriented MNCs' leaders into entrepreneurial managers (Augier and Teece, 2009; Dimov, 2007; Penrose, 1959; Winter, 2003).

2. In spite of the high levels of dilemma, simultaneous pursuit of ethics and efficiency by entrepreneurial managers is possible through transition where existing capabilities are reconfigured.

The pharmaceutical industry is particularly interesting due to the enormous pressure from civil society to respond to healthcare needs of low-income countries, its socio-ethical dilemmas, fast-paced nature and initial techno-scientific endowments to tackle global health issues as well as the, particularly stringent, regulations by which it is governed. All five major characteristics require continuous adaptation and organizational renewal underpinned by CR and ethical preferences to achieve long-term sustainability and legitimacy.

This study matters because while the focus of dynamic capabilities seems to be on adaptation of resources to emergent turbulence, market dynamism and long-term competitive advantage (Augier and Teece, 2008; Eisenhardt and Martin, 2000; Porter, 1985), the research on sustainability seems to be more of an interesting rhetoric about the sensitivity to scarce resources and social justice. This leaves the centrality of the "ethical man" and his relationship with governments and nongovernmental organizations (NGOs) out of the discourse. Moreover, these views fail to account for the time logic, systemic variables and the institutional elements which constrain organizational strategic decision-making toward the maintenance of competitive advantage to ensure that sustainability happens in the first place. This paper, therefore, provides a match between social and economic interests within the context of the pharmaceutical sector. By implication, there are substantial opportunities for a pragmatic approach in enriching and coalescing different theoretical strands into a systematic framework that takes into account current issues in global health in emerging economies. In agreement with Augier and Teece (2009, p. 418), "the dynamic capabilities framework invites further research into entrepreneurship, organizational learning, and the role of managers and leaders in enterprise performance".

Therefore, the major contribution of this paper is the creative synthesis and a nuance reinterpretation of the neo-institutional theory and the RBV which allows for a new understanding of the central role of the entrepreneurial manager's ethical posture in designing and reconfiguring resources to create change. *The central research question* in this analysis is stated as follows:

How does ethically constrained optimization of dynamic capabilities in pharmaceutical organizations within diverse institutional contexts represent both an analytical and practical (gestalt) shift from firm centeredness to a co-evolutionary development of the firm with its dynamic external environment?

Four principal themes run through this contribution, followed by discussions, conclusions, policy recommendations and suggestions for future research. *One*, the normative and ethical concerns about global health constrains how dynamic capabilities, business models and pharmaceutical firms' resources are directed toward a new form of competition and adaptation. This describes a shift from the firm centeredness and RBV (which precludes ethics and stakeholder questions but places emphasis on efficiency no matter the social cost) toward the extension to the dynamic capabilities (Augier and Teece, 2008; Teece and Pisano, 1994).

Two, the paper harnesses Williamson's (2000) path-dependence account of the political, economic and regulatory systems of different economies as comprising a network of interrelated formal rules and informal constraints which correspond to the institutional matrix at the core of economic advancement or underdevelopment. These same institutional changes shape the markets, especially in terms of the type of new innovations and product architecture as well as strategic decisions by individual managers, with

political power, in response to the sustainability and healthcare issues. Thus, institutions also determine the form of capitalism (Hall and Soskice, 2001).

Three, this leads to the design of new mechanisms via organizational renewal and the effectuation of strategic changes (Saravasthy *et al.*, 2008) aimed at meeting the current sustainable health demands. This is made possible through the anticipation of future concerns and expectations of stakeholders (Freeman, 1984). *The fourth* part offers empirical illustrations on how pharmaceutical organizations optimize distinct mechanisms, processes and innovations at different historical points.

Methodology

The conceptual framework of this *meta*-theoretical analysis draws together the dynamic capabilities perspective, ethics on the micro level and institutional analysis on the structural level. This aims at bridging the micro – macro gap with what happens in organizations in practice.

Theories and paradigms in strategic management abound but so do their levels of fragmentation and disconnectedness (Tsoukas and Knudsen, 2003). At present, there is a lack of much-needed relevance of these theories to both policy makers and practitioners, thus, emphasizing the gap between theory and practice (Starkey and Madan, 2001). It follows that a deeper reflection about the validity and relevance of knowledge and its purpose for understanding the organizations *vis-à-vis* their external environment is fundamental for our time. This is because how knowledge is generated and how the validity of such knowledge and elegant theories is scrutinized are challenging questions that require serious enquiry. Such thoughtful contemplations lend themselves to a set of critical questions or *meta*-questions whose very essence goes beyond the generation or testing of organizational theories. Rather, this process of raising critical questions and engaging in reflexivity about the validity of knowledge, its purpose and for whom it is practically relevant "makes the generation of theory itself an object of analysis" (Tsoukas and Knudsen, 2003, p. 5).

Tsoukas and Knudsen's (2003) contribution, reflexivity in research allows the detection of prejudiced assumptions about sustainable corporate practices, sometimes viewed as a cost (Friedman, 1970; Jensen and Meckling, 1976). Moreover, *meta*-theoretical analysis helps understand how some notions are more persuasive than others in capturing and explaining social and organizational phenomena. What is the relevance of theories if they cannot be linked to the overall sustainable need of the present era and its market and institutional expectations? To this end, the temporal dimension and contextual utility of this new framework are made explicit in the analysis to explain that relevance is not a universal notion but can only be construed in a universe of time, people and place.

Theoretical perspectives

Clearly, there is a theoretical and empirical link between the notion of "ethically constrained dynamic capabilities" and the neo-institutional theory to explain how sustainable global health issues present an emerging new form of competition for which an organizational renewal is an imperative for adaptation. CR is at the center of the 21st century's organizational renewal. Bowen's (1953) systematic account of the importance of the organization – society interface accentuated his definition of corporate social responsibility (CSR) as:

> [. . .] the obligation of those businessmen [and women] to pursue those policies [based on ethical principles], to make those [strategic] decisions or to follow those lines of action [strategy implementation and new business models] which are [socially] desirable in terms of the objectives and values of our society (Bowen, 1953, p. 6).

Ethical behaviors such as the production of drugs for neglected diseases (for a list of the 17 neglected tropical diseases, see www.who.int/neglected_diseases/diseases/en/) were

once considered a cost that puts the firm at an unfair disadvantage. Such a reductionist view in which the firm exists only to maximize profits at the expense of its employees, consumers and other constituents, as was sustained in the past by Friedman (1970), does not reflect present realities where the pharmaceutical industry's legitimacy depends on its proactive response to health problems in emerging economies. Disruptive business models which take advantage of the economies of scale in markets at the bottom of the pyramid and emerging markets reduce poverty and increase economic development (Yunus, 2010). Processes embedded in ethical preferences, e.g. low-cost generic drug production through cutting-edge innovative processes, are gradually becoming the rule rather than an exception (www.accesstomedicineindex.org/).

Dynamic capabilities of organizations

The RBV traces its origin from Penrose (1959) to later in the works of Wernerfelt (1984). It essentially postulates that the heterogeneity and immobility of different organizational endowments will translate into valuable resources which will, over time, sustain the competitive advantage to earn "super profits or above-average profits". This is consistent with Barney (1991) and Priem and Butler (2001). While this notion holds all things static, its shortcoming is that it does not explain how future valuable organizational resources can be generated. Nor does it explain how the current stock of resources can be reconfigured to suit the dynamic needs of the market and institutional expectations (Ambrosini and Bowman, 2009). Besides, it fails to recognize that firms confront not only markets but institutions as well.

From where the static nature of the RBV ends, dynamic capabilities take over to explain how organizations evolve to reflect historical context and time, while spotting and seizing such opportunities and reconfiguring resources to deal with emergent challenges and pressures. Therefore, dynamic capabilities underscore the organizational response to both institutional and market changes resulting from a variety of pressures (Helfat *et al.*, 2007). Eisenhardt and Martin (2000) conceptualize dynamic capabilities as a set of specific and identifiable processes comprising product development, strategic decision-making and alliancing. They are, hence, neither vague nor tautological but consist of deliberate learning and purposeful renewal of operational routines (Zollo and Winter, 2002. Augier and Teece (2008, p. 1,190) define dynamic capabilities as "the particular [non-imitable] capacity a business possesses to shape, reshape, configure and reconfigure assets so as to respond to changing technologies and markets and escape the zero profit condition". They refer to the ability of the organization to anticipate, seize opportunities and adapt to its environment in a way that permits it to exploit both the internal and external enterprise-specific competencies and deal with the organization's dynamic environment (Augier and Teece, 2008). Thus, beyond the mere possession of competencies in the short term, the long-term survival is attained by learning new innovative attributes, continuous process of renewal and superiority in an organization's value propositions. These attributes must be able to capture potential opportunities at a rate that is quicker than the competitors' while concurrently effectuating organizational renewal through entrepreneurial leadership.

Teece *et al.*'s (1990, cited in Ambrosini and Bowman, 2009, p. 11) working paper presented in Finland was the first contribution toward the theory of dynamic capabilities. In it, they point out that:

> [. . .] our view of the firm is somewhat richer than the standard resource-based view [. . .] it is not only the bundle of resources that matter, but the mechanisms by which firms learn and accumulate new skills and capabilities, and the [market and institutional] forces that limit the rate and direction of this process.

The refined version of these ideas was formally published in 1994 by Teece and Pisano. Ambrosini and Bowman (2009) and Teece and Pisano (1994, p. 537) assert the primary importance of the dynamic nature of the external environment as well as the role of strategic management which is essentially concerned with the process of "adapting, integrating and

reconfiguring internal and external organizational skills, resources and functional competencies toward the changing [market and institutional] environment(s)". The core message here is to perceive pharmaceutical firms as systems embedded in socioeconomic, political and technological realities where the managers' cognition and values-based judgment are fundamental to the process of renewal and adaptation.

The central role of managerial micro-politics and institutional change

Borrowing from Becker (1998, p. 89), decisions pertaining to what is optimized and what is constrained "are historically contingent, geographically influenced [context-bound] combinations of variety of processes [. . .]" which differ from one firm to another. They are also dependent on the goals (micro-politics) organizational leaders or entrepreneurial managers pursue (Hofstede *et al.*, 2002). Organizational culture is defined variously as shared patterns and meanings, values (ethical or unethical), beliefs and ideologies which underlie the internal behavior and managerial decisions as well as the way organizations react and adapt to their external environment (ibid.). Managerial belief systems, vision and values affect how resources are configured. These, in turn, affect the response to the changes in the institutional matrix to either enable or inhibit organizational renewal toward sustainability (Linnenluecke and Griffiths, 2010).

Niccolo Machiavelli (1469-1527), an Italian diplomat and author on politics, walked his talk on the idea that humans are by nature self-oriented and covetous; therefore, great individuals are those who are able to adapt to the evolving market forces, as they turn into masters of deceit. Three major things undergird his arguments, namely, flattery, deceit and even murder, may be necessary evils for capturing and maintaining political power. He argues strongly that vices not virtues are ideal for political life and should be encouraged because "virtues may be suicidal". He advocates the cultivation of vices if they help advance one's political goal (Machiavelli, 1952).

For March (2006, p. 201), organizations, by nature, "pursue intelligence". Thus, they seek to adopt courses of action that will eventually lead them to results that are deemed desirable in the long term, "taking into account any modifications of hopes, belief [systems], [ethical] preferences, and interpretations that occur over time as well as conflict over them [the dilemma over all the above]". For example, rational technologies permit firms to survive in a dynamic environment because they involve an attempt to understand complex changing systems of causal factors on the basis of "imperfect, ambiguous, and contested" knowledge of the environment (March, 2006, p. 204). This process entails the anticipation and shaping of the environment that is also characterized by other organizations which seek to equally and concurrently "anticipate" and "shape" their environment. Hence, there is a process of confronting inconsistencies in preferences, benchmarking across organizations and making intertemporal appraisals. It follows that pharmaceutical firms, as adaptive systems, are sustained by a process of exploration and exploitation in the midst of emerging changes. Therefore, theory, ideology (about sustainable global health) and technologies of rationality in organizations are embedded in the institutional logic which holds that the implementation of an organization's strategic CR should be the "product of the [managerial entrepreneurs'] mind and choice", not some mystery (March, 2006, p. 203). This shows how entrepreneurial managers shape institutions.

Changes in institutions undergirding what is optimized and what is constrained

Changes in institutional matrix (of socioeconomic and political dimensions) refer to the "fundamental and comprehensive changes introduced to the formal and informal rules of the game that affect organizations as players" (Peng, 2003, p. 275). Oliver (1992) argues that although institutions may be stable, under certain conditions, change emerges; in neo-institutionalism, this is known as *deinstitutionalization*. He proposes three main antecedents of deinstitutionalization, namely, political, functional (changes to the perceived

utility or technical instrumentality of institutionalized practices within the organization) and social pressures. The competing inertial and entropic pressures serve to moderate the rate of the institutional change. These three pressures or a combination of them drive the deinstitutionalization process via the delegitimization of existing social practices as a result of shifts in the distribution of power and public interest. Oliver (1992, p. 580) further postulates that:

> [. . .] whereas organizational entropy suggests natural tendencies toward erosion or decay of institutional phenomena, the notion of inertia suggests that institutionalized values and activities will exhibit inevitable resistance to erosion or change.

Institutional environments are the inhibitors or enablers of responsible or irresponsible behavior of firms (Campbell, 2007). Campbell (2007) cites both private and public regulatory conditions under which the organization operates in the presence or absence of NGOs which monitor firms' behavior, institutionalized norms within which corporate actions are deemed acceptable and the pattern of behavior that is consistent and accepted in a particular industry. Campbell further asserts that coordinated dialogs among organizations and their stakeholders are among the reasons for ethically responsible corporate practices. What is missing, however, is the role of organizations in the context of weak institutions. By weak institutions, we refer to the inability of the formal structures to enforce rules and regulations and the informal institutional environment to organize its influence against what is deemed unacceptable corporate behavior. Berger and Luckmann (1966) postulate that an institutional trajectory consists of a process of *initiation – habituation – objectification*, which in the end results in new behavioral patterns that are then "taken-for-granted", and this is how a new social reality is constructed. These considerations lead us to:

P1. The optimization of dynamic capabilities is constrained by deinstitutionalization of firm-centered industry specific norms; new formal rules by governments about sustainable health issues; and the opportunity-seeking motive of the firm to pursue competitive advantage which, in turn, is legitimacy-driven and pushed by the ethical managerial decisions to meet the emergent healthcare needs of consumers.

Results and discussion

Empirical illustration: pharmaceutical firms' response to turbulence

Massive regulatory changes and unprecedented techno-scientific advancements have now transformed the pharmaceutical industry, the structure of the markets and their geographical configuration. Pisano defines the pharmaceutical industry as a science-based business – "a commercial enterprise or a collection of enterprises that attempts to both create science and capture value from it" (Pisano, 2006, p. 2). This makes market dynamics fundamental to industry changes. Such market turbulence makes adaptation to change an imperative. As Hayek argues, socioeconomic challenges arise "always and only in consequence of change" (Hayek, 1945, p. 82). By inference, in the absence of change, there will not be any rationale for a strategic renewal.

In the quest to problematize the transition problem of pharmaceutical firms, the illustrations focus on how:

- pharmaceutical MNCs renew their firm-centered capabilities to be oriented toward fulfilling a social contract in low-income countries (in this regard, NGOs and governments are indispensable partners to make any effort sustainable); and
- the difficulty in making changes arises from the fact that pharmaceutical MNCs are stuck in the old business models in terms of pricing, research and development (R&D) and marketing operations (Table I), mainly for the rich markets of the Organisation for Economic Co-operation and Development (OECD) countries (these old models constitute inertial pressures).

Table I The dilemma of efficiency and legitimacy in the pharmaceutical firms

Strategic stake-actors	*Input*	*Functional area*	*What is constrained/optimized*	*Effects on strategy*
Suppliers	Active pharmaceutical ingredient (API), expertise	Supply chain and purchasing department	High uncertainty about the quality of API	Cost and comparative disadvantage and *vis-à-vis* rivals
Consumers/trial subjects	Source of revenue/service knowledge and value creators	Marketing and R&D	Business ethics, reduce prices and increase quality of drugs in emerging economies	Determinants of competitive advantage, production costs, brand, price premium and global performance.
Human capital internal/external expertise	Strategy implementation, tacit knowledge and information safeguard	Human resource	Opportunism, pursuit of self-interest and shirking	Value destruction or value creation in essence
EMA[a] (European Union), FDA[b] (The USA), host government and institutions	Regulators/evaluation and authorization for commercialization	Quality control and executing new regulatory directions	Non-/compliance with medical ethics and costs/time line for approval	Fines → profits and credibility ↓ (legitimacy ↓, legal constraints ↑) → strictness ↑ and compliance costs ↑ Sales volume ↓ → Unit costs ↑
Contract research organizations	Trial subjects/knowledge about drug efficacy and potency evidence-based outcomes	R&D, drug design, tests and trials	Protect rights and safety of trial subjects/operational efficiency vs rule-bending opportunities	Key to R&D investment failure/success → determinants of return on investment (ROI)
Distributing representatives	Local pharmaceutical distributors/hospitals	Marketing	Critical issues with vested groups/fake distributors and counterfeiters	Direct effects on revenue streams, brand and reputation and intellectual property right (IPR) infringements/protection
Financiers	Cash input	Finance	Uncertainty vs profits	Pivotal in projects advancement

Notes: [a]European Medicines Agency; [b]Food and Drug Administration

On the other hand, emerging economies have an extremely difficult task of making drugs available at affordable prices or protecting the value chains of drugs from counterfeits. Additionally, most of these countries lack robust pharmaceutical industries, while their young local industries tend to be in a stagnant growth due to a lack of financial and institutional support. This automatically translates into the absence of innovation, while endemic diseases such as malaria and tuberculosis continue to present a high mortality and morbidity rate.

Notwithstanding the above, pharmaceutical MNCs can now access several types of technical support and knowledge (research centers, laboratories and engineering and design centers; Malhotra and Morris, 2009). Knowledge-based operations have become as mobile as the physical activities even in emerging economies (Starbuck, 2010). The speedy growth of these economies is clearly a precondition for pharmaceutical markets to thrive (Mackey and Liang, 2012). This becomes the rationale behind the architecture of novel demand-based drugs that meet the needs of emerging markets. Despite being a highly regulated and complex industry, there are opportunities in emerging economies, whereby pharmaceutical firms can identify existing and potential therapeutic, diagnostic and prophylactic cases for innovations and R&D of essential drugs.

New corporate response to critical healthcare issues is readily verifiable from the sheer number of pharmaceutical companies that are taking the initiative to contribute to poverty eradication efforts in the healthcare sector of emerging economies to appear socially responsible through the Global Compact (2010), the World health organization (WHO) and United Nations Millennium Development Goals. An emerging business model within the pharmaceutical industry now includes the embeddedness of business strategies into social concerns through partnerships between firms and NGOs to embark on R&D to produce drugs for neglected diseases. For example, GlaxoSmithKline has R&D projects to develop anti-malarial drugs for the tropical regions of the world. In the present era, this is a typical way of gaining social legitimacy. Simply put, the mantra is "with the occasion and place comply". This technically denotes organizational isomorphism (DiMaggio and Powell, 1983). There is also industry – academia – NGO – government nexus to respond to critical health issues. Typical cases include the Harvard Malaria Initiative (www.hsph.harvard.edu/hmi/), Medicines for Malaria Venture (www.mmv.org/) and Roll Back Malaria (www.rollbackmalaria.org/).

There is evidence of industries' ethically constrained optimization of dynamic capabilities in response to the problem of accessibility of medicines in low-income countries. This corroborates with Winter's (2003) conception of the first-order dynamic capabilities. The Access to Medicines Index (AMI) independently probes how individual pharmaceutical firms are performing in promoting universal access to essential medicaments and is, thus, an important tool in improving performance in terms of R&D and equitable pricing that meets the needs of low-income emerging markets. The AMI ranks 20 of the world's largest pharmaceutical firms on their efforts to ensure that their drugs are made accessible to emerging markets. The index encourages drug companies to compete in this regard and investors and other stakeholders are then able to transparently evaluate the ethical responsibility track records of the big Pharma (www.accesstomedicineindex.org). At present, most firms' existing resources are not usually meant for such purposes. The resources are, therefore, reconfigured via heuristics, effectuation, alliances with NGOs, well-funded private institutions and governments to meet emerging healthcare needs.

Novel techno-scientific approaches, such as bioinformatics and molecular modeling (Salo, 2006), aim at reducing time and cost of the drug development process and life cycle. Carefully designed and research-based clinical trials increase safety of trial subjects, especially in emerging economies. Further, "track-and-trace" serialization and pedigree technologies are now the new frontiers for the detection of counterfeit medicines aimed at protecting intellectual property and the final consumers. The ethical component here is obvious and self-explanatory. The protection of consumers and trial subjects are

fundamental risk management processes that also allow pharmaceutical firms to avoid high compliance costs while gaining legitimacy. Designing and reconfiguring organizational capabilities are responses to the new consumption patterns, regulatory demands and social pressure on pharmaceutical firms to seek legitimacy through the production and distribution of drugs for the low-income economies of Africa, Asia and South America. Offering high-quality but cheaper versions of medicines allows access into new market frontiers and also serves as a sign of strategic CR. For example, Frost and Sullivan analysts have forecasted that pharmaceutical sales in Africa will grow from 2.28 billion in 2008 to 5 billion in 2018 due to the speedy growth of emerging economies (Macdonald, 2013). Transition into such markets requires proactive innovations that become the key sources of sustained competitive advantage (Augier and Teece, 2008; Drucker, 1974).

Despite the positive developments, the space between what is optimized, e.g. dynamic capabilities, and what is constrained, e.g. sustainable global health and social justice, is filled with conflicts of ethical and instrumental nature (Nielsen, 2003). Weaver *et al.* (1999) imply that managers with higher ethical commitment are directed by their ethical preferences more in practice than firms that engage in ethical actions as an *ad hoc* program in response to external pressures. This perhaps explains why some pharmaceutical firms strategically renew their capabilities to allow them to offer the optimal value propositions to emerging markets while others stick to profit maximization. Table I shows the dilemma of what is constrained, what is optimized and the major actors in such a process in the pharmaceutical industry.

Meta-analysis of neo-institutional theory and the dynamic capabilities view

In aggregating inputs from all the functional areas, new resources and capabilities are developed in the quest to achieve and maintain a sustainable competitive advantage. These intra-functional relationships allow the creation of social capital, new organizational learning and approaches that spur innovation. This changes the firm's role, especially in markets with weaker institutions.

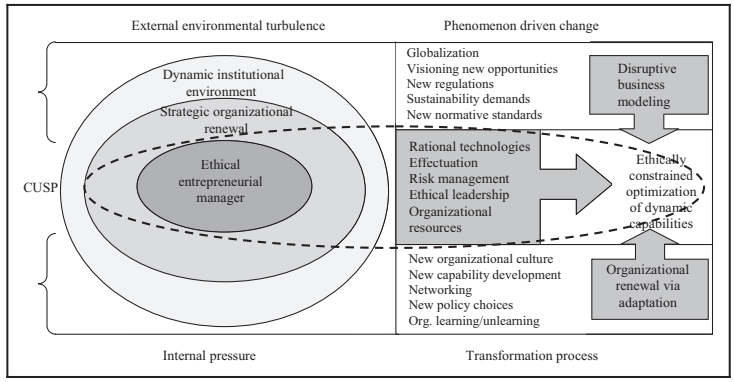
Porter (1985) asserts that organizations must establish unique positions employing the generic strategies of cost leadership, product or service differentiation or by pursuing a sustained competitive advantage and the possibility of a long-term survival in a dynamic and competitive market, especially in low-income countries. The neo-institutional theory holds the premise that organizations' conformity to institutionalized practices is to gain legitimacy and reduce uncertainty rather than to improve technical and financial performances. While McKinley and Mone (2003) view competitive strategy and neo-institutional theory as being at variance, it is argued that firms remain institutionally isomorphic due to the market environment; the legal framework and emerging ethical/normative concerns that constrain them to mimic each other, influencing internal structures and resource endowment and how they are renewed over time to adapt. Therefore, technical and functional changes are both essential elements in attaining legitimacy in the pharmaceutical industry context.

On the other hand, organizations pursue differentiation and other strategies which accentuate their uniqueness. This also means that organizations mimic each other not only to attain legitimacy but also to outperform each other by doing the same thing in diverse ways given the firm-specific competencies. This may explain why some organizations continue to thrive, while others get extinct under similar environmental conditions (Drucker, 1974). Operational efficiency based on capabilities and scientific knowledge will require constant innovation to adapt accordingly.

Dynamic capabilities as a theoretical foundation for sustainable global health

Figure 1 presents a model of ethically constrained optimization of dynamic capabilities toward sustainability with the assumption that it is possible to pursue ethics and efficiency simultaneously. The cusp refers to a threshold or a transition from one historical point to

Figure 1 A model of ethically constrained optimization of dynamic capabilities toward sustainability – it postulates the possibility of simultaneous pursuit of ethics and efficiency



another, where environmental turbulence and internal pressures force organizations to renew their structures to adapt to the external environment. The optimization of dynamic capabilities is strongly influenced by environmental turbulence, which consists of external forces such as environmental changes (e.g. climate change and pollution), human rights, global health issues and pressures from external stakeholders. The optimization is also influenced by internal pressures such as demands from internal stakeholders (e.g. employee safety and transparency in corporate governance and work – life balance). This changes the dynamics of the nexus between the firm and society. Environmental turbulence must not be construed only as market and institutional disorders but also as new opportunities, especially in emerging economies constrained by the larger society of which the firm is part. This means the ability of the firm to reconfigure capabilities via managerial entrepreneurship underscores the creation of competitive advantage. As Helfat and Peteraf (2009) put it, dynamic capabilities view is the Holy Grail which attempts to answer the specific question of a firm's sustainable competitive advantage in a changing environment.

This "inside out" view, despite its cogency, fails to consider the ethical constraints which lead to the successful optimization of dynamic capabilities. The dynamic capabilities and managerial entrepreneurship enhance the development of products and services that, in turn, allow organizations to differentiate, become cost leaders or offer unique value propositions to consumers. These unique and compelling theses represent the cornerstone of firms' reputation in their quest for both market and institutional legitimacy via mimetic, coercive or normative mechanisms depending on the industry, sector, circumstances and context (DiMaggio and Powell, 1983). By implication, isomorphism does not preclude organizational uniqueness and the creation of competitive advantage. The inimitability of dynamic capabilities constrained by the ethical decisions of the entrepreneurial manager allows for business solutions for social issues at profit. Defining socioeconomic or technological problems worth solving for profit is a win – win initiative. This, however, requires dynamic capabilities and networking for building the needed novel technologies in managing complex operations in different institutional milieus with new marketing opportunities. Efficiency matters but institutions may be everything; addressing it may be non-trivial.

The second proposition from the empirical illustration and the model is that:

P2. Pharmaceutical organizations which do not consider ethical questions in the optimization of dynamic capabilities and effectuation of renewal run a high risk of

creating a competitive disadvantage that renders their value propositions obsolete, given the institutional, ethical and market dynamics that underpin virtually every innovation. Therefore, the greater the ethical preferences in the optimization of dynamic capabilities are, the greater will be the organization's level of legitimacy in society and, hence, its sustained competitive advantage.

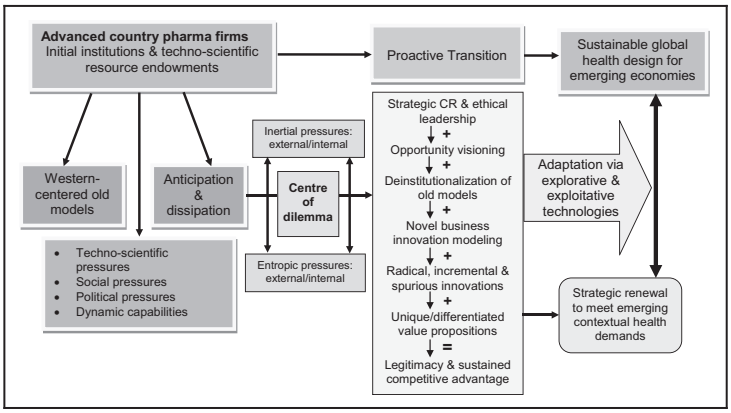
The transition: balancing entrepreneurship and strategic renewal

As an inductive theory-building exercise, following the *meta*-theoretical analysis, the key concept *strategic renewal* is, hereby, operationalized as the profound organizational changes and conscious design at varying degrees of transformations in a firm's dynamic capabilities that allow it to innovatively adapt and maintain sustained competitive advantage over a long period. This process consists of shaping and being shaped by the environment constrained by market opportunities and challenges, on one hand, and technological and institutional constraints and enablers, on the other. All these are centered on the un/ethical sensibility of the entrepreneurial manager. The reference to varying degrees of transformations describes removal and replacement of old business models, the deinstitutionalization of existing operational patterns and institutionalization of a new mindset, as well as structural and technical changes. The internal transformation may be rather slow and relatively minor, but substantial enough to help the firm adapt to the external turbulence. In some cases, very radical transformation in terms of organizational structure, culture and capabilities is required to exploit the new windows of opportunity which promise scale and profitable avenues. For Agarwal and Helfat (2009), major transformations may also present themselves as both large and multidimensional, making it difficult for the firm to serve the radically changing markets that affect business models, technological capabilities and the organizational mindset. Agarwal and Helfat (2009, p. 282) define strategic renewal as "the process, content and outcome of refreshment or replacement of attributes of an organization that have the potential to substantially affect long term prospects". Implied, here, is that strategic renewal is about adaptation to changes through an innovative design transitioning into the future in ways that affect the firm's success or failure to create value ethically and efficiently.

The process of metamorphosis to respond to emergent changes requires structural modifications within the political institution of the firm (Uhlenbruck *et al.*, 2003). Second, the transition problem does not only regard incoming investors but also the recipients (host nations) which will have to equally adapt the local systems to global approaches. This cooperative value-creation process (Austin, 2010) may take the form of joint ventures, mergers, acquisitions or other types of alliances. This is where human capital with a global mindset will be required to mitigate or lessen the liability of foreignness (Luo *et al.*, 2002), while serving as a bridge between diverging corporate governance systems and home versus host country interpretation of strategy and CR (Peng and Pleggenkuhle-Miles, 2009). Following Oliver (1992), the above considerations are depicted in the model below (Figure 2).

Against the backdrop of major socioeconomic and health challenges faced by emerging economies, there is consistent evidence of corresponding inflation of expectations in markets and institutions to address pertinent healthcare issues ranging from access to medicines to technologies for consumer protection. Nevertheless, changes in organizations in response to these issues may also involve superficial façades and genuine deceptions, to paraphrase Starbuck (2010). It is undeniable that persuasive apparatus to deceive stakeholders pervade organizations. Hence, before substantive changes and learning can be very effective, firms must diligently unlearn unethical practices, while learning about the changes in industry and institutions (Cohen and Levinthal, 1990; Nyström and Starbuck, 1984). This is easier and feasible via collaborative efforts with governments, NGOs and other non-business actors with knowledge of the special needs of certain market segments and contexts. High profits stem from moving away from the zero-sum traps. However, this is also dependent on partial monopolies based

Figure 2 The trajectory of transition



predominantly on location-specific advantages in neglected markets of emerging economies, sustained reputation and licenses, etc. (Starbuck, 2010). How Western pharmaceutical organizations can capture the profitable, scalable and potential markets remains a question of transition based on CR orientation (Figure 2).

First, they require a process of visioning new opportunities, i.e. "sensing", "seizing" and capturing these markets in the long term via transition into new organizational mindsets. This is what Louche *et al.* (2010) refer to as CR that moves from mere risk management to innovativeness and value creation. Such organizational changes are also performance-driven but ethically constrained.

Second, they require business model innovation which according to Casadesus-Massanell and Ricart (2011) refers to ethical preferences and consequences which comprise three main choices: asset, policy and governance choice. Such models must characteristically be integrated into the firm's goals in ways that yield expected results. They also need to be auto-reinforcing and complementary such that they promote synergy, robust enough to fend-off quick imitation by players. Additionally, they should increase bargaining power and limit firms' complacency and substitution by rivals (*ibid.*).

Third, in the same vein, Chesbrough (2010, p. 362) argues that the fundamental "role of [ethical] leadership is to ensure effective governance of business model experimentation" in emerging markets. For Doz and Kosonen (2010), strategic sensitivity to various developments requires leadership unity to make quick strategic – ethical decisions and fluid resources that are easily and readily configured and deployed to capture emerging opportunities. *Fourth*, operations in these markets are no longer going to be based on rent-seeking and exploitation. Such a shift in thinking requires strategic organizational renewal that balances the external demands of social good with firms' success (sustained growth and survival).

Fifth, incremental, spurious and radical innovations will be required to meet the new market opportunities (Dimov, 2007). As Eggers and Kaplan (2009, p. 473) conclude on cognition and renewal: "managerial cognition [influenced by ethical decisions] and organizational orientation are important factors in understanding firms' response to new technical opportunities". This is consistent with Bansal (2003) who argues that managerial values and belief systems lead the firm to certain consequences and are constrained by institutional pressures to affect CSR directions to set and identify agendas which may include performance-driven organizational renewal (Donaldson, 1999).

Summary

Constrained optimization of dynamic capabilities toward sustainable global health and CR via processes embedded in ethical preferences and social concerns are critical issues which have now become major priorities in the pharmaceutical industry. The ethical posture of the manager is crucial in strategic decision-making for the optimization of dynamic capabilities in the light of markets and institutions.

This paper bridges the neo-institutional theory with the dynamic capabilities perspective through a meaningful analysis which can be applied in empirical work. With great caution, this is not to suggest that existing theories are being rendered redundant. They are rather being reinvigorated in fresh global discourses to give them practical relevance (Peng and Pleggenkuhle-Miles, 2009). The essence here is not the pursuit of generalizations but applicability and relevance in the context of pharmaceutical industry and emerging economies. It is argued that an organization's resource endowment and pursuance of dynamic capabilities *per se* would not translate into higher performance and greater wealth creation, relative to competitors (Ambrosini and Bowman, 2009; Augier and Teece, 2008). Rather, when managerial entrepreneurs search for opportunities with the willingness to take risks, considering the ethical demands in their reconfiguration of resources, they stand a greater chance of achieving success in this era where society puts a premium on social innovations that answer health and environmental questions (Louche *et al.*, 2010). The managerial implications concern the applicability of the notion that if the development of dynamic capabilities is embedded in ethically shaped rational technologies, firms can successfully adapt to the environment by way of legitimization and institutional recognition which represents value for both the organization and its constituents.

Beyond the insightful contributions of Teece *et al.* (1997) and Eisenhardt and Martin (2000), the uniqueness of the present analysis is the focus on the institutional environment and the ethical posture of decision-makers with political power. These two factors influence and shape dynamic capabilities orientation. This is missing in the extant analysis. The model presented here is not perfect, that notwithstanding, it is an attempt to grasp the organization – society interface and the central role of an ethical manager. The process of *meta*-theoretical analysis encourages pragmatism and reduces parochialism in theoretical analysis. For the pharmaceutical MNCs, striking a balance between the instrumental logic and sustainable practices in low-income countries is complex but not impossible. It will require strategic organizational renewal in all functional areas and the yet-to-be-established subsidiaries must certainly adapt to the new environment.

Conclusions and suggestions for future research

The present study makes theoretical, technical and managerial or policy-based contributions. It sought to analyze the "evolution by design" of pharmaceutical firms through dynamic capabilities and strategic renewal to adequately and innovatively respond to critical health needs in emerging economies. It has been argued that ethics constrain the central role of entrepreneurial managers' decisions on adaptation to the dynamic environment. Therefore, the simultaneous pursuit of efficiency and ethical preferences is possible, irrespective of the institutional matrix within which change occurs. Thus, pharmaceutical firms and their environments are both reciprocally influenced (March, 2006).

Three important conclusions emerged from the *meta*-analysis. *First*, to suggest that the health problems of emerging economies are emergent is simply inexact because they have always been there, but only met with a general pattern of indifference from the pharmaceutical industry over the past decades. Where there was any action, it was sporadic, controversial, here and there, when firms could. The motives are still understudied. But the novelties reported in the empirical illustration tend to suggest that the global forces (e.g. institutional dynamics, sustainable capitalism, innovation and

stakeholder pressure) are pushing firms to engage in strategic CR through transition. *Second*, the study explains how firms transition from old governance models to the new ones. Pharmaceutical markets in advanced economies are now getting saturated but new market frontiers are opening up in emerging economies at a fast pace (Mackey and Liang, 2012). Pharmaceutical firms' long-term success depends, to a large extent, on how they optimize their dynamic capabilities to capture such new opportunities without sacrificing socio-ethical and new institutional expectations. It is inferred that strategic ethical leadership fused into managerial entrepreneurship in an innovative organizational culture within an enabling institutional context allows new advancement in organizational renewal and contextually relevant value propositions. The effectuation and reconfiguration of firms' internal resources to meet the emergent techno-scientific, market and institutional demands allows for engineering and product redesign at lower social and functional costs while achieving higher positive externalities. When this becomes the core of management thinking, it creates differentiation that leads to a competitive advantage and legitimacy. *Third*, it is clearly illustrated in the examples that this area of inquiry and practice does not only change society and the business landscape but also, most importantly, puts the entrepreneurial manager at the crux of the discourse of change.

On the macro-sociological level, questions of legitimacy and legal constraints are solved when firms bend no rules, while the rate of dynamic capabilities' optimization increases a firm's success and adaptation as a self-sustained and competitive entity *vis-à-vis* rivals its dynamic environment. It follows that the institutionalization of ethical obligations toward sustainability reflects the current world order of a popular culture that demands ethical actions from organizations albeit the presence of institutional structures that are the main determinants of the extent to which organizations respond to such an order. That notwithstanding, organizational actions that are not compatible with the changing global health needs will hardly create value for the firm and a society as a whole, thereby inhibiting the firm's long-term sustainable competitive advantage.

This represents the *gestalt* shift in existing theories and their managerial implications and relevance. While the neo-institutional theory seems to be a good explanatory guide, it faces a bigger dilemma where corporations seem to be even more powerful than certain countries where they operate. There is the need for comparative institutional analysis that allows for theorizing under what conditions firms operate sustainably in countries where institutions are weaker but markets abound. Future research will be directed toward this perspective. Campbell (2007) does not explain to what extent the presence of NGOs influences a firm's actions. It is conjectured that the presence of stakeholders and NGOs *per se* does not translate into a formidable force or urgency to coerce organizational change. The greater the power of NGOs' constellations is, the greater their influences are. However, that influence is empowered by their organizational authority to pull fragmented groups together to garner more institutional power and support. Future research may also look into how external pressure in emerging economies affects organizational change.

Jackson and Apostolakou (2010) and Hall and Soskice (2001) posit that variations in national institutional environments affect the strategic coordination of firms. The capitalist systems are put into two groups of unique models of market actors:

1. liberal market economies in the Anglo-Saxon economies; and
2. coordinated market economies in the continental Europe.

Considerations about emerging economies are either taken for granted or their former colonizers' economic systems are used as a proxy to analyze such markets. Nevertheless, most emerging economies operate under completely different socio-political and economic conditions.

As Mangham (2003) maintains, unregulated capitalism produces a different ethical climate from regulated capitalism in that, managerial values-based decisions are irreducibly social

and never idiosyncratic. It is proposed that a comparative institutional analysis of organization-stakeholder relations and what motivates certain forms of innovations in emerging economies will provide empirical exposures about how well we understand these contexts. Here, the transaction – cost economics perspective will help explain governance choices and actions of organizations under conditions of operational uncertainty. This is because, hitherto, the concept has been applied to advanced countries with stable market and institutional conditions which makes contractual choices feasible (Hoskisson *et al.*, 2000). Future studies which direct attention toward emerging economies will represent both a practical and theoretical shift toward a new form of investigation, in the light of current global health problems that demand techno-scientific solutions. Further, an understanding of the goals pursued by the Chief Executive Officers (CEOs) of pharmaceutical firms will be a viable research area.

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About the author

Frederick Ahen is a Doctoral Researcher at the University of Turku, Finland. Frederick holds an MSc in International Business from the London South Bank University and a BSc in Economics and International Business from the Università Politecnica delle Marche, Italy. Frederick's research interests are at the interface of strategic corporate responsibility of pharmaceutical MNCs and institutional change in emerging economies. Frederick Ahen can be contacted at: Frederick.Ahen@utu.fi

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ORGANIZED ANARCHIES: MANAGING MULTIPLE LOGICS IN PUBLIC HEALTH CROSS-SECTOR SOCIAL INTERACTIONS

ABSTRACT

Breakdown in institutional orders produces undesirable outcomes. Even in the same field, conflicting institutional logics produce anarchy. Nevertheless, articulating conflicting institutional logics is complex due to their taken-for-granted nature and fragmented decision locations. This study theorizes the management of institutional complexity in and across organizations in the context of anti-counterfeiting cross-sector social interactions (CSSIs). It is argued that the performance outcomes of CSSIs are a reflection of how the complexity of the institutional logics is managed. The conclusions suggest that complexity in CSSIs leads to organized anarchy, which in turn erodes the efficiency and synergy gains possible from CSSIs. This is akin to deliberate value destruction since such conditions make CSSI a self-defeating concept and hence counterproductive. The ineffectiveness of CSSIs derives from the chaotic nature of organizing them, a product of institutional voids as well as institutional incoherence, misfit and disorientation that run parallel to well-functioning institutions in the same context. CSSIs do not change institutional logics but the emerging mutations in institutional logics at the micro level may help advance and facilitate the agendas of selected 'pockets of excellence' who act as agents of change.

Keywords: Counterfeit pharmaceuticals, cross-sector social interactions, institutional logics, patient safety.

INTRODUCTION

How do multiple institutional logics increase complexity and account for the ineffectiveness in cross-sector social interactions (CSSIs)? This is the research question that this study seeks to answer. A nascent form of governance structure for addressing the most intractable socio-economic problems is CSSIs (Austin, 2010; Parker & Selsky, 2004). This is also referred to as inter-sectorial partnerships or cross-sector alliances (Rondinelli & London, 2003). Notwithstanding the potential of such organizational forms to create access to new value—for example knowledge and resources (Austin, 2010) and innovation (Austin, Gutierrez, Ogliastri & Reficco, 2007; Kivleniece & Quelin, 2012)—and to achieve objectives that may not easily be achieved by one organization, CSSIs are not without complexity. They are deeply entrenched in institutional pluralism (Dunn & Jones, 2010; Pache & Santos, 2010) across geographical boundaries and sector-specific logics, for example non-governmental organization (NGO) and government collaboration (Rivera-Santos, Rufín, & Kolk, 2012). The cross-fertilization of diverse logics may, however, result in dysfunction and disorientation of CSSIs if not carefully coordinated.

Globally, the pharmaceutical industry in particular and the healthcare sector in general are characterized by an environment which has often been described by experts as extremely sensitive, complex and hyper-turbulent (Rod & Paliwoda, 2003; Rotarius & Liberman, 2000). National and regional healthcare policymakers struggle with the pharmaceutical industry's radical evolutionary nature in terms of spending, technologies, competition and the sheer variety of stakeholder needs. One of the formidable dimensions of this turbulence is counterfeit and substandard drugs. Pharmaceutical counterfeiting is a threatening global challenge of a complex techno-scientific, public health policy and regulatory nature (Cohen, Mrazek & Hawkins,

2007; Newton, Green & Fernández, 2010; Satchwell, 2004; Sodzi-Tettey, 2011). Its far-reaching implications cannot be overemphasized. The need to aggregate resources and approaches from a variety of partners with a stake in this problem domain is self-evident. Such collaborative efforts already exist in their multiplicity as the new strategies of engagement that offer value propositions to society by solving 'wicked problems' (Austin, 2010; Seitanidi & Crane, 2009) through the provision of public health goods. This means consumer protection ceases to be the sole responsibility of governments, businesses or civil society organizations (CSOs).

The complexity in assessing the sustained success and the full impact of CSSIs in the fight against counterfeit and substandard pharmaceuticals can be explained through several empirical realities. These include the 'national–global' nature of CSSIs, the divergence of partners' strategic intents and social goals, power asymmetry (Lister, 2000; Reed & Reed, 2009), resource constraints and political will. The *national–global nature* refers to the globalized landscape of the healthcare sector in terms of interdependence and interconnectedness, based on transnational arrangements through the harnessing of global resources and expertise to combat the threatening phenomenon of counterfeit medicines locally. Furthermore, the distinct expectations of the diverse partners (Austin, 2010) and the multiple institutional logics (worldviews including: values, norms, taboos, religiosity and cultural views towards potentially unsafe drugs) within which such partnerships evolve play a major role (Barley & Tolbert, 1997; Powell & DiMaggio, 1991; Rein & Stott, 2009; Scott, 2001; Selsky & Parker, 2005; Thornton & Ocasio, 1999, 2008; and more recently Vurro, Dacin & Perrini, 2010). The extent to which institutional logics affect the formal institutional structures (North, 1990), nonetheless, remains virgin territory in the extant literature.

It is argued that the outcomes of CSSIs are a reflection of the maturity and dynamism of the institutional matrix within which they are embedded. Following March (2006, p. 204), a multi-actor choice and strategic interaction towards consumer protection orientation is explained as "*when outcomes and choices* [of one organization] *are dependent on the choices of other organizations whose outcomes and choices are, in turn, simultaneously dependent on the first organization*". Since different organizations and actors have diverging interests and preferences, aggregating such differences into a coherent whole demands some trade-offs which are difficult to realize due to the plurality of institutional logics. This adds to the complexity of the CSSIs in the light of the theory of multi-actor choice (Arrow, 1951; March, 2006). Thus, the nature of collaborative efforts varies across sectors and problem domains but becomes even more complex when it is about how to implement common strategies, monitor their development, and control various complementary initiatives aimed at sharing a common purpose (Austin, 2000) and co-creating institutional social capital (Austin et al., 2007) and economic value (Austin, 2010) on a national or global scale. All these efforts are geared towards the quest to combat a phenomenon whose magnitude transcends the capabilities and resource base of single sectors. Therefore, fighting counterfeit pharmaceuticals typifies a complex and persistent social problem with public policy implications that requires the voluntary and mutual aggregation of efforts and organizational approaches by two or more cross-sector collaborative social partners (Austin, 2000; Selsky & Parker, 2005; Waddock, 1991).

The phenomenon of pharmaceutical counterfeiting

Global pharmaceutical counterfeiting business is now a hundred times greater than it was twenty-five years ago. It is the most lucrative criminal business since the risk of getting caught is so small (Tim Phillips, in a recent documentary '*Counterfeit Culture'*, 2013). Counterfeit medicines are *"deliberately and fraudulently mislabeled with respect to identity and/or source. Counterfeiting can apply to branded and generic products. Counterfeits may include products with correct or incorrect ingredients, without active ingredients, with insufficient active ingredient, or with fake packaging"* (WHO, 1999). On the contrary, substandard drugs are *"pharmaceutical products that fail to meet either their quality standards and specifications, or both"* (WHO, 2010). The negative impacts of counterfeit medicines on patients are vast; they include increased drug resistance as well as high morbidity and mortality rates. Counterfeiting essentially undermines institutions and threatens global peace since criminals can rechannel their profits into terrorism. Further, the counterfeits lead to a loss of efficacy of medicines and eventually, the loss of confidence in healthcare systems and clinicians. In general, counterfeiting causes financial losses to families and healthcare sector and at the business level it infringes on the intellectual property of legitimate manufacturers. This means that all the financial resources committed into R&D of new therapeutic and prophylactic treatments, optimizing existing dosage, conducting clinical trials, manufacturing medicines and introducing new regulatory measures become a waste (Newton, Green & Fernández, 2010).

Purpose of the study

This study seeks to theorize the management of complexity in and across organizations in the context of anti-counterfeiting CSSIs. I explore the causes and effects of organizational complexity in the context of national–global CSSIs and how outcome-oriented practices (value creation through consumer protection) within the boundaries of CSSIs are fundamentally shaped by conflicting institutional logics. The overarching purpose of this paper, therefore, is to explain how particular empirical variables within the institutional logics increase complexity and account for the ineffectiveness in anti-counterfeiting CSSI initiatives in emerging economies. There is currently no known systematic study about institutional breakdowns and how deep conflicting institutional logics are entrenched in the context of anti-counterfeiting CSSIs in emerging economies. This is an important novel feature of the study.

An empirical field study seems to be the logical pathway to shed light on this unclear scenario by theorizing the management of institutional complexity in and across organizations in the context of anti-counterfeiting CSSIs. By exploiting the tensions that emerge from diverging institutional logics, this inductive theory building exercise, through a qualitative approach (Bansal & Corley, 2012), seeks to create interest, inspiration and potentially increase our understanding of a scantly studied phenomenon in an unconventional context (Ghana) with global linkages (Siggelkow, 2007; Yin, 2009). This gap matters because it connects theory with reality. *"If theory talks only to theory, the collective research exercise runs the danger of becoming entirely self-referential and out-of-touch with reality, of coming to be considered irrelevant"* (Siggelkow, 2007, p. 23).

The results provide an explanation for the link between CSSIs' ineffectiveness and the breakdown of the institutional order. The study provides insights that are of technical content with applicability in the real world to improve the efficacy of consumer protection interventions and to fuel fundamental changes in CSSIs' internal culture and external rapport with partners, especially in the institutions of emerg-

ing economies. This study makes three major contributions: (a) it explains how the complexities of CSSIs are caused by the divergence of institutional logics; (b) it reveals how the lack of credible information flow between organizational leaders creates poor coordination and undesirable outcomes due to goal ambiguities and idiosyncratic solutions; (c) it provides a theoretical framework for understanding how the complexity of anti-counterfeiting CSSIs leads to organized anarchies and the problem of attribution of responsibility.

THEORETICAL PERSPECTIVES

This issue-oriented study involves a multi-actor process with conflicting interests and goals. It is therefore possible to employ different theoretical lenses to fully enrich the study. For example, the stakeholder theory would be a useful theoretical framework since it explains how individuals and groups affect and are affected by the firm or the organization (Freeman, 1984). Also, stakeholders are both the risk-bearers and the beneficiaries of organizational actions (Donaldson & Preston, 1995; Freeman, 1984; Post, Preston & Sachs 2002). In fact, network analysis (Håkansson & Snehota, 2006), which looks at how actors commit resources and activitities to perform future actions, could also be a useful theoretical model for explaining issues of trust, commitment and conflict. The concept of co-opetition (Afuah, 2000), where actors compete and cooperate simultaneously, as well as alliance literatures (Das, 2012; Rondinelli & London, 2003) address similar themes of conflict and differing perspectives among various parties. While the above theoretical options remain useful, institutional logics provides a much deeper understanding of the motives and socio-cultural antecedents of actors' actions in CSSIs for creating value (Austin, 2010; Kivleniece & Quelin, 2012). These motives and world views (institutional logics) have received scant attention in the studies of CSSIs. Within the CSSIs, government agencies, supranational organizations such as the World Health Organization (WHO) and INTERPOL, the private sector and other health-oriented NGOs engage in some form of co-opetition that generates conflicts due to their diverging interests and understanding of the same issue.

Theoretical positioning

For Jackall (1988: 112) institutional logic is:

> *the complicated, experientially constructed, and thereby contingent set of rules, premiums and sanctions that men and women in particular contexts create and recreate in such a way that their behaviour and accompanying perspective are to some extent regularized and predictable. Put succinctly, an institutional logic is the way a particular social world works.*

Furthermore, institutional logics are defined as *"cultural beliefs and rules that shape the cognitions and behaviors of actors"* (Dunn & Jones, 2010: 114). Thus, the concept implies that values, norms, and belief systems structure the cognitions of varieties of social and economic agents by providing a collective understanding and guidelines of how problems are seen and solutions enacted (DiMaggio, 1997; Orlitzky, 2011; Scott, 2001). Following Friedland and Alford (1991), institutional logics provides a framework of theories and a conceptual basis for understanding why and how individual and collective actors become the outcome of interrelated systems of

socio-cultural and normative elements. These elements then become the platform for worldviews/belief systems that defines how agents operate and cooperate and the rationalization behind that. Different settings of institutional order crystallize into the unique settings of institutional foundations that stimulate the cognition of actors and their reasoning as well as how rationality and emotions are experienced and expressed in response to the environment. That is, socio-economic, cultural and formal institutional structures play a major role in how actors seek to confront the problem of counterfeits. Different geographical and socio-economic clusters, countries, and regions offer opportunities for the examination of diversities of both organisations and individuals. What has received scant attention is that when these sectors interact with each other, moral values and the prevailing institutional order affect analytical and methodical decision making (Jackall, 1988).

Vurro et al. (2010) refer to the dominant content of institutional logics as ***institutional orientation***, and the diverse institutional logics which compete in a particular context as ***institutional coherence***. For our purpose, policy-based approaches to solving the problem of pharmaceutical counterfeits seem to be the dominant logic since the role of business is minimal in the institutional setting under consideration (Ghana). Institutional coherence also refers to the extent to which the institutional logics provide adequate guidance to the behavior of actors. The higher the coherence is, the higher the convergence among the actors. This points toward a high degree of stability, common direction, and limited conflicts. On the other hand, a low level of coherence or fragmented positions among CSSI actors represents a lack of consensus and continuous friction.

By contrast, building on Vurro et al. (2010), a reversed configuration of the institutional logics based on a theoretical model of institutional coherence and institutional orientation is proposed for further analysis. I operationalize ***institutional incoherence*** as the empirical condition whereby the institutional logics lack proper guidance, leading to disorganized CSSIs and minimal stability, order and direction. ***Institutional misfit*** on the other hand refers to the empirical condition within and among organizations whereby powerful multilateral organizations or influential local organizations propose strategies and transfer policies which fail to work due to the imported first best approaches. These approaches do not take into consideration the significant heterogeneity of the institutional logics of the context where the policies are enacted.

As Austin (2010, p. 13) argues, with a paradox:

> *The differences across sectors constitute both obstacles and advantages to collaboration. The partnering challenge is to overcome the former and leverage the latter. Among the barriers are differences in missions and strategies, values and cultures* [questions of sociological misfit], *capacities and resources, organizational and governance structures, and decision making and administrative processes* [questions of strategic misfit].

In essence, strategic and sociological misfit together configure into institutional misfit. Moreover, for Pache and Santos (2010, p. 457) "'*conflicting institutional demands' then refers to antagonisms in the organizational arrangements required by institutional referents*". When several uncoordinated organizations are embedded in opposing or diverging logics about the goal orientation in terms of what is legitimate

or best practice, the possibility of competing logics increases (Pache & Santos, 2010). This type of non-intersecting logics is what I refer to as ***parallel institutions***.

Institutional disorientation means that the dominant content of the institutional logics misleads the CSSIs in such a way that the desired results cannot be achieved, nor are they measurable given the prevalence of idiosyncrasies among several organizations acting in the same field. All these lead to the disorientation of institutional responsibilities: that is, when the direction and scope of CSSIs' strategies, policies and political will in allocating resources move in diverse directions due to the lack of structured communication and coordination on one hand and differing perceptions about the same object of purpose on the other. For example, when the objective of a multinational company (MNC) is to protect its intellectual property rights, other partners (e.g. NGOs) may erroneously view the partnership as solely, purposefully for consumer protection. This was my observation during the field study. This can be explained not only by the poor communication of the agenda among the partners but also the worldviews which shape how they see the gravity of the counterfeit phenomenon.

There seems to be a fine line between these four configurations of institutional logics (institutional incoherence, misfit and disorientation and parallel institutions) within the context of anti-counterfeiting CSSIs in Ghana. They are differentiable but they are not mutually exclusive; in some cases they even overlap. The nature of this complexity of organizing makes anti-counterfeiting CSSIs akin to configurations of ***organized anarchies***. Thus, different organizations represent social groups which strive towards adaptation and survival within fast-changing institutional circumstances by instilling values, novel ideas and acceptable standard procedures within the limits of the rules of the game in daily routines in order to fit in (Scott, 1987). Cohen, March, and Olsen (1972) advance the view that organizations are in part organized anarchies with the following major characteristics: (a) 'problematic preferences', or operation under inconsistent and ill-defined preferences; (b) vague technologies, operating under heuristics in order to survive; and (c) fluid participation, which connotes the varying degrees of commitment of members over time and within uncertain and unspecified boundaries. Building on the above, Cohen et al. (1972) postulate that two additional points merit further analysis: (a) organizational choice, or when organizations lack consistency and shared objectives because the decision-making processes are fraught with 'goal ambiguities', leading to interventions that lack clear bargaining models or general consensus; and (b) varying preferences and degrees of commitment that are constrained by the increasing pressure created by conflicting institutional logics in the organizations.

EMPIRICAL MATERIAL AND METHOD

This study follows the naturalistic tradition of interpretive research (Denzin & Lincoln, 1994). The interpretive research captures meaning, social processes and real-life interactions in their complexity (Gephart, 2004). Thus, I conducted a field study of organizations that are concerned with consumer protection (patient safety), focusing primarily on their interconnectedness with global healthcare institutions. The approach was motivated by the fact that a field study is holistic in nature and is feasible in answering 'how' questions in a real-life context, especially when the boundary between the phenomenon and its national–global nature are not definitively evident (Yin, 2009). It is also an excellent strategy for studying a relatively little known contemporary phenomenon over time as it captures both the meso (organizational)

and macro aspects of the case in depth, in a way that would be difficult in a quantitative study (Eisenhardt, 1991; Yin, 2009).

Data were sourced principally from observations, documents (unpublished and published information, press reviews and other sources of data) and semi-structured interviews. The interviews were the main approach to acquiring data from three principal entities in the empirical setting of Ghana: (a) CEOs and functional managers of a local pharmaceutical firm; (b) health policymakers from the Ministry of Health (MoH) and the WHO; and (c) experts from the Pharmacy Council, the Pharmaceutical Society of Ghana (PSGH), Ghana Statistical Service, the Food and Drugs Authority (FDA-GH), INTERPOL, academia, the Customs Excise and Preventive Service (CEPS) and the Ghana Standards Authority. In addition, academics and experts from industry and policy-making bodies were interviewed in Europe and the USA. The semi-structured questions used in the interviews were aimed at establishing the enabling and inhibiting institutional logics and how they render CSSIs effective or ineffective, respectively. For more detailed background information about the interviewees and the questions asked, see Appendices A and B. For the sake of robust data triangulation, the websites of these organizations were also consulted for data acquisition.

Following the desk research in 2009, the field study began in March 2010 and after changes were made to the research protocol, follow-up data collections were conducted in August 2011, January–February and November 2012. Overall, 49 in-depth semi-structured interviews (ranging from ca. 5 to 110 minutes) were conducted between May 2009 and November 2012. The process ended when there was obvious data saturation. Due to the sensitivity of the issues I was not allowed to tape-record during most interviews. For the same reason all the interviewees will remain anonymous. Note-taking was the main mechanism for assembling the interview data.

Data analyses were conducted immediately after each data collection to ensure that the work is divided into manageable parts. The (series of) analyses were conducted taking into account context, nuances and the cues with which I interpretively made sense of the discourses used by experts in interviews and in archival data. This was the process of searching for 'better stories and not better constructs' to make a rigorous case (Dyer & Wilkins, 1991) that makes analytic generalizations possible (Firestone, 1993). Data transcription was not done word for word; instead only the relevant discourses that answered the research questions were used through pattern matching and the relationships between the constructs. Thus, there was no intention to reproduce all the exact words of the interviewees but to present some excerpts from the field notes of my understanding on what they said and, when necessary, clarifications were sought. A discursive construction of the nature of actors and their roles was the main unit of analysis.

First, I analyzed different actors in CSSIs as explained by experts. Second, I made use of archival data in the form of articles and unpublished official documents by analyzing how competing ideas and motives are interpreted by a variety of experts. The process of analysis included the coding, thematizing and grouping of converging themes to allow for a coherent interpretation. I analyzed the responses of public officials about how they work by drawing cues from their understanding of the institutional complexity; that is, complications arising out of their cooperation with the other actors. These complications are not simple but various layers of variables including socio-cultural and technical patterns. This is important in contexts where formally-structured organizational systems have minimal impact whilst an informal way of operating prevails. Borrowing from Friedland and Alford (1991) and

March and Olsen (1989) the institutional logics approach to this analysis defines the role of contingent sets of normative systems which serve as traffic rules of engagement by which individuals and organizations operate in their quest for appropriateness in their conduct. The final part of the process was to incorporate the conceptual, theoretical and analytical frameworks. This helped to maintain a chain of evidence based on which final conclusions were drawn.

FINDINGS

Dimensions of institutional logics in anti-counterfeiting CSSIs

To understand the diverse dimensions of the institutional logics and organized anarchies in the anti-counterfeiting CSSIs in Ghana, excerpts from interviews and other forms of data were thematized and codified as shown in Table 1.

Table 1. Codification and conceptual framework of institutional logics

Dimensions of institutional logics and organized anarchies	Code for high institutional dimensions	Code for low institutional dimensions	Evaluation/measurement mechanism
Institutional misfit	HIM	LIM	Measured by mismatches in policies, strategies and operational guidelines (between imported and local institutional logics or divergence in local institutional logics).
Institutional incoherence	HII	LII	Measured by misunderstood communication and lack of consistency in operational direction.
Parallel institutional orders	extPIO	indPIO	Measured by degree of fragmentation of approaches in the public health field or non-intersecting value orientations between policymakers and orthodox and traditional practitioners.
Institutional disorientation	HID	LID	Measured by misleading nature of the dominant institutional logic, prevalence in idiosyncrasies, and lack of coordination, guidance and stability.

extPIO: extreme parallel institutional orders or non-intersecting logics; HID: high institutional disorientation; HII: high institutional incoherence; HIM: high institutional misfit; indPIO: neutral/indifferent parallel institutional orders or non-intersecting logics; LID: low institutional disorientation; LII: low institutional incoherence; LIM: low institutional misfit.

Examples of the institutional misfit, incoherence, parallel institutional orders and institutional disorientation, reflected in various data sources across diverse sectors, are presented in Table 2.

Table 2. Expert perceptions about dimensions of organized anarchies within the structures of anti-counterfeit collaborations

Data sources and type of organization	Role in public health and anti-counterfeiting interventions	Data sample
National enforcement and regulatory agencies		
Focus group at FDA-GH	Monitoring and controlling the importation/exportation, manufacturing, distribution and sales of both orthodox and herbal/alternative medicines within Ghana's territorial jurisdiction.	*"They [consumers] think everything from outside is better so they patronize imported goods. Poverty and ignorance has a big role in this. I think education is the key." (HIM)* Obs: Too many traders and business people do not understand the FDA-GH's role. There is a general atmosphere of frustration at FDA-GH about the resistance posed by manufacturers and sellers, the lack of human/technological resources, and the lack of policing powers in the discharge of their duties. *(extPIO)*
Customs	Conducting agency duties for MoH, ensuring that standards are met, control and confiscation of smuggled products.	*"We conduct regular workshops and training sessions with companies to acquire in-depth understanding of tricky product identification. We have collaborations with INTERPOL, copyright holders and intergovernmental organizations". (LII)* Obs: There is a greater concentration on the collection of revenues and import duties than there is on consumer safety as a reason for controlling incoming goods. *(HIM/HID)*
Ministry of Health: National Procurement and Health Policy experts, traditional and alternative medicines experts	Procurement division: Responsible for purchasing and dispensing drugs to government hospitals.	*"Nowadays, manufacturers are creating alliances with NGOs...but emotional attachments make somebody a real watchdog...otherwise it is difficult to track and trace, get feedback from stakeholders and heighten awareness about potential risks." (HII)* *"In our area of traditional medicines reporting is a weakness. Adulteration by unscrupulous individuals escapes quality assurance." (HIM)* *"The lack of unity and strong collaboration is a missed opportunity...Nobody can go it alone." (extPIO)* Obs: There are several documents of well laid out plans but they lack a specific time schedule and indication of sources of finances for the execution of projects. Such an important sector is receiving too little support from the government. *(HID)*

Ministry of Health: Traditional Medicines Practice Council (TMPC)	*"We promote, control, and regulate traditional medicines practice."*	*"We have several practitioner associations but they are self-regulating due to their number. We do not know with certainty how effective this can be. We can only assume that they do things right." (HII)* *"We lack strong support and collective responsibility…We have inadequate resources, and no global partners yet…We lack data management systems about indigenous practitioners…There is a need for patient-practitioner relation." (HIM)* Obs: What brings conflict, who goes to whom for support? TMPC is unstructured and still in the pipeline. It is difficult to understand how they perform, let alone to understand, how they measure outcomes. It needs substantial work to be called a proper organization. *(HID)*
Global health governance		
WHO, FDA		Obs: They seek to "universalize their values" but local understanding of the counterfeit problem differs significantly from global organizations. Reconciliation will require more dialogue but that is impossible without equal footing in power politics. *(HID)*
National regulation of practice, academia, professional bodies		
Pharmacy Council	Policy making, regulation of practice, consumer protection, education.	*"You know the biggest problem is that we hear each other but we are not understood by one another." (HII)* *"We do not know the extent of the counterfeit problem. There are all kinds of statistics flying everywhere. So we don't see the problem with the same sense of urgency." (extPIO)* Obs: Professional pharmacists understand the economics of counterfeits much better than policymakers and law enforcement agents. *(HID)*
Academia	Responsible for training/educating pharmacists/ physicians/etc. on their role in civil society, concerned for patient safety in general.	*"Only a few studies have been done about the counterfeit situation but they use non-uniform methodologies. This means they are all not reflective of the nations' situation…The counterfeit sector is not properly regulated just like the informal sector". (HII)* Obs: There is deeper understanding and strong concern about non-evidence based drugs in circulation but these are only confined to areas of practice and have little to do with policy and regulation. *(HID)*

Pharmaceutical society of Ghana	Professional body	*"Contrary to popular perception, as for counterfeit and fake drugs, anybody can be a victim; it is not only the illiterate rural communities. Of course they are more vulnerable; farmers and chemical sellers there have no idea about packaging, dates of manufacture, etc. You are empowered to ask if you are educated to ask. Consumers need to exercise their rights but how?" (HII)* *"Our frustration is too much because the authorities are too slow. Everything needs to go through the attorney general's office. The FDA-GH needs prosecutors. That will make things more efficient and effective." (HID)*
Industry		
MNC, USA	Offering customer value through life-saving drugs for patients and payers.	*"There is so much fragmentation among firms on the issue of counterfeits. There is the need to pool our resources. There is a shared recognition of the problem* [of counterfeits] *but a lack of clarity on how bad counterfeits are." (extPIO)* Obs: MNCs offer any form of collaboration as long as it serves as a CR concern and helps to protect IPRs and APIs. They are more concerned with API theft and market share lost to counterfeits. They may also be concerned about the consumer but that is not clearly evident. *(HID)*
SME, Ghana	Offering quality and safety.	*"We are focused on acquiring the WHO prequalification. The FDA-GH is responsible for cleaning the market, but we use holograms on our packaging which seem to work pretty well." (indPIO)* Obs: SMEs are more concerned about the consumer. *(LID)* *"As you can see, from the production room through analytical labs to the packaging room, we do our best here to make sure that we go beyond the set standards to protect our patients. The regulations are fragmented but we also need a united front and more control of counterfeits" (LII)*
Police, judiciary	Law enforcement	Obs: Critical in ensuring enforcement and punishments but requires a great level of accountability and a renewed understanding of the problem. The rules governing this are old and do not reflect the emerging realities. *(HID)*

API: active pharmaceutical ingredient; CEPS: Customs Excise and Preventive Service, Ghana; CR: corporate responsibility; FDA: U.S. Food and Drug Administration; FDA-GH: Food and Drugs Authority, Ghana; IPR: intellectual property right; MNC: multinational company; MoH: Ministry of Health, Ghana; NGO: non-governmental organization; Obs: observation; PSGH: Pharmaceutical Society of Ghana; SME: small and medium-sized enterprise; TMPC: Traditional Medicines Practice Council; WHO: World Health Organization.

Empirical context: Ghana as a proxy

Consistent with McCabe et al. (2009) I observed that the pharmaceutical distribution network in Ghana is chaotic and fragmented (see Figure 1 for the three main sources of drugs to the consumer). MNCs operate with agents, apart from the manufacturer/wholesalers and importer/wholesalers who must all acquire licenses from the FDA-GH. In fact, the persistence of low-income households—despite the growing middle-income status of Ghana—high drug prices, a backwards or total absence of modern healthcare infrastructure in some regions, open fraud and negligence of professional duty, and socially acceptable forms of corruption increasingly waste resources specifically allocated to consumer protection (Cohen et al., 2007). Why do counterfeits thrive on the Ghanaian market? A sample of anecdotal evidence from both experts and consumers confirms what is already known in literature. But there are surprises: lack of access to quality drugs from secured chains, ignorance of the difference between evidence-based drugs and toxic substances in beautiful packages, price and perceived quality, unethical consumption, peer pressure and self-medication, easy access to manufacturing/sales technologies and direct-to-consumer marketing. The underprivileged have limited choices and deceptive marketing by sellers and street vendors also plays a major role. Ultimately, a big supply meets a great demand.

Societal contexts have a direct impact on unethical or irresponsible behaviour (Gonin, Palazzo & Hoffrage, 2012). The prevailing institutions which promote informal businesses lead to lone-wolf production of counterfeits as a form of entrepreneurship. *"The problem is that they don't even think that producing things which are not only unapproved but also not following good manufacturing practices can lead to pernicious results"* (Vice President/US Pharmacopeial Convention). Thus, institutions promote destructive, productive or unproductive entrepreneurship (Baumol, 1996). Furthermore, the socio-cultural context of Ghana and the abundance of informal markets make tracking counterfeit data difficult.

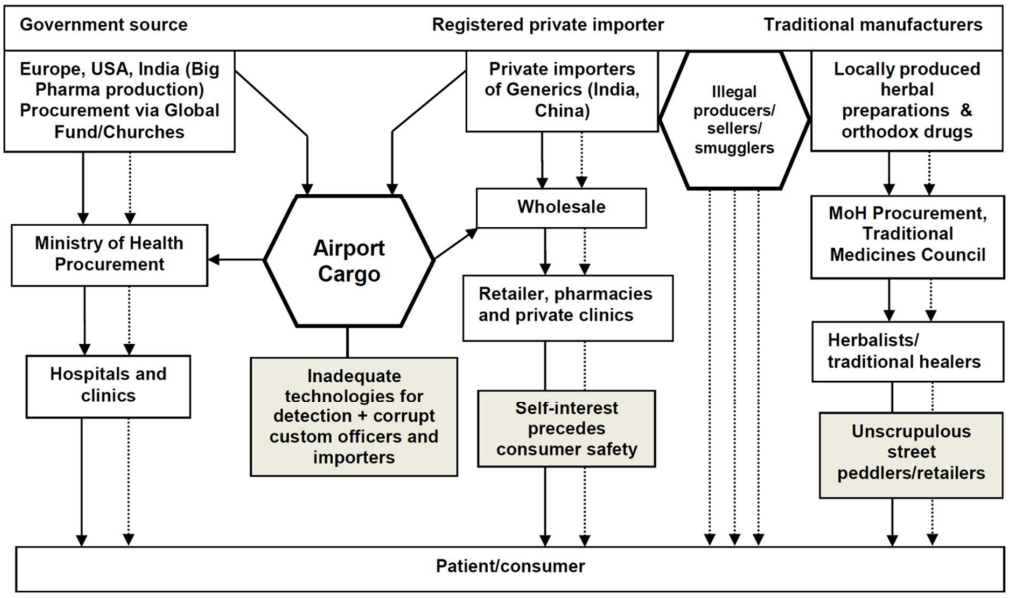

Figure 1. The main sources of approved drug routes to the consumer and several invisible/illegal sources (dashed lines). Gray boxes describe the institutional logics

under which the actors operate.

In Ghana, the CSSIs for combating counterfeits involve statutory agencies in the MoH and the FDA-GH, in collaboration with other professional organizations and supranational agencies. Other actors include Big Pharma which offers training and information about counterfeit drugs. Moreover, the U.S. Agency for International Development (USAID) through the U.S. Pharmacopeial convention (USP) offers minilabs (low-cost but high-tech field test kits) for rapid drug quality verification and detection of counterfeits; there are already over 330 minilabs in Africa (as of April 2014)[19]. Other novel technologies such as mPedigree (Simons, 2013) which tracks medicines based on text messages are also on trial in Ghana and other African countries. In 2013, USP opened a Centre for Pharmaceutical Advancement and Training in Ghana to promote access to good quality medicines.[20] Additionally, the WHO's International Medical Products Anti-Counterfeiting Taskforce (IMPACT)[21] networks with local actors in Ghana. These CSSIs represent, however, very fluid configurations since they lack institutional coherence.

The FDA-GH is Ghana's main medicines regulatory agency. A major part of its activities is to ensure the quality of food and drugs on the market to guarantee consumer safety.

> *Our main tasks include inspecting of premises, pre-licensing of manufacturers, post-market surveillance as well as monitoring the different forms of advertising of food and medical products. We strictly enforce good manufacturing practices and we have dozens of technicians in our quality testing lab* (Focus group/FDA-GH).

At regular intervals the FDA-GH sends samples to government universities for testing. This indicates a level of collaboration with the academic community. "*We have the labs here so they [FDA-GH] bring samples and they trust that we are able to give them accurate results of the tests*" (Academic-1/University) *(LIM)*. Most of these tests are conducted on high risk consignments imported into the country as well as on pre-registration samples provided by businesses and post-market surveillance (McCabe et al., 2009).

The existing regulatory infrastructure makes it difficult to control the drugs that are available on the market. "*Some are banned medicines from outside Ghana, unregistered medicines, expired medicines, and even medicines from government hospitals, ports, stolen or donated goods*" (Local Pharmacist-1). The latter two sources provide a clue about the taken-for-granted crisis of integrity and therefore are susceptible to analysis under the institutional logics (norms, work ethics, endemic but accepted corruption that is perpetuated by those with higher bargaining power in some organizations) (indPIO). For example, the Minister of Trade, Hanna Tetteh, lamenting the deplorable quality of goods (including fake and substandard pharmaceuticals) in the Ghanaian market asked, "*The big question is what are the Ghana Standards Authority and the Food and Drugs Board* [now FDA-GH] *really doing to check what comes into the country?*" (Mpare, 2012).

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[19] Global Pharmaceutical Health Fund e.V., GPHF; http://www.gphf.org/

[20] http://www.usp.org/global-health-impact-programs/center-pharmaceutical-advancement-and-training-cepat

[21] http://www.who.int/impact/en/

> *The snag is that whilst most of these* [consumer protection activities] *need to be done with other agencies, some goods slip into the country either through unapproved routes or the four main entry points by circumventing proper control and official mandatory sample testing prior to clearance* (Official-1/MoH).

This massive illegal entry of counterfeits is exacerbated by the fact that some custom officials have questionable levels of integrity and professionalism (McCabe et al., 2009) *(indPIO)*.

Evidence of complexities leading to goal ambiguities

Institutional voids and conflicting institutional logics merge to create the complexity that leads to goal ambiguities and hence, unproductive outcomes.

Lack of consensus in defining core concepts. First, there is no general consensus on the definition of counterfeit medicines, nor the act of counterfeiting. ***Data evidence:*** "*The definition of counterfeits is quite problematic: we have fake, counterfeit, spurious, or substandard drugs…So we have info wars going on here. There is a lack of transparency in communication…Regulations are not stringent either*" (Academic-2/University). "*Another fundamental problem is the definition of [counterfeit] and the recognition of this definition by different actors. We use the WHO definition*" (Expert/Pharmacy Council) *(HIM)*.

Second, there is no cross-sector consensus on who the counterfeiters are. ***Data evidence-1 (observation):*** Having spent some time in mostly informal roundtable discussions with the FDA-GH focus group, it became evident that there was ample contradiction in what they see on the ground and who the police believe are the counterfeiters. For most of the experts I interviewed, these counterfeits are operated by sophisticated ring of criminals. ***Data evidence-2:*** "*I think these are well-organized underground businesses that require immediate and robust attention before they become too powerful*" (Official-1/MoH) *(HIM)*. Nevertheless, INTERPOL believes they are mostly individual criminals with loose networks. ***Data evidence-3:*** "*I don't think they are cartels or such sophisticated organizations…normal individuals bring these drugs from neighbouring countries through unapproved routes*" (Officer/INTERPOL). Similarly, according to the representatives of the Partnership for Safe Medicines, INTERPOL and Pharmaceutical Security Institute, with whom I spoke at the Washington DC Global Interchange, criminal entrepreneurs can create born-global enterprises from their homes. It can also happen that: *"Most of these local producers are not criminals. They just don't know any better, they only do it to survive"* (Vice President/US Pharmacopeial Convention). On the other hand, it has been reported in the literature that *"the Russian Mafiya, Mexican gangs, Chinese triads and Colombian drug cartels have all moved into this form of income generation [international counterfeit drug trade], a shift that has been attributed to the pressure exerted by the American war on drugs"* (Reynolds & McKee, 2010). According to MoH and FDA-GH, cartels and sophisticated underground networks with industry connections are shifting from narcotics to pharmaceuticals due to weak legal framework. Generally, most interviews agree that it is a lucrative business for any criminal mind. For some experts, counterfeiters are cartels, for others they are lone-wolf criminals; no-one suggested both. From this it was evident that approaches to fighting counterfeiting will vary depending on the perception of the organization in question. In some cases, the political will exists but unclear motives lead to unclear

communication of intents and strategies. Such incoherence in the institutional logics creates anarchy in cross-sector collaborations.

Lack of statistical data. The lack of uniform data on counterfeit medicines influences the coherency in setting up goals within CSSIs. ***Data evidence:*** *"We do not have aggregate statistical data on counterfeit medicines. So, the various organizations cannot appreciate the magnitude of the counterfeit problem. People use different sources of data"* (Statisticians-1&2; Ghana Statistical Service) *(HID)*.

Conflicting institutional logics. The problem of a weak legal system in Ghana is very much associated with leniency and the non-punitive nature of law enforcement. ***Data evidence-1:*** A case in point is the situation where the drug inspectorate team worked tirelessly to ensure the conviction of a person caught red-handed in the sale of fake drugs. The criminal was sent to prison for just one week. Some are hardly made to pay the maximum penalty of 200 Euros, which is destructive to the consumer protection efforts of all the FDA-GH and its collaborators (Sodzi-Tettey, 2011). ***Data evidence-2:*** "*Some professional pharmacists do not go beyond rejecting suspicious drugs because they have to report to the authorities and serve as witnesses in the case: This is time consuming and there are no incentives apart from getting someone arrested who will be released after a few days anyway*". (Official/PSGH) *(HII)*. ***Data evidence-3:*** "*Studies regarding the impact of increasing the severity of sentences for criminal offences...indicate that such policies...unfortunately do not have the desired impact*" (Dervan, 2012). ***Data evidence-4:*** "*I don't believe in these laws. Laws are barriers. Make accessibility* [to drugs and commercialization] *simple. They* [governments] *crack down on licensed sellers instead of the bad guys.* [Rather], *bring the unlicensed to the main stream; they have the relationship marketing techniques to reach the people…strong laws, no, because they are hard to implement*" (Partnerships for Safe Medicines Expert, India). The CEO of the Pharmaceutical Security Institute (PSI), Thomas Kubic, has a contrasting opinion. ***Data evidence-5*****:** "*While the manufacture and sale of counterfeit products are serious crimes in any context, counterfeit medicines pose a grave public danger to public health that warrants a harsher punishment*" (Taylor, 2011).

While these two views seem to be at odds, they do not in reality depict at all what the institutional logics seem to infer. Thus, some missing text is very well implied in the larger meaning and context of the shared beliefs. The increased number of maximum statutory sentences can certainly serve as a deterrent to prospective criminals. Nevertheless, when existing criminals are hardly ever apprehended and prosecuted under existing laws, changing the law will not be a panacea since arrests and prosecutions cannot serve as a reliable measure of the CSSIs' impact *(HII/extPIO)*.

Several unsolved controversial issues, such as the above, lead to goal ambiguities among cross-sector actors. For example, the Ghana Standards Authority claims to have all the modern facilities for drug testing, which in an ideal world should stop most counterfeits from entering the country, but the evidence suggests the contrary. The same applies to customs. ***Data evidence*****:** "*Our main objective is to increase our fee collection on imports and inspecting documents but not necessarily looking for counterfeits which we assume is the responsibility of the FDA-GH*" (CEPS official/Ghana) *(HIM)*.

Different ethical views versus incentives and recognition

Furthermore, owners of pharmacies have incentives not to be strict adherents to the ethical practices that protect the consumer. The near-ubiquitous nature of counterfeits

is such that incentives may be aligned with punishment to increase the vigilance of pharmacies that are not owned by professional pharmacists. "*Almost every pharmacy has a little bit of fakes because at least 20% of the medicines on the market are from unapproved routes. They all sell fake drugs and the government needs to check them*" (Academic-3/University).

Even within the industry, an incentive to be unethical is seen by some as normal behavior that dictates the actions of some firms: "*We see firms with New Drug Applications and approved New Drug Applications that also market products without proper FDA* [the U.S. Food and Drug Administration] *approval. We also see firms who have as their primary business model marketing unapproved drugs*" (Park, 2011) *(extPIO)*.

The FDA-GH naturally collaborates with other agencies but these collaborative initiatives are loosely coordinated, their actions are sporadic and no specific agenda or specification of input within a time frame really exists. Thus, the FDA-GH is overburdened, though this is also because they receive all the praise and attention. Within the cultural understanding in Ghana, it matters very much to whom recognition is attributed. In the absence of this recognition, the inter-organizational collaborations turn into a turf war. Whoever possesses the lion's share of resources 'runs the show'. There is a general atmosphere of poor communication, that is, when actors fail to declare their intentions clearly, express their grievances, or when the full scope of partner motivations is not completely understood (Rondinelli & London, 2003; Selsky & Parker, 2005) *(HIM)*. It is always the FDA-GH that warns the public, leads the arrests of offenders, identifies non-conforming retailers and closes down unapproved manufacturers. However, few media reports make mention of the roles of the other agencies. To recognize others means to allocate resources and to use their expertise (with reward) to create shared value for and with the patient.

Ineffective coordination by design

"*I mean we don't even sit down and talk*" (Academic-2/University). "*We* [all stakeholders involved in consumer protection] *need clear and implementable goals*" (Chief Pharmacist/MoH). The developments in CSSIs, though chaotic and incoherent, are punctuated by some useful initiatives. "*There are pockets of excellence, though*", as one professor (Academic-2/University) reassures. These pockets of excellence stem from the fact that once in a while there comes an organizational leader who uses his social network to create common ground and to seek consensus on common goals and strategies. However, the magnitude of the problem makes such passionate inputs minimal in the face of the hardened criminals who keep wreaking havoc on consumers. Two major explanations can be offered to shed light on the observed organized anarchies within the anti-counterfeit CSSIs in Ghana: (a) *limited social capital*, stemming from the lack of relational bonds between organizational leaders, and most importantly social capital in grass roots organizations such as health-oriented religious NGOs (Brown & Ashman, 1996; Fukuyama, 1995); (b) *institutional disorientation*, resulting from, for example, fragmented agendas, the lack of proper coordination and synergy, overlapping proposals, and the lack of consensus in defining the purpose of initiatives.

The impact of a cross-sector collaborative initiative is mostly the aggregate of the efficient or inefficient functioning of the dominant members of organizational models. That is, within CSSIs there are always (a) focal organizations (who are the *believing missionaries* possessing both the resources and expertise to affect outcomes, e.g. FDA), (b) the strategic actors or organizations whose long-term alliances are fundamental (e.g. police, judiciary), and (c) the peripheral organizations which

partly consist of spectators, consumers, confused groups, the 'wait-and-see' or 'just-happened-to-be-there' actors, apostates who stop believing in the system, thieves, bullies, traitors and free-riders. Within these are hidden opponents and dependents, 'come-and-go' private and collective NGOs (Programme officer/Ghana Malaria Control Programme), and policymakers who do not affect the long-term but instead the seasonal outcomes depending on their budgets. By nature, they 'creatively disrupt' relational processes with their presence and leave a knowledge and resource vacuum that no organization is ready to fill immediately. The core or focal organization in this case is the FDA-GH. The strategic actors include governmental agencies such as the Ghana Standards Authority, the CEPS, and intergovernmental organizations, with the peripheral organizations being the smaller local NGOs (see Figure 2).

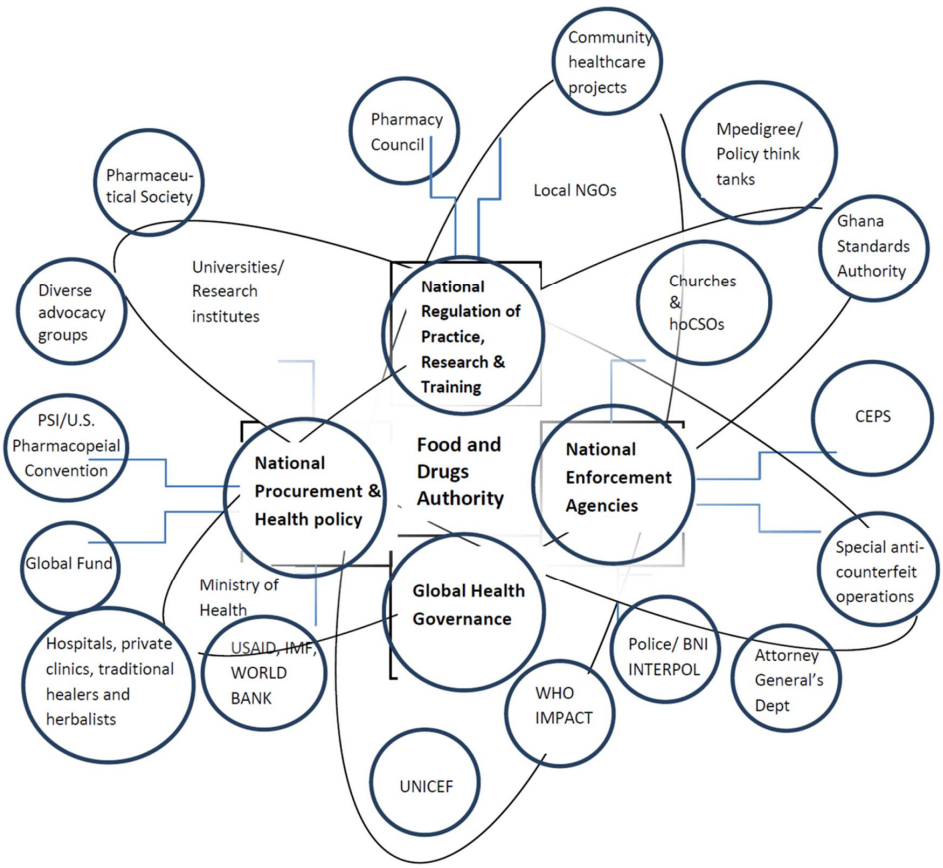

Figure 2. Organized anarchies. The structure of pharmaceutical anti-counterfeit collaborations: national–global linkages. BNI: Bureau of National Investigations, Ghana; CEPS: Customs Excise and Preventive Service, Ghana; hoCSO, health-oriented civil society organization; IMF: International Monetary Fund; PSI: Pharmaceutical Security Institute

Figure 3 represents an analytical model of institutional disorientation aimed at pinpointing explanatory variables and "*the causal relations between them*" (Schemeil, 2013, p. 22). These variables were arrived at based on qualitative data from the fieldwork obtained from interviews and empirical observations. It can then be defended as a tested model.

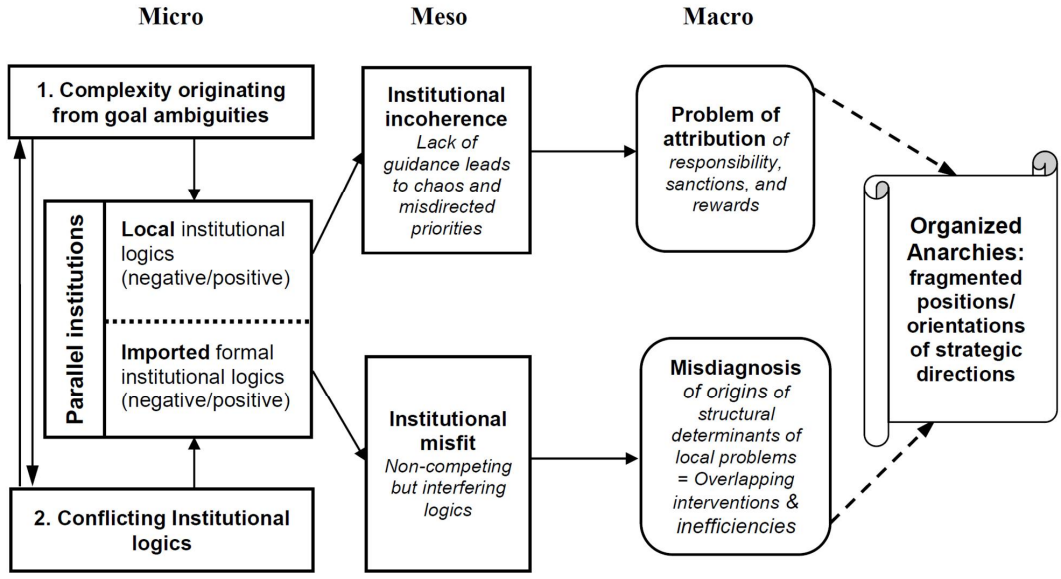

Figure 3. An analytical model of institutional disorientation. **1. Goal ambiguities**: Unclear definition of organizational position, orientation, mission, vision; incongruous institutional orders have led to the problem of attribution of responsibility. **2. Conflicting institutional logics**: External pressures, differing strategic directions and leadership styles, limited social capital also result in cooptation. **3. Micro-level:** Beliefs and background of leaders constrain decision choices. **4. Meso-level:** Rivalry, incompatible ideologies, dispersed resources. Finally, 1–4 configure into **5. Macro-level:** Organized anarchies.

The model does not mean that all imported best practices (e.g. by WHO) are negative. In fact, they are highly sophisticated, cutting-edge science-based policies. The problem is that they do not fittingly capture the nuances of local institutional logics and the structural determinants of health within the local institutions in order to produce the desired outcomes. They are mostly cure solutions rather than prevention and management. On the other hand, some local frameworks are outdated, parochial or do not adapt well to the emerging changes. Still, the alignment of the positive sides of these parallel institutional logics is undermined by the anarchy produced by differing logics.

DISCUSSION

This study sought to answer the question: *how do multiple institutional logics increase complexity and account for the ineffectiveness in CSSIs*? The study shows that

the regulatory agencies lack information on what is really happening on the ground in order to conduct effective administrative coordination—incoherent public administration and to some extent neglect of responsibility. The data basically reveals that there are many institutional voids, that is, the absence of strong regulatory frameworks and enforcement mechanisms in Ghana. It also shows that the knowledge about counterfeiting is neither evenly distributed nor equally understood. Therefore, different organizations and individuals act differently, based on their institutional logics. This means that the study finds itself theoretically at the cross-roads of old institutionalism (North, 1990) and neo-institutionalism (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Powell & DiMaggio, 1991; Thornton, Ocasio & Lounsbury, 2012).

Complex and wicked problems such as global pharmaceutical counterfeiting clearly require CSSIs for mitigating them; especially when their transcendent, extraterritorial and multidisciplinary nature requires the creative synthesis of resources, policies, technologies and combined efforts of different sectors. In theory, this seems like a panacea. Nevertheless, the following issues add to the complexity of this process: the cross-sector nature of actors, their differing philosophical foundations and institutional logics, their changing roles, the dynamism and ever-evolving nature of their interactions, positions and levels of embeddedness in the global anti-counterfeiting networks, the national global nature of initiatives and the different ways of interpreting agendas as well as the huge expectation gulf that exists between various actors in CSSIs. This results in vague problem definition, unclear agendas and immeasurable outcomes. Put together, it has been argued that institutional incoherence leads to the problem of attribution of responsibility, sanctions or rewards whereas institutional misfit leads to misdiagnosis of problems, and both lead to organized anarchies and the total ineffectiveness of CSSIs.

Surprisingly, this study finds that there is not a total collapse of pharmaceutical anti-counterfeiting CSSIs in Ghana but 'pockets of excellence' emerge to resurrect abandoned but implementable agendas and to reflect the institutional logics or worldviews of certain leaders on alternative pathways in redeeming the situation. Whereas extant literature sometimes views the possibility of a dominant logic or a compromise where there are divergent logics (Sawhney & Prandelli, 2000), this study finds that at the macro-level there is a complete absence of compromise or the strong dominance of one organization within the anti-counterfeiting CSSIs in Ghana or globally. However, there is a micro-level interaction both at the formal and informal levels between certain individuals with similar institutional logics (worldviews) in different organizations. Patient-oriented actors with similar educational backgrounds (for example the MoH, FDA-GH, the WHO, professional clinician organizations and the health-oriented NGOs) tend to think differently from the police, the judiciary, the customs and the Ghana Standard Authority. These organizational leaders who share a similar educational background (e.g. in pharmacy or medicine) circumvent the chaos by creating new innovative paths to mitigate the problem of drug counterfeits. This is what I refer to as 'pockets of excellence'. Here, irrespective of the organizational differences in logics and philosophical foundations on efficiency, equity or recognition for a singular organization, the right and safety of the patient becomes their central focus. In Ghana specifically, the FDA-GH and clinician organizations such as the PSGH and informal collaborations with colleagues at the MoH give birth to the novel agenda. This finding, however, does not fall outside the natural paradigm of expectation from these actors.

CONCLUSIONS

The study reached three conclusions. First, differences in institutional logics lead to difficulty in enacting agendas in collaborative initiatives unless there is a deliberate attempt to create a fit between the strategic and social goals of the various organizations. A consolidated CSSI is much more effective than the sum of its disintegrated parts. The complexity of such disintegrated parts consists of a web of interconnected variables such as inefficiency, ineffectiveness, institutional incoherence, misfit and disorientation. These variables culminate in two complex problems with stark implications for theory: the problem of attribution of responsibility and cooptation of smaller organizations. Without an overriding sense of responsibility and a nuanced approach in the coordination of CSSIs, institutional incoherence, misfit and disorientation will produce more anarchies and the problem of attributing recognition will emerge in cycles of irresponsibility.

Second, the question that research has not succeeded in providing explanatory evidence for is what CSSIs are not; put differently, what CSSIs do not do. CSSIs do not change institutional logics, but the emerging changes in the institutional logics (from the pockets of excellence) help advance the agendas of serious CSSIs since institutional complexity is by unconscious design.

Finally, the mismatch in the institutional logics among various organizations serves as foundations upon which the formalized institutional structures are built. The informal systems are the anchors of rationales for the establishment of legitimacy claims, the bases of order and compliance among others (Scott, 2001). Therefore, it is the informal structures that create institutional complexity leading to less desirable outcomes. Since there is an institutional void in the oversight structure of the market and anti-counterfeiting governance, it is clearly not surprising that the actors have idiosyncratic perspectives on the actions to be taken. Analyzing the complexity of CSSIs is a vigorously-contested terrain. However, where the search for effectiveness is high on the agenda, real outcomes in CSSIs are possible even when the expectations of some organizational leaders are mostly at odds with the performance and value orientations of the upper echelon of other organizations. This is a timely study about a robustly re-emerging sinister phenomenon with vast implications for understanding how institutional logics affect the management of organizational complexity. Complexity theorists have argued that organizational initiatives are likely to create the desired results if the agenda is set a priori through compromises or adaptation to the dominant logic. This is because the structural forms of organizations as 'complex adaptive systems' reflect the function of flexible organic arrangements that are ideal for surviving in complex situations. This allows them to avoid chaos (Sawhney & Prandelli, 2000, p. 32).

On the contrary, this study finds that there is an informal institutional structure that must be linked to the wider formal system to produce efficient results in partnerships, notwithstanding the complexity. To this end, questions of unpredictability lead to uncertainty, which in turn poses questions of preference ambiguity (i.e. when '*preferences of values, wants or utilities that are served by action*' [March, 2006, p. 204] are neither clear nor consistent). Nevertheless, these factors will require strategic orientation of actors towards desirable consumer protection outcomes whilst preventing value destruction by counterfeiters. This can happen through well-defined and coordinated roles in CSSIs even though they are hybrid organizations with competing interests (Pache & Santos, 2012). Deciding who to select and commit to in partnerships is the first step towards decreasing complexity in organizations in order to achieve the maximum consumer protection outcomes.

The present study has both theoretical and applied research relevance. It offers theoretical contributions on institutional logics, and managerial and policy implications for managing complexity in cross-sector interactions. The findings of the study have raised new urgent issues for policy intervention. Currently, global anti-counterfeiting initiatives in general and in Ghana in particular provide few or no logical pathways in their institutional logics towards understanding and measuring their effectiveness. Hence, innovative management systems and well-coordinated governance based on proper resource allocation and research-informed policies will help reverse the organized anarchies at the operational level.

The dominant recommendations have been to change the laws and make them more punitive and stringent or that more financial resources should be made available—but laws are not self-enforcing. The analysis of this must seriously consider the role of polity, "*since it is polity which specifies and enforces formal rules*" (North, 1994, p. 1). Nevertheless, if the political will of those with higher bargaining power in the polity is lacking, then a part of the equation for the solution is missing. For emerging economies, changing the rules will not be a silver bullet; the existing laws must be applied but more education is also required to put the consumer center stage.

Emergent themes for future research

Future research into how CSSIs could be reconfigured to consolidate varieties of resources and competencies to synergistically produce outcomes will shed light on the characteristics of well-governed CSSIs. Further, future research questions which look at the tipping points which trigger change in the informal institutional structures and their effects on CSSIs will certainly be of interest.

The incoherence of institutional logics reflects a deeper insight into the internal struggles of the anti-counterfeit CSSIs. The absence of data is an attempt to conceal the magnitude of the problem. The financial resources and human efforts in curbing counterfeits, increasing access to quality drugs and researching into new therapeutics, while contributing to some extent, have not produced the most desirable results. The next relevant questions are: One, how can organized anarchies be reversed in order for CSSIs to produce the maximum social benefits? Two, what determines the success of the CSSIs and how can such factors be measured?

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AXIS OF POWER: INSTITUTIONAL PATH DEPENDENCE OF GLOBAL HEALTH GOVERNANCE[22]

ABSTRACT

This study problematizes the structural role of the major global health actors. It explains how path dependence in the strategic political management of global health inhibits institutional change. Pharmaceutical counterfeiting is used as an investigative lens whilst historical institutionalism and discourse analysis are employed as analytical approaches based on fieldwork. The institutional path dependence of global health governance results in a five-fold paradox in emerging economies: complex formal bureaucratic structures/high institutional void; relatively stable political institutions/weak public health systems; resource abundance/high dependency; high economic growth/weak structural determinants of health; and increase in emergent non-communicable diseases/lack of political will to enact change. The path-dependent nature of global health governance makes it harder for weaker actors to actually change the institutional conditions that produce global health inequalities. The axis of power for the securitization of global health is constructed around economic influence, medico-techno-scientific innovation and geopolitical status of cartel-like super-rich actors. These strategic geopolitical commodities are centralized in the core region and dispensed in the periphery. The power of actors in global health governance lies not only in how resource owners influence others, but also in the consequences of the periphery's passivity and voluntary renunciation of sovereignty, leading to the ultimate preference for non-optimal solutions. These novel findings have implications for the management of internationalization and global harmonization of issues concerning food and health security.

Key words: global health diplomacy, global health governance, institutional change, institutional path dependence, international organizations, patient safety, pharmaceutical MNCs, power asymmetry

INTRODUCTION

'Medicine is a social science, and politics is nothing else but medicine on a large scale.' Rudolf Virchow

Institutional path dependence exists when social and economic agents with strong bargaining power, derived from the institutional framework, are incentivized to maintain their *status quo* or perpetuate the existing system whether or not it is mutually beneficial to all parties (North, 1995). Williamson's (2000) account of the path dependence of the socio-political, economic, and regulatory systems of different economies comprises a network of interrelated regulatory and social constraints. This corresponds to the institutional matrix which determines the long-term results of socio-economic and political action. An exceptional example of such path dependence is how the governance of global health by powerful actors shapes today's public health outcomes in emerging economies.

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The purpose of this contribution is to problematize the structural role of the major global health actors and to explain how power asymmetry and path-dependent patterns of global health governance inhibit institutional change. The phenomenon of global drug counterfeiting (Liang, 2008; Mackey & Liang, 2011; Shepherd, 2010) is used as a lens to study institutions by explaining the structural role of pharmaceutical multinational companies (MNCs), patient safety-oriented international non-governmental organizations (INGOs), intergovernmental organizations (IGOs), and host/home governments. From the historical institutional perspective (Steinmo, 2008), the study delineates how the role of these global health actors impacts outcomes when the actors interact at the national–global level. This paper addresses the following question:

How do path dependence and power asymmetry in strategic political management of global health inhibit institutional change?

Here, *change* refers to beneficial transformations in the fundamental institutional underpinnings of global health governance that reduce structural inequalities at cross-sectorial levels: (a) value for the consumer/patient in the form of improved rights to health, access to medicines, and protection against counterfeit medicines; (b) legitimacy for the firm as a social 'licence to operate' responsibly and protection of intellectual property rights; (c) institutional responsibility of governments in providing health as a public good – the *raison d'être* of a government; and (d) the role of INGOs/global governors in changing the rules of global health for patient protection at the helm of world polity (Shim, Bodeker, & Burford, 2011). The study seeks to contribute to the understanding of institutional change in the governance of sustainable global health through patient safety in the emerging economies of West, East, Central and Southern (WECS) Africa, using Ghana as a proxy.

This interdisciplinary research domain speaks to health policy makers and practitioners in the pharmaceutical industry or scholars from fields such as management, political economy, international relations, international business and global health. The regimes of global health, international strategy and emerging health security problems open an interesting door to connect and engage the above disciplines through institutional theory. Thus, I draw on the fragmented but overlapping conceptual lenses to make a theoretical contribution to the neo-institutional theory (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Scott, 2001; Williamson, 2000). More specifically, the findings are generalizable to "the internationalization of issues related to food, health and safety" (Runge & Michelmann, 1990: 187) and the global harmonization of health security issues that are exacerbated by counterfeit medicines. The main discovery of this contribution is that the path-dependent nature of global health governance and power asymmetry makes it harder for weaker actors to actually change the institutional conditions that produce structural inequalities in global health. This results from the preference for non-optimal solutions—designed irresponsibility—to ensure the survival of actors and the maintenance of status quo and the attendant incentive structures (profits and power).

RESEARCH CONTEXT

The proliferation of pharmaceutical counterfeits has a serious public health impact in emerging economies. This, however, is just the harbinger of a colossal global health

crisis which is being recorded even in markets with more stringent regulatory systems and highly aware patients (Mackey & Liang, 2011). The immediate and long-term implications of counterfeit medicines for pharmaceutical MNCs (Big Pharma), governments and civil society are vast. Easy access to manufacturing facilities, packaging and distribution technologies, globalization that allows easy movement of goods and services, institutional environments that aliment 'destructive entrepreneurship' (Baumol, 1996), and the high cost of branded medicines (Stiglitz & Jayadev, 2010) are among the factors contributing to the problem of counterfeits especially in the emerging economies of WECS Africa (CPIAWG, 2011). More prominently, the Internet globally facilitates the cyber version of this type of crime. Mitigating such a complex phenomenon clearly requires efficient diplomacy at multiple levels: national statecraft, MNCs' non-business strategies (Doh, Lawton, & Rajwani, 2012) and regional and global interventions with the global governors (such as International Monetary Fund (IMF), the World Health Organization (WHO) and the World Bank) as adaptive hybrid organizational forms (Schemeil, 2013).

Theoretically and empirically, a scenario in which the healthcare systems of emerging economies were devoid of health-oriented civil society organizations, INGOs or IGOs' collaboration with MNCs and host governments would be hard to explain. The extant literature bears ample evidence that healthcare crises in general, and counterfeit problems in particular, are the "reflections of history, geography, domestic policies, and geopolitics" (Sachs, 2006: 188) of which international organizations have always played a significant role (Arts, 2003). Jeffrey Sachs calls these kinds of collaborative initiatives to solve intractable problems in global health 'ecosystems of engagement' (Green, 2013). Influential international organizations play a major role as agents in the architecture of either institutional change (Doh, 2003) or the perpetuation of certain 'vested positions' (Oliver, 1992) in global healthcare and patient protection (Inoue & Drori, 2006). Their position as inhibitors of unpopular health policies or enablers in shaping social identities and political discourse on global public health remains ever formidable (Doh & Teegen, 2002). While national organizations appear to know the local conditions and appropriate solutions, they may not be in the position to enact change due to a complex set of historical and institutional reasons. Among these reasons, path dependence and power asymmetry stand out although they have not been systematically formulated and explained, regarding how the prominent global actors legitimize over 150 years of activities in emerging economies (Feldbaum, Lee, & Michaud, 2010; Fidler & Gostin, 2006).

Global health diplomacy

Global health governance is enacted through global health diplomacy. There is no consensus on what the term *global health* actually stands for (Dyar & de Costa, 2011; Macfarlane, Jacobs, & Kaaya, 2008). Sharp (1997: 59) defines *diplomacy* as being characterized by "increasing institutionalized multilateralism aimed at a stronger international order either by improving cooperation between states or transcending the need for it". Global health as a foreign policy issue is otherwise called *global health diplomacy*, a term that refers to "the process by which state and non-state actors engage to position health issues [such as counterfeit drugs] more prominently in foreign policy decision-making" (Labonté & Gagnon, 2010: 1). Global health diplomacy fosters international cooperation in global health-related issues, interventions and the advancement of foreign policy interests for the well-resourced nations (Feldbaum et al., 2010).

Global health diplomacy is structured into six policy domains*:* security, development, global public good, (international) trade, human rights, and ethical reasoning (Labonté & Gagnon, 2010). Similarly, for Stuckler and McKee (2008), global health policy can be presented in five metaphors: global-health as (i) a foreign policy (e.g. trade governance and economic development); (ii) a security issue (fighting counterfeits, bioterrorism and drug resistance); (iii) a charity (fighting poverty in paradoxically resource-rich countries); (iv) an investment (maximizing economic development); (v) a public health issue (maximizing health effect and reducing global disease burden). These fields are all strictly tied to aid and international business while forming the basis for international cooperation and even for foreign direct investments (King, 2002). In this study, global health diplomacy and strategic political management of global health are used interchangeably.

For the sake of simplification, three main categories of actors are identified in global health at the governance, civil society and industry levels. These groups, although not exclusive, face three dilemmas: (i) how do we protect consumers; (ii) how can we ensure access to medicines at affordable prices; (iii) how can we balance these demands with the firms' quest for profits. An overview of the complex interdependence between these global health actors is presented in Figure 1.

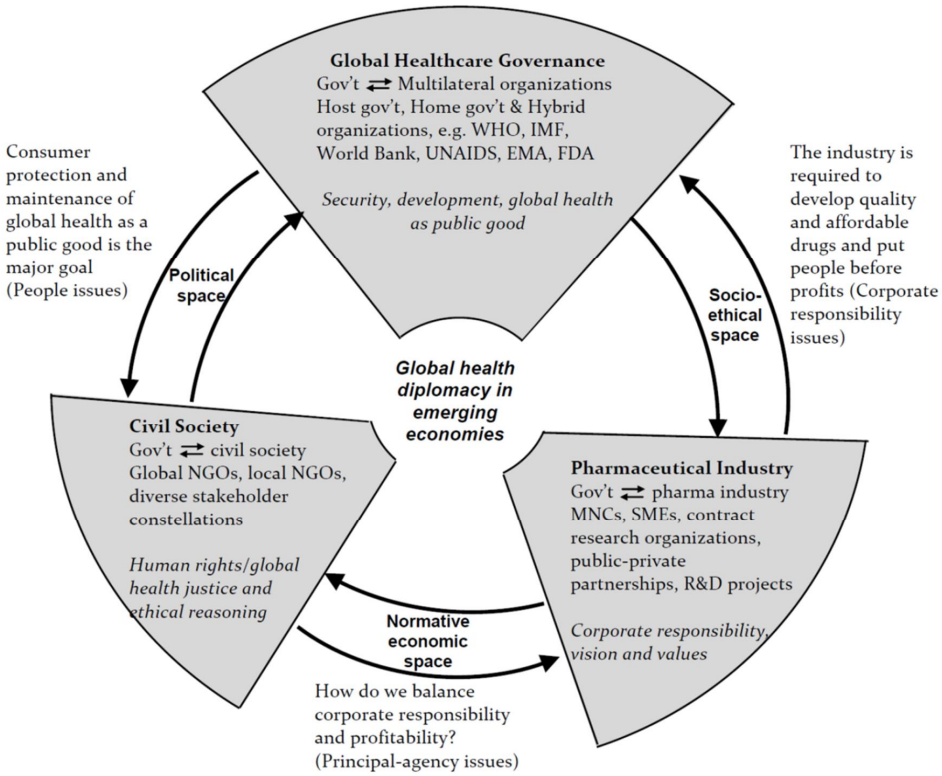

FIGURE 1. Ecosystems of engagement in global health diplomacy. EMA: European Medicines Agency; FDA: The US Food and Drug Administration; Gov't: government; UNAIDS: United Nations Joint Programme on HIV/AIDS.

RESEARCH APPROACH

Principally, this study uses fieldwork to answer the research question. The data analysis involves discourse analysis and historical institutionalism. Historical institutionalism is neither a theory nor a method, but an approach with an orientation towards understanding how institutions shape political behavior in the real world (Steinmo, 2008). Understanding contemporary global health is extremely difficult, indeed almost impossible, without recourse to its historical path. Steinmo (2008) outlines three important reasons why history matters: (1) all political events occur within a historical context with direct effects on major decisions; (2) historical events shape today's actions and (3) future expectations are molded by the past.

The empirical setting

Ghana is a middle-income emerging economy in West Africa. Although it is a politically stable country with a population of over 25 million, and among the fastest growing economies in the world, it is still not immune to the disease burden that is characteristic of most WECS African countries. Notwithstanding the rising incomes, the demand for pharmaceuticals is exponentially rising, indicating a shortage in supply of public health goods. This compressed development leads lower-income households to patronize counterfeit medicines. Infectious diseases account for the high morbidity and mortality rates. By the WHO's estimates (2012),[23] Ghana's gross national income per capita is US$1,910 and life expectancy at birth 61/64 years (male/female, respectively). The total expenditure on health is 5.2% of GDP. The high cost of branded medicine, coupled with inadequate healthcare, has given rise to the prevalence of counterfeit drugs on the market. The 38 local, small pharmaceutical companies are barely able to meet 30% of the demand (present data). Ghana was chosen as the empirical setting for four reasons: one, its relatively strong institutional setting, which facilitates data collection compared to other WECS African nations. Two, the profile of its epidemiological situation is similar to most African countries, in spite of their institutional heterogeneity. Three, the Ghana Food and Drugs Authority and other governmental institutions have strong links with the global governors, the US Food and Drug Administration (FDA), INTERPOL and other relevant pharmaceutical anti-counterfeiting INGOs. Finally, the author's familiarity with the research setting was an additional motivating factor.

Data collection

Primary data were collected through semi-structured interviews and participant observation principally in Ghana and Washington, DC, but also from global experts in Europe. Washington is naturally important because it is the centre of global health politics and decision making. For three consecutive years (2011, 2012, and 2013), I attended the Partnership for Safe Medicines Interchange in Washington, DC where several global experts on consumer protection in Europe/US/Canada and managers from pharmaceutical companies converge. In Ghana, I interviewed experts and collected unpublished internal documents from the Food and Drugs Authority, Ministry of Health, Pharmaceutical Society of Ghana, Pharmaceutical Manufacturers Association of Ghana, Ghana Statistical Service, WHO, INTERPOL, academia, and a local

[23] http://www.who.int/countries/gha/en

pharmaceutical SME and a local media company. The recurrent interview questions, which were modified for each interview session, were: (1) for global actors: *How would you describe your changing role in global health in emerging Africa*? (2) for national actors: *What difficulties do you encounter in collaborating with international organizations in mitigating counterfeits?* Altogether, 51 interviews were conducted, ranging from ca. 10 to 110 minutes in duration (see Appendix A).

Other forms of data included naturally occurring data (Silverman, 2001): (i) policy-related documents from the International Alliance of Patients' Organizations (www.patientsorganizations.org), the Partnership for Safe Medicines (www.safemedicines.org), the Pharmaceutical Security Institute (the Pharmaceutical Security Institute), and the Counterfeit Pharmaceutical Inter-Agency Working Group's report to the Vice President of the USA (CPIAWG, 2011); and (ii) relevant scientific articles on global health governance, collected via search engines such as PubMed and Scopus, using query words such as: 'global health', 'global health diplomacy', 'counterfeit medicines/pharmaceuticals', 'developing economies', 'Africa'.

Data analysis

Data analysis involved constructing *discourses* based on the iteration between literature, interviews and documents. This offered deep insights into the rich historical-institutional tapestry and current trends in global pharmaceutical security and consumer protection. "Analysis during data collection lets the field worker cycle back and forth between thinking about the existing data and generating strategies for collecting new—often better quality data" (Miles & Huberman, 1984: 49). As Bogdan and Taylor (1975; cited in Mullins & Kiley, 2002) argue, such an approach provides both 'evidence and cue at the same time'. Discourses are structured collections of meaningful texts (Maguire & Hardy, 2006)—along with the related practices of producing, disseminating, and consuming these texts that "systematically form the object of which they speak" (Foucault, 1977: 49). The production and dissemination of texts and information are ways by which the major global health players create meaning, purpose, agendas and strategies, based on their relationships to achieve particular common objectives (Deetz & Mumby, 1990).

A discursive approach provides several advantages. It allows us to draw meaning (Hardy & Phillips, 1999) and to make nuanced interpretation of the debates and policy documents. Language and knowledge, being inextricably connected, form a part of organizational behavior which is constructed within multiple realities (Foucault, 1977). The accounts of these realities and their path dependence are hence demonstrated through the use of language and texts, as well as assumptions and logics that underpin them. A discursive process allows us to unveil the obfuscated realities of the power play between the local, national, and global representation of agendas (Pereira, 2002) and to understand certain euphemistic locutions. Dwelling on the work of Meyer and Rowan (1977) from an institutional perspective, I interpret the *vocabularies of motive* used to explain the national–global linkages and the power structures that prescribe organizational functions. These functions reflect the evolution of organizational language in accounting for the actions and relationships. Terms such as 'who' (actors), 'what' (functions), 'when' (historical context), 'where' (nationally and globally), and 'why' (explanation) are used for interpretation. Vocabularies of motive as a sociological construct were developed by C. Wright Mills (1940). For example, 'collaboration, assistance, and cooperation' are taken-for-granted dictions which mean, among other things, 'dependence on the global gover-

nors and donors for help'. Excerpts from the experiential digest of experts from the field study interviews and relevant documents are reported as supporting evidence. In this study, whereas the aggregate level of international organizations of various kinds is fairly clearly analysed and assessed, the local level has received much less attention.

ANALYSIS AND INTERPRETATION OF FINDINGS

The historical-institutional path dependence of global health

The institutional field for the study consisted of multiple actors whose relationships are characterized by *competition, contestation, and cooperation* (Maguire & Hardy, 2006). Within this field of anti-counterfeiting initiatives in global health, actors "seek to influence a shared outcome [such as regulation] and pay attention to one another in the process" (McNichol & Bensedrine, 2003: 220) by creating the institutions which will serve as the traffic rules of future coopetition. These policy discourses and interactions have a direct and indirect impact on the institutionalization of patient protection as a core part of global health.

Stability and change can be viewed from the perspective of historical institutionalism (Steinmo, 2008). The current state of healthcare systems in WECS Africa represents the product of centuries of decisions, policies, and institutional dictates at national and global levels (Acemoglu, Johnson, & Robinson, 2001; Acemoglu & Robinson, 2012). These antecedents serve as a precursor for what the future would potentially look like, given the condition of increasing returns: that is, path dependence. Figure 2 demonstrates the epochal changes but path-dependent nature of global health diplomacy.

All health-oriented international organizations established prior to 1870 originated solely from religious backgrounds (Inoue & Drori, 2006). The year 1851 marks the origin of contemporary health diplomacy with the first international sanitary conference of cooperation on cholera, plague and yellow fever (Feldbaum et al., 2010). The aftermath of World War II saw the establishment of the WHO, within whose framework past agreements were amalgamated into a unique set of regulations referred to as the International Sanitary Convention. This was later re-invented as the International Health Regulations. Countries that adhered to and ratified these regulations, in essence, gave the WHO new powers to encroach on their national health agendas and state interests. In this way, countries "privileged global health governance over state sovereignty by allowing the use of surveillance reports by non-governmental organizations and electronic surveillance systems" (Fidler & Gostin, 2006: 90). Contemporary practices of global health governance by INGOs, IGOs, and MNCs are structured in the colonial vestiges and hence their practices should be seen as a *historical product* (Wainwright, 2008). For example:

> "After decades of prioritizing Western medicine only, diversification to take advantage of the local alternative medicines with great potential for the cure of tropical diseases is only gradually beginning to gain momentum in Ghana now. The approval and dispensary of such herbal medicines started in 2012 by the procurement division of the Ministry of Health". (Expert/Ministry of Health/Ghana)

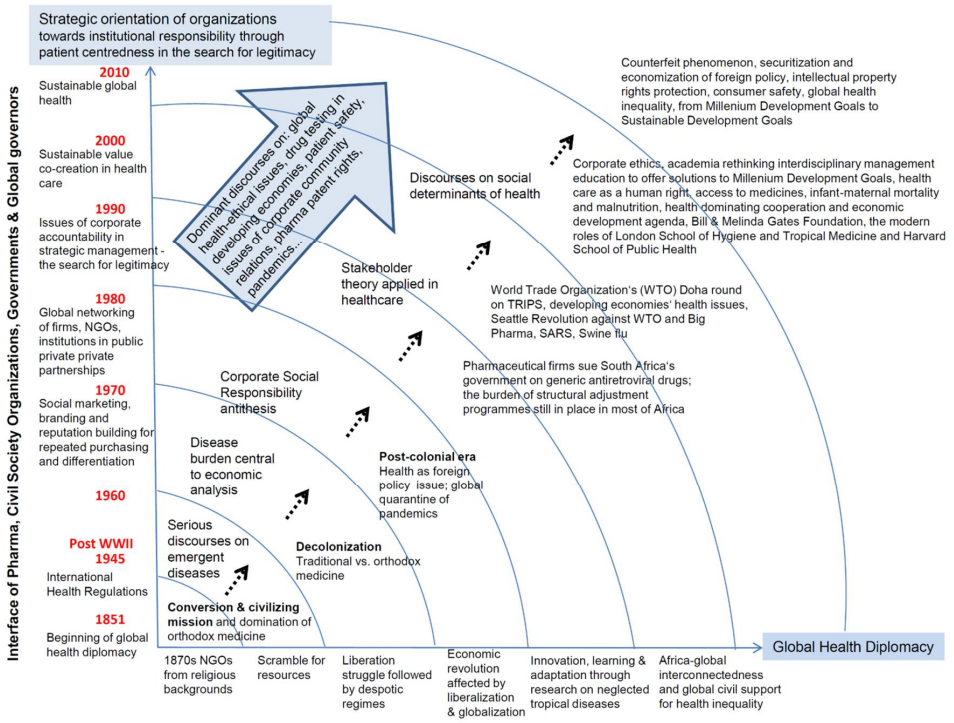

FIGURE 2. Epochal path dependence of global health diplomacy: Chronicle of critical incidents. SARS: severe acute respiratory syndrome; TRIPS: Trade-Related Aspects of Intellectual Property Rights.

For example, Shim et al. (2011), explain how legitimized, highly institutionalized systems of global governance (e.g. WHO) require conformity of the lower order systems to their prescriptions (Meyer & Rowan, 1977; Shim et al., 2011). Secondly, their historical role and lopsided control of medico-techno-scientific resources and political status suggest a certain level of uncontested credibility and bargaining power. Thirdly, the total number of international treaties ratified by weaker nations and/or their membership in international organizations is one major way by which scholars measure the degree of conformity to these 'higher order global forces' (Inoue & Drori, 2006). By implication, the articulation of cure, based on Western allopathic medicine, is also dominated by MNCs and has led to apathy towards traditional medicine (Shim et al., 2011).

In the sections that follow, I shed light on the historical and structural roles of governments, pharmaceutical MNCs and international organizations. Further, I theorize the national–global linkages of global health and explain how power asymmetry has led to the current outcomes through the ultimate preference for non optimal solutions.

The responsibility of national governments

The extant literature on corporate responsibility places much emphasis on MNCs' responsibility whilst ignoring the role of governments in global health (Baylis & Smith, 2005). In theory, the role of governments is to mitigate value destruction through health risk governance, policies, services, and diplomacy through their various institutions by way of public health reforms and budget provisions. Governments

are, therefore, expected to create conducive conditions and the legal framework for competition by MNCs and SMEs whilst allocating resources to protect healthcare as a public good (Porter & Teisberg, 2006). However, there is one problem with country-specific variations: in emerging economies, major responsibilities are shifted to the global governors, donors, philanthropists or private sector instead of the government. Organizations such as UNAIDS, USAID, and the US Pharmacopeial Convention support the governments of these economies to combat endemic diseases and counterfeits (CPIAWG, 2011). Through global health governance such international institutions (though actively helping low-income households) also serve the geopolitical interests of the core region. In this way, however, global health equity is hardly achieved because dependence on aid leads governments to avoid responsibility and effective implementation of universal care:

> "There have also been remarkable advances based on development assistance (e.g. United Nations Millennium Development Goals) which non-experts interpret as government success. You see, we are very aware of the health problems our country faces and we have programs on the table, but we have to wait for a long time before we hear something from those who make the budget. As a pharmacist this is really frustrating." (Expert/Ministry of Health)

Exceptions to this dependence-creating rule are, for example, the Bill and Melinda Gates Foundation or the so-called proto-institutions (the Global Fund and the Global Alliance for Vaccine and Immunization) which avoid wastes, increase impact and reduce overall health inequity (Gates & Gates, 2014).

Other ways governments avoid responsibility, thereby reversing healthcare gains, is through bureaucracy, the non-implementation of policies, and lack of strong collaboration . Also, Ghanaian experts lament the weak enforcement of anti-counterfeiting laws in the country. They argue that it makes all stakeholders' work difficult and allows the counterfeiters to thrive:

> "So, one major problem is law enforcement. I know I don't have to say this, but there is also corruption in the system. So to bring about change government needs to be at the table." (Expert/WHO/Ghana)

Despite the above, I observed that at the micro-level, there are very many public health experts (in institutions such as the Ministry of Health, the Food and Drugs Authority, or the Pharmaceutical Society of Ghana) who truly appreciate the public health debacle but lack the power and resources to change things.

Strategic political management by Big Pharma in global health

Historically, the market involvement of the pharmaceutical industry in Africa has been very low. The lateness of pharmaceutical FDI in Africa is explained by the perceived lack of market (Sachs, 2006; Stiglitz & Jayadev, 2010). Currently, however, Big Pharma, like all MNCs, plays a massive political role (Abraham, 2002) in emerging economies where weak institutions allow them to have a strong bargaining power (Scherer & Palazzo, 2007). They affect local institutions through heavy investments in advertisements and the exportation of Western cultural commodities (Shim et al., 2011). This is facilitated by the internet, other marketing approaches,

and globalization in general (Baylis & Smith, 2005; Schuerkens, 2007; Shim et al., 2011; Sklair, 2002).

Pharmaceutical MNCs enjoy several freedoms under international treaties such as the World Trade Organization's TRIPS (Trade-Related Aspects of Intellectual Property Rights) ('t Hoen, 2002). Despite such privileges, a more plausible reason for the pharmaceutical MNCs' engagement in strategic political management is the quest for legitimacy (Suchman, 1995), both internally with stockholders and externally with global governors/INGOs and host countries, by appearing socially responsible. This allows them 'to enhance their survival prospects' (Meyer & Rowan, 1977). "We [Big Pharma] don't see the healthcare needs of emerging economies of Africa only as novel frontiers for organizing production and marketing but also an opportunity for showing corporate responsibility" (Manager-1/Big Pharma).

Examples of such corporate responsibility actions include the Access to Medicines Index (www.accesstomedicineindex.org) where the biggest MNCs in the pharmaceutical industry are ranked according to how they are able to make drugs accessible to developing economies. To achieve this, criteria such as new pricing models, philanthropy, donations and several other interventions are factored into the analysis:

> "Fundamentally, pharmaceutical MNCs export medical commodities to developing economies. They define what a disease is and the appropriate cure from the Western medicine perspective. They also provide financial and technological support for the FDA and INTERPOL to combat global counterfeits in the quest to protect their intellectual property." (Manager-2/Big Pharma)

Most global experts seem to suggest a public–private partnership in consumer protection. For example:

> "The INGOs need to use the MNCs' models to ensure accountability. The MNCs are businesses but in the face of global challenges, they cannot be alienated." (Expert-1/Academia/USA)

> "Governments cannot just throw money at diseases. They need to tap into computerization to ensure proper control and accountability. I am a bit skeptical about global governance outcomes; it should include MNCs and follow their model instead of demonizing them as profit-making machines." (Expert-2/Academia/USA).

In essence, Big Pharma exerts influence through corporate diplomacy (Ordeix-Rigo & Duarte, 2009) or effective strategic political management (Oliver & Holzinger, 2008) to earn legitimacy. Notwithstanding the usefulness of vaccine donations and other philanthropic exercises (Class, 2012), in the long term this is not sustainable. First, it has created dependency. Second, as a seemingly unintended (though designed) result, local pharmaceutical firms bear the negative consequences of this pattern of dependency due to market distortion: "Even though we have the most advanced laboratories and manufacturing systems, we still don't have the WHO prequalification. This stifles our efforts because we cannot take part in competitive bidding" (Manager/SME/Ghana). Further, dependency perpetuates corruption, maladministration, and bureaucracy to stifle the healthcare sector (Okuonzi & Macrae, 1995; Rashid, 2006). Hence, emerging "Africa continues to depend on the Global

Fund for the acquisition of drugs for tuberculosis, malaria, and AIDS and this is not being affected by the financial crisis" (Expert/Global Fund). This allows governments to evade responsibility, thereby maintaining the path dependence of the dependency phenomenon that constantly undermines global health in the South.

The path dependence of INGOs, IGOs, and adaptive hybrids

International organizations are not unified rational actors but complex settings and governance structures, with multiple external and internal stakeholders, and therefore, non-linear organizational structures. The conditions that permit complex, hybrid international organizations to survive through path dependence include the vast network of cartel-like global structure that is centralized in the core region and the organizations' immunity and resistance to institutional changes that deviate from their pre-calculated agenda. They are complex hybrids because, as (Schemeil, 2013: 219) argues, their formula for survival consists of a web of "local, national, regional, and transnational" ingredients. That is, they are "made up of public agencies, private firms [e.g. Big Pharma], third sector associations, and expert, activist, or lobbying interest groups" (*ibid.*).

How do international organizations influence institutional change through strategic political management of global health? There are at least two plausible explanations: **(i) Filling the institutional voids:**

> "The churches and others established schools and clinics where governments lacked the resources to do so in the past in order to build capacity. Nevertheless, the vacuum still exists and that is why local and international counterfeit drug barons take advantage of the situation." (Expert/Academia)

Institutional void results from the vacuum created by a fast socio-economic growth and a slow pace of development of social structures (the purpose of rules and their implementation) to adapt to emerging changes (Rodrigues, 2013). INGOs fill institutional and regulatory voids (Fransen & Kolk, 2007) by building formal healthcare infrastructure as a way of gaining legitimacy. In this way, the organization protects its activities and conduct from being questioned (Meyer & Rowan, 1977). Currently, their major roles involve the operation of healthcare centers and control, coordination and distribution of complex forms of health-related information (Strengthening Pharmaceutical Systems Program, 2011). For example, "the private and the NGO sectors including the Christian Health Association of Ghana provide over 40 per cent of healthcare in Ghana, especially in the rural areas" (WHO, 2009). As experts argue, this is attributed to the fact that "in healthcare matters, Ghanaians are mostly on their own despite the health insurance system. It's either out of pocket or NGO support and the rest from government. But the rural people are mostly underserved, increasing their risk to buy fake medicines" (Expert/Pharmaceutical Society of Ghana).

(ii) International organizations **play a role in creating social value** (Austin, 2010) in terms of better healthcare. These roles are more generally delineated in Table 1.

TABLE 1. Roles of international organizations in creating social value in global health

Role	Description
Consumer empowerment	Through education, grassroots work, and human resource development (e.g. USAID)
Leading advocacy and providing leadership support (Hilson, 2005).	Via lobbying and policy initiatives INGOs represent (a) the 'voice of the voiceless'; (b) the driving force behind accountability and equity in healthcare in developing nations; and (c) the provider of exposure and visibility to less known grassroots and national patient-centered anti-counterfeit organizations at the global stage (e.g. the Partnership for Safe Medicines).
Financial and technical assistance	Source of financial, economic and knowledge support for weaker organizations "The role of IGOs is to act in the capacity of delegated monitors who provide both technical and logistical support in promoting global health and the international pharmaceutical businesses associated with it" (Expert/WHO).
Mediators	INGOs serve as both moderators and mediators between host government and MNCs and sometimes are full participants in influencing the direction and scope of agendas through diplomacy (Doh & Teegen, 2003).
Global health change makers	"At present, the roles of NGOs are increasing in multifaceted forms: ranging from infant care to pandemic/epidemic relief operations. Organizations such as the Partnership for Safe Medicines are patient safety-oriented whilst the US Pharmacopeial Convention offers advanced technologies, training and information exchange" (Expert/US Pharmacopeial Convention).

Essentially, these organizations play both complementary and substituting roles in the public health institutions of emerging economies. Their path-dependent nature, however, has retarded the institutional change for sustainable healthcare solutions.

Power asymmetry in global health

Weber (1978: 53) refers to power as "the probability that one actor within a social relationship will be in a position to carry out his will despite resistance." Fleming and Spicer (2014) identify four faces of power: (i) coercion—the ability of actors with power to directly use the power to achieve their goals; (ii) manipulation—here there is no direct use of duress but an implicit approach to shape agendas that suit the interests of the user of power; (iii) domination—deals with the arbitrary hierarchical structures that are made to appear as the natural order of things through the ideological shaping of perception; (iv) subjectification to curb possible resistance: "This type of influence seeks to determine an actor's very sense of self, including their emotions and identity" (p. 244). The first two are said to be episodic (less visible and rarely used) while the second two are systemic (used often and on a larger scale). Fleming and Spicer further argue that there are four sites via which power is enacted; thus, power enacted 'in', 'through', 'over', and 'against' organizations.

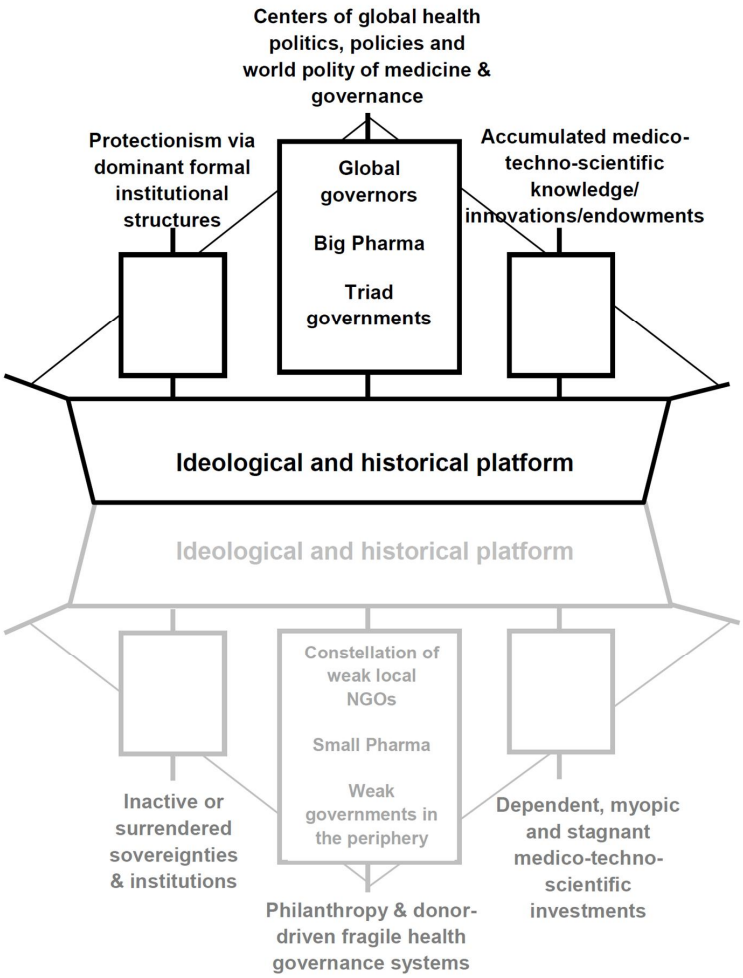

FIGURE 3. An empirical model of 'the axis of power'.

Towards an empirical model of the axis of power. In global health, there are the 'globalizers' and the 'globalized' and this is the basis for contestation and debate. The cumulative asymmetric power relationship that is built on lopsided regulatory, political, decisional, *discursive* and agenda-setting power (Arts, 2003) increases global health inequity. Here both stronger and weaker actors express different expectations and domains of competence. The empirical model in Figure 3 attempts to capture the essential elements which explain the global power asymmetry in healthcare governance. Currently, the periphery's weak governance and institutional structures are like a mirror image of the global power structures in the core region. Politics and ideologies define the nature of global health, aided by globalization and a complex network of formal bureaucratic structures (Baylis & Smith, 2005; Huynen, Martens, & Hilderink, 2005). Global health as a foreign policy issue is the result of centuries of institutionalization, mainly in the West, through global governors with sovereign immunity statuses. Moreover, despite the high disease burden in emerging

Africa, global health governance systems are centered outside the core areas of need. The axis of power is constructed around three major dimensions: business and non-business ***actors***, ***instruments,*** and ***functions***. The most influential actors in global health diplomacy are the global governors and Big Pharma. They possess the instruments that allow them to function through their decision-making power (Arts, 2003). These geopolitical commodities (e.g. economic influence, medico-techno-scientific innovation and the geopolitical status) are centralized in the core region and dispensed in the periphery.

Surrendered power

Whereas *power* has been conceptualized as the ability of one or more actors to influence others (Burt, 1977), the findings suggest that power is the ability to disempower others from action for as long as one's interests are met. Hence, power lies not only in how the core influences the periphery, but also in the negative consequences resulting from the periphery's complacency. Holding power consists essentially of being a player and a referee at the same time, both enjoying impunity and the capacity to put your interests first.

Power in global health governance is not expressed through despotic controlling mechanisms. Rather, it is exercised through a shrewd mechanism of benevolent donations from MNCs, charity by INGOs, and economic aid packages from governments and multilateral organizations from the core region, with strings attached. These have the ability to transform governments and the governed into complacent, irresponsible 'yes men' and cowed followers, resulting in over-dependence that never weans itself from underdevelopment in combating the disease burden and its attendant problems. See Table 2 for examples of the vocabularies of motive that label purposes, ideas, the culture of interaction and situations in the pharmaceutical anti-counterfeiting initiatives in Ghana.

There are varieties of ways through which governments relinquish the power to change institutions to external actors. The interviewees do not say that the government lacks resources. They rather point to a lack of leadership and healthcare investment priorities:

> "The government puts less money in healthcare. That is why healthcare in developing countries is donor-driven. But you see, Ghana is now an emerging economy, so those donors such as DFID [UK Department for International Development], DANIDA [Denmark's development cooperation] and USAID are withdrawing their resources slowly. Another reason for this is that Ghana and many other African countries have natural resources whose profits could be channeled into the healthcare sector. As you know, the politicians cannot always be trusted to do what seems logical. So we envisage massive financial challenges in the coming years. They [donors] give promises but they don't act on them. You see, within the institutions you have less innovation and less learning because everyone wants to control his turf. For any organization to be successful much depends on the leader." (Expert/WHO/Ghana)

TABLE 2. Vocabularies of motive in anti-counterfeiting initiatives in emerging economies

Locutions/semantics	Interpretation	Category
Cooperation	Seeking 100% financial help	*Total dependence*
Collaboration	'We have the plan, you bring the money, we will do it your way'	*Renounced power*
Development Assistance	Financial and technical aid as usual	*Total dependence* (ignoring local content)
Consumer protection (MNCs)	Protection of intellectual property rights	*Euphemistic locutions/codified orthodoxy*
Consumer protection (NGOs)	Patient safety	*Open code*
Global health	Health agendas that are important to the strategic interests of the triad (USA/Canada-Europe-Japan)	*Path dependence*
Global health diplomacy	Multilateral engagements in which weaker actors ratify the agendas of the powerful	*Weak governments and strong bargaining power of global actors*
Global consumer protection	Protection of populations in the triad and to some extent in some emerging economies with voice (e.g. Brazil, India, China)	*Path dependence*
Official statistics	Neither host government's nor NGOs' figures but the WHO, IMF or World Bank's.	*Path dependence*
'We don't have the personnel and equipment'	Expressing the huge gap between social structures and formal institutional structures	*Institutional void*

In addition to the donor-driven healthcare, more evidence to how power is surrendered can be found in three major areas:

(1) Financially undernourished medico-techno-scientific R&D in universities and local industries: Since most countries in emerging Africa (including Ghana) do not nurture a strong techno-scientific research tradition in healthcare, almost all cutting-edge research and innovation are undertaken by global governors, pharmaceutical MNCs, and private enterprises outside Africa. The systematic neglect of responsibility has meant that collectively these countries contribute only 1% of annual global budget for healthcare. Global power shifts in science and technology are occurring in India and China, but this is minimal in Africa. The lack of local technologies is telling: "Major operations, such as 'Opération Harmattan' to arrest pharmaceutical counterfeiting criminals in Ghana, are sometimes organized from France in cooperation with the INTERPOL. They [Lyon, France] provide the resources, lead information, and technology for our operations" (INTERPOL/Ghana). This explains the level of dependency on external resources in the securitization of consumer safety nationally.

(2) Extremely poor working conditions and low incentives for nurses, pharmacists and doctors resulting in a 'brain drain' of qualified health professionals (Schubert, 2003) and thus a 'brain gain' for the advanced countries (surrendered knowledge); only 3% percent of global healthcare professionals work in Africa.

(3) Dependence on scientific and knowledge articulations on health by institutions and firms in the core region and statistical and surveillance data from global governors.

Ghanaian experts are even more perplexed about the third point: "If you want statistical data you need to consult the world governing bodies such as the WHO [or their websites]. We don't even have the finance for conducting major surveys, let alone embark on projects" (Experts/Ministry of Health/Food and Drugs Authority/Ghana Statistical Service).

This surrendered power explains the path dependence of the incessant external projections on Africa's healthcare structure and development. "We [US Pharmacopeial Convention] have now built a US$1.5-million pharmaceutical training centre in Ghana that will serve the whole of WECS Africa and we also provide portable technologies for the detection of counterfeit medicines" (Expert/US Pharmacopeial Convention). In the Global Engagement Report published in April 2012, the FDA announced the organization's aim to become the global health agency that protects the health of its own citizens as well as the health of the whole world from threatening dangers (FDA, 2012). Currently, the FDA has offices in Africa, Asia, Europe, America, and the Middle East and is strengthening its international functions to ensure that the imported food stuff, medicines and medical equipment fulfill the same safety and quality requirements as those in the USA. Although pharmaceutical anti-counterfeiting interventions are dominated by global governors or governmental agencies such as the FDA, national and regional bodies are increasingly gaining voice, recognition, and inclusiveness, given the institutional transformation, albeit in small measures (Fan & Liang, 2012).

The major problem with the renounced sovereignty and surrendered power is that the institutional contexts breed 'fragile varieties' of organizational models. When this adds up to the employment of the first best approaches (standard approaches used in advanced countries) by INGOs in the developing world, it produces the least desirable results. This represents a huge setback to healthcare transformation. Containing the issue of pharmaceutical counterfeiting is clearly possible but, as highlighted by Shepherd (2010: 366), "it is a technological and human resource challenge" that must be met with cooperation or effective strategic political management.

Summary of the roles of major global health actors

Overall, a huge gulf in expectation exists between MNCs, governments, INGOs, and multilateral institutions in terms of global public good/value to be created and appropriated. Hence, the path-dependant nature of dependency on external knowledge and resources remains intact. The following encapsulates the asymmetric power relations between national and global actors in global health:

> "We provide training and capacity building. We collaborate with the Ministry of Health or NGOs acting in health, e.g. National Coalition of NGOs in Health. We also collaborate with Pharmaceutical Manufacturers Association of Ghana. We use them as a platform to reach the communities. The major involvement of the WHO is that we are a technical organization; we provide guidelines and import and export best practices by showing the effectiveness of some healthcare institutions from elsewhere. We strongly encourage the government to adopt such practices and integrate them. We advocate for

> change; we talk with evidence; we generate data and present it to the government. So, I mean sometimes the government has to feel that they own the process. So we are actively involved in the Millennium Development Goals and we promote standard guidelines. Generally, the government of Ghana is very cooperative. The problem we have during collaboration is that when there is a change in government and change in people, the discussion that follows also changes. Some of the talks get stalled and we don't know why." (Expert/WHO/Ghana)

The roles of firms, governments, and INGOs are infinitely overlapping, constantly contested (political spaces), and naturally self-modifying to suit the strategic agenda at any given time. The end results are therefore predictable (see Table 3).

Theory of ultimate preference for non-optimal solutions in global health governance

This section develops a theory of ultimate preference for non-optimal solutions in global health governance. It explains how global health diplomacy has maintained its historical path dependence and, hence, that of global health inequity. Here, values, micro- and macro-politics, power asymmetry, corporate irresponsibility and institutional path dependence are the explanatory variables of this theory.

For any given set of global health solutions for creating social value, a range of market and institutional possibilities always exist but non-optimal choices (quick fixes) are preferred to sustainable ones. This rather creates relevance for actors (organizations) at the expense of populations (consumers). This means that the solutions are not optimal for the society but essential for the actors' long-term survival, maintenance of the *status quo* and the attendant incentive structures (profits and power) of firms, INGOs and governments. That is, in global health diplomacy equity is neglected by design. This is consistent with Schemeil's (2013) reasons (reinventing themselves) for the survival of international organizations even when their original mandates have expired. Their prescriptions are mostly far-removed from the desired maximum social benefits. Rather, their preferences are modeled by maneuvers that will call for their direct/indirect re-involvement through consultation, medico-techno-scientific assistance and finance (especially aid) from the centers of power.

At the micro-level, individuals (managers/policy makers) and groups (boards and executives) with micro-political power make the same choice to reflect the organizational character: (i) to maintain the survival of their organizations; (ii) to remain relevant; (iii) to maintain the status quo of the professionals and epistemic communities of experts as well as their associated influential networks in their quest for legitimacy.

At the structural level, beyond the allocation of medico-techno-scientific resources, global health is designed to (i) prevent diseases (and health threats including counterfeits) from the South from spreading to the North and (ii) to protect the foreign policy interests of the core region in the periphery (i.e. firms and their employees) and therefore to facilitate international trade—capturing profits and taking resources from the periphery.

TABLE 3. The structural determinants of global health diplomacy outcomes

Agents	*Input*	*Capabilities*	*Interests*	*Outcomes*
Economic space (pharmaceutical industry: biomedical/pharmaceutical domain that addresses diseases)				
Market actors: MNCs	Technological and R&D resources	Pharmaceutical services, drug R&D; marketing	Legitimacy, markets, resource seeking	Mitigating value destruction via intellectual property right protection and dialogue
Ethical space (large private funders/philanthropists)				
Non-market actors: Payers	Source of massive finance and services	Improvement and protection	Seeking global health equity	Mediators and last resort when market and government fails
Political and regulatory space (multilateral agencies: socio-economic and political domain that addresses the structural determinants of health[a])				
Global governors	Regulators, donors, global oversight, foreign trade, cooperation for global security; e.g. WHO	Unlimited political power that influences all parties	Foreign policy interests, human rights and global public good, protection against emergent diseases, bioterrorism, and epidemics	Legitimization strategies, mitigating threats through diplomatic efforts
Institutional space of host/home government (bilateral agreements)				
Host and home government and institutions	Defends own pharmaceutical industry, pivotal in creating the right institutional environment	Economic policy, negotiation and bargaining	Protection of the general public; health as public good	Intellectual property right infringements/ protection, dealing with vested groups

[a]CSDH, 2008

There is a constant dependence on imported 'best practices,' that in nature, are one-size-fits-all. These measures in some cases ignore essential local nuances and complexities. Consistent with Shim et al. (2011), there is theoretical and empirical evidence with direct causes and effects to explain the skewed nature of the national–global linkages between supranational organizations and national health organizational systems in emerging Africa. In Figure 4, the solid arrows indicate how the core region with the centers of policy and medico-techno-scientific resources exerts influence on the periphery. The dashed arrows show the weakness of the periphery and the modest or total absence of influence on the core region.

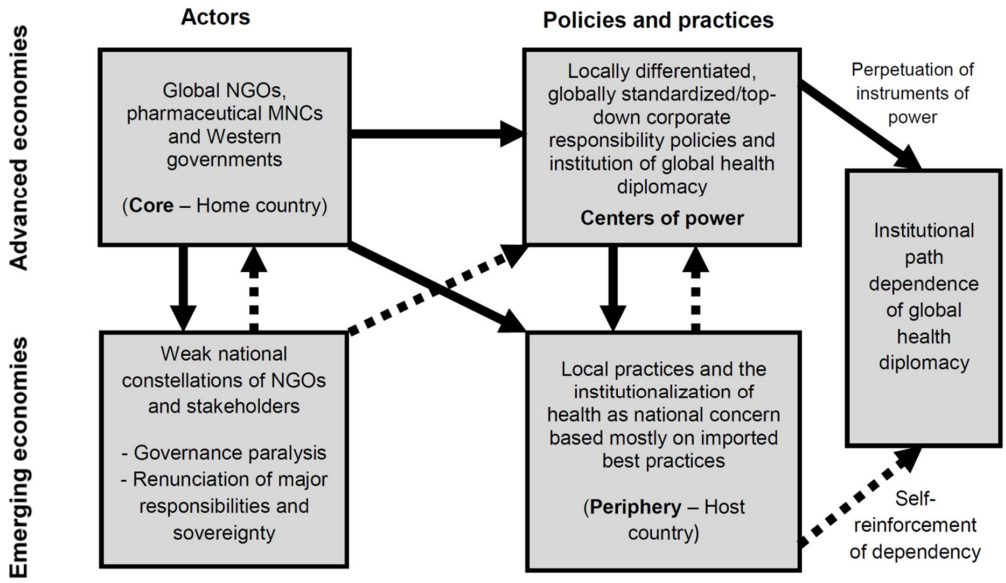

FIGURE 4. Theoretical model of national–global linkages of institutions and power dependence in global health diplomacy.

As a result, healthcare solutions are used as geopolitical commodities with which the strong actors have a competitive edge and a bargaining power while legitimating their actions. As Stuckler and McKee (2008: 86) put it:

> "Global health as a foreign policy (diplomacy) is based on politicians using global health policy to create a worldwide reputation and exert political influence, forging alliances with countries where they have strategic interests, opening new markets for trade and protecting domestic pharmaceutical companies."

In summary, survival-seeking, relevance-seeking and incentive-seeking as well as the representation of the foreign policy interests of the core region define the relationships in global health diplomacy—leading to irresponsible preferences that do not yield the maximum social benefits for the periphery.

Two main propositions are advanced with this theory of ultimate preference for non-optimal solutions: (i) In global health governance, without the local content, resources, values and responsibility for institutional change, public health will change into the same with only aesthetic modifications and constantly recurring consequences for the most vulnerable composition of the populations. (ii) In global health, major actors, such as MNCs and INGOs, should not be substitutes but complementary partners in building the national health institutions.

CONCLUSIONS AND POLICY IMPLICATIONS

Global health inequality represents a major 'form of structural violence' that defines the gap in the living conditions between the Centre and the Periphery (Galtung, 1969). This gap is now being filled by medical counterfeiters. Using global pharmaceutical counterfeiting as a lens, this study problematized the structural role of major actors in global health by analyzing the path dependence of power asymmetry that exists in national–global linkages of global health. Taking a cue from North (1990), it is hard to find proof to fit any novel hypothesis that global health governance has shifted towards a new trajectory other than the known path dependence.

The findings suggest that whilst power is attributed mostly to the ability of one actor to influence other actors in global health, however, it is the periphery's surrendered power to well-endowed institutions through policies and political inaction in the polities (Fidler & Gostin, 2006) which are then institutionalized and taken for granted (Meyer & Rowan, 1977). The surrendered power and renounced responsibility therefore serve as the weak link between national and global health governance. Real change can only come about as a fusion of transformative national initiatives that meet a massive global response through equitable global health governance. National or global efforts alone will not suffice to yield a positive institutional change in the global health governance for patient protection and their minor forms will remain as only artificial façades. This can be attributed to the historical durability of the global health policy structure, power asymmetry, the complacency with the culture of dependency in national–global linkages, and national healthcare governance paralysis in emerging economies of Africa. Ghana for example presents a five-fold paradox: (i) complex formal bureaucratic structures/high institutional void and lack of enforcement mechanisms for consumer co-protection; (ii) stable political institutions/weak public health system; (iii) resource abundance/high dependency on donors; (iv) high economic growth/weak structural determinants of health, leading to high disease burden; and (v) increase in non-communicable diseases/lack of political will to enact change. This can be generalized to most emerging economies.

There are other inertial conditions which block fundamental changes. These include institutional turf protectionism, the lack of political will and commitment of state agencies, perennial fragmentation and misallocation of techno-scientific endowments, and the path dependence of the dependency mentality in emerging economies. It is has been argued that there is a conspicuous absence of people-centered strategic design in global health. The institutionalization of health as a social concern is rather organization-centered. Global health diplomacy uses resource concentration and power asymmetry as the geopolitical commodity in framing solutions and gaining competitive advantage. That means global health interventions are still top-down, slow by design, privilege cure over value co-protection (prevention), are disease-specific and non-holistic. Further, they are path dependent in their institutional make-up where surveillance, medico-techno-scientific, decisional, discursive and agenda-setting processes hinge on the asymmetric power, whose pendulum swings in favor of the strongest actors in global health diplomacy. Here, scientific solutions are privileged over social solutions and technical solutions are seen as better than mitigating widespread negative social determinants of health. Pharmaceutical counterfeiting itself and how it is mitigated only reflects a serious fundamental problem in global health governance. These findings may be generalized to the internationalization and global harmonization of issues concerning food and health security.

Future research will focus on the comparative study of the institutional logics undergirding the governance of healthcare in public organizations in emerging economies. Given the unspecified institutional space and the opaqueness of the industry, outsiders have difficulties in fully understanding the complexity of how global health governance is organized and the human agency involved in this will also need to be studied.

The 'corporate responsibility' now falls on governments to invest in sustainable healthcare innovations since no nation has prospered based on charity. Governments must gain relevance as active players in the global health discourse by prioritizing self-sufficiency through improved national health institutions. This approach could also include harnessing intellectual inputs from non-scholars or traditionally excluded members of public health through what Shivarajan and Srinivasan (2013: 381) refer to as 'global knowledge networks through trust-based partnerships' among neglected consumers and business and non-business actors.

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