Alexandra Michaela Kaasch

Global Social Policy in the Field of Health Systems

International Organisations and their Policy Models

Submitted in Fulfilment for the degree of

Doctor of Philosophy

Department of Sociological Studies

University of Sheffield

(February 2011)

Contents

Acknowledgements **6**

Abbreviations and Acronyms **8**

PART I: GLOBAL SOCIAL POLICY IN THE FIELD OF HEALTH SYSTEMS **11**

1. Introduction: Global Social Policy and the Study of Health System Models **11**

1.1 Research Purpose and Research Questions 11

1.2 Global Social Policy: Key Terms and Concepts 12

1.2.1 The Terms global, global actors, ideas and health systems 12

1.2.1.1 The Term "global" 12

1.2.1.2 International Organisations as Global (Social Policy) Actors ... 13

1.2.1.3 Ideas 14

1.2.1.4 Health Systems 16

1.2.2 Origins and Characteristics of Global Social Policy Research 24

1.2.3 Global Social Policy Definitions 27

1.3 Characterisations of Global Social Policy: A Literature Review 32

1.3.1 Competition at Three Levels 32

1.3.2 The Global Discourse on Pension Systems as Global Social Policy 35

1.3.3 Global Ideas on Other Social Policy Fields 37

1.3.4 Global Social Policy in the Field of Health Systems 38

1.4 Methodological Approaches to Studying Global Social Policy Ideas in the Field of Health Systems 42

1.4.1 International Relations 43

1.4.2 Global Governance Approaches 46

1.4.3 Comparative and Global Social Policy Approaches 48

1.5 The Units of Analysis 53

1.6 Limitations 55

1.7 Summary and Outlook 56

2. Methodology and Data Collection: A Comparison using Documents and Elite Interviews **59**

2.1 Comparative Research Design 60

2.2 Qualitative Content Analysis 62
2.3 Data 64
2.3.1 Documents: Analysing Websites and Publications 64
2.3.2 Interviews 76
2.4 Summary 83
3. Studying the Global Social Policy Models for National Health Systems: Analytical Framework 84
3.1 Who? – Identifying global health policy actors 85
3.2 What? – Analysing and Comparing Health System Models 92
3.3 How? – Studying Communication Channels 104
3.4 Summary 111

PART II: FINDINGS 113
4. Who? – Global Health Actors 113
4.1 Health Policy Actors Within the UN System 113
4.1.1 World Health Organisation (WHO) 117
4.1.2 International Labour Organisation (ILO) 124
4.1.3 World Bank 126
4.2 Organisation for Economic Cooperation and Development (OECD) 131
4.3 Collaborations and Partnerships 133
4.4 Conclusions: Is There Competition at the Level of Mandates? 134
5. What? Ideas about Health System 140
5.1 Different Approaches to Health Systems from the WHO 141
5.1.1 Two Ways of Looking at Health Systems 142
5.1.2 The Commission on Macroeconomics and Health's "Minimal" Model 150
5.1.3 Going back to PHC: Commission on Social Determinants of Health 152
5.1.4 A Comparison of WHO Health-System Ideas 157
5.2 Health-System Concepts from the World Bank and the IFC 159
5.2.1 The Evolution of Health-System Ideas of the World Bank 160
5.2.2 IFC – Supporting the Private Sector 171
5.2.3 Two Strands of World Bank Ideas 174
5.3 The ILO's Focus on Social Health Insurance 174
5.4 ILO-GTZ-WHO Consortium on Social Health Protection 183
5.5 The OECD's Careful Approach to Health Systems 185

5.6 Conclusions 190
Excursus 1: The Power of the World Trade Organisation 200
Excursus 2: An Alternative Model – The Global Health Watch 204
6. How? Communication Channels 207
6.1 The WHO's Limited Communication Means 208
6.2 Research and Conditional Loans from the World Bank 215
6.3 Early International Health Law and Campaigns from the ILO 223
6.4 OECD: Comparative analyses and data 228
6.5 Collaboration and other activities 231
6.6 The Same or Different Communication Channels? 234

PART III: DISCUSSION 242
7. Characterising Global Ideas about Health Systems 242
7.1 Global Health Actors and their Mandates 244
7.2 Global Ideas on National Health Systems 253
7.3 Ways of Communicating Health-System Ideas 258
7.4 More Similarities than Competition with Different Power to Act? 262
8. Comparing Pensions and Health Systems Models 264
8.1 Characteristics of the Global Pension Discourse 264
8.2 Comparing Global Social Policy Ideas 266
8.3 Conclusions 273
9. Contesting Contestation in Global Social Policy 276
9.1 Global Social Policy Actors – More Than Competing and Overlapping Agencies? 277
9.2 What If Ideas are Just Not That Contested? 283
9.3 Challenges to Communication 287
9.4 Reflections about Analytical Frameworks and Methods 292
9.5 Summary 299

Annexes 301
Annex 1: List of Documents 301
Annex 2: List of Interviews 309
Annex 3: Email template 310
Annex 4: Typical Structure and Questions of an Interview 311
Bibliography 312

Abstract

This thesis is a discussion of some fundamental elements of global social policy concepts. The dimension of global social policy that is about the social policy models of global actors has been characterised by primarily referring to pension policy. Analysing global policy ideas of national health systems, this thesis tests to what extent these definitions and concepts of global social policy hold true when taking into account policy models other than for pension policy.

The analysis focuses on a number of international (inter-governmental) organisations that appear as global social policy actors in the field of health systems, most notably the World Health Organisation (WHO), the World Bank, the International Labour Organisation (ILO) and the Organisation for Economic Cooperation and Development (OECD). Based primarily on a detailed document analysis, the thesis is structured to study, and to compare, the organisations' mandates as global health actors, the models for health systems developed by these organisations, and their communication channels. The characterisations of the global policy models of health systems are then compared to those for pension systems and related to more general understandings of global social policy.

The key arguments developed in this thesis are that (1) not all social policy fields are characterised by the same structures and processes; that (2) not all social policy fields are about competition and contestations, but for models of health systems, we find a significant degree of similarity between the models promulgated by international organisations; and that (3) global social policy analysis would benefit from more nuanced ways of understanding the nature of its actors, the specifics of its ideas and concepts, and the implications of different communication channels.

Acknowledgements

This thesis could not have been written without the tremendous support of many others. I would like to thank my supervisors, Bob Deacon, Zoe Irving and Lutz Leisering, for their comments and all kinds of support over the past years. Bob, you know I enjoyed this a lot and I would need at least one more chapter to express this - that, however, I am sure you would be very critical about.

There were also a number of colleagues who supported me and commented on my work which was important for developing the ideas and arguments of this thesis, most importantly Mirella Cacace, John Clarke, Anja Jakobi, Meri Koivusalo, Kelley Lee, Paul Stubbs and Claus Wendt. Very special thanks to Rianne Mahon for our conversations in Stockholm and Hamburg. I also benefited a lot from the discussions with Ines Vitic and Veronika Wodsak. Thanks also to the students I have taught at Sheffield, Bielefeld and Bremen and who I "forced" to discuss my research with me. Many thanks to my informants from the World Bank/IFC, WHO, ILO, IMF, OECD and "Global Health Watch" for taking the time to talk to me and discussing global health policy. I hope you can live with my findings and interpretations. Jo Ingold and Amy Barnes did not get tired of revising my German-English style. Thank you so much for this! Thanks also to Erica, Morgan and Masoud who patiently listened to any PhD studies worries even in the middle of the night.

I am deeply indebted to my partner Imke who has supported me in all possible ways, and to my children Marieke and Joshua who show me other than the PhD sides of life. Thank you so much for your love that carried me through all ups and downs of a PhD! I would also like to thank my parents, Gitte and Bernhard, for giving the horse the legs to run. All of you and Margarete, Hans, Mocki, Hilde und Siegfried and a number of babysitters made it possible for me to enjoy working and traveling even when the children fell ill and we were lacking childcare. My brother Andreas was always there when the computer went on strike.

Last but not least, enjoying this kind of PhD studies was made possible through the financial support from Imke, Gitte, Bernhard, the University Fee Bursary from my Department and the Research Training Group on World Society in Bielefeld. Thanks also to my colleagues at Bremen for being patient!

Alexandra Kaasch, Bremen, December 2010

Figures and tables

Figure 3.1	Regulatory Relationships in Health Systems	101
Figure 5.1	Regulatory Relationships (WHO)	149
Figure 5.2	Regulatory Relationships (CMH)	152
Figure 5.3	Regulatory Relationships (CSDH)	155
Figure 5.4	Regulatory Relationships (World Bank)	171
Figure 5.5	Regulatory Relationships (ILO)	182
Figure 5.6	Regulatory Relationships (OECD)	189

Table 3.1	Comparison of Health System Models (analytical)	103
Table 3.2	Communication Channels (analytical)	110
Table 5.1	Comparison of Health System Models	191-2
Table 6.1	Communication Channels (WHO)	214
Table 6.2	Communication Channels (World Bank)	221
Table 6.3	Communication Channels (ILO)	226
Table 6.4	Communication Channels (OECD)	230
Table 6.5	Comparing Communication Channels	235
Table 8.1	Comparing Health System and Pension Discourses	267

Abbreviations and Acronyms

CCS	Country Cooperation Strategy (WHO)
CMH	Commission on Macroeconomics and Health (WHO)
CRC	Convention of the Right of the Child
CSDH	Commission on the Social Determinants of Health (WHO)
CSO	Civil Society Organisation
CSR	Corporate Social Responsibility
CTC	Close to Client
DAC	Development Assistance Committee (OECD)
DAH	Development Assistance for Health
DALY	Disability-adjusted life year
DELSA	Directorate for Employment, Labour and Social Affairs (OECD)
EB	Executive Board (WHO)
ECOSOC	Economic and Social Council (UN)
EDRC	Economic Development Review Committee (OECD)
EU	European Union
GA	General Assembly (UN)
GATS	General Agreement on Trade in Services (WTO)
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
GHW	Global Health Watch
GTZ	German Enterprise for Technical Cooperation
HCF	Health Care Financing
HFA	Health for All
HIPC	Highly Indebted Poor Country
HLF	High Level Forum

HNP	Health, Nutrition and Population (World Bank)
HSS	Health System Strengthening
IBRD	International Bank for Reconstruction and Development
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDA	International Development Association
IDPF	International Drug Purchasing Facility
IED	Institute of Economic Development (World Bank)
IFC	International Finance Corporation (World Bank Group)
IFFIm	International Finance Facility for Immunisation
IFI	International Financial Institution
IGO	International governmental organisation
ILC	International Labour Conference (ILO)
ILO	International Labour Organisation
IMF	International Monetary Fund
INGO	International non-governmental organisation
ISSA	International Social Security Association
LIC	Low-Income Country
MDG	Millennium Development Goal
MIC	Middle-Income Country
NAM	Non-Aligned Movement
NGO	Non-governmental organisation
NHS	National Health Systems
OECD	Organisation for Economic Cooperation and Development
PAYG	Pay As You Go
PHC	Primary Health Care
PROST	Pension Reforms Options Simulation Toolkit (World Bank)

PRSP	Poverty Reduction Strategy Paper
STD	Sexually Transmitted Diseases
STEP	Strategies and Tools against social Exclusion and Poverty (ILO)
TRIPS	Agreement on Trade-related Aspects of Intellectual Property Rights (WTO)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN DESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
WBI	World Bank Institute
WDR	World Development Report (World Bank)
WHA	World Health Assembly (WHO)
WHO	World Health Organisation
WHOSIS	WHO Statistical Information System
WHR	World Health Report (WHO)
WTO	World Trade Organisation

PART I: GLOBAL SOCIAL POLICY IN THE FIELD OF HEALTH SYSTEMS

1. Introduction: Global Social Policy and the Study of Health System Models

1.1 Research Purpose and Research Questions

This thesis is a discussion of some fundamental elements of global social policy concepts. It attempts to contribute to theorising global social policy by analysing international organisations' ideas about health systems and comparing them to those about pension systems. The results of this analysis are then used to contribute to a refined understanding of global social policy concepts. Accordingly, the basic research questions guiding this thesis are: ***Are the findings on the global discourse on pension systems replicated when examining models of national health systems brought forward by global social policy actors? And what does that imply for general concepts of, and analytical approaches to, global social policy?*** The main focus is on whether and how different international (inter-governmental) organisations differ and compete, or – on the contrary – become more similar and collaborate, in the health system models they present and spread.

This chapter includes discussions of the key terms and concepts used (section 1.2), the literature review (section 1.3), the methodological approaches (section 1.4), the units of analysis (1.5), and limitations of the analysis (1.6).

1.2 Global Social Policy: Key Terms and Concepts

1.2.1 The Terms *global, global actors, ideas* and *health systems*

Given the purpose of this analysis, namely testing and contributing to a specific concept of global social policy, it is important to spell out some of the key terms and concepts used in the global social policy literature and in this thesis specifically. This leads to the following specifications:

1.2.1.1 The Term "global"

Reflecting the use of the adjective *global* in the global social policy literature, *global* is used in this thesis to refer to a specific dimension of social policy making, and a particular type of actors and processes involved in social policy, that goes beyond the nation state. The actors concerned are different kinds of organisations that are comprised of regional or global groups of governments and/ or various types of civil society organisations (CSOs), business organisations, professional organisations and so on. The processes of policy formulation and/or decision-making (as far as the latter actually happens) are different from those of national policy making in that they are legitimated in other ways than national (democratic) procedures (e.g. through mandates by member states and through the specification and interpretation of these mandates by the organisations themselves) and often less, or at least differently, organised (for example as networks, policy learning processes) (see for example Boswell, 2008). It has, however, to be noted that there is a disagreement in the literature about the usefulness of *global* versus that of *transnational*. This is due to the connotation with *global* of meaning to be applicable in the same way at any place and time, thus having *universal* applicability. The disadvantage of the term *transnational*, on the other side, is that it is – literally – still attached to "the national" while global social policy concepts also include forms of a "truly" global social policy, for example, in the sense of global redistribution, regulation and rights as a response to global social problems. Further, global

social policy studies have also focused on the relationships between global actors. In both cases, the processes are not only and not always shaped by the unit of the nation state. *Transnational,* thus, is rather a useful term when the issue to be explained still connects to national redistribution, regulation and rights, or in studies that trace the transfer and translation of policies into national contexts. Given the focus of the thesis on the activities and ideas generating from the (secretariats of) international organisations mainly, and reflecting the use of the term in much of the global social policy literature, the term *global* is used referring to the actors, ideas and communication channels under study.

1.2.1.2 International Organisations as Global (Social Policy) Actors

The term 'global actors' is used as the general term under which international organisations are one type. International (inter-governmental) organisations are the category of global social policy actors that are the specific focus of the study reported in this thesis. This does not imply that the issue under investigation is the interaction between governments within international organisations – as a literal reading of the term *inter-national* or *inter-governmental* suggests. The focus of this research project is primarily on ideas developed within the secretariats of international organisations, and by staff of international organisations who are concerned with rather theoretical contributions to social policy issues. The link between member states and international organisations in the context of this thesis appears in a rather indirect way: First, mandates given to international organisations by member states link the two units in a way that makes an international organisation more and other than the pure interaction between member states. Second, the potential recipients of the ideas communicated by (the secretariats of) international organisations are, amongst other things, the governments of member states. These indirect links imply for this study that actors (secretariats of international organisations) are studied in their independence from member states and as actors in their own right, and it

reflects the terms used in the global social policy literature. De Senarclens (2007) has referred to the relative autonomy of the secretariats of international organisations. A more recent body of literature under the term international bureaucracies develops upon this further (Brock and Wikler, 2006).

1.2.1.3 Ideas

Further, the thesis talks about global ideas as those ideas being developed and communicated by global social policy actors. *Ideas* as a concept have been understood differently in the literature. Studies on policy ideas are based on the assumption that not only mechanisms like hard law or trade sanctions may make countries change existing national structures and policies, but also norms or models advocated and discussed at other than national levels or with the participation of "external" actors (unlike national players). McNeill (2005:58) defines ideas as "collective images" that powerfully influence policy and that develop through the "interplay between the academic and policy domains", and Emmerji et al. (2005:214) as those "normative or causal beliefs held by individuals or adopted by institutions that influence their attitudes and actions". Normative ideas are "broad, general ideas about what the world should look like"; and causal ideas describe "more operational motives about what strategy will have the desired result or what tactics will achieve a particular strategy" (Emmerji et al., 2005:214, see also Beyeler, 2004). Ideas matter in two ways: on the one hand, in the form of *shared ideas* they serve the goals of achieving consensus across institutions and between member states at the international level. On the other hand, *contested ideas* between different actors at the global level can be observed. In this second understanding, ideas appear as an important source of power (McNeill, 2005:57).

When it comes to their potential influence, Beyeler (2004:4) defines ideas more narrowly as models or theories providing solutions to problems, thus as alternative theories that seem to be more appropriate to a problem.

Orenstein (2003) states, though, that a crisis in a policy field is not sufficient for a policy innovation. Some authors argue that ideas need to harmonise with the underlying values and norms of a society if they want to be influential (e.g. Hall, 1999). Related to this is also the connection between ideas and interests and the importance of individuals "to grab new ideas and promote them" (Ross, 2000:25, see also Sikkink, 1991). Sikkink (1991:248) further stresses the point that "if these ideas do not find institutional homes, they will not be able to sustain themselves over the long term". In turn, this also means that the decisions an actor takes are dependent on the institutionally-defined roles (March and Olsen, 1989), and a new idea will be more powerful or influential if it fits well with already existing ideas (Sikkink, 1991, Beyeler, 2004). At the same time, Maxwell and Stone (2005) and McNeill (2005) argue that ideas can also be sources of power independent of providing solutions to particular (national) problems or bound to institutional homes, but also for the power of, and relationship between, international organisations.

While the potential power of ideas, both in the sense of influencing social policy making as well as shaping the interactions between global social policy actors is part of the consideration and background to this study, the central question in this study is not *if* ideas matter, but to understand the sources of ideas as well as their content and the ways to communicate them. Ideas for the purpose of this thesis are understood as those social policy models for fields of national welfare states that are developed and communicated by international organisations. More concretely, the study focuses on ideas as models of (national) health systems and the communication channels used to make these ideas travel.

1.2.1.4 Health Systems

The concept of health systems, as well as similar concepts such as health sector reform, refers to a broad and extensive body of literature. However, it also comes with very different connotations and issues of investigation and interest. In the following some of these definitions and understandings by different fields of the literature are briefly presented. It needs to be emphasised, however, that this section is not supposed to define a particular understanding of a *health system*. The reason for this is that definitions of health systems are part of the set of analytical questions. The issue here is not to test whether or not the health system definition of a particular international organisation fits a pre-defined definition or how it relates to such a definition, but to see the similarities and differences between definitions and understandings of health systems generated by the different international organisations. For example, the definition of health systems contained in the World Health Report 2000 (WHR2000) of the World Health Organisation (WHO) that states health systems "compris[e] all the organizations, institutions and resources that are devoted to producing health actions" is one of the definitions described and analysed in the findings chapter 5. In contrast, this chapter presents different scholarly perspectives on health systems and highlights the specific perspective used for the analysis of this thesis, namely looking at health system definitions and concepts as part of the broader concept of the welfare state. Health systems are the analytical focus of the thesis and therefore the framework to study them is provided in more detail in chapter 3.

One important discipline dealing with health systems is *health economics*. McPake and Normand (2009:5) summarise the aims of economic analysis in health and health care as having two main goals: "improving the health status of the population and fairness or equity". However, "[i]n economics it is recognised that choices must be made – it is not possible to get everything you want. While some policies may offer the opportunity to increase both equity and health improvement, others require a choice between equity and health improvement – in other words we must sometimes choose to trade off

efficiency (the achievement of better health) and equity (the fairer distribution of health)" (WHO, 2009:8). Nevertheless, much of that literature acknowledges, and tries to take account of, the particularities of the health sector that seriously question the use of standard economic recipes for running health systems and tackling health problems. For example Hurley (2008: 67) summarises that demand for health care is derived from demand for health; that there are externalities; that there are informational asymmetries between patients and providers; and that there is a significant level of uncertainty related to the need and effectiveness of health care. This is also why much of the non-economic literature is critical, and pointing to the deficiencies, of economics dealing with health systems. Wendt (2006:272) points to health economics being primarily focused on issues of finances and expenditures while neglecting important issues of provision and governance. Similarly, Hodgson (1995:251) criticises that the "predominant mainstream focus in the literature has been on issues of measurement and quantification, to the relative neglect of the big questions". He further stresses that health systems are "non-linear, complex and have strong interactive effects".

Already in the 1960s, Arrow (2003) had discussed the uncertainty with respect to health care. At this time, health policy and health systems came more into focus of (health) economists. Brian Abel-Smith, for example, discussed issues of financing health systems with a particular focus on the differences between the US and European systems (Brekke and Sørgard, 2007), and the UK's national health service (NHS) (Pellegrino, 2005, 1963). Further important contributions came from Kenneth Lee and Anne Mills, for example the edited volume 'Economics and Health Planning' (Lee, 1979), exploring the economic aspects of the British medical care system. Particularly Anne Mills later increasingly focused on international health issues, especially health policy in developing countries (e.g. Hervey and Trubek, 2006, Fotaki et al., 2008).

While one of the missing bits of economic approaches has been identified in the lack of comparison (Elola et al., 1995), this is where *sociological* and *social policy* perspectives have their strengths. Sociological perspectives may place health systems in a historical and/or comparative perspective and look at issues like the convergence (Field, 1973) or institutionalisation (Inoue and Drori, 2006). They also tend to regard health systems as a specialised sub-system of society, with the totality of health systems in a society adding up to one (national) health system, and existing "alongside other functionally relevant systems such as education, welfare, communications etc." (Field, 1973:768). Accordingly, Field (1973:765) defines the health system as the "social mechanism that has arisen or been devised to deal with the incapacitating aspects of illness, trauma and (to some degree) premature mortality".

Yet other approaches, more originating from medical, sociological or even anthropological perspectives, are those that come with the label *public health studies*. They typically focus on the health of particular groups of the population and start up with assumptions about the improvement of the health of the population (such as smoking and tobacco control), but the interest also extends to health system issues. Gill Walt, for example, defined health policy as "embrac[ing] courses of action that affect the set of institutions, organisations, services, and funding arrangements for the health care system. It goes beyond health services, however, and includes actions or intended actions by public, private and voluntary organisations that have an impact on health" (Walt, 1994: 41). However, health policy is often also linked to the concept of "public policy that aims to explain the interaction between institutions, interests and ideas in the policy process" (Walt et al., 2008:308). Those writing within frames of health/ public policy in connection with health systems see health policy as articulating and shaping the structure of a health system (see for example Janovsky and Cassels, 1996). A common feature of such studies is also that health policy is directly linked to health outcomes.

A *health systems* approach as employed by Mackintosh and Koivusalo (2005) tries to combine the economic approach to health systems with one of public health and medical systems. They define, therefore, "health policies and health systems [...] [as] public policies and health policies [that] form part of the broader public policy framework in a society" (Mackintosh and Koivusalo, 2005:5), and point to the fact that health policies "are also part of normative policy-making within a society, and embedded in legal rights and commitments made as part of public policies" (Mackintosh and Koivusalo, 2005:5). This implies that "[i]n practice health policies are rarely defined explicitly in a society unless a process of reform or policy change is suggested" (Mackintosh and Koivusalo, 2005:5).

Social administration literature is concerned with how to manage the welfare state and its institutions of social protection. This includes issues such as the cost-effectiveness of benefits and the quality of services. The focus of this kind of studies is usually on the administrative intermediaries between governments and welfare claimants (e.g. welfare administrators, professional organisations, patient representations) (Fotaki et al., 2008). This is connected to the "New Public Management" approach (Minogue, 1998) including ideas about the purchaser-provider split, private providers and decentralisation (Le Grand, 2007). The solutions to problems are proposed to lie in networked governance rather than top-down policy-making, and public-private partnerships.

Comparative social and health policy approaches do study health systems in a different way than just as issues of reform and change. Health system reform, on the one hand, commonly refers to a particular type of reform, such as moves towards a mixed service provision, the liberalisation of clinical provision and pharmaceuticals, moving to a mainly regulatory role of the government, the introduction of decentralisation and user fees (Mackintosh and Koivusalo, 2005). Models or regime types of health systems, in contrast, try to identify specific types of welfare state arrangements for handling illness and treatment. While reform directions

might be towards liberalisation or marketisation, the basic character of the system (which also to some extent affects the form and outcome of any reform) is described differently. A country is characterised by its welfare state model, and therefore also its health system can be regarded, for example, as of the Nordic type, the Bismarckian type or the liberal type. A study on models and regime or ideal types demands a different form of analysis to one of policy reform. The particular approach of this thesis for studying health system models is developed later in this section and of course elsewhere in this thesis (chapter 3).

Within and between the interests of all these, and other health-related, disciplines, we find a number of crucial and characteristic health system issues being raised. Regarding broader models, there is the question of whether or not taxation systems provide better health financing and provision mechanisms than insurance systems. The latter itself is divided between the advantages and disadvantages of private or public/ social health insurance. Proponents of taxation models point to the fact that this type is cheaper and more egalitarian (e.g. Elola et al., 1995). Those who favour insurance models usually point to the advantages regarding quality and flexibility in the provision of services, and less waiting times (for an overview see Hussey and Anderson, 2003). Yet others stress the particular promises of health provision by private entities and/ or the increase in consumer choice and quality of services through private health insurance (e.g. Hoel and Saether, 2003). Given the fact that health systems all over the world are understood to be in crisis due to raising costs and changing demographics, there is also a common discussion about whether and how to cut (public) expenditure in the health sector.

Looking at the different functions of health systems, namely provision, financing and regulation, there are even more such debates. In service *provision*, the issue of for-profit versus not-for-profit providers is important (e.g. Brekke and Sørgard, 2007). Also themes like gatekeeper systems

(primary care, access to secondary and tertiary care) feature here (e.g. Pellegrino, 2005).

In financing, we find controversial issues about user fees or out-of-pocket payments (e.g. McIntyre et al., 2006, Hoel, 2005), and the structure and calculation of contributions in insurance systems. This is also connected to the degree or character of redistribution through health systems (Breyer and Haufer, 2000).

Regarding regulation, there are important discussions, for example, concerning budgeting and the remuneration of private doctors. The access of potential providers to health care markets have seen controversial debates particularly related to the freedom of services within the EU (Hervey and Trubek, 2006), but also with regard to trade discussions about the WTO's activities (see excursus I in chapter 5). Other issues concern the question of the access of patients to service providers – should this be organised as free choice of providers or should a particular doctor be assigned (Fotaki et al., 2008)? There are also issues around who and how to define the content of the benefit package (Kutzin, 2000, Brock and Wikler, 2006, Mills, 2007). Questions concerned are: what is basic health care? Are services free for children? Is dental health care included? What is the relationship between preventive and curative measures?

Currently, there are further heated debates about universal access to health care in the US, while in European countries, the need to provide health care to everybody is rather consensual (even though there are issues about the scope of the services) (Reibling, 2010). This is also connected debates about the rights to health.

Health reform debates commonly see a high number of different actors and powerful interest groups involved. Apart from governments and different ministries (e.g. health, finance, social protection), particularly the medical professions, and pharmaceutical industries are powerful players in health politics. But also patients' organisations raise their voices on various health

issues; and charity organisations as health care providers also join political debates.

Once the specific characteristics and needs of low- and middle-income countries and development issues are taken into account, even more controversial issues are added to the mapping of health system debates. In terms of health provision, barefoot doctors were seen as a way of improving health in remote locations (Smith, 1974). Currently, some of the Millennium Development Goals (MDGs) focus on a number of health issues and there is controversy on the choice of focus on specific diseases and health problems (e.g. the major communicable diseases), instead of following more comprehensive strategies to strengthening health systems. Also, in development contexts, health issues need to be tackled with a much broader perspective than in most OECD countries – water and sanitation and nutrition cannot be separated from health policies. But also more truly transnational processes such as the brain drain (in health workers) and cross-border health services are crucial issues and subject to controversy in national and global health debates.

Returning to the focus on health systems we have seen that health systems have been approached from numerous analytical perspectives, various disciplines and different starting points. Part of the above mentioned literature is concerned with how to reform health systems with particular ideals in mind (health economists, social administration). The underlying question is: how to best reform health systems? Other literature is rather concerned with questions of definition and scope: What is a health system? What should be part of a health system? And again other literature is interested in the interactions, the politics of health system reform. This thesis is deeply grounded in a social policy or welfare state tradition, and thus the focus and methodology primarily refers to that body of the literature. More specifically, this thesis is therefore about *ideal types* or *models* of health systems, and the similarities and differences between them. If this project were about comparing countries' health systems (as the

typical focus of comparative welfare state research), the question would be: How are health systems organised in different places? Here, in the case of ideas from different international organisations, this translates into: to what extent do health systems models developed by international organisations resemble ideal-types of health systems, and, connected to this, how do they compare to each other? It further implies that approaches that study health systems as part of the welfare state are primarily interested in health systems as systems of social protection, forming one part of the broader concept of the welfare state, or social policy systems. Health system studies as part of welfare state research are typically related to Esping-Andersen's (1990) work on diverse types of welfare states and discuss to what extent health systems, as parts of the welfare state, are captured by ideal types (Bambra, 2005b, Mills, 2007). Accordingly, designing a study within the tradition of global social policy research, health systems in this thesis follow the logic of health systems as social policies or as part of the welfare state and are addressed at the link between comparative social policy studies and global social policy phenomena.

It is, thus, in the context of this thesis, less important to define at the outset *health systems* as such. The study is concerned about the *definitions* and *models* of health systems expressed by others (i.e. international organisations). They are to be compared with each other regarding, not contrasted against, a pre-defined understanding about what health systems should be like. It is therefore that the emphasis is on the analytical framework to understand ideas about health systems by a defined group of organisations. The fit of the cases with the ideal types and potential variations between them is the issue in this piece of research.

This also means that the issue here is *not* on whether or not a particular country (like the US) does have a welfare state and if health systems are necessarily a part of the welfare state. While this frequently results in misunderstandings in the literature, welfare state literature uses the term *welfare state*, amongst other things, to refer to the sum of social policy

arrangements in a country. Health systems, for example, in their redistributive functions, or related to rights to health care, are therefore seen as parts of the welfare state. Accordingly, for this particular thesis, it is an *analytical decision* to look at health systems as the common welfare state literature does; because the discussion of this thesis intends to speak to the literature of global and comparative social policy.

The focus on *models* and their resemblance to ideal types or regime types also implies that the focus is less on changes or reform proposals, but more on units such as "taxation model" or "insurance model". The aforementioned core debates are often connected to the reform of health systems and they usually form part of the health debates in different countries with different regime types (models) of health systems. Identifying models is, thus, a different type of study to one that attempts to capture the *reform* debates.

1.2.2 Origins and Characteristics of Global Social Policy **Research**

Originally, global social policy approaches have been developed by social policy scholars as a particular perspective of social policy research, that, instead of engaging with the common comparative frameworks of international social policy analysis, moved on to analysing external actors' influence on national social policy making, and to the even more truly "global", forms of social policy, such as the global formation of labour policy (O'Brien, 2008, Farnsworth, 2005a).

This shift in focus with regard to the study of social policy and the welfare state has built up on a more complex relationship between globalisation and the welfare state than is taken into account in other welfare state literature that often merely looks at the impact of economic globalisation on the state's capacity to run existing welfare state arrangements. More concretely, literature on social policy, or on the welfare state, has traditionally been

concerned with the emergence and reform of social policy or social security arrangements within national frameworks (e.g. Bonoli, 1997, Iversen and Cusack, 2000, Esping-Andersen, 1990). While such studies increasingly acknowledge the existence of external influences on national policy making in general, most of them are still mainly national (even if internationally comparative) in focus, particularly the welfare state research on OECD countries. The role of international organisations, in contrast, has been a focus of research regarding transition states (e.g. Müller, 2003, Müller et al., 1999, Deacon, 2000, Deacon et al., 1997) or developing countries (e.g. Mkandawire, 2004a). In general, there are various connections between globalisation processes and welfare state development for all groups of countries, however with different implications for each of them, as discussed by some of the contributions in Benvenisti and Nolte (2004b). For example the chapter by Tsilly Dagan (2004) demonstrates how bilateral tax treaties facilitate rich instead of poorer countries to collect taxes and, by that way, create a regressive redistribution of wealth benefitting rich countries. An exception regarding the group of countries in focus of transnational policy influences is the volume by Armingeon and Beyeler (2004) that studies the OECD's impact on European welfare states.

However, not only concerning different groups of countries, globalisation processes are in many and complex ways impacting on national social policy making. Both Deacon (2007:9ff) and Yeates (2008a) list a number of examples of this, including setting welfare states in competition with each other; bringing social policy issues to supranational policy levels; creating global private markets in social provision; facilitating the global movement of peoples with consequences for welfare obligations and entitlements; and creating new social risks. Different perspectives and judgements as to the impact of globalisation on social policy development can be found.

One perspective is to trace the negative influences of (economic) globalisation on social policy. Mishra (1999:3ff), argues that globalisation is weakening and constraining the influence and ability of national

governments to organise their social policies according to the objectives of full employment and economic growth. This brings about increasing inequality in wages and working conditions; a downward pressure on systems of social protection and social expenditures; the weakening of the ideological underpinnings of social protection, and the basis of social partnership and tripartism; and a reduction of policy options. These processes have been characterised with expressions like the "race to the bottom" (Alber and Standing, 2000).

Such perceptions are considered to be exaggerated by other scholars writing on social policy and globalisation like Yeates (2005b:164) who points to "the continued importance of political agency, social conflict and struggle in determining the pace, course, timing and impact of globalization". Swank (2005:192) also shows that "[t]he latest research on the direction and magnitude of the impacts of economic internationalisation on the welfare state largely dispels what for a decade or more was conventional wisdom, namely that globalisation means the inevitable retrenchment of generous systems of social protection and the diminution of democratic policy choices". Similarly, Mkandawire (2004b:29) summarises from the contributions of the edited volume *Social Policy in a Development Context* (2004a) that there is no simple relationship between globalisation and social policy as, for example, the chapter *'Late Industrializers' and the Development of the Welfare State* by Pierson (2004) shows. But Mkandawire (2004b:29) also states that "[g]lobalization affects social policy both at the normative level and in a more practical way, by setting constraints that social policy must be attentive to. Adhesion to international conventions, adjustment to fiscal pressures and responses to an international discourse on 'social rights' permeate domestic politics and affect social policy – or at least the thinking about it."

The link between globalisation and social policy can also be regarded as positive or constructive. Benvenisti and Nolte (2004a:VII) discuss the potential opportunities arising through globalisation, for example the

possibility of globalisation leading to increased global standards of living, security and political freedoms. Similarly, summarising an edited volume on globalisation and health (Lee et al., 2002a), Buse et al. (2002:279) point to "alternative approaches to global policy that can result in improvements in human security and justice", however, that requires managing the process of globalisation (e.g. by governing labour standards, structuring multilateral trade agreements or regulating emerging global health markets). This potential of globalisation for strengthened globalised social policy can also generate political projects of global social policy (e.g. GASPP team, 2005).

A more manifest outcome of globalisation has been the emergence of global markets of goods and services, including social provision. This has made it more difficult to regulate business and guarantee social rights at the national level and has furthered the private provision of services. The latter, as argued by Deacon (2007), has led to an increase in the private share of the public-private welfare mix.

1.2.3 Global Social Policy Definitions

Global social policy as a field is not represented by a particularly large body of literature. With a rather broad focus, the topic has been approached most comprehensively by Bob Deacon (particularly Deacon, 2007, 2006, 1997), but also by Nicola Yeates (2008b, 2001) and Lutz Leisering (2005, 2007). Related to specific social policy fields, or particular groups of actors, there are further contributions that are detailed in the paragraphs to follow. It is important to see that exploring the different dimensions and fields of global social policy opens the way to a whole range of literature often not explicitly linked to global social policy research, but which nonetheless makes an important contribution to understanding global social policy phenomena.

The attempts to define global social policy here are based on the work of Deacon (2007, 1997), Orenstein (2005), Leisering (2007), and Yeates (1999, 2008a). In short, Deacon (2007:1) explains:

> *Global social policy consists of two things: first, it is the social policy prescriptions for national social policy being articulated by global actors such as international organisations; second, it is the emerging supranational social policies and mechanisms of global redistribution, global social regulation and global social rights.*

Thus, global social policy can be said to have two *dimensions*: (1) policy models for national social policy or different social policy sectors (the focus of this thesis), and (2) a supranational social policy understood as global redistribution, regulation, and rights.

Similarly, Orenstein (2005:177) defines global social policies as "those that are developed, diffused, and implemented with the direct involvement of global policy actors and coalitions at or across the international, national or local levels of governance". Leisering, however, categorises forms of global social policy, differentiating three levels that cross-cut the two forms distinguished by Deacon; namely (1) ideas, norms, and targets; (2) actors and institutions; and (3) political initiatives and instruments, as necessary components for a global welfare state. Only if all of these are present to a substantial degree should one talk about "global social policy" (Leisering, 2007).

Referring to still other dimensions of global social policy, Yeates (2008a:13) points to the value of "embedded transnationalism [that] does not draw a strict demarcation between the national (that is, internal) sphere from the transnational or global (that is, external) one, and is informed by a recognition of the existence of transnational spaces within nation states and the playing out of transnational processes within national territories as well as across them".

All of these definitions also involve an important role of different global policy actors and their contributions to forms of global guidance and global

governance related to social policy. The initial approach (Deacon et al., 1997) primarily focused on institutional and policy elites (Yeates, 1999). Now, Yeates (2008a:14) argues:

> *Global social policy analysis has come to embrace a variety of sites, spheres and scales of socio-political collective action to influence social policy. While a core focus on IGOs*[1] *remains, there is increasing focus on the* ***multiple socio-spatial sites and scales*** *across which social policy formation occurs, the wider range of global policy actors and the 'everyday' transnationalisms of social welfare provision and policy making.*

Looking at the different dimensions of global social policy, the global activities of advising national social policy are different from forms of a *supranational social policy*, namely global social redistribution, regulation and rights (Deacon, 2007). Sometimes the boundaries between the two forms are not that clear and some global social policy topics and debates cross-cut the two dimensions.

Global social redistribution means a compilation of policies and issues, mainly in the context of development policy. It is about aid and its effectiveness, debt relief and international finance facilities and global funds. Global redistribution does not happen as part of a so-designed "global welfare state" (see discussion in Leisering, 2007), but means development assistance, or – in a more critical sense – also financial flows from the South to the North in terms of cheap products and labour. Health is an important field in which global social redistribution can take place. Many of the innovative financing facilities are connected to health issues (e.g. the International Finance Facility for Immunisation (IFFIm), or the International Drug Purchasing Facility (IDPF)). There are further global funds for supporting health development, most importantly the Global Fund to Fight Aids, Tuberculosis, and Malaria (GFATM). Of ever increasing importance is also the Bill and Melinda Gates Foundation, a philanthropic organisation, spending immense amounts of money on various health projects. In terms of

[1] International governmental organisation (added by AK)

international organisations, there is, for example, the ILO's Global Trust pre-pilot scheme that provides families in Ghana with health care coverage through subsidisation of their premiums. While not yet having been identified or studied as explicitly contributing to global social policy discourses on national health systems, global health projects run, and supported by, such actors naturally also carry particular ideas on health system issues and influences. Another important issue is that the GFATM has been recommended to take on the lead position on health systems (Center for Global Development, 2007).

Another issue within this global social policy dimension is connected to the definition and potential provision of global public goods (Kaul et al., 2003, Kaul et al., 1999). Health plays an important role, as a number of health issues have been identified as having a "global public good" character, like the global surveillance of infectious diseases (as through the WHO) or the global control of tobacco consumption and illicit drugs (e.g. Jha and Chaloupka, 2000, Gilmore et al., 2007, the WHO's Framework Convention on Tobacco Control is an important document in this context WHO, 2005 (updated reprint)).

Concerning *global social regulation*, critical issues are international or global labour and social standards, trade matters, voluntary codes of conduct by business, global tax regulation and migration. In contrast to the dimension of redistribution where health issues are a key field of activity, this is less so for regulation. However, an important discussion in this context is that of the implications of trade agreements and the World Trade Organisation's (WTO) role in the health sector. The concern here is that through facilitating trade also in social and health services, detrimental effects for the health of people and social security systems can arise (e.g. Koivusalo, 1999, 2003a, 2003b, 2003c, Holden, 2003, 2005, Sexton, 2001, Pollock and Price, 2000). Another issue, connected to migration and particularly relevant for health, is "brain drain" that is the weakening of health systems due to staff shortages caused by migration (e.g. Kapur and

McHale, 2005, Martineau et al., 2004). Further, global food standards are also related to health issues (e.g. Post, 2005).

As the third element of a supranational global social policy, *global social rights* have to be considered. These represent a particular type of rights as – compared to civil and political rights – they require resources in order to be met (Deacon, 2007:136). Such social rights have been formulated, amongst others, in the International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1976, the Universal Declaration of Human Rights of 1948, and the Convention on the Rights of the Child (CRC) of 1990 and the International Covenant on Civil and Political Rights (ICCPR) of 1976. Rights issues are particularly important in the context of gender, ethnicity or other issues that are prone to discriminatory practices; and include health-related rights (see for example Deacon, 2007, Mishra, 1999, Tarantola, 2008). Tarantola shows how health as a social right came into focus in the context of dealing with HIV/AIDS due to the belief that "human rights were [...] a prerequisite for open access to prevention and care by those who needed them most; away from fear, discrimination and other forms of human rights violations" (Tarantola, 2008:15). These issues are also important for the organisation of health systems.

These forms of global social and health policy represent only some examples of what is happening at the global level. Particularly regarding the second form of global social policy as supranational social policy, this is also connected to a potential future global welfare state, as discussed by Leisering (2007) or a global health system as envisaged by Kickbusch (2003). However, the form, feasibility or desirability of such a development in all its dimensions would still have to be proved.

The particular focus of this thesis is on the global social policy ideas by international organisations. The following sections primarily focus on the characteristics of this form.

1.3 Characterisations of Global Social Policy: A Literature Review

1.3.1 Competition at Three Levels

Turning now to the first dimension of global social policy (see above) and approaching the focus of this study analysing the ideas, connected actors and communication channels in one particular social policy field (health systems), the characteristics are as follows.

Global policy actors may have a number of different functions when it comes to providing models for national social policy. For example, they may act as sources of normative standards; as research institutions producing and communicating knowledge about social policy issues (for example Stone and Maxwell, 2005); or as "meeting points" for national governments for policy exchange and mutual learning. The ideas developed and communicated in such contexts are said to be powerful means of influencing national policy making. However, it has been found that different global institutions promote different, contradictory policy models, generating global discourses about desirable national social policy. These discourses are connected to particular international organisations, other actors and associated networks or epistemic communities. In 1997, Deacon et al. described this as evidence for a new "locus of the future ideological and political struggles for better global and national social policies" (p.10) at the global level.

The characterisations of global social policy are well demonstrated in the chapters of an edited volume, *Understanding Global Social Policy,* by Nicola Yeates (2008b), showing that global social policy research is driven by key assumptions about the relationship of global policy actors and their ideas. Bob Deacon (2008:44, emphasis added) suggests:

> *The system of global social governance is a mosaic of international organisations often* ***competing*** *with each other to shape policy.*

Yeates (2008b:22, emphasis added) concludes:

> *Global social policy is concerned with the* ***competing*** *interests and pressures on social policy formation and with the different applications and impacts of global ideas and policies on welfare systems and people around the world.*

While these two quotes *explicitly* describe global social policy as being fundamentally characterised by competition, both regarding global policy actors and ideas, such notions are rather *implicit* when it concerns the communication of global social policy ideas. Deacon (2007:24) formulates:

> *International organisations influence national policy through a variety of channels:*
>
> • *research, agenda setting and the development of knowledge frameworks;*
>
> • *policy-based lending and project conditionality; and*
>
> • *establishing global codes, rules and norms.*

These different channels are often discussed as being more or less powerful means to influence national social policy.

This is, of course, not all that defines and characterises global social policy, and in the course of the argumentation many other elements are introduced and discussed. However, the points made in the above citations relate to three key assumptions that explicitly and implicitly also run through many other scholarly contributions to global social policy. There are (1) competing actors (international organisations and others), (2) competing interests (expressed as ideas on national social policy), and (3) particular (more or less powerful) ways to make these ideas travel (communication channels).

More concretely, global social policy literature has been characterised by assumptions of, and a focus on, struggle or competition between global policy actors. Such contestations have emerged in – at least – three different dimensions. (1) There are competing agencies at the level of *mandates*, roles or responsibilities given to, or defined by, the respective actors themselves

when it comes to justifying the engagement in a particular policy field. On this dimension, common statements are, for example, that one international organisation, such as the WHO, is more mandated to fulfil a particular global task than another organisation, such as the World Bank (Koivusalo and Ollila, 1997, 2008). Orenstein, however, states that an actor becomes a global social policy actor by the fact of its engagement in the matter – the scope of activity, without going further into questions of legitimacy (Orenstein, 2005:177). Particularly characterising Deacon's work are (2) contestations at the level of *ideas*. This contest of ideas is expressed in the different approaches promoted by epistemic communities within and around the World Bank and the International Monetary Fund (IMF) (safety net social liberalism), the ILO, the European Union (EU) and the Council of Europe (conservative corporatism), and the United Nations Children's Fund (UNICEF) and the United Nations Development Programme (UNDP) (Deacon et al., 1997). However, in 2007, Deacon concluded that the World Bank strategy is also sector-specific, with support for privatisation in the field of pensions, but less so in the field of health. Further, Deacon (2007:171) summarises:

> *Thus the ideas about desirable national policy carried out and argued for by the international organisations [...] reveals something approaching a 'war of position' between those agencies and actors within them who have argued for a more selective, residual role for the state together with a larger role for private actors in health, social protection and education provision and those who took the opposite view. This division of opinion often reflected a disagreement as to whether the reduction of poverty was a matter of targeting specific resources on the most poor, or whether it was a matter of major social and political-institutional change involving a shift in power relations and a significant increase in redistribution from rich to poor. It does seem, in 2006, that the tide has turned against the targeting and privatising view [...]*

A third dimension of struggle between organisations has been discussed in relation to their *communication channels* (3). This means that, in combination with mandates and ideas, some global actors have been identified as weaker than others at getting their ideas promoted.

1.3.2 The Global Discourse on Pension Systems as Global Social Policy

The descriptions of contestations just presented have been particularly typical for characterisations of the global discourse on pension policy. Even more, a review of the global social policy literature (most notably Deacon et al., 1997, Deacon, 2007, Orenstein, 2005) suggests these assumptions have been developed from studying pension systems as global social policy, on the one hand, and various topics and issues from development studies, on the other. Other social policy fields usually associated with the "welfare state" (such as health systems and education) do not seem to have been studied in a similar way to that of global pension policy in order to generate a (more comprehensive or sustainable) definition of global social policy.

Both Orenstein (2005) and Ervik (2005) have analysed the role of global policy actors in the development, transfer and implementation of the "new pension reform". The global discourse on pension policy has been characterised in the following way: It was the ILO that, during the 1940s, was the internationally leading organisation in debates on pension models and the diffusion of ideas about them. The ILO's ideas were formulated in its *Declaration of Philadelphia* (1944). This included the model of a unified, national pension insurance system under a central social security administration and a unified set of (old-age and disability) pension benefits which was rather influenced by the Bismarkian German idea of an old-age pension system (a pay-as-you-go (PAYG) system). This approach is sceptical about private financing and supports taxation or social security contributions.

However, building on the case of Chile, which implemented a specific set of pension reforms, the World Bank theorised and developed a model that became widely spread through the publication of a flagship report entitled *Averting the Old Age Crisis* (World Bank, 1994). The pension model promoted is comprised of three pillars. The first one is a public one,

ensuring a very low basic pension (redistribution). The second pillar is a compulsory private pillar based on defined contributions rather than defined benefits, funded and managed privately (savings). The third pillar is open to any desire for further protection funded privately. By this way, the redistributive and income-related benefits function in different pillars. More recent publications on pensions, as well as the formulation and review of the World Bank's social security strategy (Holzmann, 2009, World Bank - Human Development Network, 2001) continue the reasoning of earlier work. While differing in its pension model considerably from the actual case of Chile (Orenstein, 2008:78), the model, amongst other things, built on the case of Chilean pension reform and the example was used to teach policy-makers from other countries. This model of a multi-pillar pension system has been influential in countries' pension reform policies and taken up in scholarly literature as well. These ideas also streamlined further World Bank activities. The popular model and communication policies of the World Bank generated a disagreement between different international organisations (World Bank, IMF, US institutions *vs.* ILO, International Social Security Association (ISSA)) and international epistemic communities on the best pension model. This debate was, amongst other things, about public versus private pension schemes, the link between social security/ pensions and economic growth/ globalisation and the definition of the problem. The World Bank model turned out to be more prominent and influential than that of the ILO because of "a clearly focused research agenda; a platform that emphasized ancillary benefits for economy-wide savings and investment [...]; consistency with neoliberal reform agenda; limited opposition from vested interest groups; coordination of campaigning organisation and ability to leverage various resources more effectively" (Orenstein, 2005:192f. see also Brooks, 2004). However, Deacon (2007:170) has recently argued that:

> *Although the World Bank took over the general leadership role in the 1980s and 1990s, and argued for and secured the role-back [sic] of the state system of pensions in favour of privatised and individualised forms, the ILO fought long and hard to*

> *expose what it regarded as flaws in the dominant World Bank thinking on pensions by arguing that there was no demographic imperative leading to privatisation, that the European-type schemes are reformable and sustainable, and that the privatisation strategy is merely a cover to increase the share of private capital savings.*

Averting the Old Age Crisis was followed and supplemented by a *Pension Primer* to help governments to design and implement reforms[2], and the Bank's Pension Reforms Option Simulation Toolkit (PROST) (a standard actuarial software for quantitative analysis). Further, the World Bank Institute is teaching flagship courses on pension policy.

1.3.3 Global Ideas on Other Social Policy Fields

It has been argued that a main focus of existing global social policy research has been on pensions. However, there is also some work on other social policy fields, such as education and labour. These are, though much less comprehensively and thoroughly studied compared to the pensions discourse, or the focus is often on issues that are only marginally connected to social policy as a matter of coverage, access or financing.

In Hulme and Hulme (2008) education is used as an example to exemplify characteristics and processes of policy transfer. Referring to Robertson (2005) and other authors (Lefrere, 2007, Wickens and Sandlin, 2007, Rutkowski, 2007), the chapter suggests that in education there are similar patterns of controversial ideas as in pensions. However, a look at the literature referred to could also lead to the conclusions that, on the one hand, it is rather focused on concepts of learning or literacy (Robertson, 2005, Wickens and Sandlin, 2007), but on the other, it does not provide for a detailed analysis and findings on the policy ideas of the different actors

---

[2] See http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTPENSIONS/0,,contentMDK:20579507~pagePK:148956~piPK:216618~theSitePK:396253,00.html, accessed 29 December 2010

addressed here (Lefrere, 2007, Rutkowski, 2007). Accordingly, it is difficult on that basis to develop a meaningful comparison to the discourses on pensions and health systems as attempted in this thesis.

Turning to labour policy issues, these are primarily located in aspects of transnational social policies such as global regulation or human rights, ILO conventions or corporate social responsibility (CSR). However, O'Brien (2008) also briefly addresses issues of policy models such as the ILO Decent Work agenda, and the implications of conditional loans by international financial institutions. There is evidence for a typical controversy between the World Bank/IMF ideas (more flexible and cheap labour to increase competitiveness) and those of the ILO (without proper labour market institutions, macroeconomic stabilisation plans risk failure) (O'Brien, 2008:133). However, this limited discussion does not allow either for a meaningful comparison to pension and health systems.

1.3.4 Global Social Policy in the Field of Health Systems

What could be, in accordance with pensions, called the global "discourse" on health systems has been studied only to a limited extent. There are, however, some contributions touching upon issues like user fees or single functions of health systems. These contributions, while naturally having different foci and being driven by different aims, also indicate contestations at the levels of mandates, ideas and communication channels.

In relation to health systems and their functions, there have been contributions by Lee et al. (2002a) and Koivusalo and Ollila (1997, 2008). At the level of mandates, it has been argued that the WHO was the only international organisation with a "normative mandate" in the field of health; and that, for example, the World Bank was not sufficiently mandated to intervene in the health field despite the fact that it had been active in this area (Koivusalo and Ollila, 1997, 2008). At the level of ideas, differences

have been identified regarding the support of so-called comprehensive Primary Health Care (PHC) approaches, usually connected to the WHO and other UN social agencies, and those of selective health approaches, associated with UNICEF and the international financial institutions (IFIs) (see for example Koivusalo and Ollila, 1997). Vertical approaches are, in their "pure" form, programmes or interventions that concentrate on a single disease and are usually organised independently. In contrast, horizontal approaches encompass several health interventions within a more comprehensive primary care approach (see for example Victora et al., 2004). Walsh and Warren's (1980), for example, have argued for selective PHC because they say it "cannot be overemphasized that the greatest immediate efforts in health care in less developed areas should be aimed at preventing and managing those few diseases that cause the greatest mortality and morbidity and for which there are medical interventions of relatively high efficacy" (p.146). They do this with regard to the Alma-Ata Declaration (for a more detailed discussion see further down), that had clearly called for a comprehensive, horizontal approach in health. However, health systems per se cannot be fully equated with horizontal approaches – rather, periods of interest in horizontal approaches have provided a platform for engaging with health systems more thoroughly.

Controversial discourses have further been studied on a number of health system-related issues such as user fees (e.g. Evans and Morries, 1995, Gilson et al., 1995, McPake, 1993). Despite such different health policy agendas, Lee and Goodman (2002) have demonstrated that the time since 1994 has been marked by an hegemonic policy network or epistemic community. This means that a "widespread acceptance of the need for multiple resources of HCF[3] had replaced debates over public versus private financing, with research and policy discussions shifting to such issues as contracting out; purchaser-provider split and the public-private mix" (p.

[3] Health Care Financing

101)[4]. Accordingly, on the one hand, there have been controversial issues and concepts, but, on the other hand, there has also been a process of becoming more similar in policy ideas that has, at least partly, been generated by the increasing engagement (amongst other things in research). A third dimension could be seen in diffusion processes leading to particular debates characterising policy-making and knowledge generation at various levels without purely conscious processes and policies to transfer them – for example, Lee and Goodman mention that particular health system debates began in a small number of high-income countries and then gradually spread (Lee and Goodman, 2002:102).

Accordingly, communication channels have been discussed and understood in different ways. While for Lee and Goodman (2002), the explanation is in the identification of a policy network of a highly specialised elite; for Koivusalo and Ollila (1997) the issue has been more about the different mandates, resources and situations of global policy organisations. Inoue and Drori (2006), from a neo-institutionalist perspective, observe the increasing global engagement with health issues over a longer time-frame and argue that even a "global health system" has consolidated "reflecting a fusion in understanding health as a global concern, or a 'global social problem'" (p.212).

However, at the same time, it is still being argued that

> *One of the major consequences of the changing role of the state in health policy has been the blurring of the respective roles, responsibilities and jurisdictions of the public and private spheres [...]. The period [...] from the later twentieth century [...] has been marked by ideological disagreement over the appropriate role of the state and other institutions in the so-called social sectors. For many of the policy issues examined [...], this debate has been largely won by those who support a minimal role for the state, one of basic social support as a last resort to those most in need. The main engine and provider of economic wealth should come from the private sphere, with the state 'filling gaps' only when markets and other private*

[4] Referring to Hammer, J. (1996): Economic analysis for health projects. Policy Research Working Paper no. 1611, May, Washington DC: World Bank

initiatives fail. Based on this perspective, the relative size of the public and private spheres has shifted towards the latter.

(Buse et al., 2002:253, see also Cutler et al., 1999)

This is similar to Deacon's characterisation of global social policy. However, it has also been shown in global social and global health literature that global ideas on health systems are not extreme examples for promoting privatisation (Deacon, 2007, Lee and Goodman, 2002).

The contributions just mentioned do not necessarily explicitly link to global social policy, but can be read as global social policy studies. There are further some overviews of public health issues that include organisational issues of health systems to some extent, though they do not explicitly refer to health systems, for example Smith *et al.* (2003), Koop *et al.* (2001) and McKee *et al.* (2001).

The global social policy contributions on health policy in particular have been limited (mainly Lee and Goodman, 2002, Koivusalo and Ollila, 1997, Hein and Kohlmorgen, 2008) and the focus is often on the health-trade link and its implications for national health policy (Woodward, 2005, Pollock and Price, 2000, Koivusalo, 1999, 2003a, 2003b).

There are also international health policy approaches which, for example, have focused on health issues as they transcend borders (e.g. Kickbusch, 2000). Such literature is often linked to global ideas about health sector reform (e.g. Walt and Gilson, 1994, Musgrove, 1999). The concept of international health has been further developed into definitions of global health policy:

'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'

UNIVERSITY
OF SHEFFIELD
LIBRARY

(Lee et al., 2002b:5)

Global health governance more specifically looks at those international organisations NGOs, other actors, legal frameworks, public-private partnerships, national programmes and so on that make up the complicated governance structure in health policies and their cross-border dimensions (see for example Musgrove, 1999, Hein and Kohlmorgen, 2008, Thomas and Weber, 2004). In contrast to the global social policy approach on health, it is more focused on the nature and power of governance than the content of ideas.

1.4 Methodological Approaches to Studying Global Social Policy Ideas in the Field of Health Systems

As was described, the emphasis on pension policy in global social policy research and analysis has contributed to an orientation in global social policy literature that is very much focused on notions of competition, also described as reflecting class struggles that have gone beyond national decision-making fora to transnational levels or scales. This can be shown for example when looking at the chapter on global labour policy by Robert O'Brien (2008) and the article on poverty by St Clair (2006a). Does the same apply in this study of global health policy ideas? Here we set out the methodologies used to understand global social policy, particularly with regard to health systems.

Given the complexity, multi-scale and multi-actor character of global social policy as outlined above, its study demands a multi-disciplinary approach, combining, in particular, traditional forms of national, comparative and international social policy research with theories of international relations and global governance. At the same time, however, the research presented here is strongly oriented with Deacon's approach to study the pensions discourse and thus applying a global social policy approach that is interested in the specific social policy *ideas* developed and spread by international organisations.

1.4.1 International Relations

Capturing the role, importance and functions of international organisations in social policy or any other policy field is primarily a matter of studies of international relations within political science. International relations literature provides tools to understanding international organisations as such and within their institutional environment. The literature is characterised by a number of approaches that each give a different role to international organisations. The *realist* approach (e.g. Krasner, 1999) takes states as the principal actors. Thus, global governance "can only be understood as a function of the international distribution of power or as a result of behavioural practices, norms, rules and decision-making procedures that have developed over time" (Wilkinson, 2002:1). International organisations and other, non-state actors do not matter a great deal in this approach. In contrast, *liberal institutionalists* (e.g. Keohane, 1984) assume that international institutions "can, at particular junctures, have significant impact on international interaction, [but] are wary of suggestions that a system of global governance has emerged and is taking form" (Wilkinson, 2002:1). International institutions play a role regarding the benefits they deliver to states: they "empower governments rather than shackle them" (Keohane, 1984:3) and they serve as moderators in power politics through facilitating specific forms of multilateral, transgovernmental and transnational politics (Ikenberry, 2001). By doing this, they represent "relatively autonomous mechanisms mediating between the hierarchy of state power and global public policy outcomes" (Held and McGrew, 2002b:12). Further, *Marxist* and *neo-Gramscian* theories (e.g. Cox, 1993) assume that, as in realism, geopolitics and US hegemony explain the pattern and significance of global governance, but that, in contrast to realism, these factors have to be seen within the structure of globalising capitalism (Cox, 1993,1997). In this understanding, global institutions function as instruments for expansion of global corporate capitalism. However,

institutions of global governance are also seen as "sites of struggle with the potential for transforming world order" (Held and McGrew, 2002b:12).

While these approaches make statements about the importance of international organisations in relation to the power of nation states, another approach to the study of international organisations that strikes the middle ground between the others (Adler, 1997) is *constructivism.* Important proponents of this approach are Wendt (1987, 1999), Kratochwil (1989) and Ruggie (1993). Finnemore and colleagues' work is particularly interesting when it concerns the role of international organisations (for example Barnett and Finnemore, 2004, Finnemore and Sikkink, 1998). Price and Reus-Smit (1998) provide a useful overview of the content and different streams of constructivist approaches. They summarise the characteristics of constructivist approaches as being driven by a concern with the social construction of world politics, and offer three ontological propositions. First, with reference to Adler (1997) and Wendt and Duvall (1989), next to the importance of material structures, normative or ideational structures are stressed "because institutionalized meaning systems are thought to define the social identities of actors, and [...] social identities are said to constitute actors' interests and shape their actions" (Price and Reus-Smit, 1998:266). This means that there is a structural dimension to all institutions, "made up of one or more internal relations or *constituting principles* that generates socially empowered and interested state agents as a function of their respective occupancy of the positions defined by those principles" (Wendt and Duvall, 1989:60). Second, identities are importantly linked with interests and action (see for example Wendt, 1992:398) and need to be taken into account when studying international relations. Third, agents and structures are mutually constituted, as to the importance given to normative or ideational structures that "define the meaning and identity of the individual actor and the patterns of appropriate economic, political and cultural activity engaged in by those individuals" (Boli et al., 1989:12). Still, despite the considerable constitutive power of such structures, they are also dependent on the knowledgeable practices of the social agents.

The earlier approaches are important in studies of global policies and governance as they point to dimensions of power and struggle at the global level, and they are also to some extent concerned about the relationships between states and international organisations. The latter approach of constructivism is important for global social policy analysis on account of actors, more specifically, international organisations, as they take their roles and activities beyond the interactions of their member states and statements of being actors in their own right. Constructivism opens the possibilities to regard an actor's actions and positions as part of their social identities that are, amongst other things, connected to their original mandates.

More specifically on the character of international organisations some more points need to be made. International organisations are usually built by, and comprised of, national government representatives[5] and designed to engage in specific global problems. More concretely, amongst other things, they execute international agreements between states, make global authoritative decisions, and work intensively on domestic governance issues (Barnett and Finnemore, 1999, 2004). They also "make rules, [...] create and define new categories of actors [...], create new interests for actors [...], and transfer models of political organization around the world" (Barnett and Finnemore, 1999:699). Also organisation theorists stress their power to transform agendas and goals, and their functions as creators of meaning and identity (Olsen, 1997, Cyert and March, 1963, Simmons and Martin, 2001).

Pursuing these kinds of tasks, international organisations have often been regarded as generally "good" actors (Barnett and Finnemore, 2004:viii). They usually try to sell their work as "impersonal, technocratic, and neutral – as not exercising power but instead as serving others" (Barnett and Finnemore, 1999:708). Other authors, however, have been concerned and very critical about particular international organisations' (potential) power and content of activities (e.g. Kapur, 1998). More specifically, Vaughan (1999) looks at the "dark side of organizations" and analyse different forms

[5] There are important exceptions, however. For example the ILO also has representatives of trade unions and employer associations in its decision making body.

of shortcomings in their work. There is also a tendency of 'mission creep' and expansion of original mandates (Einhorn, 2001) that might result in unintended consequences.

Turning to the field of health, the actor set has been most usefully mapped by Koivusalo and Ollila (1997), and by Lee and Goodman (2002) specifically regarding health financing. Under the term global health governance, there has been a whole range of further studies focusing on related issues (for example Dodgson and Lee, 2002, Hein and Kohlmorgen, 2003, Cooper et al., 2007). The role of the WHO in particular has been addressed for example by Peabody (1995), Siddiqi (1995), and Taylor (2002). The World Bank's health activities are the focus of contributions from Ruger (2005) and Beyer et al. (2000); and recently the International Finance Corporation (IFC) also gained attention as an emerging actor in global health (see Wogart, 2003, Lethbridge, 2005). Important to mention here is also the WTO that is increasingly emerging as a global health actor, as demonstrated and discussed for example in the work by Koivusalo (1999, 2003b) and Holden (2005). Further, and particularly important for the health field, is the work of philanthropic foundations, public-private partnerships (Bartsch, 2003, 2007, Buse and Walt, 2000, 2002), and the role of the hybrid organisation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) (e.g. Bartsch, 2005).

1.4.2 Global Governance Approaches

Basic characteristics of global governance are usually described as a "changing fabric of international society" (Held and McGrew, 2002b:1f), a "new configuration of actors" (Hein and Kohlmorgen, 2008:84) or a "growing complexity" (Wilkinson, 2002:2) due to diverse agencies and networks with overlapping jurisdictions, power resources and competencies. The institutional architecture is said to be multilayered, polyarchic or

pluralistic, with a variable geometry in the sense of different political significance and regulatory capacities in different parts of the world and concerning different policy fields (Held and McGrew, 2002b, Wilkinson, 2002). Brand (2005:160) usefully summarises the characteristics of global governance, particularly paying attention to the dimension of discourse inherent to the concept. He describes global governance as being a "discourse on political regulation, which takes changes in the political as its subject and will intervene in them". In particular, the global health governance literature often includes *regulation* as an important element to defining global health governance (e.g. Hein and Kohlmorgen, 2008, Lee, 2007).

More specifically for global *social* governance, Deacon (2007:143f) avoids an explicit (theoretical) definition and rather goes for a characterisation of the situation:

> *Thus at the global level there are a number of competing and overlapping institutions, all of which have some stake in shaping global social policy towards global social problems. This struggle for the right to shape policy and for the content of that policy is what passes for an effective system of international social governance. The fragmentation and competition may be analysed into different groupings of contestations. First, and most damagingly, the World Bank, and to a lesser extent the IMF and WTO, are in competition for influence with the rest of the UN system. The Bank's health, social protection and education policy for countries is [...] not always the same as that of the WHO, ILO, or UNESCO respectively. While the world may be said to have one emerging Ministry of Finance in the shape of the IMF (with lots of shortcomings) and one Ministry of Trade in the shape of the WTO, it has two Ministries of Health, two Ministries of Social Security and two Ministries of Education. Then again, the UN social agencies (WHO, ILO, UNICEF, UNESCO) are not always espousing the same policy as the UNDP or the UN Department of Economic and Social Affairs. Moreover, the Secretary-General's initiatives, such as the Global Compact or the Millennium Project, may by-pass and sideline the social development policies of the UN's Department of Economic and Social affairs. The UN Chief Executive Board for Coordination brings together the Chief Executives of all the UN agencies and attempts to ensure policy coherence within the UN system, but in terms of global social*

> *policy this is frustrated by the fact that a) the World Bank, IMF and WTO are present, and that b) the five main social agencies are gathered in the company of a total of 26 agencies with very different briefs.*

Similarly, Mishra (1999) identifies three broad groupings of supranational activity concerned with social policy: (1) intergovernmental organisations with a primarily neoliberal agenda (e.g. IMF, World Bank, OECD); (2) non-economic international organisations (UN and affiliated agencies); (3) and regional or other trading agreements.

1.4.3 Comparative and Global Social Policy Approaches

The purpose of this thesis is to contribute to the development of a more sustainable understanding and concept of global social policy than one based only on studies of global pension policy, and the focus of the research is thus on health systems as models developed by international organisations. It is about the models brought forward by global social policy actors (i.e. the secretariats of international organisations) in a fairly comprehensive way and understood as part of a wider system of social protection or welfare state.

What is the tradition of global social policy methodologies and what does this imply for the methodology guiding this analysis? In the field of social policy or welfare state studies, health systems are usually dealt with in a comparative perspective, following traditional comparative welfare state literature. For the purpose of this analysis health systems are understood as parts of the concept of the welfare state. On the identification of welfare state types, most influential has been the work of Gøsta Esping-Andersen (1990) who classified OECD welfare states according to the relative importance of each of the components of state, market and family, and discussed aspects of rights and stratification. Esping-Andersen identified three types of welfare state regimes: liberal, conservative and social

democratic (for a general overview see Hort, 2005, Kennett, 2001, Alcock, 2001). Doing this, he followed an earlier classification by Wilensky (1975) who distinguished four types of welfare states (liberal democratic, totalitarian, authoritarian oligarchic, and authoritarian populist) and also the work of Titmuss (1974) who had differentiated between the residual welfare model, the industrial achievement-performance model and the institutional redistributive model.

Such comparative welfare state studies usually use typologies in order to explain the systems and policies in different countries. This includes defining ideal types with specific sets of macro-institutional characteristics along which the welfare state may vary (Blank and Burau, 2004). As typical for comparative welfare state research in general, also comparative health policy asks for similarities and differences of health systems and reforms, usually using the concept of convergence. Blank and Bureau (2004) further explain:

> *The convergence thesis, bolstered by globalisation, suggests that health policy across disparate country environments has tendency to become more similar over time. Chernichovsky (1995[6]) for example suggests that despite the variety of health systems, health reforms have led to the emergence of a 'universal outline or paradigm' for health care financing, organisation and management. This paradigm cuts across ideological (private versus public) lines and across conceptual (market versus centrally planned) frameworks, as it combines principles of public financing of health care with principles of market competition applied to the organisation and management of its consumption and provision (1995:340).*

While much of this comparative research is focused on high-income OECD countries, development studies have been concerned with health systems in low-income countries. Development studies' interest in health systems is focused on health problems and health systems in development contexts and connected to poverty reduction strategies; as for example the activities of

[6] CHERNICHOVSKY, D. 1995. Health Systems Reforms in Industrialized Democracies: An Emerging Paradigm. *The Milbank Quarterly*, 73, 339-356.

the Institute for Development Studies evidence[7]. Ian Gough and colleagues have worked on the development of ideal-types of welfare state arrangements that reach beyond Esping-Andersen's OECD perspective (Gough and Woods, 2004).

Rather than being designed as a development study, it is the OECD-focused comparative welfare state *tradition* that guides the research undertaken in this thesis in two important ways: on the one hand, the analytical framework to capture the ideas or models developed within international organisations is based upon this comparative welfare state and health system literature. On the other hand, the study as such is characterised by a comparative perspective in that it compares international organisations and their health system models similarly to welfare state comparisons between countries. The reason for this approach is primarily that the study design was developed as to reflect, and to be comparable to, existing global social policy research in the field of pension systems.

Global social policy research has attempted to cross the border between the two different fields of study, namely social policy and international relations, in particular ways. Originally coming from a focus on Central and Eastern European welfare state research, in the context of the transition of these countries' welfare states, the activities of international organisations and other global policy actors have emerged to be an important explanation for social policy change (Deacon et al., 1997). In addition to studies that try to understand the impact of global policies (actors) on a concrete country or region, there is a global social policy literature trying to understand global social policy actors, ideas and global social governance *as such* – assuming, not explicitly analysing, a general relevance for national social policy. These studies have been in particular on the World Bank (Group) and the IMF, as well as the ILO, OECD, UNICEF, UNDP and other United Nations (UN) organisations; but also regional supranational organisations, most importantly the EU; and, particularly important regarding the health sector,

[7] http://www.ids.ac.uk/go/news/making-health-systems-work-for-the-poor-beyond-scaling-up, accessed 29 December 2010

the WTO (trade agreements). Studies on international actors have, amongst other things, shed light on the role of specific actors, actor groups or actor constellations in particular social policy fields. There are numerous studies about the World Bank (and the IMF), looking at the lending activities (e.g. Woods, 2006), its role as a research institution (e.g. St Clair, 2006b, Broad, 2006) and its policy advice (Orenstein, 2005, Deacon et al., 1997). The UN "social agencies" are another example of actors that have been studied as to their various activities in the social policy field (Deacon, 2007) and the OECD is also increasingly perceived as a global social policy actor (Armingeon and Beyeler, 2004, Deacon and Kaasch, 2008). Regarding other types of actors: business actors have, for example, been studied by Farnsworth (2005a); the role of think tanks have been analysed by Stone and Denham (2004); and Stubbs (2003) elaborated on non-state actors in social policy.

This shows that, while for each of these organisations individual roles and activities have to be understood, global social policy is characterised by more than the pure sum of activities of different global social policy actors. It is also about collaborations between, or transnational *networks* of, such actors (Deacon 1997). Deacon (2003:27) found there is a

> *shift in the locus and content of policy debate and activity [...] to a set of practices around Networks, Partnerships and Projects which, in some way bypass, the [...] [more formal] institutions and debate and present new possibilities for actually making global change in particular policy arenas.*

This suggests two things: on the one hand, global policy actors do not operate in isolation; but on the other hand, we do not have a global government with clearly ascribed roles and responsibilities at a supranational level. Such discussions about the functions and organisations, but also about the general structures of governance at transnational policy levels, have been discussed under the heading of global social or health governance.

However, the current tendency to describe global social policy in the field of health systems using characteristics developed mainly from the study of the global pensions discourse might not do justice to the specific field of health systems. Is what we refer to as global social policy (understood here as policy models by global social policy actors) rather global *pension* policy combined with some elements of *supranational* social policy? Do these characterisations and notions of competing actors, contesting ideas and varying communication channels fully hold true when it comes to policy models for other social policy fields?

There are indicators that this indeed is the case. The general global social policy literature (particularly Deacon, 2007, and the contributions in Yeates, 2008b) often assume and conclude that there are different groups of global actors equipped with different means of communicational influence that relate to each other by ways of competition and struggle about ideas concerning desirable social policy. Also, the regular *Digest* in the Global Social Policy Journal[8] continually features examples of different ideas and opinions from different international organisations and other actors in relation to a number of social policy fields. However, detailed analyses on particular systems of social security or the welfare state are rare, and the digest does not substitute for such thorough analyses of other welfare state arrangements when it comes to defining global social policy. Regarding health systems, this omission is particularly critical. Also in comparative welfare state research, there has been concern about health systems not being well integrated into the development of categories of welfare states, which not only has implications for the understanding of health systems, but also to that of the welfare state (Moran, 2000). Thus, how do we know that global social policy is sufficiently described when its understanding is based on a very limited account of social policy?

[8] See http://www.gaspp.org, accessed 29 December 2010

1.5 The Units of Analysis

The above characterisation of global social policy, its definition and its methodological tools bring us back to the issue of the specific focus of the thesis. As stated earlier, this study intends to contribute to the theorising of global social policy in the sense of comparing the characteristics of the global discourse on pension systems with ideas on health systems. In terms of defining the units of analysis, this means given the scope of a PhD thesis, but even more given the literature to be tested, the thesis focuses primarily on a particular group of global social policy actors, namely international (inter-governmental) organisations. The focus is, further, on the activities (research, knowledge production) of the secretariats of international organisations, not on power games within the governing bodies of international organisations and between governments and/or other parties involved. This is not a statement about the relative importance of different actors or the lines of contestation that might evolve between different actors. It is mainly an echo to analyses of the global pensions discourse and a test as to whether or not we can observe international financial organisations promoting one social policy or health system model and global social institutions another. There are, of course, important other actors or networks that might even be more powerful, such as Global Public Private Partnerships, various types of civil society organisations, private sector actors and so on.

In addition, also echoing the research on the global discourse on pension systems, the focus is on rather abstract social policy models, or health system models. The actual impact of the social policies of international organisations on national health systems are not part of the analysis. In analytical terms this means that the research concerns the fit of global ideas with ideal-types of models or regime as identified and described in OECD comparative welfare state literature. These ideal-type models are used to classify and compare the ideas developed by international organisations. Nevertheless, the reports of international organisations often include both

general models, as well as more concrete applications or models for particular groups of countries. The latter has been included in the discussions of this thesis only when it was important to point at particular distinctions and differences in approaches that could not be summarised into one coherent picture (particularly in the findings of the thesis). Other than that, the discussion of national health systems and their reforms in particular countries has not been part of the discussions in this thesis. The justification for this focus on generalised (abstract) models instead of the more concrete recommendations to particular (groups of) countries is due to the global social policy understanding to be tested. The literature on the global discourse on pension systems has provided evidence for the fact that it would be wrong to think that the ideas developed and spread by one particular international organisation would only be taken up, and apply to, the very group of countries it is originally mandated for. For example, the three-pillar pension model advocated by the World Bank has entered academic and policy debates all over the world and this structure finds reflection even in a highly developed welfare state like the Swedish one.

The research undertaken in this thesis is explicitly not about actual health systems, neither in Latin America, or about the status of health systems in low- and middle-income countries; nor does it concern the question as to whether or not welfare states and health systems are necessarily linked or what their status might be in difficult cases such as the US. It is also not a comparison between OECD countries (the OECD is understood as an international organisation and not referring to the group of countries that make up its membership) and World Bank policies – it is purely a comparison of global social policy ideas in the form of health system models developed and communicated by a number of international organisations (i.e. their secretariats).

Regional initiatives and approaches, such as WHO regional documents have consciously been excluded from the analysis as – in a comparative study as the one in this thesis – they would have demanded equal consideration of

health system models developed within and for other world regions which would have gone beyond the scope of this thesis.

1.6 Limitations

This study is limited in several perspectives. It is for example explicitly focused on the global level and lacks evidence how global social policy matters in terms of actually shaping national social policy. While criticising such an approach is certainly justified, one also has to take into consideration that the neglect by social policy scholars of thoroughly studying global social policy actors and their ideas has also led to some commonly held assumptions about each of the organisations and their respective "typical" ideas that are sometimes not supported by sufficient evidence for specific policy issues. Accordingly, while perhaps somewhat lacking in terms of the evidence of impact, such a study nevertheless can make a contribution as one piece of a more detailed picture or assessment of policy transfer processes and the impact at national and other policy levels. Furthermore, this thesis provides a contribution to a theoretical, or conceptual, debate, rather than an argument as to whether international organisations matter in practice or not.

To put it differently: this study is *not* a global health governance study. It is situated in and designed to contribute to global social policy literature in the tradition of Bob Deacon and others, and thus uses (global) social policy or welfare state concepts and terms. This implies that it is centred around the study of different ideas in the sense of models of social policy fields. It is *neither* driven by a strong normative position, but rather interested in understanding models as part of an organisation's character and mandate, instead of judging the validity of this engagement from a normative point of view. Naturally, every researcher has norms underlying and shaping the research to a certain extent, and the "Western" perspective or German scholarly traditions cannot fully be avoided, but the purpose of this

particular piece of work is not to contribute ideas about *better* global social policy and governance in general or in the field of health systems, but to compare social policy models and the characteristics of different global social policy discourses and ideas, and discuss the implications for global social policy definitions and concepts as such.

1.7 Summary and Outlook

On the basis of the understanding of global social policy as outlined in this chapter, this thesis intends to make a contribution to that literature. The guiding research question is whether or not what has been found in the research on pensions is also a valid characterisation of the global models for health systems. What are the implications of using these models for generating a definition and understanding of global social policy?

This chapter has attempted to give an overview of the current state-of-the-art in global social policy research by reviewing the most relevant literature on the topic. Developing an understanding of the matter of global social policy, various links between globalisation and social policy have been discussed. Global social policy has been defined as describing both, (1) forms of social policy models by global policy actors, and (2) mechanisms of a supranational social policy in the form of global social redistribution, regulation and rights. It has detailed how global policy actors, particularly international organisations, function in different ways in advising national social policy; and that the global social policy dimension of policy models has been described as being characterised by contestations in different dimensions (mandates, ideas, communication channels). This has included looking at the important role of global social policy actors and global social governance as a number of competing and overlapping agencies. As the prime example of global social policy in its policy model dimension, the global discourse on pensions has been described, and this is compared in this thesis with the findings of the analysis of ideas on health systems.

Much less is known on health systems than on pensions when it comes to global social policies. The characteristics of global ideas on health systems, therefore, have not significantly contributed to developing the above definitions of global social policy. This is particularly true for the dimension of policy models. However, the dimension of global social redistribution is importantly characterised by initiatives in the field of health. This study attempts to fill this gap, and studies the characteristics of the global ideas on health systems, looking in particular at specific moments of potential contestation in the dimensions of mandates, ideas and communication channels. This is then used to discuss and add to the current understanding of global social policy in general.

The key arguments developed in this thesis are that (1) not all social policy fields are characterised by the same structures and processes; that (2) not all social policy fields are about competition and contestations; and that (3) global social policy analysis would benefit from more nuanced ways of understanding the nature of its actors, the specifics of its ideas and concepts and the implications of different communication channels.

In order to answer the above questions, the thesis is structured so as to facilitate the argument as follows:

Part I further introduces the methods of data collection (chapter 2) and the research design and analytical frameworks used for the analysis reported in this thesis (chapter 3). **Part II** reports the findings of the *global ideas on health systems* within three dimensions of analysis. Chapter 4 maps the key global health *actors* and discusses their respective *mandates* with a focus on how they came to have a health system responsibility, and if that has created a situation of overlapping and competing agencies. Following this initial analytical step, the further analysis mainly focuses on four particularly important international organisations: the WHO, the World Bank, the ILO and the OECD. In chapter 5, on the basis of an analytical approach to health systems introduced in part I, the different international organisations' *ideas* or *models of health systems* are analysed and compared to each other with

particular attention to similarities and differences in the proposed role of the state. Chapter 6, finally, turns attention to the organisations' respective *communication channels* and their implications for exerting a meaningful and powerful role in providing ideas on national health systems.

Part III discusses the findings of the preceding analysis and implications for the understanding of, and approach to, global social policy. Chapter 7 summarises the findings of part II to characterise the global ideas on health systems in the light of the theoretical approaches introduced in part I. These characterisations of the global health ideas are then taken up in chapter 8 to facilitate the comparison between the fields of pensions and health systems. This discussion finally culminates in reflections about an enriched understanding of global social policy in general in chapter 9.

2. Methodology and Data Collection: A Comparison using Documents and Elite Interviews

Chapter 1 has set out the context and basis for this study on global social policy. It has also developed the research questions guiding the analysis, namely: ***Are the findings on the global discourse on pension systems replicated when examining global policy models for national health systems? And what does that imply for general concepts of, and analytical approaches to, global social policy?*** These questions are approached by contrasting the characterisations of the global discourse on pension systems with ideas on health systems. While the discourse on pensions is summarised based on secondary literature, global social policy in the field of health systems is analysed in the form of a detailed and organised comparison of the mandates, ideas and communication channels of a number of international organisations employing a comparative research design. The literature on global social policy, that this thesis is based on, mainly uses qualitative data. Qualitative data is suitable for discovering and interpreting meaning and conceptions. Basically, qualitative data consists of words – both from primary data (such as interview transcripts) and secondary data (i.e. existing written material). Qualitative data provides rich descriptions of social phenomena and forms the basis of qualitative data analysis. Accordingly, the research conducted for this thesis included the collection and analysis of qualitative data and the research design draws from the strategies of comparative analysis and qualitative content analysis. This chapter is structured as follows: Section 2.1 introduces the comparative research design, and section 2.2 explains qualitative content analysis. Section 2.3 details the methods of data collection. Section 2.3.1 focuses on the search, identification and use of documents in the analysis of the international organisations' mandates, ideas and communication channels. It distinguishes between the use of websites as research tools and the identification of the particular documents relevant for this analysis. Section

2.3.2 discusses the use and techniques of elite interviews for the study. A summary is provided in section 2.4.

2.1 Comparative Research Design

A comparative logic guides the analysis reported in this thesis. This applies with regard to the global social policy tradition in comparative welfare state research more generally, but even more concerning the specific design chosen for this analysis. The comparison is conducted both at the level of comparing international organisation, and by comparing different global social policy fields (pensions and health systems) in order to generate a better understanding about what global social policy can look like. It also serves to answer questions of "what" and "how", as the ones asked in this research project.

Nevertheless, different choices in terms of research design would have been possible, too. Some studies look at the interactions between global social policy actors in a world society perspective (e.g. Meyer, 2001, Inoue and Drori, 2006), others study discourses (e.g. Scollon, 2005). Still other studies focus on policy transfer processes and how they are facilitated by particular global social policy actors or as the influence on national social policy reforms (e.g. Dolowitz, 2000).

The choice of this methodology is based on the value of comparative analyses in testing prior hypotheses. At the same time, as a rather generic tool employed in various disciplines, it is open for combining several theoretical perspectives. This approach serves also for capturing both the specificity and the complexity of cases, as well as it delivers a level of generalisation (on comparative methodology see for example Przeworski and Teune, 1970, Alcock, 2001, Boswell, 2008).

Comparative study designs are dependent on an organised and disciplined set of questions and checklists for variables. The relationship between the

cases analysed is established and discussed due to set-theoretic nature – not as an actual form of interaction (as would be the case in a genuine discourse analysis). The interest lies on the similarities and differences between cases. Accordingly, the results are expected to be at the scale of more or less similarity and difference between models. The analytical framework for conducting this comparative analysis is set out in the following chapter and draws, consequently, on comparative welfare state frameworks and typologies to facilitate the analysis at the level of ideas (the main focus of this thesis).

As a methodology that is case-oriented and set-theoretic at the same time, comparisons provide tools to focusing on specific groups of actors in the wide array of – in this case – global social or health governance. The cases under investigation in this analysis are international (intergovernmental) organisations, or more precisely the rather theoretical contributions about health systems produced by the secretariats of a number of international organisations. Given a diverse and complicated global health governance structure, such a choice cannot do justice to the whole picture more than pointing to other actors involved. Comparative studies (at least qualitative ones), however, have to limit the number of cases in order to be effective. Defining the specific actors to be studied requires the definition of nested categories, following particular criteria that are characterised by the presence/absence of particular features. Scope and possibility conditions need to be applied in order to decide about the relevance or irrelevance of a particular actor with regard to a specific global social policy field. Even though this has been criticized (Yeates, 2008b), the main focus of the global social policy literature is on international organisations, particularly the studies on the global pensions discourse that serve as the point of reference in this thesis. This is why the first criterion for an actor to be included is to be an international (inter-governmental) organisation.[9] This serves to limit

---

[9] Again, this does not say anything about the importance of international organisations compared to other global social or health policy actors. Various CSOs or INGOs raise their voices in global social policy discourses. Nation states may appear as global health actors bringing forward health system issues (e.g. UK DFID, proposals at G8/G20 summits).

the number of cases, but also is necessary to make the two social policy fields (pensions and health systems) comparable. The second criterion for inclusion was the significance and comprehensiveness of the ideas (health system models) produced by the respective international organisations. Only those international organisations that produce and communicate work containing health system ideas that can be regarded as a (more or less) comprehensive model can be included.

The approach, however, also has limitations. Comparative study designs almost always focus on states, and thus more specific comparative analytical tools are very much characterised by this choice of unit(s) of analysis. Looking at international organisations, thus, requires adaptation to the fact that they are organisations or institutions that have different features to nation states. This is why international relations approaches are needed to support the analysis. The study of general and specific mandates of international organisations over time replaces national history and tradition. The ideas or models are studied in their resemblance to ideal-type of health systems.

2.2 Qualitative Content Analysis

The comparative research design is supported by the tools of qualitative content analysis, particularly directed qualitative content analysis, or deductive category application, as also has been described as especially suitable for studies that test "existing theory or prior research [...] about a phenomenon that is incomplete and would benefit from further description" (Hsieh and Shannon, 2005:1281, see also Potter and Levine-Donnerstein, 1999).

Individuals may appear as important sources of theoretical and practical global health contributions, such as Bill Gates or Jeffrey Sachs.

Qualitative content analysis has been understood by Mayring as "an approach of empirical, methodologically controlled analysis of texts within their context of communication" (Mayring, 2000: paragraph 5). Früh (1991:24) defines it as an empirical method that systematically and reliably describes the characteristics of a message as to its form and content.

In this case, the approach chosen is that of directed content analysis or deductive category application for validating or contributing conceptually to an existing theoretical framework, and involving "giving explicit definitions, examples and coding rules for each deductive category, determining exactly under what circumstances a text category can be coded with a category" (Mayring, 2000: paragraph 15, see also Potter and Levine-Donnerstein, 1999, Hsieh and Shannon, 2005).

Denscombe (2007:237) enumerates a number of steps to be undertaken in any content analysis: choose an appropriate sample of texts (according to explicit criteria), break the texts down into smaller units (such as relevant paragraphs), develop categories for analysing the data, code the units along the categories (manually or with specific software), and analyse the text.

Some potential disadvantages of qualitative content analysis need to be taken into account. Hsieh and Shannon (2005) point to the danger of finding evidence that is supportive, rather than unsupportive of the theory tested. The findings and conclusions from this analysis, however, include both supporting and unsupporting evidence in relation to the general global social policy literature and the pension discourse in particular. Another drawback of qualitative content analysis is said to be the "over emphasis on the theory blind researcher to the contextual aspects of the phenomenon" (Hsieh and Shannon, 2005). This is a serious issue, particularly as the categories of analysis, thus the fields of possible contestation, have been extracted from a range of literature, and are then discussed as being of similar weight, while the major attention is on the dimension of ideas, supported by the question of mandates, and added by the dimension of communication channels. This provokes both a focus on contextual aspects and also tests particular

interpretations of the approach or theory under scrutiny that might be seen differently. These biases can only be mentioned here and not entirely avoided.

2.3 Data

Two methods of data collection were used: a comprehensive search and compilation of documents and a limited number of elite interviews. The methodological principle of triangulation, thus employing two or more methods for studying something, was intended to facilitate this analysis by providing checks of the assumptions gained from documents by testing them in interviews. This generated more reliable conclusions than the use of only one source of data would have. However, the two data sources have not been equally weighted. The documents were the most important source of data, while interviews have been used to test some of the findings from the document analysis.

The documents used were those publicly available because the interest of this study was not so much in the reasons behind particular positions or ideas, or the hidden drivers of the communication of particular ideas. Instead, the research project settled for studying the models as communicated by the international organisations.

2.3.1 Documents: Analysing Websites and Publications

The principal source of data used in this thesis is primary and secondary documents produced and communicated by the international organisations under study. Two types of documents can be distinguished. On the one hand, websites have been regarded as representing the international organisations, organising the content of policy ideas and serving as a means of communicating knowledge. On the other hand, the organisations'

publications such as reports, policy papers and constitutional documents or strategy papers have been analysed to understand the specific mandates and ideas expressed by each of the organisations.

The international organisations' websites have been used in different ways for the purposes of this analysis. They have been regarded as part of the representation of an organisation and its mandates, as a source and tool for identifying various documents (such as international treaties constituting the organisations, work agendas, or all kinds of policy and research publications) and as a means of communicating ideas.

On the one hand, websites, as representing international organisations, have been studied by taking account of the general self-descriptions and missions expressed on them. On the other hand, the websites also offered explanations and justifications for concrete engagement in particular policy fields, such as health systems. These websites provided useful accounts for a general understanding of how and why an organisation is engaged in producing knowledge and providing advice on national health systems.

More concretely, apart from descriptions at the websites themselves, attached documents and links were followed up. These could be links from a more general website on missions and activities in the particular policy area, but also online bookshops with searching facilities, emails lists alerting the publication of new documents, and events (conferences or workshops) with specific websites that usually contained background reading and similar material. It should, however, be noted here that there is an ever-increasing number of websites and volume of information (e.g. Richard and Chandra, 2005, Wang and Emurian, 2005). This requires a certain level of training from the site of the researcher, a clear analytical framework that facilitates the organisation and categorisation of information to be taken into account in the analysis. Connected to the problem of the amount of information is also the linking to various other organisation-internal and –external websites that requires careful attention to issues of authorship, credibility or trustworthiness and authenticity (Denscombe, 2007). The analysis took

account of this by checking for international organisations' staff, explicitly engaged with health systems, being the authors of the reports; and the degree of these documents representing something close to "an international organisation's position" – even though most of the documents come with disclaimers as to not representing an official view of the respective organisation. Ideas expressed in flagship reports, annual reports or as part of explicit strategies for a specific policy field, as central data used in this analysis, do, however, come as close as possible to what a particular international organisation stands for in terms of policy models (even though the local translation of policies might look completely different).

However, it needs to be taken into account that websites are updated, rearranged and changed regularly, depending on a variety of factors such as the prominence of a particular policy issue at a time, changes within the organisation, public reactions to particular contents of the information released by an organisation, and so on. To what extent is this an issue for a study such as the one conducted in this thesis?

While one certainly finds expressions of current policy issues reflected in the change of websites over the period of the research, the general mission and character of an international organisation does not change quickly. It might be to some extent rhetorically adjusted, but at their bottom institutions are rather path-dependent and bound to mandates that do not change dramatically over a period of writing a PhD. This does not mean that the organisations do not undergo significant changes. The World Bank, for example, has recently seen changes to its governing structures as well as to its policies regarding the accessibility of documents, but this concerns rather its governance and public relations than the content of its ideas.

Accordingly, it can be doubted that such changes are quickly and dramatically reflected in the rather theoretical work within the international organisations' secretariats. Changes in such models seem to evolve more gradually, and often in the sense of becoming more comprehensive (i.e. taking into account more and more issues on a particular subject matter),

instead of quickly changing opinions. An exception might be times of crisis that may cause more radical changes and departures from traditional positions. Even those are, though, not disconnected from the original ideas of social policy and health system models.

Naturally, including a number of documents does not create one single idea or model brought forward by an international organisation. Neither are all documents representative for the respective organisation in the same way. The study dealt with such "incoherences" in two ways. On the one hand, different traditions or models could be distinguished for one single organisation (as happened in the case of the WHO). On the other hand, the distinction of a number of functions and variables designed for comparing the cases also served as a tool for identifying variance or similarities between the documents of one organisation and would be reported as such (e.g. the WDR 2004 compared to other World Bank documents).

However, it needs to be taken into account that organising information from a variety of documents by different international organisations does not necessarily generate a value on any category. There may be omissions, uncertainties, explicit and implicit knowledge gaps on specific issues that are difficult to classify and to interpret. This is, on the one hand, a clear disadvantage in the focus on models and the comparative study design that defines relevant categories prior to looking at the cases. The alternative could have been looking at clearly formulated recommendations or conditions attached to development aid. On the other hand, such "gaps" may be indicative for particular discussions that are either not raised at global policy levels, or part of other than social policy global discourses such as those on taxation or trade, even though they are clearly related and part of health systems.

The focus in terms of the type of documents was primarily on those (parts of) documents that reported research or rather theoretical concepts, and thus formed part of the knowledge production activities within international organisations (e.g. Stone, 2005, St Clair, 2006b). This has been chosen for

the sake of comparability with other global social policy literature, particularly descriptions about the global discourse on pension systems. The more specific analytical framework is reported in the next chapter.

Further, this thesis concentrates on major documents such as big reports, advocacy instruments and strategy papers that have a relatively high uptake and experience significant reaction by outside observers. Policy papers, research reports and other documents on specific health system issues have only been taken into account if needed to clarify specific points or highlight underlying discourses. This approach reflects other global social policy contributions that focus on a number of key documents in analysing global social policy phenomena.

The websites have been further regarded as means of communicating information. It is obvious that an organised and intuitive navigational system affects the use of a website and thus the spread of information (see Chevalier and Kicka, 2006).[10]

Attempting to catch changes under the time of writing this thesis, the relevant websites were screened once in four months to take into account new documents. This included checking the websites specifically dedicated to health systems and their functions in terms of changes (new documents, new initiatives, etc.), as well as publication searching facilities and news releases.

The documents were in both print and electronic format and were mainly accessed via the organisations' websites (including print media like articles, books and reports; but excluding film material and other more interactive web tools). More concretely, the following types of documents have been taken into account: constitutional documents (Articles of Agreement, Constitutions, other founding documents as applicable), proceedings of international conferences and meetings (as far as available[11]), strategic

[10] This is discussed in more detail in chapter 4.
[11] These documents are much easier to access in the case of UN social agencies than for the international financial institutions.

outlines (regarding roles in providing policy models for health systems), but, most importantly, advocacy and research reports produced or initiated and distributed by those organisations that deal with health systems in a comprehensive way.[12]

More specifically, on questions of the mandates of *actors* to deal with health systems, constitutional documents, websites, general descriptions of work and/or strategy papers have been used. Following the identification of key actors in this dimension of global social policy, documents were searched related to their ideas on health systems. Regarding the content of policy *ideas,* the most direct approach to identifying documents was to look for related titles on the international organisations' websites. This was approached through general search facilities, as well as through particular websites, such as online bookshops[13]. This, together with, secondly, the *Global Social Policy Digest*, and, thirdly, subscribing to a number of email lists informing about recent publications and other activities, has generated a list of relevant documents on health systems by the actors in question (see Annex 1). Lastly, for the historical documents, it was more useful to check references in primary and secondary literature. At the same time, websites and collections of documents, disregarding their content, formed part of the analysis of the categories, means of *communication* (this is further elaborated in chapters 3 and 6). Doing this, the websites and documents turn into units of analysis *per se*, and do not just appear as data bearing particular information.

As the analysis of the particular ideas or models of health systems is the most important part of the analysis, some more specifications are needed on this. As a first step, all documents were collected that had a title and/or

---

[12]The different sorts of documents as means of communication are also discussed in chapter 6.

[13] For example the World Bank's Publications and Documents website (http://www.worldbank.org/reference/, accessed 29 December 2010), the WHO's Publications website (http://www.who.int/publications/en/, accessed 29 December 2010), the ILO's Publications and Research website (http://www.ilo.org/global/What_we_do/Publications/lang--en/index.htm, accessed 29 December 2010), and the OECD's Publications Website (http://www.oecd.org/publications/, accessed 29 December 2010).

subtitle featuring health systems or connected main models such as social or private health insurance and health sector reform. At the same time, the most prominent publications by each of the organisations (for example the World Health Reports, World Development Reports, World Labour Reports) were searched notwithstanding their specific titles on whether or not they were tackling health systems. Further, secondary literature on global health policy and governance was evaluated in relation to the documents that had been studied.

As a second step, the contents and executive summaries of the collected documents were scrutinised in order to assess whether or not they contained definitions, descriptions or models on health systems and/or their functions. This included a crude coding in the sense of marking those chapters or sections worth studying in the context of this analysis.

In a next step, following the set of questions related to the functions and dimensions of health systems, sections of the documents were identified that contained information on the different functions and dimensions of health systems. As far as possible, the use of documents only covering single functions within health systems was avoided for two reasons: on the one hand, it was a matter of the sheer volume of documents that would have to be taken into account (particularly for the World Bank and the WHO). On the other hand, the opinions about single functions of health systems taken together do not necessarily constitute the health system model proposed by an organisation in a comprehensive sense.[14] However, the drawback of this choice is that, on occasion (for example, as has been studied by Lee and Goodman (2002) concerning health financing), documents may be labelled as concerning *one* health system function, but discussions may go well beyond that single function and rather be an expression of the focus of attention than a strict limitation on that function. In this sense, health systems may be addressed in a comprehensive way even if the heading might suggest otherwise.

[14] That would certainly be another interesting issue to be investigated in further research on the topic.

Then, for each organisation, the analytical framework was applied to the documents or document sections. Accordingly, the relevant sections were coded in the following categories: (1) context within which health systems are approached, (2) principles guiding health policy, (3) definitions of health systems, (4) provision, (5) financing and (6) different dimensions of regulation. A more detailed description of the analytical framework used is given in chapter 3. This led to specific descriptions of health system ideas and models for each of the organisations that were further used to conduct a comparative analysis between international organisations. Health systems, as the discussion about the different definitions and approaches in chapter 1 demonstrates, are, of course much more complex than this crude categorisation suggests. However, the above categories serve well to make the models of pension systems and health systems comparable and facilitate a more general discussion about definitions and understandings of global social policy.

The reliability of the information analysed and the conclusions drawn was controlled in two ways: on the one hand, as an issue of consistency between documents of one organisation (see for example research on the OECD by Armingeon and Beyeler (2004) and Mahon and McBride (2008)); on the other hand, by means of a limited number of interviews to test the validity of the findings. The main concern here was to present interviewees with a summary of what the analysis of the respective health system models had revealed and see if they agreed or not.

The actual analysis was been undertaken in a manual way and not using computer programmes like Nudist or NVIVO. This was due to the basic concern about getting an overall impression of the kind of documents under analysis that could have been lost by simply being left with software-generated text fragments. This method would have caused further risk to the tendency in content analysis to dislocate the units and their meaning from their context and the intentions of the author (Denscombe, 2007:237). At the same time, not every step of the analysis would have benefited from using

such software. For example, for the analysis of the organisations' *mandates*, the first step was not more sophisticated than searching for the expression "health" (or "health (care) system") to get an impression of the respective health mandates and the contexts of the health engagement. For such an exercise, searching functions of standard word or pdf programmes or web browsers proved to be entirely adequate. In relation to the analysis of health systems models (*ideas*), it could have made more sense to use such software, particularly giving the possibility of including more documents. The third step on *communication channels* required a detailed analysis of the documents and other communication means – rather than written descriptions of communication channels. This would not have benefitted from the use of software designed to code and analyse texts.

The general attempt of this thesis has been to understand international organisations' roles in global health policy, dominant or "official" health system models developed within the organisations and developing an understanding of their means of communicating such knowledge. However, some notes of caution need to be made at this point. Such documents are never neutral, de-contextualised accounts of global social policy actors and ideas and not pure representations of their communication means: indeed, all documents are constructed (Gurak and Lay, 2002). In order to get an idea about the more specific aspects of policy ideas and models as studied in this thesis, the analysis concentrated on the main body of documents that dealt with health systems thoroughly. Headings and executive summaries of documents are often more prone to lip service while in more comprehensive and detailed accounts ideas and proposals are more thoroughly discussed. This includes basically two options for possible differences: the more general websites, headings, executive summaries or speeches at major international conferences could either give a view that is very similar (just shorter) with more detailed accounts or one that adjusts to political correctness while the true face appears when going more into detail.[15] As

[15]However, as has been emphasised before, this study does not go as far as to studying real impact on countries' social policies, that might come along with different recommendations

Atkinson and Coffey (1997:46) indicate, it is important to understand how documents are produced, circulated, stored and used for a variety of purposes. Accordingly, account was taken of the meaning of different sorts of documents, different forms of communication and the different quality of "opinions" expressed by an organisation in different forms. In this context, it is also important to acknowledge that almost all reports, policy papers or research publications contain a disclaimer saying that this was not the "official view" of a particular organisation but that of the authors'. This implies that there are different (groups of) individuals engaged in preparing the documents and also different processes of knowledge production depending on the respective organisations. Thus, while not systematically addressed as an issue of particular individuals or networks/ epistemic communities in the research reported in this thesis, there are important issues relating to authorship. The assumption underlying the research conducted in this thesis is rather based on different organisation units within an organisation producing different kinds of work. Regarding ideas and models of health systems this is rather theoretical, general research based work; in contrast to knowledge applied to local contexts, but neither so closely linked to processes of intergovernmental relations. Naturally there are similar aspects about readership (Atkinson and Coffey, 1997:58), however this analytical step has been neglected in favour of a more detailed analysis of the organisations' communication channels.

It is not unproblematic to treat the summarised accounts of health system responsibilities, models and communication means as the roles, ideas and strategies *of* particular organisations. Nevertheless, Bloomfield and Vurdubakis (1994) also show how textual communicative practices are used by organisations to create 'reality' and connected knowledge. Accordingly, it is important to be aware of the possible use of the documents as they do "construct particular kinds of representations with their own conventions" (Atkinson and Coffey, 1997:47).

---

and driven by different thinking about the design of social policy arrangements, or the status of social policy as such.

Another issue critical to the research was the comparability of data from different international organisations. There were issues with both quantity and quality. On the quantity side, one needs to consider that some of the organisations have produced substantially more documents (such as the World Bank or the WHO) than others (such as the ILO and the OECD). Accordingly, while for the latter organisations all relevant documents could be taken into account, for the former it was necessary to select based on issues of primary relevance. Connected to the quality of data, it is important to see that international organisations have partly different ways of formulating and making public their mandates and ideas; not all of them release particular information in the same form. While for the WHO and the ILO it was rather easy to also trace some discussions from, for example, meetings of member state representatives (as such documents are readily available from the websites) and see how they relate to the models proposed, for the World Bank and the OECD one had to rely on documents produced by their secretariats. At the same time, one has to consider that single documents are not completely independent from each other; they are always inter-textually linked with other documents (Atkinson and Coffey, 1997:55f). They belong to particular series of documents, they are the output of commissions or research programmes, they are produced for teaching purposes, and so on. Furthermore it is important to see how they are usually interlinked historically, with documents such as previous sector strategies in the case of the World Bank, or systematically linked to constitutional documents or basic declarations (as in the case of the ILO) (Atkinson and Coffey, 1997:57).

Further, the study has focused on documents that were publicly available. On the one hand, this was due to the literature to be tested that also primarily focuses on these kinds of documents, instead of trying to gain access to documentation not available to a wider public. On the other hand, this was also a result of the constraints of a PhD research project that was only partly funded. A multi-actor analysis would have led to a much bigger task when trying to get access to internal documentations in a number of

different organisations without having the gate-keepers in place right away. Extending the project in such a way would also have been difficult within the time frames for a PhD project. On the other hand, it has to be taken into account that the data needed to answer the research questions asked in this study and the particular documents studied for this research project are primarily conceptual or theoretical accounts about a particular policy field. International organisation staff working on such issues are rather interested in getting the ideas out than obscuring them. This is not to deny different interests and positions between these peoples, and the degree of public relations that accompany any official and formal utterance by international organisations. It is a typical feature of organisations as such that finally there is a decision about releasing certain information either hierarchically or in form of a review process that needs to be completed. The documents are, thus, to a certain extent streamlined, hiding underlying discourses, however, this is also what makes them the product and opinion (with or without disclaimers) that can be ascribed to, or is associated with, a particular international organisation.

Another important issue to be aware of is the different languages and forms that documents use (Atkinson and Coffey, 1997:49). Given the small community of people engaged in producing reports and their networked relationships (Lee and Goodman, 2002), the languages of the texts of different organisations do not always differ significantly. However, the fact that they do differ to some extent makes the analysis more difficult; for example, different adjectives combined with "access", such as "universal" or "equal", are not always used coherently or attached to one meaning, but sometimes express different concepts. As this study was rather focused on broader concepts, it was difficult to go much into detail with all connected wordings. A similar point could be made regarding the specific forms of documents. While most research reports, strategy documents or advocacy reports are characterised by a similar form or structure, each organisation's publications have particular characteristics. Thus, for most of them it would be obvious to a knowledgeable and regular reader at the first glance where a

particular publication comes from. Such issues have been considered whenever there was a sense that this would matter for the actual points to be made. However, these has not been addressed and considered in a comprehensive way throughout the analysis.

2.3.2 Interviews

Additional data were gained from interviews and email exchanges with relevant staff from international organisations. While not equally weighted with documents in terms of providing data for analysis, these interviews have been used to test conclusions derived from the documents' analysis and to assess the significance of the documents studied. The interviews were not intended to be means for studying personal judgements of people involved but, naturally, they also provided an account of interviewees' involvement in and opinions about health system issues. The data collection for the research reported in this thesis has employed the specific form of *elite interviews* conducted in a *semi-structured* way.

Basically, *interviews* have been defined as "a conversation with a purpose" (Berg, 2007:89). They are, however, not a "natural communication exchange" (Berg, 2007:114). More specifically, Holstein and Gubrium (1995:11) define them as "conversations where meanings are not only conveyed but cooperatively built up, received, interpreted, and recorded by the interviewer." There are different types of interviews (Leech, 2002a:665), for example with regard to their structures and formats of the interview schedule. Crucial decisions are connected as to the questions of whom to see, how to access potential interviewees, how to conduct the interviews and how to analyse the results (Burnham et al., 2004:205).

Elite interviews belong to the "family of qualitative interviews" (Rubin and Rubin, 1995). They are interviews with people who "are referred to as 'elite' if they have knowledge that, for the purposes of a given research

project, requires that they be given individualized treatment in an interview", thus a person's "elite status depends on their access to information that can help answer a given research question" (Manheim and Rich, 1999:320, Leech, 2002b, Lilleker, 2003). According to this specific form, the interviews are little standardised: "In elite interviewing, each respondent is treated differently to the extent that obtaining the information that that individual alone possesses requires unique treatment" (Manheim and Rich, 1999:321).

The *target group* studied for this research project were staff members of international organisations (and contributors to the Global Health Watch) who have been involved in producing the publications of the respective international organisations with regard to health systems that have been analysed in this thesis. They can be called an "elite" as they possess expert knowledge and have been participating in the production of knowledge and events related to health systems.

Identifying appropriate interviewees was a different process for the different organisations. Burnham (2004:209) points to the importance of targeting appropriate individuals for interview, particularly in large organisations, and how this necessitates being well informed about the respective organisation. For most of the organisations, the collection of documents, as well as the study of websites, gave a fairly good idea about who could be an appropriate interviewee. For the World Bank and the WHO there were more options and choices than for the ILO or the OECD, for there were fewer staff working on the issue.

In order to prevent unrepresentative sampling (Seldon, 1996:356) and to provide for some form of validation between interviews, I attempted to have the same amount of interviewees for each of the organisations. At the same time, this added to the comparability of cases, and to the reliability of the information, but it also served for keeping an eye on time constraints (Burnham et al., 2004:207f) and financial resources (Seldon, 1996:357). An in depth study of each one of the organisations would have required a higher

number of interviews to explore the processes and details, however for a multi-actor study using interviewing as an additional, secondary method of data collection, two interviewees per organisations was deemed appropriate.

Getting *access* and *arranging* the interview is at its core a sampling issue (Goldstein, 2002:669) and usually described as a difficult task due to an important characteristic of "elites": such individuals are not easy to get in touch with and are often very busy (Burnham et al., 2004:208, Manheim and Rich, 1999:324). Literature further notes the importance of showing how the interview could also have a benefit for the respective interviewee (Burnham et al., 2004:208). Staff from international organisations concerned with health systems are certainly not the most difficult group to access. For most of them, there seemed to be an interest finding out about, and thus participating in, the study. When arranging some interviews, I mentioned that I had already interviewed people from another organisation and, to ensure comparability, needed to interview a representative from this organisation, too. This may have been an incentive to participate in the research.

All interviews were organised by email. These emails included a short description of the research project and the purpose of the interviews.[16] On demand, more information was provided, however, most interviewees did not ask for it. A list of interviews can be found in Annex 2.[17]

Thus, organising the interviews (or *access*) appeared to be much less of a problem than anticipated. People were willing and happy to talk about their respective organisation's health work. In some interviews, interviewees expressed that there were too few experts on health systems and that much still needed to be done and learned. This situation probably worked out in

[17] It needs to be mentioned at this point that the two interviews at the OECD actually took place in a somewhat different context when writing a joint book chapter with my supervisor. For that purpose (and the purpose of my thesis) we went to Paris to meet people from the OECD's Directorate for Employment, Labour and Social Affairs (December 2006). It was my responsibility to lead the interview with the health staff, and to ask the questions concerned with my PhD project.

my favour when I approached and interviewed people, and also stresses the argument that is made below that, despite repeated expression of the importance of health systems, the actual health-system research and activity is not sufficiently developed, and there is much more uncertainty and a lack of knowledge than there is promotion of a particular model.

Parallel to the actual interviews, additional and useful information was also exchanged via emails with staff from international organisations or other actors; whether or not these eventually led to an interview. I had also the opportunity to discuss my research with staff from international organisations more informally when taking part in various international conferences and similar events (e.g. the World Bank's ABCDE conference in Stockholm (2010) and the FISS Conference in Sigtuna (2010)).

Turning now to the actual process of interviewing, literature continuously points to the need to being well *prepared* when doing elite interviews (Burnham et al., 2004:211, Berg, 2007, Raleigh Yow, 1994). Leech (2002a:665) nicely phrases this: "In an interview, what you already know is as important as what you want to know. What you want to know determines which questions you ask. What you already know will determine how you ask them." It is important to have good knowledge of the facts, organisations and interviewees (Manheim and Rich, 1999:322, Berg, 2007), and it thus makes sense, particularly when testing findings from document analysis, to conduct interviews at a later stage of the research process (see for example Lilleker, 2003:212). This was particularly crucial for the research conducted for this thesis as the very reason for doing the interviews was to test findings gained from documentary research.

Preparing the interviews also included knowing as much as possible about a staff member's role in the organisation and in the production of the documents studied, and about professional education and path. Getting such information was not always possible, at least concerning personal career history. It was easier to get an idea about the person's writings and opinions. In the interviews, not all took up the question saying something about their

career, and I did not insist on this as it was not a fundamental issue to be investigated in this project.

It was generally a specific set of questions that guided all interviews (see Annex 4). Comparability (as an important goal of standardised interviews (Babbie, 2001)) was a fairly minor issue as the intention of the particular interviews undertaken for this research project was to check conclusions and fill gaps. Accordingly, while following similar structures, the specific interviews were each tailored to the very specific need of information regarding the respective international organisation.

Regarding the actual interview and the techniques used, the most common *technique* for doing elite interviews, namely semi-structured interviews (Burnham et al., 2004:205, see also Berg, 2007:95) was also used in this case. Such interviews do not follow a common format, and usually they have both more structured and less structured parts (Burnham et al., 2004:212, Leech, 2002a:665). Semi-structured or unscheduled interviews are particularly valuable for elite interviews because they involve a process of learning from the side of the researcher in what the respondent perceives as important and relevant to the research (Manheim and Rich, 1999:321). I used semi-structured interviews basically to allow for both paths. Depending on the interview situation and expectation of the interviewee, I went more or less to forms of a structured interview in that "interviewers are required to ask subjects to respond to each question, exactly worded" (Berg, 2007:92). This resulted in quite different interviews: the one at the ILO was a pure discussion of issues around my thesis that started so readily that I was not even able to get my preparatory notes on the table. Other interviewees (particularly at the WHO) expected a simple question-answer interview.

For reasons of research ethics and confidentiality, interviewees were promised that their names would not be revealed. To most of my interviewees this point did not seem to have too much importance, but others stressed the point that they wanted to be informed about the use of what they said. Interviewees did however appear to be very conscious and

controlled about what they actually revealed. At the same time, the research and the interview questions were not intended to reveal very confidential issues. Accordingly, only twice did people ask me not to quote them on what they had said.

The interviews lasted from half an hour to almost two hours. One of the questions connected to the preparation and conduct of interviews is whether to use a tape recorder or take notes (Burnham et al., 2004:211). The interviews conducted for this thesis were not taped, but notes were taken during and directly after the interview. These were formulated in more detailed transcripts shortly afterwards. The reason for not taping the interviews was to make the interview situation less formal. It was further not perceived that taping the interview was really necessary, as these particular interviews served as a check of findings and were in each case tailored to the specific role and issues that had arisen about a particular organisation. The information gathered through interviews was, accordingly, less about detailed accounts or things like the direct comparison of the way interviewees described an issue. Thus, written notes were considered to be sufficient for the purpose of the study.

Quinn Patton (2002:49f) discusses the researcher's stance towards the interviewee and proposes to approach interviewees with "empathetic neutrality". This is meant to be "a middle ground between becoming too involved, which can cloud judgment, and remaining too distant, which can reduce understanding". Related to this, but also to some extent to the issue about the degree of structure of an interview (see above), personally I found those interviews worked best where my interviewee took the role of a supervisor to my research project and we discussed my main findings. Interviewees in such a case would usually stay with their perspective but help me to "see things right", which helped me more than anything to understand what their main concerns and issues (in health systems) were. It also made it easier to be on "their side". If I wanted to have a specific statement, for example about the competition between institutions or the

public-private mix, that I knew could cause negative emotions or anger or mistrust, I always said: "I see a lot of focus in the global social policy literature on competing institutions. For health systems, my impression is that you rather share an idea about what would be appropriate health system models? Did I get this right?" This would usually result in, on the one hand, interviewees supporting my finding from documentary research that there were no strongly oppositional models with regard to health systems[18], but, on the other hand, a further statement about the differences between organisations teaching me a lot about the possibility of different ways of having "competing and overlapping" actors. However, this suggestive question also had the disadvantage that it was less likely to reveal small differences, for I turned the focus to the commonalities, rather than to the differences.[19]

Related to the outcome or success of the interviews, literature has pointed to the fact that this usually depends upon the situation (Manheim and Rich, 1999:324). One thing to be taken into account that there is no obligation for the interviewee to tell the truth (Berry, 2002:680). This has to be considered both in the actual interview situation, and in analysis of the data. Accordingly, elite interviews are characterised by "produc[ing] data that are difficult to condense and summarize and that may not allow precise comparisons among respondents. The asset accompanying this liability is a greater opportunity to learn from respondents and acquire unexpected information that can lead to truly new ways of understanding the events being studied" (Manheim and Rich, 1999:321). It is, however, important to

[18] One could argue here that this was a leading question and that it was very unlikely that an interviewee in this situation would argue for a struggle of ideas instead. However, from a colleague working on a similar project focused on pensions I learned that her interviewees strongly made the point about contesting ideas, even though she was not fully convinced that this was the only way of understanding it.

[19] It needs to be mentioned that this strategy worked less well when interviewing CSO representatives.Because part of their background and justification for engagement in health is based on providing alternative ideas, they naturally did not follow me on the "same idea course", which made the interviews harder than expected. Reflecting back, a much more conscious and specific strategy for these interviews should have been developed. Most certainly, the issue of adjusting interview techniques to different groups of actors would have been even more of an issue had I extended the study to more actors.

handle with care the information obtained in an interview. Literature on elite interview frequently points to the fact that the interviewees are people who are deeply involved in the processes and activities that are being studied by the researcher. This can result in all kinds of biased statements – from giving inaccurate information unintentionally to intentionally lying (Manheim and Rich, 1999:321f). This, however, should not downplay the role of interviews as providing "immense amounts of information that could not be gleaned from official published documents or contemporary media accounts" (Lilleker, 2003:208).

2.4 Summary

This chapter has discussed the research design and the methods of data collection used for this study of global social policy. It was explained why and how a comparative study design employing tools from qualitative content analysis is useful for tackling the research questions. It has been shown how documents were identified and collected, as the major source of data using websites, and other documentation. Further, it has been explained how elite interviews were used to enrich and check the findings from document analysis. The next chapter elaborates on how this data have been analysed in developing analytical frameworks for each of the study's dimensions (actors, ideas, and communication channels).

3. Studying the Global Social Policy Models for National Health Systems: Analytical Framework

Following the review of the literature on global social policy, the development of the research questions guiding this thesis and the methodology and data collection, this chapter is about the analytical framework developed and employed for analysing global social policy as the models for health systems by global social policy actors.

Global social policy topics have been studied in various ways, depending on the approaches of different disciplines. These include ethnography (e.g. Stubbs, 2002), the influences of global actors on particular countries (e.g. Dion, 2008) or network analysis (e.g. Lee and Goodman, 2002). According to the type of study (theory testing) and the issues focused on (actors, ideas and communication channels), generally speaking, this study refers to political science (international relations) when it concerns issues of mandates and global governance; to social policy and comparative welfare state research in order to assess different ideas on health systems; and to sociological approaches to the spread of ideas (e.g. policy diffusion) when discussing the dimension of communication channels. These different issues are held together by an overarching comparative design. It is, however, not possible to define hard lines between these steps and related disciplines as some of the issues have been studied by several disciplines, employing different perspectives and approaches.

The core of the analysis is structured to answer the functional research question as developed in chapter 1: Are the findings for pensions replicated when studying the global ideas on national health systems? In analytical terms, two broader sub-questions result from that question: What characterises the global ideas on national health systems? How does this compare to the global discourse on pensions? The answers to these two questions are then used to discuss global social policy concepts and approaches in a more general way.

Facilitating the comparison with pensions and the contribution to global social policy in general, this study of global policy models with regard to national health systems needs to be analysed following the main elements of the approach(es) to global social policy in its dimensions of global models for national social policy. It also needs to follow the logic and approach of the analyses on the global discourse on pensions. In short, the latter has been described as importantly being driven and shaped by global policy actors, the pensions systems were characterised by a global discourses concept, and by more or less effective communication channels at the disposal of different actors. Accordingly, the issues to be investigated in order to describe the global policy models for health systems follow the questions: (1) Who are the global *actors* when it comes to the ideas on health systems? (2) What is the content of their advice (*ideas*)? And (3) how can and do they *communicate* these ideas?

More specifically, the ways of identifying relevant global health actors and their mandates are presented in Section 3.1. In section 3.2, the approach to analysing and comparing the different international organisations' ideas about the structure of national health systems is developed. This is followed by the analytical approaches to understanding communication channels (Section 3.3). The final section (3.4) summarises and critically discusses the choice of methods.

3.1 Who? – Identifying global health policy actors

The first analytical step undertaken in this research project consists of identifying the global policy actors relevant to global social policy as global policy models for national health systems. This is related to approaches of "political mapping" (Lee and Goodman, 2002), and also an important element in studies of global (health) governance, described by Dodgson and Lee (2002:101f) as "requir[ing] identification of the key actors and their contribution to such a system [while] [...] recognis[ing] the diversity and

dynamic nature of global health that, in turn, produces governance mechanisms that may vary with the nature of the health issue, and the political and economic priorities given at any given time." Similarly, Wilkinson (2002:2) states that – in analytical terms – the exercise of "identify[ing] the range of actors involved in the act of management, as well as to uncover the variety of ways in which they are connected to each other" is needed in studies of globalisation and global policies. In the same vein, global social policy literature has included exercises of identification and mapping of relevant actors, and the relationships between them with a focus being on the content of policy ideas.

Accordingly, in order to do such a mapping, searching methods and criteria for the identification of the relevant actors need to be developed. This analysis has employed a combination of strategies that have been intended to research both the global social policy actors identified by Deacon (2007, 1997), Koivusalo and Ollila (1997), and Lee and Goodman (2002) as they are to be "tested", and other possible actors to whom sufficient attention has not been paid.

Thus, first those actors within the global social policy literature were listed that had been described as having a say in health matters. Then, secondly, compendia of international organisations were used in order to check if there were further actors. Also, thirdly, other (global) health literature was taken into account (not explicitly linked to global social policy and rather concerned with health issues such as HIV/AIDS) for possibly identifying other crucial actors to the field. In addition, fourthly, the health sections of the *Global Social Policy Digest* were combed through for any potential new actors or developments. Lastly, links and partnerships of already identified actors with other organisations were followed up.

At first view, this has generated a rather extensive list of organisations that – in one way or another – are concerned with, and potentially influence, national health systems. Only few of them, however, engage with health systems in the way of producing elaborate models of their actual and

desirable structure. Meeting this criterion was essential given the question of comparing the global social policy fields of pension and health system models. Accordingly, in applying the criterion of comprehensive research and/or advocacy activity with regard to health systems, the number was significantly reduced to four main organisations. Such organisations able to function as "research institutions" (for example Stone, 2003, 2005), have included the WHO, the World Bank, the ILO and the OECD. In addition, some other UN bodies and non-governmental actors have been considered as appropriate, though not included in the systematic and comprehensive analysis.

Identifying these actors as important with regard to national health systems emerged through studying their designated mandates and their actual activity in providing policy models for national health systems. Current global social and health policy literature, while discussing issues of (un)justified engagement of particular organisations in related political matters, often devotes only short statements on the issue of *what* makes an organisation (or individual) a global social policy actor. Orenstein (2005:177) states, quite typically for the literature: "Global policy actors are defined by the scope of their policy activity, not their constitutional nature." This is unproblematic concerning the pure identification or mapping of such actors, and concerning the acknowledgement of particular organisations like national states or national research institutions that also function as global policy actors. However, I would suggest that it is nevertheless crucial to *understand* their mandates when analysing their activities, but even more when making claims about the justification of a particular organisation's involvement in a specific policy issue. Such "mandates", however, naturally take very different forms for different types of actors. In the global health literature, Koivusalo and Ollila (1997) have employed the approach to systematically trace global health organisations' mandates.

The understanding and approach to global social policy driving this thesis includes a certain bias to giving *international (governmental) organisations*

(subsequently referred to as "international organisations") the most decisive role in global social policy and governance. There is good reason for doing this since they are comprised of and legitimised by nation states which are usually regarded as the responsible units for national social policy. However, some authors underscore the importance of other actors (Yeates, 1999), such as non-governmental organisations (e.g. Weiss, 1999), business organisations (e.g. Farnsworth, 2005a) or private philanthropy (like the Bill and Melinda Gates Foundation). They might have an impact not only *in relation to* international organisations, but also independently in forms of parallel discourses or independent influence on national (or subnational) policies. A number of authors have pointed to the multiplicity of actors at the global level and also the role of international organisations within it. O'Brien et al. discuss this using the concept of "complex multilaterism". They argue that:

> *there is a transformation in the nature of governance conducted by MEIs*[20] *as a result of their encounter with GSMs*[21]*. This transformation is labelled 'complex multilateralism' in recognition of this movement away from an exclusively state based structure. At present the transformation primarily takes the form of institutional modification, although some policy innovation is occurring. Such changes explicitly acknowledge that actors other than states speak on behalf of the public interest.*
>
> (see O'Brien et al., 2000)

Thus, next to international organisations, there is a whole range of non-governmental actors (see Higgot et al., 2000, Williams and Young, 1994) with different attributes as to their roles in global governance. These are, for example, international non-governmental organisations (INGOs), global social movements and business actors.

The roles of international non-governmental organisations (INGOs) have often been regarded as very positive: furthering a more democratic development (Clark, 1991); providing development alternatives (Drabek,

---

[20] Multilateral economic institutions (added by AK)
[21] Global social movements (added by AK)

1987); being "vehicles for popular participation" (Farrington and Bebbington, 1993); the mobilisation, articulation and representation of people's interests at different levels of decision-making (Jordan and van Tuijl, 2000:2051); or NGOs as agents of accountability (Fox and Brown, 1998). Others have assessed the role of NGOs more critically regarding their performance, accountability, transparency, and the politics underlying their operations (Bebbington, 2004, 2005, Jordan and van Tuijl, 2000). When it comes to global social policy in particular, Weiss (1999) discusses a number of roles of NGOs. They enjoy consultative status in some international organisations; they organise and make themselves heard in conferences that run parallel to major international meetings; and they fulfil surveillance functions. Within the ILO due to its tripartite governance structure, they are even a decision-making authority.

There are also think tanks (Stone, 2000a,b) and global social movements. The importance of global social movements is closely connected to the concept of *global civil society*. According to Kaldor (2003), global civil society is made up by INGOs, networks, allies of transnational business, a new radical anti-capitalist movement, nationalist and fundamentalist movements. She describes these organisations and groups that represent (groups of) people at global levels of decision making as "a new form of global politics that parallels and supplements formal democracy at the national level" (p.107). These actors are said to build an essential force concerning the future direction of globalisation (see also Higgot, 1999). Such issues have also been discussed using or in relation to the concept of "transnational activism" (Bennett, 2004).

Among business actors, health receives relatively little attention (Farnsworth, 2005b:75). Business actors' impact on health systems through other related policy fields (such as drug prices/pharmaceuticals) rather than through a direct engagement in the health sector, and might also have an impact on supranational health regulations.

Given the specific theoretical topic of this study, namely explicit and comprehensive models of health systems, the number of non-governmental organisations is small, and even then the few are not focused upon in this thesis. Many CSO activities are either concentrated on very specific health issues, on specific regions, or primarily active in on-the-ground actions. They might be directly engaged with international organisations, and try to influence their ideas and activities, however, their independent engagement for producing comprehensive or complex ideas, models and reform suggestions on health systems, appears to be rather limited. An important exception is the *Global Health Watch*, which does develop a comprehensive concept of health systems and provides for complex recommendations on the matter. Therefore, it is considered and included as an excursus in chapter 5 and studied as an alternative policy model, but not in terms of a full comparison with international organisations on the dimensions of actors and communication channels.

Still, this study primarily focuses on international organisations. This is, on the one hand, due to the scope of a PhD thesis, but, on the other hand, particularly because the approach of Bob Deacon (2007, Deacon et al., 1997) has mainly analysed such international organisations and elites, and this is the main body of research to be tested here. The limited focus on international organisations must not be confounded with a statement about the "most important" group of actors. It is, however, an important focus regarding those aspects of the research design that tackle the roles and responsibilities of global social policy actors. Asking about mandates and relationships to member states apply to international organisations, while in the case of other actors like CSOs or business actors these units would have to be phrased, studied and compared differently.

What is perhaps more problematic about the categories used in the analysis is that they turn a blind eye towards organisations that do not *explicitly* engage in policy models for health systems, but that understand elements or functions of health systems as belonging to other sectors, namely health care

provision as *services* and thus a potential area of global trade. I touch upon these forms of global health policy, as appropriate, but do not take them as organisations truly engaged in the global health activities in focus in this thesis. An excursus in chapter 5 does, however, provide a summary discussion of the WTO's (trade agreements) potential impact on national health policy.

The attention of global social policy literature has further been on the secretariats of international organisations, the research work undertaken and reported by different departments within international organisations, the advocacy activities, and the interactions with national policy makers and research institutions (see for example Stone and Maxwell, 2005, Deacon, 2007, Orenstein, 2005). This study on global health policy accordingly assumes international organisations do have a life that is independent from their member states, and focuses on issues of explicit and implicit mandates, their research and communicative activities in relation to national health systems, and their strategies to fulfil their roles and gain influence over national and global health policy debates.

The way that international organisations and other actors have just been described suggests they function as actors to some degree independently from their member states. However, apart from the question of the dependence or independence from their member states or other composing units, these organisations also often collaborate on particular topics or issue areas. When they build alliances, these are often referred to, and studied as, *networks*. In contrast to understandings of networks as a modern form of policy process (Keohane and Nye, 2000, Castells, 2000) or as a means for transfer (Evans and Davies, 1999), networks in this sense are institutionalised networks (Held and McGrew, 2002b). Such networks may have the functions of coordinating the work of experts and functionaries, for example, within international organisations, and the corporate and the NGO sector; setting policy agendas, communicating information, formulating rules, establishing and implementing policy programmes; and being

mechanisms through which civil society and corporate interests are effectively embedded in the global policy process (Held and McGrew, 2002b).

While the analysis of this thesis is not specifically on networks, but rather on comparing and contrasting actors and their work, and discussing them in relation to each other. However, the data collected also provides evidence for collaboration and network structures. There are, for example, some documents that have been produced jointly by some of the actors in focus (for example Dror and Preker, 2002), and there is involvement by staff from different international organisations in the same teaching activities and other events. One needs to be aware of these structures, but this particular thesis does not study these networks and their functions and instead just points to collaboration where it occurs.

3.2 What? – Analysing and Comparing Health System Models

It has been explained that an important characteristic of global social policy research is the analysis of the *ideas* articulated by the different global policy actors. In chapter 1 it has been shown that such ideas often appear as contested ideas, representing a struggle between different (groups of) global policy actors. This has been characterised as a global discourse on social policy matters. Before we can state anything about the character of these ideas in relation to each social policy actor in the field of health systems, however, we need to define a way of studying and comparing them.

For the purpose of this study on global social policy, health systems are understood as elements or functions of the more comprehensive concept of the welfare state, and as models (regime types). The definition of global social policy and the review of the related literature in the last chapter showed that global social policy debates in the dimension addressed here, have concerned the appropriate role of the state in social policy and have

associated the models of particular global actors with the characteristics of specific welfare state regimes. This does not necessarily imply that within international organisations coherent views are held on the role of the state in social policy, but there can be several models proposed from staff by the same international organisations and they can change over time. Accordingly, in order to classify and explain the ideas and models proposed by global policy actors, it is important to have a general idea about the functions and models of welfare states and health systems. It needs to be noted that these definitions and categories have been derived from research on OECD countries. The reason for doing this is mainly the fact that the global social policy research and findings to be tested with the study reported in this thesis followed this stream of thinking and approach. Using Esping-Andersen's (Esping-Andersen, 1990) descriptions of types and differences of (OECD) welfare states, the pension policy models of international organisations were analysed and compared (see particularly Deacon et al., 1997). This is not an unproblematic choice. Pressing global policy ideas and models into the analytical framework from OECD countries is prone to being blind to issues arising in developing countries not fitting the model (OECD policy ideas). But for the sake of comparison with the categories used to analyse the global pension discourse this thesis uses the same reference points for analysing global health system ideas.

On the identification of welfare state types, most influential has been the work of Gøsta Esping-Andersen (1990) who classified OECD welfare states according to the relative importance of each of the components of state, market and family, and discussed aspects of rights and stratification. Esping-Andersen identified three types of welfare state regimes: liberal, conservative and social democratic (for a general overview see Hort, 2005, Kennett, 2001, Alcock, 2001).

In *liberal regime types* like USA, Canada, Australia and Britain, the decommodification effects are minimized. This regime type "effectively contains the realm of social rights, and erects an order of stratification that is

a blend of a relative equality of poverty among state-welfare recipients, market-differentiated welfare among the majorities, and a class-political dualism between the two" (Esping-Andersen, 1990:27). They are characterised by a predominance of means-tested assistance, limited universal transfer or social insurance schemes.

The *conservative regime type* comprises countries like Germany, Italy, Austria and France. The welfare state is created within a corporatist tradition; the Church, traditional familyhood and status differentials importantly shape the welfare state. The institutionalisation of rights is attached to class and status; thus, the social security system is rather designed to maintain status than to create opportunities and to preserve gender divisions rather than to integrate women into the labour market.

The *social democratic regime type* includes the Scandinavian countries. Such welfare states are based on "equality of the highest standards, not on equality of minimal needs as was pursued elsewhere" (Esping-Andersen, 1990:27). The decommodification potential is high due to universalist programmes. The regime type is characterised by a fusion between welfare and work.

This approach and the categories have been criticised from various perspectives, for example from a feminist perspective (e.g. Langan and Ostner, 1991) or for the fact that only a limited range of types of welfare provision are taken into account (Alcock, 2001:6), e.g. disregarding the delivery of services (e.g. Bambra, 2005a). There are also studies that add further regime types to Esping-Andersen's typology (e.g. Leibfried, 1990, Lessenich and Latzer, 1995). Despite the criticisms, Esping-Andersen's model has been most influential and forms the major part of current studies on the welfare state and social policy.

More recently, the focus has also shifted so as to take more account of non-OECD social policy systems (Wood and Gough, 2006). While it would also be an interesting expansion of global social policy research to analyse to

what extent non-OECD arrangements have served as policy learning examples, this thesis does not go that far. This could be a limitation due to the risk of overlooking or misinterpreting policy advice that does not follow a "Western model". The decision is, however, motivated by two reasons. On the one hand, the analysis of the global pensions discourse, used as the case to be tested, has been based on models of OECD regime types. On the other hand, the production of the knowledge in the secretariats of international organisations is itself very much based on OECD countries' social policies. Surely, we can observe two things. First, there is a problematic use by global policy actors of Western models and solutions to problems in developing countries that have very different (social and health) needs. Second, there are various global health debates that also go into the specific needs of developing countries, such as health issues related to malnutrition, maternal and infant mortality, malaria and other 'tropical' diseases. One has to acknowledge that the ideas about health system *models*, are to some extent dis-connected both in analytical means and in actual global social policy debates. The study reported in this thesis, however, is not primarily concerned with such issues. It is located at the global level in terms of an arena within which social policy debates take place, not about the appropriateness of these debates in capturing and responding to the real needs of countries.

Understanding health systems as part of welfare states would imply that they are rightly captured by, or integrated in, such welfare state types. On the relationship of health systems and the welfare state Moran (2000:139) points out: "Health-care institutions are influenced by, and of course influence, the wider welfare state; but they are also shaped by dynamics of their own – some of which are internal to, and some of which are external to, the health-care system." However, the relationship between health systems and welfare states is not straightforward in the literature on welfare states or on health. A number of authors in the field have remarked that health systems are not well theorised (Thurner and Kotzian, 2001), and not well integrated in the general welfare state literature (see for example

Moran, 2000). While within welfare state studies health systems have been rather neglected; literature on health as such often focuses purely on financing issues or diseases, disregarding its social security dimensions.

Comparative health system scholars have critically discussed the usefulness of Esping-Andersen's welfare state categories for health systems. Bambra (2005a, 2005b) and Moran (2000) argue that Esping-Andersen's approach is problematic, because when he classifies welfare states according to stratification and decommodification, he ignores the dimension of services that is particularly relevant for the field of health care. However, health systems show the characteristics of welfare state schemes to the extent that they "address one of the major forms of social risks people face, and there is a widely held view that it is not ethically acceptable that access to care when ill should depend on ability to pay" (Koivusalo and Mackintosh, 2004:9, see also Wendt, 2003 for discussion on how the values of health as a special good, social justice and solidarity are realised and safeguarded within health systems). In this respect, health services are personal welfare services (Moran, 1999) and the health system forms part of the wider welfare state.

Similarly and related to the categorisations of general welfare state comparative research, there have been different attempts at categorising health systems per se. Moran (1999) distinguishes three governing arenas for the health care state: the government of consumption, of professionals and of production. In a later article, he partly rephrased the governing arenas into: consumption, provision and technology (Moran, 2000). This distinction generates four families of health care states: entrenched command and control states, supply states, corporatist states, and insecure command and control states. States belonging to the first group (*entrenched command and control states*) are Scandinavian states and the UK. The state is absolutely dominant in the consumption (resources are gained through the taxation system and allocated through administrative mechanisms) and sets the rules for provision ('means of production' in public ownership; 'private-interest' government mainly regarding education, training and ethical

practices). As it is almost impossible to control the apparatus of innovation, "[d]omestic medical technology production is in private hands" (Moran, 2000:147); though, due to the state's power in the consumption and provider arena, "powerful gatekeepers regulat[e] the diffusions of technological innovations throughout the health-care system" (Moran, 2000:148). The dominant example for a *supply state* is the United States (possibly also Switzerland). Based on the history of the American health system, this system gives priority to the supply of hospital-centered, and technologically sophisticated health care – instead of being concerned about access to the health system. Suppliers have a powerful role in the decision-making processes, the system "combines rampant cost inflation with a lack of universalism" (Moran, 2000:151), and the "weight of the American regulatory state has been bearing down on all three arenas of health-care government- consumption, provision and technology" (Moran, 2000:151). Germany is the paradigmatic case for the *corporatist health-care state*. In the consumption arena, the state is only significant as provider of a regulatory framework while public law bodies are the dominant actors. The delivery arena is dominated by public law associations of doctors. Technology innovation is underdeveloped (Moran, 2000:152f). *Insecure 'command and control' health care states* comprise Portugal, Spain, Italy and Greece. They are built up according to the idea of the British NHS "but in none has command and control been able to entrench itself in the manner of the north European systems" – the problem being that they have not been successful in creating universal coverage (Moran, 2000:154).

Another important differentiation that is being used for health systems is the one between national health systems (NHS), social insurance systems and market systems; categories which are then often "further differentiated along different institutional attributes, e.g. financing source, public vs. private provision of health care" (Thurner and Kotzian, 2001:3). Moran (2000) describes this as merely relevant to what he calls the "government of consumption" (Moran, 2000:139).

This typology is useful to understanding types of health systems and is considered in the final analysis and conclusions of this thesis in order to discuss whether or not a health system model resembling one of these types has been promoted or not. However, including some of the issues of 'provision' and those of innovation makes it hard to keep the definition of health systems as being part of welfare states. The latter would imply a more focused view on issues of rights and access, redistribution and regulation in the sense of setting frameworks for private actors. Accordingly, the distinctions needed to conduct this analysis would indeed rather follow the NHS – social insurance – market based systems and thus the 'consumption' dimensions. On the other hand, these types are limited in the sense that they mainly look at financing models, plus to some extent associated provision models, but are blind on the possible disconnect between financing and provision.

Thus, a more useful approach to the analysis of health system ideas appears to be looking at the proposed role of the state within different functions of health systems, as is described in the next section. This shifts us from the focus on particular types of health systems proposed to distinctions within different functions of health systems, and gives us both a frame for a number of categories and issues connected to health systems as welfare systems that have been briefly and incoherently addressed in the literature on global social policy; and a basis to identify potentially diverging policy models and an idea about the extent that they diverge.

The approach employed here builds up on the functions distinguished by Freeman (2000) and Alber (2001), namely delivery or provision, finance and regulation; though in a slightly adapted way and on the basis of an analytical framework developed by Grimmeisen and Rothgang (2004).

However, before going into detail with the analytical framework developed from Grimmeisen and Rothgang (2004), and connected to issues of contextualisation (see above), the analytical categories used in this thesis also include those related to the context or situation within which health

systems are addressed by a particular international organisation, the goals and underlying principles coming with this engagement in health system research, and the respective definitions of health systems employed by different international organisations. These questions take account of the particular character of policy ideas from international organisations in contrast to the analysis of national policies and ideas that are closely connected to national culture, national political actors or the specific character of national welfare arrangements.

Contexts for addressing health systems can be, for example, poverty reduction, a focus on a particular group of countries (such as OECD, transition or low-income countries) or the MDGs (e.g. the broader health system context for improving maternal care). *Underlying goals or principles* comprise, amongst other things, the promotion of particular rights (social rights with regard to health), poverty reduction and improvement of the health of poor people. Concerning the *definition* of health systems, the crucial issue is to what extent they are similar or divergent to the analytical model used in this thesis and how to allocate particular ideas to the different analytical questions (see also above on coding).

The role of the state in the different functions is described by Grimmeisen and Rothgang (2004) in two dimensions, along an organisational and a territorial axis. The extent of state engagement in the *provision* of health care for its citizens is on the organisational axis between public and private provision. More concretely, "the property form of the institution which provides the respective health care services [...] to which the resources of the overall health care budget are located to" (Grimmeisen and Rothgang, 2004:4). On the one extreme, these are public providers; in the middle, private non-profit providers (charitable organisations, trade unions, social insurance agencies); and on the other side private for-profit providers. On the territorial axis, the level of provision (nation state, local, international) is the issue.

Regarding the *financing* dimension of health systems, it is the question of public versus private resources to finance health services. This can be further sub-divided into taxes (and other governmental sources of financing), social insurance contributions, private insurance financing, and out-of-pocket payments (Saltman 2003; Wendt 2003). In the territorial axis, again, it is the question of the level (national, subnational, international) of sources of health care financing (Grimmeisen and Rothgang, 2004).

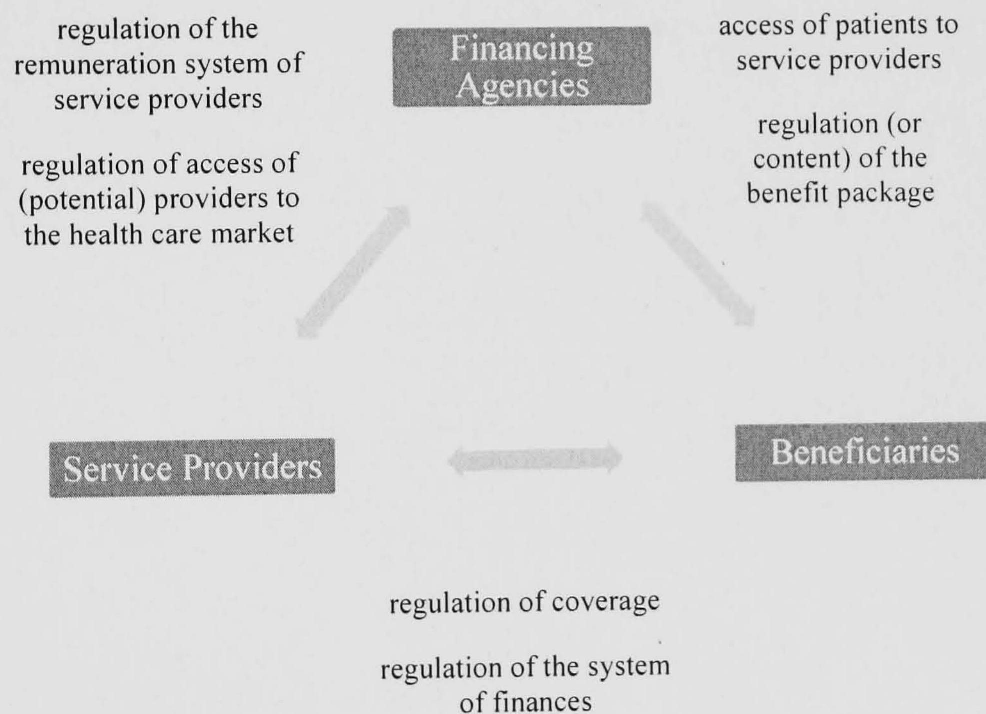
While the state or the government may have a stronger or weaker role in directly financing and providing health care (goods and services), and given the fact that in both real systems and in proposed models of health systems the state is hardly the only actor on the scene, the issue of the role of the state in *regulating* the health sector is in fact the crucial one. This regulatory role concerns the mutual relationship between the three core instances of the health care sector, namely financing agencies, health care providers and (potential) beneficiaries (Grimmeisen and Rothgang, 2004, Rothgang et al., 2005). Six regulatory relationships and thus areas of regulation arise from the interplay of stakeholders (see Figure 3.1). When it concerns the relationship between the (potential) beneficiaries and the service providers, it is the regulation of coverage (inclusion of parts of the population in public and/or private systems); and the regulation of the system of financing (taxes, social insurance contributions) vs. private (private insurance contributions, out-of-pocket). In relation to global discourses, the issue of user fees would be located here. Regarding the relationship of financing agencies and service providers, the main issues are the regulation of the remuneration system of service providers; and the regulation of the access of (potential) providers to health care markets (access to financing agencies). Finally, on the relationship between service providers and patients, it is the access of patients to service providers and the regulation or content of the benefit package that is to be defined (Grimmeisen and Rothgang, 2004, Rothgang et al., 2005). For the purpose of this analysis, three important dimensions of that regulatory role are emphasised and discussed. These are the issue of *access* (universal access versus targeting vulnerable groups; and the right to

health care), the *system of financing* (tax-based system, social insurance or a mix of elements of both models), and the decision about the *benefit package* (who should decide on the content and how?).

In terms of the concrete questions guiding the analysis and the connected comparison of the ideas coming from different international organisations, table 3.1 provides an overview of the relevant categories and units.

In summary, this section has presented the analytical framework for examining the ideas expressed by different global health actors. For this purpose, the section described common understandings and categorisations of welfare states and health systems and discussed to what extent they go

Figure 3.1 Regulatory Relationships in Health Systems



Source: Rothgang et al. (2005)

together. It then took up a particular approach to health systems distinguishing functions and dimensions. This approach has been presented

to facilitate the analysis of health system ideas under a social policy or welfare state perspective. The questions guiding the analysis on the aspect of 'ideas' are, thus, directed at the respective role of the state in three key functions of health systems (financing, provision and regulation).

Table 3.1 Comparison of Health System Models (analytical)

		WHO	World Bank	ILO	OECD
context, situation					
goals, underlying principes					
Definition					
Provision					
Financing					
regulation	**health care coverage**				
	system of financing				
	remuneration of providers				
	access to markets				
	access to services				
	benefit package				

3.3 How? – Studying Communication Channels

The third step of the analysis of global policy models for national health systems is to study the organisations' communication channels. Accordingly, the analysis covers how the knowledge produced is presented and communicated. Some elements of policy transfer and diffusion literature facilitate the study of such communication activities and mechanisms by global policy actors. These will now be discussed in turn. However, it needs to be taken into account that this thesis only focuses on the "sender side" and suggests only the relative influence of the actors. Any comprehensive assessment of mutual influence would relate to the sum of ideas expressed and the mutual uptake between international organisations, which has not been the primary interest of this research. The descriptions of the global discourse on pension systems do not actually use methods like citation analyses or observation of international meetings (regarding the interaction between staff from different international organisations) as their main approach. They also study and compare different positions and draw conclusions about the relation between these positions and between different international organisations, *or* they study the impact on international organisation on national governments. The study of the content of ideas and the ways of communicating them undertaken in this thesis is used to assess whether or not we can draw conclusions about a form of global social policy discourse in the field of health systems. That is why the term "global discourse" is not a central focus of this thesis and not indicating a particular perspective or methodological or analytical approach, but rather the potential conclusion of a study and comparison of "global ideas" as reviewed in chapter 1. However, the means by which the international organisations seek to disseminate their health system ideas is a focus and can be analysed within the context of a discussion of processes of policy diffusion to which this section now turns.

One group of theoretical approaches that have something to say about the processes of the communication of ideas or policy models is that of *policy diffusion*. However, the literature on diffusion is broad and not entirely coherent (Braun and Gilardi, 2005:4). Diffusion approaches are generally based in *world society theory* (Luhmann, 1999, Meyer et al., 1997) or *world system theory* (Wallerstein, 1974), with an understanding of society being a relatively closed context of action and communication that itself produces all structures and processes that can be observed within it by the differentiation of function systems (e.g. world economy, world politics, world religions) (Stichweh, 2004). These approaches are more characterised by the spread of a "universal knowledge" than on a notion of contesting ideas and discourses. Most diffusion definitions focus on the level of *process*, rather than the result or outcome of diffusion (Elkins and Simmons, 2005). Leisering (2005:78) remarks that it is important to distinguish between the two, but taking into account that there is more than process. He points to phenomena of spurious diffusion and failed transfers or diffusion that show how important it is to also look at the outcome and not only at the process.

Still, these approaches provide for some important explanations, also with regard to actor-centred analyses. One important feature in the diffusion literature is the concept of interdependence, as Levi-Faur (2005:28) describes:

> *It is our observation of one another, rather than the mere actions of others that often make our actions interdependent. This "social" interdependency of choice implies that the probability of action by one actor is positively or negatively connected to the observed action of others.*

While this is not the place to discuss all characteristics of diffusion in detail, the mechanisms of diffusion are important in this context (Orenstein, 2003, Braun and Gilardi, 2005). A number of such diffusion mechanisms can be found (Simmons and Elkins, 2004) and they vary slightly from one author to another. Braun and Gilardi (2005:12ff), for example, distinguish between

learning, *competitive interdependence*, *cooperative interdependence*, *coercion*, *common norms*, *taken-for-granted* and *symbolic imitation*.

> *Learning means the behaviour of A has an impact on that of B because it conveys relevant information about policy choices; competitive and cooperative interdependence means that the choice of A creates policy externalities that B must take into account; coercion means that powerful actors can impose costs and rewards on policy alternatives; common norms of action are created by the interaction of actors; taken-for-grantedness means that widespread policies can be almost automatically considered as the appropriate choice; and finally, symbolic imitation means that orthodox policies are rewarding.*
>
> *(Braun and Gilardi, 2006:299f)*

Orenstein (2003:174) defines the categories for diffusion mechanisms as *interstate competition for economic resources and legitimacy*, *the role of interstate organisations*, *the role of epistemic communities in spreading new ideas and information about policy reform*, and *the role of regional models in demonstrating policy feasibility*. Elkins and Simmons (2005:4) distinguish between "those [diffusion mechanisms] for which another's adoption alters the value of the practice and those for which another's adoption imparts information". For the first category, *adoption to altered conditions*, they further distinguish between *cultural norms*, *support groups*, and *competition*. For the second one, *learning*, they identify different methods, namely *information cascades*, *learning and availability* and *learning and reference groups*.

Similar is the *policy transfer* approach, developed by Dolowitz and Marsh (2000). Policy transfer is described as the process of bringing ideas, programmes, institutions, policies or administrative arrangements from one place and/or time into another place and/or time. This process can take different shapes like lesson drawing, coercive policy transfer, policy harmonisation or cross-national policy learning. The basic assumptions of the policy transfer approach are that, due to global economic forces and the growth of communications of all types, the exchange of information is

growing. International organisations are one type of facilitator of influence on national policies (Dolowitz and Marsh, 2000:5ff).

According to these analytical approaches, the documents collected for this analysis that have so far been treated as data to understand the content of mandates and policy ideas, in the third step of the analysis turn into means of communication channels. They become units of analysis per se, not just written data bearing particular information. In addition, the *websites* have also been used to understand the organisations' communication channels, as well as the teaching activities of the organisations through their own research institutes and staff.

More concretely, the collection of material has led to a distinction among the following categories of communication channels to be analysed for each of the organisations.

(1) Formal negotiations: International conferences as meetings of heads of states, ministers or other representatives of national governments that may lead to forms of international health regulation or provide forums for policy learning. Such meetings do not only serve the purpose of having states and/or other groups meet, but also provide an opportunity for the secretariats' staff to foster particular ideas about an issue through agenda-setting and the distribution of background material.

(2) Various forms of publications, distinguishing between (a) strategy documents, (b) advocacy documents and (c) research documents. Theoretically, not all of the strategy papers are supposed to also represent a tool for communicating ideas, but rather organisation-internal guidelines for work. However, as international organisations are constantly watched by other international organisations, as well as member states and other actors (CSOs, business actors, professional associations) the content of these documents is also perceived (by the institutional environment) as substantial ideas and information provided by an organisation. Advocacy documents can serve as important means to inform the international community and

shape the perception of global health problems and their possible solutions (theoretically, this also includes more traditional public relations means such as speeches and press releases; due to the highly complex analytical model regarding health systems functions, it was, however, difficult to have them included in a meaningful way). Research documents are intended to provide for analytical and technical information and knowledge.

(3) Conferences and workshops organised by one or several international organisations are used to inform and "teach" national policy makers and/or staff from other international organisations. They also use the publications by the organising organisation and others and also academic publications, as they often invite the exchange of national policy-makers and/or bureaucrats related to specific policy or reform issues.

(4) More direct involvement in national policy making may happen through financial (conditional) support and project activity; often combined with advice given as to the structure and reform of policies.

(5) International organisations further engage in developing indicators, and collecting and reporting data. This also sometimes includes the ranking of countries, or lengthy reports of a country's performance in a particular policy field.

(6) The websites and connected means (such as email lists and newsletter) – that have served in this study as the main gate to identifying and accessing information – are of course also part of an organisation's communication channel. They present the respective organisations and spread information and knowledge.

(7) Related to particular sets of ideas are also campaigns to advocate a particular policy model or idea.

(8) Finally, international organisations build up and participate in networks or epistemic communities that also lead to a spread of ideas, to the

promotion of particular models, the definition and common use of terminology.

Table 3.2 demonstrates these categories as studied for each of the global health actors analysed here. In summary, when it comes to the dimension of the communication of ideas, a number of approaches to the global spread of ideas provide useful tools to support the analysis. While some approaches are rather focused on the factors and processes of diffusion, this study – so as to be comparable to the mainstream global social policy literature to be tested – attributes an important role to actors and their engagement and various forms of communication. This study focuses on the global level only, and on the "sender" side of the process (cf. Leisering, 2005), more specifically on the perspective coming from the international organisations and – to a lesser extent – of other global actors. That includes the intention of the related actors to communicate ideas both at the global level and reflecting the relationship with member states. As has been stated earlier, this focus on international organisations and their strategies is not a statement about their unique or powerful role, or about their share of decision-making when it comes to national social and health policy processes, but is rather about the individual and joint activities by international organisations. According to these analytical approaches and the organisation of the documents and other data collected, the chapter has developed analytical categories that organise the information and provide

Table 3.2: Communication channels (analytical)	**WHO**	**World Bank**	**ILO**	**OECD**
formal negotiations				
publications				
workshops				
direct involvement				
Data				
websites etc.				
campaigns				
networks				

the means for a better understanding of different forms of communicating ideas.

3.4 Summary

This chapter has engaged with approaches to studying global policy actors, ideas and communication channels, providing the analytical tools to test global social policy literature. It was shown how qualitative content analysis is used as a method to test existing approaches to global social policy; however, it was also discussed how that may produce biases in the methodology and findings. The analysis distinguishes three dimensions: actors, ideas and communication channels.

On the question of actors, the study focuses on international organisations, instead of intending to identify all possible actors in the mapping exercise. This is a limitation due to the scope of a PhD thesis. However, it is also due to the particular approach to be tested that often focuses on international organisations. The intention is, thus, not to reveal new actors or a contribution to the better understanding of the particular power of one group of actors, but to see whether or not those actors that are the main focus of current global social policy research have similar roles and undertake similar activities in the different fields of social policy.

The chapter has discussed a number of approaches of international relations to provide for some analytical basis as to the role and character of international organisations. It has been discussed how they are linked with interests and actions. In such a context, international organisations are connected to their member states in different ways, but at the same time they are actors in their own right, which are also involved in other global structures and processes in the spread of knowledge, and engaged in different scales of policy making.

Referring to the second analytical step, the chapter has elaborated on the role of ideas in global policies and more specifically provided for a particular analytical framework to approach the data. This included both the distinction of different welfare state and health care arrangements, and the functions of health systems. It is designed to facilitate the analysis and comparison of the different international organisations' policy models on health systems, as well as the contextualisation of the related findings and the comparison with the global ideas on pension systems.

The analysis of communication has been supported by approaches to policy diffusion and transfer, and strengthened the focus of the global, horizontal perspective and the attention to policy actors. A number of categories have been developed as the analytical framework for studying communication channels.

The next chapters report the findings of each of the analytical steps developed in this chapter.

PART II: FINDINGS

4. Who? – Global Health Actors

As a first step in the analysis of the global policy models for national health systems, this chapter addresses *who* are the relevant global health actors and their mandates for engaging in such activities. It provides an overview of the global policy actors in policy models for health systems and discusses how they are legitimated to do so. The focus is on the production and communication of knowledge or ideas on the form of health system principles and models, not on actual interventions in countries or mechanisms, like conditionality attached to loans.

The chapter first turns to organisations within the UN system (4.1), more specifically, the mandates of the WHO (4.1.1) and the ILO (4.1.2). Further, the World Bank (Group) (4.1.3), plays a role in this dimension of global social policy. In terms of international organisations outside the UN system, the OECD (4.2) is important to take account of. Last but not least, collaborations or networks of such organisations are referred to in section 4.3. The chapter concludes (4.4) with a summary and discussion of the global health actor set in relation to the global social policy understood as policy models for national health systems.

4.1 Health Policy Actors Within the UN System

The "UN system" describes a group of international organisations and a package of international law and is large and confusing in its structure. The different bodies and international organisations within this system do not all have the same status, importance, power or independence (White, 2002). Accordingly, it does not represent a logically functioning system of global governance, even though there have been attempts to get somewhat closer to that (for example, the Report of the Secretary-General's High-Level Panel

on UN System-wide Coherence (UN, 2006)). Describing the whole UN system in order to allocate the bodies and organisations concerned with health would go beyond the scope of this thesis. Thus, those institutions are referred to that play some role in global health policy[22] and, more concretely, their respective roles in producing models of national health systems are discussed.

The UN was established, amongst other things, with the purpose "to cooperate in solving international economic, social, cultural and humanitarian problems and in promoting respect for human rights and fundamental freedoms; and to be a centre for harmonizing the actions of nations in attaining these ends"[23]. The General Assembly (GA) is the UN's main deliberative organ, composed of the representatives of all member states (nearly universal membership). Among its functions are to initiate studies and make recommendations to "promot[e] international cooperation in the economic, social, cultural, educational, and health fields" (UN Charter, Article 13; see also Articles 55, 57, 62). According to this, UN initiatives on these issues have limited binding character (in a legal sense); something that also applies to the UN specialised agencies working in the field (see for example White, 2002:15ff).

At GA level, global health policy has predominantly taken place in the context of global goals like the Millennium Development Goals (MDGs) that include three on health (see point 19. of the Millennium Declaration; and goals 4, 5 and 6). These goals were developed on the basis of the United Nations Millennium Declaration (GA A/RES/55/2) adopted in September 2000 at the United Nations Millennium Summit. Based on the fundamental principles and purposes of the UN, the MDGs go back to a set of earlier commitments made at the 1995 World Summit for Social Development in Copenhagen. Despite the lack of enforcement mechanisms for such goals, the MDGs and the connected process, have gained huge importance and

[22] For a chart on the UN system see Annex 5 (or http://www.un.org/aboutun/chart_en.pdf, accessed 29 December 2010)
[23] See http://www.un.org/aboutun/untoday/unorg.htm, accessed 29 December 2010

popularity in the work of many global actors. It has, however, also been argued, that the MDGs represent a step back in commitments already made (GASPP team, 2005, Deacon, 2007: chapter 4). The Millennium Declaration further established a framework or programme of work for the entire UN system, including the cooperation among the various bodies and organisations (point 30. of the Declaration). In this context, the UN's Economic and Social Council (ECOSOC) was supposed to be strengthened "to help it fulfil the role ascribed to it in the Charter" (point 30. of the Declaration).

In 2002, then-UN Secretary-General Kofi Annan commissioned the *Millennium Project,* established to develop a concrete action plan for the achievement of the MDGs. It concluded in 2005 with the presentation of the final recommendations and separate reports of each of the 10 thematic task forces. The three task forces on the health MDGs, amongst other things, also addressed the importance of health systems for the achievement of the respective goals. A joint statement on health systems of the three health working groups was announced "to reflect our shared conviction that strengthening these institutions will be the key to achieving the health Millennium Goals" (UN Millennium Project - Task Force on HIV/AIDS, 2005:xii), but there is no sign of this having been turned into action (not at the related websites; and confirmed by an interview at the WHO – in December 2006). During 2006, work continued on implementing the report's recommendations. From January 2007, the UN Millennium Project secretariat has been integrated into the UNDP.[24]

On the health MDGs, there has been other activity, also independent from those conducted within the Millennium Project and the UNDP, side-lining the general MDG activities. For example, in September 2007 the Global Campaign for the Health Millennium Development Goals[25]was launched, giving particular attention to the health of women and children. This

[24] For the material, final reports and current progress and campaign see http://www.undp.org/mdg/, http://www.endpoverty2015.org/, accessed 29 December 2010

[25] See http://www.norad.no/globalcampaign

consists of several other initiatives, including the International Health Partnership (IHP) established by the UK in September 2007; the Catalytic Initiative by Canada and UNICEF in November 2007; the Results-Based Financing Initiative by Norway and the World Bank in November 2007; and the Providing for Health Initiative by Germany and France in Spring 2008. Further, the Health 8 (H8) advocating the health MDGs started in mid-2007. This is an informal group comprising the WHO, UNICEF, the United Nations Population Fund (UNFPA), UNAIDS, the GFATM, the Global Alliance for Vaccines and Immunization (GAVI), the Gates Foundation and the World Bank. These initiatives also represent forms of different organisations networking with each other; an issue that is taken up again later in this chapter. Such activities, organisations and networks show how the two dimensions of global social policy discussed in chapter 1, the policy models and the transnational social policy form are not always clearly distinguishable.

Accordingly, some UN bodies (i.e. the ECOSOC, UNDP, UN DESA, UNICEF) touch upon health policy, usually in the context of development policy or, more specifically, in the process of working towards the attainment of the MDGs, but rarely in the form of more comprehensive health system models. Most pronouncements appear, instead, in the form of short political statements. This is different for some of the specialised UN agencies and IFIs, which are international organisations in their own right with separate councils, assemblies, secretariats, budgets and so on. They deal with global and national health matters, more thoroughly and are discussed in the following sections.

4.1.1 World Health Organisation (WHO)

There is one UN specialised agency explicitly entrusted with health: the World Health Organisation (WHO). Founded in 1948, the WHO's origins go back to the League of Nations and earlier regional health organisations in Europe and America. The WHO's headquarters are located in Geneva (Switzerland), but the organisation is also characterised by its regionalised structure (six regional offices).

The representatives of the WHO's member states (nearly universal membership) meet regularly in the World Health Assembly (WHA) to determine the policies of the organisation. The Executive Board (EB) is responsible for preparing the WHAs, and to give effect to the decisions reached at the WHA. The WHO's Secretariat is comprised of the Director-General and the technical and administrative staff.

Given the organisation's name, the WHO's general mandate for health does not need much clarification or justification. The organisation was founded with the general objective of working for the "attainment by all people of the highest possible level of health" (Constitution of the WHO). Among its functions are the directing and co-ordination of international health work (Article 2 (a)), and to assist governments in strengthening their health services (Article 2 (c)). It has, thus, a norm-setting as well as a coordinating function. This has included activities on health systems, but to varying degrees at different points of time, as the WHO's role regarding policy models for health systems has never been an easy and straightforward one.

Attempts to define an appropriate role for the WHO on the function of guiding national health systems have been on-going since the 1970s at various occasions and in numerous reports and other documents. In 1973, a WHA resolution entitled Organisational Study on Methods of Promoting the Development of Basic Health Service (WHA, 1973) was on developing a

role for WHO to assist member states improving their health delivery systems. It envisaged the WHO's role as that of a "world conscience", providing a forum for the discussion of new ideas. Additionally, resolution WHA27.44 of 1974 called on the WHO to report to the EB on steps undertaken by the WHO "to assist governments to direct their health service programmes toward their major health objectives with priority given to the rapid and effective development of the health delivery system" (quoted in Litsios, 2004). A more comprehensive concept, in the form of the Primary Health Care (PHC) approach and the Health for All (HFA) strategy was then developed in the context of the Alma-Ata Conference and the Alma-Ata Declaration (WHO/UNICEF, 1978a). With the update of the HFA strategy in 1998, an interesting shift occurred regarding the role of the WHO from being described as the "world health conscience" (a formulation that could still be found in the document prepared for the session of the Executive Board still in EB101/8) to a "health advocate" (WHO, 1998).

While the WHO has been searching for its appropriate role in health systems research and guidance, it does not consider itself as being the only global health organisation. The WHO has been trying, however, to establish itself as some form of the *lead agency in health*, coordinating the activities of various global health actors. As the organisation itself states:

> *Even as the lead agency in health, we have to recognize that the agenda is too broad for WHO alone. We have to be realistic, and start to define how WHO can contribute most effectively to this agenda in the coming years.*
>
> (WHO, 1999:xi)

This global role has been defined to "promote global health [...] by providing a facilitating and enabling environment within which the diverse range of partners for health can work effectively together" (WHO, 1998: point 50) and which the WHO would do in collaboration with other international agencies (WHO, 1998: point 52). More recently, it has been stated that the WHO should focus on activities of its "comparative advantage and build on its existing strengths" (WHO, 2006b:23). However,

an explanation of what this could be, or, more specifically, what this means in relation to health systems is not provided. While it says in one place that there is an "evolving role of WHO as directing and coordinating authority in international health work" (WHO, 2006b:1), there is still uncertainty about what its concrete role should be.

As one of the more recent accounts of the WHO's role, the WHO's 11th General Programme of work (WHO, 2006b,b) formulates a Global Health Agenda, setting out a global framework for a health promotion strategy, that does not only address the WHO's role in such processes. Among the priority areas is the strengthening of health systems and equitable access and the strengthening of governance, leadership and accountability (WHO, 2006b:ii). While in general the WHO's role is described as "the evolving role of WHO as the directing and coordinating authority in international health work" (WHO, 2006b:1), a more detailed plan for its role is summarised (WHO, 2006b:iii), including the support of research activity, norm-setting and providing technical support. The WHO's framework for action in 2007 entitled "Everybody's Business" (WHO, 2007) makes a strong case for the WHO's responsibility in providing models for health systems. It says:

> *WHO's mandate, neutral status and near-universal membership give it unique leverage and advantage. Indeed, having so many players active in health today does not reduce but rather accentuates the importance of WHO's role in strengthening health systems. [...] WHO's involvement in all aspects of health and health systems is a strength and, too often, an under-utilized resource.*
>
> (WHO, 2007:13)

Turning now to the health-system related activities by the WHO, these have fluctuated with the predominance of earlier vertical or horizontal approaches to health at any given time. As is shown by Brown et al. (2006), this general debate has accompanied the WHO throughout its entire history. In particular, the failure of the malaria eradication programme in the 1960s led to a new emphasis in the WHA towards the development of rural health

systems and the integration of malaria control into general health services (Brown et al., 2006, see also Litsios, 2004, Koivusalo and Mackintosh, 2004). The major shift towards horizontal, and thus more comprehensive, approaches to health that is still regularly referred to, though not always and only by the WHO, came in at the end of the 1970s in form of the International Conference on Primary Health Care in Alma-Ata (then Soviet Union) in September 1978. Its outcome was the so-called Alma-Ata Declaration (WHO/UNICEF, 1978a), introducing the Health for All (HFA) by the year 2000 strategy, as well as the primary health care (PHC) approach. In 1998, the WHO renewed the concept in its strategy Health for All in the 21st century (WHO, 1998). In this sense, the horizontal approach to health has supported more attention to health systems, but is not the same question and does not give the WHO a more specific role in providing policy models to member states for their health systems.

Recently, the WHO (2007:27) has attempted to develop the idea of a "diagonal" approach with the following characteristics: taking the desired health outcomes as the starting point for identifying health system constraints; meeting specific health outcomes simultaneously with supporting system-wide effects and other programmes; primarily addressing health systems policy and capacity issues; encouraging comprehensive national health sector strategies and plans; and monitoring and evaluating health systems.

Irrespective of the difficult process of defining a role for the WHO, in the second half of the 1990s the WHO undertook major activities in relation to advising national health systems, culminating in the World Health Report 2000 on health systems (WHR2000) (WHO, 2000). In this case, the ball was set rolling by the countries of the Non-Aligned Movement (NAM) presenting a proposal on strengthening health systems development in developing countries, that was adopted by the WHA (resolution WHA50.27), resulting in a plan of action (as called for in resolution EB100.RB1). Following this, an ad hoc group on health systems

development was put into place, as well as an external advisory group to examine the plan of action for the global initiative. While the WHR1999 Making a Difference (WHO, 1999) concerned the WHO's role, this work resulted in the WHR2000 on health systems.

In the beginning, the WHO was quite euphoric about the WHR2000 and its "new role". Through this new focus, the WHO had attempted to "restore its position as an international expert leader in the field of health" (Taipale, 2000:1). Nevertheless, the reaction to the report by some member states and academics has not helped or furthered the position of the WHO and its work on health systems. The literature on the topic includes severe criticism about the indicators used to assess health systems and the resulting rankings (e.g. Ollila and Koivusalo, 2002, 2000, Navarro, 2001). Thus, instead of a strengthened WHO with a new role as global health leader, other organisations (like the World Bank and the OECD) gained strength as a consequence of the WHO's failings. While within the WHO that criticism was acknowledged and considered to some extent (see Murray and Evans, 2003a), subsequently it had to withdraw from further rankings and major analytical activity in the field, due to the withdrawal of support by some of its member states. At the same time, other member states continue to request health system analyses by the WHO as repeatedly mentioned in WHO reports (e.g. Murray and Evans, 2003a, WHO, 2007). This point was also stressed by the interviewees from the WHO.[26] More recently, the issue of monitoring has come up again; however, perhaps rather more humbly compared to what had been attempted with the WHR2000:

> *A monitoring system for health systems strengthening needs to capture trends in health system inputs and outputs, supported by coverage data with a small set of indicators. Progress can be summarized with a country "dashboard" that includes key indicators for these core areas and describes progress on an annual or bi-annual basis. The dashboard should also provide contextual information such as the country health situation in relation to its level of economic development or health expenditure.* (WHO, 2007:20)

[26] Interview at the WHO in Geneva, 2006.

Proceedings from the 117th session of the WHO's Executive Board in 2006 indicated attempts to define the WHO's responsibilities anew. According to this, the Secretariat had started work on elaborating a draft strategy on strengthening health systems (point 4). This had been preceded by a consensus-building exercise across all levels of the WHO in 2005 (point 9). The current Director-General Margaret Chan has also expressed the need for a more selective approach for the WHO. At the same time, however, a new cluster at the Secretariat was launched headed in the first place by Anders Nordström (now Carissa Etienne) and called 'Health Systems and Services', reflecting one of the WHO's declared core areas of work.[27]

While the health system activities discussed so far have been directed to all member states, the WHO also provides for work on development issues and health systems, for example in the context of meeting the MDGs.[28] A Task Force on Health Systems Research was set up for the purpose of studying the role of health systems in achieving the MDGs in March 2003. The resulting report recommends, roughly, that the WHO should pay attention to the best possible health system research, work on the topic across clusters and programmes and support member states in their health systems research efforts (Task Force on Health Systems Research, 2005, see also WHO, 2005a).

From time to time, the WHO appoints commissions to work on particular issue areas to generate knowledge and provide general guidance. These are requested by the WHA and then appointed by the Director-General. The commissions are made up of external researchers and specialists, coordinated by teams within the WHO. They work on a limited and fixed time basis and usually provide a number of reports. Two such commissions are worth mentioning here, the Commission on Macroeconomics and Health (CMH) and the Commission on the Social Determinants of Health (CSDH).

---

[27] See http://www.who.int/mediacentre/news/notes/2007/np08/en/print.html, accessed 29 December 2010

[28] See http://www.who.int/mdg/en/, accessed 29 December 2010

The Commission on Macroeconomics and Health (CMH), working from 2000 to 2001, brought together some of the world's top economists, headed by Jeffrey Sachs. It released its final report in 2001 (WHO CMH, 2001). The relevance and implications of this commission have been differently regarded and assessed. Seidel (2003:117) states that "[a]lthough encompassing not entirely the volume and the originality of work that characterised the preparation of the World Bank's annual World Development Report (WDR) 1993 Investing in Health, the report of the CMH constitutes a landmark and reference point for the international health policy discussion and the relative importance of health within development assistance". There is also evidence that the CMH descriptions and recommendations did have important implications on how economists look at health systems (see for example Hsiao and Heller, 2007). Others however, like Banerji (2002:733), have severly criticised the CMH's composition and work as "ahistorical, apolitical and atheoretical".

From 2005 to 2008, the Commission on Social Determinants of Health (CSDH)[29] worked on the social determinants of health. It had been appointed by then-director general Lee Jong-Wook and comprised a number of working groups with members from academia, practitioners, civil society representatives and so on. The work also importantly included health systems (as social determinants of health). This has happened most comprehensively in the Knowledge Network on Health Systems, however to some extent also through the networks on Women and Gender Equity, Globalisation and Priority Public Health Conditions. The composition of the CSDH and its knowledge networks reflects people perceived as "being innovators in science, public health, policymaking, and action for social change" (Irwin et al., 2006). They have been expected to establish and fulfil an advocacy and political leadership role.

[29] See http://www.who.int/social_determinants/thecommission/en/index.html, accessed 29 December 2010

Concluding, despite the official mandate and long-standing, justified engagement in advising national health systems, the WHO's role, and partly also performance, has been unclear and weak. In addition to the above discussion, others also mentioned the WHO's bureaucracy, powerful single states, other, more powerful actors, limited resources and the lack of acting as a funding organisation as a problem to the WHO's performance (Hein and Kohlmorgen, 2008, Peabody, 1995, Kickbusch, 2000). These weaknesses have certainly encouraged other actors to step into this field, most prominently the World Bank and more recently the OECD. These other global actors do not seem to rely on the WHO's ability to guide other international organisations on such matters either.

Overall, the WHO has been clearly mandated to take on a role in global policy models for national health systems and has also been trying to fulfil such a role. A look at the history and activities suggests that it has been rather difficult for the organisation to keep up continuous work on the issue: there have been several attempts to be a global leader on health systems, however, this has not always supported or strengthened the WHO's position.

4.1.2 International Labour Organisation (ILO)

The International Labour Organisation (ILO), established in 1919, is the UN agency concerned with the promotion of social justice and internationally recognised human and labour rights. It formulates international labour standards, amongst other things, in the fields of social security and occupational safety and health, including work on the expansion of welfare programmes. The ILO operates somewhat differently to other international organisations as it has a tripartite governance structure with representatives of the government, organised labour and the business community of each member state, meeting in the International Labour Conference (ILC).

The ILO's mandate in health is embedded in both its engagement in social security matters and the concern about occupational health and safety. It is specified in various documents, namely the Constitution of the ILO, the Declaration of Philadelphia, ILO Recommendations and Conventions (particularly the Medical Care ILO Recommendation No. 69 from 1944; the Social Security (Minimum Standards) Convention 1952 (No.102) and Medical Care and Sickness Benefits Convention 1969 (No.130), in the ILO's decent work concept and in the New Consensus on Social Security. More concretely, the rationale for the ILO engagement in health is based on the understanding that exclusion from social protection in health is a widespread and significant problem when it concerns, amongst other things, human rights and illness-inflected unemployment and disability. Thus, social protection in health is described "a key instrument to address poverty, income security and access to health services" and also as contributing to the health-related MDGs.

The ILO's Social Security Department is particularly important. Its objectives are the enhancement of capacity of social security managers and the design and administration of sustainable social security schemes. The Global Campaign on Social Security and Coverage for All has served as a platform for the attainment of these objectives. Further, within the STEP (Strategies and Tools against social Exclusion and Poverty) programme the extension of social protection coverage and reduction of poverty of workers in the informal sector has been pursued. In the STEP programme, it was particularly the health sector that was in focus when it was about extension of social security. More recently, there has been work on designing a minimum package of social protection in the concept of a global social security floor (ILO Social Security Department, 2007, 2008).

Overall, in a global health policy environment characterised by a number of actors involved in global social policy as policy models for national health systems, multiple vertical health initiatives and repetitive announcements

about the importance of strengthening health systems, the ILO tries to present and establish itself as the only international organisation that is able to do proper social and health budgeting as a good approach to bring together external and internal financing into one system, as for example through social health insurance (SHI) models.[30]

4.1.3 World Bank

The World Bank[31], together with the International Monetary Fund (IMF), was established in 1944 in Bretton Woods. Accordingly, these two organisations are often referred to as the Bretton Woods institutions, but also as the international financial institutions (IFIs). The World Bank is also part of the UN system, but it has always acted quite independently (Koivusalo and Ollila, 1997:25). As other international organisations within the UN system, the Bank has a broad membership and a world-wide reach.

The general mission of the World Bank is to fight poverty and improve living standards in the developing world (see Articles of Agreement of the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA)). For lack of official mandate to speaking on health matters, and according to the Articles of Agreement, the legitimisation has usually been in economic terms, and is not supposed to be political (Koivusalo and Ollila, 1997:25). However, in practice the Health, Nutrition and Population (HNP) Sector Strategy Paper of 1997 (World Bank, 1997) states as one of its principles the recognition of the political dimensions of reforms. Health or HNP is only one of many policy fields that the World Bank is concerned with; nevertheless, the number of

[30] That has also been reflected in conversations with informants from the ILO.

[31] What is called "the World Bank" here, is in fact two out of five organisations building the World Bank Group, the IDA (International Development Association) and the IBRD (International Bank for Reconstruction and Development); the others are MIGA (Multilateral Investment Guarantee Agency), ICSID (International Centre for the Settlement of Investment Disputes, and IFC (International Finance Cooperation). The latter is discussed below.

staff (though decreasing, particularly as concerns health system specialists), as well as the financial resources for this sector are immense (especially compared with the WHO with the prime task of tackling health problems) (Koivusalo and Ollila, 1997). The Bank's activities encompass a range of things, including lending and project activities, but also important research and policy advice.

Initially, the Bank became engaged in the field of health through its work on population policies. A formal health policy was adopted in 1974. The importance of this work within the Bank then increased, resulting in the 1997 HNP sector strategy paper (World Bank, 1997) that is instructive for understanding the Bank's role and positioning towards health care policy making. The paper points out the important role of the World Bank in generating and diffusing knowledge, as well as in supporting projects financially. Two of the HNP objectives as formulated here are *enhancing the performance of health systems* and *securing sustainable health care financing.*

There has been a significant change in the Bank's objectives in the HNP sector. The 1997 strategy included the objectives to

> *assist client countries to [...] enhance the performance of health care systems by promoting equitable access to preventive and curative health, nutrition, and population services that are affordable, effective, well managed, of good quality, and responsive to clients [; and] secure sustainable health care financing by mobilizing adequate levels of resources, establishing broad-based risk pooling mechanisms, and maintaining effective control over public and private expenditure*
>
> (World Bank, 1997)

In contrast, the new strategy, revised in 2007, states that among the World Bank's objectives is to increase assistance to countries related to their health systems (World Bank, 2007: point 40), and "although focus on strengthening health systems is essential, this strengthening is seen as a

crucial means for helping countries achieve HNP results rather than a policy objective in itself" (World Bank, 2007: point 36).

Due to the rising number of global actors in various health fields, the Bank – like the WHO – sees an increased need to justify its role in the field and its focus of activity within it. While the Bank in 1997 was satisfied with explaining its comparative advantage by its "global experience and ability to combine country-specific research and analysis with the mobilization of significant financial resources across many sectors" (World Bank, 1997), the new strategy is much more detailed about this issue and lists: an intersectoral and systems approach to country assistance, which allows the Bank to engage at national and sub-national level with all government sectors but particularly ministries of finance; its capacity for large-scale implementation of projects and programs including its financial management and procurement system for large-scale operations; its multiple financing instrumental and products; its global nature allowing facilitation of inter-regional sharing of experience; its core economic and fiscal analysis capacity across all sectors; its substantial country focus and presence; engaging private health actors through both the Bank (IBRC) and IFC; health system development and strengthening (but not in every aspect of it). In particular, on health system performance, the comparative advantages are summarised as follows: health financing (e.g. level and source of funding, health insurance organisation and regulation, health service contracting and provider payment mechanisms); system governance; accountability for health service delivery; and demand side intervention (e.g. conditional cash transfers to boost demand for health interventions, communities' and consumers' voice and choice in the delivery of health services) (World Bank, 2007:17f).

Thus, it is obvious that more comparative advantages are listed than in case of the WHO. Further, there is a clearer sense of more actors in the field, asking for more justification of engagement and a specific approach (but not necessarily in terms of content). Furthermore, the Bank covers the main

functions of health systems. Even if the declared focus is on countries' needs, it demands substantial theoretical and comparative work to give advice in these fields.

A further particularity of the World Bank's approach is its strong focus on country-specific activities that continues throughout both strategy papers (World Bank, 1997: point 34, World Bank, 2007). Other activities are also connected to global goals like achieving the MDGs – including the consideration of the role of health systems in their achievement. This is also shown by the acknowledgement of the new DAH (Development Assistance in Health) situation of more actors and increased interest in many global health issues (World Bank, 2007: point 50ff).

This means that while the World Bank itself does not describe its role in health and its expanding activities as concurrent with the one of the WHO, literature on global health governance is rather critical about these activities, and the position of the World Bank as the most powerful global health actor (Koivusalo and Ollila, 1997:25, Kickbusch, 2000). However, apart from that question about the most powerful global health actor, the scene has also always been marked by collaboration, and ideas from one organisation that featured in the work of the other. For example, the World Bank's WDR 1993 Investing in Health has, on the one hand, been interpreted as the World Bank challenging the WHO's position (Koivusalo and Ollila, 1997:30f); but, on the other hand, Kickbusch (2000:982) states that "[p]aradoxically the World Bank's interest in health went back to WHO's approach to the World Bank and the 1993 Investment in Health Report was the long term outcome of a meeting between WHO Director General Halfdan Mahler and the President of the World Bank MacNamara".

Some degree of contradiction to the World Bank's work and approach arises through the fact that another organisation within the World Bank Group, the

International Finance Corporation (IFC), is also increasingly active in health and has developed its own health strategy.

The IFC's Articles of Agreement state the purpose of the organisation "to further economic development by encouraging the growth of productive private enterprise in member countries, particularly in the less developed areas, thus supplementing the activities of the International Bank for Reconstruction and Development" (Article 1). As for the World Bank in general, this is happening with the intention to fight poverty, follows a "country-by-country approach" and is "guided by our overreaching goals in the sector (to improve health outcomes, to protect the population from the impoverishing effects of ill health, and to enhance performance of health services)"[32]. However, it is only concerned with the private sector involvement and, accordingly, sets out its specific strategy for the health sector on its website. It presents further two objectives for the health sector:

> *The business objective aims to provide value-added financing to viable projects. The development objective seeks to ensure that our investments contribute to institutional and systemic capacity building and promote efficiency and innovation within the sector, while improving health security and expanding financial protection against impoverishing effects of ill health. These objectives govern the way in which potential projects are screened and how they are monitored. Together with the analysis of global trends and IFC experience to date, they form the basis for our overall investment strategy.*

Accordingly, the IFC's investments concentrate on the hospital sector, but are also expanding to non-hospital investments, including private health insurance, pharmaceutical and medical devices and health workers' education and training (see also Lethbridge, 2005).

It is further worth noting that the IFC has both, a profit goal and a development goal. Officially, the IFC "complements the work of the World Bank in public sector reform, by focusing on the development of the private sector" (Lethbridge, 2005:207).

[32] See http://www.ifc.org/ifcext/che.nsf/Content/Strategy, accessed 29 December 2010

Overall, the World Bank has developed to be an important and powerful global health actor, particularly due to its financial means and staff resources, that support the World Bank's different roles of being a development bank, but also a research institution. Accordingly, the World Bank is able to shape both global and national health policy in different ways. It is less clear if the engagement with health issues has been growing out naturally from its broad and general development mandate or whether it was also related to the performance of the WHO or an attempt to challenge this organisation. However, today the World Bank seems to feel more forced to justify such activities.

4.2 Organisation for Economic Cooperation and Development (OECD)

Concerning knowledge production on social policy, one important organisation outside the UN system is the Organisation for Economic Cooperation and Development (OECD). This organisation, comprised of 30 member states (mainly high-income countries), is dedicated to improving economic and social policies in its member states, but also to some extent in transition and developing countries that do not form part of the organisation (through its Development Center, and more indirectly through the Development Assistance Committee (DAC)).

A justification for the OECD's concern and activities in health issues can be derived from its general mission to improve the economic and social policies of its member states. However, the actual justification frequently provided by the OECD is that the background and focus of the OECD's engagement in health policy issues is due to the explicit demand and request of its member states (for example OECD, 2004b).

The OECD's engagement in the field of health has grown out of its statistical work. A first report specifically on health was Public Expenditure on Health (OECD, 1977). The report was part of a broader project on issues of resource allocation and government expenditure, undertaken by a working party to deal with questions of economic growth within the Economics Policy Committee. Its main interest was not in health policy as such, but the expansion of the public sector. From the 1980s onwards, health has been approached under the social policy work of the OECD, beginning with a report on the Financing and Delivery of Health Care (OECD, 1987) and in the 1990s with a focus on health care reforms (OECD, 1992, 1993a,b, 1994, 1995, 1996). While all of this work had come along with a strong emphasis on data and statistical issues, particularly since the beginning of the 21st century, the OECD has expanded its health activities to also include more analytical work, as well as having begun peer-reviews specifically on the performance of single member state's health systems. With the launch of the OECD Health Project (2001-2004), the OECD's analytical health work has increased significantly. The OECD Health Project concluded in 2004, releasing a final report (OECD, 2004b) as well as a number of other reports on the specific research topics undertaken as part of the Project (see for example the one on private health insurance discussed below OECD, 2004a). Due to the success of the OECD Health Project, the work has been continued and even expanded.

Institutionally, this is reflected through the OECD Health Committee (earlier Group on Health) directing the OECD work on health and advising the Council on appropriate priorities; in the creation of a new Division on Health within the Directorate for Employment, Labour and Social Affairs (DELSA); and the comparably high number of staff. At the same time other Directorates, namely Financial and Enterprise Affairs and also Fiscal Affairs touch on the domain of health policy. Also, the Economic Development and Review Committee (EDRC) increasingly integrates social and health policy indicators in the Economic Surveys.

Thus, while so far rather marginally considered in the global health literature, the OECD is in a process of developing to be an increasingly important global health actor. The strengthening of the OECD's position can be regarded as a consequence of the failed attempt by the WHO to rank health systems (see above). Further, its ideas may go well beyond influencing its member states' thinking about health systems (Deacon and Kaasch, 2008).

4.3 Collaborations and Partnerships

Apart from rather unofficial connections between organisations, forms of mutual influence between international organisations, or organisations that are established to provide for a forum like the ECOSOC, global health governance is also characterised by organised partnerships or networks. The following paragraphs represent only a small sample intended to point at some of the partnerships, while this study is not further dedicated to tracing the exact scope of formal and informal networking and its importance for the travelling and shaping of ideas. This is only a decision on the scope and focus of the thesis, not a statement about the importance of networks.

An example of such collaboration is the ILO-GTZ-WHO Consortium on Social Protection in Developing Countries', established in 2004. The three organisations agreed to work together in the field of social protection in health, sustainable health financing systems and efficient contracting. A first conference on social health insurance was held in Berlin in December 2005 (outcome document: ILO et al., 2006). A follow-up meeting took place in Copenhagen in June 2006 (Copenhagen Meeting on Extending Social Protection in Health).

In the context of the health MDGs, there is collaboration in the form of a High-Level Forum (HLF) on the Health Millennium Development Goals[33].

---

[33] http://www.hlfhealthmdgs.org/index.asp, accessed 29 December 2010

The secretariat is provided by the WHO and the World Bank and forum participants include ministers and senior officials from developing countries, heads of bilateral and multilateral agencies, foundations, regional organisations and global partnerships. Five such meetings have taken place so far.

Most of the collaboration takes place, however, when it is about collecting data. There is, for example, the *Health Metrics Network* that was the outcome of one of the HLFs on the health MDGs. Its goal is "to increase the availability and use of timely and accurate health information by catalysing the joint funding and development of core country health information systems"[34]. Among the membership are included developing countries, multilateral and bilateral agencies, foundations, other global health partnerships and technical experts, and the WHO, the World Bank, the OECD and UNICEF. A major contributor is the Bill and Melinda Gates Foundation.

Further regarding data is an OECD-WHO-EUROSTAT co-operation that is primarily for industrialised states. Additionally, the WHO and the OECD have also started to work on joint country reviews (see OECD and WHO, 2006).

4.4 Conclusions: Is There Competition at the Level of Mandates?

Identifying and mapping global policy actors engaged in providing policy models for national health systems has provided a fairly typical picture for global (social) policy fields or issues. There is a multiplicity and variety of actors involved in producing models of health systems, however to different extents, within different contexts, and as part of different mandates.

For most of these actors, the responsibilities for the specific form of global social policy studied in this thesis are not so much about clearly assigned

[34] http://www.who.int/healthmetrics/en/, accessed 29 December 2010

health mandates as, amongst other things, they are derived from more general mandates, result from intersectoral policy issues and/or mark processes of mission creep. There is thus no structured division of labour among the organisations. While there are attempts regarding the UN system, as well as from the major international organisations to define different organisations' roles and respective responsibilities more clearly, the feasibility and desirability of a division of labour on global policies has been contested.

Accordingly, the WHO has been identified as the organisation with the clearest health mandate as to global policy models for national health systems. The ILO's health engagement as part of a social security mandate (in addition to the one on occupational health and safety) can also be regarded as substantial. The case of the World Bank is more difficult – from a general economic mandate it has developed a rather political health sector engagement. This can be interpreted, on the one hand, as a considered approach to fulfil its mandate in a meaningful way (as health policy is an important element of a country's development strategy). However, given extensive criticism of its engagement, the World Bank is now increasingly pressured to justify its health activities.[35] When it comes to the OECD regarding its development of a health mandate from a very general mandate on economic and social development, one could argue the same as for the World Bank. Specific requests for concrete activities in the form of research on specific policy issues have also led to an increasing role of the OECD in health matters.

An international organisation's general mandate usually does not fundamentally change, nor are international organisations frequently suspended. International organisations with a health mandate have been engaged in related activities from early on. However, the emergence and development of other international organisations as global health actors

[35] It is interesting to consider that the IMF, faced with a similar problem, has not developed such a role. It is argued by the IMF that it would rely on the World Bank in health matters. Nonetheless, the IMF has been criticised for not taking into account the special needs of the health sector in its activities.

through defining their broader mandates into health responsibilities has challenged former positions. There has already been an issue about health system responsibilities of the WHO and the ILO respectively. The extension of the World Bank's HNP sector, however, has challenged the WHO's role considerably. Accordingly, the WHO has been described as weak not only compared to other emerging global health actors, but also regarding its bureaucracy (Hein and Kohlmorgen, 2008, Peabody, 1995, Kickbusch, 2000). We have further argued that the more recent OECD work on health is having a similar impact on the WHO's position (Kaasch, forthcoming, Deacon and Kaasch, 2008). The World Bank and the OECD, on the other hand, do not seem to challenge each other considerably because they serve the needs of different groups of countries. The ILO's contribution is fairly restricted by the small number of people working on related issues. However, it might be a challenge to World Bank activities when it concerns projects within developing countries – an issue not studied in this thesis.

The number of international organisations involved, and the different ways of defining and dealing with mandates and the health sector, show well how complex issues of divisions of labour can become when it comes to fulfilling global roles or mandates in a responsible way. While global policy models for national health systems are not necessarily connected to projects at the country level and immense financial resources, they do require some capacity and resources for knowledge production and communication; at least if they are understood to be more than occasional public statements and commitments to specific ideas. Accordingly, by way of conclusion, it is primarily four international organisations, namely the WHO, the ILO, the World Bank and the OECD, that are considered to be providing a comprehensive contribution to the task.

The more continuous work within the secretariats of international organisations is supplemented by time-limited groups, such as the Millennium Project or the WHO's commissions. These feed into the debates with reports on specific global health policy issues at some point, but then they dissolve.

The focus has mostly been on formal international (governmental) organisations. However, global social and health policy is driven by more than these organisations in different ways. Global business might influence national health policy making or, for example, engage in the Global Compact concerning global standard setting in labour and production. NGOs and CSOs run health projects at local and national levels, join global policy debates about providing alternative policy models and watch international organisations. Similar activities can be undertaken by private think tanks. Increasingly important is, further, the hybrid organisation of the GFATM. Last but not least, there is an increasing importance of private philanthropy, more specifically foundations like the Bill and Melinda Gates Foundation. These fund, with immense financial resources, all kinds of global health projects, including research activities. Their involvement in the explicit advice to health policy is not in all cases that obvious, however, the complexity of health systems naturally open the way for many different forms of intervention occurring through various (types of) transnational actors – intentionally as well as unintentionally. This, again, points to the difficulty of keeping apart the different global social policy dimensions of policy models to countries and supranational policy.

The UN system has established some structures and connections between the international organisations within it. Further, many of the international organisations have organised links to other organisations like CSOs. However, beyond that, there are many different ways in which global actors network and collaborate, such as organising and participating in conferences, writing joint publications, collaborating in the collection and distribution of data (these issues are further discussed in chapter 7). A rather formal network that is important in this context is the ILO-GTZ-WHO Consortium, discussing ways of realising social health insurance in developing countries.

International goals, like the MDGs, further provide for a basis of common objectives and result in more or less coordinated activities among and between global actors to achieve them. These common goals or objectives

also provide for a legitimate reason to become engaged in issues not directly connected to an organisation's mandate.

Overall, there are a number of reasons why global actors emerge or engage in national and global health activities. It can be concrete mandates, but also a specification of broader, more general mandates, as well as health being one element in tackling issues connected to specific societal groups or other policy sectors. While official mandates imply rather long-term engagement, different processes can lead to legitimate engagement in providing policy models for health systems, like attempts to achieving global goals or at times when horizontal approaches and comprehensive health systems are globally fashionable.

All this implies that there is a certain degree of competition for the right and scope within which an organisation is mandated to take on such an advisory function to national health policy. It is, however, scholarly literature that expresses these relationships as mutual challenges, or as one organisation having a more justified role for becoming active in this dimension of global social policy than another. International organisations themselves do not necessarily challenge each other openly and explicitly, although there are attempts to define their respective roles with the broader global health environment in mind. Such attempts usually place the respective organisation "in the middle", giving also some role to others. Such notions have also been expressed in interviews, when interviewees would typically point to the particular advantages of their respective institution and how the others lack that particular expertise. This, however, has always been accompanied by the generally perceived need for more research and activity in relation to health systems, and thus not a notion that other organisations should stop their work on the issue. Also, while there has been competition, international organisations and other actors have continuously been collaborating on various activities as well. This leads to the conclusion that the attempt by international organisations to establish trust and legitimacy is not only pursued in individual ways but also by the means of joining forces with other organisations.

In the next chapter the focus is primarily on the continuous work on health systems carried out by the WHO, the World Bank, the ILO and the OECD, supplemented by others' ideas as appropriate. Amongst other things, it is discussed to what extent the competition at the level of mandates is replicated when it concerns knowledge production or ideas; and later in chapter 6 in relation to communication channels.

5. What? Ideas about Health System

After the introduction of the previous chapter into the formal roles and actor constellation in global health governance in global social policy as policy models for national health systems, the next step is to take a look at the health system policy models proposed by different international organisations. What are their ideas on health systems? Are these ideas similar or different to each other?

In order to understand and classify the respective ideas, an analytical framework and methodology is employed as developed in part I. A number of selected key documents by the respective international organisations in focus have been analysed according to the following categories and questions:

(1) In which *context* are health systems being addressed (e.g. poverty reduction, maternal care, specific groups of countries)? What is the description of the current situation or problem concerning health systems?

(2) What are the goals and *underlying principles* associated with health systems?

(3) How are health systems *defined* and what functions are distinguished and stressed?

(4) What is the proposed role of the state in health care *provision* along the dimensions of public and private involvement, as well as concerning the proposed level of governance?

(5) What is the proposed role of the state in health care *financing*, again, regarding the public-private mix and the degree of (de)centralisation?

(6) How should the state engage in *regulating* the relationships between service providers, financing agencies and (potential) beneficiaries? This final question includes a number of issues, namely (a) what kind and mechanism of health care coverage is proposed? (b) How should the system

of financing be organised (e.g. taxes, social insurance contributions, out-of-pocket)? (c) How should service providers be remunerated by the financing agencies? (d) How should access of (potential) providers to health care markets be realised? (e) How should access of patients to service providers be guaranteed? (f) How should the benefit package be decided upon?

Mirroring the last chapter, this chapter is structured by the main international organisations, the WHO, the World Bank, the ILO and the OECD. The contributions of other international organisations are summarised as appropriate. Accordingly, section 5.1 focuses on the different streams of ideas developed by the WHO. Section 5.2 presents the changing and different World Bank (Group) models. Section 5.3 focuses on the ILO's ideas. Section 5.4 covers the ILO-GTZ-WHO Consortium's approach to social health insurance in developing countries. The OECD's ideas are addressed in section 5.5. The findings from these organisation-focused analyses finally culminate in a comparison and discussion about the different organisations' views on health systems (section 5.6). Somewhat completing the picture with another important international organisation in global social policy, an excurses is added on the role of the WTO. Not being an international governmental organisation, but still a voice where ideas and the policy models for health systems are concerned, another excursus presents the model developed in the *Global Health Watch* (2005).

5.1 Different Approaches to Health Systems from the WHO

In the previous chapter, the WHO has been described as the international organisation "officially" responsible for guiding national health systems, while it has been questioned as to whether or not it has been effectively living up to that task. However, despite the search for a general role or function of the organisation towards national health systems, in the course of time, there have been different attempts and approaches to improving the understanding of what health systems are and/or should be.

The WHO's constitution contains the basic idea that "[g]overnments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures" (Constitution of the WHO). This notion has been echoed in later political statements and resolutions and the more detailed analytical work produced through the WHO's secretariat. Concerning more concrete or comprehensive ideas on health systems, two main streams can be identified within the WHO's work: This is, on the one hand, ideas connected to the Alma-Ata Declaration (WHO/UNICEF, 1978a); and, on the other hand, the concepts around the World Health Report 2000 on health systems (WHR2000) (WHO, 2000) (some of the latter's ideas had already been prepared in the WHR1999 (WHO, 1999)). The concepts introduced in these documents are not mutually exclusive; but they have a different character. While many of the reports and other documents following these two basic documents at least mention the Alma-Ata Declaration and adopt definitions of the WHR2000, they stand for different approaches and their respective importance as points of reference has varied over time. At the same time, additional concepts have been developed within the commissions appointed by the WHO, namely the CMH and the CDSH that are considered separately in sections 5.1.2 and 5.1.3 respectively.

5.1.1 Two Ways of Looking at Health Systems

The following paragraphs summarise the WHO's ideas on the different functions and dimensions of health systems. For each of the analytical questions introduced above, it is shown what the Alma-Ata declaration and connected work and the WHR2000 and connected work contribute to modelling ideal health systems.

Concerning the *context* of health systems, as a specialised agency within the UN system, the WHO is basically concerned with all (groups of) countries and attempts to provide policy advice to all countries. However, different

countries, also depending on their stage of development, do have different needs and expectations at the transnational policy level. Thus, basic common principles might be applied in different ways. This is to some extent realised through the WHO's regional offices. The analysis of this thesis, however, focuses on the WHO work regarding the most general principles and concepts on health systems, rather than on the differences for different groups of countries. It is a search for the fit with a particular model or regime type of the health system ideas proposed, as has been explained in part I.

The starting points as to the critical issues within health systems are different between the two main documents on health systems. The Alma-Ata Declaration starts from the notion of health inequalities considered to be a problem in all countries and develops its ideas accordingly. The WHR2000 commences with every country having a health system, though their respective performance may be different. It mentions fragmentation of health systems, describing that countries usually have "no single health care system, but several distinct health financing and provision subsystems, embracing different types of traditional and alternative practice, as well as public, private and not-for-profit hospitals and clinics, sometimes offering services for limited population subgroups" (WHO, 1999:31).

Regarding the *goals* or *principles* of health systems, the Alma-Ata Declaration is normatively based on the notion of health as a fundamental human right, and "the attainment of the highest possible level of health [...] [as] a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector" (WHO/UNICEF, 1978a:I). Connected to this is the "Health for All" (HFA) principle. The WHR1999, on the other hand, is more pragmatic, summarising health systems as aiming to achieve the following: improving health status; reducing health inequalities; enhancing responsiveness to legitimate expectations; increasing efficiency; protecting individuals, families and communities from financial loss; and enhancing fairness in the

financing and delivery of care (WHO, 1999:32f.). According to the WHR2000, health systems should guarantee the "best attainable coverage level – goodness" and at the same time the "smallest feasible differences among individuals and groups – fairness" (WHO, 2000:26).

On *defining* health systems, the Alma-Ata Declaration marked the first attempt to introduce basic principles for health systems, accompanied by a model of the organisation of health systems. It introduced the Primary Health Care (PHC) approach that is "in the spirit of social justice" (WHO/UNICEF, 1978a:V). This PHC model envisaged an important role for and responsibility of the state or government regarding the health of the people to be realised by the provision of adequate health and social measures (WHO/UNICEF, 1978a:V). Governments were, accordingly, recommended to develop national policies, strategies and plans of action for primary health care within a comprehensive national health system (WHO/UNICEF, 1978a:VIII). Following Kickbusch (2000:981), this did not only give governments the responsible position for the health of their people; but "was no less than a redefinition of the norms and expectations of the state role in regard to health". However, the Alma-Ata Declaration does not only focus on the role of the state, but also states that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (WHO/UNICEF, 1978a:IV).

The WHR2000 defines health systems as "comprising all the organizations, institutions and resources that are devoted to producing health actions", while health actions are "any effort, whether in personal health care, public health services or through intersectoral initiatives whose primary purpose is to improve health" (WHO, 2000:xi). In order to operationalise health systems and develop measurable indicators accordingly, the WHR2000 distinguishes four functions of health systems: service provision, resource

generation[36], financing and stewardship. The Alma-Ata Declaration, on the other hand, does not define health systems, but primary health care as

> *essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*
>
> (WHO/UNICEF, 1978a:VI)

This is a broad definition and concept that has been understood, interpreted and used in different ways (WHO CSDH, 2005). A problem connected to the analytical framework employed in this thesis is not only that the document itself is brief, but also that it is focused on levels of care rather than on functions. Accordingly, the following sections are primarily based on the concept of the WHR2000. An attempt to also capture an Alma-Ata based approach within this thesis' analytical framework has been undertaken in relation to the final reports of the CSDH (section 5.1.3).[37]

Provision is regarded to be the core function of health systems while "[t]he other functions matter because they contribute to service provision" (WHO, 2000:49). Accordingly, the key issue is said to be the "dysfunctional organization of the health system, even when the needed inputs exist and financial support is adequate and fairly distributed" (WHO, 2000:49). Wrong service delivery arrangements lead to perverse incentives for providers in the sense of potentially providing wrong services or providing

[36] Though one of the major topics currently addressed by WHO and other organisations (due to the focus and analytical framework of this thesis) this function is not taken into account.

[37] The World Health Report 2008 on primary health care (WHO 2008. The World Health Report 2008: Primary Health Care Now More Than Ever. Geneva: WHO.) was published during the phase of final revisions to the thesis and could not be studied in detail.

services to wrong people. The report, thus, considers options regarding the choice of service, the organisation of provision and provider incentives. Both public and private providers are regarded to be acceptable. The contracting and reimbursement of private providers gives governments a regulatory tool concerning the criteria of service provision (WHO, 2000:61). At the same time, however, also concerning the decentralisation of service provision, the report warns that the fragmentation of health services "has negative consequences for both the efficiency and the equity of the referral system unless explicit policies are introduced to ensure some sort of integration among the resulting semi-autonomous service delivery units" (WHO, 2000:68). The differentiation between the dimensions of public and private and those of centralisation and decentralisation is, however, not completely clear in the report. Discussions about the degree of decentralisation mainly discuss the potential roles of private providers, and their degree of autonomy when taking decisions, rather than systematically discussing the possible roles for different governmental levels. This new approach was called "new universalism" and supported diversity and competition in the provision of services; and, as not all services could be provided, gave priority to the most cost-effective service in a given setting.

Regarding the *financing* function, the WHR2000 distinguishes between three sub-functions: revenue collection, pooling of resources and purchasing of interventions. It is said, when it comes to personal health care, that the question that really mattered was not about public or private, but about pre-payment or out-of-pocket spending. From the perspective of social security, the question of pooling, or the insurance function, is decisive. The report supports the widest possible separation between contribution and utilisation, and discusses different forms of health insurance in the context of pooling:

> *As a result of large pools, society takes advantage of economies of scale, the law of large numbers, and cross-subsidies from low-risk to high-risk individuals. Pooling by itself allows for equalization of contributions among members of the pool regardless of their financial risk associated with service utilization. But it also allows the low-risk poor to subsidize the*

> *high-risk rich. Societies interested in equity are not indifferent to who is subsidized by whom. Therefore, health financing, in addition to ensuring cross-subsidies from low to high risk (which will happen in any pool, unless contributions are risk-related), should also ensure that subsidies are not regressive [...]*
>
> (WHO, 2000:99f)

Pools have to be as big as possible. This is, however, not an absolute argument for one national public pool: a taxation system. Nevertheless, particularly regarding low-income countries, the report discusses the difficulties of building up a comprehensive system of pooling and also the problems connected to large informal sectors. The main issue here is the complexity of the institutional and organisations arrangements in realising one or several big pools (WHO, 2000:98ff). As this is conceived to be even harder in taxation systems, it is usually different forms of health insurance that appear to be easier to realise (as a starting point at least) in developing countries. In this context, forms of co-payments or user fees are also discussed and are not considered desirable unless in clear cases of over-utilisation, but are regarded to be unavoidable in particular situations or contexts (WHO, 2000:99). Further, the report discusses the risks of decentralisation and other forms of fragmented pools that have to be avoided or substituted by some form of cross-subsidisation between pools or through a combination of pooling and government subsidy.

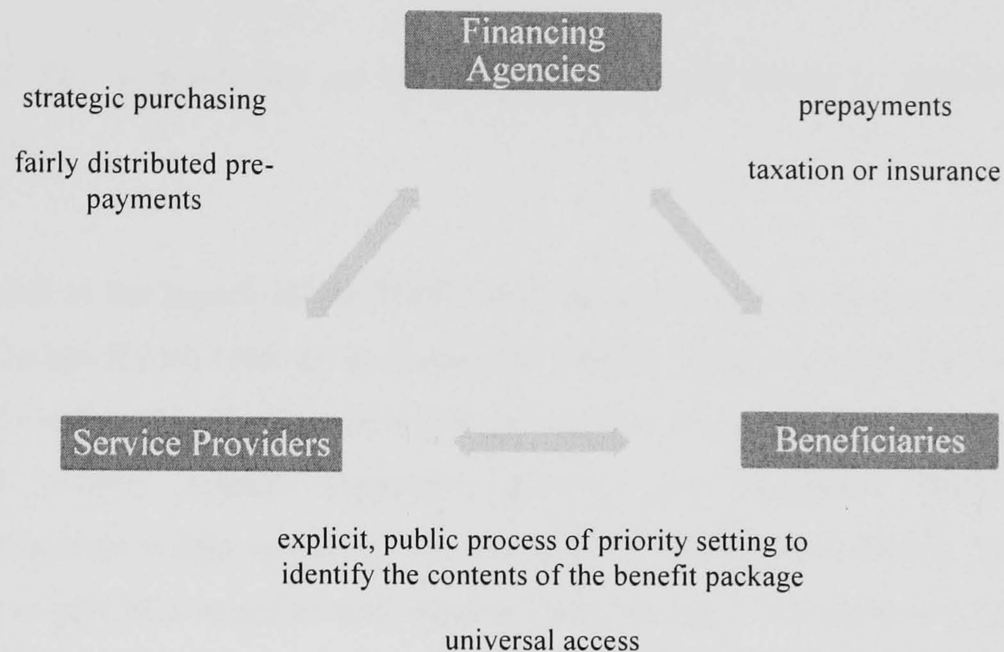
The WHR2000 explains that it moved away from the idea of providing and financing everything for everybody, but also from a predominantly market-oriented approach to recognising the limits of governments while "retain[ing] government responsibility for the leadership and financing of health systems" (WHO, 1999:33). On health system *regulation*, therefore, the WHR2000 introduces the *stewardship* model, defined as the "function of government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry" (WHO, 2000:119). The state is supposed to be the "prime mover" of stewardship. This involves the tasks of formulating health policy

(defining the vision and direction), exerting influence (approaches to regulation) and collecting and using information and knowledge (WHO, 2000:122). For the regulation of the financing dimension this means no out-of-pocket payments, but increasing pre-payments, with no special emphasis on either taxation or insurance models. All providers should be recognised and paid from fairly distributed pre-payments, using, amongst other things, strategic purchasing and applying cost-effectiveness criteria (WHO, 2000:139). How people can access services is, however, not part of the discussion of the WHR2000; instead, the Alma-Ata Declaration approaches this with the PHC model. The benefit package – available to all – should be decided upon in an "explicit, public process of priority setting" and reflect local disease priorities (WHO, 2000:137).

Summarising, the WHO approaches and understands health systems in a broad way, employs different perspectives, contexts and starting points. The WHO's approach in general is intended to apply to all countries (Murray and Evans, 2003b:5), while that may take different shapes and concrete recommendations or forms of policy models to different groups of countries. Regarding the Alma-Ata ideas, it is interesting to see how much of the discussion is connected to developing countries, while in practice it has perhaps been most effective in the European region (see Kaasch, 2006 for further discussion on that point). Also, the WHR2000 in some cases distinguishes between countries when it does not appear easily possible to realise concepts such as big risk pools in particular settings.

As shown by the approaches represented by the Alma-Ata Declaration and the WHR2000 respectively, the ideas expressed by the WHO do not only differ with regard to different groups of countries. While the former is normatively based, concerned about inequality in health and representing a rights-based approach; the latter is a rather analytical and technical approach to health systems, their functions and measurement.

Figure 5.1: Regulatory Relationships (WHO)



Health care provision is considered the core function of health systems. The WHR2000 supports a public-private mix, but there is no clear statement about the desirable degree of (de)centralisation. Concerning the financing of health systems, the report states that it is not the question of public versus private sources of financing that matters, but that of pre-payment versus out-of-pocket payments (including user fees). Different forms of insurance systems are considered more realistic than a universal tax-based system. Pools should add up to comprehensive redistributive systems, and financing should be organised in rather a centralised way. The role of the state in regulation, finally, should be – according to the *stewardship model* – that of defining the vision and direction of health systems, regulating the relationships between the different elements of health systems, and generating and providing information on health system related issues. According to the analytical approach taken here, this means a system of universal access with a prepayment system (taxation or insurance), fairly distributed pre-payments and strategic purchasing. The content of the

benefit package should be decided upon by an explicit, public process of priority setting (see Figure 5.1).

5.1.2 The Commission on Macroeconomics and Health's "Minimal" Model

Parallel to the launch of the WHR2000, the *Commission on Macroeconomics and Health (CMH)* took up its work. The CMH's final report (WHO CMH, 2001) is thematically situated within the context of poverty and the world's poor people, related economic growth, and long-term economic development within countries. The investments in health are said to "work best as part of a sound overall development strategy", including an "active role of government in [...] ensuring core investments in health, [...] guaranteeing the rule of law..." (WHO CMH, 2001:25f). Health systems in developing countries are described as being strained and requiring more resources (including potential donor resources) (WHO CMH, 2001:39), but there is no further definition of health systems as such. According to this focus on the poor, the CMH report discusses the minimum of health provision, as a starting point for the countries and people in focus (WHO CMH, 2001:56). Thus, the estimates and recommendations provided by the CMH are based on this idea of a rather minimal health system (WHO CMH, 2001:56).

On the public-private dimension, the report is concerned about the role of public provision and financing, including the option of private providers. It discusses the difficulties of public financing, without promoting the private sector as an alternative. Out-of-pocket payments should be re-directed into community financing schemes for covering community-based health delivery. This could entail "an incentive scheme in which each $1 that the community raises for pre-paid health coverage would be augmented, at some rate of co-financing, by the national government (backed by donor

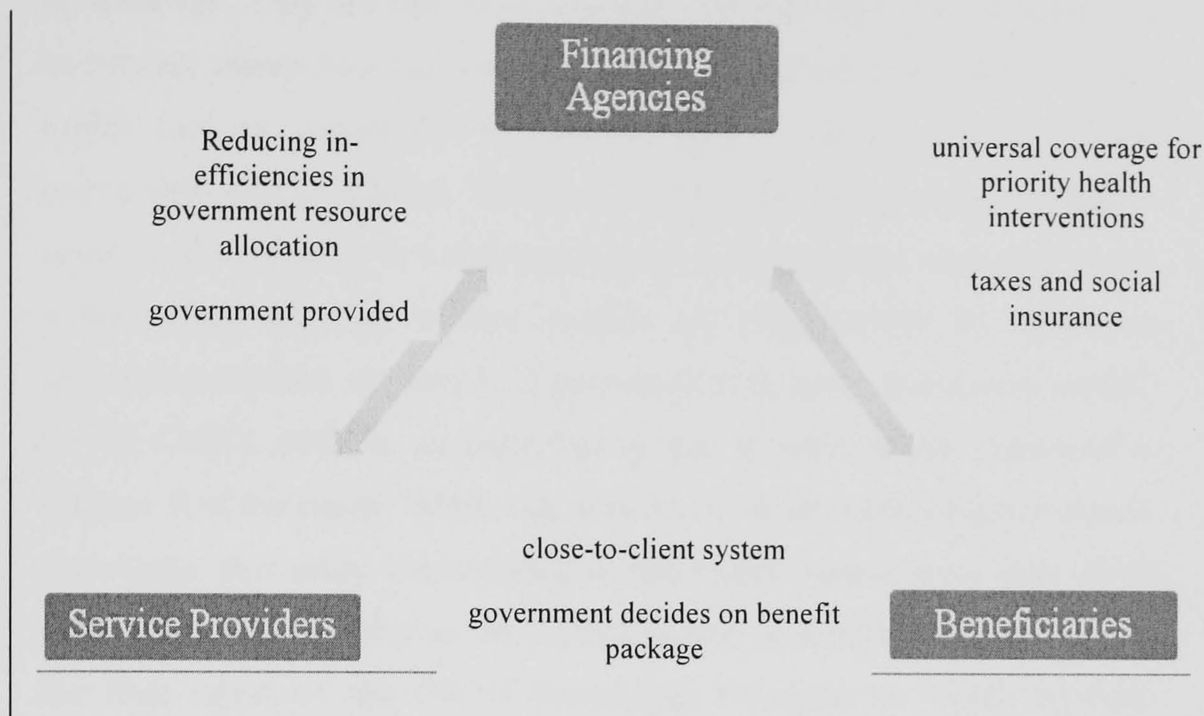
assistance)". Such a system is, however, proposed as an initial way to increase pooling. It is not promoted as an ultimate and comprehensive model of a health system (WHO CMH, 2001:60f). The CMH, more concretely, proposes six steps:

> *(1) increased mobilization of general tax revenues for health, on the order of 1 percent of GNP by 2007 and 2 percent of GNP by 2015; (2) increased donor support to finance the provision of public goods and to ensure access for the poor to essential services; (3) conversion of current out-of-pocket expenditures into prepayment schemes, including community financing programs supported by public funding where feasible; (4) a deepening of the HIPC[38] initiative, in country coverage and in the extent of debt relief (with support from the bilateral donor community); (5) efforts to address existing inefficiencies in the way in which government resources are presently allocated and used in the health sector; and (6) reallocating public outlays more generally from unproductive expenditures and subsidies to social-sector programs focused on the poor.*
>
> (WHO CMH, 2001:62)

On regulatory issues, the CMH report proposes a mixed system of tax and social insurance components, with the aim of providing universal coverage for priority health interventions. It calls for more efficiency in allocating government resources to the health sector, while health services can be provided either through the state or contracted to private providers. A "close-to-client" (CTC) system should guarantee patients' access to the health facilities, and the government decides on the content of the benefit package. At the same time, the CMH's report recommends the benefit package to include the major communicable diseases and maternal and perinatal conditions. How minimal that package is, it is evident what it does not include: for example trauma and emergency care, tertiary hospitals, and family planning beyond the first year after birth (WHO CMH, 2001:56). These regulatory relationships are summarised in Figure 5.2.

[38] Highly indebted poor countries (added by AK)

Figure 5.2: Regulatory Relationships (CMH)



In summary, the CMH has been concerned about the pure minimum of health services within the context of poverty reduction in poor countries. It does not provide for a future, more advanced health system model. In that sense it proposes community financing schemes that are financed from contributions, tax revenues and foreign assistance. There should be universal coverage, at least, to this very narrow benefit package, defined by national government and covering the major communicable diseases and maternal and child care.

5.1.3 Going back to PHC: Commission on Social Determinants of Health

The reports by the CSDH (WHO CSDH, 2007a, 2008) address health systems in the context of promoting social justice and the fight against health inequities, and are thus in the tradition of the Alma-Ata Declaration. From this perspective, it is stated that "health systems are appallingly weak in many countries, with massive inequity in provision, access and use between rich and poor" (WHO CSDH, 2008:8). The concept encompasses all countries.

In this context, health systems are given an important role in different perspectives. They are said to be important for tackling health inequalities, as they are themselves considered as social determinants of health. Further, health care is considered a common good, explicitly not a market commodity (WHO CSDH, 2007b, 2008:8). Concerning broader welfare systems, the argument is not primarily that health systems form part of the welfare state, but that welfare systems are characterised by "generous universal protection systems [...] associated with better population health" (WHO CSDH, 2008:7), an issue that is also at some length expressed in Chapter 8 of the report. While this would also be an interesting concept to investigate, this study concentrates on the health system ideas only. With reference amongst others to the Global Health Watch (2005) (see below), the final report of the CSDH Knowledge Network on Health Systems (WHO CSDH, 2007b:12) adds the following problems of health systems:

> *Over the last decades health systems worldwide have been assaulted by economic, political and social forces that underpin the equity problems they currently face. Three key forces are: commercialisation and globalisation; the health policy choices made by international and national health system leaders; and the bureaucratic culture of the public sector health system, including the social and gender power differentials embedded within it.*

The CSDH's work takes up the PHC approach

> *that emphasizes locally appropriate action across the range of social determinants, where prevention and promotion are in balance with investment in curative interventions, and an emphasis on the primary level of care with adequate referral to higher levels of care*
>
> (WHO CSDH, 2008:8).

In addition, in the final report of the CSDH's Knowledge Network on Health Systems (WHO CSDH, 2007b), ideas on health systems are much more detailed. They are defined, following the WHR2000, to "include all activities whose primary purpose is to improve health" (WHO CSDH,

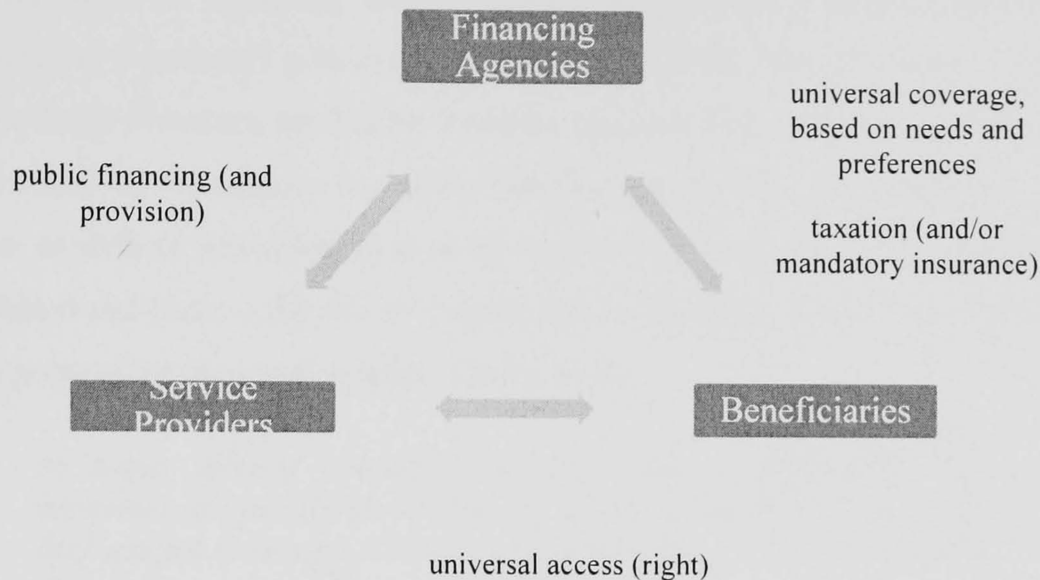
2007b), and the report discusses how health systems can address health inequity.

In general, there is a strong emphasis on the importance of the public sector – a public sector "that is committed, capable and adequately financed" (WHO CSDH, 2008:2). This includes public financing, even going as far as discussing arguments for global approaches to taxation (WHO CSDH, 2008:12). Out-of-pocket financing and user fees are rejected (WHO CSDH, 2008:8) and public financing is argued to be "always redistributive and reducing inequality" (WHO CSDH, 2007b:10).

When it comes to provision, the PHC approach is central, however, not to be understood as just a basic level of primary care, "but rather a health system model that acted also on the underlying social, economic, and political causes of poor health" (WHO CSDH, 2008:33). Accordingly, comprehensive, integrated and appropriate care is promoted with an important role of the primary level care in combination with a well functioning referral system (WHO CSDH, 2007b:5). While not particularly calling for private providers, the report acknowledges still that "experience from higher income settings indicates that for-profit private providers can sometimes play important roles within the overall health system, whereas adequate managerial capacity allows effective contracting arrangements" (WHO CSDH, 2007b:29).

On regulation (summarised in figure 5.3), various actors are said to be important in running the health system, including health ministries, civil society, local communities, business and international organisations. The latter is with a particular focus on the WHO's role, because of the organisation's mandate. At the same time, the report explains that also community or civil society action is indispensable to ensure that there are comprehensive rights and fair (re)distribution (WHO CSDH, 2008:18). Further, governments should make sure that "responsibility for action on health and health equity [is placed] at the highest level of government, and ensure its coherent consideration across all ministerial and departmental

Figure 5.3: Regulatory Relationship (CSDH)



policy-making" (WHO CSDH, 2008:22). It is, however, not addressed how providers should be remunerated for their services. Also, the decision about, or scope of, benefit packages is not discussed.

Concerning the question of access, the CSDH documents understand health as a right and thus promote the idea of universal health care coverage – regardless of the ability to pay (WHO CSDH, 2008:9). The health right is, however, more generally phrased than just a right to health care:

> *The right to the conditions necessary to achieve the highest attainable standard of health is universal. The risks of these rights being violated is the result of entrenched structural inequities.*
>
> (WHO CSDH, 2008:18)

More specifically, the final report of the Knowledge Network on Health Systems distinguishes three dimensions of access, namely availability, affordability and acceptability (WHO CSDH, 2007b:9). Universal coverage is further defined to require "that everyone within a country can access the

same range of services on the basis of needs and pays for these services on the basis of their income" (WHO CSDH, 2007b:27).

The system of financing should ideally be that of a taxation (and/or mandatory insurance) system (WHO CSDH, 2008:8). The final paper of the Knowledge Network on Health Systems explains that it is not completely convinced by mandatory insurance that first covers only the employed, or other models of social health insurance since everybody is not immediately included and there is the risk of fragmented models that do not easily form a comprehensive universal system. Thus it states:

> *In lower income countries, the first step in addressing the problems of patchwork funding is to use tax funding to improve and extend coverage for hard-to-reach groups, whilst ensuring these groups do not have to pay for care.*
>
> (WHO CSDH, 2007b:33)

The paper appears unconvinced about strategic purchasing and states that cost-effectiveness should not come first; instead a fairly comprehensive range of services should be made available everywhere [...] even if it is quite narrow initially and expanded over time as budget resources allow" (WHO CSDH, 2007b:28).

In summary, the CSDH approaches health systems within a broad concept of the social determinants of health and the context of tackling health inequities. Health systems are regarded and treated as one determinant of health. This includes a focus on rights and universal access to health care (and related commodities, such as clean water, and sanitation). The CSDH's recommendations take up the Alma-Ata declaration's PHC model. The emphasis is on the public sector, particularly public financing (ideally a taxation system), while for provision, it is more acknowledged that there are also acceptable private providers in place. However, it does not go into detail with the specific mix. As rather natural to approaches emphasising public systems in general, the dimensions of financing and provision are not

always clearly differentiated. The state is given an important role and ultimate responsibility in the regulation of health systems, but also other levels, actors and civil society are considered as being crucial in decision-making. The proposed strategies for Ministries of Health (WHO CSDH, 2007b:24) show a process focus, that opens the space for context-specific health system arrangements.

5.1.4 A Comparison of WHO Health-System Ideas

As these descriptions have shown, there are important differences in approaches, but also remarkable similarities in terms of health system models. Two general WHO models have been presented, along with two approaches of commissions initiated by the WHO.

Except for the CMH, the WHO approaches are usually characterised by a universal approach in the sense that they are supposed to apply to and inform all countries. Of course, wherever appropriate and necessary, distinctions are made as to the applicability to different groups of countries (distinguished by their average level of income). The CMH was explicitly devoted to the context of low-income countries; some of the recommendations also apply to middle-income countries.

The starting point and definitions of the critical issues regarding health systems are significantly different between the Alma-Ata Declaration and the WHR2000. While the former develops a model out of the concern about inequities in health, the latter pursues a rather technical goal of defining, in detail, the functions, elements and options of health systems in a generalised way.

The Alma-Ata Declaration introduces the so-called PHC model, giving the state a central role in the development of national health policies with regard to PHC and the broader health system. While the WHR2000 approaches

health systems in an all-encompassing sense and distinguishes functions (provision, resource generation, financing and stewardship), the PHC model is more focused on levels of care (provision) and decision-making processes.

The WHR2000 regards provision as the core function. Both public and private providers are considered important, while government is responsible for contracting, reimbursement and, thus, regulation of providers. There is no clear statement regarding (de)centralisation, or rather the discussions of public-private and centralised-decentralised dimensions overlap. On the financing dimension, the issue is said to be pre-payment, not the public-private question. The separation between contribution and utilisation is considered important, leading to a discussion of different forms of health insurance in the context of pooling. While such a pool should be as big as possible, a taxation system is still not considered the best and only option, but just one of two options. The decentralisation of financing bears the risk of fragmented pools; that could be overcome by forms of cross-subsidisation between pools or by combining insurance with government subsidies. The stewardship model on regulation includes organising a pre-payment system with public and/or private providers; and the definition of a benefit package.

The CMH, with its particular focus on poverty and low-income countries, draws a health system model oriented to the very basic health needs, taking into account public and private providers. It proposes community-based financing and delivery, with a concept including national and international contributions. The central point here is about how to increase the financial base of the health systems. The system would thus entail tax and social insurance components with public and/or private providers, proving universal coverage for a defined (very minimal) benefit package.

The CSDH goes back to the PHC model, approaching health and health systems in the context of inequity. Health systems are addressed as one of the determinants of health. The public sector is much in focus, particularly

financing (a taxation system is more or less proposed); on provision it is less categorical and the issue is less discussed. Referring to the Alma-Ata Declaration this represents a rights-based approach, with the aim of equitable, universal access.

All documents generally reject user fees; however, there is a difference in whether or not they are categorically rejected or not considered desirable (unless in cases of over-utilisation). The latter case, for example in the WHR2000, implies that it might not be easy just to abolish them without a sound means of substituting the missing revenue.

5.2 Health-System Concepts from the World Bank and the IFC

The previous chapter showed that the engagement of the World Bank in health issues is connected to, and in the *context* of, its commitment to fighting poverty. Accordingly, its policy models and advice are usually tailored or applied to low and middle-income countries, and with an implicit or explicit focus on poor people. This, however, looks rather different depending on whether the models come from the World Bank or the IFC.

Accordingly, the *goals* or *principles* of the World Bank's health system activities are deeply grounded in the alleviation of poverty and the provision of services to poor people. More advanced or comprehensive reflections and models of health systems may be independently written and serve as background material. It is shown, however, that the IFC combines that with a business objective.

Following from this, the World Bank's publications are less concerned about what a health system *is* (in terms of definition), than what it should achieve. This is best exemplified by the following quote from its recent revised HNP strategy paper that does, in its main part, not even try to define health systems but focuses on "strengthening health systems":

> *"Strengthening health systems" may sound abstract and less important than specific disease control technology [...] But, well-organized and sustainable health systems are necessary to achieve results. [...] Strengthening health systems is not a result in itself. Success cannot be claimed until the right chain of events on the ground prevents avoidable deaths and extreme financial hardship due to illness because, without results, health system strengthening has no meaning. However, without health system strengthening, there will be no results.*
>
> (World Bank, 2007:14)

The following sections discuss the World Bank's ideas on health systems in their development over the years, as well as comparing the World Bank's and the IFC's approaches respectively.

5.2.1 The Evolution of Health-System Ideas of the World Bank

First ideas on health policy were formulated in the World Development Report 1980 (World Bank, 1980b), linking problems of health and malnutrition to poverty, and arguing for a greater emphasis on social sector lending (Ruger, 2005). At the same time the 1980 Health Sector Policy Paper (World Bank, 1980a) provided a first rationale for investments in the health sector. Brunet-Jailly (1999:349) observes that this paper introduced a system of basic health services with three levels: community health workers, a second level facility (a rural health center, an urban clinic or a small district hospital) and a third level in the shape of a referral hospital. While the report was detailed regarding the provision function, it was much less so on financing: "the proposals for financing health care services go into little detail, are on the optimistic side (the resources on health were forecast to increase over the following two decades [...] vague, and even unrealistic (for example local insurance systems, or for cooperatives responsible for importing and distributing essential drugs)" (Brunet-Jailly, 1999:349).

In the second half of the 1980s a shift towards interest in the financing function of health systems occurred. A study entitled Financing Health Services in Developing Countries: An Agenda for Reform (World Bank, 1987) went further into the topic (see for example Brunet-Jailly, 1999, Ruger, 2005). At that time, the perception was that "public spending in general cannot be increased; indeed, in many countries, it must be curtailed" (World Bank, 1987:1, quoted in Brunet-Jailly, 1999). Accordingly, the idea was that public money could be saved by only paying for health services for the poor (see Brunet-Jailly, 1999:350).

The following, and probably best known, publication of the World Bank in the field has been the World Development Report 1993: Investing in Health (World Bank, 1993). The context of the argument is the health situation in poor countries. The problems are described as the misallocation of public money, inequity and lack of access for the poor, inefficiency (wasted money) and exploding health costs (World Bank, 1993:3).

On the *provision function*, the report proposes a strong reliance on private providers (examples given were religious NGOs or private doctors) that are said to be often more efficient than public providers. Government involvement was necessary where it increased the supply of public goods. The District Hospital is suggested as the best organisational level for the service provision (World Bank, 1993).

Regarding *financing*, the WDR1993 proposes to reduce government expenditure on tertiary health care facilities and specialist provision. Instead, government should finance, implement and ensure the delivery of a package of public health interventions (World Bank, 1993:6). Public subsidies "if they mainly benefit the wealthy, should be phased out during a transitional period" (World Bank, 1993:7). The remaining services should be financed privately or through public or private health insurance to be promoted and regulated by governments. More concretely, the report calls for less public spending on less cost-effective interventions, and instead doubled or tripled spending on the basic public health programmes (World

Bank, 1993:6f). The report further promotes some degree of targeting (instead of universal provision) and user fees as applicable (World Bank, 1993:118ff). Administrative and budgetary responsibility should further be organised in a decentralised way. Summarising with regard to the provision and financing of health care this means the

> *[p]rovision of cost-effective health services to the poor is an effective and socially acceptable approach to poverty reduction. Most countries view access to basic health care as a basic human right.*
>
> (World Bank, 1993:5)

On the *regulatory* responsibilities, the report describes highly centralised decision making as problematic (regarding the hospital sector) (World Bank, 1993:4). Nevertheless, "[g]overnments have an important role to play in regulating privately provided health insurance, in order to ensure widespread coverage and hold down costs" (World Bank, 1993:5). Governments are also responsible for defining the benefit package according to cost-effectiveness measurements, namely disability-adjusted life years (DALYs). Further criteria are: mother and child care, family planning services, tuberculosis control, Sexually Transmitted Disease (STD) control, and some treatment for minor infection and trauma, advice and alleviation of pain; and if further resources are available some emergency care. The rights and status of women were regarded as particularly decisive for furthering development. Governments were also made responsible for regulating any social or private health insurance schemes for clinical services outside the basic package, and to monitor health provision and financing (World Bank, 1993).

The World Bank was heavily criticised for the ideas promoted in this report, particularly those on user fees, structural adjustment, use of DALYs and privatisation (Ruger, 2005:68). As a consequence of such criticism, the World Bank's own Operations Evaluation Development Department reviewed World Bank projects (see Ruger, 2005). It pointed to the narrow focus on capital investment, the focus on the rather immediate situation and

the fragmented HNP portfolio. This has led to a shift away from basic health services to broader policy reforms, and the 1997 HNP Sector Strategy Paper (World Bank, 1997:15, see also Ruger, 2005). As the 1997 Strategy further explains: "Recently, these observations led the bank to focus more on systemic reforms, both in the case of broad health systems/financing reforms and in the case of more targeted interventions" (World Bank, 1997:15) and that these seem to have been more successful. Despite such changes, the World Bank's approach has continued to be highly contested.

Taking a similar starting point to the description of the current health situation and context as the WDR1993, the 1997 HNP Sector Strategy Paper (World Bank, 1997) approaches the question of health systems in a context of development and intersectoral concerns, including issues of housing, access to safe water and so on. Amongst other things, the 1997 strategy paper is concerned about the increases in health care expenditure and mentions the following reasons for this development: the new medical technology, the epidemiological transition in disease patterns, rising population expectations, and the growth of fee-for-service medicine and third party insurance (World Bank, 1997:4).

The principle aims of health systems are named as *equity*, on the one hand, to be realised through securing access by the population to HNP services; and on the other hand, *efficiency*, thus the correction of market failures related to public goods and health insurance (World Bank, 1997:5).

On the *provision* function, the 1997 strategy paper calls for services to be affordable, effective, well managed, of good quality and responsive to clients' needs (World Bank, 1997:x). For both, provision and financing, a public-private mix is considered best, "however, the optimal balance between public and private involvement varies considerably from one country to another, and is different in the case of financing from that in the case of service delivery" (World Bank, 1997:6). Further, in a general manner, the report supports decentralisation, without specifying in more detail what that implies for health care provision.

About the *financing* of health systems, the paper states the general necessity to "protect the population from the impoverishing effects of illness, malnutrition and high fertility" (World Bank, 1997:x). To realise that, broad-based risk-pooling mechanisms are needed; but also the mobilisation of additional resources, both at the national level and from external sources (World Bank, 1997:x,9). However, this must be accompanied by measures to reduce "ineffective, inefficiently managed, and low quality care" (World Bank, 1997:4). Essential health services are to be financed publicly (World Bank, 1997:6). For financing too, no particular model of public and private financing, or the form and degree of (de)centralisation, is proposed. The issue of user fees does not represent a significant element of discussion in the paper.

Concerning the *regulatory role of the state* the report makes the state responsible for securing equitable access (thus universal access combined with some targeting as appropriate for the specific development context) to preventive and curative care and other nutrition and population services (World Bank, 1997:x, 6). The state further is to effectively control public and private expenditure and provision; and this regulatory role is to be increased in the process of building up an effective health system in favour of otherwise private involvement (World Bank, 1997:x, 9).

This report shows the first signs of what will be argued later, namely that the global ideas on health systems are, amongst other things, characterised by uncertainty and no clear model which is in contrast to advice given in relation to pension systems. As the report states: "Much more research is needed to understand fully the factors that influence the performance of health systems" (World Bank, 1997:3).

Turning now to the more *recent* documents, here understood as the "current" World Bank health system approach, the following sections summarise a number of documents, most importantly the World Development Report 2004 Making Services Work for Poor People (World

Bank, 2003) and the 2007 HNP strategy paper Healthy Development (World Bank, 2007).

Describing the *context of health systems* (with the focus on low- and middle-income countries), or the problems that require health action, the Bank publications usually make one or several of the following points: the private sector is dominant in most LICs and many MICs; this includes private service delivery; however also private funding via household out-of-pocket spending; multiple and fragmented forums of risk pooling arrangements coexist; and low participation in risk pooling in LICs and among the poor (in MICs in the informal sector and among the self-employed) (e.g. World Bank, 2007: point 51, 81, Annex L). When addressing health systems, their strengthening is, for the focus of the Bank's work, not a policy objective in itself, and needs to be linked with a country's fiscal policy and competitiveness (World Bank, 2007: point 36).

The significance of strengthened health systems is only in the context of improving health and the financial protection in relation to the costs of illness *(World Bank, 2007:14)*. Point 106 of the paper summarises:

> *A well-organized and sustainable health system is essential to achieve financial protection by preventing the impoverishing effects of health shocks (e.g. through health insurance) and mitigating their effects. An efficient public financing and pro-poor subsidy policy in the health sector, access to effective financial risk-pooling mechanisms (e.g. health insurance), and household access to borrowing through better financial market environments are among the interventions that can help improve financial protection. Client countries face options in organizing risk pooling, including general tax-based systems, social insurance systems (financed out of payroll-tax contributions), and/or private health insurance arrangements, including not-for-profit community health insurance.*

Referring to the WHO's WHR2000, the paper *defines* health systems as "encompass[ing] all country activities, organisations, governance arrangements and resources (public and private) dedicated to improving and maintaining, or restoring the health of individuals and populations and/ or prevent households from falling into poverty (or becoming further

impoverished) as a result of illness" (World Bank, 2007: point 15; see also point 84). They are further described as "adaptive systems", comprised of mainly four functions: stewardship (regulation), health service provision, health financing and health service input (World Bank, 2007: 169 (Annex L)).

In general, the new strategy gives governments the responsibility to "ensure people's access to essential services and financial protection [by] rais[ing] stable, sufficient, long-term public and private financial resources, predictable, equitable, efficient and in a way that minimizes economic distortions" (World Bank, 2007: point 112).

While not describing *provision* as the most important function (see above for WHR2000), the new health strategy paper calls "[p]ublic and private health service provision [...] the most *visible* product of the health care system" (World Bank, 2007: Annex L, p.169; emphasis added). As in the earlier strategy paper (World Bank, 1997), a public-private mix in provision is understood to be the reality in countries and has to be developed to a coherent system. The WDR2004 states that "[t]here is no presumption that one type of provider – public, for-profit, or not-for-profit – is likely to be better than any other" (World Bank, 2003:151), and the 2007 HNP sector strategy paper (World Bank, 2007: point 82) describes the World Bank's role in providing policy models for health care provision as follows:

> *Bank advisory capacity on health system strengthening needs to be able to provide sound, feasible, and sustainable advice on when and how to invest in in-house public service delivery infrastructure or contract out with the private sector (for-profit and not-for-profit) in LICs and MICs.*

While referring to the common call to decentralisation in service provision, the WDR2004 points to the mixed results of decentralised health service provision:

> *Transferring the provision function to local governments has often overwhelmed them, leaving them with little capacity and incentives to develop the policy function and encourage citizen oversight*

(World Bank, 2003:147)

Regarding the financing function, some publications (e.g. Gwatkin et al., 2005, Yazbeck, 2006) argue that health services primarily benefit the better off, and thus propose that public spending should only be on the poor. However, the 2007 strategy paper appears to be indifferent concerning the question of public or private financing:

> *Household out-of-pocket private funding dominates health financing in LICs and in many MICs. [...] Thus, improving financial protection requires the Bank to provide sound policy advice to client countries not only about the best use of DAH*[39] *but also how to pool household out-of-pocket expenditures for the non-poor so that household demand and insurers (public and/or private) offer better pooling of financial risk. In the same context, user fees have a role to play as copayment when there is evidence of excess demand.*
>
> (World Bank, 2007: point 104)

It then continues to affirm that there is no support for one specific approach, no "one-size-fits-all blueprint for organizing risk pooling across countries" (World Bank, 2007: point 109). There is also a differentiation for proposed action with regard to LICs and MICs. While for LICs the three challenges are said to be expanding participation in risk pooling, solving the DAH volatility problem, and ensuring sufficient economic growth; the challenges to MICs read differently: "fiscal sustainability linked to systemic efficiency and potential challenges from past decisions linking social health insurance financing to labor status. The insurance-labor link can distort labor markets and labor costs through the use of payroll taxes as the main revenue-raising mechanism for social health insurance" (World Bank, 2007: point 113). There is also scepticism about the usefulness of decentralisation in health financing.

Generally, on *regulation* the 2007 HNP strategy paper refers to the *stewardship* concept and term of the WHR2000 (World Bank, 2007: point 84, 90, and Annex L). Issues of governance and accountability are included

[39] Development Assistance for Health (added by AK)

as a new policy objective of the World Bank's work in HNP (World Bank, 2007: point 36). The issue at stake is said to be to adjust public policy to facilitate a viable public-private complementarity in health care provision and financing and to improve access to services for the poor, and "to ensure effective regulation to enhance equity and efficiency" (World Bank, 2007: point 59, 81).

The WDR2004 on services makes the case for a certain level of cross-subsidies, either through social insurance or general taxation (World Bank, 2004:146). The regulatory link between government and providers is summarised by the WHR2004 to be to benchmark performance of services that can be monitored easily; to foster autonomous providers for clinical services; and to establish a strong monitoring function (World Bank, 2003:149). The World Bank's new strategy further remarks that financial risk pooling is the "core function of health insurance mechanisms", and states:

> *Participation in effective risk pooling is essential to ensure financial risk protection. It is also essential to avoid payment at the moment of utilizing the services, which can deter people, especially the poor from seeking health care when sick or injured. Each society chooses a different way of pooling its people's financial risk to finance its health care system. Most high-income countries follow one of the two main models: the Bismarck model [...] or the Beveridge model [...] Improving financial protection in Bank client countries requires a substantial effort to increase participation in risk pooling*
>
> (World Bank, 2007: Annex L)

These ideas of insurance models have also been addressed in Health Financing Revisited: a Practitioner's Guide (Gottret and Schieber, 2006), while adding that "[v]oluntary and community-based financing schemes can serve as pilots for countries as they seek to expand the role of prepaid health coverage schemes". The ideas about the system of financing do not include a clear model of the remuneration of providers.

These main papers are also less specific about the benefit package, unless it is about particular health issues such as maternal health care or HIV/AIDS (see for example World Bank, 2007).

In summary, due to health not being an initial mandate of the World Bank, the concern about the sector has evolved out of the insight that it was an important factor when supporting a country's development, thus in the context of poverty alleviation. The World Bank's engagement has increased ever since the 1980s, not only in scale, but also in how comprehensively health systems have been understood. The first major contribution in terms of ideas was the WDR1993 that provoked a number of controversial debates such as on user fees and privatisation (see for example Brugha and Zwi, 2002). The World Bank's take on the issue, focus and ideas have changed and concretised since then.

Besides issues of inequity and lacking access to health services for some groups of the population, World Bank work (e.g. World Bank, 1993) has also been concerned with the misallocation of public money, inefficiency and expanding health costs.

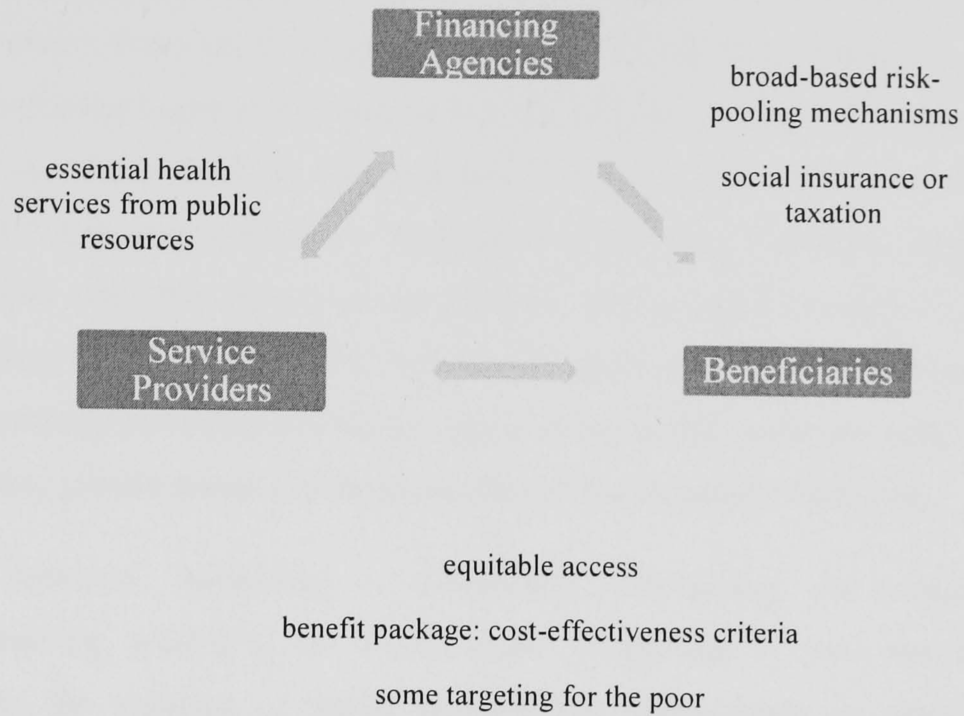
On *provision*, while an actor-mix is the option, the stress used to be more on the advantages of private providers and decentralisation (via District Hospitals) (World Bank, 1993). The 1997 Strategy Paper (World Bank, 1997) continued with the idea of a mix, however, concrete models are not discussed. The recent 2007 strategy paper (World Bank, 2007) also promotes the mix, but here it is particularly concerned with the importance of building up a coherent system. The WDR2004 had made explicit that neither type of provider (public or private) would be better as such and had expressed caution about decentralisation in service provision.

On *financing* the WDR1993 had proposed reducing government expenditure for other than basic health care and public health interventions. The concern was – and can still be seen in some of today's policy papers by World Bank

staff (Gwatkin et al., 2005, Yazbeck, 2006) – that scarce public spending could be wasted on rich people, who could also buy their health care to the detriment of the poor. As this only concerns the public-private distinction in terms of state/taxation versus out-of-pocket spending, the question of decentralisation (at the level of pooling) becomes obsolete. The 1997 strategy paper also marks a change in this regard; the issue being risk-protection and pooling mechanisms (plus the mobilisation of additional resources). At the same time, it continues to state that essential health services should be financed publicly. (De)centralisation is still not an issue in the debate and the issue of user fees which was an important element in earlier work and discussions, has almost disappeared. This more or less continues for the 2007 strategy paper. Here, however, it is mentioned that decentralisation in health financing is probably not useful, nevertheless, community financing could be a means to extending coverage.

On *regulation*, the WDR1993 gives governments an important role in regulating private and social health insurance, defining the benefit package according to cost-effectiveness criteria and other areas such as giving particular attention to women's rights and status, and to monitor health provision and financing. This, again, sounds different in the 1997 strategy paper: here, the state is made responsible for securing equitable, universal access (combined with some targeting) to preventive and curative care; and for controlling public and private expenditure and provision. The regulatory role of the state should be strengthened, while for the other functions, private involvement should be increased. This, again, is similar in the 2007 paper. In contrast, the WDR2004 had been more explicit with regard to cross-subsidies through insurance or general taxation. Risk-pooling is now an important component of ideas on health financing (World Bank, 2007). Figure 5.4 captures the recent ideas about health system regulation.

Figure 5.4: Regulatory Relationships (World Bank)[40]



equitable access

benefit package: cost-effectiveness criteria

some targeting for the poor

[40] This figure captures the current World Bank approach to regulatory issues. Some of the issues have changed over time.

5.2.2 IFC – Supporting the Private Sector

As has been shown in the previous chapter, more recently and with a somewhat different emphasis, the IFC has also begun to intervene into the health sector. From an examination of the IFC Health Care Strategy[41], it is evident that the health policy approach of the IFC shows clear differences to that of the World Bank as just described. Based on its general purpose to support "open and competitive markets in developing countries, support companies and other private sector partners, and generate productive jobs and deliver basic services" (IFC Articles of Agreement), the IFC sets out its health strategy providing it with the "opportunity to play a pioneer role" via supporting private sector involvement through health project financing.

It is, however, surprising – particularly considering the common understanding prevailing in World Bank documents – how the IFC describes the situation of health systems that then support its role and responsibilities in the sector. The strategy argues that, so far, there has been reliance only on the public sector and that had not proved to be viable and sustainable. Other World Bank documents would argue that there are private actors in place and that the health sector should be regulated in a way that meets the expectations of improving health. In contrast, the IFC explains:

> *Global trends point to a significant and expanding role of the private sector as a partner with public health systems, particularly in the provision of health care. Many governments are rethinking the respective roles of public and private agents in the health sector, and are beginning to turn to market instruments to enhance the efficiency and quality of health care provision. The aim of much of the recent health care reforms in various countries has been to increase the role of the private sector as the provider (rather than the financier) of care, while complementing the activities of the public sector. The general argument is that these reforms can retain equity in the financing of health care, yet promote efficiency by introducing and encouraging competition. High performing health systems are characterized by mixed delivery of services, with private providers playing an integral role. This private sector role is*

[41] See http://www.ifc.org/ifcext/che.nsf/content/strategy, accessed 29 December 2010

> *enabled by an appropriate regulatory framework and strong government participation in financing.*

The strategy does not provide evidence for this account of the situation of health systems, nor does it properly define health systems. Furthermore, there is no justification as to why the IFC nevertheless attempts to also enter the health insurance market with the aim of increasing private involvement. A further important omission is that the threat of fragmentation (when supporting single hospitals etc.) is not addressed at all. The strategy rather continues to show how the two "core objectives" of the IFC fit together for the health sector:

> *The business objective aims to provide value-added financing to viable projects. The development objective seeks to ensure that our investments contribute to institutional and systemic capacity building and promote efficiency and innovation within the sectors, while improving health security and expanding financial protection against the impoverishing effects of ill health.*

What is provided by the IFC is, thus, not really a comprehensive health system model, but a commitment to supporting the private sector, without that being integrated into the activities of other global health actors (including the World Bank) with a more comprehensive view on the issue. Accordingly, the IFC's work does not feature any reflections about regulatory issues in health systems.

In summary, the IFC, concerned with supporting the private sector, has developed a health strategy on its own; by arguing that the other World Bank support to the public sector has not proved to be particularly successful. On the basis of its business objective, the IFC has increased its support to private providers and also attempts to intervene in health insurance arrangements. The IFC's strategy does not provide evidence for a comprehensive account of knowledge or research on health systems, but instead sticks with the simple idea of private sector support.

5.2.3 Two Strands of World Bank Ideas

The World Bank provides for a comparably long history of engagement in health, both in its lending and research activity, while the IFC engagement is rather recent, but ambitious. In the course of time, World Bank ideas have changed: more attention has been given to the health sector, particularly acknowledging that economic principles that might have worked in other policy fields, are not necessarily translatable to health. This has included taking into account ideas from the WHO and also criticism from the side of CSOs (Shaw, 2007). The World Bank, now, is concerned about both equity and efficiency; while that approach is not easily to be found in IFC activity. The latter is understandable given the IFC's objective and focus and particularly its business objective; however, from the perspective of overall health system policy, this approach does not meet the current state of knowledge about desirable health policy. The fact that World Bank and IFC staff have also jointly engaged in publishing on health (see Preker et al., 2007), does not appear to make a change to the IFC's health approach. As a consequence, the IFC's activities appear not only to be poorly contextualized with regard to the context of health systems, but the World Bank Group's approach as a whole is little coordinated.[42]

5.3 The ILO's Focus on Social Health Insurance

Even though the ILO is not usually considered as an important global health actor, this section shows that some ideas were formulated first by the ILO; and it had even been proposed as *the* official organisation to deal with health insurance matters at some point in history (Siddiqi, 1995). At the same time, the ILO's health system ideas appear to have emerged in a somewhat different form to those of the organisations looked at so far.

[42]This concern has also been raised in an interview with a World Bank staff member.

Besides consideration of health in early general documents, namely the ILO Convention from 1919 and the Philadelphia Declaration of 1944[43], specifically on health, there have been early conventions, namely the 1952 Social Security (Minimum Standards) Convention (No. 102) and the 1969 Medical Care and Sickness Benefits Convention (No. 130). These still apply and are referred to in recent ILO documents (e.g. International Labour Office, 2001). Ideas on health systems, particularly on forms of social health insurance have also been developed in the World Labour Report 2000 (WLR2000) (International Labour Office, 2000), *Social Security: A New Consensus* (International Labour Office, 2001) and, more recently, concepts generating from the *Global Campaign on Social Security and Coverage for All* (ILO Social Security Department, 2007, 2008).

The *context* of dealing with health systems has been connected to the ILO's concern about workers. The link between this traditional focus of the ILO and health can be described as being two-fold and has led to different streams of health-related work: on the one hand, there is health at the workplace (occupational health issues); on the other hand, and the focus here, health is one dimension of social security that shapes the lives of workers. Health is understood as a pre-condition to work, but also as personal needs, and the approach to social security in health focuses on health insurance (ILO Conventions 102, and 130). The WLR2000 further mentions the adverse effects of ill health on people's earning capacity, the financial risks of ill health, and the rising overall costs of health care as important problems of the health sector (International Labour Office, 2000). The *principles* of health systems are importantly connected to social justice, equity and targets of preventing unemployment, poverty reduction or the promotion of common welfare, as can be seen in the *ILO Convention* from 1919 and the *Philadelphia Declaration* of 1944 (see also International Labour Office, 2000, ILO Social Security Department, 2007, 2008).

---

[43] At the Philadelphia Meeting of the International Labour Conference the delegates adopted the Declaration of Philadelphia which was annexed to the Constitution and still represents the Charter of the aims and objectives of the ILO.

Similar to the World Bank's approach, the ILO's accounts of health systems are not particularly concerned about *defining* health systems in a comprehensive way; it is more about establishing their role for achieving specific aims and principles. While the Alma-Ata Declaration is often called the first document giving the responsibility for health care explicitly to the state (Kickbusch, 2000, Koivusalo and Ollila, 1997), it is interesting to see that the Medical Care Recommendation already in 1944

> *generally recognised [...] that the State has the overall responsibility for creating a medical care service for all persons, whether or not they are gainfully employed, with a view to: a) restoring health (providing curative care), and b) protecting and improving health (providing preventive care)*
>
> (ILO and ISSA, 1997:6, see also International Labour Office, 2001: point 2, International Labour Office, 2005: fourth item on the agenda)

Similarly, the WLR2000, amongst other things, was intended to "show[...] how governments can work to guarantee access for all to health care and protect individuals from the detrimental effects of poor health on income security".[44]

At the same time, however, the ILO's traditional focus on workers and concepts of *processes* towards extending *coverage* (instead of comprehensive models of coverage of all) as in the ILO Convention 102 on Social Security (Minimal Standards) results in an astonishing set of requirements. Namely, it

> *does not require that the full range of health care is available to the whole population, indeed the Convention's requirements are satisfied with 50 per cent of employees, 20 per cent of the economically active population, or 50 per cent of residents*
>
> (ILO and ISSA, 1997:6)

---

[44] http://www.ilo.org/public/english/standards/relm/gb/docs/gb279/pdf/esp-7.pdf, accessed 29 December 2010

Also, in later accounts (International Labour Office, 2001), the proposed degree of coverage is not entirely clear: is it about universal coverage or just social insurance for workers (and their dependents)? The 1952 Convention also says insurance should cover "a substantial part of the persons whose earnings do not exceed those of the skilled manual male employee" (Article 6). However, Article (9) talks about prescribed classes of employees and their families. The convention of 1969 goes further in defining the groups to be included as a large part of the economically active population and residents in general. As far as persons are part of an insurance scheme, health care is to be provided according to need ("[...] in respect of a condition requiring medical care of a preventive or curative nature...", Article 7). Also, the new consensus on social security reaffirms:

> *Social security covers health care [...] It is not always necessary, nor even in some cases feasible, to have the same range of social security provision for all categories of people. However, social security systems evolve over time and can become more comprehensive in regard to categories of people and range of provisions as national circumstances permit. Where there is limited capacity to finance social security, either from general tax revenues or contributions – and particularly where there is no employer to pay a share of the contribution – priority should be given in the first instance to needs which are most pressing in the view of the groups concerned.*
>
> (Social Security: A new consensus. Conclusions concerning social security, p. 4)

More recent work has explicitly focused on extending social security, including health care, for all (ILO Social Security Department, 2007, 2008).

The ILO documents do not say much about the *provision* function and focus instead on health *financing* options. The WLR2000 names three financing mechanisms – taxation, insurance and non-insurance funding systems – and explains that most countries use a combination of the three (International Labour Office, 2000:83). Being critical about decentralised financing systems, the report is very much in favour of insurance systems, particularly social health insurance. This is because they make it possible to ensure a

right to a defined benefit package and access to care depending on need. It is not only the system as such, but also the options it offers related to processes of decision-making:

> *Social health insurance revenues are managed independently and separately from general government revenue by autonomous institutions. These institutions are generally governed by tripartite or bipartite governing bodies composed of representatives of those who finance the health insurance scheme (i.e. workers, employees and – if applicable – governments).*
>
> (International Labour Office, 2000:85)

Considerable space is given to discussing the option of micro-insurance schemes as "a complementary strategy to improve equity of access to health care for the excluded" (International Labour Office, 2000:87f). Also, this mechanism is process-related and includes the idea of community members participating in decisions about the scheme. Such micro-insurance schemes "are not, however, designed to become the main pillar of a country's health financing system" (International Labour Office, 2000:87, 202ff). Discussions at the 89th ILC in 2001 provide evidence for some disagreement between the workers' and the employers' parties within the ILO. The Worker Vice-Chairperson considered several options regarding the extension to a universal health system, with micro-insurance schemes contributing only in a limited way. However, the Employer Vice-Chair rather saw micro-insurance as a successful option per se and warned against "placing an extra financial burden on employers and workers in the formal sector to finance benefits for the informal sector" (International Labour Office, 2001:2f). Community-based social protection schemes, for example models of micro-insurance, have been worked out and tested in the Strategies and Tools against Social Exclusion and Poverty (STEP) programme. This has, for instance, included the development of study guides to micro-insurance schemes (ILO STEP, 2005).

The WLR2000 also discusses the option of user fees for the financing of a health systems, however, does not support them due to their regressive

character and their uneven effects on access to and utilisation of health services, amongst other things (International Labour Office, 2000:91ff). There is no particular benefit package defined; rather the different kinds of care (e.g. general practitioner care, specialist care) and decisions about essential pharmaceuticals are left to the medical profession. Cost-sharing (out-of-pocket contributions) is considered possible. Revenue collection should happen through insurance contributions or taxation. The contributions should be affordable to poorer persons (International Labour Office, 2000).

Following the new consensus on social security, the *Global Campaign on Social Security and Coverage for All* was launched. As part of that, the most recent ILO attempt to conceptualise social security, including health care, has taken the shape in the concept of a "Basic Social Security Floor" (with reference to a "Global Social Floor or Global Socio-economic Floor", see World Commission on the Social Dimension of Globalization (2004)). The role of the state, in general, is described as "facilitator and promotor" (ILO Social Security Department, 2007:27), and as sharing responsibilities for defining the functions and responsibilities for each subsystem of the health system, including the development of a legal framework and ensuring adequate funding and services. The idea is to provide for a "base of social and economic rights that are outside the realm of social security" (ILO Social Security Department, 2008:2). This basic set of guarantees includes, amongst other things, that "all citizens have access to basic/essential health care benefits through pluralistic delivery mechanisms where the state accepts the general responsibility for ensuring adequacy of the delivering system and its financing" (ILO Social Security Department, 2008:2). The basic social transfers may be in cash or in kind and it is up to countries how to realise them, as they are "formulated as a set of guarantees rather than a set of defined benefits" (ILO Social Security Department, 2008:3). Most likely, these guarantees would be financed through general taxation and, while integrated into a country's social security system, be provided in the form of social assistance.

In that context, social health protection is defined as "a series of public or publicly mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earning or the cost of necessary treatment that can result from ill health" and it is "founded on burden sharing, risk pooling, empowerment and participation" (ILO Social Security Department, 2007:3). The approach is to recognise all existing forms of social protection within a country or context. Accordingly, a discussion of different options for financing and organising health systems follows. Further, policy-makers are advised on ways to realise universal and equitable access, financial protection in health; and efficient and effective health care provision (ILO Social Security Department, 2007:3). It is proposed:

- *First, taking stock of all existing financing mechanisms in a given country;*
- *Next, assessing the remaining access deficits, and*
- *Last, developing a coverage plan which fills gaps in an efficient and effective way.*

(ILO Social Security Department, 2007:27)

Far from providing a list of services that should form part of the benefit package, the ideas about the benefit package have somewhat departed from a process-oriented to a substantial recommendation:

> *The ILO advocates that benefit packages [...] should be defined with a view to maintaining, restoring and improving health, the ability to work and meet personal health-care needs. Key criteria for establishing benefit packages include the structure and volume of the burden of disease, the effectiveness of interventions, the demand and the capacity to pay*
>
> (ILO Social Security Department, 2007:13)

However, this (still) should involve social partners and social dialogue in policy processes and governance schemes (ILO Social Security Department, 2007:27, 37f). Also, the medical profession is considered to be important in this process.

The paper provides for a route to develop a comprehensive plan and strategy for the achievement of universal coverage that includes the development of a national health budget to assess the financial status and development of the health system (ILO Social Security Department, 2007:29). Concerning the governance of health systems, with a particular view on financing, it says:

> *In order to fulfil the criteria of good governance, the financial and administrative separation of health insurance funds from Ministries of Health and Labour is essential. Generally, revenues earmarked for social health protection should be separated from government budgets and it should be ensured that contributions are used only for health-care benefits and administration of the scheme [...]*
>
> (ILO Social Security Department, 2007:39)

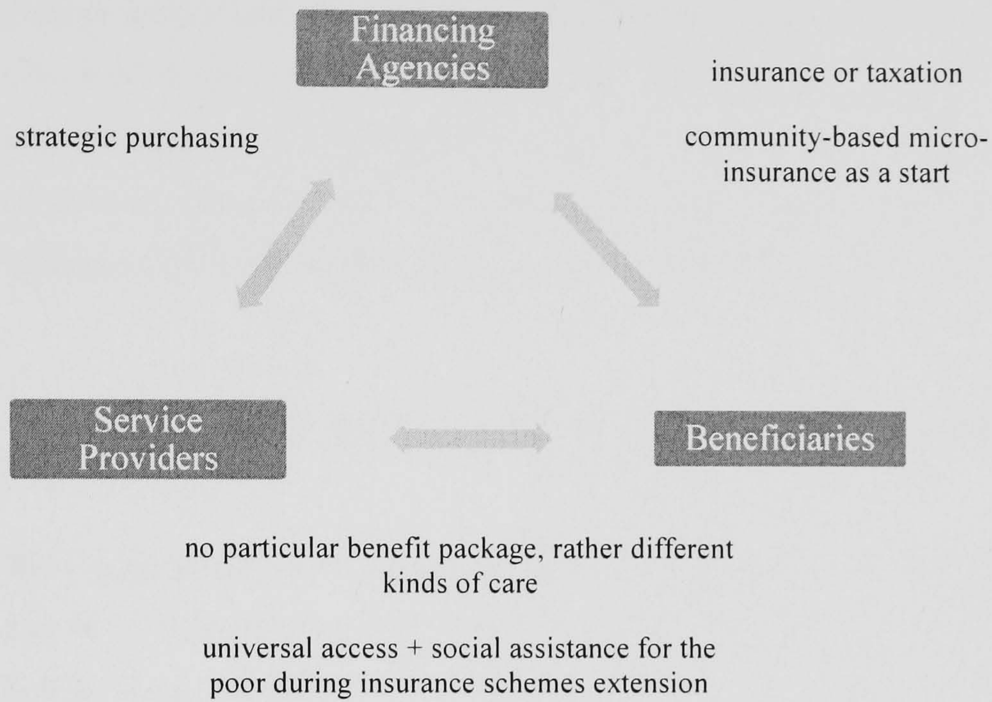
It recommends decentralisation or organisational units, and strategic purchasing (ILO Social Security Department, 2007:39).

The current regulatory relationships proposed by the ILO are summarised in figure 5.5.

Overall, it could be said that coming from a two-streamed approach to health (health and safety at the workplace, and health as an element of social security), recent ILO work is evolving to embrace a concept of social security with social assistance (social health protection) while the workplace issue, of course, continues as well. The ILO had traditionally been concerned about access to care; it has been ambiguous, though, whether the concern was exclusively on workers and their dependents or on universal access including all citizens or inhabitants of a country.

Much emphasis has been on insurance systems, particularly social health insurance, expected to ensure a right to a defined benefit package and access to care depending on need. The process of defining the benefit package reflects the ILO's ideal about tripartite governance and decision-making. Concerning the extension of coverage, the focus has been on micro-insurance schemes. Most recent ideas from ILO staff, however, introduce a

Figure 5.5 Regulatory Relationships (ILO)[45]



[45] . The figure does not take into account the change in focus towards a more inclusive model of social health protection that goes beyond the workers' focus, as has been described earlier in this section.

"Global Social Security Floor", independent from concepts of social security. This takes up the idea of the need of all people to be covered by a certain level of health care, as a set of basic guarantees, financed through general taxation and integrated into a country's social security system (thus a form of social assistance). Accordingly, the ILO concept has allowed to accommodate other than primarily work-focused social security to elements of poverty reduction and social assistance. This shift has, however, been limited to ILO staff and not yet visibly extended to the governing parties.

5.4 ILO-GTZ-WHO Consortium on Social Health Protection

With a particular focus on one health financing model, the ILO, the GTZ, and the WHO collaborate on developing and communicating ideas on social health insurance within the Consortium on Social Health Protection in Developing Countries.[46]

The basic ideas to be found at the Consortium's website and the Berlin Recommendations of Action (ILO et al., 2005) are the following: Focused in poor countries, the context is described as being very limited access to health services for poor people and catastrophic health expenditure. The basic principles or aims to be achieved are thus universality, equity and solidarity within sustainable systems of social (health) protection. Health (security) is considered as a human right, and the question is accordingly about universal access to effective and affordable health care (i.e. preventive, curative and rehabilitative health interventions) (ILO et al., 2005:3). Similarly to the ILO concepts above, the key to approaching this problem is a country's financing system (ILO et al., 2005:4).

Extending social protection in health can be done through various forms of taxation, insurance and mixed systems. The critical issue, however, is that of enhanced risk-sharing and risk-pooling, thus increasing the share of

---

[46] http://www.socialhealthprotection.org, accessed 29 December 2010

prepayment related to that of out-of-pocket payments. Ideally, this includes subsidies and cross-subsidies between risk pools. For social health insurance schemes, it is particularly stressed that they are also based on principles of responsibility and participatory governance by the social partners and the insured and, thus, regulation needs to be based on social dialogue.

Building up social protection in health should be "embedded in a comprehensive strategy of health sector reform", include an increase in the level of health spending (including external money in low-income countries) and take into account the broader determinants of ill health like social exclusion and so on. A mix of financing mechanisms is favoured, arguing:

> *Combining contribution-based financing with tax-financed subsidies enables the coverage of population groups or specific epidemiological necessities. A mix of financing methods could share the burden of health care expenditures among a broader tax base while also promoting greater potential for cross-subsidy by having contributors and non-contributors in the same pool.*
>
> *(ILO et al., 2005:5f)*

It is stressed that the way towards universal coverage will be a long term process and a complex task. The state is given an important role in the facilitation, promotion and extension of health protection, including regulating high quality and low cost (efficient) health care provision, including both public and private providers.

> *Health care providers also need to be acquainted with the principles of modern health care purchasing arrangements, including the procedures of accreditation, contracting and payment mechanisms' advantages and limits within a third party payment agreement.*
>
> *(ILO et al., 2005:10)*

Concluding, the approach is based on the notion of health as a human right and strives to realise access for all to effective and affordable health care. The Consortium focuses on the financing dimension, promoting social

health insurance for enhanced risk-sharing and risk-pooling. This includes elements of both the WHO and the ILO approaches. However, it will be interesting to see how the ILO combines the "Global Social Security Floor" concept with that of the consortium.

5.5 The OECD's Careful Approach to Health Systems[47]

The previous chapter has introduced the OECD as an evolving global health actor that is increasingly engaged in analytical (in addition to its data) work on health systems. However, the first documents considered here reach back to the 1980s.

As to the *context* of health systems, the OECD publications are characterised by an understanding of health care as an important social service and, at the same time, an important economic factor (e.g. OECD, 1987, 2004a). However, taking a historical look at the publications shows that there was still some "way" to get to the current balanced socio-economic view. Earlier publications seemed to have struggled somewhat with understanding health policy as something that cannot be captured only with economic thinking (see for example OECD, 1992:14f). More recent publications treat health care with a more balanced, socio-economic approach, a typical statement being that health is both a major economic factor *and* an important element of social cohesion (OECD, 2000, 2004a).

The portfolio of OECD health work approaches the topic of health systems in a broad and inter-disciplinary way. However, while statistical work has been more directed to health systems as a whole, the analytical work is

[47] The findings of this section are published in DEACON, B. & KAASCH, A. 2008. The OECD's Social and Health Policy: Neo-liberal stalking horse or balancer of social and economic objectives. *In:* MAHON, R. & MCBRIDE, S. (eds.) *The OECD and Global Governance.* UBC Press, KAASCH, A. forthcoming. A New Global Health Actor? The OECD's Careful Guidance of National Health Care Systems. *In:* MARTENS, K. & JAKOBI, A. (eds.) *Mechanisms of OECD Governance - International Incentives for National Policy Making?* (the health section of the former publication was written by AK, and the related research has been undertaken by AK, too).

characterised by a careful selection of specific health policy issues or topics that are identified as of particular interest to, or requested by, OECD member states. It includes work on the organisation and performance of health systems and is based on this broader statistical work.[48] The focus is mainly on OECD member states, but as part of its outreach work, the organisation also addresses other countries.

The basic (common) objectives, or *principles,* of health systems identified by the OECD can be summarised as follows: accessible health care (for all citizens; adequate and equal), high-quality health care, (macro- and micro-) economic efficiency (in use and provision), but also the redistributional and income-protection functions are frequently listed (OECD, 1987, 1992, 1994, 2004a). The 1992 report further includes freedom of choice for consumers and appropriate autonomy of providers (OECD, 1992). These objectives, according to the publications, may vary between countries regarding their relative importance or rank.

The OECD approaches health systems by their characteristic stories and problems, less by how they are *defined.* The "health system story" as described in OECD publications is that of a rapid growth of health systems in OECD countries after 1945, followed by a relatively stable phase until the 1970s and 1980s, when many countries encountered for the first time financial constraints regarding health care. While the earlier reforms had focused on universal access and extending rights to health, the reforms of the 1970s and 1980s attended to tightening budgets. In this context, it became clear that health care delivery was inefficient. Since the mid-1990s, the OECD identifies remarkable changes in the situation and reform of health systems in its member states. The general concern in related debates and reforms is the search for "strategies to enhance the effectiveness and

[48] But first and foremost it is particular studies on the co-ordination of care; pharmaceutical pricing policies and innovation; disability trends and costs of care for older populations; health workforce and migration; information and communication technologies; and the economics of prevention.

responsiveness of health systems" (OECD, 1994: Foreword) connected to *efficiency* criteria (see for example OECD, 1987, 1992, 1994).

An important characteristic of the OECD's health approach, underlying its typical focus on comparison and mutual learning, is the identification of similarities, common challenges and problems of different health systems. Accordingly, besides the "common story" as told above, there are also common characteristics, problems and solutions. The common problems frequently listed are, amongst others, the rising costs because of new medical technology; ageing populations and demographic change; increased utilisation of services (while also taking into account that there is a certain degree of under-utilisation by some groups of the population); inappropriate use of services; the inadequacy of care, and the lack of responsiveness; waiting times; biological, cultural, and social factors; rising expectations; inappropriate incentives for providers, unsuitable organisational and management structures, poorly designed regulation mechanisms; remedial gaps in information about effectiveness and costs (OECD, 1987, 1992, 1994, 2004a). The final report of the OECD Health Project adds that there are significant shortcomings in the *quality* of care (OECD, 2004b).

This balanced health approach that is – in addition – very much concerned to not openly and directly blame any member state, makes it very difficult (if not wrong) to identify a "health system" model favoured by the OECD. However, there are still some points to make: earlier publications were more willing to propose or express their favour of specific arrangements, like the *Health Maintenance Organisations (HMOs)* and prospective reimbursement systems (OECD, 1987); or the *public contract model*[49] said to being best suited for combining the strengths of public and private health care (OECD, 1992).

The 1992 report further describes managed markets as the most successful ones. However, this publication was a comparison of seven OECD countries

---

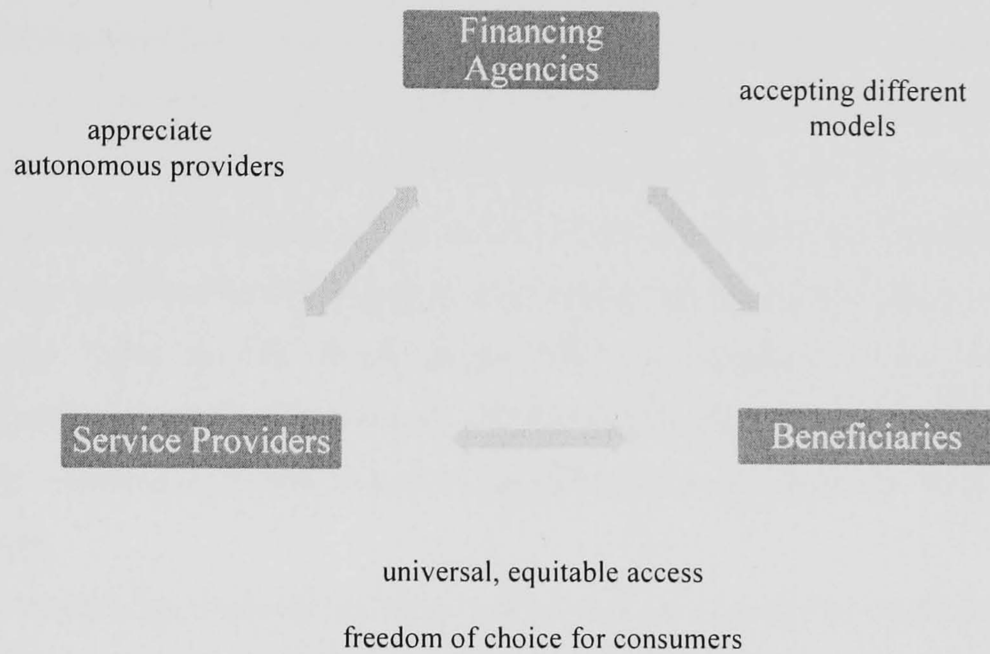
[49] These are sickness funds, financed by compulsory, income-related contributions, which contract directly with independent providers of services, supplied free of charge to patients.

– and thus the conclusions were based on these seven health systems. Two years later, another study followed comparing the remaining 17 OECD member states that partly altered these findings, and concluded there seems to be no relationship between successful cost containment and the organisation of health services (OECD, 1994). In contrast the 2004 final report of the OECD Health Project does not favour any specific model or intervention but is characterised throughout by discussing advantages and drawbacks of different models. If there is a general recommendation, it is the call for more and better data.

The OECD publications on health systems show a shift in the main focus between different health system functions. Problems and possible solutions (reform options) in the very early health work (OECD, 1977) concentrated on the *financing* function. The 1987 report somewhat marked the way for changes in the publications of the 1990s, when the belief was expressed that reforms and attempts to tackle health sector problems were mostly connected to the *provision* function: the need for more quality assurance and for better information on health outcomes and costs (OECD, 1992:141). Current OECD health publications are characterised by a tendency to see *regulation* as the main function to be crucial for any change. This turn regarding health system functions, however, is not to be understood as absolute or mutually exclusive. Due to the OECD's careful approach to health systems and its focus on particular issues connected to health systems, some of the sub-functions of health systems do not seem to be addressed, such as the remuneration of providers and the benefit packages.

In summary, the OECD's approach in relation to health systems is characterised by identifying a common story, common problems and common objectives of all OECD health systems, and, from that, building the basis for mutual policy learning in how to approach common health policy problems and reform constraints. The more recent analyses are driven by a balanced socio-economic perspective, and, while there is no "one" model identified that is favoured by the secretariat, there are some characteristics

Figure 5.6: Regulatory Relationships (OECD)



to the OECD health approach that are also summarised in figure 5.6. Among those are a very careful handling of policy recommendations, except for the general call for more and better data; an understanding of health systems consisting of different functions that can be driven by different public-private mixes; and by a shift in functions most likely to make a change when reformed (financing to provision to regulation).

5.6 Conclusions

This and the last chapter have shown that even though health policy is still a primarily national competency, there are a number of actors involved in producing knowledge and giving policy models for national health systems. This is in line with the general call for more consideration of comprehensive models, and a health system view concerning the fight against diseases or other more specific health policy issues. At the same time, for instance, the renewed justification for engaging with health systems in the 2007 Health Strategy Paper by the World Bank (2007) is evidence of the serious difficulty and severe constraints in fulfilling such a task, despite permanent public statements by the international community to take care of health systems.

This chapter has analysed the ideas and models developed and expressed by a number of international organisations, particularly the WHO, the World Bank, the ILO and the OECD for they were identified as the key players. The main characteristics of their approaches are summarised in table 5.1, following the approach and categories to understanding health systems and their functions that has guided this analysis.

What do these findings suggest in terms of the degree of models becoming more similar or different? Firstly and most generally, there are both remarkable differences, as well as similarities.

The differences are most obvious in terms of the underlying goals or principles of health systems. This means that different organisations, as well as different documents, take different starting points to approaching health systems. They might not be entirely mutually exclusive, and many documents refer to a number of such goals or principles. However, documents are usually driven by one main conception. Thus, documents in the tradition of the Alma-Ata Declaration argue around conceptions of human or social rights to health; accordingly that is also the character of the reports by the WHO CSDH. Another, related point is that of raising equality in health (e.g. WHR2000, CSDH). A very different starting point is that of improving the health status of populations connected to fighting poverty.

Table 5.1 Comparison of Health System Models

	WHO				World Bank Group		ILO	OECD
	Alma-Ata Declaration	***WHR2000***	***CMH***	***CSDH***	***World Bank***	***IFC***		
context, situation	all countries health inequalities	all countries poor health fragmentation	low-income countries poor health	all countries health inequalities	low-/middle-income countries poor health; inequalities, inefficiency, lack of access, fragmentation	low-/middle-income countries weak public sector	all countries ill health, financial risk, rising costs	(mostly) OECD countries effectiveness, efficiency, quality problems
goals, underlying principles	human/social right	goodness + fairness	poverty reduction, economic growth	right equality	poverty reduction	Introd. market instruments; equity in financing, efficiency	social justice right	Universal, adequate, accessible health; effi-ciency, re-distribution
Definition[50]	PHC within a comprehensive nat. health system	improving health action; functions	-	social determi-nant of health; WHR2000 def.	based on WHR2000	-	-	health = social sector + econ. factor
Provision	public (+ private)	public + private; (decentralised)	public + private; (decentral.)	public (+private)	public + private	private (+ public)	public + private	(appreciation of autonom. providers)
Financing	public	pre-payments centralised	discussing difficulties of public sector	public	public (at least for basic health care)	strong government participation; (future: support private health insurance market)	public (+ private)	(discussion about (dis-)advantages of different financing options)

[50] The CMH and the IFC are primarily focused on health interventions in specific contexts, instead of making general remarks about how health systems could be understood. The ILO addresses health in the contexts of social security or safety at the workplace and by this way skips more thorough theoretical discussions about the definitions of health systems.

Table 5.1 (cont.)

		WHO				World Bank Group		ILO	OECD
		Alma-Ata Declaration	*WHR2000*	*CMH*	*CSDH*	*World Bank*	*IFC*[51]		
Regulation	**health care coverage**	universal, equitable coverage	universal coverage	universal coverage for priority health interventions	universal, equitable coverage	equitable access	-	universal coverage (but partly worker-focus)	universal, equitable coverage
	system of financing	(public financing)	taxation and/or insurance	community-based financing schemes/ taxation	taxation model (+ mandatory insurance)	social insurance or taxation	-	social health insurance (+ taxation/ social assistance)	(no particular preference)
	remuneration of providers[52]	-	strategic purchasing	government pro-vided or contracted	-	-	-	strategic purchasing	-
	access to markets[53]	-	-	-	-	-	-	-	-
	access to services	PHC	-	CTC system	PHC; based on needs and preferences	(some targeting)	-	depending on need	freedom of choice to consumers
	benefit package	-	public process of priority setting (concrete proposals)	minimal benefit package (defined)	-	essential health services	-	tripartite process + medical profession	-

[51] The IFC is primarily focused on a number of projects that support the private sector in health care provision, and refrains from broader health systems discussions, particularly about regulation.

[52] The issue of the remuneration of providers is not frequently addressed in the documents that approach health systems in a broad or general way. However, there may be separate discussions about strategic purchasing as such.

[53] The fact that this row is blank demonstrates that the issue of access to markets is left out from general discussions about health systems in the documents of international organisations. It is, however, an important issue when it comes to trade regulation.

This can be found in the WHR2000 as well, but particularly in the approaches of the WHO CMH and the World Bank. The OECD finds other expressions for the concerns of health systems, but clearly supports the goals of universal, adequate and accessible health in an efficient and redistributive way, while primarily focusing its work on effectiveness, efficiency and quality of health systems.

Behind these goals and principles are, amongst other things, different concepts of equity in health. They are usually linked to different approaches to fairness or justice, such as in distributive terms or seen as a question of equal opportunities with regard to social goods (Rawlsian tradition). Equity in health can also be seen in a Titmuss sense of national responsibility for providing, for example, equal access to health care. Understanding and studying such basic concepts of equity in health are certainly important for understanding different health debates. However, the focus here is on the concrete models proposed by the organisations in the way they resemble regime types of welfare states and health systems (see above). The fundamental and important question about equity in health is not central in this particular research.

Not all organisations thoroughly define health systems. Implicitly or explicitly, definitions or understandings either follow the Alma-Ata Declaration with the PHC approach, focusing on levels of care, and processes of decision-making; or taking a more technical view on functions (WHR2000, World Bank). The CSDH appears somewhat mixed with reference to the WHR2000, but clearly in the tradition of the Alma-Ata Declaration, and, at the same time, introducing the understanding of health systems as a social determinant of health. Again, the OECD expresses things differently defining health systems as both a social sector and an economic factor. These are mainly different perspectives and starting points to the matter.

Despite the different normative positions, and also partly different languages used to describe issues, the health system models currently proposed show remarkable similarities. On the one hand, this may be due to the fact that the models are rather inconclusive and vague. However, on the other hand, there is indeed some degree of consensus about the need of universal coverage, and a turning away from the idea that the health sector should either be used for general budget savings or provided predominantly by the private sector. There is evidence from outside the context of this thesis that even in the current (2010) dramatic cut-backs imposed by the new UK government, health care was excluded from the plans for cuts in spending. Nevertheless, people are concerned it could also affect the health system. The US has been a notable exception in this field, given that there is indeed strong opposition against reforming the current US health system into one that increases access to health services and health insurance, but even here progress towards the insurance coverage of more citizens has been made.

The models proposed by the WHO, World Bank (IDA, IBRD), OECD and ILO lie somewhere in between two extreme cases, namely the pro-market one of the IFC, and the pro-state one of the Global Health Watch that come closer to ideal-types. The IFC model is clearly in favour of private providers and more support to private funding, too. The state should play a role primarily in regulating the health system. The Global Health Watch, in contrast, regards the public sector as central in the process of running health systems. Financing should happen through a single national pool with a strong redistributive function. Providers should be public or private non-profit. Regulation should be public, too, involving also communities. It has, however, to be noted, that these two extreme cases also come with a significant lack of detail about the specifics of the health system functions analysed in this thesis. The other organisations' proposals delve more into the different options and discussions connected to the different functions of health systems, and face much more complexity in concluding in favour of one or another preference.

With partly different emphases in relation to the relative share or extent, health care *provision* is commonly described to be driven, and also more or less suggested to be rightly undertaken, by a mix of public and private providers. Approaches in the Alma-Ata tradition would prefer more of a public (and not-for-profit) share, while the World Bank is also open for more for-profit private sector involvement. Little is explicitly stated about the degree of (de)centralisation, however many provision models tend towards a decentralised system; the WHR2000 also makes this explicit.

Financing is generally proposed to be public, with the important issue being pre-payment (in contrast to out-of-pocket at the point of seeking health care). In contrast to the clearly expressed ideal model of the Global Health Watch, the debate about prepayment or insurance vs. public tax based funding appears to be underdeveloped in the documents analysed and it is possible that there are hidden disagreements here or differences in emphasise as between, for example the World Bank and the WHO. The IFC though, is clearly different in that it does not appear particularly concerned about understanding the implications of supporting the private sector in health insurance, while planning projects of that kind.. This argument in favour of public funding has also shifted attention away from the former discourse on user fees. These are no longer considered desirable (unless in the very specific situation of over-utilisation), however, organisations differ in the extent of radical views on abolishing them when there is not (yet) secure replacement financing for them. The idea is further to have a more or less centralised health financing system (big pools better than small ones), at least theoretically. More practically and concretely, organisations concerned with health in development contexts go for decentralised insurance models as a starting point for extending coverage.

Concerning the key *regulatory relationships*, there is no controversy about the desire for universal, equitable *coverage*, with variations only due to specific foci. This means that the CMH was concerned with poverty reduction, rather than conceptualising a final-stage health system and, thus,

focuses primarily on the poor. The case of the ILO is more complicated, as it seems to veer from its concern and responsibility for the well-being of workers, to a conception of universal health. Naturally not everybody is a formally employed person or a dependent of one, and so recent ILO ideas have elaborated on a Global Social Security Floor, thereby introducing something akin to social protection in the field of health.

Interesting in terms of shared or contested ideas is the question of the proposed *systems of financing*. In particular, while the above identified differences in the norms behind the concepts would lead one to expect major differences in the system of financing, here also the variation could be described as varying between a taxation model with elements of social health insurance (e.g. CSDH) and social health insurance with elements of taxation financing (ILO's global social security floor), or simply saying it could be one or the other. There is actually more difference in the headings of the related publications (for example, social health insurance for the ILO and WHO, private health insurance for the World Bank and OECD) than there is in the proposed models. Private health insurance is discussed, but hardly promoted as an alternative to the other two forms. The other issue which has been mentioned before is that of what to do in places with non-existent or fragmented health systems. Here, the idea of trying a national taxation system right away is hardly ever discussed. Instead, at least in development contexts the ideas centre around community-based models with mixed sources of financing such as contributions from insurees plus government subsidies supported by external aid, while none of the higher-income countries does seem to serve as a clear example for a good health system.

If there is mention of the *remuneration of providers*, it is strategic purchasing that is discussed in its potential to save costs, but also pointed to as not being suited as the main criteria for purchasing health care. The ILO and World Bank express themselves rather similar ideas here. This issue is not, however, usually discussed at length in the documents studied for this research.

The finding that the *access of providers to health markets* is completely ignored in the documents that have been analysed leads to the conclusion that there is no promotion of commercialised and market-based health systems. This, however, contradicts global health activities in the context of trade agreements (GATS, TRIPS) (see excursus on WTO). A further meaningful discussion on the issue of health systems would require combining the two streams of approaches and literature on health systems.

The access to services is usually discussed within PHC approaches or the CTC-system of the CMH. It could, however, also be seen as related to the question of rights to health care, and on what criteria health care is provided (e.g. need, preference). The OECD expresses the issue in a more marketised way by talking about the freedom of choice for consumers.

There are two, or even three, ways of addressing the issue of defining a benefit package: (1) as a process of decision-making (WHR2000, ILO); (2) as the definition of the kind of services to be included in a given context (and declaring government to be responsible for such decisions) (e.g. CMH, World Bank); or (3) not as a particular issue, as the ideal is equitable access to all services and by all (Alma-Ata Declaration, CSDH). It is interesting to see that, only in the case of the ILO, is the medical profession viewed as suitable actor for taking decisions about appropriate benefit packages.

Accordingly, while there have been controversies on health system related issues, such as user fees and questions of privatisation, the current broader models developed and proposed by the main international organisations engaged in policy models and the development of models for national health systems are not fundamentally different (though starting from different normative viewpoints) – or to put it differently: the ideas about different functions of health systems do not add up to clearly distinguishable, ideal-type models of health systems, but are rather characterised by both being vague and unclear, and agreeing on a range of issues. Having said that and relating to all the commonalities, it is important to see that the IFC is an outlier in many of these issues. It does have a different story, interpretation

and approach to the current health situation that does not meet the current knowledge on health systems.

Some further notes of clarification are still necessary. First, despite the broadly consensual knowledge identified, the ideas do not express one-size-fits all approaches, as can particularly be seen in the question about taxation or insurance models. Second, while this analysis does not suggest that there has been a historical move from fundamentally different models to today's more similar views, there have been changes in the focus of interest and content of policy advice when looking at the development of the health ideas of different organisations. Quite typically, there seems to be a shift from a focus on provision over financing, to now particularly stressing the role of national governments to regulate public and private provision and financing schemes (for the World Bank and the WHO). For the OECD and the ILO there is evidence for a slightly different sequence: financing – provision – regulation. However, not in the sense of completely replacing functions, but rather the tendential focus and interest has shifted. As regards content, the evolution of health ideas for the World Bank and the OECD is characterised by an increasingly "social" view on health systems, while the ILO has shifted from very much employment-related concepts to universal ones. Shifts in the WHO's ideas are less obvious, there have rather been parallel streams of ideational concepts going up and down in attention in the course of time.

Why is it that global ideas on health systems are so consensual? There might be several explanations for this. First, regardless of the normative base, there is a commonly held objective that these should be universal access to at least (!) a minimum package of services. Secondly, health systems are extremely complex and the models proposed by international organisations are evidence as much for considered advice on the matter, as on uncertainty as to how to approach health systems (there are no perfect models either theoretically or practically). Thirdly, there is evidence from documents and

interviews that the "coherence" is not unintended (ILO, 1999)[54], but a decided consequence from the observation of the controversial pension discourse (along with the careful OECD approach in the matter avoiding any clashes). Fourthly, the number of experts in the field that are engaged in doing research and writing reports, and so on, about the issue is rather small, and likely to be engaged with different international organisations over the course of their professional activity (see Lee and Goodman, 2002).

Given the situation of more or less shared ideas on health systems by the main global health actors, the next chapter takes a look at how this translates into communication channels. Before doing so, however, an excursus sheds light on yet other, alternative models.

[54] The report says literally: "The ILO has a long tradition of setting standards and offering policy advice on financing and delivery of health care, and in future, besides continuing to advocate the extension of social health insurance, the ILO will examine the scope for innovative schemes, such as community-based micro-insurance. This could be done in collaboration with other agencies, notably the World Health Organization and the World Bank — a cooperative approach that should help avoid the kind of protracted international debate and confusion that characterized pension reforms in the 1980s and 1990s."

Excursus 1: The Power of the World Trade Organisation

While not the focus of this thesis' analysis, a number of authors have pointed to the World Trade Organisation's (WTO) role and potential impact with regard to national health systems (e.g. Holden, 2005, Koivusalo, 2003c, Koivusalo, 1999). An important part of the work of those international organisations that are in the focus of this thesis is producing and communicating knowledge on health systems. The implications for the field of social and health policy with regard to the WTO's activities rather grow out of the "basic underlying philosophy of the WTO [...] that open markets, non-discrimination, and global competition in international trade are conducive to the national welfare of all countries" (Koivusalo, 1999:15)[55], and "in general health [...] impacts are considered in the WTO mostly as consequence of economic growth which is presented as yielding cheaper consumer products, [and] health technology improvements [...]" (Koivusalo, 1999:15). Thus, while potentially influencing national health policy and having been described as "a new potential forum for many labour, environmental and health related matters" (Koivusalo, 2003c:2), the agreements of the WTO, namely the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) and the General Agreement on Trade in Services (GATS), as well as the pronouncements of this organisation, cannot be interpreted as contributing ideas about *best* health systems. Still, on the other side Koivusalo (2003c:7) argues that "[t]he focus on health care as an industry may easily lure attention away from the fundamental functions of a health care system."

The literature on the WTO as a global actor within the field of health policy mainly focuses on the implications of these two WTO agreements – TRIPS (e.g. Koivusalo, 1999) and GATS (e.g. Woodward, 2005, Yeates, 2005a,

[55] Referring to HOEKMAN, B. & KOSTECKI, M. 1997. *The Political Economy of the World Trading System*, Oxford, Oxford University Press.

Sexton, 2001) – on national health (and social) policy. While discussing the potential dangers that such trade agreements might have for national health policies, both streams of argumentation are "largely speculative in nature" (Woodward, 2005:515). Critics fear that international agreements on trade "may in practice also effectively limit government abilities to impose regulatory measures" (Koivusalo, 1999:37, see also Timmermans, 2004) and that it will lead "towards less effective, costlier and inequitable health systems development" (Koivusalo, 1999:38). Further, there is concern that the hidden dangers of making commitments regarding health services, such as what a certain regulation actually means for the health sector, would not be obvious at the moment of signing the contract (Koivusalo, 1999:39, Timmermans, 2004:454), and could be very difficult to change later (Woodward, 2005, Sexton, 2001). It is also feared that commitments in the field of health services could be enforced by trade sanctions (Sexton 2001:5; Koivusalo 1999:18). The critics of WTO politics in relation to social or health policy, point to the danger that WTO agreements represent to public policies. Koivusalo (1999:18), calling this problem *trade-creep*, argues that "WTO policies may have 'creeping impacts' in public policies, which cannot be dealt with solely in the context of trade interests of countries, and may lead to systematic adverse incentives and impacts upon health and social policies." It is also acknowledged that so far, for example, GATS has not been an important driver of privatising health services, even though such services are listed there as potentially open to competition; and that the WTO accepts governments' hesitation to commercialise hospitals (Sexton, 2001:18, Vanduzer, 2005:189).

More concretely on the GATS, this agreement (in effect since 1995) has different parts: a framework agreement containing the general rules and disciplines; and the national "schedules" (individual countries list their specific commitments). It defines rules for international trade in practically all services, without a definition of services as such (Sexton, 2001:4). For the health service sector, there are four sub-sectors: medical and dental services; nursing and midwifery; hospital services; and other health

services. The GATS comprises four modes, namely cross-border provision of services (for the field of health e.g. telemedicine), cross-border movement of consumers (e.g. cross-border movement of patients to receive health services), commercial presence of providers (e.g. foreign ownership of health facilities), and cross-border movement of providers (e.g. temporary migration of health professionals).

Woodward (2005:515) distinguishes two streams of literature concerning GATS and trade in health services: a *trade* faction emphasising the developmental chances arising through trade without really looking at health systems, and the *health systems* faction discussing the dangers to health systems. Still, even the critics admit that - up to now - the implications of GATS have been limited, as those services that are primarily provided by governments and are thus excluded from the reach of GATS (e.g. Koivusalo 1999; Pollock and Price, 2000; Lipson, 2001; Hilary, 2001; Sexton, 2001). Koivusalo and Mackintosh (2004:16) state that "the impact of GATS in health care has so far been limited, though the liberalisation of insurance markets may be increasingly important in health". They further point to the dangers of market failure in the field (e.g. exclusion from care due to inability to pay). More directly connected to the organisation of health systems is that "the rapidly increasing privatisation of public sector services provision and contractual arrangements in public sector may [...] change the picture fast creating conditions for increasing the role of private sector actors as well as providing possibilities for competition on government contracting and procurement" (Koivusalo, 1999:36). Holden (2005:679) considers first steps towards privatisation could already lead to blurring the public and private boundaries, and thus fall under GATS provisions. Further, there is concern that the health sector itself could be involved in GATS processes, as there have been occasional moves towards that, for example the U.S. coalition of Service Industries has intended to use the GATS negotiations to further U.S. companies' expansion into foreign health care markets (Holden, 2005:685, Sexton, 2001).

At the same time, a publication by the WHO and the WTO (2002:113) tries to convince us that the GATS "leaves countries the flexibility to manage trade in health services in ways that are consistent with national health policy objectives". The fact that certain services are excluded by GATS, namely those "provided in their exercise of government authority", defined as "any service which is supplied neither on a commercial basis nor in competition with one or more service suppliers", does not really provide a safeguard as the critical terms are not defined (Woodward, 2005, WHO and WTO, 2002:119). It has been argued that for countries that have an internal market in health care, it is not easy to keep that market closed to foreign trade (Lethbridge 2004:6).

On the TRIPS, the implications for health care centre around issues of patents, copyrights, trade marks and the licensing of pharmaceuticals. It has been argued that the TRIPS is an example of an agreement with substantial indirect implications to health and health systems. The most important of these implications are mediated through pharmaceutical and research policies and technology transfer. The TRIPS has further been characterised as not being about liberalisation of services, "but essentially about protection of commercial interests and rights" (Koivusalo and Mackintosh, 2004:27, see also Lethbridge, 2004, 2005).

In summary, there are indicators and arguments for WTO facilitated trade agreements that have implications on the provision and organisation of health systems. Those have so far been described as being rather speculative; however the developments in trade negotiations certainly need to be closely watched in order to prevent detrimental effects. The justification for not considering these issues within the analysis of this thesis, however, remains: the WTO's activities in relation to the health sector are not explicitly policy prescriptions for or production of knowledge about health systems; rather the connection to health systems appears indirectly.

Excursus 2: An Alternative Model – The Global Health Watch[56]

While the focus, so far, has been on international organisations, it is important to make an excursus to point to a non-governmental actor that has provided a comprehensive model of health systems. There are, thus, alternatives to the "mainstream". Civil society organisations have stepped in to provide such by compiling an alternative world health report, the *Global Health Watch*[57]. The first report was published in 2005 and is subject to this analysis; the second was released at the time of final revisions to this thesis and is therefore only briefly considered.

The *Global Health Watch* addresses a number of global health topics and functions. However, here, the focus is on the ideas on health systems only. The report's basic underlying approach is an understanding of health that is explicitly political and also comprehensive (including poverty); as well as being interested in equity and rights, in a broad sense including (besides political and civil liberty human rights) social, economic and cultural rights. The chapter on health systems starts with the observation that millions of people are without access to health care because of non-existent, weak or struggling health systems. In order to approach these shortcomings, it develops an agenda for health system development going back to the *Alma Ata Declaration* (WHO/UNICEF, 1978a). As a first step, the Declaration's principles are presented and interpreted: a comprehensive approach to health, emphasising preventive interventions and promoting a multi-sectoral approach; the integration of different clinical services and different levels of health care; an emphasis on equity; the use of 'appropriate' health technology (socially and culturally acceptable); appropriate community involvement; and a strong human rights perspective. Subsequently, the *District Health System* (DHS) model, developed by the WHO following the

[56] This section in based on KAASCH, A. 2007. CSOs in the global discourse on health care systems. The Global Health Watch. *Presented at the London Workshop on Civil Society Organisations and Global Health Governance.* London School of Hygiene and Tropical Medicine.
[57] See http://www.ghwatch.org, accessed 29 December 2010

Alma-Ata conference, is described as a model to realise these principles within the health system. The DHS is characterised by clearly demarcated geographical areas. It builds the basis for the integration of different level health services; it is coordinated with other key sectors (e.g. water); and is organised by a district-level management team concerned about comprehensive and integrated health care. The report continues to provide a number of far-reaching recommendations to "restore a proper balance and relationship between the public and private sectors as well as between public health care (population and community-based approaches to health) and individual private health care" (Global Health Watch, 2005:79). The public sector is said to have the central role in this process. Ten recommendations are developed that need to be implemented together, and adjusted to the particular context in a given country. Specifically, on the main functions of health systems (financing, provision, regulation), the following is stated: There is a general stress on the role of the public sector in all three functions. Regarding *financing* a single national pool is the aim "with the capacity for cross-subsidization between high-income and low-income groups, and risk sharing between, for example, the young and the elderly" (Global Health Watch, 2005). For low-income countries, there is further a dimension of external financing that must happen through debt relief and medium- and long-term external financing, channelled through Ministries of Health. If there are private providers, the choice should be non-profit providers. Strong and clear national *regulation* is necessary, with community involvement. The DHS is presented as the model to fulfil these functions, as:

> *It creates a decentralized system to allow health plans and programmes to be tailored to the needs and characteristics of the local population and topography. It provides a platform for the integration of policies and priorities emanating from different programmes and initiatives at the central level, and for getting the appropriate balance between top-down and bottom-up planning. Districts can form the basis for resource-allocation decisions informed by a population-based assessment of need, and can help central levels of the health care system to identify areas requiring additional capacity development or support.*

(Global Health Watch, 2005:92)

Compared to the models promoted by international organisations which have been discussed in this chapter, the Global Health Watch's DHS model is much more focused on provision and explicitly favours a decentralised approach to provision, as well as participation in decision-making. It has a strong emphasis on the public sector and supports one single public pool for health care financing.

6. How? Communication Channels

Having discussed the general, as well as specific global health (system) mandates and ideas, this chapter is devoted to analysing *how* these ideas are *communicated* by the global policy actors. The previous steps of the analysis have shown that different international organisations base their activities on different mandates, but that the models proposed do not differ significantly. Remaining is the third analytical step to understanding the degree of contestation in global social policy in the dimension of global policy models for national health systems. This is conceptualised as the communication channels of the international organisations, not as actual impact on member states. This is perhaps the most difficult step, because the different communication channels seem to have been addressed least in the global social policy literature.

Again, the chapter is structured to first study the different international organisations' communication channels respectively, and then to discuss them in relation to each other. The WHO's communication channels are summarised in section 6.1, the World Bank's in section 6.2, the ILO's in section 6.3 and the OECD's in section 6.4.

The analysis looks at a selected number of communication means as presented in chapter 3. These are:

(1) international conferences;

(2) different forms of publications, distinguising between:

(a) strategy documents,

(b) advocacy documents, and

(c) research documents;

(3) conferences and workshops intended to inform and teach national policy makers and/or staff from other international organisations;

(4) more direct involvement in national policy making (including financial support); and

(5) international organisations' engagement in developing indicators and collecting and reporting data;

(6) websites and connected means (email lists, newsletters);
(7) campaigns to advocate a particular policy model or idea; and
(8) building of and participation in networks or epistemic communities.
More emphasis is given to collaborative activities when concerned with the spread of ideas in section 6.5. Section 6.6 summarises and discusses the findings.

6.1 The WHO's Limited Communication Means

Earlier chapters have explained that, given the WHO's mandate, it is often regarded as the most important global organisation for policy models for national health systems. It has produced or initiated a range of work and ideas related to the structures, problems, reforms, and so on, of health systems; both at a general level, and related to different groups of countries; different health issues; different groups of the population; or connected to different global campaigns or goals, like the MDGs.

The WHO has also employed various means of communicating its ideas. One is through ministerial meetings or other ***international (political) conferences*** involving government representatives as well as other societal actors (such as CSOs). For the Alma-Ata conference, for example, WHO and UNICEF, as well as CSOs, had prepared important conceptual work that was then discussed at the conference. However, Kickbusch (2000) also shows how the PHC approach was importantly shaped by the then-Director General of the WHO, Halfdan Mahler. In a speech to the 61st WHA (20 May 2008), Mahler himself stressed the importance of an organisational study by the WHO Executive Board (EB) that led to the decision to convene the Alma-Ata conference in 1978 (Mahler, 2007). These ideas were further discussed and developed at the declaration's anniversaries.[58] The Alma-Ata

[58] Subsequent meetings: 10th anniversary meeting in Riga in 1988; 15th in Almaty, Kazakstan in 1993: "Primary Health Care and Health Sector Reform",WHO and UNICEF; 20th in Almaty again in 1998: "Everybody's business"; Madrid 2003: "Global Meeting on Future Strategic Directions for PHC. PHC and Human Resources Development. Document

Declaration has indeed been understood as a kind of formal document to guide international health work. Realising this in practice, however, has appeared to be much more challenging. The World Health Assemblies (WHA), too, are regular points of discussion for health system issues and actions by the WHO. As for the other conferences, they are usually accompanied and prepared in the form of reports by the Secretariat.[59]

Such international meetings can even result in forms of international law, and the WHO, in that sense, can appear as a facilitator of international health regulations. There are indeed some such regulations like the International Health Regulation[60] that came into force in June 2007, or the Framework Convention on Tobacco Control[61]. However, these instruments are only marginally important for health systems as understood in this thesis.

Another means for the WHO to communicate ideas are ***different kinds of publications.*** There are *strategy documents* (a) as to the role the WHO intends to fulfil in advising national health systems, like the recent 11th Programme of Work (WHO, 2006b). Also the WHO's Everybody's Business (WHO, 2007) combines the strategic outline for the organisation with ideas on health policy. *Advocacy documents* (b) like the WHO's annual World Health Reports (e.g. WHR1999, WHR2000)[62] are important means to inform the international community and shape the perception of global health problems and their possible solutions (see also Kickbusch, 2000).

---

prepared by Human Resources Development Unit. Strategic Health Development Area: PHO/WHO Sept 2003

[59] This analysis does not go much further into the questions of internal knowledge production, consultancy and so on. While this is clearly a limitation of the study, the categories of mandates, ideas, and communication have importantly not included the dimension of knowledge *production*. There is more on this issue for example in LEE, K. & GOODMAN, H. 2002. Global policy networks: the propagation of health care financing reform since the 1980s. *In:* LEE, K., BUSE, K. & FUSTUKIAN, S. (eds.) *Health Policy in a Globalising World.* Cambridge: Cambridge University Press.; and in the intellectual history of the UN project by EMMERJI, L., JOLLY, R. & WEISS, T. G. 2005. Economic and Social Thinking at the UN in Historical Perspective. *Development and Change,* 36, 211-235.

[60] See http://www.who.int/csr/ihr/en/, accessed 29 December 2010

[61] See http://www.who.int/tobacco/framework/en/, accessed 29 December 2010

[62] See http://www.who.int/dg/speeches/2007/eb120_opening/en/index.html, accessed 29 December 2010

Other publications, namely *research documents* (c) are for example the edited volume by Murray and Evans (2003a) which develops further concepts presented in the WHR2000. WHO staff, together with allied academics, have further published in the WHO Bulletin (e.g. Murray and Frenk, 2000) and other health journals (e.g. Murray and Frenk, 2001). Also, the Making Health Systems Work Series[63] includes contributions on health systems, and related commissions of the WHO, namely the Commission of Macroeconomics and Health (CMH) (for example Hensher, 2001) and the Commission on the Social Determinants of Health (CSDH) (see Gilson et al., 2007) have been producing important background documents as well as more advocacy-like final reports, building on the knowledge produced by various task forces.

All of these documents can transport important messages from the side of the WHO to both other international organisations and national policy makers concerned about health policy and engaged in health policy reform. Norms, analytical concepts and frameworks and more concrete recommendations about how to approach a problem or the desirable direction of reforms can be part of these kinds of communication means and support policy learning from the side of member states, and spread of global models among international organisations and other actors. It has to be taken into account, however, by also looking at other international organisations, that many of these documents are not supposed to represent the "official" view of the organisation (as frequently pointed out in the publications' disclaimers).

Such publications are also used as preparatory or teaching material for ***conferences and workshops*** that serve as platforms to facilitate mutual learning and support partnerships among transnational health policy actors. Staff from international organisations are involved in organising such events and in teaching on health systems. However, due to limited resources, the WHO currently does not appear to be able to facilitate related courses, and

[63] See http://www.who.int/management/mhswork en/index.html, accessed 29 December 2010

most of the activities to assess health systems[64] have been limited. A recent note on health policy and systems research is in fact calling for designing courses anew (Alliance for Health Policy and Systems Research, 2007)[65].

International organisations also have direct, more or less coercive or powerful ways of ***interacting with single member states***. As the WHO is a nearly universal organisation in terms of membership, these relationships vary according to the different member state's needs. The WHO, therefore, has different functions and partly different communication channels. Part of that variation is, in fact, realised through the decentralised structure of the WHO, and thus, through the work of the regional organisations. However, the focus here is on the headquarters only. At a regional level, and for high-income countries, the organisation rather provides for places to meet and discuss health system constraints (Kaasch, 2006). For low-income countries there are the so-called 'Country Cooperation Strategies' (CCSs)[66]. Country's health systems are supposed to be strengthened through these CCSs that have been developed with a number of member states since 1999. They serve as a means "for WHO alignment with national health and development plans and strategies" (WHO, 2006a:19), or "a framework for WHO cooperation in and with the country concerned, highlighting what WHO will do, how it will do it and with whom" (WHO, 2005b:8). In contrast to comparable strategies like the Poverty Reduction Strategy Papers (PRSP), the CCSs seem not to be taken into consideration in the global health literature.

The WHO is also engaged in the collection and reporting of ***health data***, an activity that represents a communication channel in the sense that the way indicators are defined and the way data is collected, analysed and represented may frame others' understanding of what health systems are and

[64] See http://www.who.int/health-systems-performance/ehspi.htm, accessed 29 December 2010

[65] See http://www.who.int/alliance-hpsr/resources/AllBriefNote1_5.pdf, accessed 29 December 2010

[66] For more information on the CCSs see: http://www.who.int/countryfocus/cooperation_strategy/en/, accessed 29 December 2010

should be like. However, as has been explained in earlier chapters, the WHO's attempt to fulfil such a role for health systems has not been particularly successful. The organisation is now, for example, undertaking some of that work in collaboration with the OECD (Joint OECD-WHO-Eurostat Health Accounts Data Collection). In a more general approach, however, there is WHOSIS (WHO Statistical Information System)[67] that presents the most recent and comprehensive health data on all of the 193 WHO Member States; including indicators on health service coverage, health system inputs, and differentials in health outcome and coverage; and are published annually (World Health Statistics). Further, the National Health Accounts (NHA)[68] monitor trends in health spending (public and private, different health care activities, providers, diseases, population groups and regions in a country) in order to support the development of national strategies for effective health financing.

The WHO raises awareness of its activities and provides access to its various forms of publications on its ***website***[69]. Particularly on health systems[70], there are plenty of well-organised links and information on health systems in general, their functions, data, and related issues and organisations.

Campaigning for particular ideas is also a part of the WHO's activities. The PHC model could be regarded as one such campaigning issue, but also the health MDGs. At the same time, depending on the global political climate, it could be health workers, climate change and health or similar issues that are treated in a campaigning sense, and not only as a topic area that the WHO produces or initiates specialist knowledge on, but also related to its mandate as a norm-setting institution.

International organisations also raise their profile, spread ideas, and gain a broader base in research activity through collaborating with and/or

---

[67] See http://www.who.int/whosis/en/index.html, accessed 29 December 2010
[68] See http://www.who.int/nha/en/, accessed 29 December 2010
[69] www.who.int, accessed 29 December 2010
[70] See http://www.who.int/topics/health_systems/en/, accessed 29 December 2010

consulting academic researchers. The WHO works for example together with the World Bank and the OECD on data and with the ILO and GTZ on social health insurance. Lee and Goodman (2002) discuss this in relation to the ***networks*** around the WHO and the World Bank.

Table 6.1 gives an overview of the WHO's communication channels.

Concluding, at the WHO headquarters, there is certainly a strong commitment to the responsibility of providing direction for national health systems, and the organisation also uses different means to communicate information and thus advise member states on their health policy. Concerning health systems, however, there does not appear to be a particularly successful or powerful approach.

While in the 1970s, following the Alma-Ata conference, the PHC concept might have provided for a comprehensive framework that was normatively rich enough to give some spirit to that task, recent documents and declarations of intent are driven by the constant reassertion that health systems *are* an important issue; that it *is* the role of the WHO to provide for policy models for health systems; that it *does* have comparative advantages to fulfil that role; and what the aims and principles guiding such a role and work *should* be. However, it does not seem to get much further than that. The comparative view, later in this chapter, however, will show that the pure task of advising national health systems is a difficult one and that it is not just the WHO that is struggling to fulfil such a role.

On the side of the horizontal ideational or conceptual influence of the WHO, the role of providing background knowledge for other international organisations to work does not go beyond quoting the basic definition. I have argued that the ideas promoted by different global actors (international organisations) are not substantially different, but there is no significant sign that this is due to the WHO being able set the tone. The WHO's problem, besides the complexity of the issue, is certainly that it is trying to tackle the

Table 6.1: Communication Channels (WHO)

international conferences		Alma-Ata Conference (1978) + follow-up WHAs
publications	Strategy papers	WHA (1973) Organisational Study on Methods of Promoting the Development of Basic Health Services. WHA26.35., WHO (2005b) WHO Country Cooperation Strategy. A guiding framework., WHO (2006a) Country Support Unit Network 2005. Partnerships for health., WHO (2006b) Engaging for Health. 11th General Programme of Work, 2006-2015. A Global Health Agenda., WHO (2006c) Engaging for Health. Eleventh General Programme of Work 2006-2015. A Global Health Agenda., WHO (2007) Everybody's Business. Strengthening Health Systems to Improve Health Outcomes. WHO's Framework for Action.
	Advocacy reports	WHO (1981) National decision-making for Primary Health Care. A study by the UNICEF/WHO Joint Committee on Health Policy., WHO (1998) Health for all in the 21st century. A51/5., WHO (1999) The World Health Report 1999. Making a Difference., WHO (2000) The World Health Report 2000: Health Systems: Improving Performance., WHO (2005a) Health and the Millennium Development Goals., WHO CSDH (2007a) Achieving Health Equity: from root causes to fair outcomes. *Interim Statement.*, WHO CMH (2001) Macroeconomics and Health: Investing in Health For Economic Development. Report of the CMH., WHO CSDH (2007b) Challenging Inequity Through Health Systems. *Final Report Knowledge Network on Health Systems.*, WHO CSDH (2008) Closing the Gap in a Generation. Health Equity Through Action on the Social Determinants of Health. Final Report of the CMC, WHO/UNICEF (1978b) Primary Health Care. Report of the International Conference of PHC. Alma-Ata, USSR, 6-12 September 1978
	Research publications	MURRAY, C. J. L. & EVANS, D. B. (Eds.) (2003a) *Health Systems Performance Assessment: Debates, Methods and Empiricism.*, MURRAY, C. J. L. & FRENK, J. (2000) A framework for assessing the performance of health systems. *Bulletin of the World Health Organization,* 78, MURRAY, C. J. L. & FRENK, J. (2001) World Health Report 2000: a step towards evidence-based health policy. *The Lancet,* 357, 1698-1700, WHO-CSDH (2005) Action on the Social Determinants of Health: Learning from Previous Experiences. A Background Paper prepared for CSDH., Making Health Systems Work Series
workshops		(currently not; lack of funding)
direct involvement		Country Cooperation Strategies, Single country health system assessments
Data		WHOSIS/ World Health Statistics, National Health Accounts (NHA)
websites etc.		www.who.int, www.who.int/topics/health_systems/en/
campaigns		PHC, MDGs
networks		With World Bank and OECD on data. With ILO and GTZ in Consortium on Social Health Insurance

entire issue while actually not having the capacity to do that, in terms of staff, financial resources and so on.[71]

Concerning the vertical influence, the WHO's activities on the matter mostly occur through both diffuse forms like the facilitation of policy learning, and in more directed forms like research and publications on particular countries or problems – mostly on the demand of the member states. As has been argued earlier, the attempt to introduce a common evaluation framework accompanied by a regular ranking has not proven to be successful, in the sense of being accepted in its consequence by a number of member states, and has been criticised in the literature (e.g. Häkkinen and Ollila, 2000).

6.2 Research and Conditional Loans from the World Bank

The World Bank has been characterised as having developed a health responsibility derived from its general mandate. The last chapter showed the considerable research and knowledge production on health systems conducted within the World Bank. This knowledge serves several purposes when it concerns the more concrete role in providing policy models and is communicated in different ways. It informs the World Bank's other, namely lending activities, and it is also supposed to increase knowledge about health issues in a more general sense.

Unlike the WHO and the ILO, the World Bank does not convene norm-setting ***international conferences***, although it might, on occasion, be involved in financially supporting such conferences and participating in

[71] It has to be taken into account – given this argument – that the less academic the respective documents are the higher the risk that no proper quoting and reference practices are in place. Interviews suggest that health experts at the different institutions are well aware of what the others are doing and the mutual influences are certainly higher than such quoting habits suggest. A useful contribution to that question is again the network analysis reported in LEE, K. & GOODMAN, H. 2002. Global policy networks: the propagation of health care financing reform since the 1980s. *In:* LEE, K., BUSE, K. & FUSTUKIAN, S. (eds.) *Health Policy in a Globalising World.* Cambridge: Cambridge University Press.

them. The World Bank does, however, have a strong position concerning the continuous production and release of all kinds of ***publications***. The World Bank has from time to time formulated its health *strategy* in health sector strategy papers (for example World Bank, 1997, 2007). Given the critical observation by various academics, civil society representatives and others, the Bank's plans are keenly observed.[72] An important *advocacy instrument* for the World Bank's work in general is the annual World Development Report[73]. Several issues of this report (particularly World Bank, 2003, World Bank, 1993) also contained ideas about health systems and drew a picture of desirable health policy.

Besides that, the World Bank publishes a substantial number of *research documents* providing background, knowledge, models, examples (case studies), guidelines and best practices on various health and other topics. This includes many different books (e.g. Preker et al., 2007) and working papers discussing health system issues.[74] As argued for the WHO, these publications do not all represent official positions of the World Bank and also reflect ongoing research and debates about policy issues.

The World Bank also produces material for its ***courses*** organised by the World Bank Institute (WBI) (e.g. Roberts et al., 2008). The WBI regularly runs courses for policy makers, staff from other international organisations, NGOs, training institutions and academics to help them understand and frame health policy related issues and reform. Most of this material concerns HIV/AIDS, however discussing broad issues and the attainment of the MDGs or establishing and developing the PSRPs are also considered. The courses include consideration of the health system in a broader sense. However, one of the World Bank's flagship courses is specifically on health systems. This is repeated annually and further courses are adjusted to

[72] One of my interviewees confirmed that it was really a message to the outside much more than a strategy guiding the actual work at the headquarters.
[73] See http://econ.worldbank.org/wdr/, accessed 29 December 2010
[74] See for example http://go.worldbank.org/7ITY0W5Z00, accessed 29 December 2010

national or regional contexts as relevant.[75] The objectives of these courses are to provide participants with analytical and practical frameworks and tools to address health related problems, including those related to the organisation of health systems (especially financing issues for the flagship course; but also other functions of health systems). Parts of these are discussed within the context of more specific health aspects like the health component of PRSPs or the health related MDGs and particular health policy fields.

What is actually being taught in the courses – at least judging from the course material and reading that can be obtained through the WBI websites – follows many of the ideas described in chapter 6. Roberts et al. (2008), for example, write[76]:

> *In general we observed that to truly provide risk protection, a universal system based on ability to pay is required. It is no surprise, then, that middle- and upper-income countries mostly rely on social insurance or general revenue to finance their health-care systems. As countries move up the development scale, social insurance is often especially attractive because the social contract implicit in such a system often improves tax compliance. [...]*
>
> *In poor countries, household surveys reveal that even poor people pay substantial amounts out-of-pocket for care – either for private providers or for fees, drugs, and "gratuities" in the public sector. To more effectively utilize these funds we believe community financing and other forms of decentralization have much to offer. We also believe, however, that only improved management in the public sector and improved quality of care will lead citizens to be willing to make financial commitments to a system that provides at least some measure of risk protection. [...]*

---

[75] See for example Health Outcomes and the Poor http://go.worldbank.org/RA6M9NCD00; Accelerating Progress Towards the Health Millennium Goals and other Health Outcomes http://go.worldbank.org/UJSUS4W6O0; Achieving the MDGs: Poverty Reduction, Reproductive Health and Health Sector Reform http://go.worldbank.org/C9Y4LID3H0; Flagship Course on Health Sector Reform and Sustainable Financing for China http://go.worldbank.org/8M44NLFGV0 (all accessed 29 December 2010)

[76] I quote here in some length in order to show several points already made in the previous chapter, i.e. it is about *social* models, decentralised financing systems are regarded as a tool to enhance coverage (but not necessarily the final system to reach), private health insurance is not promoted and it is not the US system that serves as any type of good example.

Finally, we view with some trepidation the growth of private insurance in upper-middle-income nations. Such systems have very high transaction costs, require sophisticated regulation, and offer only limited risk-sharing – especially where they allow individuals to withdraw from social insurance pools. We realize that many countries are under pressure from their own elites to allow the creation of such schemes, which give the rich access to better care than the public system can offer. We also understand that the temptation of mobilizing the willingness to pay of upper-income individuals to raise additional funding for the health-care system is very great. For nations that follow a private insurance route, instead of an opting-out model, as in Chile, reformers might want to consider an Australian-style approach where such insurance is in addition to, not a substitute for- public coverage. [...]

[...] Improving access to the extraordinary advances of modern medical science could make an enormous difference to the lives of millions, if not billions of our fellow human beings. We hope that the fact that we come from an industrial country in the world that does a particularly poor job in this regard does not undermine our credibility on this point – for we are hardly defenders of the American system, in part because of its poor equity performance.

(Roberts et al., 2008:315ff)

The WHR2000 is an important component of the teaching material, several chapters are used as reading materials and it is frequently quoted concerning basic definitions.[77] An important objective of the courses is, however, how to analyse and understand the problem and look for solutions, rather than a particularly narrow policy idea or communicating concrete recommendations (Roberts et al., 2008). It is about analytical and practical tools, on the one hand; and on the other hand, the element of exchange between participants is an important component of the courses.

The ***direct involvement with member states*** is a particularly critical issue in the World Bank work. The core of the World Bank's work directed to

---

[77] For example e.g. Pathways to Improved Reproductive Health http://info.worldbank.org/etools/docs/library/122031/bangkokCD/BangkokMarch05/Week1/1Monday/S3Pathways/Week1MondaySession3.pdf; Health Systems http://info.worldbank.org/etools/docs/library/122031/bangkokCD/BangkokMarch05/Week1/2Tuesday/S2HealthSystem/Week1TuesdaySession2.pdf (accessed 29 December 2010)

countries is giving different kinds of loans to countries that come along with conditionalities. The World Bank has been heavily criticised for the use, and alarming effects, of these conditionalities. This has occurred on the one hand from the side of civil society (for example of tribunals on the World Bank[78]) and in academic literature (for example Wogart, 2003, Koivusalo and Ollila, 1997, and for the case of Uganda Macrae et al., 1996). For the transition countries of Central and Eastern Europe, Radin (2003:34)[79] interestingly argues that

> *[a]lthough the World Bank has been more aggressive in its participation of other social reforms such as the pension system in Poland, it has been comparatively shy in its assistance to the healthcare sector". [...] the first reason [...] lack of knowledge or internal conflict within the organization [...] IBRD chose not to get involved where success was not foreseeable.*

Later, it is argued that this hesitation in proposing clearly distinguishable models for health systems (in contrast to pension models) is a typical feature of the global social policy field of health systems. At the same time, however, interventions in other fields, most importantly the general recommendation to cut public expenditures (including those in health) has in the past restricted the scope for the expansion of comprehensive health systems (McCoy, 2007, Koivusalo and Ollila, 1997, Wogart, 2003, see also for example World Bank, 2008).

Another part of the World Bank's health activities is compiling data. HNPStats[80] provides for ***data*** on health, nutrition and population, including data on health financing and on the health MDGs, but not on health systems in a broader sense. These data are country- or subject-specific. Single

---

[78] See http://www.worldbanktribunal.org/ (accessed 29 December 2010)

[79] Referring to NELSON, J. M. 2001. The Politics of Pension and Health-Care Reforms in Hungary and Poland. *In:* KORNAI, J., HAGGARD, S. & KAUFMAN, R. R. (eds.) *Reforming the State: Fiscal and Welfare Reform in Post-Socialist Countries.* Cambrige, UK: Cambridge University Press.

[80] See http://go.worldbank.org/N2N84RDV00 (accessed 29 December 2010)

countries are also assessed regarding their health policy, for example in the 'Reaching the Poor Policy Brief' series.[81]

The World Bank runs a very extensive ***website***, providing a great deal of information and links on its activities. This is an effective tool to communicate ideas and knowledge. There is a specific website on health, nutrition and population, including health systems and other health issues. The page is well organised and up-to-data. Most of the documents are downloadable without charge; some others can be purchased via the bookshop[82].

The World Bank is not particularly active in ***campaigning*** on particular issues in relation to health systems, however, as with many other international organisations, it supports and works towards achieving the MDGs and other international targets. However (particularly compared to the ILO that explicitly uses campaigns as a means of communication), it is more a bank and research organisation than an advocacy organisation and its positions (whether supported or not by others) emerge through research activity, political guidance, projects and conditional loans.

Another point about the World Bank's communication channels is that of organised ***networking***. It has been discussed to what extent the World Bank uses the Global Development Network (GDN) in order to communicate ideas and strengthen its position as a "knowledge bank" (Stone, 2003, see also St Clair, 2006b).

Table 6.2 summarises the World Bank's communication channels.

---

[81] See http://go.worldbank.org/PUJ2E7T1Z0, accessed 30 December 2010
[82] See http://publications.worldbank.org/ecommerce/, accessed 30 December 2010

Table 6.2: Communication Channels (World Bank)

international conferences		[no]
Publications	Strategy papers	WORLD BANK (1980a) Health Sector Policy Paper. WORLD BANK (1997) Health, Nutrition, and Population Sector Strategy Paper., WORLD BANK (2007) Healthy Development. The World Bank Strategy for Health, Nutrition, and Population Results.
	Advocacy reports	GOTTRET, P. & SCHIEBER, G. (2006) Health Financing Revisited. A Practioner's Guide. WORLD BANK (1980b) World Development Report 1980. WORLD BANK (1993) World Development Report 1993: Investing in Health. WORLD BANK (1994) Averting the Old Age Crisis - Policies to Protect and Promote Growth. WORLD BANK (2003) World Development Report 2004: Making Services Work for Poor People.
	Research publications	GWATKIN, D. R., et al. (Eds.) (2005) *Reaching the Poor with Health, Nutrition and Population Services. What Works, What Doesn't, and Why.* PREKER, A. S., SCHEFFLER, R. M. & BASSETT, M. S. (Eds.) (2007) *Private Voluntary Health Insurance in Development. Friend or Foe?* WORLD BANK (1987) Financing Health Services in Developing Countries. An Agenda for Reform. *A World Bank Policy Study.* YAZBECK, A. S. (2002) An Idiot's Guide to Prioritization in the Health Sector. *HNP Discussion Paper.*, YAZBECK, A. S. (2006) Economic Viewpoint: Reaching the Poor
Workshops		Flagship courses on health systems - Teaching material: e.g. ROBERTS, M. J., et al. (2008) *Getting Health Reform Right. A Guide to Improving Performance and Equity* Health Outcomes and the Poor; Accelerating Progress Towards the Health Millennium Goals and other Health Outcomes Achieving the MDGs: Poverty Reduction, Reproductive Health and Health Sector Reform
direct involvement		WORLD BANK(2008) Better Outcomes Through Health Reforms in the Russian Federation:The Challenge in 2008 and Beyond. Europe and Central Asia
Data		HNPStats
websites etc.		www.worldbank.org, www.worldbank.org/hnp
Campaigns		[MDGs]
Networks		Occasional collaboration with WHO, ILO, OECD, and others. Global Development Network

Before turning to the other organisations, again, a word needs to be said about the IFC. Despite its still quite limited scope of actual activity, and equally limited coordination with other World Bank activities, it features a "perfect" internet appearance, and its "voice" seems to be louder than its role and the scope of its health activities suggest. The IFC also organised an International Health Conference Private Health Care in Emerging Markets – Evolution or Revolution? on 18-20 April 2007, bringing together investors, specialists and financiers to explore the future of private health care and discuss business opportunities.[83]

Overall, the World Bank employs a whole range of communication mechanisms in very considered ways. Due to intensive research activity, World Bank staff constantly publish on health system issues in various forms and, thus, contribute significantly to health system research and knowledge, supporting the World Bank's well-run website with various facilities that communicate information, as well as WBI courses. At the same time, the World Bank is in a strong position to attach conditionalities to its loans; and by that way is included in national reform and project decisions – this has, however, not been the focus of this study.

However, the World Bank is also associated by many of its observers with specific sets of policy recommendations. This means that it is often judged and looked at through "neoliberal glasses", in the sense of the expectation that any idea uttered by the World Bank is neoliberal. This shapes the World Bank's potential to communicate particular ideas (that might not be in line with the alleged stereotype) in two ways. On the one hand, the World Bank's critical environment is sometimes somewhat resistant to acknowledging change in ideas. On the other hand, national policy makers might have a stereotypical idea about what the World Bank wants to hear when applying for loans. Both forms limit the actual ability of the Bank to

[83]See http://www.ifc.org/ifcext/che.nsf/Content/2007InternationalConference, accessed 30 December 2010

communicate (other than common neoliberal) ideas and cost, to some extent, credibility or trust in the institution that might not always be justified.

At the same time, the IFC is increasing its activities and most consciously spreads ideas that do not seem quite in line with the mainstream of current World Bank (IDA, IBRD) thinking. This gives another reason for concern to the critical outside observers of the World Bank's activities.

It is, however, also important to consider that World Bank staff working in different units, or on more or less theoretical issues, sometimes have different ideas and not all of them are communicated in the same way. This means that who are closely involved in on-the-ground activities might be more driven by standard neoliberal thinking than those involved with research on health systems.

Accordingly, while the World Bank is able to use a whole range of communication channels, this does not automatically mean that the message of the World Bank's output as analysed in this thesis, are ideas taken up by the outside.

6.3 Early International Health Law and Campaigns from the ILO

The previous chapters have characterised the ILO as an international organisation that is concerned with the promotion of social justice, and that has long been engaged in some activities of policy models to its member states, while hardly ever being seriously considered as an important global health actor. Due to some constitutionally assigned functions, the ILO's communication channels also comprise a range of activities and strategies that also apply to its health work.

Conferences include, first and foremost, the regular International Labour Conferences (ILC). Through the ILC, the ILO pursues its so-called

"standard-setting function" by adopting International Labour Conventions and Recommendations (Johnston, 1970:88). This implies that the ILO is the only organisation having fostered some legal means that – if implemented – do shape health policy in the sense studied in this thesis. However, ILO member states are not obliged to ratify the conventions and thus are not forced to give up sovereignty. If they ratify, member states are permanently and systematically watched by the ILO regarding their compliance (Senti, 2002).

Fulfilling its second function ("research and information function"), the International Labour Office was "charged with the duty of collecting and distributing information on all subjects relating to the international adjustment of conditions of industrial life and labour" (Johnston, 1970:88). However, the number and volume of ***publications*** produced in the field of health is limited. Further, as they are often part of ILO ***campaigns***, many publications appear as *advocacy reports*, like the World Labour Report 2000 (International Labour Office, 2000) or the recent working papers on the social security floor and health (ILO Social Security Department, 2007, 2008) as part of the Global Campaign on Social Security and Coverage for All. Those of a more research-like character are most often written in collaboration with other international organisations like the World Bank (Dror and Preker, 2002) or the International Social Security Association (ISSA) (ILO and ISSA, 1997).

Engaged in communicating information by the means of ***workshops***, there is further the International Institute for Labour Studies in Geneva[84] and the International Training Centre in Turin[85]. The former is intended to complement the research of the International Labour Office, looking at the long-term trends within society (than the actual applications through current action programmes) and resembling a university. In contrast, the latter was created as an extension of the ILO's field projects, providing for advanced technical and vocational training at various levels (Johnston, 1970:71f). The

[84] http://www.ilo.org/public/english/bureau/inst/, accessed 30 December 2010
[85] http://www.itcilo.org, accessed 30 December 2010

Social Security Department also contributes to the training of social security managers, for example through Masters programmes and training by the Universities of Maastricht and Lausanne.

The ILO also provides platforms for ideas exchange, for example through CIARIS, an electronic platform. Further, in its sessions in 2000 and 2001, the Governing Body of the ILO decided that – as part of the Sectoral Activities Programme – a 'Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness' would be established to "exchange views on new structures and approaches in health services and how they affect the capacity and effectiveness of the social partners in social dialogue"[86]. Until 1992, several meetings were held in Geneva.

In 1946, through a revision of the ILO Constitution, the organisation took on another function, namely that of providing for country-specific assistance in connection with relevant laws and regulations ("technical assistance or operational function") (Johnston, 1970:88). This means that through more ***direct relationships*** to member states, the ILO supports countries by providing a technical advisory service to governments concerning the "design and implementation of national social security legislation in conformity with international labour standards", and through its STEP programme it "has a powerful vehicle for extending social protection coverage"[87].

Concerning ***data***, with the ILO Social Security Inquiry, the organisation intends to provide social security statistics at international standard in order to "assist countries in improving their quantitative knowledge base on social security."[88] The data collected and provided include "statistical information on social security, including employment-related social security schemes,

---

[86] See http://www.oit.org/public/english/dialogue/sector/techmeet/jmhs02/index.htm, accessed 30 December 2010

[87] See http://natlex.ilo.ch/public/english/protection/secsoc/areas/index.htm, accessed 30 December 2010

[88] See http://www.ilo.org/public/english/protection/secsoc/areas/stat/ssi.htm, accessed 30 December 2010

Table 6.3: Communication Channels (ILO)

international conferences		International Labour Conference (ILC)
Publications	Strategy papers	[ILO (2005) Programme and Budget for the Biennium 2006-07.] ILO SOC SEC DEP (2007) Social Health Protection. ILO strategy towards universal access to health care. *Issues in Social Protection Discussion Paper* [I LO (2005) Governing Body. Committee on Employment and Social Policy. *GB.294/ESP/4, 294th Session.*]
	Advocacy reports	INTERNATIONAL LABOUR OFFICE (2000) World Labour Report 2000: Income Security and social protection in a changing world. INTERNATIONAL LABOUR OFFICE (2001) Social Security: A new consensus. WORLD COMMISSION ON THE SOCIAL DIMENSION OF GLOBALIZATION (2004) A Fair Globalization: Creating Opportunities for All
	Research publications	ILO & ISSA (1997) Social Health Insurance. ILO SOC SEC DEP (2008) Can low-income countries afford basic social security? *Social Security Policy Briefings Paper 3.* ILO STEP (2005) Health Micro-Insurance Schemes: Feasibility Study Guide. Vol. 1: Procedure.
workshops		Through the *International Institute for Labour Studies* and the *International Training Center*
direct involvement		STEP programme
Data		ILO Social Security Inquiry
websites etc.		www.ilo.org, http://www.ilo.org/public/english/protection CIARIS
campaigns		Global Campaign on Social Security and Coverage for All
networks		Collaboration on publications with World Bank and ISSA, on teaching with Universities of Maastricht and Lausanne Consortium with WHO and GTZ

public health, welfare and anti-poverty programmes and non-public schemes of different types transferring goods, services or cash to poor and vulnerable households"[89]. The purpose of the Inquiry is to promote common statistical standards and assist countries in building their capacity in supervising social security schemes. This includes the collection of social security statistics, provision of training and building up of an ILO Social Security Database. The further extension of this database has also been listed as one of the activities to be pursued by the ILO in its 2006-07 Programme and Budget (ILO, 2005:69).

In remarkable contrast to the other international organisations' websites, the ILO ***website*** and connected web facilities are rather difficult to use. As has been discussed in chapter 3 this might have a serious effect on the organisation's visibility and success in communicating ideas.

One strategy of the ILO in strengthening its position is "[p]olicy advocacy and national and international partnerships with international organizations, international and regional banks, development agencies, and stakeholders, such as employees' and employers' organizations".[90] This has, for example, included encouraging "Show and Tell seminars" between different international organisations (Deacon, 2007:67f, see also O'Brien, 2008:132).

Table 6.3 provides an overview of the ILO's use of different communication channels.

In summary, while much of the ILO activities on health are very limited due to few staff working on the issue, it is the global "health" organisation with perhaps the most expertise of social security systems, including health, which is able to facilitate international law in the field of health systems.

[89] See http://www.ilo.org/public/english/protection/secsoc/areas/stat/ssi.htm, accessed 30 December 2010

[90] See http://www.ilo.org/public/english/protection/secsoc/areas/policy/activity.htm, accessed 30 December 2010

Poor operation of its website further constrains the communication of ideas and the visibility of work undertaken.

6.4 OECD: Comparative analyses and data

It has been shown earlier that, more recently, within the last years the OECD has increasingly been engaged in health issues, adding to its previous work on health data, and that it is developing into a more important transnational health actor, at least for its member countries, if not beyond (Deacon and Kaasch, 2008).

The OECD hosted a number of conferences on health issues, including a conference in Canada in November 2001 discussing health system performance with health care policy makers, managers, practitioners and experts as participants.[91] More importantly, in concluding its 'Health Project', the OECD organised a ***conference*** of OECD Health Ministers[92], presenting the results of its work, providing for a platform to discuss health issues and being given the mandate to conduct further work on a number of specified health issues. This event, thus, had multiple functions in terms of providing information from the perspective of the OECD, it was a platform for discussion among policy makers, and also served the purpose of renewing the organisation's mandate on health system issues.

Within the Health Project and related activities, a comprehensive report was published (OECD, 2004b) and a number of other ***publications*** have been released that also tackle health systems (e.g. OECD, 2004a, Docteur and Oxley, 2003, Or, 2002).

While some of the publications also explain something about the OECD's activities in health, they can best be classified as research publications. In addition, and also regarding the ***interaction with single member states***, the

[91] See http://www.oecd.org/els/health, accessed 29 December 2010
[92] See http://www.oecd.org/site/0,3407,en_21571361_30968861_1_1_1_1_1,00.html, accessed 29 December 2010

OECD has started a series of health system assessments on request (for example on Switzerland, OECD and WHO, 2006). More readily taken up by policy makers and the public are the OECD's Economic Surveys of countries. These, however, increasingly also include social and health issues and the collaboration between the OECD's departments is growing. Thus qualified recommendations on health systems can be expected to also be transported through the release of such reports (see Deacon and Kaasch, 2008).

On health, the OECD has been most known for its ***data***; providing a reliable and trustworthy source of information for other international organisations, national policy makers, academics and others. Datasets include those produced for the Health Quality Indicators Project, the System of National Health Accounts and the OECD Health Data.

Part of the OECD's communication channel is, further, to strongly seek to make links with academia, such as the Brookings Institutions. The organisation is engaged in joining and building ***epistemic communities*** to make its ideas travel (Deacon and Kaasch, 2008).[93]

The OECD's communication channels are summarised in table 6.4.

In summary, the OECD's health work is characterised by even-handed, high-quality indicators and analytical publications. Also, some exchange between national policy makers has taken place through the OECD. Initial country assessments of health systems have been released, but all such work has been very careful not to become a "naming and shaming" exercise, as has been characteristic for other policy fields like education. However, as the OECD health work is still evolving, it is difficult to forecast its future role (for related discussions see Mahon and McBride, 2008, Martens and Jakobi, forthcoming).

---

[93] According to one of our interviewees at the OECD.

Table 6.4: Communication Channels (OECD)

international conferences		OECD/Canada conference "Measuring Up: Improving health system performance in OECD countries" (2001), OECD Health Ministers conference (2004)
publications	Strategy papers	[no]
	Advocacy reports	[no]
	Research publications	DOCTEUR, E. & OXLEY, H (2003) Health-Care Systems. *Economics Department Working Papers No. 374. ECO/WKP(2003)28.* OECD (1977) Public Expenditure on Health. *OECD Studies in Resource Allocation No 4.* OECD (1987) Financing and Delivering Health Services. A Comparative Analysis of OECD Countries. *OECD Social Policy Studies No. 4.* OECD (1992) The Reform of Health Care. A Comparative Analysis of Seven OECD Countries. *Health Policy Studies No.2.* OECD (1993a) OECD Health Systems. Volume I: Facts and Trends 1960-1991. OECD (1993b) Volume II: OECD Health Systems. The Socio-Economic Environment. Statistical References. OECD (1994) The Reform Of Health Care Systems. A Review Of Seventeen OECD Countries. OECD (1995) New Directions in Health Policy. *Health Policy Studies No 7.* OECD (1996) Health Care Reform. The Will to Change. *Health Policy Studies No 8.* OECD (2004a) The OECD Health Project. Private Health Insurance in OECD Countries. Paris, OECD.; OECD (2004b) The OECD Health Project. Towards High-Performing Health Systems. Paris, OECD OR, Z. (2002) Improving the performance of health care systems: *Labour Market and Social Policy - Occasional Papers No.57. DEELSA/ELSA/WD(2002)1*
workshops		[no]
direct involvement		Series of health system assessments, Economic Surveys
Data		Health Quality Indicators Project, System of Health Accounts, OECD Health Data
websites etc.		www.oecd.org, www.oecd.org/health
campaigns		[no]
networks		Collaboration with WHO on countries' health system reports, Links with academia (e.g. Brookings institutions)

Before considering other organisations, one further remark is necessary at this point. What has been described so far applies first and foremost to the OECD member states, which is a fairly small group of high-income countries. However, it was argued earlier that the OECD also carries out outreach work to non-member states. Importantly, this work does not appear to be as even-handed and careful as for member states, although, a much more detailed analysis would be needed to understand the OECD's role in this respect. What is, however, interesting is that the MDGs, including those on health, originated from the OECD's DAC and thus, to some extent, have been shaped by ideas developed there (Deacon and Kaasch, 2008).[94]

6.5 Collaboration and other activities

The global health actors described above, together and with yet others, also collaborate on a number of occasions using different means of communication. Generally, such collaboration can serve different goals and needs. It is an opportunity for pooling otherwise scarce resources for the theoretical (and practical) engagement with health systems. It creates platforms for getting to know each others work, or it increases the voice for a particular activity or set of ideas due to increased publicity. The following activities and publications are just a small number of examples to illustrate collaborative activities – this is by no means exhaustive, but networks have not been an important analytical focus of this thesis.

In terms of ***international conferences***, the 'Alma-Ata Conference' was co-convened by the WHO and UNICEF, accompanied by the joint declaration (WHO/UNICEF, 1978a) and conference report (WHO/UNICEF, 1978b) and later another related publication (WHO, 1981). The same applies to follow-up conferences on primary health care (see above). Also, other

[94] This would be an issue worthy of further study which cannot be undertaken within this thesis.

events more specifically focusing on the health MDGs have been organised jointly by different international organisations, for example, the WHO and the World Bank have convened meetings of the High-level Forum of the Health MDGs (Geneva, January 2004 and Abuja, December 2004). These meetings brought together ministries of health and finance, and bilateral and multilateral development partners, with the aim of developing consensus on what is needed to achieve the health-related goals, and reporting to the UN Secretary-General. These are both opportunities to increase the voice for particular ideas and to direct the work focus.

There are further a number of ***publications*** jointly written and/or edited by health specialists from different international organisations. From the WHO and the World Bank, there is, for example, Dying for Change (World Bank and WHO, 2002). Even though projects often do not appear to be coordinated between the two World Bank Group members, the World Bank and the IFC are collaborating on publications (e.g. Preker et al., 2007). The World Bank and the ILO have been publishing together on community health financing (Dror and Preker, 2002). The WHO and the OECD have published a joint country study on the Swiss health system (OECD and WHO, 2006). Such publications can be used to increase knowledge, to discuss perspectives, and also to collate funding for research projects.

Similarly, regarding ***workshops or courses***, there are collaborative relationships or at least references in the way that the other organisations' work is part of the curriculum (see above). For example, as early as 1984, the World Bank's Institute of Economic Development (IED), together with the WHO, organised a "Seminar on Primary Health Care Strategies"[95]. Also, WHO staff have taught on the World Bank's flagship course on health systems.

The WHO and ILO with the GTZ joined in 2004 in a consortium to promote social health insurance. These organisations together have organised conferences on the topic, and have engaged in developing a conceptual

[95] See http://www.popline.org/docs/1438/041170.html, accessed 29 December 2010

framework, hosting a joint web site. There has also been long collaboration by the World Bank and the WHO, an early example being a joint seminar in Washington D.C. on Primary Health Care Strategies.[96] Such initiatives particularly increase attention towards a particular policy model. These kinds of collaborations could also be important points of coordination, given the problem of various donors and other actors intervening in low- and middle-income countries in a rather independent way, leaving behind fragmented systems.

There is also collaboration on ***data projects***, for example between the WHO and the OECD (in the form of joint data collection, and the OECD provided data for the WHRs). Also, the World Bank and the WHO together with the US Agency for International Development, have published a Guide to Producing National Health Accounts (World Bank et al., 2003). This is a way of increasing the knowledge base and data available on particular health issues.

The GFATM should perhaps have been included here as an important global health actor in its own right. Due to the scope of this thesis, it is merely taken into account as a collaborative endeavour that some of the above described international organisations are engaged in, though without voting power. In a power point presentation to the conference on social health insurance convened by the ILO-GTZ-WHO Consortium, a representative of the GFATM presented on his organisation and social health insurance. He argued that "Social Health Insurance Systems could be the ideal framework with Global Fund 'topping-up' in areas of excessive cost"[97]. However, more recently, the GFATM has come even more into focus concerning health systems. This has particularly come with a stronger engagement, as a team of experts warned the fund that it risks 'Medicines without Doctors' if it does not finance health sector scale up (Ooms et al., 2007). The expert

---

[96] See http://www.popline.org/docs/041170, accessed 29 December 2010

[97] Power point presentation by Bernhard Schwartländer (http://www.tnchf.or.tz/typo3conf/ext/myth_repository/secure.php?u=0&file=fileadmin/Documents/Publications/01_Dr_Schwartlande_GFATM_SHI.pdf&t=1204425038&hash=a3a8f9c86e53fbe1f638df6b070e2146, accessed 29 December 2010)

advice emphasised that the Global Fund, not the World Bank, would be best placed to strengthen health systems. Taking that to heart, the Global Fund asked the WHO for advice on the issue. The WHO's recommendations include the use of an 'HSS[98] floor', "possibly as a percentage of any grant, [that] might be more useful to help promote the desired 'diagonal' approach" (WHO and GFATM, 2007).[99]

6.6 The Same or Different Communication Channels?

This chapter has presented mechanisms for communicating health system ideas or models developed by international organisations. It has been shown that all the international organisations use a number of different means of communicating their ideas about national health systems. At first glance, much of what they are doing seem to be "the same" activities or strategies: they all release different kinds of publications, are engaged in "teaching" national policy makers, are involved more or less directly in national policy making and collect, analyse and publish data on health systems, and so on (see table 6.5). There are, however, also important differences, both in quantity and quality. So, where are these differences and what do they imply in terms of effective communication channels?

In general, there is hardly any form of international law concerning national health systems, stressing the point that the organisation of health systems is "officially" still primarily a national responsibility. The ILO probably comes closest to having some regulatory "power", however without strong means to force countries to sign and implement the agreements. The WHO and the OECD activities or meetings can, theoretically, result in international agreements. The health regulations facilitated by the WHO do not really apply to health systems in the sense studied here. The OECD

[98] Health System Strengthening

[99] See http://www.who.int/healthsystems/GF_strategic_approach_%20HS.pdf; and for background documentation of this report http://www.who.int/healthsystems/upcoming/en/index.html, accessed 29 December 2010

Table 6.5: Comparing Communication Channels

	WHO	World Bank	ILO	OECD
international conferences	Alma-Ata Conference (1978) + follow-up	-	-	Health Ministers Meeting
publications	Health Strategy Advocacy Reports Technical Documents	Health Systems Strategy Advocacy Reports Technical Documents	Social Security Strategy Advocacy Report Technical Documents	Health Strategy - Technical Documents
workshops	(currently not; lack of funding)	Several courses, including a flagship course on health systems	Meetings on Social Dialogue in Health Services CIARIS	-
direct involvement	Country Cooperation Strategies Single country health system assessments	Loans; PSRPs Country Studies	STEP	Single country health system assessments (+ Economic Surveys)
Data	WHOSIS/ World Health Statistics National Health Accounts	HNPStats	Social Security Inquiry	Health Data Health At a Glance
websites etc.	√	√	√ (but shortcomings)	√
campaigns	PHC, MDGs	(MDGs)	Decent Work Agenda Global Social Security Floor	-
networks	World Bank, ILO, OECD (and others)	√	√	√

mentions its potential to "implement 'soft law' [...] and [that it] can on occasion lead to formal agreements and treaties" (OECD, 2005:7), however there is no indication that any of this applies to health systems. Accordingly, the ILO appears as the organisation with most regulatory power, however it is only to a limited extent able to use this position making itself a more important global social policy actor in the field of health systems. In addition, the WTO's regulatory power concerns also health system related issues.

On the other side, the World Bank having least power to facilitate *international* health law, is probably most powerful in influencing *national* health policy due to its health sector programmes and projects in low- and middle-income countries. All the organisations studied in this thesis have ways of interacting directly with their member states on their health systems. This often happens through both theoretical channels of analysing health systems (or just functions of the health system), as well as through different kinds of programmes at country level (with the exception of the OECD). However, as an international financial institution and the resources to provide development aid, it is much stronger than the other international organisations. The evaluation of World Bank interventions and the impact on national social policy, have been subject to a lot of literature (e.g. Radin, 2003). At the same time, it is often stated in country case studies that it is in fact the multiplicity of uncoordinated activities by different organisations within one country that is causing fragmented health systems (e.g. Walt et al., 1999), so it is difficult to measure and judge the concrete impact of the World Bank for health systems.

Important ideational tools that might feed into national health system reform debates are *assessments of single member states' health systems.* Usually at the request of member states, the WHO and the OECD are undertaking such work assessments of single member states' health systems. The WHO has developed an analytical framework in its World Health Report 2000 that was, however, strongly criticised because of the indicators it introduced and

the resulting ranking of health systems. The OECD has been receiving more resources to develop its work on health and increasingly integrates health systems in its general multilateral surveillance mechanism and in its data projects in health[100]. Such inequalities between international organisations in financial terms, but also concerning support for specific tasks, are strongly related to member states' interests. This is a communication mechanism that shows features of different groups of countries using different international organisations for the purpose of receiving evaluations of their health systems. While OECD countries seem to have moved to the OECD, other, non-OECD countries use the WHO. World Bank contributions of this kind can rather be found in the form of research papers that have a much lower status and do not appear to come as evaluations requested by member states.

On the issue of *norm-setting* conferences, the WHO is really – despite all talk about its weakness – *the* global health organisation in place. The ILO comes into the picture occasionally, as its engagement with social security concerns health. For the OECD, the 2004 Health Ministers Meeting served as a platform for policy makers to exchange and discuss ideas and to decide about the future role of the organisation in health matters, but it did not have that character of norm-setting. Both the World Bank and the OECD communicate ideas about health systems, in the sense of presenting and discussing research-like knowledge, rather than explicitly promoting particular normative models. The strong normative role of the WHO gives the organisation an important position and support from a large number of civil society organisation and particular academic disciplines, and thus an important "global voice" in the global ideas about health systems. However, as the leeway for a strong global position is to an important degree dependent upon the financial support of member states, as well as of their support of specific activities or topics to be addressed, the WHO has been losing ground for part of its health system related work with other global social policy actors benefiting from it.

---

100 See www.oecd.org/health/dataprojects, accessed 29 December 2010

Regarding *publications*, the World Bank is producing by far the most in the form of books, strategy papers and working papers and, in addition, course material. There are also – though not taken into account in an analytical sense in this thesis – a number of country- or region-specific analyses; more or less attached to loans. The WHO has produced important work in the form of the WHR2000 and related publications; and this is also taken up, at least for definitions and basic concepts, by the other organisations – for example as basic reading material in the World Bank's flagship course on health systems. The ILO's publication record is rather limited in this regard, though some publications have come out of programmes like the STEP. Since the launch of its health project, the OECD has been continuously producing working papers and reports that also cover health systems; and thus it is becoming an ever more important "voice" concerning global policy models for national health systems. The sheer number or volume of an organisation's health system publications can certainly not be equated with a more or less powerful position as a global social policy actor in the field of health systems. However, the number together with the status given to particular publications and the potential to spread this literature contributes to a more or less important voice in global ideas about health systems. There are significant differences between the international organisations studied. Both the World Bank and the WHO are able to give space to health systems in their major annual reports (WDRs and WHRs), as well as producing flagship reports or similar publications suggesting high-profile work. Using these means has characterised the global ideas on health systems, however, it has not been used to its full potential by either organisation. The OECD is increasingly pushing its way into this communication channel.

Running *workshops or courses* obviously requires considerable financial and staff resources. Currently it seems to be only the World Bank through its World Bank Institute which is able to do this in a comprehensive and independent way. The WHO presently does not have the means and support for doing anything similar. The ILO manages to provide some of this kind of idea communication through collaboration with research institutions, or

other international organisations (WHO-ILO-GTZ Consortium). While not attracting the same level of public attention as international, ministerial meetings, the fact that hundreds of professionals involved in national and transnational health system organisation have attended workshops by the World Bank Institute, does give the World Bank a significant voice in the subject matter that is possibly even more powerful in its influence than ministerial meetings. None of the other international organisations comes even close to speaking to so many people involved about concepts and organisation of health systems.

Given the typical statement by international organisations about a lack of data as one of the reasons why there are still many problems with considerably improving the state of health systems all over the world, all organisations are engaging to some extent in the development of indicators, and in collecting, analysing and reporting data. The uptake and general trust in this kind of data is an important issue of shaping the thinking and understanding of health system related indicators. Particularly scholarly literature is characterised by an over-reliance on OECD data that is perceived as being an almost-perfect match of social realities. This is to a somewhat lesser extent also true for World Bank and WHO data that do not enjoy the same extent of general trust in the institution and rather speak to particular academic disciplines, though data as such is taken up broadly and appears to be somewhat detached from other, more critical, use of World Bank or WHO ideas.

This comparison demonstrates that there are different forms of resources that international organisations draw upon when establishing or defending a position in global ideas on health systems. Not on the dimension of basic norm setting, but in general it is the World Bank's financial resources that make it possible for this organisation to make much more use of a range of communication channels, namely running an extensive website, producing and spreading large amounts of publications, offering courses and engaging

in direct involvement with member states. Looking at the currently proposed budget for the WHO secretariat in Geneva (WHO, 2009), a very crude calculation of the resources provided for the health system related work (as understood in this thesis) suggests that about $20,6 million are allocated to it (understood as the resourced to objective 10, more concretely taking together 10.2, 10.10, 10.11 and 10.12.1). Making a similar calculation for the World Bank Group is much more difficult due to the complicated structure of organisation with several organisations within the World Bank Group (including also the World Bank Institute) contributing as part of their work to knowledge production on health systems. Further, part of the money goes into lending activities that do not fully overlap with the theoretical contributions focused at in this analysis. From the data provided one can tell that in 2009, $86 million went to health and social work, with recent increased right to the field of health systems. Also secondary literature (e.g. Koivusalo and Ollila, 1997) as well as interviews conducted for this research project suggest that the WHO is comparatively underfunded and thus restricted in its activities.

At the same time, the OECD demonstrates a different sort of power as it produces "trustworthy" information and data (as perceived by national policy makers and also researchers), while focusing and specialising on very particular issues instead of trying to tackle everything that could be related to health policy or health systems. Both, the World Bank's and the OECD's position present a challenge for the WHO. The WHO, however, is provided with a normative mandate that makes it stronger in justified campaigning and promoting particular health system ideas or models. Given a significant lack of research regarding the ILO, it is very difficult to come to a conclusion about its role and position as a global health organisation in the dimension of communicating its ideas and advising national health policy – it appears to be mainly a potential, not a very real, influence.

This implies that the relative importance of different international organisations shifts when it concerns the means and scope of

communicating health system ideas, depending on the communication mechanisms they are able to use. This is a matter of financial resources that an international organisation has at its disposal, but also a matter of member states' support for the engagement of a specific organisation in health systems.

Before going into the more theoretical discussion of all these issues in Part III, a number of notes on omissions within this chapter are necessary. It must be mentioned that literature has provided examples of much less formal, less institutionalised, less "strategy-like" communication mechanisms than the ones discussed here. These are, for example, direct and frequent contacts of staff from international organisations with national policy makers. Similarly, Deacon et al. (1997) have shown that epistemic communities have facilitated national political reforms. Given the "one-sidedness" of the analysis reported in this thesis, taking into account such mechanisms has proved to be rather difficult. That is, however, not an argument about their importance and the impact of such mechanisms. Interviews nevertheless suggested that being part of, or even creating, epistemic communities is one strategy pursued by staff of international organisations to spread ideas in the academic world (see also Deacon and Kaasch, 2008). Also the international organisations' courses, for example in the case of the World Bank and the ILO, as well as the launch of WHO Commissions provide examples of links with academic researchers.

Part III summarises the findings of the three analytical steps (actors, ideas, communication channels) reported in this part of the thesis. It continues with a summary characterisation of global social policy in the dimension of global policy models for national health systems (chaper 7), a comparison of discourses on health and pensions (chapter 8) and a discussion about this study's implications for conceptualising global social policy more broadly (chapter 9).

PART III: DISCUSSION

7. Characterising Global Ideas about Health Systems

The intention of the analysis reported in this thesis was to engage with the validity of the characterisations of global social policy ideas, mostly based on studies of the global pension discourse, that characterised them in terms of overlapping mandates, and conflict and contestation between international organisations for the right to shape policy, and for the content of that policy. By studying international organisations' ideas and models about health systems, the thesis set out to ask whether the characterisations of overlapping and competing global policy actors and their ideas hold true when it comes to health system models?

In analytical terms, two broader sub-questions result from the first question: What characterises the global ideas on national health systems? How does this compare to the global discourse on pensions?

The issue of overlapping and competing actors has been examined regarding three aspects. The health system mandates of the international organisations have been studied based on an analysis of their constitutions and their ways of defining the legitimacy of their engagement (in terms of generating expertise) in the field of health systems. It has not been a global health governance analysis in the sense of studying issues such as the governance of particular international organisations (power of particular member states, power of particular individuals or units within an organisation). This first analytical step has sought to answer the questions "who are the important actors?", "why are they engaged in the field?" and "how do they justify this engagement?".

The ideas about health systems were studied in terms of how they compare to each other and fit specific ideal-types of health systems. This has been decisively kept at the most general level of health system ideas as the

interest was in making it comparable to the pension system models developed and communicated by international organisations. Such a view on broad models naturally is less able to detect and give extensive consideration to specific issues within the functions of health systems which can have very different characteristics. The questions addressed here were: "what are the health system models developed by the actors?" and "how do they compare to each other?"

The communication channels were studied in terms of the different use of a number of means to communicate ideas and how they compare to each other. It was not the intention of the thesis to talk about the impact of international organisations on the health policy of member states. It does not engage in detail, therefore, with many of the health reform debates and issues noted in passing in chapter I. Issues of legitimacy and trust have been brought up in relation to the acceptance by member states (or a global public more generally) of an organisation's right to be dealing with a specific subject. The concern in this thesis is about the "loudness" and acceptance of utterances at the global level (in a comparative perspective). This might be questioned; however, it is not an uncommon approach in global social policy studies (see chapter 1). The questions discussed with regard to this analytical step where "what communication channels are used?" and "how are they used by the different international organisations in comparison to each other?".

Accordingly, this thesis has produced three sorts of findings which correspond to the different levels of research questions developed to structure the argument. There are findings regarding the global ideas on health systems as such. There are findings about the comparison between the ideas and associated discourses on health and pensions. And there are findings related to the characteristics of, and the approaches to, global social policy in a broader sense.

This chapter is about the specific findings about the global ideas on health systems. Again, three different aspects are distinguished: actors and their

mandates (section 7.1), ideas (section 7.2) and communication channels (7.3).

7.1 Global Health Actors and their Mandates

Health systems are an important topic in current global social policy debates. The issues of health systems usually come up in one or another way, but increasingly frequent, in health debates of different origin (e.g. fighting particular diseases, tackling the health of specific groups). At the same time, particularly the example of the WHO has demonstrated how difficult it is to realise a transnational mandate and fulfil such a responsibility with regard to health systems. How and where does the engagement for producing and spreading models for health systems come about? This study has linked the activity of international organisations as global social policy actors in the field of health system to different forms of mandates.

Looking at the actors providing health system models shows that we are faced with a typical global social policy and governance scenario characterised by a multiplicity and variety of actors that struggle to some extent over positions. Four major international organisations have been identified as being particularly important for health system models: the WHO, the World Bank, the ILO and the OECD.

Referring back to the common groupings of international organisations in the global social policy literature (e.g. Deacon, 2007, Mishra, 1999), also for the field of health systems there are both *international financial institutions*, here particularly those of the World Bank Group, and what has been labelled the *UN social agencies*, namely the WHO and the ILO. Important actors outside the UN system have proved to be the OECD and, in a somewhat different sense, the WTO.

Other studies have shown how initially, the WHO took a position that could also have been justified for the ILO (Siddiqi, 1995). Since the 1980s, the World Bank has increased its activity and became the most important global health actor in terms of financial and staff resources (Koivusalo and Ollila, 1997). Following the failed attempt of the WHO to restore its position in providing advice on health systems, the OECD has significantly increased its activities in the field since about 2000 (Deacon and Kaasch, 2008).

The analysis has provided evidence for multiple ways of justifying a transnational role for speaking on health systems. This might be a direct, but general mandate through an organisation's constitution (such as for the WHO, ILO), it might be grounded on specific requests from all or a particular group of member states of an international organisation, or it might arise by way of specifying a broader mandate (e.g. World Bank). The relative importance of each of the organisations was measured by way of distinguishing different types of mandates and other support (such as specific requests) from member states and the resulting leeway to deal with health systems. This was regarded as creating a specific responsibility and task for each of the organisations resulting in a specific position within the respective global social policy issue. In addition, the mutual reference among the international organisations was used as indicator to the relative importance and mutual acknowledgement of them as health system "actors" of each of them.

The WHO, the World Bank, the ILO and the OECD all, in one or another way, are mandated to fulfil the task. The activities of international organisations as such and their engagement in global social policy, however, is not necessarily unproblematic or straightforward (Vaughan, 1999, Einhorn, 2001). It has been shown that for most of these organisations, the engagement in providing models of health systems is not based on a clearly assigned mandate (exceptions are the WHO and the ILO), but derived from processes of tailoring and broadening existing mandates, for example on fighting poverty (World Bank and some UN bodies), or on general

economic and social policy (OECD and some UN bodies). These "derived mandates" are also the result of the character of health policy in cross-cutting a number of sectors such as medicine, social security or trade. They do not necessarily imply a weaker or limited role in the matter; this supports Orenstein's (2005) definition that what makes an actor a global policy actor is purely its engagement in an issue area. It has, however, also been argued that in terms of legitimacy and trust, being sufficiently mandated to speak on a specific policy *does* matter, which is also why all the organisations justify their engagement by referring to, or establishing, some form of mandate. In a more critical way, this has been addressed with terms such as "mission creep" (see for example Einhorn, 2001) and "trade creep" when it concerns WTO's possible impact on health systems (see Koivusalo, 1999).

These organisations furnished with real, derived or even "no" mandates create a picture of overlapping agencies (Deacon, 2007) when it comes to providing models for national health systems. Accordingly, questions about legitimacy and divisions of labour are relevant. If the WHO were to fulfil such a task, it would certainly need to be much better equipped, but at the same time, it would require the WHO to speak different disciplines' languages in order to actually be able to make the information equally understandable to professionals with economics, medical and social science backgrounds, as has been shown regarding the Commission on Macroeconomics and Health. The current situation, however, is much more characterised by all organisations – probably with the notable exception of the OECD (see below) – being considerably concerned not only in defining more clearly their own role in providing health systems models, but also to some extent mapping the institutional environment in the matter and sometimes assigning roles to others. These attempts to define roles are interesting in several perspectives. Firstly, they appear thought-provoking given regular public global assertions as to the importance of health systems in various health contexts. All the international organisations constantly have to justify their engagement in the matter, despite a general "global" agreement about the importance of health systems. Secondly, defining

appropriate roles with regard to health systems seems to be a challenging task. This is due to the complexity and inter-disciplinarity of the topic, on the one hand. On the other hand, there is a general lack of a precise vision about a general global division of labour in related activities. The OECD is probably currently doing best by concentrating on a number of carefully chosen health policy issues that are supported by special "mandate" from the member states, instead of (at least openly) trying to cover health systems as a whole, or even one complete function such as financing or provision models. Thirdly, it is not just that global health actors, here international organisations, potentially challenge each other's roles, it is also the lack of trust (from the side of member states, as well as from the side of equal actors; measured as the support of member states for conceptual work about health systems by respective international organisations) in a particular organisation that might seriously constrain the fulfilment of a role in health system models at the global level. This is even true in case of officially clear mandates such as in the case of the WHO. At the same time, it can be seen that while the ILO might be able to define and justify a mandate in giving advice related to national health systems that has been relatively uncontested, its contribution is so small, that the mandate itself does not make much of a difference. Currently, particularly looking at the OECD, but also at the WHO's Commissions, it seems that it might be a successful strategy for an international organisation to work in research projects or research groups with special consent or mandate by the member states. Alternatively – as is the case for the World Bank and OECD – it might be a way forward to focus on particular groups of countries and their needs instead of pursuing general models at the global or regional level (Deacon, 2006, 2008, Deacon et al., 2007, Yeates and Deacon, 2006).

Given this, one might say that global social policy in the field of health systems is at the same time a field of general constraint for its main actors (in terms of financial and staff resources, but also in keeping up support to the respective work and activities), as it is characterised by growing importance in terms of various actors' engagement. Financial resources, but

also an organisation's trustworthiness, can be regarded as an important issue in such a situation of fragile or ambiguous support to a specific activity undertaken within the secretariats of international organisations, namely theoretical contributions to policy fields addressed. In different ways and with different implications, both the WHO and the World Bank have suffered from (partial) lack of such trust. The WHO has lost its reputation in academic circles (e.g. Ollila and Koivusalo, 2002, Ollila and Koivusalo, 2000, Pedersen, 2002), among global health experts from other international organisations (Wagstaff, 2002, Shaw, 2002) and in relation to particular member states (e.g. Häkkinen and Ollila, 2000) in the context of its WHR2000. The World Bank is associated with neoliberal policy advice and thus, in some circles, its engagement in the health sector is not supported (e.g. Koivusalo and Ollila, 1997, Global Health Watch, 2005, Waitzkin et al., 2007). At the same time, the association of the World Bank with a particular set of ideas or interventions (like user fees, privatisation and decentralisation) disregarding the particular issue or policy field in question, may also drive countries to move in particular reform directions that a World Bank health specialist would not have suggested in order to get World Bank support. This, in turn, would then give even more reason for criticism of World Bank policies and ideologies.

While there are explicit mandates, the organisations also attempt to both define themselves and their work in global social policy discourses in terms of being the most important or most competent or most legitimised actor with regard to health systems. The ILO, for example, presents itself as the best suited organisation[101], while the World Bank and the WHO are increasingly pressured to justify their engagement in the topic which can be observed in various publications. The OECD seeks to demonstrate its legitimacy on the matter by frequently hinting at special member state requests. According to the interviews[102], the WHO and the World Bank are

[101] An interview with ILO staff testified for the view that they seem themselves as best suited to deal with the issue of health systems as far as it concerns the social security aspects of it (Geneva, 5 December 2006).
[102] Interviews is Geneva, 2 April 2007, and Washington, 25 May 2007.

faced with more requests than they can deal with, it is only the OECD that has seen a significant rise in number of health staff and thus resources going to that policy field. Such positions are demonstrated both directly and indirectly. An example for indirect demonstration of an important position in global social policy in the field of health, is the World Bank that on the one hand clearly refers to other important actors while it offers a vast range of health system issues for which it claims particular expertise. In one of the interviews[103], the point was made that the WHO suffered from a lack of trust which one could see by the fact that Julio Frenk, who is connected to the WHO, did not turn to the WHO when looking for advice for his own country. This creates a situation of overlapping agencies that is increasingly complex and variable with regard to the relative importance of each of the actors over time. The division of labour between them is, thus, not clear; which increases the need for continuous justification of the engagement health system issues. The relationships between these global social policy actors for the field of health systems unfolds between mutual acknowledgement, competition and collaboration in the absence of a clear division of labour. Thus far, the mandate issues touched upon were only related to single international organisations. To what degree, though, is there a situation or degree of *competition* (Deacon, 2007) regarding mandates or justified roles in global policy models for national health systems *between* these global health actors?

Basic mandates do not fundamentally change, thus those international organisations with a concrete health mandate (WHO and ILO) have been engaged in related activities from early on. However, the emergence and growing importance of other international organisations as global health actors through defining broader mandates into health responsibilities has challenged former positions and requires the justification and specification of different sorts of engagement. Or, it calls for an explanation as to how and why the "newer" organisations do not draw on the expertise provided by existing international "health" organisations. The questions arising in the

[103] Interview in Washington, 25 May 2007.

context of the divisions of labour and the implications, or chances, or threats of overlapping and competing agencies within one policy field at the global level are complex and lead to controversy both in political and academic discussions. The historical view shows that such issues are not new, either. There have been issues about the health system responsibilities of the WHO and the ILO respectively, the extension of the World Bank's HNP sector, and the challenge to the WHO's role, and recently the potential challenge to the WHO through the growth of the OECD's health work (Kaasch, forthcoming, Deacon and Kaasch, 2008). Such challenges have also been associated with other actors like the GFATM.

This situation makes international organisations highlight their respective strengths in the sense of "the other organisations are doing good work, but we have the most comprehensive/appropriate take on the issue"[104]. The OECD in this question appears to be most self-confident – not trying to be more comprehensive or employing the most suitable approach, but ostensibly preferring to focus on the relationship with its member states and concentrating on a number of clearly defined health system issues.[105] The OECD's strategy increases trust towards the organisation from the side of the member states that continue to provide significant extra-budgetary contributions for the OECD health work. This is part of global social policy with different international organisations challenging each other's role. At the same time as there is a certain degree of contestation in terms of the "top role" in health system models, there is also a considerable degree of collaboration and networking among members of the different organisations (and other global health actors).

The current success of the OECD approach in health raises questions about future global social policy in the field of health. Might it be a way forward

[104] This has also been an issue raised in the interviews.

[105] Interviews have suggested that the OECD has intensely watched and learned from what the WHO has been doing wrong and thus comes across as the more reliable health adviser; see DEACON, B. & KAASCH, A. 2008. The OECD's Social and Health Policy: Neo-liberal stalking horse or balancer of social and economic objectives. *In:* MAHON, R. & MCBRIDE, S. (eds.) *The OECD and Global Governance.* UBC Press.

to focus on particular groups of countries and their needs instead of pursuing general models at the global or regional level?

Other international organisations have joined in the development and spread of global health ideas in various ways; for example by having a health responsibility for a specific group of the population (e.g. UNICEF) or by finding themselves intervening into the health sector while in fact being concerned with monetary or trade issues (WTO, IMF). While they perhaps provide less of a challenge to the role of the more "traditional" global health actors, their activities have implications for the content (and location) of global health discourses, and on policy reforms at the country level.

Alongside this, all organisations are bound within networks and working collaborations which testifies for both, the mutual acknowledgement of them being important global actors for health systems as well as not a purely competitive relationship. Despite individual mandates, roles and forms of competition between international organisations, global social policy in the field of health systems is also characterised by collaboration, cooperation and different forms of networks. In terms of formal networks that could also be regarded as health actors in their own right, there are the GTZ-ILO-WHO Consortium on Social Health Protection in Developing Countries and the hybrid organisation of the GFATM. The GTZ-ILO-WHO Consortium has been taken into account, as it is a source of concrete ideas on health systems. The GFATM has only been mentioned on occasion because it has not (yet) functioned in a similar way. However, it might do so in the future.

The focus of the analysis reported in this thesis has been on formal, traditional international (governmental) organisations. This was not to deny a whole number of other groups, organisations and initiatives. Organisations that have only worked on a time-limited basis with clear mandates on what to produce within that time, such as the UN Millennium Project, or the WHO's commissions have also functioned as important global social or health policy actors; contributing to the debates with reports on specific global health policy issues. Various non-governmental actors, like global

business, CSOs, philanthropic organisations, or professional organisations have a stake in influencing and shaping global ideas about health systems, as well as influencing national policy making. Their legitimacies are different from formal mandates, however, as they are usually also in need of being defined, stated and explained. Accordingly, the CSOs compiling the *Global Health Watch* (Global Health Watch, 2005) have only been part of this study regarding the content and ideas from the report (see chapter 6).

This means there is a multiplicity and variety of actors, that to different extents, based on different contexts and mandates is engaged in producing global ideas about health systems. The emergence and growth of importance of the topic has contributed to those organisations that derive their mandates to challenge those with more explicit mandates. Along with it comes a certain degree of competition for the right and scope within which an organisation is mandated to take on such an advisory function to national health policy, however not a fundamental one. There is a struggle for legitimacy that is, however, probably more connected to the need to get *support* for their own work both at the global level and from the side of the member states, than to a real concern about the *content* of the work of other "serious" global health actors. This support importantly involves issues of financing, but also those of the potential take-up of information, and possibly also issues of the potential to formulate international law in the field. While the thesis has not developed an argument about the necessity or desirability of supranational health policy with regulatory and law-making powers, it is of concern to some if the only regulation in this field would come from the formulation and adoption of trade agreements.

7.2 Global Ideas on National Health Systems

As a second and core dimension commonly characterised by contestation at the global level, the different international organisations' ideas have been analysed.

The focus of this thesis has been on the content, rather than the actual impact, of ideas. This has meant that the health system models proposed by a number of international organisations have been studied individually and compared with each other, particularly those from the WHO, the World Bank, the ILO and the OECD.

Health systems have been understood as parts of the welfare state. Thus, the analysis has been based on comparative welfare state research (Esping-Andersen, 1990) and comparative health system studies (Moran, 2000, Moran, 1999). More specifically, the analysis followed a generalised health system model as developed by Grimmeisen and Rothgang (2004), and included questions on the context within which health systems are addressed, the goals and principles underlying the concepts, definitions of health systems, and the role of the state in different health system functions (provision, financing, and regulation). While the issues with respect to the provision and financing functions have been mainly on questions of public versus private, and centralised versus decentralised; the regulation function implied more specific relationships between service providers, financing parties and patients respectively. The latter included questions related to the kind and mechanisms of coverage, the system of financing, service provider remuneration, access of providers to health markets, access of patients to service providers and the decision process on the benefit package (Grimmeisen and Rothgang, 2004).

The analysis has shown that there have been a number of attempts and models of health systems put forward by international organisations. Comparing these ideas and concepts has revealed some differences, but

much more important have been the similarities between the models developed.

The analysis has revealed significant differences in the contexts within which health systems are being addressed and the goals or underlying principles in different organisations' approaches. This includes, on the one hand, conceptions about human and social rights to health, and a concern about equality in health (Alma-Ata Declaration, CSDH); on the other hand, approaches dedicated to improving health and tackling poverty (also part of the WHO, but more importantly the World Bank and the CMH; and also to some extent the ILO in connection with making a healthy workforce). The OECD provides a set of different ideas due to its core group of mostly high-income countries and an approach to working on a number of defined health system issues instead of approaching health systems as a whole. Accordingly, the definitions and conceptualisations of health systems also differ. Documents in the Alma-Ata tradition are rather interested in *levels* of the provision of care, while others are more focused on the *functions* of health systems (WHR2000 tradition).

Nevertheless, the conclusions about the health system models per se with regard to their public-private and centralised-decentralised dimensions in provision and financing, as well as the proposed role of the state in regulatory relationships, do not differ that much between the main actors that have been studied in this thesis, or are not explicit enough to discern. These, rather similar ideas, comprise the following:

- There is no organisation which does not support universal coverage (at least for basic care in a development context).
- Health financing should preferably be organised publicly with an emphasis on pre-payments and big risk pools.
- When it comes to concrete interventions in developing countries, however, community financing schemes are preferred as a starting point for broader insurance coverage.

- The system of financing could be either social insurance style or taxation or elements of both; while there is no "one-size-fits-all" approach, but rather discussions about advantages and disadvantages of either model.

- Strategic purchasing is frequently an issue, but increasingly treated with caution.

- It is generally not a market-based model that is recommended. If the US model is mentioned in the documents it is a bad example (e.g. Roberts et al., 2008). A comprehensive distinction between policy models and reform suggestions to different groups of countries has not been undertaken, as the focus of the thesis is on general global social policy models.

- The hesitation to make clear recommendations, particularly with regard to the system of financing (taxation and/or social insurance) and the rather vague public-private mix in provision makes it difficult to clearly identify any particular welfare state or health system type in the models or ideas of the international organisations. The ideas of all organisations are taken from high-income, European welfare states that manage to achieve (close to) universal health care coverage; however neither type is clearly advocated. Rather one could say that those elements that distinguish particular health system types are brought into the discussion while not resulting in one coherent (theoretical) model. Such elements would be public financing from the entrenched command and control health systems; the importance of health research from the supply state type[106]; and regulatory elements from the corporatist health-care state (Moran, 1999, 2000).

---

[106] This issue has not been investigated in this thesis, however, part of global health policy is in fact about health system research. This is, for example, expressed in organisations like the Global Forum for Health Research (http://www.globalforumhealth.org, accessed 29 December 2010).

Only with regard to the definition of the benefit package are we faced with differences. As far as the benefit package is addressed by the international organisations, the approaches differ in terms of a process- versus content-focus. This means, for example, that a concept such as that of the WHO CMH tries to define the content of, or the criteria for, defining an appropriate benefit package; while ideas from the ILO or in the Alma-Ata tradition always importantly contain reflections on the process of how to decide upon the benefit package (such as including particular groups of the population).

Nevertheless, the approach employed by the IFC significantly differs. It explicitly supports only private providers (and in the future possibly also private insurers) without sufficiently taking into account more comprehensive concepts and concerns about health systems as a whole. This is even more astonishing as such ideas are provided by other organisations of the World Bank Group. The IFC's ideas do not match those of the World Bank and appear not to be sufficiently coordinated with other World Bank activities.

Also, the OECD is somewhat different, but less in terms of the basic content than in terms of the context in which its activities are taking place (mainly high-income countries) and the related approach to the guidance of national health systems. The OECD approach has been characterised as even-handed and of high quality. However, it needs to be taken into account that it is only partly comparable to the much more comprehensive agenda of other international organisations, both in terms of membership and approach to the topic.

While historical shifts can be observed, these cannot only be understood as a shift from oppositional models towards more similarities (such as no more mention of user fees by the World Bank). It is rather, on the one hand, an increasing concern about health systems by all international organisations, accompanied by more intensive research activity that apparently has led to similar conclusions in different organisations (certainly also supported by

mutual exchange and networking activities (Lee and Goodman, 2002)). On the other hand, shifts have occurred in relation to the respective function of the health system in focus at a particular point of time. The focus seems to have shifted from provision to financing (WHO and World Bank), or financing to provision (OECD and ILO), to currently a particular emphasis on regulation. Some have interpreted this as a sign of the retreat of the state from financing and provision to a merely regulatory role. Looking at the findings of this analysis, such a view cannot be fully supported. Regulatory concerns rather appear as a matter of strengthening the state's position in health care overall (in settings where there are perceived lacks), with considering private providers (and to a more limited degree also private insurers) to the extent that they contribute to efficient and quality care, but not at all at the expense of universal and equitable access.

In summary, the analysis has shown that ideas about health systems are not characterised by significantly contested ideas that can be related to particular health systems or welfare state ideal types. The documents of different international organisations are not all the same – reflecting characteristics of the respective organisations such as original mandates or staff composition. However, applying the analytical framework introduced in chapter 3 does not reveal major differences about what is being said and proposed. The analysis has, however, not been designed to fully capture the "silences" that might lead to somewhat different results and conclusions. McCoy (2007) and the Global Health Watch II (2008) do this in relation to the World Bank ideas and strategies, while other literature (Banerji, 2002, 2006) have assessed the WHO CMH concept, also pointing to what it does not say or do. The WHO has been criticised for using the CMH and its economic language to bid for legitimacy, however, it could equally be understood as an attempt to translate social and health principles in an economic language. As shown by Heller and Hsiao (2007) and Roberts et al. (2008) the CMH report indeed still provides a way of teaching economists some important features that characterise health policy that go beyond economic theory and need to be taken into account.

At the same time it is interesting to see how these different contexts and underlying principles, such as the aim of poverty reduction or striving towards more equality do still lead to rather similar models of the organisation of health systems. Apparently the common goal of universal access (to whatever broad package) leads to the same final models, while the desired way is still different. The World Bank would first target the poor through public funding of basic services and once that is realised sees space for developing more sophisticated health systems (living with the unequal coverage for the transitional period); while the ILO would opt for micro-insurance systems to be merged into comprehensive systems in the future (thus accepting non-coverage for excluded groups for the transitional period). The most recent ideas about the Global Social Security Floor, however, point to simultaneously providing basic care for the poor.

7.3 Ways of Communicating Health-System Ideas

Turning now to the third analytical step, attention is once again directed to the issue of communication channels. Both websites and interviews were valuable tools to understand how information is spread by international organisations, and also how different international organisations relate to each other when it concerns providing models to national health systems.

The research conducted for this thesis has shown that the four organisations that have been studied resort to similar communication channels, however that there are differences in how they use to them, both in quality and quantity. These differences partly depend on the nature of influence that results from different mechanisms (i.e. mechanisms that directly strive for shaping national social policy such as conditional loans or supranational social law or mechanisms that can be seen as providing contributions in global social policy debates and thus only indirectly may influence national policy making).

International organisations communicate their ideas by various means. The analysis in this thesis has looked at intergovernmental conferences, different sorts of publications, knowledge-focused conferences and workshops, more direct involvement in national policy-making, the development of indicators together with the preparation of quantitative, data and evaluations, websites, campaigns and networks. The aim has not been to go into each of these mechanisms (and their actual impact) into great detail but to provide an overview and reflect on the different means of communicating global social policy ideas at the disposal of different international organisations.

It also needs to be taken into account that this research is not about donor coordination, it is about ideas and their spread (see chapter 1). The issue of trust in donor coordination is about the acceptance of intervening in a country, while the discussion in this thesis was related to ways of gaining mandates to *globally speak* on a policy matter. This analytical step was undertaken by a detailed discussion about the mandates and legitimacies to speak in the matter of health systems, comparing the different international organisations to each other (chapter 4). The interviews reflected this search for legitimacy and need to justify engagement in the field.

What have we learned about the spread of global ideas about health systems through looking at these communication channels and mechanisms? Global social policy actors, here understood as international organisations providing health system ideas, possess a number of different communication channels to make their ideas travel. These are not used as a question of either-or, but all of them use about all of the communication channels distinguished for this analysis. However, they do give different emphases to the different means of communicating ideas, which leaves them with different degrees of power to raise their voice in global social policy discourses.

The communication means used do not only serve to transport a particular (set of) policy idea, but they also carry justifications for the international organisations' activities. This is despite the general importance given to health systems in global policy debates and despite the inherent need to take into account health systems in broader policy objectives.

This means that while the WHO has been successful in developing, and through publications communicating, a particular definition and conceptual framework of health systems, the World Bank's message is rather transported through the formulation of strategies and approaches to health systems within their overall work that importantly includes lending activities combined with direct policy advice (instead of generalised one).

At the same time, the particular communication channels are shaped by the degree to which the organisations have an explicit normative function. This is reflected in the WHO's and ILO's use of campaigning activities.

Another important determinant of communication strategies is connected to the scope to which an issue is tackled. While the WHO appears to be somewhat confused in doing everything and nothing, the World Bank, that is equally broad in its health approach formulates specific fields of expertise. At the same time, the OECD uses the definition of specific fields of attention as a means of providing evidence that what it does is well justified and of high quality rather than tackling a bit of everything. The ILO is in general rather weak in, or not too concerned about, its (public) communication channels and gives not too much attention to its website and the accessibility of information and documents.

The scope and the accessibility of an organisations' work is an important determinant of its ideational power. The World Bank's resources do not only allow for a high number of people working on particular issues, but this translates into a well-run website, loads of publications that are easily accessible, prominent events that attract world-wide and broad attention and so on. This is not equally the case for the other international organisations.

The example of the OECD, however, shows that not only the shere volume matters. It is also the credibility of an organisation. OECD publications and data are often considered as the "truth" rather than as an expression of the work of an international organisation based on organisation cultures, policies and so on. This is to a much lesser extent true for the other organisations which is partly reflected in them being much more critically watched (World Bank) or understood as having a clearer normative mandate (WHO, ILO).

The analysis further shows that what might be considered a particularly strong mechanism, namely international law, is fairly weakly developed and even if in place or at the disposal of an organisation it does not live up to any important source of ideational (neither practical) influence.

Overall, the uptake of an organisations' health system ideas in terms of global debates appears to be dependent on the prominence of a number of key publications subsequently referred to, which we find primarily from the World Bank and the WHO. The influence on national health systems, on the contrary, is likely to be rather dependent on the particular relationship that a country has with a particular international organisation. The ILO's and WHO's abilities to feed in normative ideas and concepts seem to be underdeveloped among international organisations, however other global actors, such as civil society organisations and think tanks, do indeed engage in the normative struggles on ideas (for example, Alma-Ata ideas).

In summary, it is certainly not so much the number or range of communication channels at an organisation's disposal, but rather the financial power behind them, the effectiveness of (e.g. in terms of web tools) and an organisation's trustworthiness in, providing health system policy models, that currently make the World Bank and the OECD appear more important global social policy actors in the field of health systems. Both organisations' activities, however, also have limitations in the sense of

their ideas being targeted at particular groups of countries. Particularly the World Bank is not free from continuous observation and criticism by other organisations that at times significantly influences trust in this organisation. The questions remains – given the identified similarities in health system models – does it really matter who is communicating the (shared) ideas most effectively? Also: perhaps it can be argued that different organisations for different groups of countries provide for "better" policy advice than the universal ones?

7.4 More Similarities than Competition with Different Power to Act?

Overall, this analysis of the actors, ideas and communication channels of international organisations engaged in providing global policy models for national health systems has revealed a multiplicity of global health actors that have not replaced each other while developing their mandates and roles in this dimension of global social policy. There is no *one* most important organisation and no clear division of labour, thus a certain degree of competition exists, and we observe various forms of collaboration.

Neither are the current policy models proposed by these actors an expression of significant differences. This can be intended or a sign of uncertainty. There are different ideas expressed on some issues, however, these do not add up to the promotion of contesting models of health systems. The hesitation to propose determined and clearly distinguishable models of health systems is a typical feature of global ideas about health systems.

The international organisations also resort to similar means in their communication channels, at least in communicating ideas in the form of theoretical and normative knowledge on health systems. At the same time, there are differences regarding the most powerful channels at the disposal of

a particular organisation. The World Bank has a prominent role due to financial strength. The OECD is increasingly important to its member states' needs of transnational guidance due to trustworthiness. The WHO still has the strongest mandate, giving it most legitimacy to advise national health systems, and an important norm-setting function. The ILO is contributing at a small scale to the ideas, however, is unable to play on its – potentially most powerful – tool of facilitating further international law on the matter.

The question would be whether it matters who communicates information most effectively or convincingly when different actors have similar health system concepts? The crucial issue with regard to the respective impact of different organisations might perhaps rather be: is there a difference between what is being presented as general health system models and what is the concrete policy advice given to specific countries or in specific situations? This would include a detailed study of other documents such as documentation of projects and loans, and a comparison of the ideas carried there with those studied in this thesis.

As this study has been undertaken with the aim to test and discuss current approaches to global social policy phenomena, the following chapters discuss these findings from the field of health systems in contrast to the global discourse on pension systems (chapter 8) and with reference to the implications for concepts and approaches to global social policy analysis (chapter 9).

8. Comparing Pensions and Health Systems Models

On the basis of the last chapter that summarised and discussed the findings, this and the next chapter go back to the initial purpose of this study – to compare the "competing" ideas on health systems with those on pensions in order to contribute to conceptual approaches to global social policy more generally. It is, thus, connected to the first research question elaborated on in this thesis, namely: Are the findings on the global discourse on pension systems replicated when examining global policy models for national health systems? Section 8.1 recapitulates the characteristics of the global discourse on pensions and thus develops the categories and issues of comparison. Section 8.2 presents the actual comparison. Section 8.3 draws some conclusions from this comparison leading to the broader discussion of its implications for the theories and approaches to global social policy in chapter 9.

8.1 Characteristics of the Global Pension Discourse

Referring to Orenstein (2005), Ervik (2005) and Deacon et al. (1997), chapter 1 has elaborated on the characteristics of the global discourse on pension systems. These can be summarised as follows:

- In the 1940s, 1950s and 1960s the ILO took an international lead in the diffusion of pension models as formulated in its *Declaration of Philadelphia* (1944). In these early days, Germany served as an example for pension policy. The approach was a PAYG system, that was adopted in a number of countries.
- In the 1970s, reforms began with Chile, that implemented a specific set of pension reforms; and that inspired the work of the World Bank and related academic networks to develop a specific "ideal-type" pension model.

- The World Bank theorised and developed this model in a widely communicated publication, namely *Averting the Old Age Crisis* (World Bank, 1994), as the so-called multi-pillar pension system. This model came to be spread, agreed with and implemented in many countries. The multi-pillar pension model has been central to further World Bank research and communication channels to influence national pension policy. It generated related tools like a Pension Primer to help governments design and implement reforms[107] and the Bank's Pension Reforms Option Simulation Tookit (PROST). In addition, the World Bank is teaching a flagship course on pension systems.[108]

- A disagreement between different international organisations (World Bank, IMF, US institutions *vs.* ILO, ISSA) and international epistemic communities on the best pension model characterised the global discourse on the model and ideas.

- This struggle included issues of the definition of the problem, public versus private pension schemes; (non)defined benefits; PAYG versus pre-funded financing; and the link between social security and pension savings and economic growth.

- The World Bank model succeeded over that of the ILO in terms of influence on reforms (Orenstein, 2005:192f), however the ILO continued proposing other ideas that had shown to have some influence on thinking about pension systems (Deacon, 2007:170).

Accordingly, the global discourse on pensions has been importantly characterised by competing international organisations and connected epistemic communities that stand for different pension models.

---

[107] See http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTPENSIONS/0,,contentMDK:20579507~pagePK:148956~piPK:216618~theSitePK:396253,00.html, accessed 29 December 2010

[108] See http://go.worldbank.org/LVUUEX7RT0, accessed 29 December 2010

8.2 Comparing Global Social Policy Ideas

Contrasting these characteristics of the global pension discourse with ideas on health systems analysed and reported in this thesis leads to the general conclusion that while there are some similar structures, the character of what could be called the "global discourse on health systems" is significantly different. The research design of this thesis was created to systematically analyse global ideas on health systems in a comparative perspective in order to come to a conclusion about the existence and character of a discourse in health systems. This chapter compares the findings from analysing international organisations' ideas and activities with regard to health systems with how the pensions discourse has been characterised several times in the literature. This includes a look at the history of model development, model cases (countries), major publications and their communication, the particular sets of actors involved, the concrete ideas, and the general characteristic of the struggle for positions around these two different social policy fields. Table 8.1 summarises the differences between the two global social policy fields.

Looking at the *actors* involved, the two global social policy fields feature similar structures. Both fields include UN social agencies, as well as the international financial institutions, particularly the World Bank, as important global social policy actors. Due to the fact that health systems (as parts of broader welfare states) are more difficult to be approached than pension systems, however, the involvement of particular actors, here other UN organisations than the WHO, is not as clear-cut.

A look at the history shows that, even though there is a significant increase in global talk about "health systems" recently, the topic is not new as such to the work of international organisations. There has been early engagement in providing global policy models for national health systems by the UN social agencies. As for pensions, there were important declarations and recommendations by the ILO already in the mid-1900s, and later in the

Table 8.1: Comparing Health System and Pension Discourses

	Pension Systems	Health Systems
Early Activity	ILO	ILO, WHO
Model Country	Chile	×
Major Publication	Averting the Old Age Crisis	WDR1993 WHR2000
Actors	World Bank, IMF, US institutions vs. ILO, ISSA	WHO, World Bank, ILO, OECD + some other activity (e.g. UN DESA) (vs. CSOs)
Epistemic Communities	Two	One
Ideas	CONTESTATION Public vs. private Social security/ pensions vs. economic growth/ globalisation Definition of the problem	CONSENSUS Extension of coverage Basic health package to all Pre-payment, risk-pooling
Communication	World Bank, with institutionalised discourse	Different international organisations with different (potential) strengths No well developed discourse
Characteristic of global power struggle	"war of positions"	Fight for (internal and external) legitimacy in times of uncertainties

1970s, by the WHO/UNICEF Alma-Ata Declaration. The ILO was even proposed to be the lead organisation on health systems. Thus, also in this regard, the fields are indeed comparable to each other and show similar structures.

Most significantly, global ideas about health systems are much less characterised by contestation about distinctive models to the system than those on pensions. The analysis provided evidence that one or several comprehensive health system models that could be related to actual (or idealised) health systems within particular countries such as NHS systems (UK, Nordic countries), or particular types of insurance systems such as in Germany), or a marketised system (as we find in the US), cannot be identified. This means, none of the organisations goes for either one ideal-type of health systems. Instead, they opt for some sort of mix in –between extreme cases (as characterise the IFC and the Global Health Watch). There are ideological debates about many aspects of the provision, financing and regulation of health systems, however, there is not one big, system-wide site of ideological contestation. Nevertheless, the increasing global concern about health systems over the past years might, of course, lead to more clear-cut models that differ from one organisation to the other more clearly and result in something comparable to the pensions discourse in the future.

Further, consensual knowledge shared by all the international organisations studied here (with the exception of the IFC) prevails when it comes to important elements and issues of health systems such as the extension of coverage, at least a basic health package to all, pre-payment and risk-pooling. It is important here to see the difference to the pensions discourse: the health system ideas and concepts, while based on different normative starting points and being expressed in somewhat different words, do not add up to clear public – private distinctions, they do not define the same problem in a fundamentally different way and they do not provide evidence for a major disagreement about the function of a health system as one observes in the pensions discourse when it is about a system to support

social security or one to support economic growth and globalisation. As has been stated earlier, issues about open markets and globalised health care do matter in the context of trade agreements, for example, and it is an important field of further research to weight the two fields of health system concerns against each other; however, this thesis never intended to go that far and its conclusions do not extent to discussions about health and trade.

Indeed controversial debate has centred around more specific aspects of providing or financing health services. An important example here is the debate about user fees.

One explanation for this situation in global health system ideas and particularly comparing to pensions, could be the fact that there is much less of one dominant European way of organising health systems as there is for pensions. The dominant pension model within Europe (except for the UK) is a Bismarckian-style pay-as-you-go system. Hence, the ILO and EU are likely to favour such a model. There is no such convergence for health systems that feature different kinds of insurance and taxation models in different European countries. This could explain the constant discussions and elaborations on advantages and disadvantages of taxation versus insurance models in health without ever coming to a statement about which one is better.

At the same time, when it is about developing countries, the more concrete interventions and suggestions usually focus on community schemes that – at least concerning health financing – are not meant to represent the final system, but a medium-term means to increase access to insurance and health care, and start a system of risk-pooling. While similar approaches to explaining the basic problems of the specific social policy field have been observed between pensions and health, the health system models resulting from these different starting points have been found not to be fundamentally different, at least not significantly in terms of the role of the state, and along the public-private or centralised-decentralised scales although there are different emphasises as between the balance of public-private etc. In

contrast to pensions, private actors are not preferred because they support economic growth, but because on the one hand they are a reality and, on the other, because of perceived failures in the public delivery of services. The reasoning is completely different.

While publications on health systems use and refer to good practices in particular countries, there is no such prime example of a health system. Most notably, the US is typically mentioned as the bad case. Thus, there is certainly no "Chile" for health system that would have served as a source for developing a model that then both spread as a world-wide idea about how to organise a pension system, as well as serving as a concrete case for policy learning in World Bank projects and advisory activities and seminars (for example in other Latin American countries and in Central- and Eastern Europe).

The processes of communicating ideas are a further bit of the difference in the picture when comparing the two fields. The Alma-Ata Declaration, the 1993 World Development Report *Investing in Health* and the 2000 World Health Report on health systems are frequently referred to in global health literature both by international organisations and also parts of the academic literature, but it would be an exaggeration to state that these had a similar dimension as *Averting the Old Age Crisis*. On the one hand, these publications – right from the start – had a different character. For example, the WDR1993 had not been given a status as the *Averting* report, referred to as "flagship report". Thus the communication process – that has been particularly conscious and extensive for the *Averting* report (Orenstein, 2008) – has been different. Further, obviously the Alma-Ata Declaration and the proposed PHC model have not proven to be sufficiently convincing in terms of providing a clear concept of policy guidance and an applicable model, and also not sufficiently successful at country level to provide for a convincing model case. Finally, the WHR2000 was flawed by combining a framework of health systems with a contested ranking of countries as to their performance, killing off much of what could have been developed out

of it in terms of modelling and policy advice. This means that there is no *one* document of reference in health. This fact might also be the reason for the lack of a clear oppositional model or contesting ideas (in addition to explanations made earlier such as conscious avoidance of controversial discourse, or uncertainty as to the topic of health systems). Nevertheless, similar to the pension story, the World Bank has also developed a flagship course on health systems that – given the teaching material used (Roberts et al., 2008, WHO, 2000, Gottret and Schieber, 2006) – does not appear to provide evidence for the promotion of privatisation or similar "neoliberal attributes" to health systems.

While there are certainly different networks (see Lee and Goodman, 2002) and also differences in ideas or expressions that characterise different documents, this does not add up to clearly distinguishable groups of organisations and epistemic communities promoting conflicting policy models. The WHO, the World Bank, the ILO and the OECD, rather, seem to be struggling with similar difficulties of not possessing final ideas, strong tools, convincing arguments for going one way or another. While some other UN organisations further contribute to health system ideas, all remain on a fairly limited level, for example, connected to promoting universal access or PHC.

Still, the different international organisations that function as global health actors with regard to policy models for national health systems are equipped with very different means to communicate their work. However, as the global discourse on health systems is not as developed and institutionalised as that on pensions, on the one hand, and on the other hand, it is more characterised by consensual knowledge, this is less of an issue relating to the current interrelationships of the global actors. Nevertheless, it does matter as soon as one turns to actual influence at country level (particularly concerning the World Bank's resources and activities), and also when one thinks about future, desirable global social governance regarding the

guidance of national health systems (which has not been the aim of this thesis).

On the issue of epistemic communities the findings suggest that there is only one epistemic community rather than two or more in health (see also Lee and Goodman, 2002). This does not imply that there are no different opinions on specific issues and that international organisations are not being criticised by other actors. Neither is it to ignore the role of the Global Health Watch that has indeed come up with a more explicit call for public, taxation-financed systems. However, having mainly focused on international organisations, strong opposing international epistemic communities could not be identified. The advocacy coalitions behind the main health reports do not seem to have been strong enough to push the agendas in an effective way. This has probably been due to a number of reasons, including people involved, lack of comprehensive convincing models and strategies, and financial and political support issues.

One reason for this weak advocacy can also be connected to what happened shortly after the Alma-Ata conference. At that point the coalition from WHO and UNICEF broke, leaving behind a discourse that was not on different health system models, but on the question of vertical *vs.* horizontal models ("selective primary health care") – again these specific debates are often, but not exclusively connected to health systems in developing countries. Expressed in relation to policy models for health systems this can translated into the question: Should we spend any resources on health systems; or should we rather focus on the fight against specific diseases and similar initiatives? The WHO has now moved to using the concept of a diagonal approach that combines both vertical and horizontal perspectives (WHO, 2006c). Nevertheless, as long as the activities on health systems by international organisations need constant justifications in order to maintain support – notwithstanding the repetitive political calls for giving attention to health systems and strengthening them – global discourses on the matter are also likely to remain under-developed.

Another reason is the lack of strong market ideologues in health. This is an important contrast to the pension discourse that has been characterised by market proponents such as Robert Holzmann and Estelle James. The only truly divergent "voices" with regard to health systems seem to be coming out of the IFC. Here, however, it has been argued that IFC staff does not seem to be interested in understanding health systems as such, but rather focus on how to fulfil the IFC's general mandate in the health system. The other divergent voice comes from the CSOs who, on their part, seem to limit their interpretation of other global health actors, particularly the World Bank, on rather outdated or one-sided information, and developing a normative position as an alternative that only partly is one.

8.3 Conclusions

In conclusion, this chapter has argued that the two global social policy fields of health and pensions are remarkably different when it comes to the forms and levels of competition or contestation between global health actors, concepts and communication channels.

Indeed, roughly the same actors are engaged in the two fields of social policy models by international organisations. One could have imagined a pension-like contestation between the World Bank on the one hand, and the WHO and/or ILO on the other. Instead looking at health suggests that there is rather consensual knowledge on the general structures and basic aims of health systems, while differences are in some specifics (for example how to approach the issue of benefit packages) and on the normative starting point of documents (thus "making health equity" versus "improving health"). In addition to these three actors, the OECD has been identified as an increasingly important health actor employing a somewhat different approach that seems to be successful in terms of legitimacy and trust (an activity-specific mandate, a careful selection of health system issues to be

tackled, and a carefully even-handed approach to member states' health systems).

Accordingly, while with pensions demonstrating "we have the best solution" seems to be part of the game, that is much less the case for health systems. Interviews with staff from the different international organisations studied here have suggested different reasons why what is going on in the field of health systems is different: An interviewee from the ILO[109] suggested that there is less opposition between different international organisations and more collaboration. An interviewee from the World Bank[110] mentioned that the discourse on health is worse (than that of pensions) because there are many positions and not two that can be clearly distinguished. An interviewee from the OECD[111] thought there were rather a lot of unanswered questions than strong contradictory positions. The models and activities have been described as being characterised by uncertainty about the issue, looking for consensus and collaboration (even to the extent of explicitly avoiding a controversial discourse as in pensions), and fighting for the right and support to appropriately deal with health systems at all rather than the a "war of positions" (Deacon, 2007) on different health models plus a unique position in global social governance in the field of health systems. This "avoidance" was expressed in both documents (explicitly in ILO, 1999) and interviews.

An interesting question would be whether or not that is "better"? The global ideas as characterised above could, on the one hand, be interpreted as a way forward to jointly tackling the issue of health systems. On the other hand, given the attribute of an under-developed discourse used above it could equally express the concern about a global health activity that is very much needed, but much less able to develop to its full potential. The lack of explicit debates at global policy levels could be an indicator of lack of real attention to the issue.

---

[109] Geneva, 5 December 2006
[110] Washington, 24 May 2007
[111] Paris, 8 December 2006

However, reasons for these differences could also be in the nature of health systems being associated with so much more than systems of social protection or redistribution. Comparing the pension discourse to that of health raises questions concerning the respective long-term *vs* short-term/emergency character of proposed models. While for pensions it is obviously about generalised, global, long-term redistribution models and issues of encouraging capital growth through savings, that is not the case for all models on health systems, or not as important as in pensions. The global reflections of health systems are often simultaneously concerned about emergency care, short-term, medium-term and long-term ideas and perhaps a reason for not coming up with one rather concrete model of health systems is the very fact that such a broad task goes beyond what a health system model can achieve.[112]

In the following chapter, the points made here are taken up and used to contribute to and to some extent challenge current definitions, descriptions and characterisations of global social policy in general, and to approaches to study global social policy.

[112] An enjoyable introduction into this is YAZBECK, A. S. 2002. An Idiot's Guide to Prioritization in the Health Sector. *HNP Discussion Paper*. Washington, D.C.: World Bank.

9. Contesting Contestation in Global Social Policy

This thesis has been set out to discuss and test some common features and understandings of global social policy analysing policy models for national health systems by a number of international organisations. For this purpose the discussion was structured to investigate patterns of (non-) contestation in global social policy literature in the fields of global policy actors, ideas and communication channels. These findings from global models of health systems were subsequently compared with those on pension systems as reported in the global social policy literature (Ervik, 2005, Deacon et al., 1997, Orenstein, 2005, 2008). This chapter goes back to discussing the main research question as introduced in the introduction (chapter 1), namely: What do the differences between the global social policy fields of pensions and health systems imply for a general theory of, and analytical approaches to, global social policy? Approaching this question, this chapter refers back to the characterisation of global social policy research and analytical and methodological approaches as presented in Part I, and reflects on this in the light of the discussions in the chapters 7 and 8.

Global social policy has been defined as being in part about the transnational sources of ideas and influences on national social policy. Particular attention has been given to its actors, ideas and communication channels. Global social policy has further been conceptualised as having two dimensions or mechanisms: a form of policy prescriptions for national social policy and a supranational form of global social redistribution, regulation and rights (e.g. Deacon, 2007). The research reported in this thesis had been situated in the first of the two dimensions, namely it has been concerned with global policy models for national health systems.

Many reflections on global social policy have been driven by assumptions about actors competing for roles in social policy at the global level and with regard to national social policy, by the notion of overlapping and competing actors, contesting ideas in the form of different social policy models

expressed by different global actors and arguments about more or less powerful means to communicate such ideas (Deacon, 2007, some contributions in Yeates, 2008b). Deacon (2007) describes a "war of positions" between global social policy agencies and actors on positions such as public versus private provision of social policy schemes and questions of redistribution. The conclusions of this thesis' analysis partly suggest otherwise and, accordingly, the main and very general argument of this chapter is: it is not all about contestation. Looking at other than the pensions discourse, and conducting a detailed comparison of models of health systems produced and communicated by international organisations lead to a much more nuanced description of global ideas on health systems, for which the term "discourse" might not be the best description. This needs to be taken into account when generalising about the nature of global social policy as such. This argument is further developed in the sections to follow. Following the structure that has guided the whole thesis, this argument is developed in section 9.1 concerning the global social policy actors and their mandates, in section 9.2 for the policy ideas developed by international organisations and in section 9.3 related to the dimension of communication channels. Section 9.4 discusses some implications for the study of global social policy in terms of the methods and analytical frameworks employed in this thesis. Finally, section 9.5 summarises these points and concludes the thesis.

9.1 Global Social Policy Actors – More Than Competing and Overlapping Agencies?

The international actor involvement in health system ideas replicates the global social policy actor scenarios of the literature, we find both international financial institutions and UN social agencies involved. In addition, there are other actors (international organisations) outside the UN system, such as the OECD and the WTO. These actors are involved in activities that can be classified as forms of providing policy models for

national health systems, namely they produce models of health systems, and communicate them through various channels. The WTO appears to have an impact on national health systems in that it influences health system regulation without theoretically engaging in the issue. This has led to the conclusion that there is a multiplicity and variety of actors engaged in this dimension of global social or health policy which accords with literature on global (health) governance (e.g. Held and McGrew, 2002a, Wilkinson, 2002, Hein and Kohlmorgen, 2008), as well as with other characterisations of global social policy (cf. Deacon, 2007). These different ways of justifying an international organisation's involvement in the field provides evidence for Orenstein's (2008:61) claim that "transnational actors seek new mandates and provide themselves with new legitimacy". However, are they competing in the way it has been described in the literature, or rather where and how do they compete? The analysis of the actors suggests that, instead of competing for an exclusive right to shape national social policy in the field of health, international organisations are increasingly pressured to justify their own activities in the field as such and to keep up institutional and member state's support for these very activities. By doing that, they acknowledge other, "competing" actors instead of downgrading them in an attempt to make themselves part of the same group and to signal comparative advantages. This is not only a rhetorical means but also reflected in the mutual use of each other's work as well as collaborative activities in producing and communicating ideas. However, in contrast to the actor constellation in pensions, both the World Bank and the "counterpart" WHO have been shown to lack power and support simultaneously. There is a shared concern in both organisations about too few staff knowledgeable on health systems. The WHO, though, sees its work much more constrained by this issue. While the World Bank also lacks expertise on health systems, it comes with more powerful means to communicate its ideas (most importantly its loan agreements, but also the website and the courses). The difficulty of providing a meaningful and conclusive role in providing health system models, prevents a fully

developed struggle at the level of actors. At the same time, an organisation outside the UN system, the OECD appears as a rather successful new health actor with considerably expanding activities. A constellation that is not yet reflected in most global social policy literature.

Those international organisations that currently appear to have a more stable position are those with a focus on particular groups of countries, namely the World Bank and the OECD. This is despite the character of the models studied in this thesis were those that are rather generalised and that do not just address health reforms in particular (groups of) countries. Organisations that approach the issue more universally – the WHO and the ILO – are stronger in norm-setting and regulatory activities, which, however, come along with the common lack of member states' financial and other support. This is also accompanied by a certain degree of competition among them. In short, competition is part of the game in this dimension of global social policy, but it is not the only characteristic, and thus the study conducted for this PhD contributes to global social policy literature by opening up to a more complex and more nuanced relationship between global social policy actors that needs to be taken into consideration as a contextual factor of global social policy studies. More concretely, this implies for our understanding of global social policy that we need to move beyond concepts of clearly identifiable antagonistic actors to a view to their potential to legitimise their positions and their actions. Only strong positions facilitate a strong competition. It has been shown that the WHO is lacking such a position, but this analysis also showed that the World Bank is also lacking it to some extent, not yet to speak about the ILO. It is not yet clear where the OECD is evolving to, but there are considerable issues about its "global scope"; nonetheless it is entering a sphere of global discourse on national social policy models.

The analysis has pointed to some issues or characteristics that might open ways to a more comprehensive or specific understanding of global social policy actors. The approach and findings of this research suggest that there

is an important link between the international organisations' activities and scope of their activities and the different kinds of mandates they have been given by their member states, combined with the different kinds of support they receive from their member states (and the acknowledgement of other global social policy actors). While there are certainly also dimensions of (potentially illegitimate and problematic) "mission creep" (Einhorn, 2001, Koivusalo, 1999), it needs to be taken into account that staff from international organisations also try to fulfil their organisations' mandate(s) in a responsible way (see also Orenstein, 2008). This does, to some degree, lead to overlapping agencies, and also to some competition, but this is not the only valid characterisation, and it is not necessarily of a concerning nature. This is an issue that clearly speaks from the analysis of this PhD and that is at risk of getting lost in other global social policy studies with a stronger normative stance regarding the right of a particular actor to get involved in specific global social policy fields.

Further, the relationships between international organisations and their mandates, their scope of activities and other global social policy actors appears to be much more complex than suggested by the characterisation of overlapping and competing agencies. While it is true that international organisations like the ones studied here usually do not dissolve and, thus, the competition between them does not imply complete replacement of one or another actor, continued support to particular activities is fluctuating and requires regular decisions at different levels of decision-making within the organisations. This is at least valid for the more continuous work going on at the secretariats. There are time-limited working groups like the WHO's commissions that are given specific tasks and are therefore protected from justifying their work while doing it. Also, the OECD example shows that activity-specific mandates for particular time-frames (though with the option of extension) can be more productive and easier to justify. For the latter, there have been comprehensive extra-budgetary contributions to the health project by almost all member states (see Kaasch, forthcoming, Deacon and Kaasch, 2008). This has happened at the same time as the WHO is

struggling to keep up with health system work and at the World Bank there have also been concerns about reductions in health system staff (thus limited allocations from the World Bank secretariat budget). The case of the World Bank, though, also testifies to the complexity of legitimacy and support for international organisations in general and to their health work in particular. This can be illustrated by Norway, which has recently decided to give extra-budgetary contributions to the health system research activity of the World Bank, at the same time as the very same country is considering refusing regular contributions to the World Bank due to discontent with policies of conditional loans.[113] Further, the case of the ILO's role in policy models for health systems shows that the mandate itself is not enough when so few staff are devoted to a particular activity. This implies that there are considerable constraints in keeping up a position once it is established, but that this is not necessarily due to another international organisation being more powerful. The analysis of the international organisations engaged in policy models for health systems has shown that there is currently more concern about getting health-system related activities properly running and extending them, than there is one of a (destructive) competition between international organisations. To that end, international organisations have also been engaged in various forms of collaborative activity in order to join forces on health systems. It is not a simple, two-sided up-and-down process with regard to the most powerful actor; and positions are not fixed in the longer term. In this, the study reported in this thesis introduces other explanations to the characterisation of global social policy than one can get by simply generalising from the pensions discourse.

The literature at times expresses concerns about the involvement of certain actors in social policies. However, instead of worries about such involvements, it is also worth considering the implications of international organisations that potentially or actually have an impact on national health policy, but are *not* extending their mandate or scope of background research activity to understanding the nature of health systems. This point can be

[113] See ***Global Social Policy*** *digest* 8.1 and 8.2

illustrated by the example of the IMF that – compared to the World Bank – has not developed a health activity from its mandate, while arguably having some impact on health policy. There is no sign of IMF staff even having taken seriously the attempt by Heller and Hsiao (2007) to teach them the basics about health (for more detailed criticism of the IMF's impact on health see Center for Global Development, 2007). Similarly, the IFC's health sector activities do not appear to be integrated into the more considered approaches of the World Bank. One would wish to see more conscious approaches from the WTO when dealing with health issues. Rather than inferring an intended "mission creep" by such actors, one could equally well understand their activities as unintended expansions to health-related issues, but within original mandates. The question would then be about how to design the policies in a way that respects the specifics of the health sector? The reaction of an international organisation in turning to research, followed by policy models for health systems, might be a corollary in the form of an expanded (definition of the) mandate, rather than a "creep" in the sense of disputing another organisation's role. This thesis has pointed to some ways of reflecting the concept of 'overlapping and competing' agencies in alternative ways to the mainstream global social policy literature.

Clearly, one can argue that all other international organisations could just refer to *the one* health organisation, the WHO. However, it has been shown earlier that, on the one hand, there are also other legitimate actors (ILO and to some extent the OECD) and that, on the other hand, the WHO has not fully been able to establish sufficient trust and to communicate knowledge in a way that would make it easy for some other actors to apply it to what they do. This way, a division of labour between global agencies becomes a complicated endeavour.

Summing up, the findings from the analysis of global health system ideas suggests that it is not for all social policy fields obvious who the actors are, how they overlap and/or compete and how the involvement of these

different actors is to be judged. A two-sided antagonistic picture is not easily drawn for global social policy in the field of health systems. A non-UN system international organisations such as the OECD might be the evolving new centre of transnational health policies in different shapes, and the very engagement of various international organisations in health system considerations are not easily classified as legitimate or illegitimate, powerful or not. This is even before we take into account various other categories of global social and health policy actors, such as CSOs.

9.2 What If Ideas are Just Not That Contested?

Considerable activity by a number of international organisations has been identified on developing ideas and models of national health systems. On the content of these policy models, it has been concluded that there are important differences as to the normative basis of different international organisations (and to some extent between approaches within the WHO), however these do not translate into fundamentally different concepts of health systems with regard to the public-private dimensions and degrees of (de)centralisation in the dimensions of provision and financing, nor with regard to the regulatory relationships (with the exception of ideas about the benefits package that differ on content- or process-focus). This means that the general models of health systems developed and communicated by international organisations are not fundamentally contested. The notable exception is the IFC that pursues a business-health objective in support of private providers (and in the future possibly also private insurers) and is poorly related to the existing knowledge and other World Bank activities on the matter.

At the same time, these shared ideas do not add up to a clear model of health system related to a particular tradition of a welfare state. This has been associated with a situation of uncertainty about best models or reform directions, along with incomplete or fragmented models. The fact that

models are less complete could be interpreted as the reason behind little contestation. However, the analysis has shown that there is factual consensus on issues such as universal access to health services and the avoidance of general budget cuts in the health sector. The process of getting more alike has further been linked to the more or less conscious avoidance of contestation with regard to health systems that might also be linked to the issue of uncertainty. However, there have also been contested issues such as the user fee debate.

Thus, compared to pensions, global ideas about health systems is much less characterised by contestation in the form of two clearly distinguishable models promoted by global agencies and advocacy coalitions. Accordingly, the findings of this analysis further challenge the commonly held view in part of the global social policy literature (e.g. Deacon, 2007, Yeates, 2008b) that global discourses are first and foremost characterised by contested ideas or represent a "war of positions" on social policy models. The following paragraphs reflect on the implications of this thesis' findings for global social policy concepts more generally.

If an adequate description of global social policy discourses is to take proper account of health systems as studied here it would need to distinguish different dimensions or forms of global policy ideas. This thesis' analysis has shown that there are differences at the level of the underlying normative stance of different international organisations or documents within particular traditions. This, however, has not – as in pensions – led to fundamentally different health system models proposed by these actors. Accordingly, a more comprehensive definition of global social policy as global discourses would have to take into account that the "war of positions" does not characterise all social policy fields in the same way and would have to recognise notions of similarities or consensus. It is noteworthy how, while talking about differences and contestation, some global social policy literature and the output of some civil society organisations finds neo-liberalism and marketisation everywhere. The literature seems to be caught

in a notion of reproducing conflictive accounts – while a parallel stream of the literature, namely that on diffusion, continues to reproduce world-wide convergences. This thesis has been an attempt to bridge the two types of explanation and develop upon notions of both differences/competition *and* similarities/collaboration.

Further, the difficulty of associating health system ideas produced and communicated by global actors with particular types of welfare state or health system arrangements has been partly explained by perception of a lack of knowledge and not possessing a "best model" on the part of the international organisations. Current models or reform ideas can be at best characterised by adjectives like *incomplete* or *fragmented*: they do not add up to a comprehensive set of policy advice to approach health systems as a whole. Thus, an appropriate definition of global social policy would not only assume the promotion of best models, but also include concepts of global uncertainty about desirable social policy. Orenstein (2008:8f, referring to Nelson 2004) states that

> *pension policy is unusual in being dominated by a clear set of ideas promoted by a powerful international organization and its partners. Other policy areas may display greater fragmentation in transnational policy advice, less focused transnational campaigns, and more resistant domestic politics. No doubt, the campaign for pension privatization has been particularly well organized and successful.*

Connected to this uncertainty, the analysis of the health system ideas along the public-private lines and degrees of (de)centralisation in the health system ideas proposed has not proved to be entirely feasible. Much of the consideration in related documents refers to advantages and disadvantages of different options without concluding on one best way. The most adequate summary of global ideas here would be that the state should be strengthened in the health sector without demonising private actors, but strongly promoting them neither. The only exception has been the IFC appearing somewhat immune to otherwise shared ideas on priorities in health systems – however the IFC's activities are a strategy for supporting private actors,

not an attempt to formulate comprehensive health systems.[114] If it is about identifying differences between approaches, global social policy approaches need to be more open to other dimensions of differences than the public-private dichotomy that often prevails.

Another, related issue is that of the possibility of *intended consensus*. In this sense, questions like the following would arise: What does this imply, and how can it be conceptualised in global social policy analysis? Are there "wars of position" hidden behind politically correct statements that only simulate consensus? Do staff within international organisations put constraints on thinking about options because they are afraid of being criticised and losing ground in terms of justifying their health engagement? And how do we gain evidence for these findings? A call for more investigation in the form of more interviews and perhaps even anthropological approaches to the topic are certainly well placed. It would, however, be a misconception to believe that this only provides evidence for opinions supporting a claim for contestation, hidden behind politically correct public relations statements as found in publicly available documents and other data sources. Interviews conducted for this research have also provided evidence for a significant perception of international organisations staff of their work not being correctly reflected in academic literature on global social policy.[115] It is crucial to be critical of oneself as a researcher also with regard to the potential impact and what kind of uptake certain interpretations generate and whether or not this has the intended result. Thus, while one certainly cannot be free from normative positions and it is up to the individual researcher to what extent one want to be guided in research by that, some global social policy literature is at risk of sticking with fixed normative positions and thereby not reflecting processes that are characterised by other features. This thesis has provided some evidence and makes a contribution to the debate by pointing out some other interpretations to global social policy phenomena.

---

[114] However, this is still a matter for concern.

[115] World Bank (Washington, 24 May 2007); OECD (Paris, 8 December 2006)

Last but not least it has been shown that the actor constellations and advocacy coalitions sharing a particular normative position (no matter how that translates into a final policy model) are not always, or not sufficiently, described by distinguishing between IFIs and social agencies. The analysis of global ideas about health systems has rather suggested that there are, amongst other things, the following groupings: (a) The IFC versus all others when it concerns the question of explicit support to private actors in health systems. (b) The World Bank and the ILO versus the WHO (Alma-Ata tradition) on the question of how to start building up health systems – with the aim of improving health as such or with the aim of (re)establishing equity. (c) The World Bank and the WHO (WHR2000) together on the analytical concepts of health system functions and their basic components. (d) At the same time the OECD produces high-quality and even-handed work but only on very specific aspects of health systems and avoids statements about most desirable health policy, and (e) the WTO approaches the field within a completely different logic and does not provide explicit models of health systems and/or their functions. Given this, it seems to be impossible to allocate actors into clearly distinguishable health system advocacy coalitions, and new explanatory attempts are needed to capture other than two-sided forms of contestation. The discussions of this thesis can only be regarded as a starting point to such an endeavour.

9.3 Challenges to Communication

On the dimension of communication, it has been found that the different global health actors use rather similar means, but with differences in the quantity and quality of their use. The ILO probably comes closest to having some regulatory "power", however this is a fairly "theoretical" power that does not make it a particularly strong health actor. Health regulations by the WHO have not touched health systems in the sense studied in this thesis. However, the latter is still the most important norm-setting organisation on

the scene. The World Bank, with comparatively least power to facilitate international health law, has been described as most powerful in influencing national health policy (through projects, conditional loans); but it is also a powerful source of numerous publications and World Bank staff regularly teach a flagship course on health systems. The OECD is likely to gain increasing communicational power through its health data, comparative work and case studies on OECD health systems because of its reputation as a source of high-quality data and considered policy advice. In general, the main form of communication has been the facilitation of exchange about health systems and thus non-coercive mechanisms of policy learning.

What does this imply for the study of global social policy? Common contributions tend not to distinguish between different forms of communication of social policy models. However, international organisations possess different communication tools and may use them in different ways. Understanding relative influence by that way requires more detailed studies about different communication channels than reflected in current global social policy research that either is very quick in determining more or less power by actors, pointing to World Bank projects versus financial constraints of UN social agencies; or focusing on case studies of the influence of external actors on national social policy making that do not always lend itself to generalise for the use of different communication channels by different global social policy actors.

Comparing pensions and health systems as global social policy fields has shown that they do not have the same importance either in the literature with regard to analysing the way global policy models for national social policy are understood, or in the inter-international organisation debate about policy models. This is reflected, for example, in the status and connected communication channels given to Averting the Old Age Crisis, compared to the WDR1993 and/or the WHR2000. The lack of a clear and convincing model for health systems has certainly contributed to the limitations of communicating related ideas. While the ideas of the GHW and that of the

IFC are more sharply differentiated, they have not been included as full cases in this study for different reasons. The GHW is not the product of an international organisation. The fact that it provides an alternative model can be interpreted as a more developed global discourse happening between groups other than international organisations. The IFC is only part of the World Bank Group and its health system concept is underdeveloped, thus it would certainly not develop its influence through the channel of communicating conceptual or theoretical knowledge about health systems. Further analysis could explore whether or not the World Bank's flagship course on health systems was developed as a copy to that on pensions, and compare the differences between these courses as tools of communication. This analysis has, however, concluded that global models about health systems are much less developed than that on pensions, which is importantly linked to the use of more or less powerful communication channels and cannot be replaced by a search and description of some instances of contestation on some detailed aspect of health systems. If we want to come to general conclusions and definitions of global social policy in the dimension of prescriptions to national social policy making, we need to take into account different characteristics of different fields of the welfare state.

Coming to a conclusion about communication channels in this analysis has certainly been the biggest challenge because the focus was on the sender side only (see Leisering, 2005). Thus, the strategies of international organisations were addressed without studying impact or complete transfer processes. While notions of competition and unequal power distribution have implicitly characterised global social policy literature, conceptualising them and providing for analytical frameworks has not yet been undertaken in a sufficient way. Such perspectives on just one side of, or source within, transfer or diffusion processes have been difficult to analyse to a satisfying extent. A more meaningful discussion of communication and the power of international organisations would certainly need to include analytical steps towards impact and effect of their activities. This could not be done within

this research project. The research reported here is, however, valid in the sense of mapping and discussing a *global* social policy process into detail that is commonly referred to just in one sentence as an assumption to other studies, without ever questioning the validity of that assumption.

Nevertheless, there are still some reflections and suggestions coming out of the final analytical step. One explanation for differences with regard to communication channels is connected to the different types of countries addressed. This can be seen by, in particular, looking at the World Bank's range of communication tools including conditional loans versus the OECD's careful approach to health policy models in the form of comparative discussions on the advantages and disadvantages of particular health reforms. This is not to suggest that the World Bank is not also influencing high-income countries with policy ideas (Orenstein, 2008) or that the OECD is only a point of reference to its own member states (Deacon and Kaasch, 2008). However, a careful distinction of the potential impact of different international organisations on different groups of countries (such as high-income, middle-income, low-income or transition countries) is a critical issue in understanding global social policy and the (potential) power of its actors. Further research into the field would be worth taking into account such perspectives, thus looking at different implications and characterisations of such global social policy discourses differentiating between different groups of countries, both referring to their income-levels as well as to regional affiliations.

This would probably also specify the different diffusion mechanisms as distinguished by a number of authors (e.g. Braun and Gilardi, 2006, Elkins and Simmons, 2005, Orenstein, 2003). For example, events of policy learning might have a different character when taking place at an OECD ministerial meeting, at a World Bank flagship course, or at a conference convened by the WHO.

Also, a better understanding of, and more careful distinction between, the different dimensions or mechanisms of global social policy would support a

better account of different powers to communicate ideas. Redistributional forms of global social policy connected to aid and/or conditionalities rather take coercive forms and often involve analyses of underlying notions or concepts of desirable social policy. The type of policy models analysed in this thesis is more about forms of learning and competitive or cooperative interdependence. Classifying mechanisms of global social policy and related forms of communication channels have important implications for generalising findings and characterising global social policy in general. This study, for example, has revealed that only few actors are truly engaged in developing models on health systems, while others (most prominently the WTO) might have an important influence on the development of health systems using other global social policy mechanisms, namely forms of regulation or international law. It is important to improve our understanding of such mechanisms in order to avoid simple support or rejection of the involvement of particular actors and support this with compilations of evidence that just speak for one interpretation of the matter.

It has further been shown that while international organisations do have a degree of autonomy and function independently as global social policy actors, they are nevertheless dependent on the support from their member states, both concerning financing and legitimacy to act. The link to particular member states has not so much played a role in shaping concrete ideas or models, but it has been shown how different international organisations are in different ways empowered or constrained by their member states to act with regard to developing and communicating ideas on health systems. This includes the problem of particular images of, or unintended messages from, international organisations that influence communicational power. The example given has been the World Bank that is continuously associated with the promotion of user fees, even though it has changed its position on this. Also, countries are engaged in the decisions about the character and scope of international organisations' guidance of health systems; they ask for policy analyses and may or may not take up on general or country-specific advice that has been produced in forms of

studies and publications by international organisations. Accordingly, countries are not only *exposed* to global social policy actors.

There is still much to learn about communication channels and it is hardly possible to come to conclusions here as to whether they are used in rather competitive ways or rather characterise shared strategies. It is most certainly both. Still, in the light of the conclusion that the policy models proposed do not significantly differ, one has to ask if it matters who is most powerful at the level studied in this thesis. This again speaks to more careful distinctions between different forms of communicational power.

9.4 Reflections about Analytical Frameworks and Methods

While the above summaries and discussions have primarily been about the fundamental elements of global social policy concepts, the analysis undertaken for this thesis also allows for some reflections and conclusions about the methods and analytical approaches used to study global social policy. The starting point for developing the research questions guiding the analysis has been the assumption in global social policy literature that there are different global policy actors in competition with each other for the right to shape global social policy, for particular social policy models and for communication means. The research design has been developed to conduct such an analysis of contestation using documents and a few interviews as data sources.

Combining a comparative study design with the use of directed qualitative content analysis (cf. Hsieh and Shannon 2005, Potter and Levine-Donnerstein 1999) has been a useful way of testing and studying global social policy. This made it possible to make data (texts) comparable that used different terms and had different structures. It has not led to only finding supporting evidence to the research question and approach to be tested (cf. Hsieh and Shannon, 2005), but rather to supporting *and*

unsupporting evidence. However, comparative analyses have weaknesses, and they have also become apparent in the research for this thesis. Comparisons tend to be descriptive, and do not capture the relationships between actors as well as other methodological tools such as impact analysis or discourse analyses. The explanations are generated from the fit or non-fit between cases and/or ideal-types, not by tracing the real interactions between organisations. While this is a clear limitation, looking at global social policy literature more broadly, it is, however, evident that this kind of detailed and careful analysis of the models proposed by global social policy actors as has been conducted here is often neglected in favour of a normative or reformist ideal guiding the analysis. Both types of analyses are valuable. I would argue, however, that it is important to distinguish between them more carefully in academic work. It is a common criticism from part of the academic community that global social policy is atheoretical (Yeates, 2008) and too normative, and the kind of analysis undertaken in this thesis was an attempt to give a more empirical and grounded basis to the understanding of global social policy in its dimension of policy prescriptions by global social policy actors.

The research has involved the use of qualitative data, only. This was adequate for the research questions, however, it could have also been argued that some more sense of quantities (e.g. number of documents by particular organisations or staff numbers) could have been informative. Only looking at mandates, content of documents and strategies (particularly when leaving out actual impact), might overemphasise one actor in relation to others. At the same time, disqualifying actors from the analysis just because they are not able to produce the same amount of information or the same quality of communication means would also limit the analysis in two perspectives. First, the actors discussed here do acknowledge each other as global social and health policy actors. This means, they are more or less informed about each other's work, might consult each other and collaborate to some extent, and by that way "make" each other global health actors with regard to health systems. Second, thinking about desirable global social and health policy

might intend to strengthen particular actors that are, currently, not comparable in terms of output and power, but might be well justified to engage more in the future. Particularly the use of qualitative data analysis software would certainly provide a useful tool for further research to include quantities in the analysis in terms of the use of certain terms of concepts in documents that are not so clearly about health systems.

Further, with regard to the interactions between actors, citation analysis and a more extensive use of interviews would be worthwhile when making further research in this area. While citation analysis provides information about the take-up of particular reports and ideas, interviews can deliver more insights to the role of individuals involved, their possible movements between organisations, the history behind documents and issues that are not disclosed in official documentation. The interviews conducted for this PhD research did reveal a few instances of such information, however, the specific purpose of this study and the extent to which interviews have been undertaken, was – in the opinion of the author – not enough for generalising from these findings.

What do the conclusions of this analysis say about the analytical approaches used? The comparison was undertaken for three dimensions of global social policy understood as the ideas of global actors about national social policy, namely issues of the mandates, ideas and communication channels of international organisations. The aim was to compare different global health actors on these three dimensions in order to come to conclusions about the degrees of differences between them. However, it was also important to allow for capturing (potential) similarities. The value of a comparative approach is that it is open for both kinds of findings and conclusions, not searching for examples or instances of differences.

This is, of course, not a suitable approach for an analysis of global social or health *governance* in the sense of mapping all of the actors involved in a particular policy issue or the interactions between them or analysing the power of actors in a particular country or region. The study has not claimed

to do that, but further research building up on the findings of this thesis would certainly be worth analysing if and how the models identified here matter in specific contexts. Such analyses could draw on the policy transfer literature and development literature more extensively than this study did.

Looking at the *methods* used, the combination of documents as the main data source and elite interviews with staff from international organisations has turned out to be adequate for the purpose of the analysis. Naturally, conducting a multi-actor study limits the extent to which one can go into detail with any of the organisations studied in terms of number of documents and interviews. However, the analysis and discussion of findings revealed numerous ways that more in-depth analysis of specific aspects could lead to a refinement of the conclusions. For example including more interviews or tracking the biographies of professionals moving between international organisations which might explain a degree of similarity between organisation ideas but also reveal real differences behind specific terms much better. It is the very character of a rather macro- and comparative perspective that limits the research of exploring some of the more specific, interesting and crucial policy and reform impact issues involved.

The use of websites for gathering data has turned out to be a rewarding activity due to their multidimensional functions, and the amount of information that can be accessed through them. However, it also needs to be taken into account, that organisations differ as to what information are made available through the websites and how easy it is to use them. These issues can only be learned, less changed by the researcher. Studying websites is, for this reason, also not the only way to gain data. References from primary and secondary literature appeared to be a useful additional tool for getting an idea about the scope of an organisation's activities in the field. Interviews, on the other hand, were not very useful in obtaining further documents. Another issue was the difference in information presented at the websites and the different forms of documents available. The text of the

websites itself has only at rare occasions been taken into account as the source of information as such and has rather been used for checking consistency. The websites are, of course, as means of self-representation of organisations much more prone to statements of political correctness than are other documents. At the same time, one cannot equate the information provided at the website of an international organisation with, for example, national governments' pronouncements on their web sites. While part of the utterances of political correctness from international organisations are there to make sure they stay within their mandates and justify their work appropriately in order to secure their own funding, there are still differences to nationally elected politicians and governments. It has to be taken into account that international organisations are not democratically elected institutions, and that they have also other than "political" functions. One of these functions is research-like activities and products, as have been studied in this thesis. Finding ways to capture this, however imperfectly as has been shown in this thesis, is the very issue of framing global social policy as a theory and methodology more thoroughly.

Selecting documents that approached health systems in a comprehensive way (instead of selecting material for each of the health system functions) generally worked well. However, regarding the aspect of access of health providers to health markets, it turned out that this was not addressed in the documents studied, while it is certainly an issue of global health policy, namely with regard to trade agreements that have been taken out of the analysis for other definitional reasons. This is one of the issues that would certainly be worth taking up in further research. This implies, that there is plenty of documents from the actors studied here and other, additional actors that would be worth being subject to further study. One could look at the degree to which they accord with the general models identified, but also in the sense of an impact analysis regarding which kind of communication channels matter most or in what way.

The interviews were rewarding concerning the testing of findings and interpretations. It would be worth, in future research, to make more use of interviews in order to get a better understanding about some of the single organisations' health systems' activities and trace some more background stories to particular ideas, documents or programmes. It would also be worth studying other actors than international organisations with regard to their health system ideas and activities, however, this would require adapted analytical and methodological approaches.

In terms of the analytical framework, regarding *mandates*, the mapping of international organisations was a useful step for identifying relevant global policy actors for the field of study. However, this analytical step did not reveal any "new" actors, but was rather focused on those typically engaged in global social policy activities. Still, the ILO and the OECD were identified to have a more important role than they are usually given in the literature on global social policy. Allowing for both competitive and collaborative relationships between actors, the study has not embarked on any single way of conceiving global social policy and its governance, but on different approaches of international relations literature in order to grasp the complex actor constellation. This has allowed for highlighting at the same time intergovernmental processes going on, as inter-organisational or struggles between epistemic communities. Constructivist perspectives have further allowed for the linking of the activities of international organisations with their social identities and thus their original mandates. Nevertheless, using a multiplicity of approaches has, to some extent, been to the detriment of systematically tracing specific global social policy structures such as particular forms of networks.

Coming back to the use of the term *discourse* it has been explained that global ideas on health systems have been studied in order to conclude on the existence and character of a discourse that could be compared to the one in the field of pensions. It was not an analytical decision for a genuine discourse analysis. In future research, a thorough discourse analysis could

be undertaken with regard to the fight over specific issues within health system functions, such as the specific mix of public-and private actors in health provision.

The decision to focus on international (governmental) organisations has been due to the literature tested and the scope of a PhD. Given more recent developments such as suggestions to strengthen the role of the GFATM with regard to its health system (Ooms et al., 2007) and health system activities with regard to G8 summits (e.g. Task Force on Global Action for Health System Strengthening, 2009), future research should definitely take into account also other actors, also including CSOs as shown with regard to the *Global Health Watch.*

The analytical dimensions of mandates and *ideas* were linked through including questions about contexts, underlying principles and definition to health systems to the health system models of international organisations. Particularly with regard to ideas, developing a detailed analytical framework to capture the functions and sub-functions of health systems in general (based on comparative welfare state and health system literature) has generated interesting results. For example, it made it possible to identify discussion about particular issues or functions within health systems instead of just focusing on "big ideas". It has also avoided taking discourses on specific issues such as user fees for discourses on health systems as a whole. Another advantage of the analytical approach used to study the content of ideas was that changes in ideas could be studied not only in terms of shifting normative positions, but also as shifts in focus on particular aspects (functions) of health systems.

A continuing problem with designing global social policy research on the basis of comparative welfare state research is, however, the applicability of models and categories developed from and for OECD countries to non-OECD countries. For analytical reasons this might be less of a problem in a study such as the one conducted in this thesis because the theoretical work of international organisations is also often strongly based on experiences

and models from developed countries. It might, however, be a problem with regard to doing justice to other countries' health systems development and, thus, also with regard to judgements about the usefulness of policy models for these countries through the global actors studied.

For the issue of *communication channels*, diffusion, transfer and actor-centred approaches all have contributed to understanding the mechanisms and strategies used by international organisations (or the "sender" side of communication processes). To some extent, this study provides an argument to findings from diffusion or world society studies as they point to patterns of convergence, more than competition. Particularly concepts of mutual observation (Levi-Faur, 2005) and inter-organisation learning have served as useful explanatory tools for what is going on between global health actors. At the same time, it needs to be taken into account that part of the commonalities also stem from the fact that international organisations as a group of actors also have similar features bound, for example, to structures such as mandates and member state demands. These issues are better captured in approaches to global social policy actors.

9.5 Summary

Echoing the introduction to this chapter: it is indeed not all about contestations. If there were a general "war of positions" in global social policy, a look at the health systems ideas suggests that it is much more complex than two groups of international organisations (and other actors) with two versions of desirable social policy and more or less powerful means of getting their ideas across.

It has been shown that the roles of international organisations and their policy advice can at times be ambiguous and multi-faceted and that alliances are not necessarily fixed, both looking at different social policy fields, but also at different bits of ideas that make up health systems. The scope and

ability to engage in developing health system models have also varied over time. This is importantly connected to member state support to the work of international organisations. In this context, it has been shown that mandates do matter, at least as much as "mission creep" matters. Global models of health systems have further been characterised as importantly including elements of uncertainty, neutrality, and intended consensus or convergence.

All this suggests that in order to be comprehensive current global social policy concepts need to take account both conceptually and analytically of more than just competition and contestation patterns. To make a truly comprehensive description of global *social policy* would require inclusion of other social policy fields as to the extent that they support or reject the current definitions of global social policy. This goes along with a general call for more theoretical investigation of the concepts used in global social policy research. This PhD research has been intended to be a start to this endeavour. It has raised significant questions as to the degree of contestation and thus the generalisability of existing studies on the topic of characterising global social policy.

Annexes

Annex 1: List of Documents

<u>World Health Organisation</u>

MURRAY, C. J. L. & EVANS, D. B. (Eds.) (2003a) *Health Systems Performance Assessment: Debates, Methods and Empiricism,* Geneva, WHO.

MURRAY, C. J. L. & EVANS, D. B. (2003b) Health Systems Performance Assessment: Goals, Framework and Overview. IN MURRAY, C. J. L. & EVANS, D. B. (Eds.) *Health Systems Performance Assessment: Debates, Methods and Empiricism.* Geneva, WHO.

MURRAY, C. J. L. & FRENK, J. (2000) A framework for assessing the performance of health systems. *Bulletin of the World Health Organization,* 78.

MURRAY, C. J. L. & FRENK, J. (2001) World Health Report 2000: a step towards evidence-based health policy. *The Lancet,* 357, 1698-1700

WHA (1973) Organisational Study on Methods of Promoting the Development of Basic Health Services. WHA26.35. WHO

WHO-CSDH (2005) Action on the Social Determinants of Health: Learning from Previous Experiences. A Background Paper prepared for the Commission on Social Determinants of Health. March 2005.

WHO (1981) National decision-making for Primary Health Care. A study by the UNICEF/WHO Joint Committee on Health Policy. Geneva.

WHO (1998) Health for all in the 21st century. A51/5. Geneva, WHO.

WHO (1999) The World Health Report 1999. Making a Difference. Geneva, WHO.

WHO (2000) The World Health Report 2000: Health Systems: Improving Performance. Geneva, WHO.

WHO (2005a) Health and the Millennium Development Goals. Geneva, WHO.

WHO (2005b) WHO Country Cooperation Strategy. A guiding framework. Geneva, WHO.

WHO (2006a) Country Support Unit Network 2005. Partnerships for health. Geneva, WHO.

WHO (2006b) Engaging for Health. 11th General Programme of Work, 2006-2015. A Global Health Agenda. Geneva, WHO.

WHO (2006c) Engaging for Health. Eleventh General Programme of Work 2006-2015. A Global health Agenda. Geneva, WHO.

WHO (2007) Everybody's Business. Strengthening Health Systems to Improve Health Outcomes. WHO's Framework for Action. Geneva, WHO

WHO (2009) PPB/2010-2011. Proposed Programme Budget 2010-2011

WHO CMH (2001) Macroeconomics and Health: Investing in Health For Economic Development. Report of the Commission on Macroeconomics and Health. Geneva, WHO.

WHO CSDH (2007a) Achieving Health Equity: from root causes to fair outcomes. *Interim Statement*. Geneva, WHO.

WHO CSDH (2007b) Challenging Inequity Through Health Systems. *Final Report Knowledge Network on Health Systems*.

WHO CSDH (2008) Closing the Gap in a Generation. Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva, WHO.

WHO/UNICEF (1978a) Declaration of Alma-Ata. *International Conference on Primary Health Care.* Alma-Ata, USSR.

WHO/UNICEF (1978b) Primary Health Care. Report of the International Conference of Primary Health Care. Alma-Ata, USSR, 6-12 September 1978, Geneva:WHO

World Bank

GOTTRET, P. & SCHIEBER, G. (2006) Health Financing Revisited. A Practioner's Guide. Washington, The World Bank

GWATKIN, D. R., WAGSTAFF, A. & YAZBECK, A. S. (Eds.) (2005) *Reaching the Poor with Health, Nutrition and Population Services. What Works, What Doesn't, and Why,* Washington D.C., World Bank

PREKER, A. S., SCHEFFLER, R. M. & BASSETT, M. S. (Eds.) (2007) *Private Voluntary Health Insurance in Development. Friend or Foe?,* Washington D.C., World Bank

ROBERTS, M. J., HSIAO, W., BERMAN, P. & REICH, M. R. (2008) *Getting Health Reform Right. A Guide to Improving Performance and Equity,* New York, Oxford University Press.

WORLD BANK (1980a) Health Sector Policy Paper. Washington D.C., World Bank.

WORLD BANK (1980b) World Development Report 1980. Washington, World Bank.

WORLD BANK (1987) Financing Health Services in Developing Countries. An Agenda for Reform. *A World Bank Policy Study.* Washington D.C., World Bank.

WORLD BANK (1993) World Development Report 1993: Investing in Health. Oxford, New York et al., Oxford University Press/ World Bank.

WORLD BANK (1994) Averting the Old Age Crisis - Policies to Protect and Promote Growth. Washington, D.C., World Bank.

WORLD BANK (1997) Health, Nutrition, and Population Sector Strategy Paper. Washington, World Bank.

WORLD BANK (2003) World Development Report 2004: Making Services Work for Poor People. Washington, Oxford University Press/ World Bank.

WORLD BANK (2007) Healthy Development. The World Bank Strategy for Health, Nutrition, and Population Results. Washington D.C., World Bank.

WORLD BANK (2008) Better Outcomes Through Health Reforms in the Russian Federation: The Challenge in 2008 and Beyond. Europe and Central Asia, Human Development Department, Russian Federation Country Management Unit, The World Bank

WORLD BANK (2008): The World Bank's Budget: Trends and Recommendations for FY09, August 6, 2008

YAZBECK, A. S. (2002) An Idiot's Guide to Prioritization in the Health Sector. *HNP Discussion Paper.* Washington, D.C., World Bank.

YAZBECK, A. S. (2006) Economic Viewpoint: Reaching the Poor. Washington D.C., World Bank

International Labour Organisation

ILO (2005) Programme and Budget for the Biennium 2006-07. Geneva, ILO

ILO & ISSA (1997) Social Health Insurance. Geneva, ILO.

ILO SOCIAL SECURITY DEPARTMENT (2007) Social Health Protection. An ILO strategy towards universal access to health care. A consultation. *Issues in Social Protection Discussion Paper 19.* Geneva, ILO.

ILO SOCIAL SECURITY DEPARTMENT (2008) Can low-income countries afford basic social security? *Social Security Policy Briefings Paper 3.* Geneva, ILO.

ILO STEP (2005) Health Micro-Insurance Schemes: Feasibility Study Guide. Vol. 1: Procedure. Geneva, ILO

INTERNATIONAL LABOUR OFFICE (2000) World Labour Report 2000: Income Security and social protection in a changing world. Geneva, ILO.

INTERNATIONAL LABOUR OFFICE (2001) Social Security: A new consensus. Geneva, ILO.

INTERNATIONAL LABOUR OFFICE (2005) Governing Body. Committee on Employment and Social Policy. *GB.294/ESP/4, 294th Session.* Geneva, ILO

WORLD COMMISSION ON THE SOCIAL DIMENSION OF GLOBALIZATION (2004) A Fair Globalization: Creating Opportunities for All. Geneva, ILO

Organisation for Economic Cooperation and Development

DOCTEUR, E. & OXLEY, H. (2003) Health-Care Systems: Lessons From the Reform Experience. *Economics Department Working Papers No. 374, ECO/WKP(2003)28.* Paris, OECD

OECD (1977) Public Expenditure on Health. *OECD Studies in Resource Allocation No 4.* Paris, OECD.

OECD (1987) Financing and Delivering Health Services. A Comparative Analysis of OECD Countries. *OECD Social Policy Studies No. 4.* Paris, OECD.

OECD (1992) The Reform of Health Care. A Comparative Analysis of Seven OECD Countries. *Health Policy Studies No.2.* Paris, OECD.

OECD (1993a) OECD Health Systems. Volume I: Facts and Trends 1960-1991. Paris, OECD.

OECD (1993b) Volume II: OECD Health Systems. The Socio-Economic Environment. Statistical References. Paris, OECD.

OECD (1994) The Reform Of Health Care Systems. A Review Of Seventeen OECD Countries. Paris, OECD.

OECD (1995) New Directions in Health Policy. *Health Policy Studies No 7.* Paris, OECD.

OECD (1996) Health Care Reform. The Will to Change. *Health Policy Studies No 8.* Paris, OECD.

OECD (2000) A System of Health Accounts. Paris, OECD.

OECD (2004a) The OECD Health Project. Private Health Insurance in OECD Countries. Paris, OECD.

OECD (2004b) The OECD Health Project. Towards High-Performing Health Systems. Paris, OECD

OR, Z. (2002) Improving the performance of health care systems: from measures to action (a review of experiences in four OECD countries). . *Labour Market and Social Policy - Occasional Papers No.57. DEELSA/ELSA/WD(2002)1.* Paris, OECD

Joint

DROR, D. M. & PREKER, A. S. (Eds.) (2002) *Social Re-Insurance. A New Approach to Sustainable Community Health Financing,* Washington, Geneva, World Bank, ILO

ILO, GTZ & WHO (2006) Berlin Recommendations for Action - Final Version - 3 July 2006. *Internatioanl Conference on Social Health Insurance in Developing Countries*

OECD & WHO (2006) OECD Reviews of Health Systems. Switzerland. Paris, OECD

WHO & GFATM (2007) The Global Fund Strategic Approach to Health Systems Strengthening. Report from WHO to the Global Fund Secretariat. Geneva, WHO.

WHO & WTO (2002) WTO Agreements and Public Health: a Joint Guide by the WHO and the WTO Secretariat. Geneva, WHO/WTO

WORLD BANK & WHO (2002) Dying for Change. Geneva, WHO.

WORLD BANK, WHO & US AGENCY FOR INTERNATIONAL DEVELOPMENT (2003) Guide to producing national health accounts with special applications for low-income and middle-income countries. Geneva, WHO

Other

GLOBAL HEALTH WATCH (2005) 2005-2006. *An alternative world health report*. London, New York, Zed Books

HSIAO, W. (2000) What Should Macroeconomists Know About Health Care Policy? A Primer. *IMF Working Paper*. Washington D.C., IMF.

HSIAO, W. & HELLER, P. S. (2007) What Should Macroeconomists Know about Health Care Policy? *WP/07/13*. Washington D.C., IMF

ORTIZ, I. (2007) National Development Strategies *Policy Notes* Social Policy. New York, UNDESA

TASK FORCE ON HEALTH SYSTEMS RESEARCH (2005) The Millennium Development Goals will not be attained without new research addressing health system constraints to delivering effective interventions. Report of the Task Force on Health Systems Research. Geneva, WHO

UN (2006) Delivering as One. Report of the Secretary-General's High-Level Panel on UN System-wide Coherence. New York, United Nations.

UN MILLENNIUM PROJECT - TASK FORCE ON HIV/AIDS, M., TB, AND ACCESS TO ESSENTIAL MEDICINES, (2005) Combating AIDS in the developing world. London, Sterlin/VA., Earthscan.

UN MILLENNIUM PROJECT (2005) Who's got the power? Transforming Health Systems for Women and Children. Summary version of the report of the Task Force on Child Health and Matenal Health. New York/USA.

UNICEF (2001) We the Children. Meeting the promises of the World Summit for Children. New York, UNICEF.

UNICEF (2004) UNICEF and the Global Strategy on Infant and Young Child Feeding (GSIYCF). Understanding the Past - Planning the Future. *UNICEF Working Paper*

Annex 2: List of Interviews

WHO

1) Geneva (Switzerland), WHO, 2 April 2007

2) Geneva (Switzerland), WHO, 6 December 2006

World Bank Group

1) Washington (USA), Center for Global Development, 24 May 2007

2) Washington (USA), IFC, 22 May 2007

3) Phone (Bielefeld – London), IFC, 21 June 2007

International Labour Organisation

1) Geneva (Switzerland), ILO, 5 December 2006

Organisation for Economic Cooperation and Development

1) Paris (France), OECD, 8 December 2006

2) Paris (France), OECD, 8 December 2006

"Global Health Watch"

1) Nürnberg (Germany), University Erlangen-Nürnberg, 21 October 2006

2) London (UK), University College London, 29 July 2007

Annex 3: Email template

Dear [...],

I am currently working at the University of Sheffield on a project on global health policy in the field of health systems.

My research includes the mapping of international policy actors engaged in giving health systems related advice to countries, the analysis of their respective ideas, as well as the ways those ideas are communicated.

While the main methodological focus is on the analysis of policy documents (major report, strategy papers, etc.), I try to check and validate my findings by doing a limited number of interviews with people involved in developing such ideas, writing the reports etc.

Having done such interviews with staff from the [WHO/ILO/OECD/World Bank], I am in urgent need (as to the balance of information) of one or two interviewees from your institution. I wonder if you would be willing to being interviewed in this context?

I plan to be in [...] from [...]. Ideally I could have an hour or so of your time, or – alternatively – I could phone you or send some questions via email.

Thank you for reading this.

Yours sincerely,

Alexandra Kaasch

Alexandra Kaasch, PhD student

Department of Sociological Studies, University of Sheffield

Elmfield, Northumberland Road

Sheffield, S10 2TU, UK

Annex 4: Typical Structure and Questions of an Interview

1. Very short summary of my PhD research and the context and aim of the interview

2. How did the [...] get engaged in the topic of health systems? (origin, mandate, focus, programme, aims, missions, ...)

3. How does that relate to the roles and activities of other global health actors (particularly international organisations)? (division of labour, collaboration, competition, desirable global health governance, ...)

4. How is the relationship with the member states regarding the guidance of national health systems? (e.g. projects, conferences, publications; but also: are there particular (groups of) countries particularly interested in such work by the respective international organisation)

5. Questions on the content of the policy models. These were different for the different interviews mostly intended to make sure whether or not aspects of the analytical questions on health systems have been understood correctly and no information has been missed out.

Bibliography

ADLER, E. 1997. Seizing the Middle Ground: Constructivism in World Politics. *European Journal of International Relations*, 3, 319-63.

ALBER, J. 2001. Recent Developments of the German Welfare State: Basic Continuity of Paradigm Shift? *ZeS Arbeitspapier*, 6/2001.

ALBER, J. & STANDING, G. 2000. Social Dumping, Catch-up, or Convergence? Europe in a Comparative Global Context. *Journal of European Social Policy*, 10.

ALCOCK, P. 2001. The Comparative Context. *In:* ALCOCK, P. & CRAIG, G. (eds.) *International Social Policy.* Houndsmills, New York: Palgrave.

ALLIANCE FOR HEALTH POLICY AND SYSTEMS RESEARCH 2007. What is Health Policy and Systems Research and why does it matter? Briefing Note 1.

ARMINGEON, K. & BEYELER, M. (eds.) 2004. *The OECD and European Welfare States*, Cheltenham: Edward Elgar.

ATKINSON, P. & COFFEY, A. 1997. Analysing documentary realities. *In:* SILVERMAN, D. (ed.) *Qualitative Research: theory, method and practice.* London: Sage.

BABBIE, E. 2001. *The Practice of Social Research*, Belmont, CA, Wadsworth.

BAMBRA, C. 2005a. Cash Versus Services: `Worlds of Welfare`and the Decommodification of Cash Benefits and Health Care Services. *Journal of Social Policy*, 34, 195-213.

BAMBRA, C. 2005b. Worlds of welfare and the health care discrepancy. *Social Policy and Society*, 4.

BANERJI, D. 2002. Report of the WHO Commission on Macroeconomics and Health: A Critique. *International Journal of Health Services*, 32, 733-754.

BANERJI, D. 2006. Serious Crisis in the Practice of International Health by the World Health Organization: The Commission on Social Determinants of Health. *International Journal of Health Services*, 36, 637-650.

BARNETT, M. & FINNEMORE, M. 2004. *Rules for the World. International Organizations in Global Politics*, Ithaka, London, Cornell University Press.

BARNETT, M. N. & FINNEMORE, M. 1999. The Politics, Power, and Pathologies of International Organizations. *International Organisation*, 53, 699-732.

BARTSCH, S. 2003. Global Public-Private Partnerships in Health: Potentials and Limits. *In:* HEIN, W. & KOHLMORGEN, L. (eds.) *Globalisation, Global Health Governance and National Health Politics in Developing Countries. An Exploration into the Dynamics of Interfaces.* Hamburg: Deutsches Übersee Institut.

BARTSCH, S. 2005. The Global Fund to Fight Aids, Tuberculosis and Malaria: Establishment, Current Issues and Future Challenges.

Salzburg Seminar on the Governance of Health. OSI/Yale University/Temple University, Salzburg.

BARTSCH, S. 2007. Global Public-Private Partnerships in Health: a Question of Accountability and Legitimacy. *Paper prepared for the 2007 Wall Summer Institute for Research.* Vancouver, June 25-28, 2007

BENNETT, W. L. 2004. Social Movements beyond Borders: Understanding Two Eras of Transnational Activism. *In:* DELLA PORTA, D. & TARROW, S. (eds.) *Transnational Protects and Global Activism.* Plymouth: Rowman and Littlefield.

BENVENISTI, E. & NOLTE, G. 2004a. Introduction: Challenges to the Welfare State in an Era of Globalization. *In:* BENVENISTI, E. & NOLTE, G. (eds.) *The Welfare State, Globalization and International Law.* Berlin, Heidelberg: Springer Verlag.

BENVENISTI, E. & NOLTE, G. (eds.) 2004b. *The Welfare State, Globalization, and International Law,* Berlin, Heidelberg: Springer-Verlag.

BERG, B. L. 2007. *Qualitative Research Methods for the Social Sciences,* Boston, Pearson Education Inc.

BERRY, J. M. 2002. Validity and Reliability Issues in Elite Interviewing. *PS Online*, 679-682.

BEYELER, M. 2004. Introduction: A Comparative Study of the OECD and European Welfare States. *In:* ARMINGEON, K. & BEYELER, M. (eds.) *The OECD and European Welfare States.* Cheltenham: Edward Elgar.

BEYER, J. A. D., PREKER, A. S. & FEACHEM, R. G. A. 2000. The role of the World Bank in international health: renewed commitment and partnership. *Social Science and Medicine,* 50, 169-176.

BLANK, R. & BURAU, V. 2004. *Comparative Health Policy,* Basingstoke, Palgrave Macmillan.

BLOOMFIELD, B. P. & VURDUBAKIS, T. 1994. Representing Technology: IT-consultancy reports as textual reality constructions. *Sociology of Education,* 28, 455-477.

BOLI, J., MEYER, J. W. & THOMAS, G. 1989. Ontology and Rationalization in the Western Cultural Account. *In:* THOMAS, G. (ed.) *Institutional Structure: constituting State, Society, and the Individual.* London: Sage.

BONOLI, G. 1997. Classifying welfare states: a two-dimension approach. *Journal of Social Policy,* 26, 351-372.

BOSWELL, C. 2008. The political functions of expert knowledge: knowledge and legitimation in European Union immigration policy. *Journal of European Public Policy,* 15, 471-488.

BRAND, U. 2005. Order and regulation: Global Governance as a hegemonic discourse of international politics? *Review of International Political Economy,* 12, 155-176.

BRAUN, D. & GILARDI, F. Year. Taking "Galton's problem" seriously. Towards a theory of policy diffusion. *In:* 46th Annual Convention

of the International Studies Association (ISA), 1-5 March 2005 2005 Hawaii.

BRAUN, D. & GILARDI, F. 2006. Taking 'Galton's Problem' Seriously. Towards a Theory of Policy Diffusion. *Journal of Theoretical Politics,* 18, 298-322.

BREKKE, K. R. & SØRGARD, L. 2007. Public versus private health care in a national health service. *Health Economics,* 16, 579-601.

BREYER, F. & HAUFER, A. 2000. Health Care Reform: Separating Insurance from Income Redistribution. *International Tax and Public Finance,* 7, 445-461.

BROAD, R. 2006. Research, Knowledge, and the Art of 'Paradigm Maintenance': the World Bank's Development Economics Vice-Presidency (DEC). *Review of International Political Economy,* 13, 387-419.

BROCK, D. W. & WIKLER, D. 2006. Ethical Issues in Resource Allocation, Research, and New Product Development. *In:* JAMISON, D. T., BREMAN, J. G., MEASHAM, A. R., ALLEYNE, G., CLAESON, M., EVANS, D. B., JHA, P., MILLS, A. & MUSGROVE, P. (eds.) *Disease Control Priorities in Developing Countries.* IBRD/ World Bank: World Bank.

BROOKS, S. M. 2004. International Financial Institutions and the Diffusion of Foreign Models for Social Security Reform in Latin America. *In:* WEYLAND, K. (ed.) *Learning from Foreign Models in Latin American Policy Reform.* Washington, D.C. and Baltimore, MD: Woodrow Wilson Center and John Hopkins University Press.

BROWN, T. M., CUETO, M. & FEE, E. 2006. The World Health Organization and the Transition from International to Global Public Health. *American Journal of Public Health,* 96.

BRUGHA, R. & ZWI, A. B. 2002. Global approaches to private sector provision: where is the evidence. *In:* LEE, K., BUSE, K. & FUSTUKIAN, S. (eds.) *Health Policy in a Globalising World.* Cambridge: Cambridge University Press.

BRUNET-JAILLY, J. 1999. Has the World Bank a Strategy on Health. *International Social Science Journal,* 161/1999.

BURNHAM, P., GILLAND, K., GRANT, W. & LAYTON-HENRY, Z. 2004. *Research Methods in Politics,* New York, Palgrave Macmillan.

BUSE, K., DRAGER, N., FUSTUKIAN, S. & LEE, K. 2002. Globalisation and Health Policy: Trends and Opportunities. *In:* LEE, K., BUSE, K. & FUSTUKIAN, S. (eds.) *Health Policy in a Globalising World.* Cambridge: Cambridge University Press.

BUSE, K. & WALT, G. 2000. Global public-private partnerships: Part II - what are the health issues for global governance? *Bulletin of the World Health Organization,* 78, 699-709.

BUSE, K. & WALT, G. 2002. Globalisation and multilateral public-private health partnerships: issues for health policy. *In:* LEE, K., BUSE, K. & FUSTUKIAN, S. (eds.) *Health Policy in a Globalising World.* Cambridge: Cambridge University Press.

CASTELLS, M. 2000. *The rise of the network society: The information age: Economy, society and culture,* Oxford, Blackwell.

CENTER FOR GLOBAL DEVELOPMENT 2007. Does the IMF Constrain Health Spending in Poor Countries? Evidence and an Agenda for Action. *Center for Global Development Report of the Working Group on IMF Programs and Health Spending.* Washington D.C.: Center for Global Development.

CHERNICHOVSKY, D. 1995. Health Systems Reforms in Industrialized Democracies: An Emerging Paradigm. *The Milbank Quarterly,* 73, 339-356.

CHEVALIER, A. & KICKA, M. 2006. Web designers and web users: Influence of the ergonomic quality of the web site on the information search. *International Journal of Human Computer Studies,* 64, 1031-1948.

CLARK, J. 1991. *Democratizing development: The role of voluntary organizations,* London, Earthscan.

COOPER, A. F., KIRTON, J. J. & SCHRECKER, T. (eds.) 2007. *Governing Global Health. Challenge, Response, Innovation,* Aldershot: Ashgate.

COX, R. W. 1993. Gramsci, Hegemony and International Relations. *In:* GILL, S. (ed.) *Gramsci, Historical Materialism and International Relations.* Cambridge: Cambridge University Press.

COX, R. W. (ed.) 1997. *The New Realism: Perspectives on Multilateralism and World Order,* London: Macmillan.

CUTLER, A. C., HAUFLER, V. & PORTER, T. (eds.) 1999. *Private authority and international affairs,* New York: State University of New York Press.

CYERT, R. M. & MARCH, J. G. 1963. *A Behavioral Theory of the Firm,* Englewood Cliffs, Prentice Hal.

DAGAN, T. 2004. The Costs of International Tax Cooperation. *In:* BENVENISTI, E. & NOLTE, G. (eds.) *The Welfare State, Globalization and International Tax Law.* Berlin, Heidelberg: Springer.

DEACON, B. 2000. Eastern European welfare states: the impact of the politcs of globalization. *Journal of European Social Policy,* 10, 146-161.

DEACON, B. 2003. Global Social Governance Reform: From Institutions and Policies to Networks, Projects and Partnerships. *In:* DEACON, B., OLLILA, E., KOIVUSALO, M. & STUBBS, P. (eds.) *Global Social Governance. Themes and Prospects.* Helsinki: Ministry for Foreign Affairs of Finland. Department for International Development Cooperation.

DEACON, B. 2006. Global Social Policy Reform. *In:* UTTING, P. (ed.) *Reclaiming Development Agendas.* Basingstoke: Palgrave.

DEACON, B. 2007. *Global Social Policy and Governance,* London, Sage.

DEACON, B. 2008. Global and Regional Social Governance. *In:* YEATES, N. (ed.) *Understanding Global Social Policy.* Bristol: The Policy Press.

DEACON, B., HULSE, M. & STUBBS, P. 1997. *Global Social Policy: International Organizations and the Future of Welfare,* London, SAGE.

DEACON, B. & KAASCH, A. 2008. The OECD's Social and Health Policy: Neo-liberal stalking horse or balancer of social and economic objectives. *In:* MAHON, R. & MCBRIDE, S. (eds.) *The OECD and Global Governance.* UBC Press.

DEACON, B., ORTIZ, I. & ZELENEV, S. 2007. Regional Social Policy. DESA Working Paper No.37; ST/ESA/2007/DWP/37.

DENSCOMBE, M. 2007. *The Good Research Guide for Small-Scale Social Research Projects,* Buckingham, Open University Press.

DION, M. 2008. International Organizations and Social Insurance in Mexico. *Global Social Policy,* 8, 25-44.

DOCTEUR, E. & OXLEY, H. 2003. Health-Care Systems: Lessons From the Reform Experience. *Economics Department Working Papers No. 374, ECO/WKP(2003)28.* Paris: OECD.

DODGSON, R. & LEE, K. 2002. Global Health Governance: a conceptual review. *In:* WILKINSON, R. & HUGHES, S. (eds.) *Global Governance. Critical Perspectives.* London/ New York: Routledge.

DOLOWITZ, D. P. 2000. *Policy Transfer and British Social Policy,* Basingstoke, England, Open University Press.

DOLOWITZ, D. P. & MARSH, D. 2000. Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making. *Governance: An International Journal of Policy and Administration,* 13, 5-24.

DRABEK, A. G. 1987. Development Alternatives: The Challenge for NGOs - An Overview of the Issues. *World Development,* 15, ix-xv.

DROR, D. M. & PREKER, A. S. (eds.) 2002. *Social Re-Insurance. A New Approach to Sustainable Community Health Financing,* Washington, Geneva: World Bank, ILO.

EINHORN, J. 2001. The World Bank's Mission Creep. *Foreign Affairs,* 80, 22-35.

ELKINS, Z. & SIMMONS, B. 2005. On Waves, Clusters, and Diffusion: A Conceptual Framework. *The Annals of the American Academy of Political and Social Science,* 598, 33-51.

ELOLA, J., DAPONTE, A. & NAVARRO, V. 1995. Health Indicators in the Organization of Health Care Systems in Western Europe. *American Journal of Public Health,* 85, 1397-1401.

EMMERJI, L., JOLLY, R. & WEISS, T. G. 2005. Economic and Social Thinking at the UN in Historical Perspective. *Development and Change,* 36, 211-235.

ERVIK, R. 2005. Battle of Future Pensions: Global Accounting Tools, International Organizations and Pension Reforms. *Global Social Policy,* 5.

ESPING-ANDERSEN, G. 1990. *The Three Worlds of Welfare Capitalism,* Cambridge, UK, Polity Press.

EVANS, G. & MORRIES, L. 1995. User Fees for Health Care: why a bad idea keeps coming back (or what's health got to do with it?). *Canadian Journal of Aging,* 14, 360-390.

EVANS, M. & DAVIES, J. 1999. Understanding Policy Transfer: A Multi-Level, Multi-Disciplinary Perspective. *Public Administration*, 77, 361-385.

FARNSWORTH, K. 2005a. International Class Conflict and Social Policy. *Social Policy and Society*, 4, 217-226.

FARNSWORTH, K. 2005b. Promoting business-centred welfare: international and European perspectives on social policy. *Journal of European Social Policy*, 15, 65-80.

FARRINGTON, J. & BEBBINGTON, A. 1993. *Reluctant partners? NGOs, the state and sustainable agricultural development*, London, Routledge.

FIELD, M. G. 1973. The concept of the `Health System` at the macrosociological level. *Social Science & Medicine*, 7, 763-785.

FINNEMORE, M. & SIKKINK, K. 1998. International norm dynamics and political change. *International Organization*, 52, 887-917.

FOTAKI, M., ROLAND, M., BOYD, A., MCDONALD, R., SCHEAFF, R. & SMITH, L. 2008. What Benefits Will Choice Bring to Patients? Literature Review and Assessment of Implications. *Journal of Health Services Research & Policy*, 13, 178-184.

FOX, J. & BROWN, L. D. 1998. *The Struggle for Accountability: The World Bank, NGOs, and Grassroot Movements*, Cambridge MIT Press.

FREEMAN, R. 2000. *The Politics of Health in Europe*, Manchester, Manchester University Press.

FRUEH, W. 1991. *Inhaltsanalyse: Theorie und Praxis [Content Analysis: Theory and practice]*, Opladen: Westdt. Verlag.

GASPP TEAM 2005. Copenhagen Social Summit ten years on: The need for effective social policies nationally, regionally and globally. *GASPP Policy Brief*, 6.

GILMORE, A., COLLIN, J. & TOWNSEND, J. 2007. Transnational Tobacco Company Influence on Tax Policy During Privatization of a State Monopoly: British American Tobacco and Uzbekistan. *American Journal of Public Health*, 97, 2001-2009.

GILSON, L., DOHERTY, J., LOEWENSON, R. & FRANCIS, V. 2007. Challenging Inequity Through Health Systems. Final Report Knowledge Network on Health Systems to the WHO CSDH. Geneva: WHO.

GILSON, L., RUSSEL, S. & BUSE, K. 1995. The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy. *Journal of International Development*, 7, 369-401.

GLOBAL HEALTH WATCH 2005. 2005-2006. *An alternative world health report*. London, New York: Zed Books.

GLOBAL HEALTH WATCH 2008. Global Health Watch 2. An Alternative World Health Report. London: Zed Books.

GOLDSTEIN, K. 2002. Getting in the Door: Sampling and Completing Elite Interviews. *PS Online*, 669-672.

GOTTRET, P. & SCHIEBER, G. 2006. Health Financing Revisited. A Practioner's Guide. Washington: The World Bank.

GOUGH, I. & WOODS, G. 2004. *Insecurity and Welfare Regimes in Asia, Africa and Latin America,* Cambridge, Cambridge University Press.

GRIMMEISEN, S. & ROTHGANG, H. 2004. The Changing Role of the State in Europe's Health Care Systems. *Annual ESPAnet Conference.* University of Oxford.

GURAK, L. J. & LAY, M. M. 2002. *Research in Technical Communication,* Greenwood Publishing Group.

GWATKIN, D. R., WAGSTAFF, A. & YAZBECK, A. S. (eds.) 2005. *Reaching the Poor with Health, Nutrition and Population Services. What Works, What Doesn't, and Why,* Washington D.C.: World Bank.

HÄKKINEN, U. & OLLILA, E. 2000. The World Health Report 2000. What does it tell us about health systems? Analyses from Finish Experts. *Themes from Finland//2000.* Finland: STAKES.

HALL, P. (ed.) 1999. *The Political Power and Economic Ideas: Keynesianism Across Nations,* Princeton, NJ: Princeton University Press.

HEIN, W. & KOHLMORGEN, L. (eds.) 2003. *Globalisation, Global Health Governance and National Health Politics in Developing Countries. An Exploration Into the Dynamics of Interfaces,* Hamburg: Deutsches Übersee Institut.

HEIN, W. & KOHLMORGEN, L. 2008. Global Health Governance: Conflicts on Global Social Rights. *Global Social Policy,* 8, 80-108.

HELD, D. & MCGREW, A. (eds.) 2002a. *Governing Globalisation. Power Authority and Global Governance,* Cambridge: Polity Press.

HELD, D. & MCGREW, A. 2002b. Introduction. *In:* HELD, D. & MCGREW, A. (eds.) *Governing Globalisation. Power Authority and Global Governance.* Cambridge: Polity Press.

HENSHER, M. 2001. Financing Health Services through Efficiency Gains. *CMH Working Paper Series, Paper No. WG3:2.*

HERVEY, T. & TRUBEK, L. 2006. Freedom to Provide Health Care Services Within the EU: An Opportunity for a Transformative Directive. *Colombian Journal of European Law,* 623, 623-645.

HIGGOT, R. A. 1999. Coming to Terms with Globalisation: Non State Actors and Agenda for Justice and Governance in the Next Century. *GHC Working Papers,* 99.

HIGGOT, R. A., UNDERHILL, G. R. D. & BIELER, A. (eds.) 2000. *Non-State Actors and Authority in the Global System,* London: Routledge.

HOEKMAN, B. & KOSTECKI, M. 1997. *The Political Economy of the World Trading System,* Oxford, Oxford University Press.

HOEL, M. 2005. Concerns for Equity and the Optimal Co-payments for publicly provided health care. *CESifo Working Paper No. 1620.*

HOEL, M. & SAETHER, E. M. 2003. Public health care with waiting times: the role of supplementary private health care. *Journal of Health Economics,* 22, 599.616.

HOLDEN, C. Year. The Global Healthcare Complex: Extent and Regulatory Issues. *In:* Policy and Politics in a Globalizing World. Conference, 2003 Bristol.

HOLDEN, C. 2005. Privatization and Trade in Health Services: A Review of Evidence. *International Journal of Health Services*, 35, 675-689.
HOLSTEIN, J. A. & GUBRIUM, J. F. 1995. *Active Interview*, London, Sage.
HOLZMANN, R. (ed.) 2009. *Social Protection and Labour at the World Bank, 2000-2008*, Washington D.C.: World Bank.
HORT, S. E. O. 2005. The Geography of Comparative Welfare State Research - A Comment. *Global Social Policy*, 5.
HSIAO, W. & HELLER, P. S. 2007. What Should Macroeconomists Know about Health Care Policy? *WP/07/13*. Washington D.C.: IMF.
HSIEH, H.-F. & SHANNON, S. E. 2005. Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, 15, 1277-1288.
HULME, R. & HULME, M. 2008. The international transfer of global social policy. *In:* YEATES, N. (ed.) *Understanding Global Social Policy*. Bristol: Policy Press.
HUSSEY, P. & ANDERSON, G. F. 2003. A comparison of single- and multi-payer health insurance systems and options for reform. *Health Policy*, 66, 215-228.
IKENBERRY, G. J. 2001. America's liberal grad strategy: democracy and national security in the postwar era. *In:* COX, M., IKENBERRY, G. J. & INOGUCHI, T. (eds.) *American Democracy Promotion*. Oxford: Oxford University Press.
ILO 1999. Report of the Director-General: Decent Work. *ILC 87th Session*. Geneva.
ILO 2005. Programme and Budget for the Biennium 2006-07. Geneva: ILO.
ILO, GTZ & WHO. Year. Berlin Recommendation for Action - Final Version - 3 July 2006. *In:* International Conference on Social Insurance in Developing Countries, 05-07 December 2005 2005 Berlin.
ILO, GTZ & WHO. Year. Berlin Recommendations for Action - Final Version - 3 July 2006. *In:* Internatioanl Conference on Social Health Insurance in Developing Countries, 2006.
ILO & ISSA 1997. Social Health Insurance. Geneva: ILO.
ILO SOCIAL SECURITY DEPARTMENT 2007. Social Health Protection. An ILO strategy towards universal access to health care. A consultation. *Issues in Social Protection Discussion Paper 19*. Geneva: ILO.
ILO SOCIAL SECURITY DEPARTMENT 2008. Can low-income countries afford basic social security? *Social Security Policy Briefings Paper 3*. Geneva: ILO.
ILO STEP 2005. Health Micro-Insurance Schemes: Feasibility Study Guide. Vol. 1: Procedure. Geneva: ILO.
INOUE, K. & DRORI, G. S. 2006. The Global Institutionalization of Health as a Social Concern. Organizational and Discursive Trends. *International Sociology*, 21, 199-219.
INTERNATIONAL LABOUR OFFICE 2000. World Labour Report 2000: Income Security and social protection in a changing world. Geneva: ILO.

INTERNATIONAL LABOUR OFFICE 2001. Social Security: A new consensus. Geneva: ILO.

INTERNATIONAL LABOUR OFFICE 2005. Governing Body. Committee on Employment and Social Policy. *GB.294/ESP/4, 294th Session.* Geneva: ILO.

IRWIN, A., VALENTINE, N. B., BROWN, C., LOEWENSON, R., SOLAR, O., BROWN, H., KOLLER, T. & VEGA, J. 2006. The Commission on Social Determinants of Health: Tackling the Social Roots of Health Inequities. *PLoS Medicine,* 3, 0749-0751.

IVERSEN, T. & CUSACK, T. R. 2000. The Causes of Welfare State Expansion: Deindustrialization or Globalization? *World Politics,* 52, 313-349.

JANOVSKY, K. & CASSELS, A. 1996. Health Policy and Systems Research: Issues, Methods, Priorities. *In:* JANOVSKY, K. (ed.) *Health Policy and systems development. An agenda for research.* Geneva: WHO.

JHA, P. & CHALOUPKA, F. J. 2000. The economics of global tobacco control. *British Medical Journal,* 321, 358-361.

JOHNSTON, G. A. 1970. *The International Labour Organisation. Its Work for Social and Economic Progress,* London, Europa Publications.

JORDAN, L. & VAN TUIJL, P. 2000. Political Responsibility in Transnational NGO Advocacy. *World Development,* 28, 2051-2065.

KAASCH, A. 2006. "Ideas from Above" - How WHO and OECD try to influence national health policy. *Presented at the ESPAnet Conference.* Bremen, Germany.

KAASCH, A. 2007. CSOs in the global discourse on health care systems. The Global Health Watch. *Presented at the London Workshop on Civil Society Organisations and Global Health Governance.* London School of Hygiene and Tropical Medicine.

KAASCH, A. forthcoming. A New Global Health Actor? The OECD's Careful Guidance of National Health Care Systems. *In:* MARTENS, K. & JAKOBI, A. (eds.) *Mechanisms of OECD Governance - International Incentives for National Policy Making?*

KALDOR, M. 2003. *Global Civil Society: An Answer to War,* Cambridge, Polity Press.

KAPUR, D. 1998. The IMF: A Cure or a Curse. *Foreign Policy,* 111, 114-29.

KAPUR, D. & MCHALE, J. 2005. *Give Us Your Best and Brightest: The Global Hunt for Talent and Its Impact on the Developing World,* Washington, D.C., Center for Global Development.

KAUL, I., CONCEICAO, P., LE GOUVLEN, K. & MENDOZA, R. R. (eds.) 2003. *Providing Global Public Goods. Managing Globalization,* New York: Oxford University Press.

KAUL, I., GRUNBERG, I. & STERN, M. A. (eds.) 1999. *Global Public Goods: International Cooperation in the 21st Century,* New York: Oxford University Press.

KENNETT, P. 2001. *Comparative social policy: theory and research,* Buckingham, Open University Press.

KEOHANE, R. O. 1984. *After Hegemony,* Princeton, Princeton University Press.
KEOHANE, R. O. & NYE, J. S. 2000. Introduction. *In:* NYE, J. S. & DONAHUE, J. D. (eds.) *Governance in a Globalizing World.* Washington, D.C.: Brookings Institutions.
KICKBUSCH, I. 2000. The development of international health policies - accountability intact? *Social Science & Medicine,* 51, 979-989.
KICKBUSCH, I. 2003. Global Health Governance: Some Theoretical Considerations on the New Political Space. *In:* LEE, K. (ed.) *Health Impacts of Globalization. Towards Global Governance.* Houndsmills, New York: Palgrave Macmillan.
KOIVUSALO, M. 1999. *World Trade Organization and Trade-creep in Health and Social Policies,* Helsinki, Stakes.
KOIVUSALO, M. 2003a. Assessing the Health Policy Implications of WTO Trade and Investment Agreements. *In:* LEE, K. (ed.) *Health Impacts of Globalization. Towards Global Governance.* Houndsmills, New York: Palgrave Macmillan.
KOIVUSALO, M. 2003b. Global Governance, Trade and Health Policy. *In:* HEIN, W. & KOHLMORGEN, L. (eds.) *Globalisation, Global Health Governance and National Health Politics in Developing Countries. An Exploration into the Dynamics of Interfaces.* Hamburg: Deutsches Übersee Institut.
KOIVUSALO, M. 2003c. The Impact of WTO Agreements on Health and Development Policies. *GASPP Policy Brief,* 3.
KOIVUSALO, M. & MACKINTOSH, M. Year. Health Systems and Commercialisation. In Search of Good Sense. *In:* Prepared for the UNRISD international conference on Commercialisation of Health Care: Global and Local Dynamics and Policy Responses DRAFT, 2004 Geneva. UNRISD.
KOIVUSALO, M. & OLLILA, E. 1997. *Making a Healthy World,* Helsinki, STAKES.
KOIVUSALO, M. & OLLILA, E. 2008. Global Health Policy. *In:* YEATES, N. (ed.) *Understanding Global Social Policy.* Bristol: The Policy Press.
KOOP, C. E., PEARSON, C. E. & SCHWARZ, M. R. (eds.) 2001. *Critical Issues in Global Health,* San Francisco: Jossey-Bass.
KRASNER, S. D. 1999. *Sovereignty. Organised Hypocrisy,* Princeton, Princeton University Press.
KRATOCHWIL, F. 1989. *Norms, Rules, and Decisions: On the Conditions of Practical and Legal Reasoning in International Relations and Domestic Affairs,* Cambridge, Cambridge University Press.
KUTZIN, J. 2000. *Towards Universal Health Coverage: A Goal-oriented Framework for Policy Analysis,* Washington D.C., World Bank.
LANGAN, M. & OSTNER, I. 1991. Gender and welfare. Towards a comparative framework. *In:* ROOM, G. (ed.) *Towards a European Welfare State.* Bristol: SAUS, University of Bristol.

LE GRAND, J. 2007. *The other invisible hand: delivering public services through choice and competition,* Princeton, Princeton University Press.

LEE, K. (ed.) 1979. *Economics and Health Planning,* London.

LEE, K. 2007. Global Health Promotion: How Can We Strengthen Governance and Build Effective Strategies? *Health Promotion International,* 21, 42-50.

LEE, K., BUSE, K. & FUSTUKIAN, S. (eds.) 2002a. *Health Policy in a Globalising World,* Cambridge: Cambridge University Press.

LEE, K., FUSTUKIAN, S. & BUSE, K. 2002b. An introduction to global health policy. *In:* LEE, K., BUSE, K. & FUSTUKIAN, S. (eds.) *Health Policy in a Globalising World.* Cambridge: Cambridge University Press.

LEE, K. & GOODMAN, H. 2002. Global policy networks: the propagation of health care financing reform since the 1980s. *In:* LEE, K., BUSE, K. & FUSTUKIAN, S. (eds.) *Health Policy in a Globalising World.* Cambridge: Cambridge University Press.

LEECH, B. L. 2002a. Asking Questions: Techniques for Semistructured Interviews. *PS Online*, 665-668.

LEECH, B. L. 2002b. Interview Methods in Political Science. *PS Online*, 663-664.

LEFRERE, P. 2007. Competing higher education futures in a globalising world. *European Journal of Education,* 42, 201-12.

LEIBFRIED, S. 1990. Sozialstaat Europa? Integrationsperspektiven europäischer Armutsregime [Social State Europe? Integration Perspectives on European Poverty Regimes]. *Nachrichten des Vereins für örtliche und private Fürsorge,* 70, 295-305.

LEISERING, L. 2005. Social Policy Learning und Wissensdiffusion in einer globalisierten Welt [Social Policy Learning and knowledge diffusion in a globalised world]. *In:* BECKER, U., ZHENG, G. & DARIMONT, B. (eds.) *Grundfragen und Organisation der Sozialversicherung in China und Deutschland [Basic questions and organisation of social insurance in China and Germany].* Baden-Baden: Nomos.

LEISERING, L. 2007. Gibt es einen Weltwohlfahrtsstaat? [Is there a Global Welfare State?]. *In:* ALBERT, M. & STICHWEH, R. (eds.) *Weltstaat und Weltstaatlichkeit: Beobachtungen globaler politischer Strukturbildungen.* Wiesbaden: VS Verlag für Sozialwissenschaften.

LESSENICH, S. & LATZER, M. 1995. *Modernization and Labour Markets Adjustment. The Case of Post-Authoritarian Spain and Portugal,* Göttingen/Bremen.

LETHBRIDGE, J. 2004. Changing healthcare systems in Asia. *Public Services International: Research Unit (PSIRU).*

LETHBRIDGE, J. 2005. The Promotion of Investment Alliances by the World Bank. Implications for National Health Policy. *Global Social Policy,* 5, 203-225.

LEVI-FAUR, D. 2005. The Global Diffusion of Regulatory Capitalism. *The Annals of the American Academy of Political and Social Science,* 598.

LILLEKER, D. G. 2003. Interviewing the Political Elite: Navigating a Potential Minefield. *Politics,* 23, 207-224.

LITSIOS, S. 2004. The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach. *American Journal of Public Health,* 94, 1884-1893.

LUHMANN, N. 1999. Ethics in international relations. *Soziale Welt-Zeitschrift Fur Sozialwissenschaftliche Forschung Und Praxis,* 50, 247-+.

MACKINTOSH, M. & KOIVUSALO, M. (eds.) 2005. *Commercialization of Health Care. Global and Local Dynamics and Policy Responses,* Houndsmills, New York: Palgrave Macmillan.

MAHLER, H. 2007. Address to the 61st WHA, 20 May 2008.

MAHON, R. & MCBRIDE, S. (eds.) 2008. *The OECD and Global Governance*: UBC Press.

MANHEIM, J. & RICH, R. 1999. *Empirical Political Analysis: Research Methods in Political Science,* New York, Longmans.

MARCH, J. G. & OLSEN, J. P. 1989. *Rediscovering Institutions. The Organizational Basis of Politics,* London, Macmillan.

MARTENS, K. & JAKOBI, A. (eds.) forthcoming. *Mechanisms of OECD Governance - International Incentives for National Policy Making.*

MARTINEAU, T., DECKER, K. & BUNDRED, P. 2004. "Brain drain" of health professionals: from rhetoric to responsible action. *Health Policy,* 70, 1-10.

MAXWELL, S. & STONE, D. 2005. Global knowledge networks and international development. Bridges across boundaries. *In:* STONE, D. & MAXWELL, S. (eds.) *Global Knowledge Networks and International Development.* Oxon, New York: Routledge.

MAYRING, P. 2000. Qualitative Content Analysis. *Forum: Qualitative Social Research,* 1.

MCCOY, D. 2007. The World Bank's new health strategy: reason for alarm? *The Lancet,* 369, 1499-1501.

MCINTYRE, D., THIEDE, M., DAHLGREN, G. & WHITEHEAD, M. 2006. What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts? *Social Science and Medicine,* 62, 858-865.

MCKEE, M., GARNER, P. & STOTT, R. (eds.) 2001. *International Co-operation in Health,* Oxford: Oxford University Press.

MCNEILL, D. 2005. Power and Ideas. Economics and global development policy. *In:* STONE, D. & MAXWELL, S. (eds.) *Global Knowledge Networks and International Development.* Oxon, New York: Routledge.

MCPAKE, B. 1993. User Charges for Health Services in Developing Countries: A Review of the Economic Literature. *Soc. Sci. Med,* 36, 1397-1405.

MEYER, J. W. 2001. Reflections: The worldwide commitment to educational equality. *Sociology of Education*, 154-158.

MEYER, J. W., BOLI, J., THOMAS, G. M. & RAMIREZ, F. O. 1997. World society and the nation-state. *American Journal of Sociology*, 103, 144-181.

MILLS, A. 2007. Strategies to Achieve Universal Coverage: Are There Lessons From Middle Income Countries? *Publications commissioned by the Health Systems Knowledge Network* Geneva: Commission on Social Determinants of Health, WHO.

MINOGUE, M. 1998. Changing the state: concepts and practice in the reform of the public sector. *In:* MINOGUE, M., POLIDANO, C. & HULME, D. (eds.) *Beyond the New Public Management: Changing Ideas and Practices in Governance.* Northampton, MA: E. Elgar.

MISHRA, R. 1999. *Globalization and the Welfare State*, Cheltenham, Edward Elgar.

MKANDAWIRE, T. (ed.) 2004a. *Social Policy in a Development Context*, Houndmills/ Basingstoke, New York Palgrave Macmillan/ UNRISD.

MKANDAWIRE, T. 2004b. Social Policy in a Development Context: Introduction. *In:* MKANDAWIRE, T. (ed.) *Social Policy in a Development Context.* Houndsmills: Palgrave/ UNRISD.

MORAN, M. 1999. *Governing the Health Care State. A Comparative Study of the United Kingdom, the United States and Germany*, Manchester, Manchester University Press.

MORAN, M. 2000. Understanding the Welfare State: The Case of Health Care. *British Journal of Politics and International Relations*, 2, 135-160.

MÜLLER, K. 2003. The Making of Pension. Privatization in Latin America and Eastern Europe. *In:* HOLZMANN, R., ORENSTEIN, M. & RUTKOWSKI, M. (eds.) *Pension Reform in Europe: Process and Progress.* Washington: World Bank.

MÜLLER, K., RYLL, A. & WAGENER, H.-J. (eds.) 1999. *Transformation of Social Security: Pensions in Central-Eastern Europe*, Heidelberg: Physica.

MURRAY, C. J. L. & EVANS, D. B. (eds.) 2003a. *Health Systems Performance Assessment: Debates, Methods and Empiricism*, Geneva: WHO.

MURRAY, C. J. L. & EVANS, D. B. 2003b. Health Systems Performance Assessment: Goals, Framework and Overview. *In:* MURRAY, C. J. L. & EVANS, D. B. (eds.) *Health Systems Performance Assessment: Debates, Methods and Empiricism.* Geneva: WHO.

MURRAY, C. J. L. & FRENK, J. 2000. A framework for assessing the performance of health systems. *Bulletin of the World Health Organization*, 78.

MURRAY, C. J. L. & FRENK, J. 2001. World Health Report 2000: a step towards evidence-based health policy. *The Lancet*, 357, 1698-1700.

MUSGROVE, P. 1999. Public Spending on Healthcare: How are Different Criteria Related. *Health Policy*, 47, 207-223.

NAVARRO, V. 2001. The new conventional wisdom: an evaluation of the WHO report: Health systems: improving performance. *International Journal of Health Services,* 31, 23-33.

NELSON, J. M. 2001. The Politics of Pension and Health-Care Reforms in Hungary and Poland. *In:* KORNAI, J., HAGGARD, S. & KAUFMAN, R. R. (eds.) *Reforming the State: Fiscal and Welfare Reform in Post-Socialist Countries.* Cambrige, UK: Cambridge University Press.

NELSON, J. M. 2004. External Models, International Influence, and the Politics of Social Sector Reforms. *In:* WEYLAND, K. (ed.) *Learning from Foreign Models in Latin America Policy Reform.* Woodrow Wilson Press/ The John Hopkins University Press.

O'BRIEN, R. 2008. Global Labour Policy. *In:* YEATES, N. (ed.) *Understanding Global Social Policy.* Bristol: The Policy Press.

O'BRIEN, R., GOETZ, A. M., SCHOLTE, J. A. & WILLIAMS, M. 2000. *Contesting global governance : multilateral economic institutions and global social movements,* Cambridge, UK ; New York, Cambridge University Press.

OECD 1977. Public Expenditure on Health. *OECD Studies in Resource Allocation No 4.* Paris: OECD.

OECD 1987. Financing and Delivering Health Services. A Comparative Analysis of OECD Countries. *OECD Social Policy Studies No. 4.* Paris: OECD.

OECD 1992. The Reform of Health Care. A Comparative Analysis of Seven OECD Countries. *Health Policy Studies No.2.* Paris: OECD.

OECD 1993a. OECD Health Systems. Volume I: Facts and Trends 1960-1991. Paris: OECD.

OECD 1993b. Volume II: OECD Health Systems. The Socio-Economic Environment. Statistical References. Paris: OECD.

OECD 1994. The Reform Of Health Care Systems. A Review Of Seventeen OECD Countries. Paris: OECD.

OECD 1995. New Directions in Health Policy. *Health Policy Studies No 7.* Paris: OECD.

OECD 1996. Health Care Reform. The Will to Change. *Health Policy Studies No 8.* Paris: OECD.

OECD 2000. A System of Health Accounts. Paris: OECD.

OECD 2004a. The OECD Health Project. Private Health Insurance in OECD Countries. Paris: OECD.

OECD 2004b. The OECD Health Project. Towards High-Performing Health Systems. Paris: OECD.

OECD 2005. *The OECD - Organisation for Economic Cooperation and Development,* Paris, OECD.

OECD & WHO 2006. OECD Reviews of Health Systems. Switzerland. Paris: OECD.

OLLILA, E. & KOIVUSALO, M. 2000. Values, Ideologies and Evidence-based Recommendations - the World Health Report 2000: WHO's Health Policy Drifting Off Course. *In:* HÄKKINEN, U. & OLLILA, E. (eds.) *The World Health Report 2000. What Does It Tell Us About*

Health Systems? Analyses from Finnish Experts. Themes From Finland //2000. Helsinki: National Research and Development Centre for Welfare and Health (Stakes).

OLLILA, E. & KOIVUSALO, M. 2002. The World Health Report 2000: World Health Organization health policy steering off course-changed values, poor evidence and lack of accountability. *International Journal of Health Services,* 32, 503-14.

OLSEN, J. P. 1997. European Challenges to the Nation State. *In:* STEUNENBERG & VUGHT, F. V. (eds.) *Political Institution and Public Policy.* Dordrecht: Kluwer.

OOMS, G., VAN DAMME, W. & TEMMERMAN, M. 2007. Medicines without Doctors: Why the Global Fund Must Fund Salaries of Health Workers to Expand AIDS Treatment. *PLoS Medicine,* 4, e128.

OR, Z. 2002. Improving the performance of health care systems: from measures to action (a review of experiences in four OECD countries). *Labour Market and Social Policy - Occasional Papers No.57. DEELSA/ELSA/WD(2002)1.* Paris: OECD.

ORENSTEIN, M. 2005. The New Pension Reform as Global Policy. *Global Social Policy,* 5.

ORENSTEIN, M. A. 2003. Mapping the Diffusion in Pension Innovation. *In:* HOLZMANN, R., ORENSTEIN, M. A. & RUTKOWSKI, M. (eds.) *Pension Reform in Europe: Process and Progress.* Washington D.C.: World Bank.

ORENSTEIN, M. A. 2008. *Privatizing Pensions. The Transnational Campaign for Social Security Reform,* Princeton, Oxford, Princeton University Press.

PEABODY, J. W. 1995. An Organizational Analysis of the World Health Organization: Narrowing the Gap between Promise and Performance. *Soc. Sci. Med,* 40, 731-742.

PEDERSEN, K. M. 2002. The World Health Report 2000: dialogue of the deaf? *Health Economics,* 11, 93-101.

PELLEGRINO, E. 2005. Rationing Health Care: the Ethics of Medical Gatekeeping. *In:* MONAGLE, J. F. & THOMASMA, D. C. (eds.) *Health Care Ethics: Critical Issues for the 21st Century.* Sudbury: Jones and Bartlett Publishers.

PIERSON, C. 2004. 'Late Industrializers' and the Development of the Welfare State. *In:* MKANDAWIRE, T. (ed.) *Social Policy in a Development Context.* Houndsmills: Palgrave Macmillan.

POLLOCK, A. & PRICE, D. 2000. Rewriting the Regulations: how the WTO could accelarate Privatisation in health care systems. *The Lancet,* 356, 1995-2000.

POST, D. L. 2005. Standards and Regulatory Capitalism: The Diffusion of Food Safety Standards in Developing Countries. *The Annals of the American Academy of Political and Social Science,* 598, 168-183.

POTTER, W. J. & LEVINE-DONNERSTEIN, D. 1999. Rethinking validity and reliability in content analysis. *Journal of Applied Communication Research,* 27, 258-284.

PREKER, A. S., SCHEFFLER, R. M. & BASSETT, M. S. (eds.) 2007. *Private Voluntary Health Insurance in Development. Friend or Foe?*, Washington D.C.: World Bank.

PRICE, R. & REUS-SMIT, C. 1998. Dangerous Liaisons?: Critical International Theory and Constructivism. *European Journal of International Relations,* 4, 259-294.

PRZEWORSKI, A. & TEUNE, H. 1970. *The Logic of Comparative Social Inquiry,* New York, John Wiley & Sons.

QUINN PATTON, M. 2002. *Qualitative evaluation and research methods,* Newbury Park etc., Sage.

RADIN, D. 2003. The Impact of the World Bank on Health Care Reform in Transitional Economies. *Politicka Misao,* XL, 30-51.

RALEIGH YOW, V. 1994. *Recording Oral History: A Practical Guide for Social Scientists,* London, New Delhi, Sage.

REIBLING, N. 2010. Healthcare systems in Europe: towards an incorporation of patient access. *Journal of European Social Policy,* 20, 5-18.

RICHARD, M.-O. & CHANDRA, R. 2005. A model of consumer web navigational behavior: conceptual development and application. *Journal of Business Research,* 58, 1019-1029.

ROBERTS, M. J., HSIAO, W., BERMAN, P. & REICH, M. R. 2008. *Getting Health Reform Right. A Guide to Improving Performance and Equity,* New York, Oxford University Press.

ROBERTSON, S. 2005. Re-imagining and rescripting the future of education: global knowledge economy discourses and the challenge to education systems. *Comparative Education,* 41, 151-70.

ROSS, F. 2000. Interests and Choice in the 'Not Quite So New' Politics of Welfare. *In:* FERRERA, M. & RHODES, M. (eds.) *Recasting European Welfare States.* London: Frank Cass Publishers.

ROTHGANG, H., CACACE, M., GRIMMEISEN, S. & WENDT, C. 2005. The changing role of the state in healthcare systems. *European Review,* 13, 187-212.

RUBIN, H. J. & RUBIN, I. S. 1995. *Qualitative Interviewing: The Art of Hearing Data,* Thousand Oaks, CA, Sage.

RUGER, J. P. 2005. The Changing Role of the World Bank in Global Health. *American Journal of Public Health,* 95, 60-70.

RUGGIE, J. G. 1993. Territoriality and Beyond: Problematizing Modernity in International Relations. *International Organization,* 47, 139-74.

RUTKOWSKI, D. 2007. Converging us softly: how intergovernmental organisations promote neo-liberal education policy. *Critical Studies in Education,* 48, 229-47.

SCOLLON, R. 2005. The discourses of food in the world system. Toward a nexus analysis of a world problem. *Journal of Language and Politics,* 4, 465-488.

SEIDEL, W. 2003. The Report of the Commission on Macroeconomics and Health - A Summary of Findings, Reactions and Follow-Up to the "Sachs-Report". *In:* HEIN, W. & KOHLMORGEN, L. (eds.) *Globalisation, Global Health Governance and National Health*

Politics in Developing Countries. An Exploration into the Dynamics of Interfaces. Hamburg: Deutsches Übersee Institute [German Overseas Institute].

SELDON, A. 1996. Elite Interviews. *In:* BRIVATI, B., BUXTON, J. & SELDON, A. (eds.) *The Contemporary History Handbook.* Manchester: Manchester University Press.

SENTI, M. 2002. *Internationale Regime and nationale Politik. Die Effektivität der Internationalen Arbeitsorganisation (ILO) im Industrieländervergleich [International regimes and national policy. The efficiency of the ILO in a comparative perspective between industrialised countries],* Bern, Stuttgart, Wien, Paul Haupt.

SEXTON, S. 2001. Trading Health Care Away? GATS, Public Services and Privatisation. *Corner House Briefing,* 23.

SHAW, R. P. 2002. World Health Report 2000: "Financial Fairness Indicator": Useful Compass or Crystal Ball? *International Journal of Health Services,* 32, 195-203.

SHAW, R. P. 2007. The Interface between CSOs and the World Bank; An Input to Global Health or Global Harm? *Paper for Discussion. Workshop on "Civil Society Organizations and Global Health" 2007 Wall Summer Institute for Research, June 25-28.* Vancouver, Canada: The Peter Wall Institute for Advanced Study, University of British Columbia.

SIDDIQI, J. 1995. *World Health and World Politics: the World Health Organization and the UN System,* London, Hurst&Company.

SIKKINK, K. 1991. *Ideas and Institutions. Developmentalism in Brazil and Argentina,* Ithaca/ NY, London, Cornell University Press.

SIMMONS, B. A. & ELKINS, Z. 2004. The Globalization of Liberalization: Policy Diffusion in the International Political Economy. *American Political Science Review,* 98, 171-189.

SIMMONS, B. A. & MARTIN, L. L. 2001. International Organizations and Institutions. *In:* CARLSNAES, W., KISSE, T. & SIMMONS, B. A. (eds.) *Handbook of International Relations.* Sage.

SMITH, A. J. 1974. Barefoot Doctors and the Medical Pyramid. *British Medical Journal,* 2, 429-432.

SMITH, R., BEAGLEHOLE, R., WOODWARD, D. & DRAGER, N. (eds.) 2003. *Global Public Goods for Health. Health Economic and Public Health Perspectives* Oxford: Oxford University Press.

ST CLAIR, A. L. 2006a. Global Poverty. The Co-Production of Knowledge and Politics. *Global Social Policy,* 6, 57-77.

ST CLAIR, A. L. 2006b. The World Bank as a Transnational Expertised Institution. *Global Governance,* 12, 77-95.

STICHWEH, R. 2004. On the Genesis of World Society. Innovation and Mechanisms. Institut fuer Weltgesellschaft.

STONE, D. 2000a. Non-Governmental Policy Transfer: The Strategies of Independent Policy Institutes. *Governance: An International Journal of Policy and Administration,* 13, 45-62.

STONE, D. 2000b. Private authority, scholarly legitimacy and political credibility. Think tanks and informal diplomacy. *In:* HIGGOT, R.

A., UNDERHILL, G. R. D. & BIELER, A. (eds.) *Non-State Actors and Authority in the Global System.* London: Routledge.

STONE, D. 2003. The "Knowledge Bank" and the Global Development Network. *Global Governance,* 9, 43-61.

STONE, D. 2005. Knowledge Networks and Global Policy. *In:* STONE, D. & MAXWELL, S. (eds.) *Global Knowledge Networks and International Development.* Oxon, New York: Routledge.

STONE, D. & DENHAM, A. (eds.) 2004. *Think Tank Traditions: Policy Research and the Politics of Ideas,* Manchester: Manchester University Press.

STONE, D. & MAXWELL, S. (eds.) 2005. *Global Knowledge Networks and International Development,* Oxon, New York: Routledge.

STUBBS, P. 2002. Globalisation, memory and welfare regimes in transition: towards an anthropology of transnational policy transfers. *International Journal of Social Welfare,* 11, 321-330.

STUBBS, P. 2003. International Non-State Actors and Social Development Policy. *Global Social Policy,* 3, 319-347.

SWANK, D. 2005. Globalisation, Domestic Politics, and Welfare State Retrenchment in Capitalist Democracies. *Social Policy and Society,* 4, 183-195.

TAIPALE, V. 2000. Introduction: There is a need for assessment and research in health policies. *In:* HÄKKINEN, U. & OLLILA, E. (eds.) *The World Health Report 2000. What Does It Tell Us About Health Systems? Analyses from Finnish Experts. Themes from Finland 7/2000.* Helsinki: National Research and Development Centre for Welfare and Health (Stakes).

TARANTOLA, D. 2008. Global Justice And Human Rights: Health and Human Rights in Practice. *Global Justice: Theory Practice Rhetoric,* 1, 11-26.

TASK FORCE ON GLOBAL ACTION FOR HEALTH SYSTEM STRENGTHENING 2009. G8 Hokkaido Toyako Summit Follow-Up. Global Action for Health System Strengthening. Policy Recommendations to the G8. Tokyo: Japan Centre for International Exchange.

TASK FORCE ON HEALTH SYSTEMS RESEARCH 2005. The Millennium Development Goals will not be attained without new research addressing health system constraints to delivering effective interventions. Report of the Task Force on Health Systems Research. Geneva: WHO.

TAYLOR, A. 2002. Global Governance, international health law and WHO: looking towards the future. *Bulletin of the World Health Organization,* 80, 975-980.

THOMAS, C. & WEBER, M. 2004. The Politics of Global Health Governance: Whatever Happened to "Health for All by the Year 2000"? *Global Governance,* 10, 187-204.

THURNER, P. & KOTZIAN, P. Year. Comparative Health Care Systems. Outline for an Empirical Application of New Institutionalist

Economics Approaches. *In:* Paper presented at the ECPR Joint Sessions, 4-11 April 2001 2001 Grenoble.
TIMMERMANS, K. 2004. Developing Countries and Trade in Health Services: Which way is forward? *International Journal of Health Services,* 34, 453-466.
TITMUSS, R. 1974. *Social Policy,* London, Allen & Unwin.
UN 2006. Delivering as One. Report of the Secretary-General's High-Level Panel on UN System-wide Coherence. New York: United Nations.
UN GA 2000. United Nations Millennium Declaration.
UN MILLENNIUM PROJECT - TASK FORCE ON HIV/AIDS, M., TB, AND ACCESS TO ESSENTIAL MEDICINES, 2005. Combating AIDS in the developing world. London, Sterlin/VA.: Earthscan.
VANDUZER, A. J. 2005. Navigating between the Poles: Unpacking the Debate on the Implications for Development of GATS Obligations relating to Health and Education Services. *In:* PETERSMAN, E.-U. (ed.) *Reforming the World Trading System: Legitimacy, Efficiency and Democratic Governance.* Oxford: Oxford.
VAUGHAN, D. 1999. The Dark Side of Organizations: Mistake, Misconduct, and Disaster. *Annual Review of Sociology,* 25, 271-305.
VICTORA, C. G., HANSON, K., BRYCE, J. & VAUGHAN, J. P. 2004. Achieving universal coverage with health interventions. *Lancet,* 364.
WAGSTAFF, A. 2002. Reflections on and alternatives to WHO's fairness of financial contribution index. *Health Economics,* 11, 103-115.
WAITZKIN, H., JASSO-AGUILAR, R. & IRIART, C. 2007. Privatization of Health Services in Less Developed Countries: An Empirical Response to the Proposals of the World Bank and Wharton School. *International Journal of Health Services,* 37, 205-227.
WALLERSTEIN, I. 1974. *The Modern World-System,* New York, Academic Press.
WALSH, J. A. & WARREN, K. S. 1980. Selective Primary Health Care: an Interim Strategy for Disease Control in Developing Countries. *Social Science and Medicine,* 14C, 145-163.
WALT, G. 1994. *Health Policy: An Introduction to Process and Power,* London, Zed Books.
WALT, G. & GILSON, L. 1994. Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning,* 9, 353-370.
WALT, G., PAVIGNANI, E., GILSON, L. & BUSE, K. 1999. Health Sector Development: from Aid Coordination to Resource Management. *Health Policy and Planning,* 14, 207-218.
WALT, G., SHIFFMAN, J., SCHNEIDER, H., MURRAY, S. F., BRUGHA, R. & GILSON, L. 2008. 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy and Planning,* 23, 308-317.
WANG, Y. D. & EMURIAN, H. H. 2005. An overview of online trust: concepts, elements, and implications. *Computers in Human Behavior,* 21, 105-125.

WEISS, T. G. 1999. International NGOs, Global Governance, and Social Policy in the UN System. *GASPP Occasional Paper,* 3.

WENDT, A. 1987. The Agent-Structure Problem in International Relations Theory. *International Organisation,* 41, 335-370.

WENDT, A. 1992. Anarchy is What States Make of It: The Social Construction of Power Politics. *International Organization,* 46, 391-426.

WENDT, A. 1999. *Social Theory of International Politics,* Cambridge, Cambridge University Press.

WENDT, A. & DUVALL, R. 1989. Institutions and International Order. *In:* CZEMPIEL, E.-O. & ROSENAU, J. N. (eds.) *Global Changes and Theoretical Challenges: Approaches to World Politics for the 1990s.* Lexington: Lexington Books.

WENDT, C. 2003. *Krankenversicherung oder Gesundheitsversorgung? Gesundheitssysteme im Vergleich [Health Insurance or Health Care? Health systems in a comparative perspective],* Wiesbaden, Westdeutscher Verlag.

WENDT, C. 2006. Der Gesundheitssystemvergleich. Konzepte und Perspektiven (The Comparison of Health Systems. Concepts and Perspectives). *Kölner Zeitschrift für Soziologie and Sozialpsychologie,* Special Isuse 46 "Soziologie der Gesundheit" (Sociology of Health), 270-297.

WHA 1973. Organisational Study on Methods of Promoting the Development of Basic Health Services. WHA26.35. WHO.

WHITE, N. D. 2002. *The United Nations System: Toward International Justice,* Boulder, CO, Lynne Rienner.

WHO 1981. National decision-making for Primary Health Care. A study by the UNICEF/WHO Joint Committee on Health Policy. Geneva.

WHO 1998. Health for all in the 21st century. A51/5. Geneva: WHO.

WHO 1999. The World Health Report 1999. Making a Difference. Geneva: WHO.

WHO 2000. The World Health Report 2000: Health Systems: Improving Performance. Geneva: WHO.

WHO 2005a. Health and the Millennium Development Goals. Geneva: WHO.

WHO 2005b. WHO Country Cooperation Strategy. A guiding framework. Geneva: WHO.

WHO 2005 (updated reprint). WHO Framework Convention on Tobacco Control. Geneva: WHO.

WHO 2006a. Country Support Unit Network 2005. Partnerships for health. Geneva: WHO.

WHO 2006b. Engaging for Health. 11th General Programme of Work, 2006-2015. A Global Health Agenda. Geneva: WHO.

WHO 2006c. Engaging for Health. Eleventh General Programme of Work 2006-2015. A Global health Agenda. Geneva: WHO.

WHO 2007. Everybody's Business. Strengthening Health Systems to Improve Health Outcomes. WHO's Framework for Action. Geneva: WHO.

WHO 2008. The World Health Report 2008: Primary Health Care Now More Than Ever. Geneva: WHO.

WHO 2009. Proposed Programme Budget 2010-2011. *PPB/2010-2011.* Geneva: WHO.

WHO & GFATM 2007. The Global Fund Strategic Approach to Health Systems Strengthening. Report from WHO to the Global Fund Secretariat. Geneva: WHO.

WHO & WTO 2002. WTO Agreements and Public Health: a Joint Guide by the WHO and the WTO Secretariat. Geneva: WHO/WTO.

WHO CMH 2001. Macroeconomics and Health: Investing in Health For Economic Development. Report of the Commission on Macroeconomics and Health. Geneva: WHO.

WHO CSDH 2005. Action on the Social Determinants of Health: Learning from Previous Experiences. A Background Paper prepared for the Commission on Social Determinants of Health. March 2005.

WHO CSDH 2007a. Achieving Health Equity: from root causes to fair outcomes. *Interim Statement.* Geneva: WHO.

WHO CSDH 2007b. Challenging Inequity Through Health Systems. *Final Report Knowledge Network on Health Systems.*

WHO CSDH 2008. Closing the Gap in a Generation. Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva: WHO.

WHO/UNICEF. Year. Declaration of Alma-Ata. *In:* International Conference on Primary Health Care, 6-12 September 1978 1978a Alma-Ata, USSR.

WHO/UNICEF 1978b. Primary Health Care. Report of the International Conference of Primary Health Care. Alma-Ata, USSR, 6-12 September 1978: Geneva:WHO.

WICKENS, C. & SANDLIN, J. 2007. Literacy for what? Literacy for whom? The politics of literacy education and neocolonialism in UNESCO and World Bank sponsored literacy programs. *Adult Education Quarterly,* 57, 275-92.

WILENSKY, H. 1975. *The Welfare State and Equality. Structural and Ideological Roots of Public Expenditure,* Berkeley, University of California Press.

WILKINSON, R. 2002. Global Governance. A preliminary interrogartion. *In:* WILKINSON, R. & HUGHES, S. (eds.) *Global Governance. Critical Perspectives.* London/ New York: Routledge.

WILLIAMS, D. & YOUNG, T. 1994. Governance, the World Bank and Liberal Theory. *Political Studies,* 42, 84-100.

WOGART, J. P. 2003. Global Health Issues and the World Bank's Involvement. *In:* HEIN, W. & KOHLMORGEN, L. (eds.) *Globalisation, Global Health Governance and National Health Politics in Developing Countries. An Exploration Into the Dynamics of Interfaces.* Hamburg: Deutsches Übersee-Institut.

WOOD, G. & GOUGH, I. 2006. A Comparative Welfare Regime Approach to Global Social Policy. *World Development,* 34, 1696-1712.

WOODS, N. 2006. *The Globalizers: The IMF, the World Bank, and Their Borrowers,* Ithaca, N.Y., Cornell University Press.
WOODWARD, D. 2005. The GATS and trade in health services: implications for health care in developing countries. *Review of International Political Economy,* 12, 511-534.
WORLD BANK - HUMAN DEVELOPMENT NETWORK 2001. Social Protection Sector Strategy. From Safety Net to Springboard. Washington D.C.: World Bank.
WORLD BANK 1980a. Health Sector Policy Paper. Washington D.C.: World Bank.
WORLD BANK 1980b. World Development Report 1980. Washington: World Bank.
WORLD BANK 1987. Financing Health Services in Developing Countries. An Agenda for Reform. *A World Bank Policy Study.* Washington D.C.: World Bank.
WORLD BANK 1993. World Development Report 1993: Investing in Health. Oxford, New York et al.: Oxford University Press/ World Bank.
WORLD BANK 1994. Averting the Old Age Crisis - Policies to Protect and Old and Promote Growth. Washington, D.C.: World Bank.
WORLD BANK 1997. Health, Nutrition, and Population Sector Strategy Paper. Washington: World Bank.
WORLD BANK 2003. World Development Report 2004: Making Services Work for Poor People. Washington: Oxford University Press/ World Bank.
WORLD BANK 2004. World Development Report 2004: Making Services Work for Poor People. Washington: World Bank.
WORLD BANK 2007. Healthy Development. The World Bank Strategy for Health, Nutrition, and Population Results. Washington D.C.: World Bank.
WORLD BANK & WHO 2002. Dying for Change. Geneva: WHO.
WORLD BANK, WHO & US AGENCY FOR INTERNATIONAL DEVELOPMENT 2003. Guide to producing national health accounts with special applications for low-income and middle-income countries. Geneva: WHO.
WORLD COMMISSION ON THE SOCIAL DIMENSION OF GLOBALIZATION 2004. A Fair Globalization: Creating Opportunities for All. Geneva: ILO.
YAZBECK, A. S. 2002. An Idiot's Guide to Prioritization in the Health Sector. *HNP Discussion Paper.* Washington, D.C.: World Bank.
YAZBECK, A. S. 2006. Economic Viewpoint: Reaching the Poor. Washington D.C.: World Bank.
YEATES, N. 1999. Social Politics and Policy in an Era of Globalisation: Critical Reflections. *Social Policy and Administration,* 33, 372-93.
YEATES, N. 2001. *Globalization and social policy,* London, SAGE.
YEATES, N. 2005a. The General Agreement on Trade in Services (GATS): What's in it for social security? *International Social Security Review,* 58, 3-22.

YEATES, N. 2005b. "Globalization" and Social Policy in a Development Context. Regional Responses. *UNRISD Social Policy and Development Programme Paper Number 18.*

YEATES, N. 2008a. The Idea of Global Social Policy. *In:* YEATES. N. (ed.) *Understanding Global Social Policy.* Bristol: The Policy Press.

YEATES, N. (ed.) 2008b. *Understanding Global Social Policy*: Policy Press.

YEATES, N. & DEACON, B. 2006. Globalism, Regionalism and Social Policy: Framing the debate. *UNU-CRIS Occasional Papers 0-2006/6.* United Nations University CRIS.