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Health Policy in a Globalizing World

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ABSTRACT

In recent years, major infectious diseases like AIDS, SARS or the Avian Flu critically revealed the need for international cooperation in the field of health. In academia, this need has been reflected by notions of 'global public health' and 'global health policy', acknowledging the massively growing number of global and international actors active in the field. Their influence in health policy is assumed to have increased at the cost of national sovereignty. Yet, public health scholars have paid little attention to the actual past and present *policy ideas* and *health care approaches* floating around within and between international organizations and their respective *resources, strategies* and *technical capacities*. This paper attempts to bridge this gap. By reviewing the recent relevant literature, the first section shall analyze how and to what extent the global health policy discourse has changed over time. The subsequent section shall explore which health policy ideas and health care approaches have emanated from the international governmental organizations and how these ideas and approaches interrelate. Finally, we compare the respective resources, strategies and organizational features of the WHO, UNICEF, WTO and the World Bank in order to demonstrate how the shift in policy ideas and approaches has been reflected by the organizational capacities of the IGOs over time. One tentative conclusion is that the global health debate today is to a great extent focussing on single 'priority diseases' and (to a smaller extent) on specific singular aspects of health systems (e.g. user fees) in contrast to former times, i.e. the debate has become more and more 'technical' again. Furthermore, the 'ideational influence' has shifted away from the WHO as the predominant *actor* towards other IGOs. At the same time new, strong actors have entered the field, such as e.g. powerful foundations (like the Bill and Melinda Gates Foundation or the Rockefeller Foundation), leading to a further fragmentation of the field in general.

1 INTRODUCTION

Health has become a major concern not only at the national level, but increasingly also at the international level given the cross-border reach of a number of major infectious diseases such as HIV/AIDS, TB, malaria, and bird flu, and the implication these diseases have for e.g. security issues, migration, development, etc.

At the national level, health care provision is a key challenge for economically developed and poorer countries alike. Rising health costs are a concern in the richer parts of the world and increasingly also in other parts of the world as well. Health costs tend to increase for a number of reasons in these countries: (1) technological and medical developments offer more solutions to health problems and thus create more and more new demand; (2) more demand due to demographic change; and (3) a greater public and media attention to health issues affects attitudes, life styles, expectations and thus also inspires new demands for health information and –treatment to name only a few. The discussion thus focuses largely on cost containment. Challenges in the field of health are of quite a different nature in many of the low income countries as a functioning public health system often does not exist. On the other hand health reforms in these countries to some extent reflect and take into account discussions in the developed nations. Health has for long been generally recognized as crucial for social and economic development, but has in more recent times also more explicitly become a human right issue. With increased globalization of trade and economic transactions of any kind, of travel and transportation, and a trend towards more open borders, the health situation in any part of the world has furthermore become an issue of increasing concern among highly developed countries sometimes simply out of pure self-interest because it affects security issues. The international attention to health issues has – for many different reasons – moved higher on the global political agenda.

Health is a special field of social policy. It is special because of its impact upon opportunity: health care makes a contribution to the protection of equality of opportunity, and is often distributed more equally than other social goods (Daniels, Kennedy et al. 2002). Health is also special and more challenging in global social policy discourses compared with e.g. pension, labour market-, and family policy issues because health issues in a globalized world have more obvious global dimensions than other social policy issues. At the same time, health care is in itself a more multi-dimensional and complex policy area where national health systems and policies vary enormously for political, cultural and economic reasons. It is thus a field where nations tend to strongly defend their right to sovereignty. For all of these reasons, the specialty of health, its complexity, national variations and national

'protectionism', international consensus on policies may be difficult to achieve, and the global discourse, to the extent it exists, expectedly takes different forms from what can be seen in other social policy fields.

Health challenges – and international cooperation on health – can be seen from a global good perspective and concern both poor and rich countries. *"Given the current trend towards increasingly porous borders and cross-border activities, many public goods can no longer be achieved through domestic policy action alone and depend on international cooperation. Yet, policy-making is still largely organized on a country-by-country basis and there is no international equivalent of the state. As a result, GBGs [Global Public Goods] are increasingly underprovided and GPBs [Global Public Bads] increasingly overprovided"* (Kaul and Faust 2001).

Globalization has brought about interdependencies that blur the distinction between domestic and external affairs (Kaul and Faust 2001). Notions of 'global public health' and 'global health policy have enriched our vocabulary, and many more actors have entered the international health arena.

It has not been and is not self-evident, however, how and to what extent these new actors – international governmental organizations, non-governmental organizations, and private commercial or non-commercial actors – are actually able to influence health policies to make such policies efficient, effective and sustainable in the short and long term. This paper seeks to approach this question and the global-national nexus embedded in it from the angle of some selected international governmental organizations active in the field of health. We shall, however, neither provide a plausible answer nor an explanatory approach as regards the relative influence of the new international actors compared to national actors and factors. Rather, our modest ambition is to map the organizational field of the global health debate by attempting to answer the following questions:

1. How and to what extent has the global health discourse changed over time?
2. Which health policy ideas and health care approaches emanate from International Governmental Organizations (IGOs) and how do these policy ideas and approaches interrelate?
3. How has the respective 'ideational influence' of the selected IGOs changed over time?
4. What resources, channels and capacities do which IGOs have at their disposal?

The question whether and to what extent international organizations and international institutions matter is fiercely debated in the scholarly literature. This is particularly so when it comes to health policy. As Ilona Kickbusch once stipulated: "*Health, which at first instance seems to be the field most destined for joint action independent of territory (how often have we heard and used the phrase that disease knows no borders), remains a policy domain most protectively linked to the nation state"* (Kickbusch and de Leeuw 1999: 286). In a first step we shall concentrate on four international governmental organizations – the WHO, UNICEF, World Bank and the WTO -, which are portrayed to have the biggest influence in international health policy in the scholarly literature. In recent years, scholars also increasingly turned to the question on how these organizations actually work.

In our subsequent analysis of organizational capacities and features of the four selected IGOs we will employ some of the dimensions (i.e. membership, scope, centralization, control, flexibility, enforcement) proposed by the "Rational Design Project of International Institutions". While the project's goal was to analyze how international institutions *"(…) operate and how they relate to the problems states face"* (Koremenos, Lipson et al. 2001b: 761), we shall use the indicators to describe the relative capacity of the organization. In addition, we will include the 'channels' vis-à-vis national governments, the scope of health-related issues, instruments and resources as analytical dimensions. The debate between Duffield and Koremenos, Lipson et al. also made clear that more attention should be paid to interest, power and ideas (Koremenos, Lipson et al. 2001a; Koremenos, Lipson et al. 2001b; Duffield 2003; Koremenos and Snidal 2003).

In a first attempt to map the organizational field of the global health policy debate we shall therefore explore which (health) policy ideas and health care approaches float around within and between international governmental organizations over time. When studying 'policy ideas' we refer to Béland's definition of policy ideas as *"specific policy alternatives (for example, personal savings accounts) as well as the organized principles and causal beliefs in which these proposals are embedded (for example, neo liberalism)"* (Béland 2005: 2).

The structure of our paper is as follows: Based on a review of relevant recent literature we shall first of all analyze how and to what extent the global health policy discourse has changed over time. In the subsequent section we shall explore which health policy ideas and health care approaches have emanated from the international governmental organizations and how these ideas and approaches interrelate. And finally we shall compare the resources, strategies and organizational features of some of the major intergovernmental actors in the field, such as the WHO, UNICEF, WTO and the World Bank, and analyze how the public

health agenda of these organizations and the 'ideational influence' among them have changed over time.

2 FROM TECHNICAL COOPERATION TO A POLITICAL DIMENSION? A LITERATURE REVIEW OF THE GLOBAL HEALTH DISCOURSE.

While for a long time the term 'international public health' has been widely used to describe international cooperation and coordination within the field of public health, it was not until recently that the term 'global public health' seems to have become the preferred authoritative term in this field. In a recent review concerning the entries under the rubrics 'international' and 'global' in PubMed, Brown, Cueto et al. find, that until the 1990s authors clearly preferred to use 'international' (49.158 entries) over 'global' public health (27.794 entries), although entries regarding 'global' public health already increased considerably during the 1990s as compared to the 1980s (7.176 entries) and to former times in general. From 2000 until 2004 there seems to be some evidence, that the term 'global' (38.840 entries) is on track to eventually overtake the term 'international' (29.193 entries) in the field of public health (Brown, Cueto et al. 2006). The exact meaning of this shift in applied terms seems to be, however, far from being clear. For example, another report which was based on conversations with 29 international health leaders in governmental, nongovernmental, professional, multilateral, and academic institutions in 1999, found that these respondents were rather strictly divided into two groups. One group "*(...) felt it unnecessary to coin a new phrase to describe business as usual. They believed that 'global health' was mere jargon"* (Bunyavanich and Walkup 2001: 1556). The other group emphasized profound differences, namely " *'International' elicited conceptualizations of coordination constrained by nation-state boundaries, whereas 'global' held a more positive connotation with improvement"* (Bunyavanich and Walkup 2001: 1556). These conversations revealed an ambivalent picture at best.

In our opinion it is therefore important to review the current literature in this field as to how and to what extent this shift in the global health discourse has been documented and explained over time. Our review, however, uncovers a spectrum which ranges from the emergence of a 'world polity' and 'world culture' (Inoue and Drori 2006) at one end of the spectrum and a revival of national interests (Ingram 2005) in the field of public health at the other end of the spectrum. Although *per se* this does not necessarily have to be a contradiction, interpretations markedly differ as will be shown in the subsequent section.

International cooperation and coordination is not a new phenomenon in public health. First attempts to regulate public health between nations can be dated back as far as to the fourteenth century, when the city-state of Venice used force to quarantine ships which were expected of carrying plague-infected rats. The practice soon spread to other ports (Buse, Mays et al. 2005). These early practices later paved the way for more formal international agreements in the nineteenth century. While tracing the dates of the founding of health-related international organizations and their respective stated objectives, Inoue and Drori in their seminal article find four distinct approaches and respective phases in international health, namely international health as (1) an act of charity mainly from the 17th until the end of the 19th century, (2) a professional activity mainly until WW II, (3) a means of development (mainly until 1990s) and (4) more recently as a basic human right (Inoue and Drori 2006). The bulk of the 2640 health-related international organizations detected by Inoue and Drori, have been founded after WW II and especially from the beginning of the 1970s onwards. They conclude that "*these globalization trends – namely, the consolidation of a global organizational field and the thematic shift in its framing of health – have dramatic implications for the delivery of health care and for the establishment of health systems on a national level. In their role as 'teacher of norms', these international organizations imprint national structures (governmental and non-governmental) with (1) the understanding that health is a core social concern and (2) the specific understanding of the social role of health"* (Inoue and Drori 2006: 200).

In our opinion two questions derive from Inoue's and Drori's analysis: (1) How have thematic shifts in the international health field been interpreted by others? (2) How can the respective 'ideational influence' of the various actors be described? Especially the second point, which is somewhat linked to the first point in our opinion, holds some importance. Though the relation between founding date and organizational objective certainly provides useful information on *discursive trends* and the *potential* of a certain discourse over time, it pays little to no attention to the *actual* ideational influence of actors and the respective power relations. Given, however, that a pure neo-institutionalist perspective was followed, it could hardly pay any attention to these factors.

While most scholars would certainly agree, that before the nineteenth century the predominant discourse dimension was based on charity, there exist different interpretations concerning the other three predominant approaches and their respective classification by time period. With regard to the development policy context and discourse and taking into account the *actors, context and process* within policy reform, Walt and Gilson identify two distinct post-war phases: (1) a low-politics phase dominated by a medical paradigm up to the

late 1960s and (2) a high-politics phase with a debate on comprehensive versus selective health care at its forefront (Walt and Gilson 1994).

Until the late 1960s they discover international health to be *"(…) a relatively restricted policy field dominated by medicine"* (Walt and Gilson 1994: 356). Consequently during this period the state played a central development role and *"health policy had been decided largely on consensual grounds, partly because it was controlled by a medical elite"* (Walt and Gilson 1994: 356). Health policy appeared largely as 'low politics', which was repeated in international circles with few international organizations (especially the WHO) providing technical expertise and funds for specific single-disease focussed programs. Walt and Gilson hence come to label the period between WWII and the end of the 1960s as a period dominated by a 'medical paradigm' (Walt and Gilson 1994), which would largely correspond to Inoue's and Drori's professional paradigm. By the late 1960s the medical paradigm came more and more under fire from within the medical discipline and from historians, epidemiologists, social scientists and economists, who commented on the social and economic dimension of health. Most visible this new approach found expression in the Alma Ata declaration of 1978 (described below in more detail), as for the first time the role of politics and conflict in health policy has explicitly been mentioned. From then onwards international health began to move up the ladder from being largely a 'low politics' issue to become more and more a 'high politics' issue, markedly leaving the consensual grounds of former times. Especially the debate concerning comprehensive versus selective primary health care gained momentum during this time partly due to the emergence of neo-liberalism in the 1980s and the concomitant preference for selective health care approaches (Walt and Gilson 1994).

Other scholars studying the global-national politics nexus differentiate the different international health regimes into a 'Westphalian public health governance' and a 'Post-Westphalian public health governance' (Fidler 2005). The former regime, which is meant mainly to have lasted until WWII, comprised three aspects, namely *"(1) the only actors are states; (2) the classical regime contained no provisions about ,and showed no interest in, public health conditions inside states; and (3) the classical regime is laid down in consent-based rules of international law"* (Fidler 2005: 168). The latter regime began with the founding of the WHO after WW II and the WHO's constitution's preamble emphasizing the human right to health. This marked a departure from the hitherto horizontal governance approach, which characterized the Westphalian era, and the beginning of a vertical governance approach. The zenith of the post-Westphalian approach occurred in the late 1970s with the launch of the Health for All campaign (Fidler 2005). Major differences in

contrast to Westphalian times were, that (1) local sources of diseases and general local health problems were now addressed by the WHO and (2) concurring concepts (primary health care approach) were developed. From the 1990s onwards, however, Fidler also detects a revival of the Westphalian approach –a neo-Westphalian approach - in parallel to the ongoing post-Westphalian approach, which is mainly due to the US again becoming re-engaged with public health policy (Fidler 2005). This assessment is further backed by Ingram, who after having compared public health approaches of the UK and the US, concludes that there exist *"divergences and contradictions within the new global public health agenda, reflected in differences between US and UK policies. US approaches have been characterized by consistent unilateralism, neoliberalism and an increasing securitisation in relation to global health problems. These contrast with the approaches that the UK has promoted, which, while recognising the links between health, foreign policy and security, have placed much greater emphasis on multilateralism, the new meta-narrative in development, and the maintenance of development and security policies as relatively autonomous policy areas"* (Ingram 2005: 397).

Coming back to our initial debate on 'international' versus 'global' public health, the picture remains ambivalent after the literature review. While on the one hand scholars seem to clearly agree as shown, that firstly numerous new and heterogeneous actors have entered the international stage and that secondly their operations reach and influence the local level in contrast to former times, there seems to exist controversy about the *actual thematic shifts* and the *ideational influence* of international organizations over time be they international governmental or nongovernmental organizations. In this paper we attempt to shed some light on this issue. In our analysis we shall, however, restrict our focus to some of the most important international governmental organizations, namely the WHO, UNICEF,World Bank and the WTO, because these organizations often form the node for many of the non-governmental organizations. If indeed there was a development of a field of 'global health politics' underway as some scholars stipulate (Kohlmorgen, Hein et al. 2003), then we should at least find some evidence of this development in our analysis despite the fact that many of the new international actors are not considered in our analysis.

3 THE ROLE OF INTERNATIONAL ORGANIZATIONS. PROMOTER OF A POLITICAL GLOBAL PUBLIC HEALTH AGENDA?

3.1 The World Health Organization (WHO)

3.1.1 Health Policy Ideas and Health Care Approach

When the WHO started its work it "*was the main, and, because of its technical expertise, authoritative actor in a fairly small policy arena"* (Walt 2006: 141) with a largely single disease-focussed approach. Despite its visionary constitutional objective the WHO in its first years mainly concentrated on the eradication of single diseases such as e.g. the 1955 malaria eradication programme or the 1959 commitment to the global eradication of smallpox. This changed tremendously during the 1970s as developing countries became WHO members, the funding base changed and a wider network of interests became involved in international health policy. The tenure of Director-General Halfdan Mahler – a tuberculosis specialist from Denmark - lasting from 1973 to 1988, is often portrayed as the *"golden age of WHO"* (People's Health Movement/ GEGA/ Medact 2005: 272) characterizing a period, when the WHO finally embarked on a stronger political role in contrast to its earlier focus on technical expertise. The most visible expression of this shift in the WHO's role was the 1978 'International Conference on Primary Health Care' in Alma Ata, co-sponsored by the WHO and UNICEF, and the resulting Alma Ata declaration on primary health care (PHC), which some reckon to be "*a very radical contribution to a new social paradigm of health care"* (Narayan and Unnikrishnan 2003: 5). The cornerstones of the new primary health care approach, which was to achieve the objective of 'health for all' by the year 2000 focussed on (1) health as a fundamental human right, (2) universal accessibility and coverage, (3) comprehensive care with an emphasis on disease prevention and health promotion, (4) community involvement in health care and education, (5) inter-sectoral collaboration for health and (6) appropriate technology and cost-effectiveness in relation to available resources (Sanders 2003). Further achievements of Mahler's tenure were the expanded program on immunization, the model list of essential drugs and the international code of breast feeding. With these initiatives Mahler was able to establish the WHO as the 'world's health conscience' (People's Health Movement/ GEGA/ Medact 2005).

While, in general, the PHC approach of 1978 subsequently remained to be at least the declared normative yardstick in the years to follow until today, much attention was drawn away from it in the following years due to competing views within the organization, competing programs of other IGOs, financial set backs and poor management. WHO's next two Director-Generals, Hiroshi Nakajima (1988-1998) and Gro Harlem Brundtland (1998-2003),

followed a markedly different path than their predecessor Halfdan Mahler with vertical programs again rapidly gaining importance. The tenure of Hiroshi Nakajima, a Japanese researcher with experience in drug evaluations, can easily be described as the most controversial tenure in WHO's history due to his autocratic and widely alleged poor management abilities along with cronyism and corruption rising rapidly (Brown, Cueto et al. 2006). Most remembered is his open dispute with Jonathan Mann, a highly respected American physician who was in charge of WHO's global program on AIDS and who finally resigned from his position due to the conflict. Mann later became the main driver for the establishment of UNAIDS, substantially weakening WHO's influence and reputation in the international health community. Nakajima's tenure was further accompanied by extra-budgetary funding finally overtaking the regular budget by the beginning of the 1990s, contributing 54% to WHO's overall budget (Brown, Cueto et al. 2006). Needless to say, the bulk of the money went into vertical programs and was largely beyond WHO's control.

This trend was further exacerbated during the subsequent tenure of Gro Harlem Brundtland. However, also two other legacies of Gro Harlem Brundtland stand out: (1) the restructuring of WHO's central organization and (2) bringing WHO back as a crucial player on the international scene. With regard to the first point, Brundtland was rather successful as to changing the management of the headquarters, but her reforms did not extend to the regional and country offices. Concerning the second aspect, Brundtland established a Commission on Macroeconomics and Health, chaired by Jeffrey Sachs and including former ministers of finance, the World Bank, IMF, WTO and UNDP. The resulting report identified a set of disease priorities, which would require focussed attention. Furthermore the report affirmed the role of the state in providing health services in poor and middle income countries and cautioned against reckless privatization (Brown, Cueto et al. 2006). Later on Brundtland also pushed successfully for health to be a key aspect of the Millennium Development Goals. In order to sustain WHO's role in the international arena, she tried to strengthen WHO's financial position by organizing global partnerships and global funds (e.g. Roll back Malaria and Stop TB initiative) to bring together private donors, governments, and bilateral and multilateral agencies often in the form of PPPs. Not only did ties to the World Bank become much closer during Brundtland's tenure, but the focus shifted ever more to vertical programs and towards a narrower focus on certain 'priority diseases' (Brown, Cueto et al. 2006).

Today the WHO seems to attempt to revive Alma Ata's primary health approach, at least this was the main agenda of Brundlandt's successor Lee Jong-wook (Jong-wook 2003) during his short tenure from 2003 until he died in May 2006. Similar signals come from the current Director-General Margaret Chan (who succeeded the brief interregnum of Anders Nordström

in November 2006). In the 2005 World Health Report the WHO thus advocates universal coverage, which is to be achieved by phasing out user fees and introducing pooled prepayment systems either through general taxation, social health insurance schemes or mixed systems. External resources should therefore also be channelled through these pooled prepayment systems (World Health Organization 2005). At the time of writing it is still too early to judge, whether this revitalization of Alma Ata's vision and approach will be successful or not. Given the resources and technical capacities reviewed in the subsequent section, success seems highly unlikely.

3.1.2 Organizational Capacity

The World Health Organization (WHO), which was founded as a specialized UN-Agency in 1948 attempting to bring international cooperation and organizations in the field of health under one common umbrella, is often portrayed as the "*world's leading health organization*" (Ling 2002b) not least in its own constitution. In this vein the organization can claim universal ***membership***, i.e. it comprises currently of 193 member states plus two associate member states (World Health Organization 2007). In order to fulfil its broad ***mandate*** as stated in Article 2a of "*directing and coordinating international health work"* (World Health Organization 1948) to reach its objective as stated in Article 1 namely "*the attainment by all peoples of the highest possible standard of health"* (World Health Organization 1948), the WHO relies on a decentralized ***structure***, comprising of six regional offices in Copenhagen (European Region), Washington (Region of the Americas), Cairo (Eastern Mediterranean Region), Brazzaville (African Region), New Dehli (South-East Region) and Manila (Western Pacific Region) in addition to its headquarters in Geneva. The regional offices have significant discretionary power over the allocation of the regular budget, i.e. they are responsible for formulating and implementing the annual budget and determining program priorities (Walt 2006). This decentralized structure together with the significant amount of independence of the regional directors from the headquarters has led some critics to speak of 'seven WHOs' (Kickbusch 2000). The positive effect of the decentralized structure is, however, that the WHO with its very wide ranging mandate covering up to 22 functions, has the ***flexibility*** at least in theory to respond to changing contexts and priorities not to mention WHO's significant independence from the UN-family in general. Furthermore, the ***rules for controlling*** the organization are overly democratic, i.e. the 'one state –one vote'-rule applies in the World Health Assembly (WHA) as the supreme governing body, giving also the many developing countries unparalleled opportunities to exert influence. Most decisions are made by consensus. Although conventions and recommendations adopted by the WHA typically cannot be ***enforced*** and are legally non-binding, some of the initiatives such as the

International Health Regulations (IHR) of 1969, which replaced the International Sanitary Regulations and are the only binding rules governing international health or the 1977 "Essential Medicines List" were very influential. Hence, the WHO has earned the reputation as "t*he leading global authority preparing guidelines and standards on numerous issues, and the foremost source of scientific and technical knowledge in health*" (People's Health Movement/ GEGA/ Medact 2005: 275). Altogether these points underline the role of the WHO as the world's leading health organization and at the same time give rise to expectations, which would like to see the WHO as the prime driver and promoter of a political global health agenda. However, other crucial organizational features point in the opposite direction uncovering an organization which is dramatically losing significance compared to former times. Why is that?

Table 1: Organizational Capacity of the WHO

Dimensions	
Membership Rules	Universal. 193 members plus two associate members.
Scope of Issues	Limited. Health and Environmental Issues only.
Centralization of Tasks/ Management	Decentralized. 34-member executive board plus six regional offices (Staff 3608 fixed term and 4746 short-term, 37% professionals, 58% general service). The six regional offices have a significant amount of independence.
Rules for controlling the organization (Voting arrangements & Financing)	One state, one vote (most decisions are made by consensus) BUT: 72% of the budget is earmarked for specific projects and programs (beyond WHO's control as this requires consultations with donors)
Flexibility of arrangements	Formally high, 22 functions and high amount of decentralization.
Enforcement	Not possible. Conventions are non-binding.
Channels	- rather sparse, primarily through giving advanced health expertise to key national health agencies and research institutions -trying to create binding instruments like the framework convention on tobacco
Scope of health-related Issues	Broad.
Instruments	- Research & Debate - Setting norms and standards - Technical support (to help make norms, standards and policy options available, but no implementation) - Monitoring
Resources	Small. Total WHO budget for 2006-2007 is only US-$ 3.3 billion.

First and foremost, this is due to the financial ***resources*** the organization has at its disposal and which are mainly spent on staff and production of knowledge (Kickbusch 2000). In 2001, 3608 fixed-term employees or career-staff plus 4746 short-term employees worked for the WHO, one third of them being professional staff (Minelli 2006). In terms of the financial resources the organization is dependent on a small number of member states, with the US being the biggest contributor but also the contributor constantly in arrears. The biannual regular budget, which is collected from the regular dues of the member states has remained almost constant over the last years and amounted to US-$ 842 million in the period of 2000-2001 and 2002-2003 respectively (Minelli 2006). The biannual regular budget of 2006-2007 saw a slight increase to US-$ 915 million (World Health Organization 2007). The regular budget today, however, makes up only 28% of the total WHO budget, the lion's share existing of so-called voluntary contributions, which mainly come from member states (67%), other UN organizations (17%) and foundations (6%) adding up to a comparably tiny sum of US-$ 3.3 billion as the total WHO budget for 2006 and 2007 (World Health Organization 2007). These voluntary contributions have risen enormously in the past and have more than tripled from US-$ 742 million in the period of 1989-1990 (Minelli 2006) to US-$ 2.4 billion in the period of 2006-2007. Voluntary contributions are, however, to a great extent earmarked to specific projects and vertical single-focus disease programs and are virtually beyond the control of the WHO. These extra-budgetary resources provide health ministries with more financial resources but this method is often used to bypass WHO's regional and country offices (Walt 2006). In this vein, 53% of WHO's expenditure is spent on so-called "essential health interventions", i.e. vertical programs, while only 13% is spent on health policies, systems and products (World Health Organization 2007).

Another important aspect is the ***channels*** through which the WHO acts vis-à-vis national governments. In the case of the WHO, these channels are comparably restricted. Due to the fact that the WHO's mandate - despite it being rather broad - is mainly restricted to the health sector, the main interface is with the notoriously weak and low-prestige national health ministries. Thus, often the small and poorly funded WHO country offices, which are often housed within the ministry frequently have to spend their entire budget on "*ad hoc financing of fellowships or study tours, workshops and miscellaneous supplies and equipment"* (Walt 2006: 137). Consequently, there is often no room *"to assist in any strategic planning for the health sector or programming the allocation of scarce resources"* (Walt 2006: 137).

Last but not least, WHO's focus on expert knowledge is also reflected in the recruitment practice of the organization. Still, the overwhelming majority of the professional staff is

doctors, which are ill-equipped in terms of policy and management knowledge (People's Health Movement/ GEGA/ Medact 2005).

3.2 UNICEF

3.2.1 Health Policy Ideas and Health Care Approach

Being basically a relief agency in the beginning, UNICEF in the early 1950s mainly furnished equipment and supplies to countries for mass-disease campaigns on malaria, yaws, TBC, typhus etc., with WHO providing the technical support (Ling 2002a). From the 1960s, and due its engagement in rural health services together with the WHO and the Food and Agriculture Organization (FAO) of the UN, UNICEF attempted to broaden its focus to the 'whole child' (Ling 2002a). By the early 1970s, UNICEF had successfully shifted its emphasis to the provision of basic services for children, which now also included education. Hence, from the 1970s onwards UNICEF visibly had changed from a relief agency into a development agency (Ling 2002a).

A landmark in UNICEF's development was the co-sponsored Alma-Ata conference mentioned above, which led to the declaration of primary health care and the goal of 'Health for All in the Year 2000'. Shortly afterwards, however, this approach was criticised as too idealistic. This began in 1979 at a small conference in Bellagio, Italy, sponsored by the Rockefeller Foundation, with assistance from the World Bank. The participants comprised the president of the World Bank, the vice president of the Ford Foundation, the administrator of USAID, and the executive secretary of UNICEF. The Bellagio conference focussed on an alternative concept than that articulated at Alma Ata, namely the selective primary health care (SPHC) concept (Brown, Cueto et al. 2006). This approach recommends pragmatic low-cost intervention and strongly advocates a shift of priority to diseases with the (1) highest prevalence, (2) highest morbidity or mortality, (3) highest risk of mortality and (4) possibility of control in terms of effectiveness in method and cost of intervention (Rifkin and Walt 1986). In their seminal article, Rifkin and Walt point out that this alternative approach is not a mere pragmatic approach to realize PHC, but in fact a diametrically different approach, leading to very different outcomes. While PHC understands health (improvement) primarily as a process dependent on individual knowledge and choice, SPHC understands health improvement primarily as a result of programs based on medical and technological interventions, leading – as Rifkin and Walt show – to a fundamentally different understanding of (1) health in general, (2) the importance of equity, (3) the relevance of a multi-sectoral approach and (4) the importance of community involvement (Rifkin and Walt 1986).

In practice SPHC found expression *in persona* of UNICEF's new executive director James P. Grant and the launch of the so-called 'Child Survival and Development Revolution' in 1982, which focussed on four inexpensive interventions to reduce child deaths. The acronym 'GOBI' represents these four program components of CSDR, namely (G) Growth monitoring to detect early signs of child malnutrition; (O) Oral rehydration to prevent death by dehydration as a consequence of diarrhea; (B) Breast-feading to stop the unhealthy and often deadly effects of infant formula in poor communities; (I) Immunization against the six vaccine-preventable diseases. GOBI-FFF afterwards added food security, female education and family planning to the list (Ling 2002a).

The subsequent tenure of Carol Bellamy then saw a slight shift away from the narrow 'child survival' approach towards a more comprehensive agenda for child development and rights. Thus, in general the rights of children, the importance of girls' education and early childhood development gained significance during her tenure (People's Health Movement/ GEGA/ Medact 2005).

At the time of writing, it is still to early to assess the main focus of the tenure of the new executive director Ann M. Veneman. However, a step towards a comprehensive health approach and the development of a closer working relationship with the WHO, in which the WHO takes the lead in developing the respective strategies, would come as a major surprise.

3.2.2 Organizational Capacity

The United Nations Children's Fund (UNICEF) was originally created in 1946 as the UN International Children's Emergency Fund as a temporary agency to provide urgent relief aid to children in post-war Europe. Only seven years later – in 1953 - it was transformed into a permanent agency. It spends as much as 80% of its funds on public health programs (Ling 2002a). Undoubtedly, UNICEF's contribution to international health should thus not be underestimated.

Being an integral part of the UN-system, it can claim universal ***membership***. Despite its rather limited ***mandate*** from the United Nations General Assembly "*to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential*" (see also http://www.unicef.org/about/who/index_mission.html), the organization has widened its ***scope of issues*** considerably. It encompasses today areas as diverse as humanitarian

assistance, girls' education, immunization, child protection, early childhood development and HIV/ AIDS (UNICEF 2006). As an 'operating agency' of the United Nations system it enjoys – formally speaking - no such independence from the UN-family as the WHO or the World Bank, i.e. the executive director is appointed by the UN Secretary-General in consultation with its 36-member executive board. Board members are in turn elected by the Economic and Social Council (ECOSOC) of the UN for a three-year term (Ling 2002a). Although there exists no formal agreement, UNICEF has always had a US Executive Director. The recent appointment of Ann M. Veneman, however, the former head of the US Department of Agriculture and an agrochemical and food industry lawyer and lobbyist, has led to fierce criticism of this procedure and the foundation of a respective "Save UNICEF" campaign by the People's Health Movement (Margetts 2005; People's Health Movement 2005).

Like the WHO, UNICEF has a decentralized ***structure***, comprising of seven regional offices and 126 country offices, with a unique number of 90% of its staff (currently ca. 7000) being located in country or regional offices (People's Health Movement/ GEGA/ Medact 2005). Thus, Ling notes "*UNICEF representatives at the country level have considerably more authority and resources than those of its sister UN agencies, but they generally serve under the leadership of the UN resident coordinator*" (Ling 2002a: 4). UNICEF thus faces similar challenges as the WHO, i.e. on the one hand this structure allows UNICEF to have a ***high degree of flexibility*** to respond to different contexts and changing priorities, but on the other hand this structure causes high transaction costs.

As most other UN organizations, UNICEF has an unweighted ***voting*** structure and a consensus-oriented decision-making procedure (Jolly 1991), giving developing countries in theory good opportunities to influence the organization's policy. In contrast to the WHO, however, this does not apply to the election of the executive director, which in turn guarantees considerable US-influence over UNICEF's policy as has been shown earlier.

Table 2: Organizational Capacity of UNICEF

Dimensions	
Membership Rules	Universal.
Scope of Issues	Limited. Health and Educational Issues only.
Centralization of Tasks/ Management	Decentralized. 36-member executive board plus seven regional offices and 126 country offices. 90% of the 7000 staff work in regional or country offices and have significant amount of independence.
Rules for controlling the organization (Voting arrangements & Financing)	One state, one vote (most decisions are made by consensus). BUT: executive director is always US-citizen. Income entirely derived from voluntary contributions and 71% of these are virtually beyond the organization's control.
Flexibility of arrangements	High.
Enforcement	Not possible.
Channels	Formally restricted, but good access through 'national committees' and celebrities.
Scope of health-related Issues	Broad. Although primarily focused on children and mothers, nearly all encompassing.
Instruments	- Research - Emergency relief - technical support -Monitoring
Resources	Small. Total annual budget for 2005 was US-$ 2,7 billion.

This is further underlined by the fact that in contrast to the WHO UNICEF derives its ***resources*** entirely from voluntary contributions. The voluntary contributions can be divided up into (1) so-called 'regular resources', which are unrestricted in their use and are used to fund UNICEF's country programs, and (2) so-called 'other resources', which are restricted in their use for specific purposes detailed by donors. In 2005 these 'other resources' accounted for 71% adding up to a total annual income of US-$ 2,7 billion (UNICEF 2006), which is a rather tiny sum compared to the respective resources of the World Bank in the health field, but already notably higher than the WHO's annual budget. One has to take into account, however, that there has been a considerable increase in UNICEF's income between 2004 (US-$ 1,9 billion) and 2005, which was due to the Indian Ocean tsunami and South Asia earthquake (UNICEF 2006). In general, 'regular resources' have increased at a much slower pace than 'other resources'. Another unique feature of the financing structure of UNICEF is the large share of private sector funding, which made up 38% compared to 50% government funding, 4% NGO funding, 3% IGO funding and 3% inter-agency arrangements in 2005 (UNICEF 2006).

Like the WHO, UNICEF's ***channels*** vis-à-vis national governments seem on first sight to be as restricted. However, due to its unique organizational feature of the so-called 'UNICEF's National committees', of which there are currently 37 in the industrialized world, UNICEF is able to mobilize considerable support for its programs not least in industrialized countries. In 2005, the national committees alone were able to contribute 37% of all UNICEF income (UNICEF 2006) not to mention the several channels through which they raise public awareness e.g. through dedicated celebrities and their good access to national governments of donor countries.

3.3 The World Bank

3.3.1 Health Policy Ideas and Health Care Approach

The Bank summarizes its health policy approach as follows: *"…the global community should focus on helping countries design policies that can foster access by the poor to health-enhancing services and protect the poor and near-poor from catastrophic health spending. User fees can be harmonized to achieve these objectives if they reduce financial barriers to the poor by improving the quality of public services, reducing waiting time, reducing the need for costly self-medication, or substituting lower-priced quality public services for more expensive private care"* (Gottret and Schieber 2004: 31).

Since its inception in 1944, the World Bank has undergone a number of severe changes in the field of health policy. In the 1950s and 1960s, the Bank focused mainly on infrastructure projects and physical capital and relied on the prevailing wisdom that economic growth would "trickle down" and development would follow. A remark by Robert Cavanaugh, the Bank's chief fundraiser in 1961, summarized the Bank's position at the time in a nutshell: "*If we got into the social field […] then the bond market would definitely feel that we were not acting prudently from a financial standpoint. […] If you start financing schools and hospitals and water works, and so forth, these things don't normally and directly increase the ability of a country to repay a borrowing*" (Ruger 2005: 63).

Health policy at the World Bank began *indirectly* in the mid-1960s, when population growth in developing countries started to become a health issue (Walt 2006 :126). Starting in 1968, under the presidency of Robert McNamara, "*the Bank expanded its project and sector work activities from what is normally called "economic" to 'social' infrastructure*" (Wogart 2003: 191). Dragoslav Avramovic, head of the economics department under McNamara, supported

new academic thinking on basic needs and criticized the prevailing orthodox economic policy (Ruger 2005). Slowly, the Bank's focus began to shift towards family planning and nutrition. Yet, family planning still only represented a very small fraction of overall Bank lending and the first nutrition loan was not granted until 1976 (Ruger 2005). In 1974, the Bank issued the first report on the policy aspects of lending in the health sector, in which the authors recommended to "stay the course" and finance health-related *components* of projects instead of pure health projects (World Bank 2007a).

Direct support for health services followed in 1979, when the Bank realized that health policy and poverty reduction could not be separated. In that year, the World Bank's Executive Directors decided to expand the program to provide direct lending for health projects and created the World Bank's Department for Health and Nutrition and Population (HNP). However, in the 1970s and early 1980s, health sector projects still made up only a small fraction of overall World Bank spending (Wogart 2003) and health policy at the Bank was still mainly an issue of population control (e.g. safe motherhood). According to Wogart, "*the Bank's involvement in health and nutrition gave it […] a better opportunity to discuss population issues in the context of less controversial major health issues*" (Wogart 2003: 193).

By the end of the 1980s, the Bank had come under excessive scrutiny due to its structural adjustment policies (Pieper and Taylor 1998; Easterly 2001; Abouharb and Cingranelli 2006). A review by the Bank's Evaluation Departments conducted between 1970 and 1995 criticized several aspects of the Bank's health policy. A main critique was the fragmentation of the programmes. As a consequence, the Bank started to think health policy in terms of broader poverty concerns (Ruger 2005).

In *Financing health care: an Agenda for Reform* (1987), the World Bank issued its first health policy strategy (Walt 2006). Not surprisingly, the report focused on less state involvement and more private health care. The 1987 report openly promoted a "neo-liberal" agenda, which supports privately managed services backed up by public health programs (Wogart 2003). In particular, the report emphasized the need for improved health sector financing including highly controversial user fees/charges. These are often criticized for reducing the demand for health care and the uptake of services. Moreover, critics argue that user fees have serious implications for equity as they disproportionally affect the poor (Abbasi 1999; Ruger 2005).

In its *World Development Report: Investing in Health* from 1993, the World Bank reaffirmed this position and set the framework for a health policy based on cost effectiveness (Walt 2006). Previously, an internal World Bank review of 1800 projects in over 130 countries with a total budget of roughly US$ 140 billion had found devastating results: almost one-third of the projects completed until 1991 were considered a failure (Wogart 2003). In the first Development Report focusing completely on health, the Bank put forward several key recommendations: "*educating girls and empowering women, reallocating government resources from tertiary facilities to primary care, investing in public health and essential clinical services, and promoting private and social insurance and competition in health services delivery*" (Ruger 2005: 66). In particular, the latter policies were heavily contested due to their focus on privatization. In addition, the introduction of "disability adjusted life years" (DALYs[1]) provoked harsh criticism. DALYs allow that a monetary value is attached to each health care intervention (Abbasi 1999). Thus, socioeconomic values are not taken into account sufficiently and the measures attributes different values to different ages (Abbasi 1999; Ruger 2005).

After James Wolfensohn took over the presidency in 1995, the Bank started to change its priorities from purely macro-economic strategies towards strategies to fight poverty (Kohlmorgen, Hein et al. 2003; Wogart 2003). In 1997, the Bank published a strategy paper for its future involvement in health policies. Mainly, the strategy was supposed to target the poor and increase the efficient allocation of public health finances. Alex Preker, principal economist at the World Bank, is cited by Abbasi to clarify the Bank's position towards user fees: "*We, in this paper [the 1997 sector strategy], distance ourselves from [user fees] and make it quite clear that it isn't bank policy. The bank doesn't have a particular policy on whether user charges should or shouldn't be used* " (Abbasi 1999: 1005).

Among the key developments within the World Bank was the espousal of the sector-wide approach, which was strongly supported by Robert Feachum, director of the HNP department (Abbasi 1999). In the sector-wide approach, the entire health sector is addressed instead of single diseases or fragmented projects (Cassels and Janovsky 1998). Donors agree to fund projects for the entire health sector from one single basket and to negotiate spending together with the lending country (Garner, Flores et al. 2000). However, the "sector-wide" approach does not necessarily imply a choice for a specific policy (e.g. universal health insurance), but instead refers to the mode of resource-allocation. The goal is

1 WHO definition: DALYs for a disease are the sum of the years of life lost due to premature mortality (YLL) in the population and the years lost due to disability (YLD) for incident cases of the health condition. The DALY is a health gap measure that extends the concept of potential years of life lost due to premature death (PYLL) to include equivalent years of 'healthy' life lost in states of less than full health, broadly termed disability. One DALY represents the loss of one year of equivalent full health.

to reduce duplicity of projects and develop a more coherent approach. While the sector-wide approach has the advantage of pooling previously fragmented donor involvement, it means less influence for national governments, since donors gain a voice in the national allocation of resources (Abbasi 1999).

The private sector branch of the World Bank, the IFC, entered the health stage in the mid-1990s, when the rising economies in East Asia and Latin America increased the demand for international funding of private services in the health field (Wogart 2003). The large majority of these projects funded private hospitals; additional projects include financing medical research in laboratories or larger health institutes (Wogart 2003). All of these measures are at best indirect "anti-poverty" measures and rely first and foremost on the idea that technological advances will further economic development and thus health.

Poor countries hoping to receive debt-cancellation and/or borrowing the World Bank's low-interest loans are required to produce a Poverty Reduction Strategy Paper (PRSP) describing how revenues would be directed towards poverty reduction and macroeconomic adjustment. Although in principle all of these strategies are supposed to be individually fitted for each country, in practice IMF and World Bank are criticized for applying a homogeneous "one-size-fits-all" approach: maintaining low inflation rates and price stability, privatization and reduction of administrative costs, lowering tariffs and protectionist policies and deregulating capital markets (Abouharb and Cingranelli 2006).

The most crucial argument for IMF and World Bank influence is the fact that every national poverty reduction strategy has to be approved by the Boards of IMF and World Bank (Eberlei 2003). These are in turn influenced and shaped by the dominant industrial powers, most notably the United States, which leaves much leeway to formulate conditions: "*In the case of health insurance, this translates into "individualism with a safety net*"" (Wogart 2003: 200).

However, reviews of health policy in Poverty Reduction Strategy Papers (PRSPs), introduced in 1999 as successors of the Structural Adjustment Programs (SAPs), show that a majority of strategies "*lack country-specific data on the distribution and composition of the burden of disease, a clear identification of health system constraints and an assessment of the impact of health services on the population*" (Laterveer, Niesen et al. 2000: 138). Moreover, while most PRSPs include technical strategies for reducing diseases, the (re)organization of health care spending is addressed in less than half of the PRSPs (Laterveer, Niesen et al. 2000). This finding is contrary to the World Bank rhetoric on health as the top-priority. The authors corroborate that only one-fourth of the strategies actually addressed issues of equity and

distribution. Only very few of the papers had included actual budgets for health expenditure (Laterveer, Niesen et al. 2000). This is not surprising, given the fact that the IMF had stated several times before that "*the usual track of macroeconomic adjustments is not negotiable in the context of PRSPs*" (Eberlei 2003: 70). The fact that health strategies are not a fixed part of all poverty reduction strategies seems to support Buse and Walt, who argue that "*health is viewed within the Bank, not as a right, […] but instead as an economic commodity*" (Buse and Walt 2000: 177).

Recently, the Bank has started to recognize the increased salience of international (non-governmental) organizations. Due to the global public private partnerships, such as the initiative to Roll-Back Mararia, Stop TB and the Global Alliance on Vaccines and Immunisation (GAVI), the World Bank is increasingly looking for its unique position among the donor institutions. Most of these initiatives have focused on combating single diseases and are investing millions. In addition, new private actors such as the Bill & Melinda Gates Foundation are taking over the field of single diseases (Bartsch 2003). These initiatives have increased spending to such an extent that the World Bank is forced to highlight its "added value" - even though the World Bank is still the most important global actor when it comes to health (Hein 2003; Ruger 2005).

In response to these developments, the Bank has issued a new strategy in May 2007 to emphasize the importance of health systems. Rather than disbursing funds for specific projects, the goal is to link *outcomes,* e.g. the vaccination of children, directly with Bank loans. In *Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results*, the Bank redirects its focus on strengthening health care systems as a whole (World Bank 2007b). Fairly self-critical, the Bank also admits that health, nutrition and population spending had the lowest performance in the Bank since 2001 (World Bank 2007b). Unfortunately, it is too early to assess any effects of the newly devised strategy yet, since the strategy has not yet found its way into budget allocations.

3.3.2 Organizational Capacity

The World Bank Group is one of the biggest and most influential development agencies and the single largest external financier of health projects worldwide (Buse and Walt 2000; de Beyer, Preker et al. 2000). With its ***membership*** of 185 member states, the Bank has the same coverage as the IMF or the ILO. The origins of the World Bank date back to 1944, when the International Bank for Reconstruction and Development (IBRD) was set up as the original institution of the World Bank Group together with its sister organization, the

International Monetary Fund. Sixteen years later, in 1960, the International Development Association (IDA) was established with the ***objective*** to reduce poverty by providing interest-free loans and grants to the least developed countries. Today, IDA and IBRD complement each other – the IDA serves the world's poorest countries while the IBRD lends to middle-income countries. The rest of the World Bank group comprises the private sector arm of the Bank, the International Finance Corporation (IFC), the Multilateral Investment Guarantee Agency (MIGA), which provides political risk insurance, and the International Centre for the Settlement of Investment Disputes (ICSID).

The World Bank employs roughly 10 000 people in Washington, D.C. or in one of the more than 100 country offices. Only 3 000 of the employees work in country offices in developing countries (World Bank 2007b). The World Bank's presence in most lending countries provides the Bank with long-term contacts and the possibility to influence policy decisions "on-the-spot". The distribution of personnel between Washington and the country offices reflects the centralized structure within the World Bank, within which decisions are dominated by the 24 Executive Directors.

Table 3: Organizational Capacity of the World Bank

Dimensions	
Membership Rules	185 Member States
Scope of Issues	Broad scope of issues related to poverty reduction and economic development
Centralization of Tasks/ Management	Centralized. Main loan decisions are taken by the Executive Board (24 members - of which 5 for the biggest donors). The Board of Governors meets once a year. The World Bank has approximately 10,000 staff members. Of these, 7 000 work in Washington and 3 000 are employed in 100 regional offices.
Rules for controlling the organization	Shareholder principle.
Flexibility of arrangements	Little flexibility.
Enforcement	Loan conditionality, but no "hard" institutionalized enforcement mechanism.
Channels	Broad access due to the large range of issues covered (access to all sector ministries).
Scope of health-related Issues	Nutrition, health sector financing, health insurance, public health expenditure, infectious diseases, population control, family planning
Instruments	- Financial Assistance and loan conditionality - Research & Debate - Setting goals for macroeconomic development and public spending - Technical support (to help implement macroeconomic development strategies, specific project) - Monitoring
Resources	Large. US$ 23.6 billion for projects in developing countries in 2006. Approximately US$ 5 billion for health-related projects (Walt 2006)

The World Bank's ***rules for controlling the organization***[2] are based on the principle "those who pay decide". It is organized like a cooperative, where the member states are shareholders (World Bank 2007a). Voting rights within the Bank are based on shares. In practice, the Bank's management decides most issues, rather than the member states (Walt 2006), i.e. the Board of Governors is "largely ceremonial" (People's Health Movement/ GEGA/ Medact 2005), representing the shareholders and meeting once a year at the general meetings of the IMF and World Bank. Year-round decisions are taken by the 24 Executive Directors, of which the five largest shareholders, France, Germany, Japan, the United Kingdom and the United States each always appoint one Executive Director. The rest of the shareholders are divided into 19 constituencies, each represented by one director. Currently, China, Russia and Saudi-Arabia also each represents a single "constituency", each electing

[2] The analysis of World Bank work will concentrate on IDA and IBRD.

one Executive Director on their own. The US holds almost 17% of the shares, thus giving it the possibility to veto any decision requiring a so-called “super-majority” of over 85% (People's Health Movement/ GEGA/ Medact 2005; World Bank 2007c). Taken together, the five largest shareholders currently control 37.39% of all votes (World Bank 2007c). In contrast, 21 African countries are grouped in one constituency, together only represented by one single Executive Director with a voting share of 3.36 % (World Bank 2007c). Woods explains how the voting shares are attributed: *“voting power [..] depends upon the country’s “quota”, which is determined by a formula which attempts to translate relative weight in the world economy into a share of contributions and votes”* (Woods 2001: 85).

Due to the broad range of issues covered by the World Bank , the organization has important ***channels*** of influence vis-à-vis national governments. The financial institutions have access to all of the sectoral ministries, most importantly the ministries of finance and the Prime Minister’s Office. This gives the World Bank significant ideational influence when it comes to devising national health care strategies.

The Bank’s impact on (health) policies stems not only from the fact that they can support the public sector directly, but also from their significant multiplicator and signalling effects to other donors. Via (1) monitoring, (2) provision of information, (3) technical assistance and (4) financial assistance, the Bank is able to exert a significant ideational and financial influence on the development of health policies in borrowing countries (Easterly 2001; Craig and Porter 2003; Eberlei 2003; Abouharb and Cingranelli 2006). With an overall spending ***budget*** of roughly US$ 25 billion a year (People's Health Movement/ GEGA/ Medact 2005), the Bank has an immense impact on development policy (the IMF has outstanding loans of about 28 billion US$ to 74 countries). With cumulative disbursements of US$ 12 billion and cumulative new lending of US$ 15 billion between 1997 and 2006, the Bank spent more than any other development agency on health projects (World Bank 2007b). In addition, the Bank provided policy support with more than 250 reports and analyses between 1997 and 2006 (World Bank 2007b).

3.4 WTO

3.4.1 Health Care Policy Ideas and Health Care Approach

The WTO addresses the *procedures* of trade related health issues, not the content. Thus, it is difficult to identify health policy ideas of the WTO. Yet, its activities have an immense impact on global health in two ways: they determine which (health) issues are part of the

trade agreements, and they set the scope of trade among WTO members (Koivusalo 2003). Four areas of agreements shape the national provision of health care: first, the *Agreement on Technical Barriers to Trade (TBT)*, covering issues such as trade in biotechnological and pharmaceutical commodities, involves equal access and questions of benefit sharing of health (medicines and genetic) resources. The *Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS)* is decisive when it comes to patenting new medicines and providing developing countries with access to cheap medicines. The General Agreement on Trade in Services (GATS) involves, among others, health care services, movement of patients or cross-border provision of health care services. The *Sanitary and Phytosanitary Agreement (SPS)* lays out rules for countries which want to restrict trade to ensure food safety and the protection of human life from plant- or animal-carried diseases (Bettcher, Yach et al. 2000).

Eight major health issues are influenced by WTO regulations (WTO and WHO 2002): (a) infectious disease control; (b) food safety; (c) tobacco; (d) environment; (e) access to drugs; (f) health services; (g) food security and nutrition; and, (h) emerging issues (such as biotechnology).

In the following section, each of the main WTO treaties will be analyzed separately to draw a comprehensive picture of the different instruments via which the WTO shapes national health policies.

The ***Technical Barriers to Trade (TBT)*** came into force in 1995[3] and requires all member states to ensure that product requirements do not create unnecessary obstacles to trade. However, countries are allowed to obstruct trade for "legitimate" reasons, such as health. According to the WTO, of the 725 notifications that were received in 2000, 254 addressed human health or safety issues (WTO and WHO 2002). Mostly these refer to harmful substances or technical devices which might have an impact on human health (such as electromagnetic waves). In practice, it proves to be quite difficult to decide which measures are necessary "to protect human, animal or plant life or health" – and which are not.

When the WTO was created in 1994, increasing global trade had led industrialized countries and multinational corporations to pursue regulations on intellectual property rights. Most developing countries opposed the agreement, fearing that revenues on global (biotechnological and genetic) resources would be directed to the multinational corporations

3 Until 1995, the TBT agreement involved only 46 countries. The Agreement had first been established in 1980 and involved only 46 countries. After 1995, it became part of the WTO agreements and contained more stringent obligations than the preceding version of the agreement.

of the North only (Bettcher, Yach et al. 2000; Koivusalo 2003). Before the ***Protection of Intellectual Property*** *(TRIPS)* agreement came into force at the Uruguay Round, the previous intellectual property regimes had lacked enforcement (Bettcher, Yach et al. 2000)[4].

TRIPS raised a variety of concerns in the health sector. The fear was and is that medical technologies and pharmaceuticals in developing countries would be too expensive to be accessible to a wide range of people (Woodward, Drager et al. 2001). On the other hand, pharmaceutical corporations and many industrialized countries argue that intellectual property rights foster and facilitate the development of new and improved medicines. The European Community and the US both have pressured consistently for strict regulations, in line with the demands of the pharmaceutical industry (Koivusalo 2003). Yet, research has shown that the pharmaceutical industry still has little incentive to develop medicines for "typical" developing country diseases such as malaria or tuberculosis (Winstanley and Breckenridge 1997). Basic concerns remain regarding the repercussions of TRIPS on medical R&D and the prevalence of commercial research over needs-based research. The question of cheap medicine for developing countries surfaced at the WTO in 2001, when several governments, most prominently Brazil and South Africa, passed a bill that allowed the import (and export) of cheaper generics. Almost forty pharmaceutical companies, headed by the big players GlaxoSmithKline, Merck and Roche then brought the case to court via their governments (Lee and Drager 2005). It was the pressure of non-governmental organizations such as Médécins Sans Frontières and Health Action International which prevented the companies from following through with their claims. Later the same year, the Doha Ministerial Council agreed to integrate a TRIPS clause allowing member states "*to protect public health and, in particular, to promote access to medicines for all*" (Lee and Drager 2005: 91). Now, TRIPS allows measures necessary to protect public health and nutrition, provided they are consistent with other TRIPS provisions (TRIPS Agreement Article 8). Each member state has the right to grant compulsory licences. These licenses allow the government to produce pharmaceuticals without the consent of the original patent-holder in the case of a national emergency (TRIPS Agreements Article 31b). "*Public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency*" (Lee and Drager 2005: 91). At a meeting of the WTO in August 2003, WTO members decided to allow compulsory licences so that any member country can export generic pharmaceutical products made under compulsory licences to meet the needs of importing countries.

4 Previous agreements were the Paris Convention for the Protection of Industrial Property and the Berne Convention for the Protection of Literary and Articstic Works. In 1968, the World Intellectual Property Organization (WIPO) was created.

The General Agreement on Trade in Services (GATS) is the first system to establish a worldwide system of regulations for trade of services. Trade in health services is growing rapidly. Medical transcription services are a fast-growing sector, especially between developing or transition countries and developed countries, e.g. between India and the US (Lee and Drager 2005). Private health insurance or health care abroad is also rising. For developing countries, the migration of health care professionals to developed countries is a problem since these countries lose qualified personnel for the establishment of a domestic health care system. GATS has an influence on health services in several ways:

1. Movement of consumers relates to patients seeking treatment abroad or students seeking education abroad.
2. Movements of persons supplying services relates to the movement of health personnel.
3. Foreign commercial presence relates to foreign direct investments in health care (hospitals, care centres) or health insurance.
4. Cross-border trade relates to care-delivery, medical education or technical expertise in medical issues.

GATS does *not* include any service by governments, thus also excluding public health care. Article 1.3 establishes two criteria defining government services: (1) they must not be supplied on a commercial basis and (2) they must not be supplied in competition with one or more service suppliers. Just like the agreements for TRIPS or TBT, Article XIV of GATS entitles members to protect health issues – under the condition that non-discrimination is applied. However, in most countries private and public providers of health care coexist – is health care then commercial? Critics contend that solidarity and public health care might decrease if the GATS is followed trough (Pollock and Price 2003). The GATS agreement increases the chances that publicly funded health services are affected (e.g. via contracting-out to NGOs) (Koivusalo 2003; Pollock and Price 2003).

The ***Sanitary and Phytosanitary Agreement (SPS)*** was a result of the fear of many developing countries that health and environmental issues would be used to protect domestic agricultural sectors. The Agreement lays out rules for countries which want to restrict trade to ensure food safety and the protection of human life from plant- or animal-carried diseases. The goal of the SPS Agreement is thus precisely to ensure "*that a sanitary or phytosanitary requirement does not represent an unnecessary, arbitrary, scientifically unjustifiable, or disguised restriction on international trade*" (Preamble of the SPS Agreement). In contrast to the TBT Agreement, which allows states to pursue a variety of national objectives (such as

human health), the SPS agreement allows restrictions only when scientifically justified (WTO and WHO 2002). The field of application is restricted to the protection of human life or health. Scientific justification may, for example, be based on international standards such as the FAO/WHO Codex Alimentarius. However, the definition of a scientific justification is especially difficult when it comes to precautionary measures (Lee and Drager 2005). The most prominent example is the beef hormone dispute between the US and the EU. The US had successfully challenged the EU's ban on beef treated with artificial hormones (Koivusalo 2003; Shaffer, Waitzkin et al. 2005). The EU had argued that these hormones have negative effects on human health (e.g. men eating meat with oestrogens are more prone to be infertile). Precaution would have demanded to forbid trade with hormone-treated meat (Bettcher and Lee 2002). Similar disputes arose between the EU and developing countries regarding pesticides. The assessment of agricultural agreements always draws a thin line between protectionism and justified health protection.

All things considered, the WTO provides a number of loopholes from free trade for the health sector. Since GATT has been incepted almost 60 yeas ago, Article XX guarantees the right to restrict trade in goods when those measures are necessary to protect the health of humans, animals and plants (Article XX(b)) or otherwise relate to the conservation of natural resources (Article XX(g)) (WTO and WHO 2002). Article XIV of the GATS authorizes Members to restrict services and service suppliers for the protection of human, animal or plant life or health. Any restrictions must always be applied in a non-discriminatory way and be based on scientific principles. As the discussion on genetically modified organisms has shown, this is extremely difficult to implement in practice since scientific results are seldom 100% clear. Yet, WTO decisions have reiterated a number of times that WTO Members have the right to determine the level of health protection they deem appropriate (e.g. in the Agreement on Technical Barriers to Trade and the Agreement on the Application of Sanitary and Phytosanitary Measures). Moreover, there is no requirement under Article XX of the GATT 1994 to quantify the risk to human life or health (WTO and WHO 2002). More difficult is the process of defining whether a measure is "necessary" or not. According to a joint report issued by the WHO and the WTO in 2002, this involves *"weighing and balancing a series of factors which include the importance of the interests protected by the measure, its efficacy in pursuing the policies, and its impact on imports or exports. The more vital or important the policies, the easier it would be to accept as "necessary" a measure designed for that purpose"* (WTO and WHO 2002).

The dispute settlement mechanism, which will provide the core of international case law on trade issues, is first and foremost an instrument for settling trade disputes – not an

instrument settling health disputes. Meri Koivusalo summarizes pointedly: "*The real dilemma in the context of trade and investment agreements is […] between public interests and public health policies and commercial and private sector profit interests reflected often in national trade and export emphases*" (Koivusalo 2003: 203).

3.4.2 Organizational Capacity

The World Trade Organization (WTO) is among the teenagers of international organizations. Founded after the Uruguay Round (1986-1994), the WTO succeeded the General Agreement of Tariffs and Trade (GATT) in 1995. Today, the WTO has a ***membership*** of 150 states, covering 97% of the world's trade (WTO 2007).

While the GATT dealt with trade in goods only, the WTO covers trade in services and intellectual property as well. Thus, the WTO, while not concerned with health policy as such, can have far-reaching implications for national health policy. The ***objective*** of the WTO is laid out in the preamble to the Agreement Establishing the World Trade Organization from 1994: *"…raising standards of living, ensuring full employment and a large and steadily growing volume of real income and effective demand, and expanding the production of and trade in goods and services,…"*

What does that mean? Mainly, WTO's structure serves as a *forum* for states to settle trade agreements, monitor national trade agreements according to these agreements and to settle trade disputes. The WTO does not have a unique health strategy, but its policies have an immense impact on health. Its agreements on trade (GATS, TRIPS etc) have significant *market creation* functions (Hein 2003). Mainline WTO economic theory follows Adam Smith's "invisible hand" of the market. According to this school of thought, trade will diminish economic disparities to the benefit of all. Liberalization of markets and competition are seen as main motors of economic growth, which in turn reduces poverty which in turn improves health (Koivusalo 2003; Ruger 2005).

The Bretton Woods negotiations that had led to the creation of the GATT established two general principles which now provide the basis for all WTO agreements: the *Most-favoured-nation principle* (MFN) asserts that all WTO member are to treat any other WTO member as they would treat the nation with the most privileges; and the *National treatment principle* demands treating foreigners and locals equally.

Table 4: Organizational Capacity of the WTO

Dimensions	
Membership Rules	150 Member States
Scope of Issues	Global Rules of Trade
Centralization of Tasks/ Management	Centralized. The Ministerial Conference meets at least once every two years. The General Council - which also meets as the Trade Policy Review Body and the Dispute Settlement Body - meets several times a year. In addition, a number of specialized Councils (Goods Council, Services Council and Intellectual Property (TRIPS) Council) and some smaller committees are concerned with the different agreements. The WTO Secretariat is fairly small with 600 staff members and concentrates on legal questions.
Rules for controlling the organization	One state, one vote (decisions are made by consensus)
Flexibility of arrangements	Little flexibility as all rules of trade are made by states and the WTO has only very limited capacity for providing legal implementation advice. States maintain the right to restrict trade if deemed necessary to protect health issues.
Enforcement	Possible via the Dispute Settlement Body (with Appellate Body).
Channels	Negotiations led by the ministries for international (economic) cooperation
Scope of health-related Issues	Multilateral Trade (in Goods) Agreements (MTAs): trade in biotechnological and pharmaceutical commodities, global food trade Trade-related Aspects of Intellectual Property Rights (TRIPS): patenting rights for medicines General Agreement on Trade in Services (GATS): health sector services Sanitary and Phyto-sanitary Agreement (SPS): nutrition and agricultural trade
Instruments	- Setting regulations for trade in health-related sectors - limited technical assistance on implementation of agreements, mainly to developing countries
Resources	Very small. Total annual budget for 2007 was US-$ 149 million.

The WTO ***structure*** is based on three councils, one each for trade in goods, services and intellectual property. Six additional committees with a smaller scope cover issues such as regional trade agreements and the environment. Topmost is the ministerial conference which has to meet at least once every two years. The day-to-day work in between ministerial meetings is handled by the General Council comprising representatives of all WTO member states. It also meets, under different rules, as the Dispute Settlement Body and as the Trade Policy Review Body (WTO 2007). Formal voting follows the rule “one state, one vote”, and decisions are made by consensus.

The secretariat is quite small with approximately 630 staff members headed by a director general. Its annual budget is roughly 160 million Swiss francs. Like the WHO, it is based in Geneva, but, unlike the WHO, it has no regional offices. The secretariat carries out the administrative every-day duties, including: supporting the WTO delegate bodies, providing technical support for developing countries, analyzing trade performance and policy, assisting with legal advice in trade disputes and supporting governments considering membership. While the WTO grants technical assistance in implementing WTO agreements, it does not offer any form of general development assistance (WTO and WHO 2002).

Unlike the GATT before it, the WHO, UNICEF or most of the UN sub-bodies, the WTO has a sanctions mechanism. Thus, the WTO is one of the few worldwide organizations with a "hard" ***enforcement*** instrument. States that do not comply with the rules made by the WTO are called before the Dispute Settlement Body. The decisions of the Dispute Settlement Body are binding for WTO members.

4 CONCLUSION

The WHO was initially the prime health-related international actor and node for all international health-related activities due to its authoritative mission. This position changed dramatically from the 1970s onwards as more and more other IGOs, NGOs and private actors entered the health field and challenged the WHO's unique position. This development was reflected by the increasing *resources, strategies* and *technical capacities* other actors like UNICEF, WTO and the World Bank gained over the following years strengthening their position at the cost of the WHO.

Although most organizational features of the WHO supported its authoritative position in the beginning, this changed considerably from the 1970s onwards. As UNICEF (which was a pure relief agency until the 1970s) the WHO, unlike the World Bank, combined open membership rules, a broad mission and competence in health issues with a highly decentralized management structure and overly democratic rules for controlling the organization. Although the WHO unlike the WTO and to some extent also the World Bank never had an enforcement mechanism, its internationally agreed upon 'rules of the game' can be considered as immensely successful until the 1980s. Given the fact, that WHO's channels vis-à-vis national governments were - and still are - fairly restricted compared to the World Bank or the WTO, this was not considered a major problem until the 1970s, as most countries relied nearly exclusively on WHO's international health expertise. The same can be

said about WHO's rather tiny but comparably stable amount of regular financial resources at that time.

As health became more and more a question of 'higher politics' and other organizations like UNICEF and the World Bank (and later WTO) entered the health arena, WHO's organizational features turned increasingly into a disadvantage. In contrast to the WHO, the World Bank is characterized by a centralized management structure and rules for controlling the organization, which are based on the relative economic power of countries - in practice reflecting the agreed upon interest of the most highly developed countries at the cost of developing countries. Although the World Bank, like the WHO or UNICEF, has no formal enforcement mechanism, in practice the World Bank's loan conditionalities may have a similar effect (Okuonzi and Macrae 1995). In a nutshell the World Bank, in contrast to the WHO, is hence able to 'implement' to some extent the agreed upon (western) health strategy in developing countries and to frame the health debate accordingly. Although not being an organization in the actual meaning of the term, only the WTO has a 'hard' enforcement mechanism, namely the Dispute Settlement Body. Furthermore, compared to the WHO, the World Bank and the WTO have considerably more channels through which they can act vis-à-vis national governments, as at least the World Bank today covers all relevant policy fields. Last but not least, the financial resources of the World Bank exceed dramatically the respective resources of the WHO, i.e. whereas the World Bank spends an annual amount of approximately US-$ 5 billion on health issues, the WHO has a current regular annual budget of approximately US-$ 458 million.

Table 5: Comparison of Organizational Capacities

Dimensions	WHO	UNICEF	WTO	WB
Membership Rules	Universal	Universal	Not universal	Nearly Universal
Scope of Issues	Limited	Limited	Broad	Broad
Centralization of Tasks/ Management	Decentralized	Decentralized	Centralized	Centralized
Rules for controlling the organization	One state, one vote	One state, one vote	One state, one vote	Shareholder principle
Flexibility of arrangements	High	High	Low	Medium
Enforcement	Not possible.	Not possible.	Possible	Soft enforcement via loan conditionality
Channels	Restricted access	Restricted access	Broad access	Broad access
Scope of health-related Issues[5]	Broad	Broad	Limited	Medium
Instruments	- Research & Debate - Setting norms and standards - Technical support - Monitoring	- Research - Emergency relief - Technical support -Monitoring	- Setting regulations for trade in health-related sectors	- Financial Assistance and loan conditionality - Research & Debate - Setting goals for macroeconomic development and public spending - Technical support - Monitoring
Resources	Small	Small	Very small	Large

Undoubtedly, the WHO is thus no longer the prime health-related international actor, but one important actor amongst others – most notably the World Bank. Consequently, the respective *ideational influence* has shifted away from the WHO as the prime actor. Does this mean, however, that due to the increased ideational influence of other IGOs, the international health field becomes more politicized? Does it mean, that alternative comprehensive health care models are discussed and promoted? In fact, it does not. On the contrary, our analysis revealed, that like in the early years of the WHO, the focus of the debate has shifted again towards specific priority diseases in contrast to the times of the Alma Ata declaration. In a

[5] This dimension captures the variety of health-related activities as well as the expertise in all matters related to health.

nutshell one could thus adhere, that the global health debate has become increasingly 'technical' again, i.e. the focus has shifted away from a process-oriented and socio-political approach towards the largely technology-based interventionist approach of former times.

Table 6: Comparison of Health Policy Ideas and Health Care Approach

Dimensions	WHO	UNICEF	WTO	WB
Focus of Debate	Comprehensive versus Selective Primary Health Care	Comprehensive versus Selective Primary Health Care	Liberalization of global trade vs. protection of national social policies from competition and open markets	Sector-wide approach vs. single-disease approach
Health Care Policy Approach	Primary Health Care Approach	Selective Primary Health Care Approach	No original health care policy approach. The WTO provides a forum for regulating international trade. Health care is viewed largely in economic terms but exceptions for "public health" exist in all trade agreements.	No single health care approach, but several important elements: Sector-wide approach focusing on an efficient allocation of health care services Targeted public health programs for the poor Public/private ix in financing Focus on specific priority diseases.
Definition of Social Risk	Broad definition, i.e. all levels of income are seen at risk.	Narrow definition, i.e. services should be targeted to the poor	-	Narrow definition. Individualism with a safety net
Definition of Health	Process-related. Defined as 'physical, mental and social well being of the individual'.	Related to technical methods. Defined as merely *'absence of disease'.*	-	Viewed as an economic commodity

This development has been further fuelled by the numerous global PPPs on specific diseases forming the node for many of the new actors active in the field. This is not to say, however, that these vertical programs on specific diseases cannot have spill-over effects for health policy in general, which certainly points to a global dimension of health policy. But whether further attempts to revive a debate on comprehensive health care approaches on the international scene will be successful or not is still too early to say. Given the high fragmentation of the health field on the international level compared to other sectors of social policy, this seems unlikely in the foreseeable future at least.

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