CHAPTER 10

Characterizing Global Health Governance by International Organizations: Is There an Ante- and Post-COVID-19 Architecture?

Alexandra Kaasch

Introduction

Health is commonly considered as one of the most fundamental, but also highly challenging needs in individual and societal life. As a policy field, it extends and connects to an incredibly broad and complex set of issues such as different notions of well-being, different types of illnesses (e.g. infectious and non-infectious), different groups of people, the various functions and elements of public and private health care systems and diverse service providers. Part of these issues extend beyond national spheres of social problems or policymaking—most clearly communicable diseases do not stop at national borders. Furthermore, migration leads to national systems of social and health protection being confronted with constantly new categories of people as well as new health challenges; health care professionals, pharmaceutical companies and other providers

A. Kaasch (✉)
Faculty of Sociology, Bielefeld University, Bielefeld, Germany
e-mail: alexandra.kaasch@uni-bielefeld.de

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have long crossed national borders in their provision of health care, medical goods and insurance plans.

This has led to some conceptual tension, as health care systems (here understood as institutions of social protection responsible for the provision and financing of health care) are established and organized as distinctly national (or sub-national) institutions. Nevertheless, at transnational policy levels there is significant activity on various health care system-related issues which entails the emergence and involvement of a high number of global policy actors. Better yet, there is a clear trend toward an increasing number of global actors, as for example Youde (2015, 130) puts it "the global health governance architecture has become far more encompassing and wide-ranging in recent years".

The focus of this chapter is on global actors (*population*) of and ideas (*arguments*) on health care systems, for the purpose of producing a characterization of the current global health governance architecture in the field. This first requires an illustration of global health governance in general so as to understand its specific actor set. The positions and constellation of key International Organizations (IOs) are then illustrated by a mapping of four central IOs: the World Health Organization (WHO), the World Bank, the International Labor Organization (ILO) and the Organisation for Economic Co-operation and Development (OECD). The main ideas of these four IOs regarding health care systems are presented in relation to each other and by taking into account their discourses. This is then taken further to characterize the global health governance architecture based on contestational and collaborative relationships between these IOs. While finalizing this chapter, the world has come under threat from a massive global health crisis. Thus, in an additional paragraph, this chapter also discusses the preliminary implications of the Corona Virus Disease 2019 (COVID-19) pandemic for altering that architecture. The concluding section reflects upon the implications of the ante- and emerging post-COVID-19 situation for global social governance in the field of health care systems.

Global Health Governance

The population of IOs in the field of health is subject to a very large body of literature under the frame of global health governance. For the purpose of this book on global *social* governance, I combine such approaches with those of the global social policy and governance literature.

Global social governance has generally been defined as being comprised of a huge number of different actors. Often, the relationship between these actors has been characterized by competing organizations, some of which claim to be the key and central actors in the game (particularly, Deacon 2007; Kaasch and Martens 2015; Kaasch and Stubbs 2014; Yeates 2008). Apart from other activities, these actors provide social policy prescriptions for different social policy fields, including for health care systems (Kaasch 2015). This involves various activities such as the collection, presentation and interpretation of relevant data, the development of concepts and the prescription of 'appropriate' social policy measures and instruments to meet social problems. IOs present these 'products' as information, recommendations, ideal models, reform suggestions and the like. In the academic literature, these activities by IOs and their outputs have been conceptualized and studied as ideas, discourses or knowledge production (see, e.g. Béland and Orenstein 2013; Stone and Maxwell 2005).

Concerning the population of IOs, global health governance literature draws a picture of a plurality of different sorts of actors. These include public and private actors, collective and individual ones, as well as various sorts of actor networks. Given their nature—that of being set up by governments, granted with mandates and tasks, and intensely observed and covered by worldwide political and media actors—IOs have a very important position and role.

In explaining the emergence of global policies in the field of health, some characterizations portray global health governance as a response to global health challenges, an expression of international cooperation, and as such a necessity, given current global (health) problems. Part of the argument is that the nature of global health problems and the limitations of national health care systems lead to global health governance (e.g. Fidler 2010; Smith and Lee 2017). Even though the transnational character of these problems may be more than obvious to the researcher, the political reality is that there is no consequential referral of competency to transnational policy levels. As we can see with reactions to the global threat of COVID-19, the measures and responses are strongly national. Therefore, the political and legal realities contradict explanations of the nature of the problem shaping or causing global social and health governance architectures: policymaking competence in the health care system is at national policy levels with very few and minor exceptions.

Another part of the literature characterizes global health governance more qualitatively and often combines this with normative claims on the

desired nature of global health governance. This does not contradict other assessments which describe global health governance as the concerted efforts to privatize health services and global health activities, accompanied by "indirect efforts by the same actors that present bona fide social justice and equity-oriented public health approaches" (Birn et al. 2016, 753). For sure, health markets are an important part of the global economy in many ways, and the 'concern' for public health is also strongly shared at a global level, which is reflected in the globally constituted communities raising their voices in the name of social justice in health. The notion of 'the global' informing this chapter, however, is the interest and concern of global actors as regards issues of (national) health care systems. This approach does not assume a legal competence in regulating health care systems from transnational policy levels; neither does it assume a relevance of global actors in terms of the nature of contemporary health issues. What it does is observe and study global actors with a (direct or indirect) mandate to 'speak' on health care systems. This implies an analysis of mandates, ideas and inter-actor relationships (for more detail on this approach, see Kaasch 2015; Kaasch and Martens 2015).

For the purpose of this book, this chapter focuses on only one type of actor, namely IOs. IOs have been founded with broad and general aims, usually directed at either a policy field or a group of (vulnerable) people. As part of such mandates, they intervene within, but also beyond specific policy fields and react to changing conditions as well as varying and emerging problems and crises. Furthermore, they do not conduct their work in isolation from each other. Inter-actor relationships are dynamic, susceptible to shifts, and are part of what causes changing settings in global health governance (Kaasch and Martens 2015; Fidler 2010; Cooper and Farooq 2015). Furthermore, as Ng and Prah Ruger (2011, 17) argue, such relationships are often characterized by "insufficient coordination, the pursuit of national and organizational self-interest, inadequate participation by the recipients and targets of aid, and sheer lack of resources". There is also another "concept" used to refer to global health governance: chaotic pluralism (Van Belle et al. 2018, 1). This is where the individual global health actors, including IOs, often appear in a contradictory light and are portrayed as not living up to their responsibilities for various reasons. The contradictory image in the approach used for this chapter, however, is focusing on the secretariats or headquarters of IOs and their ideas on health care systems only. While the concrete ideas developed and communicated may reflect national perspectives or experiences, these are usually

not systematically interest-driven as to any IO staff member's national background (another issue would be analyses driven by providers of extra-budgetary funding, but the level of analysis and type of documents studied is assumed to be at a level where this is not a strong factor).

The meaning of IOs in the context of this chapter is, therefore, focused on what they express and recommend (*arguments*) with regard to the specific issue of health care systems. On the one hand, such ideas are being shaped by organizational mandates generating some sort of path dependence. On the other hand, they are also being adjusted and they change in reaction to a number of contextual and historical factors. Ideas might change as concepts of a social or health problem become broader or more diversified; there might be new actor alliances that let shared terminologies and concepts emerge; better or altered problem descriptions might generate a need for new or adjusted solutions; or there might be strategic reasons (such as more and competing actors in the field) that might lead to new or different approaches by a single IO. In that sense, the population in terms of number and inter-actor relationships of global actors in the field of health care systems has an important impact on the architecture of arguments.

Mapping IOs in Global Health Governance

Global health governance is characterized by a multiplicity of actors. These actors may be very different in their composition, size, mechanisms or power. Most visible are international organizations (WHO and the World Bank in particular), philanthropic organizations (particularly the Bill and Melinda Gates Foundation), hybrid organizations (particularly the Global Fund to Fight Aids, Tuberculosis and Malaria) and non-governmental organizations (most well-known are perhaps the International Red Cross, Doctors Without Borders and the Cooperative for American Remittances to Europe (CARE)).

Looking at IOs more specifically, the answer as to which organizations matter and how many populate the field critically depends on the specific health field or issue looked at. Focusing on health care systems, WHO is in the center considering its mandate and role within the United Nations (UN) system. The World Bank is critical, given its power to provide funding for research and projects on health care systems. However, there is more than that: on the one hand, there are other IOs focused on specific health issues such as the Joint United Nations Program on HIV/AIDS

(UNAIDS). On the other hand—and this will be the focus of this chapter—there are other more generally social policy-related IOs that include health care systems as an important component in social protection in their work. These are the ILO and the OECD (see also Kaasch 2015).

In the following sections I describe the roles of WHO, the World Bank, the ILO and the OECD in matters of health care systems in more detail, as well as how they collaborate, compete or—more generally—relate to each other.

World Health Organization: Key Mandate, Encompassing Ideas but Multiply Contested Position

In terms of its mandate and position within the UN system, WHO is the first and central IO to look at when it comes to global health policies. It is the UN's health agency and by mandate concerned with all kinds of health policies at various levels. This certainly holds true for medical information and where health care systems (as institutions of social protection) are concerned, though neither its mandate nor its actual role are straightforward or uncontested.

More specifically, WHO's constitution provides the IO with both a norm-setting and coordinative function in the field of health care systems. In terms of 'policy content' or ideas, the general aim is the "attainment by all people of the highest possible level of health", stipulated in the WHO constitution, which has been specified into a mandate to assist governments in strengthening their health services (Constitution of WHO, article 2c; see WHO (2020a)). Nevertheless, due to WHO's multi-faceted mandate, the resulting role and position have been changing over time because of financial and organizational constraints as well as a changing global architecture. Over the decades, WHO has defined itself as the "health conscience" (World Health Assembly (WHA) 1973) in the 1970s, the "health advocate" (WHO 1998) in the 1990s and the "directing and coordinating authority in international health works" (WHO 2006) in the 2000s. Since the 2010s, there is a tendency to supply broad descriptions of a set of WHO roles. Furthermore, the fact that WHO is not alone and uncontested in the field, but part of a broader global governance scenarios is much more reflected: "WHO is joint lead agency with the ILO in the United Nations initiative to help countries develop a comprehensive Social Protection Floor" (WHO 2010). In its latest (13th) General Program of Work, WHO shows itself as an actor providing public goods, a

science- and evidence-based organization setting global norms and standards, an advocate for health as a human right, an organization networking "to build a community to work for the shared future of humankind" (WHO 2019, 3) and an institution to monitor global health developments. It is also active in developing plans together with national governments for better health care systems and for the realization of universal health coverage (UHC). Beyond that, at the global (horizontal) level, WHO assumes a role in "raising global awareness of UHC" (WHO 2019, 19; see also Cook et al. 2020).

Operationalizing its health care system mandate, WHO structures its strategic priorities around three main areas, namely universal health coverage, health emergencies and health promotion (WHO 2019). More specifically, the concepts under which health care systems have been dealt with have seen a certain dynamic and changes over time, even though most of them did not fully replace each other and have also seen times of 'revival'. Among them are primary health care and health for all (in the 1970s), health care systems strengthening, social determinants of health, UHC and social health protection (as part of the social protection floor initiative and collaboration in the 2010s). Furthermore, the Sustainable Development Goals (and to a lesser extent the prior Millennium Development Goals) have provided a framework within which health care systems have been approached.

Currently, WHO mostly defines its ideas and strategies on health care systems specifically in relation to the Sustainable Development Goals (SDGs), particularly in connection to the aim of achieving UHC. This is also combined with the social protection floor framework and initiative that increasingly turned into a UN initiative, including meetings on a regular basis, and which was particularly driven by WHO jointly with the ILO and the World Bank. The core idea being that essential health care should be one of four basic social security guarantees.

In sum, the arguments brought in by WHO have importantly—even if under different headings and buzzwords—centered around what is now called UHC. It stands for the aim of universal access to primary health care, to financial risk protection, to people-centered health care systems and to comprehensiveness in service provision and access. This ideational account can be regarded as a somewhat cohesive and coherent approach, promoted with the justification of a normative and coordinative mandate of the IO. WHO's position as a global actor more generally, but also the quality of its health care system assessments and recommendations, has

been questioned and criticized frequently, however, which limits the IO's power to live up to its tasks (e.g. Youde 2018; Kaasch 2015). The following sections will show how and by whom WHO got challenged in the position of the lead agency in global health governance in the field of health care systems.

World Bank: Derived Mandate, Changing Ideas and Multiple Powerful Positions

The World Bank has been founded with a completely different idea from WHO. It is a financial institution with funding means, more independent but also linked to the UN system, and it does not have a health mandate in the first place. However, over the years, it has increasingly considered the health sector as a field to engage with in aiming to fight poverty (which is part of its mandate according to the Articles of Agreement of the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA)). Thus, the World Bank has also evolved into a massive knowledge actor in the field of health care systems.

The World Bank's engagement in health developed from the 1980s onward in particular. That meant, on the one hand, that the IO increased its interest and activities in the health sector. But, on the other hand, it also led to a more encompassing and thorough understanding and concept of what the meaning and content of health care systems is. Over time, this brought the World Bank away from earlier and pretty much standard economic arguments thrown on the health sector (which were often not really appropriate either, such as the promotion of user fees, or most basic health care) to much more elaborate and comprehensive concepts of health care systems which appreciate the functions of UHC and their meaning as systems of social protection necessary for developmental success. Still, the main focus is on those health care system-related issues and needs that are particularly critical for low- and middle-income countries, as those are the World Bank's main 'clients'.

Apart from developing a health mandate out of poverty reduction, the World Bank has continuously justified its role in the field through specific strategies for the health sector that have become increasingly comprehensive and specific in terms of its understanding of and role in health care systems. Through these strategies, the World Bank manifests a very broad and very competent role in engaging with national health policymakers,

the implementation of projects, and facilitating knowledge exchange. It uses the illustration of comparative advantages to justify its role, such as expertise in health financing, governance, accountability in health service delivery and the like.

Despite a certain degree of contradiction between WHO and World Bank approaches and their claims on necessary action in health care systems, recent years have been remarkably characterized by collaboration between the two (and other) IOs, particularly in the area of UHC and social protection floors. Therefore, the 'struggle on positions' (Deacon 2007; Kaasch 2015) has been sidelined by more or less strategic collaboration and increasingly shared frameworks of reference. UHC is now the key concept used to explain and develop the World Bank's health strategy, as it is said to respond to the World Bank's twin goals (ending extreme poverty and increasing equality and shared prosperity) and is linked to the Sustainable Development Goals as well as other collaborative global health initiatives.

Nevertheless, what provides the World Bank with a clear comparative advantage is the number of staff they have, and that they possess the means to run different sorts of activities and projects related to health care systems. Within its headquarters, there are many health system experts, particularly in its Human Development Network Section on Health, Nutrition and Population, but also in its social protection unit and other units that have an overlap with health care system-related issues. In this way, the World Bank has developed into a key source for policy evidence and policy advice in this social policy field.

In terms of health care systems support (in the positive sense) or the impact on national health care systems (in a critical sense), the World Bank is certainly much more powerful than WHO, particularly when it concerns low- and middle-income countries, and to some extent also when calling for actions in and through health care systems in crisis response situations. Regarding the shaping of key ideas or arguments, however, WHO's concepts have proven more appealing and are now also reflected in many World Bank utterances and guide many World Bank initiatives.

International Labor Organization: Questioned Mandate, Coherent Ideas and Limited Position

Founded a hundred years ago, the ILO is the UN agency mandated with the promotion of social justice and human and labor rights. As a tripartite

organization, it shows quite a different structure compared to WHO and other IOs within the UN system, but in its secretariat (the International Labour Office), a number of staff also work on health care systems as part of the ILO's social protection framework. In terms of justifying its mandate, the ILO's engagement in social protection and health is, similarly to the World Bank, related to fighting poverty, addressing income security and as such improving access to health services.

However, the ILO's initial concerns were predominantly on the specific needs of *workers* and that has also informed their initial take on health care issues. That has played out in a twofold way: health issues connected to the workplace and health as dimension of social security related to the lives of workers. Accordingly, and as we can see in the World Labor Report 2000 (International Labour Office 2000), there are adverse effects of health problems on earning capacity, and there is financial risk connected to the inability to work due to health problems. In the meantime (and also in a broader than health care system sense), however, the ILO has adjusted its take on these issues in recognition of the fact that many people work in the informal sector. For example, Scheil-Adlung made this explicit by explaining that "to be meaningful, legal health coverage needs to result in effective access for all residents of a country" (Scheil-Adlung 2014, 6).

This broader perspective on residents, rather than workers, had important implications for how the ILO could position itself as a general global health actor, at least as far as health means social health protection, and in doing so it can be seen as giving voice to health care systems as well. Nowadays, the ILO even relates to the UHC aim and related agendas: it has diagnosed that insufficient funding is the main problem for providing essential health care, which then increases the risk of financial hardship (ILO 2019, vii).

The potential power of the ILO is different to both WHO and the World Bank in the sense that the ILO possesses a function in facilitating international law as a result of its tripartite assembly, which includes the Secretariat (Deacon 2013). Beyond that, the ILO has had a strong role in coordinating (partly with WHO and the World Bank) the Social Protection Floor initiative. In terms of providing specific ideas, what can be found is only derived from a very small number of staff members able to engage the issue (Kaasch 2015, 67).

Overall, even if the ILO is not considered in most of the global health literature, an account of global social governance in the field of health care systems must not leave this organization out of the picture. It is the

organization providing the frame through which to view health (care systems) as an element of social protection. In this way, the ILO contributes a logic different to the more medical or technical perspectives, but also to perspectives of the most basic provision of health care necessary to lift people out of poverty. Instead, it leans toward being an integral part of a system making societies more equal and improving health in a socially sustainable way. Nevertheless, its potential of positioning itself as a strong global actor in the field of health care systems is limited, and does not go much beyond one field within its coherent concept of social protection.

Organisation for Economic Co-operation and Development: Derived Mandate, Expanding Idea and Growing Position

Much like the ILO, the OECD is not typically considered to be a global health actor in its own right (particularly not in global health governance literature). However, global social policy and governance literature have increasingly focused on this IO (e.g. Mahon 2019; Deeming and Smyth 2019). In the past few years, there has been a significant expansion in the OECD's health work, so that my own account from 2015 describing the OECD's involvement in health policies as only just evolving and dependent on "an explicit demand from its member states for specific activities and engagement in health policies" (Kaasch 2015) now appears to be somewhat outdated.

Originally, the OECD's health work grew out of its statistical work in the second half of the 1970s. Beginning in the 1980s, health has been dealt with as part of the social policy work of the OECD, but still mostly in terms of statistical work. Then, with the 2000s, the OECD's work became more analytical, also in a qualitative sense, particularly in the context of the OECD Health Project (2001–2004). Over the past decades, the OECD's role in health seems to have become the most integral part of its engagement, and no longer accompanied by much of an explicit legitimizing reasoning.

This is the case even in a twofold sense: for its own member states, the OECD has taken on an important role in assessing and comparing their health care systems. In this way, it challenges the competence of WHO in the field of health care systems. What started with a small number of very careful, country-specific health care system assessments on demand (Kaasch 2010) has developed into an encompassing role in supporting OECD member states understanding and enhancing their health care

systems to become more people-centered. This has provided the basis for the development of new assessment methods, tools and guidance by this IO on health care systems. At the same time, the OECD is increasingly part of the global health (development) community, engaging in development agendas in the field of health, including the attainment of the SDGs and realizing the UHC agenda (OECD 2017b).

In the past, OECD health work was clearly characterized by dealing with health, on the one hand, as a social service and, on the other hand, as an economic factor. These perspectives have got increasingly balanced over time. Health care systems, according to OECD work, should provide accessible health care (for all citizens), respect equality and equity, provide high-quality health care, be mindful of economic efficiency, and also provide for redistribution and income protection (e.g. OECD 2004). Similarly to the other IOs discussed here, the OECD now fully subscribes to the UHC agenda, justifying that by stating that its work could show that "UHC contributes to promoting more inclusive growth; improves health outcomes; and is affordable" (OECD 2017a).

The OECD fulfills its health mandate by providing its highly acknowledged data and expertise, while at the same time joining in collaborative endeavors with WHO, the ILO, the World Bank and others. This mix of approaches makes it an increasingly powerful global voice on health care systems and provides the OECD with a position as a legitimate and credible actor in the field.

Characterizing Global Health Governance by Its Architecture or Arguments

Looking at the field of health care systems in terms of global social governance, we can identify several decades of discourse with an increasing number of major IOs engaging. While it is possible to follow certain traditions and the development and change of concepts, we particularly see the relationships and formation of global actors, specifically IOs, in processes of alteration. Therefore, the architecture of global social policy in this field is now significantly different from those of the past decades. The centrality of WHO might still be the same (both in terms of its key mandate and in terms of how and why it is challenged and questioned), however, the increasing number of IOs in the field, each coming with specific characteristics and resources of power, has challenged this position on a repetitive

and increasingly complex basis. At the same time, regarding the content of ideas and character of discourses, we see an increasingly shared, but also broad set of concepts, principles and aims for health care systems among many of those actors. This is in some contrast to characterizations up until the early 2000s when the emphasis was more on different epistemic communities and practices in health care systems.

More concretely, if we trace back the global health history of the past by at least 50 years or so, the Alma-Ata Declaration of the 1970s may be seen as a starting point and point of reference for emerging global health ideas and discourses—though merely for WHO and associated global actors. An important tension of the time was the different interpretations of key concepts between WHO and the United Nations Children's Fund (UNICEF), the latter leaning more toward the World Bank's basic safety net ideas of the time (see, e.g. Koivusalo and Ollila 1997). These frameworks, namely 'primary health care' (PHC) and 'health care for all' (HFA), were introduced at that time and have guided WHO work ever since. In the 1990s, global ideas and discourses on health care systems were increasingly also developed by and within the World Bank. These ideas were connected to its engagement both in the transformation states in Central and Eastern Europe (Kaasch 2015) and in emerging economies such as Indonesia sidelining their economic development with expanding health care systems.

The ILO, in the meantime, has developed a somewhat independent but minor account of health care systems as part of their social protection work. It has, however, gained increasing importance in the context of increasingly collaborative activities in the 2000s (the social protection floor initiative). At the same time, and partly due to shortcomings of WHO, the OECD continuously expanded its health work in terms of ideas and engagement in the field.

It was partly in the context of the reaction to the global economic and financial crises that the IOs discussed in this chapter also provided prescriptions for how to address the crisis through social policy measures. These contributions came rather quickly from 2008 onward and particularly warned not to repeat any cutbacks in health and other social services as had happened in the 1990s in many crisis-affected countries. Given the nature of that crisis though, the initial focus was much more on 'jobs' than on other systems of social protection. Both WHO and the OECD, however, recommended counter-cyclical public spending and stressed the role

of health care systems as well as their function as automatic stabilizers (Kaasch 2014).

In sum, the inter-IO discourse has considerably changed through the developments described in the previous sections, and so has the architecture of governance in the field: previously distinct agendas and activities are increasingly shared and merged, even though to some extent different 'languages' are being used, strongly oppositional epistemic communities cannot be identified. The UHC agenda and the Social Protection Inter-Agency Collaboration Board (SPIAC-B) are the current settings within which all IOs discussed locate their ideational accounts. Accordingly, global social governance as the architecture of arguments on health care systems can be summarized as having developed into increasingly broad concepts and shared principles among the key IOs working in the field.

Global Health Governance in the COVID-19 Context

While finalizing this chapter, the COVID-19 outbreak has not only paralyzed national and global societies and generated massive political reactions and measures, but even IOs in the field of health have been on demand and have had to adjust their activities to this new, dramatic situation. In this section, I illustrate their 'reactions' (in terms of their comments on health care systems in the COVID-19 context) and discuss the question of whether or not there is an ante- and post-Corona architecture emerging in global social governance in the field of health care systems.

Unsurprisingly and in continuity with what has been illustrated in this chapter, WHO appeared as the central, first, and most significant actor from the very beginning—although this was more in terms of its role as the health agency responsible for alerting everyone to the fact that a pandemic disease was spreading, as well as its work on the medical side of things. In terms of its mandate on health care systems, WHO delivered by providing some ideas and guidelines as well. These have been linked to its common framework on health care systems (strengthening) and UHC, the critical points being well-financed health care systems following the principles of risk-sharing and UHC. The concept referred to and used here is 'public financial management'. In a related document, Barroy et al. (2020) clarify that the COVID-19 response requires sufficient public funding and recommend a turn away from private toward public funding

modes. Funding, so the authors claim, needs to be made available and stocked up; furthermore, there is the need for balance between flexibility and accountability. Kutzin (2020) further argues that countries do not need to make a choice between health security and UHC, but rather that the two are dependent on each other. Accordingly, "investing in core health care system-functions is key to both, completed by public policy actions beyond the health care system". In more concrete, technical guiding notes though, WHO's focus appears to be slightly different. Rather than drawing on the broader social protection network, WHO appears to be collaborating with UNICEF, specifically on ideas regarding health care systems and COVID-19. This also implies placing focus back on Primary Health Care (PHC) and the community level, albeit considered within national multilevel systems. The focus is on select essential services and prevention (WHO and UNICEF 2020). In another document, WHO highlights how, as a consequence of high numbers of COVID-19 cases, the need to limit and consciously direct resources may arise. This is in some inexplicit contrast to more comprehensive social protection recommendations on health care systems; here, WHO is more situated in the older tradition and turns to postponing and suspending routine and elective services, to targeted immediate action, and at reorganization measures (for the recommendations see, e.g. WHO 2020b).

In terms of the World Bank, thus far it has not published a comprehensive piece on COVID-19 and health care systems in particular, but instead on social protection more generally in relation to the SPIAC-B (Social Protection Interagency Cooperation Board) (2020). However, it has financially supported a number of countries in strengthening their health care systems in the current situation and issued a factsheet on that. According to that factsheet, about $160 billion will be provided for assisting countries (World Bank 2020). In some contrast to the above, however, the International Finance Cooperation (part of the World Bank Group) is a strong component in this support, as there is belief in the private sector being critical to mastering and overcoming the crisis.

At the same time, some more concrete recommendations come from first short publications on related issues, namely a brief that highlights the necessity of infection prevention as well as control policies and campaigns to draw attention to necessary hygiene measures (Bedoya and Dolinger 2020); and Gillson and Muramatsu (2020) who recommend allowing cross-border movement of health personnel and goods, and exploration of tele-medicine. Thus, overall, more comprehensive and focused health care

system ideas have not yet been established and distributed. That is certainly more due to the complexity of the matter, as well as the urgency and depth of the COVID-19 crisis, than to dismissal of the World Bank from the critical role of health care systems in responding to global pandemic disease outbreaks.

The ILO's COVID-19 contributions thus far reveal its typical focus on the world of work, in that it re-emphasizes the need for social protection systems—including floors—to prevent and meet crisis situations, and stresses that emergency crisis responses should ideally be executed with a longer-term perspective in mind. This would include guaranteed access to good health care by means of additional public funds (both for emergency response, safeguarding and extending coverage) (ILO 2020c). Furthermore, and more specifically related to its social protection mandate, the ILO has focused on the meaning and role of sickness benefits as part of social health protection systems. This is not particularly an issue of the health care system, but the question of income security in the case of illness for the prevention of impoverishment (ILO 2020b). There are more specific ideas on entitlements to social sickness protection for this specific COVID-19 outbreak situation. The ILO paper argues that there is a risk of further disease spread if unprotected people continue working while contagious, and that there is a high risk of impoverishment if they are not covered by health insurance. This results in recommendations to extend coverage to all by mobilizing additional financial resources, expanding the scope of sickness benefits (e.g. in cases of quarantine or care obligations), increasing benefit levels and removing any waiting periods or other constraints to speedy delivery of sickness benefits (ILO 2020a).

As for the OECD, their work does address health care systems quite specifically, though with a common and typical focus on collecting and analyzing data as well as illustrating the variations in the first place. Their work shows how there are four key measures to respond to the COVID-19 pandemic from the side of health care systems: ensuring access, improving health care system capacity to manage caseload increases, digital solutions and data for care and surveillance, as well as improving research and development for improved diagnostics, treatments and vaccines (OECD 2020). In this case, however, the OECD report also draws rather clear conclusions and recommendations from the data:

> The current crisis demonstrates the importance of universal health coverage as a key element for the resilience of health care systems. High levels of

> out-of-pocket payments may deter people from seeking early diagnosis and treatment, and thus contribute to acceleration in the rate of transmission. However, even in health care systems that have already achieved universal coverage, an epidemic caused by newly discovered pathogens requires an early response to clarify coverage for new diagnostic tests and treatments that were not previously included in the health benefit package. (OECD 2020, 6)

In a forum contribution, Francesca Colombo, Head of the OECD Health Division, additionally highlights the need for health care systems to be adaptable to health crises like this COVID-19 outbreak (Colombo 2020).

Thus, these accounts provide some picture of 'back to the roots' in global health governance as a COVID-19 response. At the point of writing this chapter, each of the organizations is re-focused on original mandates and defining foci of attention within that, rather than on all speaking on the same matter. Nevertheless, joint and collaborative work has also been happening, despite little of it being prominently placed on websites or elsewhere, and this does provide some evidence of continuity at the same time. In terms of the content of policy advice, it is somewhere between scaling up for meeting new health needs and focusing specifically on COVID-19 at the expense of some non-urgent health services.

Conclusion

This chapter aimed at characterizing global social governance in the field of health care systems. It focused on IOs and illustrated their key ideas, as well as their relationships with each other. Given the specific timing of writing this chapter, the more general account of global health governance has since extended beyond, and to some extent contrasted with, the first moves related to the 2020 COVID-19 crisis.

The important characteristics of global health governance as dealt with in this chapter are not to do with the global nature of social or health issues as such. Instead, the interest has been in global activities and on the subject of national competencies: the ideas of health care systems. IOs have been studied as knowledge and norm providers, not as potential regulators with legal power. So, what do these characterizations mean for the architecture of global social governance in the field of health? Due to the high number of actors, the complexities of their relationships and a frustrating degree of failing multilateralism and global solidarity when it

concerns addressing global health issues, some would claim "there is 'no architecture of global health'" (Garrett 2007, 246). Others would put the World Bank and WHO in the center and others loosely around, or in concentric circles of actors (Ng and Prah Ruger 2011, 2–3). The picture gets clearer though when more carefully defining the specific meaning and focus of a health issue (though in the case of this chapter, it's still a very broad one).

The population of IOs in this field has been characterized as multi-actored, even when it concerns the selection of the most important global actors. The presentation and discussion of WHO, the World Bank, the ILO and the OECD have revealed that the ongoing relationships have been increasingly marked by collaboration. However, the architecture of arguments is also shaped by a certain duplication of work, which demands a constant effort to justify such a role (with reference to, but also clearly beyond, original mandates) (see also, Kaasch 2015). While in the 1970s–1990s the relationships were characterized more by competition and only short spots of collaboration on a non-stable basis, from the 2000s onward it has become much more common to join forces under specific global initiatives (particularly the UHC agenda and the social protection floor initiative). Global crises have also marked interruptions in the activities of IOs, but while following the global economic and financial crisis we saw a quick and rather concerted reaction, whereas the 'initial reactions' to the current COVID-19 crisis hint at more IO-mandate oriented, individual approaches on ideas regarding health care systems.

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