The role of international organizations in healthcare financing policy in Central and Eastern European countries; The case of the Latvian healthcare financing reforms

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Abbreviations

CEE(C)	Central and Eastern European (Countries)
DRGs	Diagnosis Related Group(s)
EC	European Commission
EU	European Union
GDP	Gross Domestic Product
GSP	Global Social Policy
HM	Health Minister
IMF	International Monetary Fund
IOs	International Organizations
LMA	Latvian Medical Association
MoH	Ministry of Health
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
OHCHR	Office of the United Nations High Commissioner for Human Rights
OOP(P)	Out-of-pocket (payments)
PHC	Primary Healthcare
SHI	Social Health Insurance
UHC	Universal Healthcare Coverage
UN	United Nations
WB	World Bank
WHO	World Health Organization

Part I: Dissertation Overview

1. Introduction

Healthcare policy, a core area of social policy, directly affects population well-being and reflects broader socioeconomic priorities such as equity, social justice, and human rights (Bambra, 2005; Fervers et al., 2016). It intersects with economic stability and quality of life, balancing fiscal sustainability, efficiency, and universal access (Kutzin et al., 2010a; Fervers et al., 2016), making it a key domain for examining IO influence. Among the main dimensions of healthcare policy (see Rothgang et al. 2010), financing is especially critical, as it determines resource allocation, access to care, system sustainability, and health outcomes (Phelps, 2002; Davis, 2010). It determines who receives care, what services are covered, and how costs are distributed (Kutzin et al., 2010a; Rothgang et al., 2010). Studying healthcare financing offers valuable insights into the intersection of global governance, national policy priorities, and social outcomes.

Since regaining independence in 1991, Latvia has undertaken a series of healthcare reforms shaped by chronic underfunding, political instability, institutional weakness, and recurrent economic crises (see Section 4.1) (Mitenbergs et al., 2012; 2014; Pētersone, 2019; Kaminska et al. 2021). Like other Central and Eastern European (CEE) countries[1], Latvia faced the dual pressures of transitioning to a market economy and establishing democratic institutions amid limited resources (Sachs, 1994; Roland, 2000; Lane, 2007; Bohle & Greskovits, 2012). Yet, Latvia's healthcare financing path stands out: while most CEE countries adopted social health insurance (SHI) models, adapting them to national contexts (see Kaminska, 2013; 2022), Latvia remains the only country in the region still relying on a tax-based system despite several reform efforts between 1988 and 2018 (Rechel & McKee, 2009; Roberts, 2009; Thomson et al., 2009; Davis, 2010; Kutzin et al., 2010a; 2010b; Kaminska, 2013; 2022; Kaminska et al., 2021; Popic, 2023), which highlights the complexity of its reform trajectory (Mitenbergs et al., 2012; 2014; Behmane et al., 2019; Kaminska et al., 2021).

Latvia's path has been shaped by shared regional pressures—economic vulnerability, institution-building—as well as unique national constraints, including severe financial

[1] In this dissertation, the following states are understood as CEE countries: Albania, Bosnia & Herzegovina, Bulgaria, Croatia, Estonia, Estonia, Hungary, Kosovo, Latvia, Lithuania, Montenegro, North Macedonia, Poland, Romania, Serbia, Slovakia, Slovenia, and the Czech Republic.

crises, a fragile banking system, and contested nation-building. These factors placed Latvia in a particularly weak position, further limiting reform options. Understanding Latvia's healthcare financing reform requires situating it within the broader post-communist transition context, in which IOs actively shaped social policy across CEE (Deacon et al., 1997; Deacon, 2007; Orenstein, 2008; Obinger et al., 2013; Kaasch, 2015).

Following regime change, CEE countries—including Latvia—gained access to international organizations that offered not only financial support but also ideational resources and policy advice (Deacon et al., 1997; Deacon, 2007; Kaasch, 2015). However, this access also exposed countries to external pressures, especially in the early years of transition, due to their vulnerable positions (Deacon et al., 1997; Deacon, 2007). IOs such as the World Bank (WB), International Monetary Fund (IMF), World Health Organization (WHO), and Organisation for Economic Co-operation and Development (OECD) — became active in the region, offering policy recommendations, technical assistance, and funding for health reforms (Barnett & Finnemore, 1999; Deacon, 2007; Mahon & McBride, 2009; Broome & Seabrooke, 2012; Béland & Orenstein, 2013; Kaasch, 2015; Kaasch & Martens, 2015; Sending, 2015; Niemann & Martens, 2018; Zürn, 2018; Tallberg & Zürn, 2019).

However, the extent of IOs' influence remains debated. Some scholars argue that a "policy vacuum" in CEE in early transition created space for IOs (Deacon et al., 1997:92)—particularly the WB— to take the key role by introducing new policy ideas, institutional models, and reform agendas, with SHI often viewed as a model promoted by these organizations (Müller, 1999; Deacon et al., 1997; Cerami, 2006; Deacon, 2007; Kaasch, 2015). From this perspective, the WB's promotion of SHI is seen as a clear case of policy imposition on weaker states lacking the capacity to shape their own agendas (Deacon et al., 1997; Deacon, 2007). Other sources argue that healthcare financing reforms were mainly shaped by domestic factors, with CEE countries strategically adapting external ideas to fit their political, social, and economic contexts. According to these authors, while IOs offered support, adopting SHI was ultimately a response to national needs and priorities (Marrée & Groenewegen, 1997; Lawson & Nemec, 2003; Jacoby, 2004; Rechel & McKee, 2009; Roberts, 2009; Kutzin et al., 2010a; Kaminska et al. 2021; Kaminska, 2022).

Most existing research on IO influence in CEE social policy —including healthcare financing— focused on coercive tools used by the WB and IMF due to their ability to

grant financial assistance, known as “hard governance” (Finnemore & Sikkink, 1998; Abbott & Snidal, 2000; Orenstein, 2000; 2008; Vreeland, 2003; Stone, 2004; 2008; Woods, 2006; Deacon, 2007; Kaasch, 2015; Kentikelenis & Seabrooke, 2017). This emphasis has overshadowed the role of soft governance exercised by other actors, including the WHO and OECD, and even the WB, which often relies on non-coercive tools. Soft governance involves ideational and normative influence, such as technical assistance, peer learning, and policy norm diffusion (Deacon et al., 1997; Abbott & Snidal, 2000; Mosley, 2003; Paloni & Zanardi, 2006; Woods, 2006; Deacon, 2007; Kaasch, 2007, 2010, 2015; Orenstein, 2008; Martens & Jakobi, 2010; Kentikelenis & Seabrooke, 2017; Niemann & Martens, 2018). Though less visible than financial conditionalities, these tools can be equally impactful and often wield significant influence on domestic policy, particularly in structurally weaker states (Kahler, 2009; Hooghe et al., 2017; Wireko & Béland, 2017; Niemann & Martens, 2018; Martens et al., 2021).

Moreover, a common assumption in the literature is that countries in a weak positions vis-à-vis IOs—often low- and middle-income or crisis-affected—are more exposed to IO influence and passively adopt externally imposed policies due to limited agency and reliance on outside ideas (Laurell & Arellano, 1996:13; Deacon et al., 1997; Finnemore & Sikkink, 1998; Mosley, 2003; Batley, 2004:55; Woods, 2006:72; Deacon, 2007; Deacon et al., 2007:226; Stone, 2011; Kentikelenis et al., 2016; Noy, 2017; Kentikelenis & Seabrooke, 2017; Corbett et al., 2018). However, some studies highlight that domestic actors in such states can strategically engage with, adapt, or reshape external advice to align with national priorities. Moreover, this literature indicates that actors in weak states may even instrumentalize or misuse IO recommendations for political gain, complicating the image of passive compliance and revealing a more dynamic interaction (Kpessa & Béland, 2012; Lake, 2013; Kentikelenis & Seabrooke, 2017; Diprose et al., 2019; Tallberg & Zürn, 2019; Kaminska et al., 2021; Druga, 2022; Malinar, 2022; Foli, 2023). This perspective emphasizes that IO–state relations are more nuanced than commonly assumed and merit closer examination, particularly in the context of healthcare financing reforms and the post-1989 spread of SHI in CEE.

The central academic puzzle lies in the fact that, although CEE countries were vulnerable to IO influence—given their post-communist transitions and IOs' regional presence — scholarly consensus remains limited on the extent and nature of IO involvement in shaping healthcare financing reforms, especially regarding SHI diffusion. Therefore, this

dissertation aims to address the above-mentioned gaps and inconsistencies in the existing literature. By focusing on the Latvian case within the broader CEE context, this study examines the **interaction dynamics between domestic actors and IOs** in the realm of healthcare financing reforms. In particular, the dissertation explores the soft governance employed by IOs to influence social policymaking.

During the transition period, all CEE countries were structurally weak and resource-constrained, thus assumed to be highly vulnerable to external influence. Latvia serves as a representative case of this broader regional condition, with its own specific vulnerabilities (as detailed in the Methods section). According to the dominant perspective in the literature, such circumstances would lead Latvia—like other CEE countries in similar circumstances— to exhibit limited or no agency in their interactions with IOs, representing the 'most likely' expected behaviour. The Latvian healthcare financing case study offers a unique lens to explore how IO recommendations are interpreted, adapted, or resisted under conditions where domestic actors retain agency despite limited institutional and fiscal capacity. By investigating Latvia's healthcare financing reforms from 1988 to 2019 and focusing on four empirically identified IOs—WHO, OECD, WB, and OHCHR—the study analyses how soft governance tools such as benchmarking, discursive persuasion, and policy advice were applied and negotiated in Latvia (Contributions C and D). By examining these interactions, the study contributes to a better understanding of the nuanced and context-sensitive dynamics of IO influence, particularly how soft governance functions in settings where domestic actors retain agency despite structural limitations.

While WHO and OECD are known for relying exclusively on soft governance (Kaasch, 2015), the WB also increasingly employed such tools in its engagements across CEE (Druga, 2022; Malinar, 2022). The dissertation investigates the content of IO policy advice to the CEE region and identifies the different tools IOs used to deliver their recommendations (Contributions A, B, and C). Empirically, it is the first study to map the healthcare financing recommendations of the WHO and OECD—two key actors in global health governance—across all four sub-dimensions of healthcare financing. This analysis provides insights into the IOs' policy preferences, priorities, and how their recommendations have shifted over time.

Together, these four contributions offer a comprehensive view of both the supply side (IO policy agendas) and demand side (national-level reception and negotiation) of healthcare

financing reforms in CEE, using Latvia as the representative case from CEE to understand the broader dynamics and role of IO influence in the region.

The dissertation explores the following overarching two overarching **research questions**, with each contribution addressing specific sub-questions (see Appendix No 5 for details):

1. **What were the contents of the IOs policy advice for healthcare financing in CEE and in Latvia?**
    1.1. What was the content of IOs' advice in each of the four sub-dimensions of healthcare financing, as defined by Kutzin et al. (2010a)?
    1.2. To what extent did the IO's healthcare financing recommendations for CEE countries and specifically for Latvia target the paradigmatic level, policy instruments, or specific policy parameters, as defined by Hall (1993)?
    1.3. To what extent did the IOs policy advice reflect neoliberal principles?
    1.4. Did policy recommendations differ across CEE national contexts and over time, or did they adhere to a one-size-fits-all approach?
2. **How did the interaction between Latvia and IOs evolve?**
    2.1. Which side initiated the interaction?
    2.2. What channels of communication/diffusion of policy advice were used?
    2.3. How did Latvia respond to the advice provided by IOs?
    2.4. How did IOs react to Latvia's use of IOs' advice?

In terms of theoretical approach, the dissertation is grounded in Global Social Policy (GSP) which highlights interdependencies between IOs and domestic actors in policymaking. GSP provides a strong framework for examining how states and IOs interact, cooperate, and negotiate power—especially in social policy domains like healthcare (Deacon et al., 1997; Deacon, 2007; Obinger et al., 2013; Kaasch, 2015). It allows for analysing not only direct financial coercion but also soft governance, such as persuasion, expertise, and normative frameworks, over direct financial coercion (see Section 2.1).

The dissertation applies Kutzin et al.'s (2010a) framework for understanding healthcare financing, which includes four sub-dimensions: revenue collection, pooling, purchasing, and coverage (see Section 2.2 for definitions). This framework guides the assessment of

how specific IOs influenced healthcare financing policies in Latvia and other CEE countries. The thesis also draws on Hall's (1993) classification of policy change — paradigmatic, instrumental, and parameter-level— (see Section 2.2) to evaluate the depth and focus of IOs' policy advice across the region and in Latvia.

In Latvia, external policy recommendations were not passively accepted; instead, they were actively adapted, reinterpreted, or resisted based on local needs and domestic political priorities. These dynamics highlight the agency of domestic actors and the reciprocal nature of IO–state relations. Through the Latvian case—characterized by persistent reform efforts and ongoing IO involvement—the dissertation sheds light on the negotiated nature of policy change in post-communist CEE. Ultimately, it contributes to the literature on international governance, healthcare policy, and post-socialist transformation by portraying IOs as open, learning institutions embedded in contested policy spaces, where even weak states exercise meaningful agency. These reframe challenges to conventional views of IO dominance and reveal a more interactive, co-productive model of global policy influence.

The dissertation comprises four interrelated research contributions (A, B, C, and D) which together address the research aim:

Contribution A: Stupele, L. (forthcoming). WHO's healthcare financing policy recommendations in CEE countries. In M. E. Kaminska (Ed.), *Post-1989 healthcare financing reforms in Central and Eastern Europe: The role of international organisations* (forthcoming). [2]

Contribution B: Stupele L., Malinar A. (forthcoming). OECD's healthcare financing policy recommendations in CEE countries. In M. E. Kaminska (Ed.), *Post-1989 healthcare financing reforms in Central and Eastern Europe: The role of international organisations* (forthcoming).

Contribution C: Stupele L., Kaminska M. E. (forthcoming). The role of international organizations in the healthcare financing reforms in Latvia. In M. E. Kaminska (Ed.),

[2] This dissertation was developed within the framework of Project B08: *Transformation of Health Care Systems in Central and Eastern Europe*, part of the Collaborative Research Centre 1342: Global Dynamics of Social Policy at the University of Bremen. Project results will be published in the collective monograph of the B08 project team, edited by M. E. Kaminska, titled *Post-1989 Healthcare Financing Reforms in Central and Eastern Europe: The Role of International Organisations* (forthcoming).

Post-1989 healthcare financing reforms in Central and Eastern Europe: The role of international organisations (forthcoming).

Contribution D: Stupele L. (2025, forthcoming). Misusing international organizations' authoritative resources: The case of the Latvian healthcare financing reforms. Submitted to the Journal of the Baltic Studies. As of July 2025, it has a revise and resubmit status.

The dissertation is organized as follows: Sections 2.1 through 2.4 present the conceptual framework and a state-of-the-art review of IOs' roles in healthcare and their influence on weak states, particularly in CEE. This is followed by a literature review on Latvian healthcare financing reforms and IO involvement. Section four outlines the methodology. The following chapter summarizes the four dissertation contributions. The final section discusses key findings, their significance, research limitations, and directions for future research. Part Two contains the full manuscripts of the four contributions.

2. Conceptual framework

2.1. Global social policy

This dissertation examines the **interaction between domestic actors and IOs**, with a focus on healthcare financing reforms in Latvia and the role of soft governance. Using the GSP framework, it analyses how global policy ideas are interpreted and adapted within domestic contexts. GSP highlights the interdependence between global and domestic policymaking, emphasizing that social policy is no longer shaped solely within national boundaries but across multiple territorial levels—local, national, regional, and global (Collaborative Research Center 1342, 2018; de Carvalho et al., 2021).

Emerging as a response to the limits of domestically focused theories like welfare regime typologies (Esping-Andersen, 1990) and neo-institutionalism (Pierson, 1994)—GSP and related policy transfer theories argue for a multidimensional understanding of social policy that reflects its transnational character (Deacon, 2007; Yeates, 2014; Yeates & Holden, 2022). Deacon (Deacon et al., 1997; Deacon, 2000; 2007; Deacon & Stubbs, 2007) framed this as the "globalization of social policy" and the "socialization of global politics," whereby global concerns like poverty, inequality, and health gain prominence on international agendas.

GSP views policymaking as a co-productive process between global and domestic actors. It stresses that cross-border influences—intentional or otherwise—can significantly shape domestic policy (Kaasch, 2012; Obinger et al., 2013; Nullmeier et al., 2021) and that global ideas, norms, and discourses play a key role in domestic reform (Béland & Orenstein, 2013; Yeates, 2014). According to Deacon (2007:1) GSP rests on two pillars: IOs' normative and prescriptive roles in shaping domestic policies and the emergence of global redistributive, regulatory, and rights-based agendas—known as the "3Rs." Much of the literature focuses on the tools IOs use to promote policy adoption (Deacon et al., 1997; Deacon, 2007). Within this framework, IOs are regarded as crucial actors with significant capacity to shape domestic social policies (Deacon et al., 1997; Yeates, 1999; 2014; Deacon, 2007).

GSP is grounded in the view that global challenges—such as pandemics or inequality—transcend borders and require international coordination. Drawing on welfare state theory, globalization studies, international relations, and organizational sociology, GSP highlights how domestic policies are embedded in global institutional and ideational contexts (Deacon et al., 1997; Kaasch & Martens, 2015).

In this context, IOs, supranational institutions, and transnational networks have become key actors in domestic policymaking, especially in the Global South and post-socialist regions (Deacon et al., 1997; Deacon, 2007; Kaasch, 2015). A central focus in GSP research is the prescriptive role of IOs—such as the WB, IMF, EU, and UN agencies—in domestic policymaking (Deacon et al., 1997; Deacon & Stubbs, 2007; Deacon, 2007). These IOs shape domestic reforms not only through technical or financial support but also as norm entrepreneurs and promoters of policy models, influencing domestic trajectories via the diffusion of ideas, discourses, and institutional frameworks (Béland & Orenstein, 2013; Yeates, 2014). Using tools such as policy advice, benchmarking, conditionality, and normative frameworks, they guide domestic decision-making and align domestic policies with broader global agendas (Deacon & Stubbs, 1998; Deacon, 2007; Kaasch & Martens, 2015).

Healthcare has become a major area of interest in GSP literature (Kaasch, 2007; 2007a, 2007b; 2009; 2010, 2011; 2015) reflecting the deepening interdependence between national health systems and global governance (Ruger et al., 2015). While early global agendas focused on disease-specific interventions and the Millennium Development Goals, attention has since shifted toward sustainable healthcare systems financing and

equitable access (Ruger et al., 2015; Kaasch, 2015). IOs like the WHO, OECD, and WB have advanced distinct yet overlapping agendas to support national health reforms. Section 3.1 describes it in detail.

2.1.Healthcare financing sub-dimensions and policy change levels

This research employs Kutzin et al.'s (2010a) comprehensive framework for analysing healthcare financing systems, highlighting four interrelated sub-dimensions that shape a system's capacity to achieve universal healthcare coverage (UHC) and other policy goals. These are revenue collection, pooling of funds, purchasing of services, and coverage—each playing a distinct role in health system performance. **Revenue collection** refers to mobilizing funds from households and other sources—through general taxation, payroll contributions, voluntary insurance, or out-of-pocket payments— with attention to equity and fiscal sustainability. **Pooling** is the accumulation and management of these funds to spread financial risk across populations, with a focus on equity and protection. Effective pooling reduces fragmentation and inequities from segmented risk pools. **Purchasing** entails allocating pooled resources to providers through payment systems (e.g., capitation, fee-for-service, DRGs), promoting efficiency, quality, and responsiveness. Finally, **coverage** defines the scope (services covered), breadth (population covered), and depth (cost-sharing requirements) of entitlements, balancing access, transparency, and sustainability. These sub-dimensions operate within broader governance and public financial management structures. The framework stresses coherence across functions to align financing with system-wide goals and avoid isolated reforms that hinder UHC progress.

The dissertation also draws on **Hall's (1993)** classification of policy change into three levels—paradigmatic (overarching policy ideas), instrument (policy tools), and parameter (settings)—to analyse the nature and depth of IOs' advice on four above-mentioned healthcare financing sub-dimensions, both across CEE and in Latvia. **Paradigmatic** change involves fundamental shifts in the philosophy or goals of healthcare financing, such as moving from a market-based to a solidarity-based system or redefining the aim from funding care to achieving UHC and equity. For example, it may entail changing the financial model (such as tax funding, SHI, and private financing; see Rothgang et al. 2010), replacing voluntary, out-of-pocket payments with compulsory, progressive

taxation or social insurance to promote risk-sharing and financial protection, or redefining the system's obligations to guarantee a universal, rights-based benefits package. **Instrument-level** change focuses on the tools to achieve these goals—for example, introducing earmarked taxes, shifting to income-based contributions, or merging risk pools to enhance equity. **Parameter-level** change refers to adjusting existing tools without altering the paradigm, for example, modifying contribution rates, payment tariffs, or co-payment levels, or revising drug lists and waiting time targets. This layered approach enables a nuanced lens for assessing whether reforms represent fundamental shifts or incremental adjustments in healthcare financing across the CEE region.

2.2.IOs relying on soft governance and their tools of influence

Among the various transnational actors influencing national policymaking (Deacon et al., 1997; Deacon, 2007; Kaasch, 2015), this dissertation focuses on IOs as autonomous and credible entities, not merely extensions of state interests (Barnett & Finnemore, 2004; Barkin, 2013). Drawing on GSP, it identifies a range of tools through which IOs exert influence, broadly grouped into hard (coercive) and soft (non-coercive) governance tools (Dolowitz & Marsh, 2000; Stone, 2004; Barnett & Finnemore, 2004; Deacon, 2007; Kaasch & Martens, 2015; Béland & Cox, 2016). IOs like the WB and IMF possess **hard governance tools**—for example, financial conditionalities and binding agreements—that allow them to exert direct leverage over member states' policy decisions (Deacon et al., 1997; Mosley, 2003; Cerami, 2005; Paloni & Zanardi, 2006; Woods, 2006; Deacon, 2007). Through these, IOs are able to pressure recipient countries into adopting policies they might not otherwise pursue, and, in more severe cases, they may enforce norms through sanctions against non-compliant member states (Finnemore, 1993; Jakobi, 2009). However, IOs lack formal veto power over domestic policymaking (Orenstein, 2008:55), making soft governance essential to their influence.

Some IOs, like the WB and IMF, have an option to complement hard governance tools with means of **soft governance**, like technical assistance and policy advice, using their authority to shape reforms (Abbott & Snidal, 2000; Kentikelenis & Seabrooke, 2017). Others, including the WHO and OECD, rely exclusively on soft governance—non-binding tools such as recommendations, peer reviews, and guidelines, along with strategies like persuasion, socialization, technical support, and knowledge production (Kaasch, 2007, 2010, 2015; Martens & Jakobi, 2010; Niemann & Martens, 2018). While states are not formally obligated to comply, they often follow this guidance or justify

deviations (Kelley, 2004; Niemann & Martens, 2018). Despite lacking coercive power, IOs using soft governance significantly influence policy agendas and global norms, especially in healthcare (Kickbusch & Szabo, 2014; Kaasch & Deacon, 2008).

Historically, GSP literature has focused on IOs' hard governance—especially the WB and IMF—under the assumption that coercion carries greater influence over member states (Finnemore & Sikkink, 1998; Abbott & Snidal, 2000; Orenstein, 2000; 2008; Vreeland, 2003; Stone, 2004; 2008; Woods, 2006; Deacon, 2007; Kaasch, 2015; Kentikelenis & Seabrooke, 2017). This emphasis has overshadowed the growing importance of soft governance in global policymaking. Recent scholarship increasingly acknowledges the significant role of soft governance and non-coercive tools (Kahler, 2009; Hooghe et al., 2017; Wireko & Béland, 2017; Niemann & Martens, 2018; Martens et al., 2021).

IOs using soft governance in healthcare rely on two main (re)sources of legitimacy: ideational resources and authoritative resources. **Ideational** resources involve the development and dissemination of ideas, norms, and policy advice (Abbott & Snidal, 2000:422; Ruger & Yach, 2009:3; Mahon & McBride, 2009:87; Martens & Jakobi, 2010:266). In this dissertation, *ideas* are understood as abstract paradigms explaining policy outcomes, distinct from institutional structures. Ideas— often rooted in IOs' mission statements or founding documents—are not static and evolve through social learning (Hall, 1993; Béland & Orenstein, 2013). Over time, such ideas may become global *norms* —shared expectations of appropriate behaviour of actors with a specific identity, which can be codified into treaties and subsequently adopted into national laws (Finnemore & Sikkink, 1998; Barnett & Finnemore, 2004; Deacon, 2007; Béland & Orenstein, 2013; Tallberg et al., 2020). IOs use these norms to offer targeted *policy advice*, guiding domestic decision-makers with research-based solutions to policy problems, helping to address public policy problems, or evaluating the effectiveness of existing policies (Kentikelenis & Seabrooke, 2017).

By promoting ideas and norms globally, IOs act as key sources of expertise (Kaasch & Martens, 2015:14), particularly for low- and middle-income or otherwise vulnerable countries seeking to bridge the gap between evidence and practical policy (Barnett & Finnemore, 1999:701, 707; Woods, 2006:65; Kaasch, 2010; 2015; Martens & Jakobi, 2010). IOs spread ideas and policy advice through tools such as networking, persuasion, socialization, benchmarking, peer review, naming and shaming, capacity building,

monitoring, and technical assistance (Abbott & Snidal, 2000; Barnett & Finnemore, 2004; Drezner, 2003; Kaasch, 2010; 2015; Martens & Jakobi, 2010; Park & Vetterlein, 2010; Squatrito et al., 2019; Stone, 2004). These tools allow IOs to exert influence without coercion, with their effectiveness depending on perceived authority, expertise, and the receptiveness of target actors (Maggetti, 2015; Tallberg et al., 2020; Martens et al., 2021).

The authority of IOs relying solely on soft governance is vital and primarily stems from legal mandates granted by member states (Barnett & Finnemore, 1999). Additionally, IOs are often perceived as expert bodies due to their technical knowledge and specialized competencies (Deacon, 2007; Kaasch, 2010; 2011; 2013; 2015; Béland & Orenstein, 2013; Sending, 2015). A substantial literature addresses IO authority (Hurd, 1999; Hooghe et al., 2017; Zürn, 2018; Tallberg & Zürn, 2019). This dissertation defines authority as the recognized and institutionalized power of IOs to make decisions, set standards, and enforce the rules that influence the behaviour of states and other actors (Barnett & Finnemore, 2004). Scholars distinguish between three types of IO authority. Normative or political authority involves shaping policies by setting norms, framing issues, promoting compliance through socialization and persuasion, and spreading best practices (Barnett & Finnemore, 1999; Gostin & Katz, 2016; White, 2020). This depends on legitimacy which bolsters IOs' capacity to foster cooperation and enforce standards (Buchanan & Keohane, 2006; Tallberg & Zürn, 2019). Expert authority is based on IOs' technical knowledge and access to specialized data. Often seen as apolitical and evidence-based, it positions IOs as credible sources of public health research, data, and policy development (Löwenheim, 2008; Fidler, 2004; Fang & Stone, 2012). Their perceived neutrality and appropriateness enhance their effectiveness and ability to stand out among competing global actors (Keohane, 2011; Buchanan & Keohane, 2006; Tallberg & Zürn, 2019). Moral authority, meanwhile, is rooted in ethical claims and commitments to global welfare and humanitarian values, particularly relevant for IOs focused on improving health outcomes and protecting vulnerable populations (Barnett & Finnemore, 2004).

Both ideational and authoritative resources highlight how IOs may shape national policies without coercion. Through ideational influence, normative guidance, and technical expertise, they play a pivotal role in global health governance, even in the absence of binding mandates.

2.3.Interaction between IOs and weak states

The interaction between IOs and countries—and the potential for IO influence—varies significantly based on a country's perceived strength. In this dissertation, strong countries are defined by economic power, political stability, and global influence (Smith & White, 1992; Fioramonti, 2016), while weak countries are characterized by limited resources, weak institutional capacity, vulnerability to shocks, and dependence on external aid (Barrientos et al., 2005; Grittersova, 2017). Literature suggests that these power imbalances shape how IOs engage with states, particularly in issuing policy guidance. Namely, wealthy countries often shape IO agendas and policy priorities to reflect their interests, allowing them to influence global norms and negotiate or resist external pressures (Drezner, 2003; Woods, 2006; Stone, 2011; Kentikelenis et al., 2016). In contrast, weaker countries are typically viewed as having limited bargaining power and are assumed to passively receive IO advice and conditions (Finnemore & Sikkink, 1998; Mosley, 2003; Woods, 2006; Kentikelenis & Seabrooke, 2017; Corbett et al., 2018). Rather than equal partners, they are often seen as lacking the capacity to generate independent policy ideas or resist IO prescriptions (Finnemore & Sikkink, 1998; Barnett & Finnemore, 2004; Béland & Orenstein, 2013; Corbett et al., 2018). In complex policy areas like social policy, IO expert authority further reinforces compliance, as weaker states seek to align with global standards to maintain legitimacy and avoid isolation within the global community (Acharya, 2004; Barnett & Finnemore, 2004).

Although weak states are often seen as passive recipients of international norms due to structural disadvantages, emerging scholarship highlights their capacity for agency in navigating power asymmetries with IOs—even when they are economically dependent (Stone, 2008; Heldt & Mahrenbach, 2019; Druga, 2022; Malinar, 2022). While they may not shape IO agendas directly (Mosley, 2003:103), weak states can still exercise agency. In this dissertation, agency refers to a state's capacity to make independent choices and shape outcomes within constraints imposed by more powerful actors. For weaker states, this agency is not material but strategic—manifesting through negotiation, rule navigation, or leveraging institutional dynamics (Atela et al., 2017; Chipaike & Bischoff, 2018; Clark, 2022; Dassler et al., 2022). Agency may take various forms and can be understood along a spectrum, ranging from outright rejection of external advice to more strategic behaviors like a formal commitment without implementation, non-compliance with loan conditions, selective adoption of recommendations that align with domestic priorities, or even exploiting the legitimacy conferred by IOs for domestic political

purposes (Woods, 2006; Broome & Seabrooke, 2007; Copelovitch, 2010; Kentikelenis et al., 2016; Kentikelenis & Seabrooke, 2017; Malinar, 2022; Reinsberg et al., 2022). **Advice rejection** occurs when IO proposals clash with domestic priorities or constraints, and countries strive to preserve autonomy while remaining formally engaged (Alami, 2019; Eun et al., 2022). **Non-compliance**—accepting IO conditions but failing to implement them—allows states to retain IO membership and legitimacy while avoiding domestic costs (Béland & Orenstein, 2013; Lundgren, 2015; Lutz, 2021). This tactic, often called "agreeing but not fulfilling" (Busch et al., 2021), reflects negotiation and sovereignty assertion (Drezner, 2003; Zaum, 2013; Tallberg & Zürn, 2019). Domestic actors may signal commitment while preserving flexibility, complicating assumptions about reform uptake and balancing external expectations with internal constraints (Drezner, 2003; Zaum, 2013; Tallberg & Zürn, 2019). These partial or symbolic forms of compliance often result from political resistance or capacity constraints, complicating simplistic notions of reform implementation (Nakrošis et al., 2015). **Negotiation,** a more overt expression of agency, allows weaker states to reshape policy conditions in line with domestic goals, even within prescriptive frameworks (Spector, 2013; Faizullaev, 2014; Lundgren, 2015; Karlsson-Vinkhuyzen et al., 2022). This aligns with the concept of "pro forma conditionality," where conditionalities are not unilaterally imposed but often emerge through extended consultations and mutual agreement between the lender and recipient, reflecting a bargaining process rather than simple compliance (Killick, 1998:9; Davis, 2009). Rather than simply complying, weak states use multilateral settings to assert influence and pursue more adaptable agreements, navigating ideological and power asymmetries (Boehmer et al., 2004; Panke & Stapel, 2023). **Cherry-picking** reflects selective adherence—adopting IO guidance that fits domestic agendas while discarding more demanding or politically sensitive recommendations (Alter & Meunier, 2009; Lake, 2013; Diprose et al., 2019; Tallberg & Zürn, 2019). This allows states to signal compliance while prioritizing limited resources toward domestically beneficial reforms. Such symbolic alignment may occur without substantive change (Niemann & Martens, 2018). By adapting technical advice to fit domestic agendas, states strategically navigate external pressures while reinforcing domestic priorities (Lake, 2013; Diprose et al., 2019; Tallberg & Zürn, 2019). Furthermore, **"forum shopping"** is another form, where domestic actors align with IOs that support their position to counter internal opposition (Coen et al., 2021; Rautalin et al., 2021; Clark, 2022; Ficek, 2022). Additionally, misuse pertains to the wrongful, unethical, or illegal use of IOs resources, involving actions by

domestic actors that pervert the intended goals of the IOs. This phenomenon is particularly evident when domestic political entities seek to consolidate power, garner legitimacy, or undermine political opponents (Barnett & Finnemore, 1999; Matanock, 2020). Finally, **withdrawal from IOs,** though rare, represents a deliberate strategic move when membership no longer aligns with domestic interests. Some IOs offer exit clauses that weak states use as leverage or insurance against unfavourable policy shifts, particularly in organizations with non-unanimous decision-making. In this context, the threat or act of withdrawal becomes a tactical tool to renegotiate terms or protect domestic priorities (Dassler et al., 2022; Bakaki & Böhmelt, 2023).

These agency forms are not mutually exclusive. Weak states often shift strategies based on evolving domestic and international conditions (Barnett & Duvall, 2005; Eun et al., 2022). Thus, rather than being passive recipients, they actively engage IOs to promote domestic policy goals. This challenges the traditional power-centric approach, revealing a more dynamic and negotiated relationship between IOs and weaker countries, and underlines the need for a more profound understanding of IO–state interactions—a gap this dissertation addresses.

The next section outlines the current state of the art on the role and approach of IOs in healthcare (financing) policy. It then summarizes the existing literature on IOs' involvement in healthcare financing reforms in the CEE region, with a specific focus on Latvia.

3. State of the-art

3.1. IO's role and approach in healthcare (financing)

The following paragraphs examine in greater detail the four IOs identified through empirical analysis as being involved in the post-1989 healthcare financing reforms in Latvia and their respective roles and approaches to healthcare financing policy.

The WHO, a specialized UN agency, holds a unique position in global health governance. Mandated to lead and coordinate international health efforts, it is often described as the "global health ministry" for its central normative and advisory role (Deacon, 2007; Ervik et al., 2009; Kickbusch & Szabo, 2014). Unlike other IOs in this study, its sole focus on health grants it formal legitimacy as a global standard-setter and key advisor to national health ministries (Kaasch, 2009; 2011; 2015; Klarner et al., 2008).

With universal membership and a health-specific mandate, it retains unique authority as the *"centre of the arena"* (Kickbusch & Szabo, 2014:2; Frenk & Moon, 2013; Van Belle et al., 2018; Gostin et al., 2023). Flagship publications like the *Alma-Ata Declaration*, *World Health Reports*, and *Health for All* strategies promote reform models and enable expert knowledge exchange (Kaasch, 2009, 2013, 2015; Kaasch & Martens, 2015). Though often seen as neutral and technocratic, its influence is inherently political, shaped by member state negotiations (Kaasch, 2009; Clift, 2013; Kickbusch, 2013; Bennett et al., 2015). The WHO's position on healthcare financing is rooted in its broader commitment to strengthening health systems and promoting health as a human right and a tool for social justice. It advocates for UHC, emphasizing access to quality healthcare without financial hardship, based on principles of solidarity, collective funding, and risk pooling (Kaasch, 2011; 2013; 2015; Yerramilli et al., 2018). Since the 1978 Alma-Ata Declaration, the WHO has promoted primary healthcare (PHC) as the foundation of health systems, shifting focus toward community-based care and underscoring the role of public spending and state responsibility (Ervik et al., 2009; Clift, 2013; Hanrieder, 2016; Beaudevin et al., 2020). Key strategies such as *Health for All by the Year 2000* and the *World Health Report 2000* further elaborated healthcare financing as a core function, alongside service delivery, resource generation, and stewardship (Delnoij et al., 2003; Kaasch, 2007; 2011; Hanrieder, 2016; Kaasch, 2009; 2015; Lee & Goodman, 2002). The WHO calls for strong government leadership to ensure equitable access, prevent excessive privatization, and protect vulnerable populations, especially in low-income settings, where it recommends a minimum essential health package funded by the state (Ervik et al., 2009; Kaasch, 2009; 2011; 2015; Clift, 2013; Hejdukova & Kurekova, 2016).

Despite its normative strength and international legitimacy, the WHO has limited leverage compared to financial institutions, as it cannot impose conditionalities and lacks funding power (Weyland, 2006:171). Instead, WHO relies exclusively on soft governance and non-coercive influence, which it applies through norm-setting, technical assistance, policy guidance, and data production, shaping health agendas via capacity-building, workshops, and conferences. It depends on coordination, advocacy, and mobilizing other IOs and NGOs to sustain its role in global healthcare financing debates (Abbot et al., 2015; Hanrieder, 2015a; 2015b; Kaasch, 2015). Thus, it promotes flexible, context-

sensitive policy guidance rather than uniform models, balancing its principles with national and regional realities (Kaasch, 2007).

While traditionally focused on economic development, **the WB** has expanded its scope of interest since the 1970s to include health, and since the early 1990s, it has become one of the largest external funders and policy shapers of global healthcare (Deacon, 2007; Ruger, 2005; Noy, 2017; Tichenor & Sridhar, 2017), combining its financial power with growing influence as a knowledge producer. These resources have allowed it to challenge the WHO's dominance in global health governance (Hadjiisky, 2021) leading some to regard it—alongside the WHO—as a global "ministry of health" (Deacon, 2007). It embeds healthcare policy reforms in loans and strategic advice, using tools like cost-effectiveness analysis, performance-based budgeting, and fiscal modeling (World Bank, 2007; Kentikelenis & Seabrooke, 2021). While retaining financial leverage, it increasingly relies on soft governance. Flagship reports, such as *Investing in Health* (1993) and *Healthy Development*, as well as technical assistance and policy dialogue, reinforce its role as a global norm-setter (Ruger 2005; Harman, 2009; Noy, 2017; Tichenor & Sridhar, 2017). The WB has long been associated with promoting a neoliberal approach to healthcare, emphasizing efficiency, reduced state involvement, market mechanisms, privatization, and individual responsibility—often at the expense of public health spending and equity (Laurell & Arellano, 1996; Deacon & Hulse, 1997; Brunet-Jailly, 1999; Deacon, 2000, 2007; Lehrer & Korhonen, 2004; Cerami, 2005; Nemec & Kolisnichenko, 2006; Stuckler & Basu, 2009; Kaasch, 2015; Noy, 2017). Its policies, including support for user fees and structural adjustment loans, have faced criticism for undermining welfare systems and social protections (Kaasch, 2015; Noy, 2017). However, since the late 1990s, the WB has gradually shifted its stance (Deacon, 2007; Kaasch, 2015; Noy, 2017). The *Health, Nutrition and Population Strategy* (1997) marked a turn toward more flexible, context-specific approaches, advocating stronger state roles, risk pooling, and expanded resource mobilization (World Bank, 1997; Deacon, 2007; Kaasch, 2015). This position was reinforced in its 2007 report, which emphasized equitable access, financial protection, and sustainable funding—though still employing market-oriented tools like performance-based management (World Bank, 2007; Noy, 2017). Overall, the Bank's discourse has evolved to balance efficiency with growing attention to equity and healthcare access.

The OECD, originally established to promote economic growth among high-income countries, has gradually extended its mandate to include social policy, including healthcare, largely in response to member state demands (Kaasch, 2010; 2011; Kaasch & Deacon, 2008). In this expanded role, the OECD has become a key actor in global health governance, known for health system analysis, robust data, and policy framing. The OECD operates through soft governance tools—namely, idea and discourse production, policy evaluation, and data generation—focusing on mutual accountability, peer review, and policy learning (Kaasch, 2007; 2007a; 2009; Porter & Webb, 2008; Niemann & Martens, 2018; Martens & Jakobi, 2010; Kaasch & Martens, 2015). Member states voluntarily submit to monitoring in exchange for expert analysis, benchmarking, and a platform to influence international standards (Martens & Jakobi, 2010; Kaasch & Martens, 2015). Through publications such as *Health at a Glance* and *Economic Surveys*, the OECD promotes evidence-based policy advice, emphasizing comparison, identification of common challenges, and shared learning—without relying on coercive instruments or financial conditionalities (Kaasch, 2015). The OECD's stance on healthcare financing has evolved from an early focus on curbing public spending to a more balanced approach that integrates economic efficiency with equity concerns. Initially viewing high healthcare costs as a barrier to growth (*Public Expenditure on Health*, 1977, and *Financing and Delivery of Health Care,* 1987), the OECD later embraced what some term as "inclusive liberalism," advocating for accessible, high-quality, and fiscally sustainable healthcare (Porter & Craig, 2004; Kaasch & Deacon, 2008; Kaasch, 2015). The OECD avoids promoting a single reform model, instead offering tailored, context-sensitive policy advice. While it does not prescribe specific financing systems, it emphasizes the need for better data, system performance monitoring, and policy learning. Through reports like *Health at a Glance* and targeted studies on private health insurance and care coordination, the OECD supports evidence-based policymaking while recognizing that private financing is not a universal solution but one tool among many (Dostal, 2004; Kaasch, 2007; 2007a; 2009; 2013; 2015; Martens & Jakobi, 2010).

The OHCHR, the UN's primary human rights body, holds significant political, expert, and moral authority. It assists states in meeting human rights obligations through cooperation, monitoring, advocacy, and accountability tools (Oberleitner, 2007; Alston & Goodman, 2013). In health policy, it partners with the WHO to integrate human

rights—such as accessibility and poverty reduction—into national health strategies (Hunt, 2007; Meier & Gostin, 2018). Its approach complements the WHO's, reflecting their shared UN foundation.

3.2.IOs' role in healthcare financing policy developments in CEE

Facing political and economic instability amidst the post-communist transition, CEE countries sought not only financial aid but also technical and policy expertise to build the newly established states (Brada et al., 1995). This opened the region—previously closed off during the Cold War—to IOs such as the WB, IMF, EU, and WHO, which pursued their policy agendas (Deacon et al., 1997; Cerami, 2006; Nemec & Lawson, 2008; Pop-Eleches, 2008; Kaasch, 2015). The WB and IMF quickly became the predominant source of financial assistance in the region (Brada et al., 1995:52).

Research has thoroughly documented the involvement of IOs, particularly the WB and IMF, due to their ability to provide financial assistance (Sachs, 1994; Wallich, 1995; Greskovits, 1998; Cerami, 2006), in promoting macroeconomic stabilization and neoliberal reforms in the region (Fultz, 2002; Müller, 2002). In social policy, IOs exerted considerable influence over the direction and substance of policy changes (Deacon et al., 1997), in particular in pension policy with three-pillar systems advocated by the WB (Müller, 1999; Orenstein, 2008). Regarding healthcare financing reforms, the WB stands out as the only IO offering loans, combining financial power with technical expertise (Radin, 2003, 2008; Cerami, 2006; Deacon, 2007; Orenstein, 2008; Kaasch, 2013). Although other IOs were present (Davis, 2010:56), the WB is often cited as the most influential actor in healthcare financing reforms in CEE.

Much of the debate focuses on the diffusion of SHI across the region. Unlike pension reforms—where the WB had a role that is widely acknowledged as being visible and assertive (Müller, 1999; Orenstein, 2008)—healthcare financing reforms present a more contested picture. Some scholars argue that IOs, especially the WB, used a "policy vacuum" that emerged after the collapse of communism (Deacon et al., 1997:92) to steer national reforms towards SHI adoption (Deacon et al., 1997; Cerami, 2006; Nemec & Lawson, 2008; Kaasch, 2015). While some sources suggest that the WB's involvement in healthcare was more limited compared to its assertive role in pension reform (Radin, 2003), Cerami (2006) and Kaasch (2015) claim that the WB strongly promoted the adoption of SHI in CEE during the agenda-setting stage. Cerami (2006) also claims that

SHI was promoted not only as a tool for financial sustainability but also as a first step toward privatization (Cerami, 2006), in line with the WB and IMF's primary focus on macroeconomic stabilization and neoliberal orientation. Nemec and Kolisnichenko (2006) similarly point out that health reform recommendations from IOs frequently emphasized market-oriented strategies such as decentralization, cost-sharing, private insurance development, and reduced public financing. According to several sources, these recommendations aligned with broader objectives of cost containment, individual responsibility, and limiting the scope of publicly funded healthcare (Cerami, 2006; Deacon, 2000, 2007; Kapstein & Milanović, 2001; Laurell & Arellano, 1996; Lehrer & Korhonen, 2004; Stuckler & Basu, 2009).

The EU's early role in health policy during the early transition period is widely seen as limited. The PHARE program focused almost entirely on labour market reforms, with minimal attention to healthcare (Deacon et al., 1997:97). Cerami (2006) describes the EU as reactive, often following recipient countries' agendas rather than clearly shaping them. Similarly, Jacoby (2004:62) argues that the limited scope of EU healthcare legislation constrained its impact before the late 1990s. According to the existing sources, the WHO also played a modest role in healthcare reforms in the region, its role being largely technical—offering policy advice, system assessments, and comparative data to aid national reformers. According to Cerami, while the WHO supported system-level assessments and provided comparative data, it did not advocate a specific financing model (Cerami, 2006).

While some scholars emphasize the influence of IOs in promoting the SHI diffusion across CEE, some other sources point instead to the limited leverage IOs had over national health reforms (Rechel & McKee, 2009; Roberts, 2009; Sabbat, 2010). These critics highlight the centrality of domestic preferences, political dynamics, and historical continuities in shaping reform outcomes and claim that the adoption of SHI in CEE was "largely endogenous," primarily driven by internal choices rather than external pressure (Rechel & McKee, 2009:1187). Some authors suggest that in Poland, Albania, and Czechia, the WB actually advocated for tax-based financing models—recommendations that domestic policymakers ultimately rejected (Roberts, 2009; Kaminska et al. 2021; Druga, 2022).

This stream of literature argues that the return to SHI was rooted in pre-communist traditions, particularly Bismarckian systems, and often framed as a rejection of Soviet-

era centralization (Marrée & Groenewegen, 1997; Kutzin et al., 2010b; Kaminska et al. 2021). Scholars point to internal political dynamics, dissatisfaction with communist-era healthcare, and post-communist ideological shifts as key drivers of change (Radin, 2003; Jacoby, 2004; Sitek, 2008). Domestic political dynamics also mattered: in Czechia, for example, early reforms reflected ideological battles between neoliberal approaches pushing for privatization and social liberals advocating universal access (Orenstein, 1995:187-188). The findings of the B08 research project highlight how anti-communist backlash shaped early reform trajectories in countries like Albania, Latvia, and Poland, where SHI was promoted as a rejection of Soviet-style health policies and as a symbol of Western professionalism and modernity (Kaminska et al., 2021). In Albania, Czechia, Croatia, and Latvia, medical professionals acted as key policy entrepreneurs (Lawson & Nemec, 2003; Jacoby, 2004; Rechel & McKee, 2009; Kaminska et al., 2021).

Historical legacies further shaped policy choices. Rather than emerging in a policy vacuum (Deacon et al., 1997:92) and an institutional void, post-communist reforms often blended elements from interwar Bismarckian SHI systems (Marrée & Groenewegen, 1997; Inglot, 2008; Kutzin et al., 2010b; Kaminska et al., 2021), communist structures, and new market-oriented ideas, resulting in hybrid models (Inglot, 2008; Kaminska, 2013; 2022). Reformers selectively borrowed from past institutional templates, shaped by path-dependent constraints (Hausner et al., 1995; Stark, 1991; Stark & Bruszt, 1998, 2001).

Horizontal policy learning also played a role, as policymakers looked to Western European systems—especially Germany and Austria—as models worth emulating (Jacoby, 2004; Rechel & McKee, 2009). Poland and Latvia worked with German experts, while Albania drew on the French model (Kaminska et al., 2021). SHI was seen not only as a tool for improving efficiency and transparency but also for enhancing the autonomy of the medical profession, improving care quality, and depoliticizing the health sector (Rechel & McKee, 2009; Kaminska et al., 2021).

In sum, the literature offers a complex and contested account of SHI adoption in CEE. While IOs were undoubtedly present, the evidence points to a more complex process shaped by domestic agency, historical reference points, and professional advocacy, with external models selectively appropriated to fit national reform agendas.

3.3. Latvia's healthcare financing policy evolution: What is known about IO involvement?

Since Latvia regained independence in 1991, its healthcare financing system has undergone significant reform, shaped by both pre-Soviet legacies and post-Soviet transformation. Drawing on the interwar Bismarckian system (in place from 1920 until 1940)—featuring 30 sickness funds that covered the entire employed urban and rural population, or 18.2% of the total population— Latvia initially sought to reintroduce SHI (Tragakes et al., 2008; Arāja & Krūzs 2016; Eihmanis, 2021; Krastiņš, 2023). In the early 1990s, the country embarked on market-oriented reforms, in line with the transition towards liberal democracy and a market economy. In all policy fields, and similarly to many other CEE countries, Latvia pursued the goal of severing ties with the Soviet past, re-establishing pre-Soviet structures, and adopting solutions institutionally remote from the previous system (Kaminska et al., 2021). In healthcare, this translated into the departure from the Semashko model (see Kamniska et al., 2021; Druga, 2022; Malinar, 2022), which, despite universal coverage, was plagued by inefficiencies, poor access, and public dissatisfaction (Tragakes et al., 2008; Roberts, 2009; Davis, 2010; Kutzin et al., 2010a). The Latvian Medical Association (LMA) called for model change and advocated for SHI as early as 1988. In 1989, it formulated a reform proposal that presented SHI as a policy choice in industrialized countries and claimed that Latvia—having already reached the required level of modernization—should, accordingly, adopt SHI, promising stable revenues, enhanced provider remuneration, and individual responsibility for health (Kaminska et al., 2021).

However, early socio-economic instability and competing policy priorities delayed implementation. Reforms began only in 1993 when a decentralized system of 35 local "sickness funds" funded through the state budget was installed. A contribution-based system was supposed to be introduced later (Tragakes et al., 2008; Arāja & Krūzs, 2016; Behmane et al., 2019; Eihmanis, 2021). However, the decentralization led to a fragmentation of services, weak management, and patient dissatisfaction, prompting re-centralization by 1997 (Müller et al., 2005; Mitenbergs et al., 2012; Arāja & Krūzs, 2016; Bikava & Skride, 2018; Eihmanis, 2021). By 2005, all sickness funds had been merged into a single state agency, and in 2011, the creation of the NHS completed Latvia's shift to a centralized, tax-funded system. The NHS provided universal coverage through a

defined benefits package and marked a clear departure from earlier SHI ambitions (Mitenbergs et al., 2014, Pētersone et al., 2019; Eihmanis, 2021).

Despite structural consolidation, challenges persisted. Public health expenditure was among the lowest in the EU—around 3.5% of GDP in 2010, compared to the EU average, which typically ranged from 6% to over 10% of GDP in the same period—while in 2010 OOPPs accounted for roughly 27% of total spending, almost twice the EU average (around 15%) (Eurostat). Pharmaceuticals represented a significant share of household health costs, and several essential services—like adult dental care and outpatient medicines—remained excluded from the basic package, disproportionately affecting low-income groups (Carone et al., 2012; Taube et al., 2018). The 2008–2009 global financial crisis further exposed these weaknesses, deepening underfunding and straining service delivery (Pētersone et al., 2019; European Observatory on Health Systems and Policies, 2022).

In response, Latvia revisited insurance-based models in the 2010s. In November 2013, the Cabinet of Ministers approved a draft of the Healthcare Financing Law that proposed linking healthcare access to income tax payments or designated contributions. The aim was to raise additional revenue and limit access for non-contributing Latvians living abroad (Mitenbergs et al., 2014; Behmane et al., 2019). However, the proposal faced political and public resistance over equity, social exclusion, and administrative feasibility, which ultimately stalled the law's adoption in 2014.

Nonetheless, the structural problems in healthcare persisted, and in 2016 the idea of insurance-based reform resurfaced. By the end of 2017, a Health Insurance Law was passed establishing a two-basket system that distinguished between services available to all residents and those available to individuals paying employment-based contributions (Pētersone et al., 2019). However, this reform was short-lived; after the 2018 elections, the newly appointed HM opposed the reform, citing its complexity, legal ambiguities, and the risk of undermining universal access. By mid-2019, the Health Insurance Law was formally revoked, and Latvia reaffirmed its commitment to a universal, tax-financed system (Holla et al., 2016; Behmane et al., 2019; Pētersone et al., 2019; European Observatory on Health Systems and Policies, 2022). These reform reversals reflect enduring tensions between the goals of equity, financial sustainability, and political feasibility in Latvia's post-Soviet healthcare system. Further analysis of this domestic debate and the role of IOs can be found in Contribution D.

These developments highlight the political sensitivity of healthcare financing in Latvia and the limited policy space available for structural reform amid international expectations for comprehensive, equitable healthcare systems and persistent domestic economic constraints. Repeated failures to implement an insurance-based model reveal fragile reform coalitions and ongoing tensions between fiscal constraints, political realities, and social equity.

The literature on **IOs involvement in Latvian healthcare financing** is limited, with most sources offering descriptive overviews rather than analysing the dynamics between IOs and domestic stakeholders or their respective agendas.

The most prominent and well-documented actor is the WB which first became involved in 1996 at the Latvian government's request. Between 1999 and 2004, the WB implemented the "Latvia Health Reform Project," a US$12 million loan initiative aimed at restructuring the healthcare sector (Tragakes et al., 2008). The project's primary objectives were to improve the quality, efficiency, and accessibility of services, focusing on reforming healthcare financing, strengthening existing administration and sickness funds, and enhancing healthcare information systems. Notably, the project attempted to introduce DRG for inpatient care and capitation-based payments in primary care. Project measures laid the foundation for many of the key reforms in the late 1990s and early 2000s (World Health Organization, 2001; Tragakes et al., 2008). In contrast, EU PHARE projects during the same period focused on medical education, primary care establishment, and infrastructure, without targeting financing reform (Kaminska et al., 2021).

WB's involvement was supposed to continue in a second phase, meant to implement the "Master Plan"—a package of structural reforms co-designed with the WB (Tragakes et al., 2008). Yet, due to political resistance, the implementation of the measures specified in the Master Plan—heavily influenced by earlier WB ideas—was carried out without WB financing (Tragakes et al., 2008). The Ministry of Health, together with domestic stakeholders, adopted the Master Plan in 2005 as the "Programme of Development of Primary and Hospital Care Services for 2005–2010," which aimed to consolidate hospitals, reduce bed numbers, and shift care from inpatient to outpatient settings—addressing the legacy of Soviet-era hospital-centric healthcare (Tragakes et al., 2008). In this way, the WB's framework continued to influence healthcare financing reforms in Latvia, providing ideas, momentum, and legitimacy (Aslund & Dombrovskis, 2011).

In response to the 2008 global financial crisis, Latvia sought assistance from international lenders. The WB provided a €100 million loan to support social protection measures and, along with technical assistance, helped design comprehensive reforms across public administration, including the healthcare sector (Mitenbergs et al., 2012; Taube et al., 2015). As for the Master Plan, it achieved only modest progress in expanding outpatient services, as political and local resistance had stalled its implementation. In 2009, fiscal pressures and austerity led to the Master Plan's official termination (Mitenbergs et al., 2012; Taube et al., 2015).

In October 2009, to mitigate the social costs of austerity measures, the government developed and introduced the Social Safety Net Strategy (SSNS), supported by the WB, the European Commission, and the IMF. Its primary goal was to ensure continued access to health services for low-income populations while advancing structural reforms (Mitenbergs et al., 2012). Key measures included waiving user charges for the poorest, financing overnight stays after day care, and expanding services such as home care for the chronically ill, day centers for the mentally ill, additional primary care nurses, and a family doctor helpline. Though scaled back in 2012 when the WB loan ended, the SSNS played a critical role in shifting the system away from hospital-centered care and protecting vulnerable groups during the crisis (Lukša, 2010; Mitenbergs et al., 2012; Eihmanis, 2021).

The WHO has also had a visible presence in Latvian healthcare, primarily through public health, policy guidance, and technical assistance. Latvia's key midterm strategic planning documents, such as the *Public Health Strategy* and the *Public Health Guidelines*, align with WHO's *Health for All* and *Health 2020* frameworks, which promote improving population health and reducing inequalities through stronger governance (World Health Organization. Regional Office for Europe, 1999; Tragakes et al., 2008; World Health Organization, 2013; Bikava & Skride, 2018). These frameworks also emphasize efficient use of limited resources—a priority echoed by Latvia's MoH (Bikava & Skride, 2018). Since Latvia joined the WHO in 1991, the IO has promoted an intersectoral approach to health in the country, focusing on public health, health promotion, health system strengthening, and responses to both noncommunicable and communicable diseases (Tragakes et al., 2008; Mitenbergs et al., 2012).

While the literature affirms that IOs—particularly the WB— played a substantial role in shaping Latvian healthcare reforms, it offers limited insight into how these organizations

interacted with domestic actors, what specific ideas they promoted, and how influential they truly were. This dissertation addresses these gaps by examining the interactions between IOs and domestic stakeholders to provide a more profound understanding of IOs' influence on Latvia's healthcare financing reforms.

4. Methodology

4.1. Case selection

This dissertation employs a **single-case study design** to provide an in-depth, context-sensitive analysis of the IOs role in healthcare financing reforms in Latvia. Given the focus on IO–domestic actor interaction, the analysis is situated at both levels—IO- and national level—examining the content and dynamics of IO advice and how it was received, interpreted, and implemented within Latvia's institutional context.

At the **national level**, Latvia was selected as a representative case of a vulnerable CEE country (due to its shared post-communist transition with other CEE countries and shared weaknesses) and a "most likely case" in terms of 'little to no agency' in interaction with IOs (Seawright & Gerring, 2008; Gerring, 2017). The study allows us to highlight discrepancies between international recommendations and how IO advice was received, interpreted, and implemented within specific institutional contexts. It captures the dynamics between global policy agendas and national political and institutional realities (see Kutzin et al., 2010a; Müller et al., 2005).

Like many CEE countries, Latvia experienced profound political and economic upheaval after the collapse of the Soviet Union. These vulnerabilities made it especially receptive to external actors and global policy agendas. From a political standpoint, Latvia faced the challenge of rebuilding state institutions while navigating social and ethnic tensions, particularly involving its large Russian-speaking minority[3] (Smith, 2002; Bleiere, 2019; Urazbaev & Yamalova, 2020; Sommers, 2021). Economically, it suffered a dramatic transition shock: GDP fell by nearly 50% between 1990 and 1993, inflation surged, and the 1995 collapse of Bank Baltija triggered a major banking crisis (Aslund &

[3] Latvia prioritized nation-building by clarifying citizenship rights and establishing Latvian as the official language. This process was contentious, with ethnic Latvians dominating ruling parties and ethnic Russians largely excluded from government roles. A primordial view of national identity prevailed, institutionalizing nationalism as the basis for solidarity and identity (Urazbaev & Yamalova, 2020).

Dombrovskis, 2011; Kajaks, 2012; Purfield & Rosenberg, 2010; Urazbaev & Yamalova, 2020). The 2008–2009 global financial crisis further exposed Latvia's fragility. With one of Europe's steepest GDP contractions (nearly 25% in 2009), the country became heavily dependent on international financial assistance.[4] The IMF-led bailout required strict austerity, including a 24% cut in healthcare spending between 2008 and 2010[5] (Purfield & Rosenberg, 2010; Aslund & Dombrovskis, 2011; Austers, 2014; Behmane et al., 2019).

Against this backdrop, healthcare financing reform in Latvia underwent significant transformation. Following independence in 1991, Latvia attempted to break from the centralized Soviet Semashko model, initially experimenting with decentralization before re-centralizing under a tax-based NHS model. The system is now publicly funded via general taxation with a purchaser–provider split (Mitenbergs et al., 2014; Kaminska et al., 2021; see Contributions C and D) (as described in section 2.3). Despite these reforms, Latvia remains among EU and OECD countries with the most underfunded healthcare systems**,** characterized by high out-of-pocket payments, unmet medical needs, and poor health outcomes (Thomson et al., 2015; Behmane et al., 2019).

Studying Latvia's case offers valuable insight into how IOs operate in vulnerable policy environments. Since the early 1990s, IOs have been particularly active across the CEE region, leveraging both technical expertise and policy advice to influence reform processes. Latvia's economic dependence on external actors, especially during periods of crisis, heightened the potential for IO influence— making it a valuable case for exploring how policy is made under conditions of asymmetric power.

At the IO-level, the study focuses on four key IOs: the WHO, OECD, WB, and OHCHR. Although the initial research scope included the IMF and the EU— including through PHARE-funded projects— early fieldwork revealed their limited involvement in Latvia's healthcare financing reform post-communism. Notably, during the fieldwork, the OHCHR emerged as an unexpected but relevant actor through its advocacy for equitable access to healthcare.

[4] To contain the crisis, the government requested a €7.5 billion support package from the EC and IMF (International Monetary Fund, 2009), plus a €100 million as a short-term loan from the WB (World Bank, 2010a).

[5] This involved cutting funding to hospitals, raising user fees, sharply reducing health worker salaries, and lowering pharmaceutical prices (World Bank, 2010; Mitenbergs et al., 2012).

The decision to include two contributions analysing the healthcare financing recommendations of the WHO and OECD across the CEE region is driven by three factors. First, both organizations are central to global health governance (Youde, 2012; Kaasch, 2015, 2015a). Second, they have maintained a consistent presence in the region since the early post-communist period, providing various forms of support (Lee, 2008; Rechel & McKee, 2009; Youde, 2012; Kaasch, 2015, 2015a). Finally, their selection addresses a notable gap in the literature: the content and potential influence of policy recommendations issued by IOs that rely exclusively on soft governance tools—such as technical assistance, peer review, and norm diffusion—remain insufficiently explored. This makes the WHO and OECD especially relevant for analysing non-coercive forms of influence in contexts where financial leverage is absent.

This dissertation covers the period **1988 to 2019**, spanning the final years of the Soviet regime, Latvia's early transition period, EU accession, and the aftermath of the global financial crisis. This timeframe allows for an analysis over more than three decades of how IO policy advice evolved and how the influence, strategies, and tools of IOs shifted in response to domestic and global developments. This approach balances theoretical generalizability and empirical depth, linking Latvia's experience to broader patterns of IO engagement in post-communist Europe while maintaining analytical precision through focused, context-rich analysis (Stake, 1995; Yin, 2018).

While the research design offers important insights, it also has **limitations**. Furthermore, the use of qualitative data introduces interpretive subjectivity, particularly when analysing how IO advice was adapted or resisted within Latvia's healthcare financing reform developments (Kutzin et al., 2010a; Müller et al., 2005). The exclusive focus on Latvia poses some limitations on broader regional comparison, as CEE countries—despite common post-communist experience - differ in political legacies, economic conditions, and trajectories of healthcare reforms (Cerami, 2005; Deacon et al., 1997). While the study contributes to understanding IOs' soft governance in CEE healthcare policy, these constraints underscore the importance of cautious interpretation and point to the need for future comparative research using mixed methods and wider case selection.

4.2. Data collection

This dissertation draws on extensive qualitative data collected in three rounds. The first two rounds involved field visits to Riga (early summer and fall 2019), while the final data gathering was conducted remotely (in early 2020), using a "Zoom lens"—the only viable approach due to COVID-19 travel restrictions (Howlett, 2022). The data spans the period from late 1988 to 2019 and includes two main sources: publicly available documents and expert interviews.

To ensure reliability, documents were gathered from a wide range of sources and categorized into IO and domestic publications. Domestic materials included grey literature, legislation, government strategies, and media reports from key Latvian actors, sourced from physical and online archives of institutions such as the Latvian government, parliament, national bank, and LMA. IO documents encompassed loan agreements, project reports, evaluations, and healthcare financing studies retrieved from the online databases of the WB, WHO, and OECD. The information about OHCHR's standpoint was encountered in publications from domestic actors. Key search terms included—*healthcare reforms*, *healthcare financing*, and *social health insurance*. Additional five unpublished WHO assessments were accessed through public correspondence with the organization's representative.

To complement document analysis and understand domestic perceptions and interactions with IOs, semi-structured expert interviews were conducted (Pfadenhauer, 2009). These interviews helped reconstruct expert knowledge (Pfadenhauer, 2009) and reveal attitudes, reasoning, and dynamics relevant to the dissertation's focus.

Interviewees were selected for their insider knowledge based on years of professional experience. Recruitment followed a snowball sampling method (Noy, 2008), continuing until no new insights emerged. Interviews were held both in person and online, without major difficulties, supported by my prior experience in the Latvian healthcare sector and existing networks. Participants included former ministers, healthcare officials (MoH, NHS, Latvian Centre for Disease Prevention and Control), medical professionals (LMA, Latvian General Practitioners' Association, Latvian Rural General Practitioners' Association), healthcare policymakers, and academics. An additional four interviews were conducted with past and present experts from the WB, WHO, and OECD, as well as two interviews on horizontal interdependencies with German actors. In total, 58

interviews were conducted—thirty-two face-to-face, twenty online, and six over the phone. One was email correspondence. For a full list of interviewees see Appendix No 6.

4.3. Data cleaning and analysis

Before analysis, data cleaning was necessary—especially for Contributions A and B—due to the initial strategy of collecting all available IO documents. A preliminary review showed that many documents, like OECD's *State of Health in the EU* and *Health at a Glance* publication, focused mainly on statistical data rather than concrete healthcare financing recommendations. Likewise, several WHO publications (*The European Health Report* and *World Health Statistics*) mentioned financing only briefly without offering specific policy guidance. Such documents were excluded from the analysis and not coded. The final dataset for the WHO (Contribution A) comprised 145 documents, while for the OECD (Contribution B) included 119 documents.

For each of the four contributions, cleaned data from documents and interviews were analysed using qualitative content analysis in MAXQDA. The process began with a broad review, identifying relevant segments through keywords like *health*, *healthcare*, and *health financing*, particularly in documents covering broader themes. A combination of deductive and inductive coding was applied (Kuckartz, 2014). Deductive codes—derived from the literature and research questions—ensured consistency across Contributions A, B, and C, focusing on IOs' roles in healthcare financing and their interactions with domestic actors (e.g., cooperation, contention). Additional codes addressed IO ideational perspectives (Contributions A and B) and other relevant factors (Contribution C). Contribution D used an inductive approach, with codes emerging from newly identified patterns. Interviews were analysed in their original languages, Latvian and English.

5. Overview of the dissertation contributions

5.1. Contribution A: WHO's healthcare financing policy recommendations in CEE countries

Stupele, L.

In M. E. Kaminska (Ed.), *Post-1989 healthcare financing reforms in Central and Eastern Europe: The role of international organisations*. (forthcoming).

This contribution investigates the healthcare financing policy recommendations issued by the WHO to CEE countries between 1989 and 2019. Drawing on qualitative content analysis of 180 WHO documents across 16 CEE countries, the study examines whether the WHO promoted paradigmatic change or prioritized incremental reforms through technical guidance. Relying on Hall's (1993) framework on policy change levels and Kutzin et al.'s (2010a) four sub-dimensions of healthcare financing—revenue collection, pooling, purchasing, and coverage—the study explores the form and substance of WHO's policy advice. The WHO's influence operated through soft governance tools, including normative framing, technical assistance, and epistemic authority. Findings indicate that the WHO largely refrained from prescribing specific financing models but consistently advocated for increased public spending, reduced reliance on out-of-pocket payments, and improved financial protection. Its recommendations focused predominantly on instrument- and parameter-level adjustments, tailored to domestic contexts. While the WHO promoted equity and sustainability through frameworks like UHC, it adapted its advice pragmatically in response to countries' choices and constraints. The study contributes to understanding WHO's flexible yet norm-driven role in global social policy and health governance during CEE's post-communist transition.

5.2. Contribution B: OECD's healthcare financing policy recommendations in CEE countries.

Stupele L., Malinar A.

In M. E. Kaminska (Ed.), *Post-1989 healthcare financing reforms in Central and Eastern Europe: The role of international organisations*. (forthcoming).

This contribution investigates the healthcare financing policy recommendations issued by the OECD to CEE countries from 1989 to 2019. Using qualitative content analysis of 118

OECD documents across eight CEE member states, the study explores whether the OECD promoted market-oriented reforms or aligned with the principles of "inclusive liberalism." The analysis focuses on four sub-dimensions of healthcare financing—revenue collection, pooling, purchasing, and coverage (see Kutzin et al. 2010a)—while drawing on Hall's (1993) framework on policy change levels. The OECD's influence derives from its non-coercive governance tools, including data benchmarking, discourse framing, and policy monitoring. Findings reveal that while early OECD recommendations favoured paradigmatic shifts towards general taxation, later advice emphasized incremental improvements to the existing SHI systems, reflecting a pragmatic, context-sensitive approach. The OECD consistently supported evidence-based policy instruments like DRGs and mixed provider payment models but tailored recommendations to domestic contexts. Although a preference for efficiency and financial sustainability was evident, equity considerations—such as protecting vulnerable populations—were formulated across dimensions. Overall, the study contributes to understanding the OECD's evolving and adaptive role in global social policy and health governance in post-communist Europe.

5.3. Contribution C: The role of international organizations in the healthcare financing reforms in Latvia.

Stupele L., Kaminska M. E.

In M. E. Kaminska (Ed.), *Post-1989 healthcare financing reforms in Central and Eastern Europe: The role of international organisations*. (forthcoming).

This contribution examines the role of IOs in shaping healthcare financing reforms in Latvia from the early 1990s to 2019. Drawing on 71 document analysis and 25 expert interviews, the study investigates how the policy advice of the WB, WHO, and OECD was received, interpreted, adapted, or resisted by domestic actors. The analysis is framed by Hall's (1993) typology of policy change and Kutzin's (2010a) sub-dimensions of healthcare financing—revenue collection, pooling, purchasing, and coverage. The study finds that while the WB's recommendations were largely implemented—facilitated by conditional loans and alignment with Latvia's reform agenda—WHO and OECD advice was more frequently sidelined, particularly when misaligned with domestic preferences. IO influence was exerted through soft governance tools, such as technical assistance, policy frameworks, and benchmarking. The evidence suggests that policy adoption

depended on two main factors: alignment with national priorities and the specificity of the advice. While international inputs shaped parameter-level changes, paradigmatic reforms—like the shift toward general taxation and debates on SHI—remained under domestic control. This case contributes to understanding the negotiation of global social policy in weak states and illustrates how domestic actors mediate IO influence in post-communist health governance.

5.4. Contribution D: Misusing international organizations' authoritative resources: the case of the Latvian healthcare financing reforms.

Stupele L. (2025, forthcoming). Submitted to the Journal of Baltic Studies. As of July 2025, it has a revise and resubmit status.

This paper examines the misuse of international organizations' authoritative resources and IOs reaction to it by analysing Latvia's healthcare financing reforms between 2010 and 2019. The article presents a single case study using qualitative methods, including document analysis and semi-structured interviews. The textual material was analysed through qualitative content analysis following using MAXQDA. The empirical sections tracked how domestic actors actively engage with IOs like the WHO, OECD, and OHCHR—leveraging their authority to advance specific reform agendas. The study reveals how weak countries strategically draw on IOs' resources for political gain, challenging the assumption that they are passive recipients of IO advice, and provides clear evidence that even states with limited resources can instrumentalize IO authority for domestic purposes. The study also shows IOs responses to these actions, where IOs tend to prioritize long-term relationships with the country over immediate compliance, often opting for continued engagement rather than withdrawal, thus highlighting the complexities of IO-country interactions in policy reform.

6. Results and Discussion

This section of results and discussion will respond to the research questions, summarize the key findings, discuss the broader academic significance of the findings, and conclude with a reflection on the study's limitations and future research directions.

By focusing on the Latvian case within the broader CEE context, this study examines the **interaction dynamics between domestic actors and IOs** in the realm of healthcare financing reforms. In particular, the dissertation explores the soft governance employed

by IOs to influence social policymaking. The dissertation focused on these research questions:

1. **What were the contents of the IOs policy advice for healthcare financing in CEE and in Latvia?**
    1.1. What was the content of IOs' advice in each of the four sub-dimensions of healthcare financing, as defined by Kutzin et al. (2010a)?
    1.2. To what extent did the IO's healthcare financing recommendations for CEE countries and specifically for Latvia target the paradigmatic level, policy instruments, or specific policy parameters, as defined by Hall (1993)?
    1.3. To what extent did the IOs policy advice reflect neoliberal principles?
    1.4. Did policy recommendations differ across CEE national contexts and over time, or did they adhere to a one-size-fits-all approach?
2. **How did the interaction between Latvia and IOs evolve?**
    2.1. Which side initiated the interaction?
    2.2. What channels of communication/diffusion of policy advice were used?
    2.3. How did Latvia respond to the advice provided by IOs?
    2.4. How did IOs react to Latvia's use of IOs' advice?

This section analyses the healthcare financing policy advice of the WHO, OECD, WB, and OHCHR in CEE, with a particular focus on Latvia. It explores the content of their recommendations, the policy levels targeted (Hall, 1993), and the extent to which these recommendations varied across national contexts and time, therefore highlighting the IOs' differentiated roles and policy stances. For the result summary see Appendix No 2-4.

Regarding **revenue collection**, both the WHO and OECD advocated for increased public funding across CEE and Latvia, primarily through paradigmatic and instrument-level guidance. The WHO consistently opposed SHI models in the region and Latvia due to limited fiscal capacity, weak administrative infrastructure, and equity concerns. Instead, it preferred tax-based or hybrid models, emphasizing the need to introduce progressive taxation and to reduce out-of-pocket payments. In addition to its paradigmatic stance, the WHO also offered recommendations at the instrument and parameter level, e.g., targeting a certain percentage of GDP in public spending for health. In Latvia specifically, the

WHO called for a paradigmatic shift in national priorities, urging greater public investment and prioritizing healthcare among other policy fields. The OECD initially shared the WHO's preference for general taxation in CEE—seen in its advice to Poland, Hungary, and Estonia—but shifted to instrument-level guidance when these countries retained SHI and focused on advice on how to improve the system efficiency. While both IOs supported public financing of healthcare, their rationales differed: the WHO emphasized equity and financial protection, while the OECD prioritized fiscal sustainability (Kaasch, 2015; Martens & Jakobi, 2010). The WB did not address revenue generation in Latvia.

These findings significantly contribute to the ongoing debate over the drivers of **SHI adoption** in CEE. Contrary to earlier claims that IOs were the driving force behind the diffusion of the SHI model across CEE, supported by Deacon et al., 1997; Müller, 1999; Radin, 2003; Cerami, 2006; and Kaasch, 2015, neither the WHO nor the OECD promoted SHI—in fact, both discouraged its introduction on practical and normative grounds. The WB remained neutral, offering no direct position on SHI in Latvia. In the Latvian context specifically, starting from 2010, the WHO repeatedly warned against SHI adoption. These conclusions align with recent findings from Albania, Croatia, and Poland (Kaminska et al., 2021), suggesting that the post-1989 introduction of SHI across CEE was driven by domestic political dynamics and institutional path dependencies, as well as with the earlier conclusions by Marrée and Groenewegen (1997), Lawson and Nemec (2003), Jacoby (2004), Rechel and McKee (2009) and well as Kutzin et al. (2010b) who all emphasised the endogenous character of healthcare financing reforms in the region. This highlights national path dependencies and the limited role of IOs in shaping core financing models.

The **pooling** sub-dimension was less frequently addressed by the WHO and OECD in CEE, but with the most coherence in terms of the content of their advice that offered context-sensitive guidance focused on technical improvements in fragmented or inefficient systems. The WHO advocated for a single-payer model in CEE countries due to low administrative capacity and the need for greater equity, aligning with its earlier arguments on revenue collection. Yet, despite its preference for a single-payer model, it also provided country-specific, instrument-level guidance on improving or consolidating pooling arrangements in multi-payer systems. The **OECD** offered instrument-level advice only in the CEE countries with complex multi-payer systems, i.e., the Czech

Republic and Slovakia. Its recommendations were pragmatic in nature, focusing on reducing inefficiencies or harmonizing fund operations. The **WB** applied a similar logic in Latvia, promoting the consolidation of financial flows and administrative structures to enhance allocation efficiency. It offered technical advice at the instrument and parameter levels, supporting administrative simplification while emphasizing system efficiency, cost containment, and better use of public resources.

Purchasing was a central focus for the WHO, OECD, and WB, with most guidance targeting instrument and parameter levels. The **WHO** in CEE promoted gradual DRG adoption in hospitals and capitation or mixed models in primary care, alongside reforms in monitoring, PHC, and gatekeeping. Its advice combined instrument- and parameter-level strategies with some attention to payment incentives and calibration. The **OECD** also emphasized strategic purchasing, promoting DRGs and pay-for-performance as best practices. Despite its rather standardized recommendations, the OECD allowed for contextual adaptation, often including benchmarks, expected outcomes, and timelines. In the Latvian context, the **WB** offered the most operational advice, focusing on hospital restructuring, cost containment, and system optimization—targeting instrument and parameter levels. In summary, recommendations on purchasing showed the greatest convergence across IOs, focusing on increasing efficiency, transparency, and cost-effectiveness.

IOs' recommendations on healthcare **coverage** in CEE and Latvia reflected their distinct normative orientations and institutional mandates, revealing both shared concerns and diverging approaches to access and equity. The **WHO** was the most paradigmatic, consistently advocating for the UHC principle and promoting access for vulnerable groups, reduced out-of-pocket payments, and strengthened financial protection. It also offered concrete advice on benefit package design and co-payment caps, operating across all policy levels. These patterns were evident across CEE and in Latvia specifically. The **OECD,** in contrast, adopted a more technocratic, cost-efficiency-driven stance. It supported lean benefit packages, moderate co-payments, and voluntary private insurance while recommending exemptions for vulnerable groups—intervening mostly at the instrument and parameter levels without challenging core paradigms. Despite its economic focus, the OECD acknowledged the need for redistributive safeguards. The **WB** shared this pragmatic orientation, balancing financial sustainability with basic equity. While it rarely engaged in normative debates, its 2009 loan to Latvia included

explicit protections for low-income populations, highlighting its use of targeted, context-sensitive guidance at the instrument and parameter levels. The **OHCHR,** though marginally involved, offered a paradigmatic critique of Latvia's SHI proposal, warning against exclusion of vulnerable groups and referencing international human rights principles—emphasising its normative role through rights-based framing (Hunt, 2007; Meier & Gostin, 2018).

These findings clearly show that the OECD and WB, rather than pushing for a rigid neoliberal agenda, followed what Porter and Craig (2004) call *inclusive liberalism*—balancing market efficiency with social protection. Both IOs prioritized access and stressed the importance of preserved universal coverage—signalling a context-sensitive engagement aligned with global norms. The OECD explicitly included equity safeguards in its advice, promoting fiscal sustainability alongside social protection, as noted in earlier studies (Lee & Goodman, 2002; Kaasch & Deacon, 2008; Mahon & McBride, 2009b; Kaasch, 2015; Hanrieder, 2016). Similarly, the WB recommendations in Latvia clearly deviated from a strict neoliberal approach, showing greater attention to redistributive concerns, especially emphasizing protecting vulnerable population groups in economically challenging contexts. This suggests a rather flexible stance of the WB and the OECD as pragmatic reform partners rather than ideological actors (see Béland & Orenstein, 2013; Wireko & Béland, 2017). Thus, in conformity with recent scholarship (Peck & Theodore, 2015), these findings point to a notable shift in the position of the two IOs that historically, especially in the post-Cold War period, were seen as leading advocates of liberalization, privatization, and market-oriented reforms, emphasizing deregulation and fiscal discipline (Uljens, 2007; Mahon, 2010; Middlebrook, 2012; Hong, 2024).

When examining the **levels of policy change** (Hall, 1993) targeted in recommendations, IOs' healthcare financing advice in CEE and Latvia spanned all three of them—paradigmatic, instrument, and parameter—though with varying emphasis. The **WHO** most frequently addressed paradigmatic policy issues, promoting UHC, progressive taxation, and public stewardship. It also offered instrument- and parameter-level guidance, like GDP spending targets. The **OECD** largely focused on instrument and parameter levels, providing benchmarks, fiscal strategies, and tools, although in the early 1990s —at the beginning of the transition process — it did express critical opinions regarding the shift to SHI in CEE countries in an attempt to also influence paradigmatic

discussions. The **WB** adopted a technical, implementation-oriented approach, largely operating at the parameter level with advice on hospital restructuring and cost-efficiency. The **OHCHR** engaged primarily at the paradigmatic level, warning of exclusionary outcomes under SHI and invoking international rights standards.

When looking at the **variation across countries and over time, these** findings show **context-sensitive and evolving policy advice instead of** rigid, one-size-fits-all approaches, which aligns with the findings of Stone (2004), and Gupta and Vegelin (2016), and contradicts the assumptions of uniform, benchmark-driven recommendations—particularly by the OECD (Mahon & McBride, 2009a; Heinrich, et al., 2021). Initially, both the WHO and OECD expressed paradigmatic preferences (e.g., general taxation over SHI) but shifted toward advice targeting the instrument level once the CEE countries made endogenous decisions to retain SHI systems. This shift underscores their role as epistemic actors rather than enforcers, facilitating incremental, negotiated reforms in line with national contexts and constraints (Deacon, 2007; Orenstein, 2008; Hanrieder 2015c).

The OECD's engagement in the CEE region was shaped by accession status and transition timelines: early members (e.g., Poland, Hungary, and the Czech Republic) received more directive advice, while countries like Latvia and Lithuania were offered more strategic, adaptable support. The WHO's engagement evolved from broad frameworks (1999–2001) to detailed, equity-focused advice in the post-2008 crisis period, particularly in the Baltics, consistent with Kaasch (2015). Its advice reflected equity and rights-based concerns (reflecting WHO's position on the Alma Ata Declaration and the Ljubljana Charter). The WHO emphasized public stewardship and progressive financing and cautioned against over-reliance on private insurance or high out-of-pocket payments, thus acting as a "moral compass" (Lee, 2008; Hanrieder, 2015c). The OECD functioned as an economic advisor, using fiscal tools and benchmarking to steer reforms towards efficiency, as previously mentioned in the literature (see Mahon & McBride, 2009a; Martens et al., 2021). The WB focused on technical improvements and system performance, especially in Latvia (see Radin, 2003; 2008; Ruger, 2005; Paloni & Zanardi, 2006). These roles align with literature on soft governance and strategic framing in global health policy (Kaasch, 2015; Kutzin et al., 2010a; Mahon & McBride, 2009a). Despite the differences across IOs in terms of their normative and philosophical orientations—WHO's rights-based approach vs. OECD's technocratic rationalism vs. WB's system

improvements—IOs converged on key goals, notably protecting vulnerable groups, improving purchasing, and enhancing efficiency.

In sum, IOs delivered differentiated but complementary advice across the four healthcare financing sub-dimensions, reflecting their institutional mandates and adapting to national political contexts. Their influence operated across all three policy levels—paradigmatic, instrument, and parameter—as theorized by Hall (1993). Rather than promoting uniform blueprints, IOs acted as flexible, knowledge-based actors advancing reform through negotiated and context-sensitive pathways—supporting broader scholarship on global social policy and health governance (Mahon & McBride, 2009a; Heinrich et al., 2021; Kutzin et al., 2010a).

With contributions C and D, the dissertation traces the **interactions between domestic actors and IOs** in healthcare financing reforms in Latvia from 1991 to 2019. First, the findings suggest that IOs were involved in the reforms of healthcare financing in Latvia, especially amongst and after the financial crisis of 2008/2009. Second, that interaction dynamic was almost exclusively shaped by domestic actors' initiative and agenda.[6]

In the early 1990s, healthcare reform in Latvia was domestically driven. Latvian doctors initiated the shift from the Soviet Semashko model to SHI, inspired by the pre-war healthcare system and Western European systems, especially Germany (see Kaminska et al., 2021). Contrary to the claims of a *policy vacuum* in the post-communist transition (e.g., Deacon et al., 1997:92), our findings confirm that paradigmatic change in healthcare financing emerged endogenously—in line with a number of other studies (see Marrée & Groenewegen, 1997; Lawson & Nemec, 2003; Radin, 2003; Sitek, 2008; Rechel & McKee, 2009; Roberts, 2009; Kutzin et al., 2010b), driven by aspirations of convergence with Western models (see Jacoby, 2004; Rechel & McKee, 2009) and horizontal exchanges with diaspora and international peers, similar to processes observed in Albania and Croatia (Druga, 2022; Malinar, 2022). In this period, the WHO and the WB were formally present in Latvia but not involved in healthcare financing reforms.

[6] This research found that political party affiliation of the Health Ministers and other actors had little impact on interactions with IOs, since Latvian domestic politics has been characterised by a short duration and high volatility of governments and coalitions. Additionally, there have been extremely high HM turnover, which significantly limited the ability to implement mid- and long-term strategic reforms (Müller et al., 2005; OECD, 2016). Therefore, it was not further examined in this dissertation.

The turning point was 1996, when the Latvian government formally invited the WB to support sectoral healthcare reforms, building on earlier cooperation. This finding is in conformity with other studies that suggest that prior cooperation in one policy field often leads to IOs spreading their activities to other policy domains (e.g., Mosley et al., 1995; Laurell & Arellano, 1996; Deacon et al., 1997; Aina et al., 2004; Batley, 2004; Paloni & Zanardi, 2006; Evans, 2009). This marked the beginning of IO involvement in Latvia, mirroring developments observed in other CEE countries (see Deacon et al., 1997; Cerami, 2005; Nemec & Kolisnichenko, 2006; Kaasch, 2015). The WB, having shifted its global focus to health systems (Noy, 2017; Tichenor & Sridhar, 2017), responded to Latvia's request by co-developing a reform project with local officials. Contrary to the conclusions of studies emphasizing IO-imposed conditionalities (see Dahl, 1957; Deacon et al., 1997; Cerami, 2005; Lukes, 2005; Paloni & Zanardi, 2006; Deacon, 2007; Brunswijck, 2019; Hadjiisky, 2021), the WB in Latvia supported a nationally defined agenda. Conditionalities were negotiated and were largely symbolic (i.e., *pro forma;* see Killick, 1998), serving more to frame the cooperation than to enforce compliance. Nevertheless, *pro forma conditionalities* still shaped the reform agenda by framing what was negotiable (see Yeates, 1999). During this period, the WB acted as a knowledge broker, not an agenda-setter. It facilitated horizontal learning and connected Latvian policymakers with international expertise (see also Rechel & McKee, 2009; Druga, 2022; Malinar, 2022). Functioning as part of an epistemic community (see Robertson, 1991; Haas, 1992*;* Killick, 1998; Orenstein, 2000; Larmour, 2002; Deacon et al., 2007), the WB promoted mutual learning, which confirms that policy ideas flow in multiple directions—not only from IOs to countries but also from national contexts back to IOs (see Kuhlmann et al., 2020). These findings highlight the WB's high reliance on soft governance and supporting—but not steering—Latvia's reform agenda between 1996 and 2002.

In 2002, despite the Bank's efforts to adapt its offer and continue the partnership, the newly elected Latvian government shelved the WB Project, which was a political decision similar to that observed in Croatia (see Malinar, 2022). Thus, the WB efforts to "stay in the game" were ultimately unsuccessful. However, the WB maintained a collaborative approach, engaging with Latvian policymakers and willing to act on their preferences, which echoes the WB's behaviour in other national contexts (see Noy, 2017, 2018; Wireko & Béland, 2017; Druga, 2022). Although formal involvement ended, the WB's indirect influence continued as previous recommendations and *pro forma* conditionalities

provided a frame for later reforms, a development also observed in other studies (see Robertson, 1991; Killick, 1998; Orenstein, 2000; Larmour, 2002; Deacon et al., 2007). This finding shows how soft governance tools can yield lasting effects even in the absence of formal cooperation.

The global financial crisis in 2008/2009 marked the renewal of IO engagement in healthcare financing policy in Latvia. At Latvia's request, the WB re-engaged, offering financial and technical assistance; it supported nationally developed policy responses upon mostly *pro forma* conditions, therefore lending legitimacy to politically sensitive reforms. The WB emphasized the importance of equity, particularly the need to protect vulnerable groups by ensuring access to essential healthcare. Additional focus was once again on efficiency and system-level tweaks and not on structural shifts. These actions support claims that the WB shapes policy debates through non-directive means by operating through soft governance (St. Clair, 2006; Weyland, 2006). In this period, the WHO also assumed a more prominent role, issuing technical assessments and advocating for public healthcare funding and universal coverage—marking a move toward paradigmatic-level engagement. This reflected a broader post-crisis trend of the WHO extending its focus to healthcare financing (Kaasch, 2015) and once more contesting prior claims of its diminished global influence (Hadjiisky, 2021).

Between 2011 and 2019, IO involvement increased, driven by domestic requests, particularly by HMs. Three IOs were engaged: the WHO, the OECD, and, unexpectedly, the OHCHR. IOs were mainly providing normative legitimacy amid political contestation. The WHO remained the most consistently engaged actor, offering technical expertise and equity-driven policy framing at the paradigmatic level, advocating for increased public spending and UHC (thus emphasising its global UHC agenda). The OECD was approached by Latvia in 2013 within the country's accession process and contributed through benchmarking and monitoring, rather than expressing direct advice on the domestic reform proposals, which was consistent with its established mode of operation (see Kaasch, 2015; Kaasch & Martens, 2015). Though rarely discussed in the academic literature, the OHCHR also played a role in the healthcare financing reforms in Latvia, as when the HM sought guidance on equity issues in the SHI proposal. The OHCHR emphasized the importance of non-discriminatory and rights-based access, highlighting the growing role of human rights in healthcare governance, a stance that fully

aligned with the IO's institutional focus and mandate (Hunt, 2007; Meier & Gostin, 2018).

By 2018, IO engagement declined as reform momentum was fading. While the WHO continued cooperating with HM under a shared agenda, the strategic use of IOs' resources by the HM lessened considering decreasing opposition to reforms—echoing the trends reported in the literature of IOs' involvement rising and falling as a function of domestic political contestation and reform momentum (White, 2020).

In conclusion, between 1991 and 2019, the engagement of IOs in Latvian healthcare financing reforms evolved over time in terms of its scope, the actors involved, and soft governance tools employed. The cooperation was initiated by domestic actors who strategically leveraged reform momentum, with IOs' roles adapting in response. While Latvia retained significant agency, IOs exerted influence through soft governance tools that were negotiated, responsive to local context, and aligned with domestic priorities. The WB functioned as a technical and financial partner; the WHO emerged as a normative leader promoting equity; the OECD contributed benchmarking and surveillance; and the OHCHR added a rights-based perspective. Their involvement intensified during periods of economic and financial challenges and political contestation when they served not only as technical advisors but also as sources of legitimacy. Overall, IOs' influence was dynamic and co-constituted, reflecting the interplay between external expertise and internal reform momentum. These findings resonate with Obinger et al.'s (2013) concept of *interdependent policymaking* which views IOs' influence as negotiated and mediated through local political dynamics.

The dissertation findings on the Latvian case study on the **evolving and negotiated nature of IOs' engagement** in Latvia directly challenge the prevailing assumption that countries in a potentially vulnerable position have little choice but to comply with IOs' directives (Mosley et al., 1995; Batley, 2004; Paloni & Zanardi, 2006; Tomson & Biermann, 2015). Contrary to portrayals of IOs as dominant external actors exerting influence through conditionality, technocratic authority, or normative persuasion (Finnemore & Sikkink, 1998; Woods, 2006; Mosley, 2003), the Latvian case reveals a more nuanced picture: domestic actors exercised substantial agency in shaping the terms, timing, and substance of IO involvement. These findings support research showing that domestic actors—even in structurally constrained settings—can reinterpret, resist, or strategically employ IOs' input to align with domestic reform goals (see Kpessa &

Béland, 2012; Asensio & Popic, 2019; Heinrich et al., 2021; Kaminska et al., 2021; Druga, 2022; Malinar, 2022; Foli, 2023).

HMs, in particular, strategically initiated, suspended, or reactivated IOs' engagement to match the preferences of shifting political coalitions and their reform agendas. The WB case in Latvia exemplifies this: it was invited to cooperate in 1996, sidelined when its proposals no longer aligned with national objectives, and re-engaged when no other actor could offer comparable support.

Latvian actors also instrumentalized IOs to legitimize contested reforms, enhance credibility, or mitigate opposition. This included "forum shopping" to seek endorsements from different IOs (the WHO, the OECD, and the OHCHR) and "cherry-picking" or selectively citing IOs' recommendations to signal international backing to the domestic public. Even when the domestic actors did not follow IOs guidance, they used the IOs' moral (WHO, OHCHR) or expert (OECD) authority to bolster reform legitimacy in domestic debates.

These findings build on research into weak state agency in global governance (Weyland, 2006; Wireko & Béland, 2017) and show that IOs served as political resources. Domestic actors used IOs' engagement strategically to manage opposition, frame reforms, and enhance their credibility. Cooperation with IOs was negotiated, conditional, and contingent on domestic utility, not externally imposed.

In sum, the Latvian case underscores that weak states are not passive recipients of international advice but strategic actors in global governance. They actively mobilize IOs' authority to advance internal goals, adjust reform narratives, and navigate complex political environments—demonstrating a broader repertoire of instrumentalizing tactics than previously acknowledged in the literature (see also Weyland, 2006; Bolkvadze, 2016; Eihmanis, 2018).

A partial answer to the research question on how Latvia responded to IOs' advice was already outlined above. Additionally, the **significant variation in the degree of the implementation of IOs policy recommendations** must be stressed here. The existing literature suggests that, based on their mandates, IOs often lack formal veto power and are thus unable to directly block national policy decisions (see Orenstein, 2008). The Latvian case highlights two other factors determining the extent of adoption of IOs' recommendations, namely the level of alignment of IOs' policy advice with domestic

priorities and the level of detail or specificity of the advice. As our findings show, IO advice was more likely to be adopted when it aligned with national preferences and offered concrete, actionable guidance (see Kelley & Simmons, 2015; Noy, 2017; Wireko & Béland, 2017; Bazbauers, 2018). Thus, the Latvian case challenges the notion that weak implementation is solely a result of IOs' limited authority, highlighting instead that their influence depends less on formal power and more on how strategically their advice aligns with national contexts.

The WB emerged as the most influential IO in terms of implementation. Its recommendations—focused on instrument and parameter levels—were highly specific, technically detailed, and aligned with Latvia's fiscal and administrative goals. Unlike its standard approaches in pensions and education policy (see Orenstein, 2008; Seitzer et al., 2023)—the WB's health financing advice in Latvia was context-sensitive, targeting pooling, purchasing, and efficiency. This finding aligns with research suggesting that WB does not promote a uniform approach to healthcare reform (see Weyland, 2006; Noy, 2017). Its guidance was politically feasible, steering clear of contentious financing models. While the WB had tools for hard conditionality, it relied instead on soft governance and symbolic pro forma conditions negotiated with domestic actors (Killick, 1998; Orenstein, 2008). This strategy fostered national ownership, facilitating reform adoption—similar to patterns observed by Druga (2022) and Malinar (2022). In key projects like the Healthcare Reform Project and SSNS, this alignment enabled negotiated implementation of reforms. These findings support the view that soft governance can help IOs build domestic support, foster a sense of national ownership, and ultimately, improve the effectiveness and success of loan programs (Killick, 1998; Orenstein, 2008; Bazbauers, 2018; Foli, 2023).

In contrast, the WHO and OECD were less successful in having their recommendations adopted in Latvia. Though grounded in robust normative frameworks and soft governance tools —like benchmarking, international comparisons, and discursive persuasion (Kaasch, 2015; Tallberg & Zürn, 2019)—their advice lacked operational clarity. This was especially the case for the WHO, which advocated for systemic reforms like higher public health spending or policy prioritization, thus operating mainly at the paradigmatic level. Without specific policy instruments, the proposals of the WHO and the OECD were more susceptible to political deflection, particularly in a context where broad consensus and political will were lacking. This was especially evident in the 2016 reform episode, when

IOs recommendations conflicted with national proposals and were ultimately disregarded (Contribution D). These findings indicate that IOs exert more influence when working at instrument and parameter levels—especially where major paradigm shifts are politically unviable.

In sum, this analysis reinforces a central finding of the dissertation: IO influence is shaped by the interaction of governance tools, policy levels, and domestic dynamics. The Latvian case exemplifies how weaker states can navigate and even instrumentalize IOs to pursue national objectives. These insights contribute to the GSP literature, emphasizing that IOs succeed not (only) through coercion, but (also) through context-sensitive, actionable engagement.

Additionally, the dissertation provides important insights into the role of IOs. The Latvian case shows that IOs are highly valued by domestic policymakers. As demonstrated in Contribution D, national actors often go to great lengths to secure IOs' approval for domestic reform proposals. These findings enrich the literature on global social policy and IOs' governance by revealing that IOs' influence depends not only on their institutional authority or soft governance but also on their receptiveness to the instrumentalization by domestic actors. In Latvia, IOs did not function as policy drivers but rather as sources of symbolic legitimacy, especially in politically sensitive reform contexts. Domestic actors selectively mobilized different forms of IOs' authority—expert (OECD), moral (WHO, OHCHR), or political— to support domestically pre-determined agendas, often seeking endorsement rather than advice. Crucially, IOs' limited enforcement and monitoring capacity made them susceptible to manipulation and strategic (mis)use. Their authority was invoked in public debates to legitimize decisions, signal international alignment, or neutralize domestic opposition—regardless of whether their substantive recommendations were implemented. IOs' authority thus became a resource to be "borrowed," particularly when reformers were already committed to specific solutions (Cortell & Davis, 1996; Boswell, 2009; Sending, 2015; Grittersova, 2017). This highlights the symbolic power of IOs in domestic politics: their value lay less in detailed policy input and more in the legitimacy their approval conferred. In Latvia, this symbolic endorsement often outweighed both financial incentives and ideational guidance. Based on these findings, the dissertation offers a more nuanced understanding of how IOs exercise authority in weak-state contexts and how that authority is both leveraged and constrained in domestic policymaking processes.

The dissertation findings underscore Latvia's agency in navigating IO relationships, strategically aligning international support with domestic priorities. Rather than being a passive recipient of external prescriptions, Latvia actively shaped the terms of engagement, selectively integrating IO expertise into nationally defined agendas. The findings challenge conventional narratives of one-directional IO influence, instead illustrating how even resource-constrained states can instrumentalize the resources, legitimacy, and knowledge that IOs offer—a dynamic explored in greater detail in later sections.

In response to the selective uptake or distortion of their recommendations, **IOs displayed notable strategic flexibility, adjusting their engagement to maintain access and relevance**—not only in Latvia but across CEE, as shown in Contributions A and B. Rather than withdrawing or issuing formal rebuttals, IOs opted for diplomatic persistence, favouring long-term influence over immediate compliance. As Larmour (2002:259) noted, IOs prefer subtle influence to overt control, often avoiding direct pressure on governments. Their power thus derives from soft governance, centred on persuasion (Béland & Orenstein, 2013). In the Latvian case, this was particularly evident in the WHO's approach. Even when its guidance on SHI between 2010 and 2019 was ignored or misrepresented, the WHO continued playing its advisory role without public rebuttal. This approach reflected its institutional mandate to support member states and its long-term vision for UHC globally (Klarner et al., 2008; Kaasch, 2011; 2015; Clift, 2013; Gostin et al., 2023). Its closed-door consultations allowed domestic actors to reframe or selectively apply its advice, exposing the potential weakness of soft governance. Yet, by remaining "at the table," the WHO underscored its institutional preference for ongoing engagement over loss of influence (see Finnemore & Sikkink, 1998; Tallberg & Zürn, 2019). The OECD, in contrast, was able to limit potential misinterpretation of its advice because it relied on public-facing publications like *Economic Surveys* and *Health at a Glance*. This enhanced transparency of the OECD's advisory activities and preserved the IO's credibility while still allowing for some national adaptation. Similarly, the WB resumed technical and financial support during the economic crisis, despite the earlier termination of its reform program. This re-engagement demonstrated its intent to maintain lending operations and in-country presence, consistent with patterns in Croatia, Albania, and the Pacific (Larmour, 2002; Druga, 2022; Malinar, 2022).

These cases reveal IOs' broader strategy of institutional pragmatism: reframing priorities, softening positions, and tolerating symbolic appropriation to preserve future influence. Their limited monitoring capacity and reliance on voluntary cooperation obviously left the IOs vulnerable to misuse of their resources and dependent on national receptivity for relevance and credibility. This supports the view of IOs as reactive rather than prescriptive actors—responding to domestic signals rather than enforcing fixed agendas. The Latvian case exemplifies mutual dependency: while states seek legitimacy and expertise, IOs need uptake and field relevance. This interplay aligns with the concept of institutional power equilibrium, arguing that IOs' influence is sustained through a balance of formal safeguards and informal diplomacy. Rather than reflecting unilateral power, IO–state relations are negotiated, contingent, and dynamic (Daßler et al., 2025).

The findings of this dissertation support the view that IOs are not static or monolithic but adaptive systems capable of learning. Consistent with Béland and Orenstein's (2013) ideational approach, which frames IOs as dynamic entities embedded in shifting institutional contexts, the evidence provided in this thesis shows that the WB adjusted its strategies in response to previous experiences and country-specific feedback. For instance, the WB's approach in Latvia, Albania, and Croatia (Druga, 2022; Malinar, 2022) diverged notably from its earlier interventions in Latin America (see Weyland, 2006; Pop-Eleches, 2008; Noy, 2017; 2018). Rather than imposing uniform policy models, the WB in Central and Eastern Europe adopted more flexible, context-sensitive strategies tailored to national reform priorities. This evolution suggests organizational learning from previous shortcomings, supporting the notion that IOs function as "open systems" (Béland & Orenstein, 2013:6), capable of refining their tools and discourse based on empirical feedback. These findings contribute to the literature by showing that IOs can act as learning-oriented actors, gradually developing their modes of influence to remain relevant and effective across diverse policy environments.

7. Conclusions

This dissertation, together with other recent findings from CEE countries, repositions weak countries as strategic actors in global social policy, showing how resource-constrained states like Latvia actively shape, reinterpret, and at times manipulate IOs' input to serve domestic goals. Through tactics such as forum shopping, cherry-picking, and selective misrepresentation, Latvia's behaviour towards IOs challenges the idea that

weak countries passively comply with IOs prescriptions. Indeed, this study reveals how weak states exploit institutional gaps in IOs' operations and highlights the fragility of IOs' authority, as organizations often tolerate misuse of their resources to maintain long-term access and influence. The country's ability to assert agency despite asymmetrical power relations compels a re-examination of assumptions about weak states' passivity vis-à-vis IOs. Rather than conforming to predictions of compliance, Latvia and other CEE states have demonstrated strategic behaviour that contradicts prevailing expectations in the literature. This suggests a theoretical shift is needed: from treating CEE countries as predictable recipients of international norms to viewing them as capable of strategic adaptation and resistance within global governance processes.

Another key contribution is the first systematic mapping of the WHO's and the OECD's healthcare financing advice in CEE across four sub-dimensions: revenue collection, pooling, purchasing, and coverage. This overview illustrates how IOs balance efficiency and equity, complicating simplified critiques of neoliberalism. Overall, the findings enrich the literature on GSP, post-socialist transitions, and international governance by demonstrating how domestic agency, IOs' flexibility, and institutional design interact to produce hybrid reform outcomes—offering a valuable framework for analysing state–IO relations more broadly.

While this dissertation is constrained by its single-country focus—Latvia—and its concentration on one policy domain—healthcare financing—its findings raise broader theoretical implications. The sector, although politically significant, may differ from other policy domains such as education, environmental policy, or labour market reform, limiting generalizability. Future research should explore whether similar IO–state interaction patterns occur in other sectors or weak-state settings, ideally through comparative studies in CEE or other regions like Latin America, Sub-Saharan Africa, or Southeast Asia. Further inquiry could also assess the effectiveness of IO recommendations beyond their symbolic or strategic utility.

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9. Appendixes

Appendix No 1

Overview of the dissertation contributions

	Contribution A	Contribution B	Contribution C	Contribution D
Title	**WHO's healthcare financing policy recommendations in CEE countries.**	**OECD's healthcare financing policy recommendations in CEE countries.**	**The role of international organizations in the healthcare financing reforms in Latvia.**	**Misusing international organizations' authoritative resources;** **The case of the Latvian healthcare financing reforms.**
Main findings	▪ WHO promoted incremental, context-sensitive reforms rather than paradigmatic shifts. ▪ WHO emphasized increased public spending, reduced out-of-pocket payments, and financial protection. ▪ WHO exercised influence through soft governance tools: normative framing, technical assistance, and epistemic authority. ▪ WHO advocated for equity and sustainability via frameworks like UHC, with pragmatic adaptations to national contexts.	▪ Early OECD advice supported paradigmatic reforms (shift to general taxation), later focusing on incremental adjustments. ▪ OECD consistently promoted evidence-based tools (e.g., DRGs, mixed payment models) and efficiency. ▪ OECD integrated equity considerations, particularly regarding vulnerable groups. ▪ OECD relied on soft governance tools: benchmarking, discourse framing, and policy monitoring.	▪ WB advice was widely implemented due to pro forma conditionality and alignment with national actors. ▪ WHO and OECD advice was often sidelined when misaligned with domestic preferences. ▪ IO influence hinged on alignment with national priorities and specificity of recommendations. ▪ Influence was mainly at the parameter level, while paradigmatic reforms remained domestically driven.	▪ Domestic actors used IOs authority (WHO, OECD, OHCHR) to advance political goals. ▪ Weak states instrumentalized IO legitimacy to pursue national agendas. ▪ IOs' were reluctance to withdraw, preferring long-term engagement over strict enforcement. ▪ Complex IO-country dynamics, challenging assumptions about passive policy transfer. ▪ Adds to debates on IO authority, compliance, and

	▪ The contribution highlighted WHO's flexible, norm-driven role in post-communist health governance.	▪ The contribution demonstrated the OECD's adaptive, pragmatic approach to healthcare financing in CEE.	▪ The contribution highlights how weak states assert agency in global policy processes.	domestic agency in weak states.
Data and methods	Document analysis (180)—content analysis using MaxQDA	Document analysis (118)—content analysis using MaxQDA	Document analysis (71) and expert interviews (25)—content analysis using MaxQDA	Document analysis (90) and expert interviews (17)—content analysis using MaxQDA
Author(s)	Stupele L.	Stupele L., Malinar A.	Stupele L., Kaminska Visser M. E.	Stupele L.
Publication status	In M. E. Kaminska (Ed.), *Post-1989 healthcare financing reforms in Central and Eastern Europe: The role of international organisations.* (forthcoming).	In M. E. Kaminska (Ed.), *Post-1989 healthcare financing reforms in Central and Eastern Europe: The role of international organisations.* (forthcoming).	In M. E. Kaminska (Ed.), *Post-1989 healthcare financing reforms in Central and Eastern Europe: The role of international organisations.* (forthcoming).	As of July 2025, it has a revise and resubmit status.

Appendix No 2

IOs policy advice by sub-dimension and level across CEE and Latvia

Sub-dimension/ IO	WHO	OECD	WB	OHCHR	Level(s) of Advice
Revenue Collection	Tax-based or hybrid models. Equity Spending targets	Fiscal sustainability, broader tax base, sin taxes	Efficiency of existing flows	–	Paradigm, Instrument, Parameter
Pooling	Single-payer preference. Reduce fragmentation	Reduce fragmentation	Single-payer preference; reduce fragmentation	–	Paradigm, Instrument
Purchasing	Strategic purchasing, DRGs, capitation, and pay for performance. Gatekeeping. Context-sensitive	Best practices (DRGs, mixed payments, pay-for-performance)	Hospital restructuring, efficiency	–	Instrument, Parameter
Coverage	UHC. Financial protection. Including vulnerable groups.	Limited packages, OOPP moderation, equity safeguards	Vulnerable group protection	Equal access, anti-discrimination	Paradigm, Instrument, Parameter

Appendix No 3

Summary of IOs' advice focus in Latvia's health financing

IO	Primary focus	Key recommendations	Policy level
WHO	Equity, public spending	Increase state funding	Paradigm
OECD	Efficiency benchmarks	Align with member-state averages	Paradigm, Instrumental
WB	System and purchasing optimization	DRG´s, hospital reforms	Instrumental, Parameter
OHCHR	UHC, equity, and human rights.	To keep equal, non-discriminatory access to healthcare services	Paradigm

Appendix No 4

Summary of similarities and differences in the WHO's and OECD's approaches to healthcare financing reforms in CEE countries

Dimension	Commonalities (WHO & OECD)	Differences
Approach to Reform	Rejected one-size-fits-all models; tailored advice to national contexts and evolving conditions	WHO: Rights-based, equity-focused; OECD: Technocratic, efficiency-oriented
Governance Style	Emphasized soft governance; favoured feasibility, negotiation, and incrementalism	WHO acted as a moral compass grounded in global declarations; OECD grounded in fiscal logic
Role of the State	Both underscored the state's role in ensuring equity, stewardship, and financial protection	WHO promoted strong public sector leadership; OECD balanced market tools with state safeguards (inclusive liberalism)
Policy Focus	Prioritized vulnerable populations and social inclusion across all financing sub-dimensions	WHO explicitly opposed SHI expansion; OECD pragmatically adapted to existing SHI systems
Reform Level & Scope	Focused on incremental, technical reforms over sweeping paradigmatic changes	WHO more paradigmatic in early stages; OECD emphasized instrumental and parameter-level reforms
Use of Evidence & Expertise	Relied on epistemic authority: data, monitoring, evaluation, and comparative analysis	WHO's guidance embedded in health system narratives; OECD embedded advice in macroeconomic analysis
Private Sector & Cost-sharing	Both recognized risks and benefits but emphasized regulation and protection for vulnerable groups	WHO cautious toward private insurance and out-of-pocket payments; OECD accepted both with regulatory safeguards
Flexibility & Adaptability	Both adjusted advice over time, showing responsiveness to country needs and contexts	OECD: Structured flexibility linked to accession status; WHO: Relational flexibility based on trust and crisis response

Appendix No 5

Outline of the core questions driving each contribution

Contribution	Research questions
Contribution A	▪ What were the WHO's healthcare financing policy recommendations to CEE countries during this period? ▪ Did WHO recommendations vary across countries and over time, or did they reflect a uniform, standardized approach to reform? ▪ At what level of policy—paradigmatic, instrumental, or parameters —are WHO recommendations primarily targeted?
Contribution B	▪ Do OECD healthcare financing recommendations in CEE reflect a commitment to "inclusive liberalism," or do they primarily promote market-oriented reforms? ▪ Do policy recommendations differ across national contexts and over time, or do they adhere to a standardized, one-size-fits-all approach? ▪ At what level of policy—paradigmatic, instrumental, or parameters —are the OECD recommendations primarily targeted?
Contribution C	▪ When and at whose initiative did cooperation between Latvian stakeholders and IOs materialize? ▪ Which healthcare financing dimensions (see Kutzin et al. 2010) did IOs address? ▪ Did IOs exert influence on the policy process? ▪ Which policy level (paradigm, instrument, or parameter, see Hall 1993) did their recommendations target? ▪ Did IOs promote SHI in Latvia, and how committed were they to neoliberal approaches? ▪ How aligned were their recommendations with domestic ideas on reform, and did IOs use coercion to enforce changes?
Contribution D	▪ How did domestic actors exploit the authoritative resources of IOs? ▪ How did IOs respond to the actions of these domestic actors?

Appendix No 6

Interviews conducted

No.	Name of the interviewee	Position (as of end of 2019)	Interview data
1.	Ingrīda Circene (MD)	Minister of Health (April 2003 – March 2004, October 2011 – July 2014), Member of Parliament, external advisor to the Prime Minister in health questions.	June 10, 2019. Face-to-face interview, Rīga, Latvia.
2.	Ģirts Briģis (MD)	Professor and Head of the Department of Public Health and Epidemiology, Faculty of Public Health and Welfare, Rīga Stradins University. Co-author of HiT reports, co-author of publications about Latvian healthcare system.	June 10, 2019. Face-to-face interview, Rīga, Latvia.
3.	Viesturs Boka (MD)	Former Head of the Latvian Medical Association (1999-2006), Vice president of the Latvian Medical Association (2006-2010), former Parliament member (1995-1998), professor at University of Latvia and surgeon at Rīga Eastern Clinical University Hospital.	June 11, 2019. Face-to-face interview, Rīga, Latvia.
4.	Dzintars Mozgis (MD)	Deputy Director for Prevention and Public Health, Centre for Diseases Prevention and Control, Associate Professor at Rīga Stradins University, Department of Public Health and Epidemiology, Member of Board of Latvian Medical Association.	June 11, 2019. Face-to-face interview, Rīga, Latvia.
5.	Kārlis Ketners	Professor at BA School of Business and Finance, former State Secretary at the Ministry of Health.	June 13, 2019. Face-to-face interview, Rīga, Latvia.
6.	Egita Pole	Head of the Latvian Blood Donor Centre, former head of Communications office at the Ministry of Health.	June 13, 2019. Face-to-face interview, Rīga, Latvia.
7.	Zita Altenburga	Head of the Department of Finance at the National Health Service. She was directly involved in organizing the First Latvian Medical Congress.	June 14, 2019. Face-to-face interview, Rīga, Latvia.
8.	Iveta Gavare	Head of Centre for Disease Prevention and Control.	June 17, 2019. Face-to-face interview, Rīga, Latvia.
9.	Ilona Liskova	Deputy Director at the Centre for Disease Prevention and Control.	June 17, 2019.

			Face-to-face interview, Rīga, Latvia.
10.	Indra Dreika	The Head of the Health Inspectorate, was directly involved in developing the idea of sickness funds under the research institute in Stradins Hospital.	June 17, 2019. Face-to-face interview, Rīga, Latvia.
11.	Ēriks Miķītis (MD)	Former (for a long time) Head of the Health Department in Ministry of Health.	June 17, 2019. Face-to-face interview, Rīga, Latvia.
12.	Andris Glāzītis	Former Head of the Rīga Sickness Fund.	June 18, 2019. Face to face interview, Rīga, Latvia.
13.	Pēteris Apinis (MD)	Head of Latvian Medical Association (1991–1992, 2006–2018), Minister of Health (February–December 1995) and Member of Parliament (6th and 7th Saeima), External advisor to the Prime Minister (2009–2010).	June 18, 2019. Face-to-face interview, Rīga, Latvia.
14.	Ivars Krastiņš (MD)	The first President of newly established Latvian Medical Association, Member of Parliament (1990-1993).	June 19, 2019. Face-to-face interview, Liepāja, Latvia.
15.	Rinalds Muciņš	Former Minister of Health (March 2004 – December 2004), former State Secretary at the Ministry of Health.	June 20, 2019. Face-to-face interview, Rīga, Latvia.
16.	Daiga Behmane	Head of Latvian Health Economic Centre, co-author of 2019 HiT reports.	June 20, 2019. Face-to-face interview, Rīga, Latvia.
17.	Inga Kalviša	Former state employee in the healthcare sector, participant in the study visits in Germany	June 21, 2019. Email correspondence.
18.	Māris Taube (MD)	The former head of NHS, co-author of WHO HiT reports and the publication “Can people afford to pay for healthcare?; Latvia”.	June 25, 2019. Face-to-face interview, Rīga, Latvia.
19.	Ināra Bluķe	Former head of National Sickness Fund, Board member of the Children Clinical University Hospital.	June 25, 2019. Face-to-face interview, Rīga, Latvia.

20.	Laila Ruškule	Coordinator at the Ministry of Welfare of WB project in 1998.	June 27, 2019. Face-to-face interview, Rīga, Latvia.
21.	Imants Rezebergs	Former State Secretary of Ministry of Health during the time of WB and PHARE projects.	September 2, 2019. Online interview.
22.	Aigars Miezītis	National expert in PHARE project from 1997-1999, Current board member of Latvian Health Economic Centre.	September 4, 2019. Phone interview.
23.	Otmar Kloiber (MD)	Foreign relations advisor to the German Medical Association (1991 – 1997) Secretary of the German Medical Association (1997 – 2002), Deputy Secretary-General of the German Medical Association (2002 – 2005), Secretary-General of the World Medical Association (since 2005).	September 16, 2019. Phone interview.
24.	Giada Scarpetti	Research fellow at Department of Healthcare Management at Technical University of Berlin, Co-author of Latvia HiT report 2019.	September 19, 2019. Face-to-face interview, Berlin, Germany.
25.	Wilm Quentin	Senior research fellow at the Department of Health Care Management at the Technical University of Berlin, Co-author of Latvia HiT report 2012.	September 19, 2019. Face-to-face interview, Berlin, Germany.
26.	Toomas Palu	Adviser, Global Coordination at World Bank Group, Team leader for the World Bank "Project Appraisal Document on a proposed adaptable program lending (loan) in the amount of US$ 12.0 million equivalents to the Republic of Latvia for a health reform project, October 14, 1998".	September 20, 2019. Online interview.
27.	Aiga Rūrāne	Head of the WHO Euro Country Office in Latvia, 1995–2019.	September 24, 2019. Online interview.
28.	Andris Bērziņš	Prime Minister (2000-2002), Minister of Welfare (1994-1995), Head of the Rīga City Council (1997-2000).	September 30, 2019. Face-to-face interview, Rīga, Latvia.

29.	Vineta Fortiņa	Administrative manager of WB project 1998 “Project Appraisal Document on a proposed adaptable program lending (loan) in the amount of US$ 12.0 million equivalents to the Republic of Latvia for a health reform project, October 14, 1998”.	September 30, 2019. Face-to-face interview, Rīga, Latvia.
30.	Vladimirs Strazdiņš (MD)	Member of the Latvian Medical Association, author of the first healthcare financing reform proposal in 1989.	October 1, 2019. Face-to-face interview, Jūrmala, Latvia.
31.	Normunds Zemvaldis	State Health Minister under the Ministry of Welfare (1993-1995).	October 2, 2019. Face-to-face interview, Rīga, Latvia.
32.	Inga Milašēvica	Head of National Health Service of Latvia (2017-2019), worked in State Sickness Fund Union in the early 1990s.	October 3, 2019. Face-to-face interview, Rīga, Latvia.
33.	Pēteris Apinis (MD)	Head of Latvian Medical Association (1991–1992, 2006–2018), Minister of Health (February–December 1995) and Member of Parliament (6th and 7th Saeima), External advisor to the Prime Minister (2009–2010).	October 07, 2019. Face-to-face interview, Rīga, Latvia.
34.	Viktors Jaksons	State Health Minister under the Ministry of Welfare (1997-1998)	October 8, 2019. Face to face interview, Rīga, Latvia.
35.	Imants Bočkāns	Head of the State Sickness Fund Union in early/mid 1990s.	October 9, 2019. Face to face interview, Madona, Latvia.
36.	Artis Stuburs	Head of Madona Hospital, Co-author of HiT report 2008, Head of Regional Office of national Insurance Agency (1998-2005).	October 9, 2019. Face to face interview, Madona, Latvia.
37.	Vladimirs Makarovs and Maija Poršņava	Minister of Welfare (1995-1999), Minister of Economy (1999-2000), Minister of Environment and Regional Development (2000-2002). State Secretary of the Ministry of Welfare (early 1990s - 2002).	October 15, 2019. Face-to-face interview, Saulkrasti, Latvia.
38.	Renāte Pupele	Former Deputy Director of the Rīga Sickness Fund.	October 15, 2019. Face to face interview,

			Saulkrasti, Latvia.
39.	Sybille Angele	Former representative of German counterparts involved in development projects in Baltic countries during the 1990s.	October 22, 2019. Phone interview.
40.	Jānis Meikšāns (MD)	CEO of Teva Pharmaceuticals Ltd in Hungary, Former member of the Latvian Medical Association, co-author of the first reform proposal in 1989.	November 11, 2019. Online interview.
41.	Uldis Mitenbergs	Head of the WHO Country Office in Latvia, former WHO consultant.	January 10, 2020. Online interview.
42.	Jānis Meikšāns (MD)	CEO of Teva Pharmaceuticals Ltd in Hungary, Former member of the Latvian Medical Association, co-author of the first reform proposal in 1989.	January 13, 2020. Online interview.
43.	Vladimirs Strazdiņš (MD)	Member of the Latvian Medical Association, author of the first healthcare financing reform proposal in 1989.	January 22, 2020. Phone interview.
44.	Kristīne Kļaviņa	Head of the Human Resources Development Department at the Ministry of Health.	March 4, 2020. Online interview.
45.	OECD representative	Requested anonymity.	April 3, 2020. Online interview.
	Andreas Crusius	President of the Mecklenburg-Western Pomerania Medical Association.	May 26, 2020. Phone interview.
46.	Uldis Līkops	Former State Secretary at the Ministry of Health.	June 8, 2020. Phone interview.
47.	Dzintars Mozgis (MD)	Deputy Director for Prevention and Public Health, Centre for Diseases Prevention and Control, Associate Professor at Rīga Stradins University, Department of Public Health and Epidemiology, Member of Board of Latvian Medical Association.	June 29, 2020. Online interview.
48.	OECD representative	Requested anonymity.	October 9, 2020. Online interview.
49.	Pēteris Apinis (MD)	Head of Latvian Medical Association (1991–1992, 2006–2018), Minister of Health (February–December 1995) and Member of	July 21, 2020. Online interview.

		Parliament (6th and 7th Saeima), External advisor to the Prime Minister (2009–2010).	
50.	Uldis Rutkaste	The Latvian Bank representative.	August 25, 2020. Online interview.
51.	Ilze Aizsilniece (MD)	Head of the Latvian Medical Association (since 2018), General Practitioner, Lecturer at University of Latvia.	August 27, 2020. Online interview.
52.	Kārlis Ketners	Assistant Professor of BA School of Business and Finance, former State Secretary at Ministry of Health, former Director of Budget Policy Development Department at Ministry of Finance.	September 3, 2020. Online interview.
53.	Liene Cipule	Parliamentary Secretary at the Ministry of Health (2011–2013).	September 4, 2020. Online interview.
54.	Anda Čakša	Minister of Health (June 2016 – January 2019).	September 4, 2020. Online interview.
55.	Rinalds Muciņš	Former Minister of Health (March 2004 – December 2004), former State Secretary at the Ministry of Health.	September 7, 2020. Online interview.
56.	Māris Pūķis	Representative of Union of the Municipalities.	September 11, 2020. Online interview.
57.	Ilze Viņķele	Minister of Health (since 2019), Member of the Parliament (2014–2017), Minister of Welfare (2011–2014), Parliamentary Secretary at the Ministry of Finance (2010–2011).	September 15, 2020. Online interview.
58.	WHO Europe Barcelona Office representative	Requested anonymity.	September 25, 2020. Online interview.

Part II: Contribution manuscripts

Contribution A: World Health Organization's Healthcare Financing Policy recommendations in CEE Countries

Liva Stupele

1. Introduction

This chapter presents an in-depth analysis of the healthcare financing policy advice provided by the World Health Organization (WHO) to Central and Eastern European (CEE) countries[7] between 1989 and 2019. Moreover, it lays the foundation for further exploration into whether and how WHO shaped healthcare financing policymaking in the region, which is provided in chapter XX focusing on the role of International Organizations (IOs) in healthcare reforms in post-communist Latvia.

Founded in 1948, WHO is the United Nations' (UN) specialized agency for health, tasked with advancing global health by setting standards, formulating policy frameworks, and assisting its 194 member states in designing health policies through coordinated international efforts and strategic guidance (Klarner et al., 2008; Kaasch, 2011; 2015; Clift, 2013; Gostin et al., 2023; S28; S29). In its Constitution, health is defined as *"a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity"* (S29). Organisation's activities include a broad spectrum—from surveillance and response to infectious diseases, to normative guidance, standard-setting, and policy advice on health systems (Klarner et al., 2008; Clift, 2013; Hanrieder, 2014; 2015a; Gostin et al., 2023).

Despite the rise of other global health actors — such as the World Bank (WB), the Organisation for Economic Co-operation and Development (OECD), and philanthropic foundations — the WHO remains a central player in global health governance and is often referred to as the world's "Ministry of Health" (Deacon, 2007; Ervik et al., 2009; Kickbusch & Szabo, 2014; Hanrieder, 2015a; 2015b). Rather than enforcing binding decisions, it influences national policy through epistemic authority, policy diffusion, and technical assistance (Hanrieder, 2015a; Kaasch, 2011). The WHO provides countries with

[7] The Central and Eastern European countries in this contribution are: Albania, Bosnia & Herzegovina, Bulgaria, Croatia, Estonia, Estonia, Hungary, Kosovo, Latvia, Lithuania, Montenegro, North Macedonia, Poland, Romania, Serbia, Slovakia, Slovenia, and the Czech Republic.

strategic advice grounded in globally recognized frameworks and often underpinned by evidence-based tools (Kutzin, 2013).

Although some CEE countries joined the WHO soon after it was founded, the WHO's engagement in the region was limited during the Cold War, particularly after the temporary withdrawal of the Soviet Union and its satellite states[8] (Brown et al., 2006; Clift, 2013). Following the collapse of communism, a new era of active involvement began, as post-Soviet and post-Yugoslav states joined or re-engaged with WHO to access policy guidance, technical expertise, and global networks essential for rebuilding their health systems (Jakab & Kutzin, 2009; Rechel et al., 2014). This renewed engagement aligned with broader efforts of CEE countries to integrate into Western institutions (Rechel & McKee, 2009a; 2009b; Kutzin, et al., 2010; Kaasch, 2015).

During this period, most CEE countries transitioned from tax-based healthcare systems to social health insurance (SHI) systems, with diverse institutional settings (Kutzin, et al., 2010; Wendt et al., 2013; Kaminska et al., 2021), although reform trajectories varied significantly. Post-Yugoslav states faced particularly fragmented paths shaped by conflict, decentralization, and instability, ultimately adopting hybrid financing models (Bredenkamp & Gragnolati, 2007; Stambolieva, 2011; Zec & Radonjić, 2012; Rechel et al., 2013; Jerčić, 2022). These transitions occurred under conditions of economic fragility and limited institutional capacity, increasing these countries' receptiveness to external assistance. As literature on international influence suggests, states in a vulnerable position are more exposed to external pressures, such as IOs' conditions and advice (Finnemore & Sikkink, 1998; Mosley, 2003; Woods, 2006; Kentikelenis & Seabrooke, 2017; Corbett et al., 2018).

There is no scholarly consensus on the extent of WHO's influence on healthcare financing in the region. Some argue that WHO initially focused more on primary care and communicable diseases than on financing systems, which limited its policy impact compared to actors with greater financial leverage, such as the WB and the International Monetary Fund (IMF) (Deacon & Hulse, 1997; Delnoij et al., 2003; Jakab & Kutzin, 2009; Thomson & Mossialos, 2009; Kutzin et al., 2010). Others contend that WHO's normative leadership and technical advice shaped reform strategies and policy discourse in the region, with its principles integrated into national strategies and contributing to

[8] Bulgaria, Romania, Albania, Poland, Czechoslovakia and Hungary (Cueto, et al., 2019).

broader health policy transformation (Jakab & Kutzin, 2009; Kutzin et al., 2010; Rechel et al., 2014).

This chapter addresses that debate by examining the content of WHO's healthcare financing recommendations, and together with chapter xx, researches WHO's role—as the central authority in global health governance—in shaping healthcare financing policies within CEE countries over three critical decades spanning from the post-communist transition beginning in 1989 to the onset of the COVID-19 pandemic in 2019. Drawing on primary WHO documents, the chapter evaluates the nature and scope of WHO's advice. The conceptual framework underpinning this chapter draws on the theoretical foundations presented in the introduction to this volume, particularly the frameworks proposed by Kutzin et al. (2010) and Hall (1993). Kutzin and colleagues identify four sub-dimensions of healthcare financing: **revenue collection**, **pooling**, **purchasing**, and **coverage (see Kutzin et al. 2010)**. Meanwhile, Hall's (1993) framework offers a conceptual framework for policy change, distinguishing among its three levels: **paradigmatic** (overarching policy ideas), **instrumental** (policy tools), and **parameter** (settings). The present chapter applies these frameworks to evaluate whether WHO's recommendations focused on the paradigmatic level (thus addressing whether the healthcare system should rely on general taxation or SHI as a financing model) or focused on instruments and parameters (e.g., the structure of funding, single vs. multiple funds, or contribution levels).

Guided by the framework specified above, the chapter addresses three central questions:

1) What were the WHO's healthcare financing policy recommendations to CEE countries during this period?
2) Did WHO recommendations vary across countries and over time, or did they reflect a uniform, standardized approach to reform?
3) At what level of policy—paradigmatic, instrumental, or parameters —are WHO recommendations primarily targeted?

The study draws on an original dataset constructed from the WHO Regional Office for Europe (WHO Europe) online document repository, using targeted keyword searches (e.g., *healthcare financing*, *health and finance*, *spending and health*, *funding and health*, *health policy*, alongside country names). The data set includes diverse publication types, such as Health System Reviews (HiTs), Health Policy Papers, Country Cooperation

Strategies, and technical briefings. Documents containing only statistical data (e.g., *World Health Statistics*) or explicitly disclaiming authorship by the WHO were excluded. For example, some WHO/Europe reports carry a disclaimer stating that the views expressed do not necessarily reflect WHO's official stance (e.g., *The European Health Report* series). After exclusions, the final dataset comprises 180 documents, including 76 Highlights on Health and Health Care Systems in Transition publication series, 47 country specific publications, 13 country bilateral cooperation agreements, 4 research publications, 5 meeting and conference notes, and 35 grey literature and background information sources. For a full list of analysed documents, see Appendix No 3.

Documents were analysed using qualitative content analysis, supported by MAXQDA software. The coding structure was developed deductively based on Kutzin et al.'s (2010) four sub-dimensions of healthcare financing. In addition, a fifth category was added to capture WHO's general conceptual framework and policy ideas (e.g., references to universal health coverage, fiscal sustainability, or public-private partnerships).

The chapter is structured as follows: the next section offers a literature review on the soft governance instruments the WHO can rely on to influence policymaking, as well as WHO's approach to healthcare systems (including healthcare financing). The subsequent sections (3.1–3.4) present the empirical findings on WHO's advice to CEE countries across the four financing sub-dimensions. The final section discusses the findings in light of the broader literature and offers conclusions.

2. The role of the WHO in global healthcare policy

At its founding, the WHO was the sole global authority in health(care) policy, leveraging its expertise and dominant position. While its role was challenged as other actors emerged over time, the WHO remains a central IO in global health governance alongside governmental, non-governmental, and trans-governmental entities (Ervik et al., 2009; Kickbusch & Szabo, 2014). It retains unique authority as the *"centre of the arena"* with universal membership and health-specific mandate (Kickbusch & Szabo, 2014:2; Frenk & Moon, 2013; Van Belle et al., 2018; Gostin et al., 2023). The WHO is the largest (by the number of employees) international health organization, with its "*very unique and federal type of administrative structure"* (Hanrieder, 2015a:2). It is structured into three

administrative layers: headquarters (HQ) in Geneva, six regional offices[9], and nearly 150 country offices (Hanrieder, 2015c; S20). The WHO Europe oversees 53 member states, with 30 country offices (S10) (including in Croatia, Chapter xx, and Latvia, Chapter xx) and eight technical centres (S35). Notably, the WHO Barcelona Office for Health Systems Financing (S11) plays a key role supporting countries regarding sustainable healthcare financing system.

As a multi-layered system, the WHO's decisions ultimately rest with its member states. The World Health Assembly (WHA) serves as the supreme governing body, where representatives from all WHO member countries meet regularly, and each state has one vote to balance the power relation between countries. The Director General (DG) is elected by the WHA for a five-year term (Klarner et al., 2008; Hanrieder, 2015a). The WHO Executive Board is a technocratic body producing recommendations, guidelines, and advice (Kickbusch, 2016; Gostin et al., 2023). At the regional level, Regional Committees (RC) comprise health ministers and high-level officials who vote on proposals from regional Executive Boards and expert committees. Regional Directors (RD), elected by member states, lead regional offices (Hanrieder, 2015c; Kickbusch, 2016) which implement WHO global policies while also developing region-specific programs and initiatives (Klarner et al., 2008). Lacking financial and operational resources for research, disease surveillance, and public health assistance, the WHO relies on coordination, advocacy, and mobilization to achieve its goals (Abbot et al., 2015; Hanrieder, 2015a). Although the positioned as a neutral, technocratic entity, the WHO is also seen in the literature as inherently political, as its policies and regulations are shaped by member states (Kaasch, 2009; Clift, 2013; Kickbusch, 2013; Bennett et at., 2015).

2.1.WHO's governance instruments and dissemination channels

Like the OECD (see Chapter xx), the WHO relies exclusively on soft-governance mechanisms[10] and its non-coercive influence is explicitly defined in its Constitution[11]

[9] Eastern Mediterranean, the West Pacific, the Southeast Asian, the European, the African and the American.

[10] While the WHO has issued legally binding conventions in other areas, these fall outside the scope of this book: the WHO has issued instruments of law (conventions or regulations) that are in some cases are legally binding for the member states, such as, the Framework Convention on Tobacco Control (2003), the International Health Regulations (2005) and Pandemic Influenza Preparedness Framework (2011) (Hein & Kickbusch, 2010; Kickbusch, 2013; Kickbusch & Szabo, 2014; Nikogosian & Kickbusch, 2016).

[11] WHO's Constitution defines its core functions: (1) leading and coordinating global health; (2) shaping research and knowledge dissemination; (3) setting norms and standards; (4) promoting ethical, evidence-

(Kaasch, 2007; 2009; 2015; Hanrieder, 2015a). Consequently, it lacks financial or legal enforcement power over member states and instead influences global health policy through recommendations, guidelines, and agenda-setting (Kaasch, 2007; 2009; 2015; Hanrieder, 2015a). It can only advocate, suggest and persuade countries and stakeholders to follow its guidance. Its power lies in two key functions: shaping international health discourse and setting global norms (Barnett & Finnemore, 2012). To maintain flexibility, WHO often avoids formal consent procedures with member states, preferring non-coercive governance tools to "stay below the radar" to be able to steer discussion in the preferred direction and avoid a formal consent procedure with the member states (Abbott et al., 2015; Hanrieder, 2015a). Despite lacking enforcement power, some WHO initiatives—such as the *Essential Medicines List* (1977) and *the Ljubljana Charter* (1996) (S7)—have had significant policy influence, resembling soft law (Kaasch, 2007; 2009; Clift, 2013).

By operating between policy and academic domains, the WHO both defines problems and provides solutions (Kaasch, 2009; Barnett & Finnemore, 2012; Clift, 2013). The WHO's regulatory influence on international health discourse derives from its normative work—drafting non-binding conventions, charters, global strategies, recommendations, and guidelines to set global health standards. These help shaping global discourse, framing issues, setting agendas, and aligning actors on goals and norms, as well as offering solutions and guiding policies in line with best practices (Ervik et al., 2009; Kaasch, 2007; 2009; 2015, 2021; Clift, 2013; Gostin & Sridhar, 2014; Kickbusch & Szabo, 2014; Hanrieder, 2015b; 2015c; Gostin et al., 2023).

Beyond policymaking, the WHO also serves as a platform for global health discussions, bringing together national policymakers, researchers, other IOs, NGOs, and private donors (Saltman & Ferroussier-Davis, 2000; Kaasch, 2007; 2009; Frenk & Moon, 2013; Kickbusch, 2013; Kickbusch & Szabo, 2014; Hanrieder, 2015a; Meier et al., 2020; Gostin et al., 2023). Its perceived neutrality and technical expertise, with low politicization and high neutrality, bolster its influence, as most of its staff are medical professionals (Ervik et al., 2009; Hanrieder, 2014; 2015a).

based policies; (5) providing technical support, and (6) monitoring health trends (Kaasch, 2007; 2009; Clift, 2013; Kickbusch & Szabo, 2014).

The WHO disseminates its policies through multiple channels. At the country level, WHO offices work directly with national health ministries, facilitating policy formulation, technical assistance, and knowledge sharing, in the form of workshops, study tours and meetings (Ervik et al., 2009; Hanrieder, 2015a). At regional and global levels, WHO organizes ministerial meetings, international conferences, and (technical) seminars/workshops to engage policymakers and experts (Kaasch, 2011). The most prestigious gatherings at the global level are the World Health Assembly and Regional Committee that provide forums for discussing WHO's models, which can lead to the adoption of conventions, charters, or policy frameworks (Ervik et al., 2009; Kaasch, 2015).

The WHO also disseminates knowledge through publications. Kaasch (2007; 2009; 2015) identifies two main types: theoretical reports, such as the annual *World Health Report* and the *European Health Report*, which share reform models and policy ideas; and analytical reports, such as the *Health Care Systems in Transition* (HiT) (S3) series published by the European Observatory on Healthcare Systems and Policies[12] (Observatory), which assess national healthcare systems and offer policy recommendations.

Moreover, the WHO monitors healthcare systems by developing models, indicators, and the world's largest health-related database (S16), covering over 190 countries (Clift, 2013; Hanrieder, 2015a; Hejdukova & Kureková, 2016; Van Belle et al., 2018). The database provides tools and methodological support to help countries assess their systems using standardized metrics for comparability. It includes indicators on healthcare coverage, disparities in health outcomes, healthcare spending and many other relevant metrics. Also, the *National Health Accounts (S25)* initiative tracks healthcare financing indicators to support states in developing effective healthcare financing systems. By structuring and interpreting this data, WHO shapes perceptions of how healthcare systems should function (Kaasch, 2011; 2015).

Additionally, WHO fosters global and regional networks that connect policymakers, researchers, national and international medical associations, global and local NGOs, and

[12] That is a partnership between 18 institutions (as of 2025): WHO Europe; the European Commission, the governmental agencies of several European states (namely Austria, Belgium, Finland, Ireland, Norway, Slovenia, Spain, Sweden, Switzerland, United Kingdom, France), the Veneto Region in Italy, the Health Foundation, the London School of Economics and Political Science and the London School of Hygiene and Tropical Medicine (European Observatory on Health Care Systems and Policies (S2).

civil society actors (Kickbusch & Szabo, 2014; Van Belle et al., 2018). Some networks, such as the South-Eastern Europe Health Network (SEEHN) (S12) with six CEE member countries (S12), promote healthcare financing reforms. However, Kaasch notes, that in healthcare systems, the WHO networks have not been a particularly successful (Kaasch, 2011). Lastly, WHO also shares information via websites, newsletters (e.g., *Euro-Health*) (S26), policy briefs, and social media (Kaasch, 2009; 2011).

2.2. WHO's (global) approach to healthcare financing

WHO's work on healthcare financing policies falls within its broader efforts to strengthen healthcare systems. Since the late 1970s, WHO has framed health as a fundamental human right and a tool for social justice (Ervik et al., 2009; Kaasch, 2009; 2015; Clift, 2013). Its conceptual framework is shaped by several milestones that guide WHO's global and regional healthcare strategies: the *Alma Ata Declaration* (1978), the *Health for All* strategy (1981) and its updates, the UN General Assembly Resolution on *Global Health and Foreign Policy* (2012), and the *World Health Report* (2000) (Kaasch, 2011; 2015). The *Alma Ata Declaration* (1978) (S31) introduces primary healthcare (PHC) as the foundation of healthcare systems, shifting focus from hospital-based case to community care (Ervik et al., 2009; Clift, 2013; Beaudevin et al., 2020). Secondly, it emphasizes the importance of public spending and places the responsibility for healthcare organization on governments through the provision of adequate health and social measures (Hanrieder, 2016; Kaasch, 2009; 2015; Lee & Goodman, 2002). The *Global Strategy for Health for All by the Year 2000* (1981) (S32) and its updated versions set goals for universal availability, accessibility, acceptability, and quality of healthcare (Ervik et al., 2009; Kaasch, 2009; Clift, 2013). The *World Health Report* (2000) defined four core healthcare system functions: service provision, resource generation (raising and pooling revenues), financing (paying providers) and stewardship, alongside performance indicators (Delnoij et al., 2003; Kaasch, 2007; 2011; 2015). Following criticism of its global healthcare system ranking, WHO now encourages countries to assess their own systems using this framework and methodology (Kaasch, 2007; 2009).

Central to WHO's approach is the concept of universal health coverage (UHC) which the WHO defines as ensuring access the needed quality healthcare for everyone, when and

where they need it, without financial hardship[13] (see Kaasch, 2011; 2015; Yerramilli et al., 2018). [14] In 2012, WHO members states committed to UHC, with the WHO expressing its support for strengthening national healthcare systems achieve this goal (Delnoij et al., 2003; Ervik et al., 2009; Clift, 2013). In its work, the WHO advocates for strong state involvement to carry the responsibility for the overall performance of a country's healthcare system, to prevent excessive privatization and ensure equitable access (Ervik et al., 2009; Kaasch, 2009; 2011; 2015; Clift, 2013; Hejdukova & Kurekova, 2016).

The WHO's healthcare financing policy provides guiding principles rather than prescribing uniform solutions. These guiding principles address the four-healthcare financing sub-dimensions. For **the revenue collection** sub-dimension, the WHO favours public over private financing but does not prioritize one public model (e.g., SHI vs. general taxation) over another. Its publications often discuss the advantages and disadvantages of different approaches and strategies. The WHO focuses on prepayment mechanisms versus out-of-pocket payments, emphasizing access and contribution fairness (Delnoij et al., 2003; Ervik et al., 2009; Hejdukova & Kurekova, 2016; Kaasch, 2009; 2011; 2015). The *Ljubljana Charter* (1996) (S7) underlines that healthcare systems need to provide healthcare to all citizens sustainably, with emphasis on solidarity and risk pooling (Delnoij et al., 2003; Ervik et al., 2009). While the WHO discourages co-payments, user fees and out-of-pocket payments (OOPPs), it recognizes that completely abolishing user fees or co-payments without an alternative source of revenue is not an option for governments (Kaasch, 2011; 2015). It also opposes private insurance with risk-based premiums as contrary to social solidarity (Delnoij et al., 2003). In the **pooling** sub-dimension, the WHO emphasizes the role of the state as a key stakeholder (Ervik et al., 2009; Hejdukova & Kurekova, 2016; Kaasch, 2015). It advocates for a comprehensive redistributive system with centralized risk pools but does not mandate a single national taxation model. In decentralized systems, it recommends cross-subsidization or blending insurance with government funding. WHO's work on pooling, similar to other sub-dimensions, primarily provides empirical evidence from member countries to assess

[13] This includes a full range of essential services, from health promotion and prevention to treatment, rehabilitation, and palliative care (S18).

[14] Following the 2008/2009 global financial crisis, WHO intensified its efforts to strengthen healthcare systems. Since 2010, it has focused on UHC, developed in collaboration with the Bill & Melinda Gates Foundation, the International Labour Organization (ILO), and the WB (Kaasch, 2015).

different systems and combinations, rather than prescribing universal solutions (Kaasch, 2011). In the sub-dimension of **service purchasing**, the WHO supports strategic purchasing with a mix of public and private providers (Kaasch, 2009; Hejdukova & Kurekova, 2016). Regarding **coverage**, UHC remains a priority, with a focus on protecting vulnerable groups and defining benefits through transparent priority-setting (Kaasch, 2009; 2015; Clift, 2013; Hanrieder, 2016). In less developed countries, the WHO recommends a minimum essential health package covering major diseases, maternal care, and child health services funded by national governments (Kaasch, 2011; 2015). While the WHO has strong principles on healthcare financing, it acknowledges regional and national complexities, avoiding a "one-size-fits-all" approach (Kaasch, 2007).

2.3. WHO's role in healthcare financing in CEE countries

After the collapse of communist regimes in the late 1980s and early 1990s, CEE countries actively sought integration into Western institutional frameworks by joining IOs to assert their autonomy, access policy expertise and guidance, and, in some cases, obtain financial aid (Deacon & Hulse, 1997; Deacon 2007; Orenstein 2008; Yeates, 2008). As previously noted, five CEE countries—Albania, Bulgaria, Hungary, Poland, and Romania—joined the WHO shortly after its founding. Most of the remaining CEE states became members in the early 1990s, coinciding with the restoration of independence in the post-Soviet republics and the emergence of new states after the break-up of Yugoslavia. Some post-Yugoslav countries, such as Serbia and Montenegro, became members later, in the mid-2000s (see Appendix No 1).

During the 1990s, the WHO concentrated its activities in the region on two main areas: combating infectious diseases through vaccination and public health campaigns (Delnoij et al., 2003) and promoting PHC as outlined in the 1978 *Alma Ata Declaration* (Deacon & Hulse, 1997:68-69). Some scholars note that the WHO played a key role in strengthening PHC across CEE and supported the transition from inpatient to outpatient care models, offering guidance that was sensitive to national contexts rather than imposing a universal model (Rechel & McKee, 2009a:374). Through technical support and normative leadership, the WHO Regional Office for Europe helped shape reform strategies and policy discourse in the region, with its principles integrated into national strategies and contributing to broader health policy transformation (Jakab & Kutzin, 2009:19; Kutzin et al., 2010:10, 383; Rechel et al., 2014:23).

However, the overall influence of WHO in the domain of healthcare financing reform has been debated. While the organization provided important frameworks and normative guidance, its impact on the actual direction and implementation of financing reforms in CEE appears to have been limited, especially when compared to actors with greater financial and political leverage, such as the WB and the IMF (Kutzin et al., 2010:383; Jakab & Kutzin, 2009:20; Thomson & Mossialos, 2009:38). Deacon similarly argues that despite WHO's normative contributions, its ability to shape specific financing decisions has been constrained by the dominance of more powerful economic institutions (Deacon, 2007:112).

Nonetheless, following the 2008 economic crisis, WHO Europe played a more visible role in stabilizing health systems in transition economies, balancing normative leadership with technical assistance (Kutzin et al., 2010; Kaasch, 2015). In this context, Kaasch (2015) documents the case of Poland, although she stresses that cooperation with WHO on healthcare financing reforms began only in 2012. According to Kaasch, this initiative aimed to sustain universal health coverage, mitigate the effects of the crisis, and reduce health inequalities, although she offers limited insight into the specific policy recommendations provided (Kaasch, 2015:123). More broadly, some authors suggest that the WHO's evolving engagement in the region reflects both the trajectories of CEE countries in defining government responsibility for health financing and the ongoing structural barriers to achieving universal health coverage—one of the key health-related UN Sustainable Development Goals (Tambor, et al., 2021).

Given the lack of scholarly consensus on the extent and nature of WHO's influence on healthcare financing in the CEE region, this chapter contributes to the debate by systematically examining the policy advice provided by the WHO to CEE countries between 1989 and 2019. This analysis sets the stage for in-depth analysis of IOs' involvement in healthcare financing reforms in Latvia (Chapter xx) and Croatia (Chapter xx), which explore how WHO's guidance translated into national reforms, thereby offering a more nuanced understanding of its role in post-communist healthcare transformation.

3. WHO's healthcare financing policy recommendations for CEE Countries

Following the fall of communism, most of CEE countries transitioned, or attempted to transform, from universal tax-based healthcare to SHI systems, adopting varied institutional designs and governance frameworks (see Wendt et al., 2013; Kaminska et al., 2021). This shift marked the most significant transformation in their healthcare systems (see Marrée & Groenewegen, 1997; Rechel & McKee, 2009a; 2009b; Thomson et al., 2009; and Kaminska et al., 2021). The post-Yugoslav republics followed a distinct and fragmented path of healthcare financing reform, shaped by the disintegration of Yugoslavia, armed conflict, and the resulting political and economic instability (Jerčić, 2022). Reform trajectories varied widely: Croatia and Serbia retained modified Beveridgean systems, and Bosnia and Herzegovina developed highly decentralized structures with multiple parallel systems (Rechel et al., 2013; Krstic et al., 2019; Malinar, 2022). Ultimately, many post-Yugoslav states adopted hybrid financing arrangements, reflecting their distinct socio-political legacies, legacies of conflict, decentralization, and fiscal instability (Bredenkamp & Gragnolati, 2007; Stambolieva, 2011; Zec & Radonjić, 2012; Rechel et al., 2013; Jerčić, 2022).

3.1. Revenue collection

The WHO's recommendations on revenue collection focused on both public and private healthcare financing. Throughout the CEE region and the entire period under study, the WHO consistently pointed out that healthcare systems were underfunded and called for increased public health spending (e.g., in Albania, Bulgaria, Poland, Romania, Latvia and Serbia) (D2; D46:55; D48:101; D51:30; D55:153; D34; D56; D79:10). For example, in Poland, WHO stated that *"the low level of public expenditure upon healthcare has been a major constraint upon health sector reform and has put a considerable strain upon health services"* (D46:55).

The WHO also emphasized the need to manage funds more efficiently and control unnecessary costs. This included introducing proper reimbursement schemes (Romania, 2000) (D52:75), strengthening regulatory mechanisms (Slovakia, 2004) (D60:107) and improving system monitoring and management (Serbia, 2019) (D56:177). The WHO welcomed any national efforts to raise public healthcare spending as a share of GDP.

Some WHO recommendations directly addressed SHI as a revenue collection model, particularly in Estonia, Slovakia, and Slovenia. The WHO stated that introducing a

"pluralist health insurance market has resulted in many problems. Such a system requires a great deal of financial resources and is functioning only in countries with an advanced economy" (D58:69). In Slovenia, WHO heavily criticized the SHI system in seven separate reports (D116-D122). It highlighted issues with delayed or missing employer contributions which affected the system's efficiency and stability (D68:26). It also recommended implementing more efficient *"counter-cycling mechanisms to mitigate the potential adverse effects of revenue fluctuation due to economic cycles"* caused by rising unemployment, slower wage growth, and a growing share of low-contributing inactive enrollees (D116:1). In Estonia, the WHO discussed the healthcare financing system in 16 reports (D82-D98), focusing on its sustainability given its reliance on payroll taxes. It argued that SHI systems based solely on wage contributions could create distortions and undermine financial fairness and long-term stability (D82:4).

Due to persistent challenges in collecting healthcare financing revenue across many CEE countries, the WHO gave specific recommendations focusing on two main issues: diversifying revenue sources and promoting equity. This included encouraging governments to allocate earmarked tax revenues to healthcare, accompanied by well-defined formulas to mitigate annual fluctuations and reduce political disputes (D88:7; D89:122–123; D90:14). In Estonia, the WHO recommended that the central government contribute to the Estonian Health Insurance Fund (EHIF) on behalf of pensioners who used services without contributing (D23:175; D88:7; D89:122; D90:14). It also urged the country to apply *"the social tax to dividends from capital investment, since investors can avoid paying some of the social tax if they choose to be paid mainly in dividends, but they still benefit from EHIF coverage"* (D88:7). In Romania, where only a quarter of the population paid SHI contributions, the WHO suggested expanding the contributor base (D55:153). In Slovenia, the WHO proposed three policy options: diversifying public revenues, stabilizing funding by redefining contribution rates, and revising the benefits package and co-payment policies (D117:5). Specifically, it suggested equalizing contribution rates for employed and unemployed individuals to create a counter-cyclical funding mechanism (D65:84) and warned against increasing co-payments without adequate complementary health insurance coverage (D116:13; D120:V; D122:13).

The overarching recommendation from the WHO to the CEE countries was to diversify healthcare financing sources, particularly for systems relying solely on SHI which it viewed as vulnerable to economic downturns (D2; D28; D110). It also noted that

population aging further undermined the stability and predictability of these systems (D50:206). The WHO addressed revenue stream diversification in Albania, Hungary, and Romania, and explored it in depth in Estonia and Slovenia. After the global financial crisis, the WHO urged Estonia to reduce its dependence on payroll taxes and expand the revenue base by increasing government budget transfers and introducing taxes on capital and consumption (D88:6-7; D90:14). In 2011, the WHO criticised the lack of progress in Estonia to broaden the public revenue base, reaffirming that its earlier recommendations (since 2010) remained relevant (D90:14). In Slovenia, the WHO suggested introducing an additional taxation stream to support the Health Insurance Institute of Slovenia (HIIS), calling it *"probably the most powerful option to improve the healthcare financing system in Slovenia"* to address the challenges posed by economic cycles and an aging population (D116:13). The suggested additional sources included income tax, value added tax (VAT), wealth and property taxes, savings, trade, and sin taxes[15], and small levies on corporations and tourists. While acknowledging limited revenue potential, the WHO still advised earmarking these sources for health spending (D116:2; 4; 6). It also emphasized that *"nearly all other health systems in Europe, including those traditionally thought of as SHI systems receive significant funding from general tax revenues"* (D120:V).

In addition to public sources, the WHO accepted the use of private funding for healthcare through voluntary complementary insurance or out-of-pocket payments, but explained how such mechanisms should be applied. In Estonia, the WHO indicated that relying on voluntary insurance to ease the burden of private payments was not a suitable option. It noted that developing a private insurance market would take time and mainly benefit wealthier individuals, stressing that "*unless it [private insurance] is heavily regulated, people who are in poor health face important barriers to accessing it"* (D82:3). Therefore, the WHO concluded that *"unregulated private insurance is not a good tool for improving the equity of funding in a healthcare system"* (D82:3). As a better alternative, the WHO recommended using public funds to promote equity (D82:3). In Croatia, the WHO suggested improving access to complementary insurance for poorer households by *"raising the income threshold for eligibility for free complimentary insurance […], which would address the regressivity of VHI premiums"* (D80:X).

[15] Sin or public health taxes are excise taxes imposed on the consumption of potentially harmful goods for health [sugar-sweetened beverages (SSBs), tobacco, alcohol, among others], aiming to reduce consumption, raise additional revenue and/or improve population health (Miracolo et al., 2021).

In several countries, including Bulgaria, Estonia, Poland, and Latvia, the WHO expressed concerns about high OOPPs, warning that heavy reliance on them creates significant barriers to access (D34; D35; D79:10; D101; D107:13). It emphasized that controlling OOPP levels was the government's responsibility (D88:5). In Estonia, the WHO recommended that the Ministry urgently introduce policies to promote the rational use of medicines, as drug spending formed the largest share of OOPPs. The suggested measures included enforcing compulsory generic prescribing, allowing generic substitution by pharmacists, and even requiring doctors to cover part of the cost when prescribing brand-name drugs where cheaper generics were available (D88:8; D89:123).

In summary, the WHO did not openly favour either general taxation or SHI systems but appeared sceptical of CEE countries' adoption of SHI. In a context of limited resources, the WHO highlighted the complexity, high administrative costs, and maintenance challenges of SHI compared to tax-based models. Overall, the WHO seemed to prefer mixed financing systems, prioritizing stability and continuity of funding. Countries with similar challenges received comparable policy advice, while Estonia and Slovenia stood out for receiving the most evaluations—and, in turn, the most recommendations. The WHO recommendations on revenue collection were consistently tailored to the unique member countries´ national contexts and circumstances at a given time.

3.2.Pooling sub-dimension

The WHO provided recommendations regarding financial resources pooling to five countries: Bulgaria, the Czech Republic, Estonia, Poland, and Slovakia. These focused on two key issues: the choice between single and multiple-payer models, and the administration and management of the chosen system.

In Poland, as early as 1999, the WHO raised concerns about the country's recent shift to SHI and the adoption of a multiple-pool model. It noted that *"the management capacity and information available to run such a system are in a very early stage of development"*, and expressed scepticism about the system's ability – with that level of fragmentation – to maintain universal access to services and improve service quality (D46:56). In the Czech Republic, the WHO criticized the pluralist insurance system for undermining equity, as it enabled unequal funding across insurers. The WHO also flagged payment ceilings as a concern (D74:63). Similarly, in Slovakia (2011), WHO opposed the introduction of insurer competition given the country's healthcare debt (D62:166).

Estonia received the most attention. The WHO praised the Estonian Health Insurance Fund (EHIF) for maintaining stable public spending during the late 1990s economic crisis. However, it also noted that the single-purchaser model resulted in suppressed service prices (D82:3). In Bulgaria, reacting to the request of the government that was planning a reform of the SHI system, the WHO held a policy seminar (2010) on the envisaged measures and cautioned against the government's intentions to adopt a multi-insurer system, calling it costly and problematic based on other CEE countries' experiences (D8:29). Instead, it advised strengthening self-governance, sustainability, and equity through a single-pool model (D8:29).

The second issue the WHO addressed was the administration and management of pooling systems in Estonia, Poland, and Slovakia. In Slovakia (1996), the WHO identified imbalances in payment mechanisms among insurance funds, noting that these could *"be only partly compensated through the redistribution mechanisms"* (D63:45). The WHO warned against "cream skimming" and urged measures to prevent insurers from selecting patients or offering preferential premiums (D63:45). Critical of Slovakia's move toward insurance fund competition, the WHO suggested the following improvements: defining the covered services with support from the Health Technology Assessment agency, enhancing risk adjustment, and reforming payment methods to increase fund independence (D62:166). In Estonia, the WHO advised that the single pooling agency (Estonian Health Insurance Fund (EHIF)) should *"bring further attention to improving the scope and methods for strategic allocations based on more detailed need assessment at the sub-regional level"* (D82:5). It recommended prioritizing specific geographic areas, types of care, and national health goals such as PHC and public health (D82:5). The WHO also called for merging insurance contributions with state budget transfers to eliminate separate funding pools, promoting greater equity and solidarity. Additionally, it urged standardizing the benefits package across insured and uninsured populations (D82:5). Finally, in Poland (2015), the WHO criticized the disparities in fund allocation and spending across the sixteen regions (voivodships) which led to uneven service levels and serious tensions between regional and central authorities (D108:12-13). The WHO suggested examining the "*relationship between utilization patterns (supply effects) and the average per-capita payment that is allocated to voivodships"* (D108:14) and called for a more equitable formula based on solid policy evidence (D108:13).

The WHO offered relatively few recommendations on pooling policies, focusing on only five countries in the region. Its attention centred on countries with multiple insurance funds that struggled to manage their systems effectively. Estonia, which adopted a single-pool model, stood out as a positive example and was presented as a model for others. The evidence shows the WHO's clear preference for single-payer systems over multiple-payer ones. One likely reason is that countries with multiple funds faced greater challenges in ensuring fairness, regulation, and coverage (D137). Despite this preference, the WHO adapted its advice to each country's specific context, helping policymakers improve the existing systems.

3.3.Purchasing sub-dimension

Regarding the purchasing sub-dimension, in the hospital sector, the WHO advised CEE countries to implement (e.g., in the Czech Republic, Macedonia and Serbia) or adjust (e.g., Hungary, Poland, Slovakia, and Slovenia) Diagnosis-Related Group (DRG) systems (D27; D67:182; D43:142; D46; D56:172; D63; D74:63-64; D75; D108) without, however, expressing preference for a specific DRG model (e.g., Australian or Nordic). Moreover, these were never standalone recommendations; instead, the WHO always indicated that DRGs should be paired with other measures, such as strengthening PHC and introducing or enhancing gate-keeping by general practitioners (GPs) (D27:115; D74:63-64; D88:9-10; D89:124; D90:21). Across countries, the WHO repeatedly stressed the challenges of DRG implementation, highlighting the need for gradual implementation, inclusive stakeholder engagement, and close monitoring to avoid issues like inefficiency or budget disparities between large and small providers (D6:187; D27:114; D63:45; D67:182; D108:29, 31). In Poland, it recommended mechanisms to ensure equal distribution of hospital funding across geographic areas and social groups (D46:56). In the Czech Republic, WHO urged the adoption of a more advanced and equitable hospital compensation model, proposing additional adjusters like incapacity for work alongside age (D75:83). In Slovenia, the WHO stated that *"like other countries, Slovenia would need to gradually increase the strength of the DRG-based incentives during the transition period and effects would need to be carefully monitored"* (D67:182). In Macedonia and Serbia, WHO welcomed the slow, measured rollout of DRGs, which included incentives for quality and efficiency (D43:142; D56:172). After the DRG implementation, WHO shifted focus to risk adjustment and resource equalization.

Other hospital care recommendations were more country-specific. In Hungary, WHO recommended reducing budget disparities across providers by adjusting funding formulas (D27:115). In Slovenia, WHO recommended reviewing and recalibrating the service weights in the implemented Australian DRG system to address cost-counting inconsistencies that caused some services to be overpaid and others underpaid. Concretely, the WHO suggested *"increasing the importance of DRG-based case payments and reducing the role of hospital budgets*", proposing a capped system that would restrict hospitals from exceeding their agreed budgets (D67:182). Slovenia was also urged to assign institutional responsibility for maintaining and developing the DRG payment system using proper weighting formulas (D67:182; D118:38; 46).

The WHO made broader recommendations regarding hospital purchasing in other countries. In Bulgaria and the Czech Republic, it encouraged reforming retrospective hospital payment systems. These were financially unstable and poorly aligned with service output (D6:129; D75:83), and as a result, there was *"not enough economic pressure on the hospital management to increase productivity and ensure its [hospital's] financial health*" (D75:83). In Bulgaria, the WHO also criticized the use of clinical pathways as the sole basis for hospital reimbursement, warning that the absence of caps could threaten financial stability (D6:129). Moreover, across the region, the WHO emphasized the importance of integrating quality assurance mechanisms in hospital payment systems, communicating this to Bulgaria, the Czech Republic, Hungary, Latvia, Slovenia and Serbia (D6:129; D27:115; D34:181; D56:174, 178; D71:18; D118: 31, 46). Fourth, it also recommended strategic purchasing in Slovenia and Latvia to enhance system efficiency (D34:181; D67:180). Finally, for more advanced systems like Estonia's, the WHO suggested incorporating decisions based on comparative effectiveness and cost-effectiveness, such as using Health Technology Assessment (D82:6; D88:10; D89:124).

In the field of PHC, WHO consistently recommended introducing a capitation payment system in Albania, Hungary, and Serbia (D1; D26; D56:178). In Slovenia, it advised combining capitation with risk adjustments (e.g., age weighting) and incentives for performance and service quality (D118:46). In Slovakia, the WHO supported a mix of capitation and fee-for-service, noting it would suit the country's PHC context and enhance care quality. However, by the early 2000s, WHO deemed this mixed system financially unsustainable, with no significant gains in quality or cost-effectiveness

(D58:69; D60:107). In 2012, it proposed further refinements to capitation schemes, adding a quality indicator assessment stream. Across Latvia, Serbia, and Slovenia, the WHO criticized the lack of quality and performance incentives in PHC payment models and recommended their inclusion (D34:181; D113; D118:46).

In general, across countries and over time, the WHO consistently emphasized that to ensure healthcare system sustainability and cost-effectiveness, it was essential to shift services and funding from hospital care—by reducing the number of hospital beds—to primary and outpatient care (D9; D32:91; D38:74; D55:153; D74:63-64; D88:9; D89:124; D90:22).

In this sub-dimension, the WHO consistently favoured using DRGs as the hospital reimbursement method across countries, and emphasized integrating quality assurance mechanisms into hospital payment systems. For PHC, the WHO recommended various payment methods, provided they included incentives for performance and service quality. As in other healthcare financing sub-dimensions, the WHO tailored its advice to each country's context and aimed to adjust its recommendations to improve the existing systems.

3.4.Coverage sub-dimension

In the coverage sub-dimension, the WHO's main focus was the promotion of UHC as both a comprehensive approach to disease prevention and health promotion, and as a mechanism for financial protection of the population. The UHC was set as a key objective for all WHO member states (D96:14).

Regarding the **breadth of coverage**, the WHO recommended extending statutory coverage to the entire population, as found in the documents regarding Bulgaria and Estonia. In 2011, the WHO described Bulgaria's situation as critical, with around 1.7 million people (approximately 23% of the population) lacking coverage due to high contribution rates—8% of taxable monthly income at the time (D6:143; D78:22). In Estonia, the WHO advised *"to incorporate the 6% of uninsured people in the system to ensure early access"* (D82:2-3; D96:14). In both countries, the WHO warned that the solidarity principle of the system was undermined (D7:213). In Lithuania, it raised concerns that entitlement to healthcare was linked to the payment of contributions, further weakening equity in access (D103; D104).

Across CEE, including Bulgaria and Slovakia, the WHO welcomed measures to cover health insurance payments and to improve geographical access for socially disadvantaged, economically inactive, and other vulnerable groups (D10:141; D60:108). The WHO viewed these measures as contributing to a more progressive healthcare financing system[16] and reinforcing the system's solidarity (D62:166).

Regarding **the scope of coverage**, the WHO addressed three key issues. First, it recommended clearly defining the basic or minimum basket of services in countries like Slovenia and Latvia (D118:3; D123:V). In Slovenia, the WHO made a more concrete suggestion by advising the use of Health Technology Assessment as an evidence-based tool to determine which services to include or exclude from statutory coverage (D118:3). Second, the WHO urged a revision of the benefits package's scope and cost. In Macedonia, it pointed out that the existing package was misaligned with available revenue stream. To address this, the WHO suggested *"reducing the scope of the package, introducing additional payments or increasing co-payments, to increase premiums and to decrease the number of individuals exempt from payments"* (D44:86). Similarly, in Croatia, it advised cutting luxury or non-essential benefits from the package (D15:83). Third, the WHO encouraged expanding service coverage by including outpatient medications, adult dental care, and other under-provided services, as found in recommendations for Croatia and Estonia (D13:131; D90:18).

Regarding the **depth of coverage**, the WHO was highly critical of CEE countries' heavy reliance on OOPPs, a common issue in Bulgaria, Estonia, Latvia, Lithuania, Macedonia, Poland, and Slovakia (D10:141; D23:179; D30:135; D34:153; D35:232; D43:125; D50:191; D60:108; D78:10; D88:3; D103; D104). In Bulgaria, for example, OOPPs made up 47.7% of total health spending in 2015 (D7:182, 213).[17] Across the region, countries like Croatia, the Czech Republic, Estonia, Latvia, Lithuania, and Poland also saw a significant portion of OOPPs directed toward pharmaceuticals, which at times accounted for one-third of total health expenditure—as in Poland in 2000 (D30:135, 141; D34:157-158; D35:232; D39:124, 134; D48; D50:179, 191; D80; D90:18; D93; D94; D123:10). In Croatia, the WHO suggested improving price regulation for non-reimbursed medicines

[16] In a *progressive healthcare financing system*, higher-income individuals contribute a larger share of their income to health financing compared to lower-income individuals. In contrast, a *regressive system* places a greater financial burden on those with lower incomes (D18:137, D96:14).

[17] For detailed information on OOPPs in CEE countries in the researched period, see Appendix xx of this edited volume.

and, in 2018, expressed concern over newly introduced user charges that applied broadly to services and outpatient medications. It advised shifting from a per-episode cap to annual caps to enhance financial protection (D80). In Estonia, the WHO issued several concrete recommendations: revising the national drug policy, adjusting the co-payment structure for prescriptions (D93; D94), enforcing a compulsory generic prescription policy through incentives, and creating a state-level registry of generic drugs (D90:18).

Overall, the WHO identified high reliance on OOPPs as a major regressive element in healthcare financing, as lower-income groups paid a larger share of their income for care (D30:135, 141; D34:158; D35:234; D103; D104; D123:10). It stressed that in countries such as Bulgaria, the Czech Republic, Estonia, Latvia, Lithuania, Poland, and Slovakia, financial protection was weak, and catastrophic OOPPs disproportionately impacted the poorest households (D6:177; D30:135; D34:153; D35:234; D50:192; D61:173-174; D103; D104; D101; D123:V). In Poland, the WHO reported that in 2019, around 9% of households faced catastrophic health spending[18] —a figure that rose to 30% among the poorest income quintile (D50:192).

Across the region, the WHO consistently emphasized the importance of protecting socially disadvantaged and vulnerable groups[19], with this concern particularly highlighted in Bulgaria, Estonia, Latvia, North Macedonia, Montenegro, (D7:191; D9:53; D11:73; D23:179; D30:135; D34:153; D35; D43:130; D78: 28-29; D79:22; D88:3; D105:6). The WHO noted that Latvia and Estonia had particularly weak coverage designs, shifting healthcare costs onto those least able to bear them—such as low-income individuals, people with chronic conditions, and the elderly (D123:V).

Estonia was the only country where the WHO clearly voiced its stance on **private health insurance (PHI).** In 2010, WHO stated that *"(it) does not recommend an expanded role for private health insurance in Estonia [..] since it would not improve the financial protection for the poor, older and less healthy"* (D88:6-7). The WHO criticized unregulated PHI markets as ineffective in addressing equity issues and warned that

[18] The WHO defines it as: "Catastrophic health spending occurs when the amount a household pays out of pocket exceeds a predefined share of its capacity to pay for health care. This may mean the household can no longer afford to meet other basic needs (for example, food, housing, water, electricity and fuel for cooking and heating) or cannot afford to meet basic needs without drawing on savings, selling assets or borrowing". For more information (S22).

[19] In the context of healthcare financing, the WHO includes the following groups of people: social disadvantage, unemployed, disabled, rural residents and ethnic minorities.

building a functional PHI system was a slow process; accordingly, it stated that *"considering whether private insurance take-up should be encouraged, and the market regulated, which means using public resources to try to overcome the limitations, requires paying attention to whether alternative uses of public funds may more efficiently achieve these (ensuring equity) objectives"* (D82:3). Instead of promoting PHI, it urged policymakers to consider alternative uses of public funds, such as *"broadening the public revenue base and generating additional revenue; changing coverage breadth (universality), scope (benefits) and depth (user charges); improving resource allocation and strengthening governance"* (D88:6). In Latvia and Lithuania, WHO concluded that certain challenges could only be resolved through increased public investment in healthcare (D34:154; D103; D104).

4. Discussion and conclusions

This chapter analysed the WHO's healthcare financing policy advice to CEE countries between 1989 and 2019. Unlike previous studies that have primarily focused on broader global health governance (Kaasch, 2015) this contribution provides a systematic, comparative, in-depth assessment of WHO's healthcare financing recommendations (see Kutzin et al.'s 2010) over time and across different national contexts, distinguishing between paradigmatic shifts, policy instruments, and specific policy parameters (see Hall, 1993).

The recommendations analysed in this chapter were provided through healthcare system monitoring that involved the publication of country-specific thematic evaluations and HiT reports (produced regularly for nearly all CEE countries), consistently highlighting healthcare system issues across different time periods and CEE countries. These publications clearly formed part of WHO's soft governance strategy of shaping discussions, identifying problems and suggesting broad mechanisms for addressing them (Kaasch, 2009; Barnett & Finnemore, 2012; Clift, 2013).

The dissemination of ideas and policy advice by the WHO in CEE countries evolved in distinct phases. Our findings show that the initial HiT reports (1999-2001) provided mainly broad guidelines for building healthcare systems. Yet, the unfolding of the 2008/2009 global financial crisis prompted the WHO to release more detailed evaluations

and recommendations tailored to the specific challenges faced by CEE countries. These observations align with conclusions by Kaasch (2015).

Our findings show that the WHO issued publications on healthcare financing policy recommendations to all almost all CEE countries (except Kosovo). The intensity of WHO's policy advice varied across countries, with Estonia, Slovenia, and Latvia receiving most attention and publications. This pattern of engagement likely results from a combination of factors, warranting further research at the country level. However, our findings suggest that the focus on the three Baltic States reflects differing levels of cooperation and trust between the WHO and single countries, as well as the WHO's role as a reactive entity that responds to countries' requests for assistance (Ervik et al., 2009; Kaasch, 2011; Hanrieder, 2015a). As in the case of healthcare financing policymaking in Latvia (Chapter xx), the WHO's role is shaped by strong local connections, with national offices playing a key role in linking ministries of health to the WHO Europe. Moreover, the economies of the Baltic countries experienced sharp contractions following the financial crisis, which – as already mentioned above - triggered WHO's advisory activities.

The WHO's **recommendations on revenue collection** consistently emphasized the need to increase public funding for healthcare and diversifying revenue sources. Acknowledging the challenges faced by CEE countries, particularly those with fragmented or underfunded systems, the WHO advocated for reforms that balanced public and private funding mechanisms. The organization's focus on public spending aligned with its broader goal of ensuring equitable and financially sustainable healthcare systems. The WHO did not promote introducing SHI in CEE countries, arguing that these nations lacked the necessary economic, societal, and political development to manage such a complex system. Instead, the WHO favoured general taxation or a mixed model as the basis for healthcare financing. This finding contributes to the literature examining whether the paradigmatic change in CEE healthcare systems, i.e. the introduction of SHI across the CEE, can be attributed to IOs' influence (see Deacon et al. 1997; Müller, 1999; Cerami, 2006; Kaasch, 2015, Kamniska et al., 2021) and clearly shows that not only did the WHO refrain from recommending that CEE countries adopt SHI, but it was, in fact, highly critical of such a move. However, in countries that adopted SHI, the WHO adapted its advice, shifting from recommendations on fundamental system changes to advice on refining the SHI models in place through incremental policy instruments and specific

parameters. A common recommendation was to diversify revenue sources, including increasing allocations from general taxation or specific taxes. The WHO also stressed the importance of progressiveness and criticised policies that undermined vertical equity in financing. In some cases, the WHO suggested that healthcare spending should range between 5% and 7% of GDP. At the same time, the WHO cautioned against excessive reliance on private insurance and out-of-pocket payments (OOPPs), stressing the importance of state-driven funding to provide financial protection and prevent exacerbating health inequities. This approach supports WHO's preference for a mixed financing model, which is consistent with the conclusions by Kutzin et al. (2010) on the need for diversified financing sources to ensure sustainability.

The WHO's recommendations on **pooling policy** were less frequent than in other sub-dimensions and were formulated in five countries only, focusing on the challenges they faced in managing multiple insurance funds. The WHO emphasized the importance of equity and efficiency in healthcare financing and raised concerns about the fragmentation of insurance systems which could hinder equitable access to services. As a result, the WHO showed a clear preference for single-payer systems in several CEE countries. The organization argued that multiple-payer systems were complex and difficult to manage, particularly in countries with limited administrative capacity. In contrast, single-payer systems were considered simpler, more cost-effective, and more equitable, as they allowed for resource allocation based on population needs. The WHO consistently underscored the state's critical role in managing such systems. Despite its preference for single-payer systems, the WHO remained flexible, tailoring its advice to the specific circumstances of each country and offering guidance to improve the functioning of multiple-payer systems where necessary. This approach mirrored its stance in the revenue collection sub-dimension, demonstrating WHO's commitment to supporting countries by adapting its recommendations to fit national contexts.

In the **purchasing** sub-dimension, WHO's recommendations were most consistent across CEE countries (similar to OECD, see Chapter XX). The WHO focused on improving the efficiency and equity of healthcare spending through strategic purchasing and the implementation of DRGs in the hospital sector. The WHO's recommendations highlighted the challenges of implementing DRGs and stressed the need for a gradual approach - accompanied by other reforms like strengthening PHC and introducing or enhancing gatekeeping mechanisms - and careful monitoring to avoid disrupting service

provision and inefficiencies, and stress they and financial instability. These recommendations were closely aligned with WHO's broader goal of improving the cost-effectiveness and quality of healthcare services but were tailored to national contexts, with more detailed guidance provided to countries struggling with DRG implementation. In PHC, the WHO recommended a capitation payment system or a mix of capitation and fee-for-service models, provided that these systems included risk adjustment and quality assurance incentives. In summary, the WHO was consistent in its view that any payment mechanism should enhance the quality of services and ensure the efficient use of resources.

In the **coverage sub-dimension**, the WHO consistently advocated for UHC as the ultimate goal for healthcare systems. It stressed the importance of including all population groups, particularly vulnerable groups, in line with the *"Leave No One Behind"* principle of the UN's Sustainable Development Goals[20]. Recommendations typically began with suggesting a definition of a basic service package, followed by a revision of the scope of benefits to match available financial resources. Surprisingly, the WHO sometimes suggested scaling back the benefits package in certain countries, rather than expanding it. It indicates that the WHO advocated for a moderate approach, rather than achieving complete coverage of all possible healthcare services. The WHO was particularly critical of high levels of OOPPs, which it viewed as regressive. However, although the WHO expressed disapproval of the drug policy in CEE countries, it failed to offer any concrete solutions in this context. Finally, the WHO's criticism of unregulated private health insurance markets highlights its concern for financial protection and equity, aligning with its broader policy stance against the commercialization of healthcare.

Importantly, across all sub-dimensions, the WHO underlined the **central role of the state** in healthcare, advocating for government responsibility in both financing and overseeing the healthcare system. This aligns with the concept of stewardship that sees the state as the primary actor in regulating and managing healthcare systems (Ervik et al., 2009; Kutzin et al., 2010; Clift, 2013; Hanrieder, 2016; Hejdukova & Kurekova, 2016). The WHO also emphasized the need for the state to protect vulnerable populations, particularly in the coverage sub-dimension, where catastrophic health expenditures and financial protection were key concerns. A key trend we observed was the WHO's focus

[20] See: https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind

on assessing whether a country's healthcare financing system was progressive or regressive, with a clear preference for progressive models. The WHO identified specific components, particularly in revenue collection and coverage, that influenced the system's direction and concluded that most CEE countries had regressive healthcare financing systems, except Slovakia and Slovenia.

The findings reveal that WHO's paradigmatic recommendations advocating for a concrete healthcare financing mechanism were infrequent, and if formulated at all, they emphasised the advantages of a general taxation-based system or hybrid financing model. Instead, its recommendations predominantly addressed the level of instruments, focusing on technical adjustments to payment systems, strategic purchasing mechanisms, and cost-sharing structures. Parameter-level advice focused on the fine-tuning of co-payment rates or subsidy thresholds. In conclusion, the WHO issued advice at all three policy levels (Hall, 1993), but the dominance of instrument- and parameter-related recommendations aligns with Kaasch's (2015) observation that WHO prioritizes incremental, technically feasible reforms over politically contentious paradigm shifts.

The WHO followed different approaches to policy advice. On the one hand, in the three decades under scrutiny in this contribution, the WHO offered general guidance, established frameworks, and promoted adherence to international standards, such as the UHC, thus acting as a "moral compass" for healthcare systems in CEE, promoting equity and solidarity through frameworks like the *Alma Ata Declaration* (1978) and *the Ljubljana Charter* (1996), which guide nations in aligning their healthcare systems with global health norms. On the other hand, and increasingly so in response to the financial crisis, the WHO tailored its advice to the specific contexts of individual countries. Rather than advocating for a "one-size-fits-all" approach, particularly in the purchasing sub-dimension, the WHO promoted best practices while acknowledging diverse national circumstances, a finding consistent with prior research by Kaasch, 2007. Moreover, in reaction to CEE countries choosing not to implement its recommendations, the WHO adjusted its advice, offering alternative policy ideas. For instance, when CEE countries did not implement the recommended general taxation-based financing model, the WHO shifted its focus, providing guidance on refining and improving existing SHI systems. Such a flexible approach was possible also because, unlike the OECD, the WHO may respond to countries' specific requests for thematic evaluations and technical assistance. Our conclusion here is that the WHO's aim was to ensure that healthcare systems were

sufficient, stable, and effective, and to align CEE healthcare systems with guiding principles such as UHC rather than providing rigid "how-to" instructions. As a result, the choice of specific tools and methods followed a pragmatic perspective, subordinated to the overarching goals. Even if concrete tools (such as Health Technology Assessment in Slovenia) were proposed, the decision about implementation was left to national interpretation, demonstrating the WHO's role in providing guidance on potential outcomes rather than dictating precise steps.

We conclude that the WHO's engagement with healthcare financing in CEE countries reflects its role as a normative actor in global health governance, consistent with the literature on its soft governance mechanisms. The IO exerted its influence in CEE primarily through technical assistance, policy diffusion, and epistemic authority, rather than binding regulations or financial leverage (see Hanrieder 2015a; 2015b). The WHO's healthcare financing policy recommendations in CEE countries were guided by the principles of universality, equity, and sustainability. Through its flexible, non-coercive approach, the WHO provided a framework for reform that allowed countries to adapt policies to their specific needs. However, the WHO's advice did contain some fixed elements, namely the emphasis on state responsibility and the necessity to balance fiscal sustainability with UHC, to protect vulnerable populations. The WHO's emphasis on the right to health and its focus on PHC and UHC are commitments that have long underpinned its role in shaping global norms on healthcare financing (see Kaasch 2009). Further research in this volume, analysing the role of IOs in healthcare financing reforms in Latvia and Croatia (Chapter xx and Chapter xx), explores the translation of WHO's recommendations into domestic policies.

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Appendix No 1

CEE countries joining WHO

	1947	1948	1991	1992	1993	2000	2006
Albania*	May						
Poland		May					
Bulgaria		June					
Hungary		June					
Romania		June					
Lithuania			November				
Latvia			December				
Slovenia				May			
Croatia				June			
Bosnia & Hercegovina				September			
The Czech Republic					January		
Slovakia					February		
Estonia					March		
North Macedonia					April		
Serbia						November	
Montenegro							August

Source: Author's compilation based on the S15 and S28.

*Despite Albania not being part of the UN system, it was one of the WHO founding countries in the International Health Conference in June 1946 (S30).

Appendix No 2

The coded country specific publications

Country	Highlights on Health and Health Care Systems in Transition publications	(Other) Country specific publications	Total
Albania	3	1	4
Bosnia & Hercegovina	2	-	2
Bulgaria	7	2	9
Croatia	5	2	7
Estonia	7	19	26
Hungary	4	1	5
Latvia	7	3	10
Lithuania	4	2	6
Montenegro	-	1	1
North Macedonia	4	1	5
Poland	6	3	9
Romania	5	3	8
Serbia	1	2	3
Slovakia	7	1	8
Slovenia	7	7	14
The Czech Republic	6	1	7
Total:	**75**	**49**	**124**

Source: Author's compilation based on the gathered and coded publication list. The full list of analysed publications is in Appendix No 3.

Appendix No 3

Analysed documents

No.	Target country	Author	Year	Name of the Document	Link/ Source	Document Code
Highlights on Health and Health Care Systems in Transition publication series						
1.	Albania	European Observatory on Health Care Systems and Policies.	1999	Health Care Systems in Transition. Albania.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D1
2.	Albania	Nuri, B., & Tragakes, E.	2002	Health Care Systems in Transition. Albania.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D2
3.	Albania	WHO Regional Office for Europe.	2006	Highlights on health in Albania 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D3
4.	Bosnia and Herzegovina	Cain, J. et al.	2002	Heath care systems in transition: Bosnia and Herzegovina.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D4
5.	Bosnia and Herzegovina	WHO Regional Office for Europe.	2006	Highlights on health in Bosnia and Herzegovina 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D5
6.	Bulgaria	Dimova, A., et al.	2012	Bulgaria: Health system review. Health Systems in Transition 2012.	World Health Organization, on behalf of the European	D6

					Observatory on Health Systems and, Copenhagen, Denmark.	
7.	Bulgaria	Dimova, A., et al.	2018	Bulgaria: Health system review. Health Systems in Transition 2018.	World Health Organization, on behalf of the European Observatory on Health Systems and, Copenhagen, Denmark.	D7
8.	Bulgaria	European Communities & World Health Organization.	2001	Highlights on Health in Bulgaria 2001.	WHO Regional Office for Europe, Copenhagen, Denmark.	D8
9.	Bulgaria	European Observatory on Health Care Systems and Policies.	1999	Health Care Systems in Transitions. Bulgaria 1999.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D9
10.	Bulgaria	Georgieva, L., et al.	2007	Health system review. Health Systems in Transition, Bulgaria 2007.	World Health Organization, on behalf of the European Observatory on Health Systems and, Copenhagen, Denmark.	D10
11.	Bulgaria	Koulaksazov, S., et al.	2003	Health care systems in transition Bulgaria 2003.	World Health Organization, on behalf of the European Observatory on Health Systems and, Copenhagen, Denmark.	D11
12.	Bulgaria	WHO Regional Office for Europe.	2006	Highlights on Health in Bulgaria 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D12
13.	Croatia	Džakula, A., et al.	2014	Croatia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D13

14.	Croatia	European Observatory on Health Care Systems and Policies.	1999	Health Care Systems in Transition. Croatia.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D14
15.	Croatia	Voncina, L., et al.	2006	Croatia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D15
16.	Croatia	WHO Regional Office for Europe.	2000	Highlights on Health in Croatia 2000.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D16
17.	Croatia	WHO Regional Office for Europe.	2006	Highlights on Health in Croatia 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D17
18.	Czech Republic	Alexa, J., et al.	2015	Czech Republic: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D18
19.	Estonia	European Communities & World Health Organization.	2001	Highlights on Health in Estonia.	WHO Regional Office for Europe, Copenhagen, Denmark.	D19
20.	Estonia	Habicht, T., et al.	2018	Estonia. Health Systems Review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D20

21.	Estonia	Jesse, M., et al.	2004	Estonia. Health Systems Review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D21
22.	Estonia	Koppel, A., et al.	2008	Estonia. Health Systems Review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D22
23.	Estonia	Lai, T., et al.	2013	Estonia. Health Systems Review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D23
24.	Estonia	WHO Regional Office for Europe.	2000	Health System in Transition. Estonia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D24
25.	Estonia	WHO Regional Office for Europe.	2006	Highlights on Health in Estonia 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D25
26.	Hungary	European Communities & World Health Organization.	2000	Highlights on Health in Hungary 2000.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D26
27.	Hungary	Gaal, P.	2004	Health care systems in transition: Hungary.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D27
28.	Hungary	Gaal, P., et al.	2001	Hungary: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European	D28

					Observatory on Health Systems and Policies, Copenhagen, Denmark.	
29.	Hungary	WHO Regional Office for Europe.	2006	Highlights on Health in Hungary 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D29
30.	Latvia	Behmane, D., et al.	2019	Latvia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D30
31.	Latvia	European Communities & World Health Organization.	2001	Highlights on Health in Latvia 2001.	WHO Regional Office for Europe, Copenhagen, Denmark.	D31
32.	Latvia	European Observatory on Health Care Systems and Policies.	2001	Health Care Systems in Transition. Latvia.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D32
33.	Latvia	European Observatory on Health Care Systems and Policies.	2003	Health Care Systems in Transition. HiT Summary. Latvia.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D33
34.	Latvia	Mitenbergs, U., et.al.	2012	Latvia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D34

35.	Latvia	Tragakes, E., et. al.	2008	Latvia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D35
36.	Latvia	WHO Regional Office for Europe.	2006	Highlights on Health in Latvia 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D36
37.	Lithuania	European Communities & World Health Organization.	2001	Highlights on Health in Lithuania 2001.	WHO Regional Office for Europe, Copenhagen, Denmark.	D37
38.	Lithuania	European Observatory on Health Care Systems and Policies.	2000	Health Care Systems in Transition. Lithuania.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D38
39.	Lithuania	Murauskiene, L., et. al.	2013	Lithuania: health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D39
40.	Lithuania	WHO Regional Office for Europe.	2006	Highlights on Health in Lithuania 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D40
41.	North Macedonia	European Observatory on Health Care Systems and Policies.	2000	Health Care Systems in Transition. The former Yugoslav Republic of Macedonia.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D41
42.	North Macedonia	Gjorgjev, D., et.al.	2006	The former Yugoslav Republic of Macedonia: Health system review.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D42

				Health Systems in Transition.		
43.	North Macedonia	Milevska, Kostova, N., et. al.	2017	The former Yugoslav Republic of Macedonia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D43
44.	North Macedonia	WHO Regional Office for Europe.	2006	Highlights on health in the former Yugoslav Republic of Macedonia 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D44
45.	Poland	European Communities & World Health Organization.	2001	Highlights on Health in Poland.	WHO Regional Office for Europe, Copenhagen, Denmark.	D45
46.	Poland	European Observatory on Health Care Systems and Policies.	1999	Health Systems in Transition. Poland.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D46
47.	Poland	European Observatory on Health Care Systems and Policies.	2006	Highlights on Health in Poland 2005.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D47
48.	Poland	Kuszewski, K., & Gericke, C.	2005	Health Systems in Transition: Poland.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D48
49.	Poland	Sagan, A., et. al.	2011	Poland: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D49

50.	Poland	Sowada, C., et. al.	2019	Poland: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D50
51.	Romania	European Communities & World Health Organization.	1999	Highlights on Health in Romania.	WHO Regional Office for Europe, Copenhagen, Denmark.	D51
52.	Romania	European Observatory on Health Care Systems and Policies.	2000	Health Systems in Transition. Romania.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D52
53.	Romania	European Observatory on Health Care Systems and Policies.	2006	Highlights on Health in Romania 2005.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D53
54.	Romania	Vladescu, C, et. al.	2008	Romania: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D54
55.	Romania	Vladescu, C, et. al.	2016	Romania: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D55
56.	Serbia	Bjegovic-Mikanovic, V., et al.	2019	Serbia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D56

57.	Slovakia	European Communities & World Health Organization.	2001	Highlights on Health in Slovakia.	WHO Regional Office for Europe, Copenhagen, Denmark.	D57
58.	Slovakia	European Observatory on Health Care Systems and Policies.	2000	Health Care Systems in Transition. Slovakia.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D58
59.	Slovakia	European Observatory on Health Care Systems and Policies.	2006	Highlights on Health in Slovakia 2005.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D59
60.	Slovakia	Hlavačka, S., et. al.	2004	Slovakia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D60
61.	Slovakia	Smatana, M., et. al.	2016	Slovakia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D61
62.	Slovakia	Szalay, T., et. al.	2011	Slovakia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D62
63.	Slovakia	WHO Regional Office for Europe.	1996	Health care systems in transition — Slovakia.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D63
64.	Slovenia	Albreht, T., et al.	2001	Slovenia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems	D64

					and Policies, Copenhagen, Denmark.	
65.	Slovenia	Albreht, T., et al.	2002	Slovenia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D65
66.	Slovenia	Albreht, T., et al.	2009	Slovenia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D66
67.	Slovenia	Albreht, T., et al.	20016	Slovenia: Health system review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D67
68.	Slovenia	European Communities & World Health Organization.	2001	Highlights on Health in Slovenia 2001.	WHO Regional Office for Europe, Copenhagen, Denmark.	D68
69.	Slovenia	European Observatory on Health Care Systems and Policies.	2006	Highlights on Health in Slovenia 2005.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D69
70.	Slovenia	WHO Regional Office for Europe.	2016	Slovenia. Highlights on Health and Wellbeing.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D70

71.	The Czech Republic	Bryndova, L., et al.	2009	Czech Republic. Health Systems Review. Health Systems in Transition.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D71
72.	The Czech Republic	European Communities & World Health Organization.	2001	Highlights on Health in the Czech Republic 2001.	WHO Regional Office for Europe, Copenhagen, Denmark.	D72
73.	The Czech Republic	European Observatory on Health Care Systems and Policies.	1999	Health Care Systems in Transition. Czech Republic.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D73
74.	The Czech Republic	European Observatory on Health Care Systems and Policies.	2000	Health Care Systems in Transition. Czech Republic.	The European Observatory on Health Care Systems, Copenhagen, Denmark.	D74
75.	The Czech Republic	Rokosova, M., et al.	2005	Health care systems in transition: Czech Republic.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D75
76.	The Czech Republic	WHO Regional Office for Europe.	2006	Highlights on Health in the Czech Republic 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D76
(Other) Country specific publications						
1.	Albania	WHO Regional Office for Europe.	2018	Primary health care in Albania: rapid assessment.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D77
2.	Bulgaria	WHO Regional Office for Europe.	2017	Bulgaria Profile of Health and Well-being 2017.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D78

3.	Bulgaria	WHO Regional Office for Europe.	2017	Highlights on Health and Well-being in Bulgaria 2017.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D79
4.	Croatia	Vončina, L., & Rubin, I.	2018	Can people afford to pay for health care? New evidence on financial protection in Croatia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D80
5.	Croatia	WHO Regional Office for Europe.	2012	Assessment of health-system crisis preparedness. Croatia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D81
6.	Estonia	Couffinhal, A., & Habicht, T.	2005	Health system financing in Estonia: situation and challenges in 2005.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D82
7.	Estonia	De Maeseneer, J.	2006	Strengthening the model of primary health care in Estonia. Assessment report.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D83
8.	Estonia	Ferrario, A., et al.	2016	Availability of medicines in Estonia: an analysis of existing barriers and options to address them.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D84
9.	Estonia	Guisset, A. L., et al.	2009	Performance management, developing a culture of measurement and continuous quality improvement in Estonian hospitals: Recommendations on	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D85

				alternative entry points and ways forward.		
10.	Estonia	Jesse, M.	2008	Governance of the Health System, Health Insurance Fund and Hospitals in Estonia. Opportunities to Improve Performance.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D86
11.	Estonia	Maynard, A.	2008	Payment for Performance (P4P): International experience and a cautionary proposal for Estonia. Health Financing Policy Paper, Division of Country Health Systems.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D87
12.	Estonia	Tomson, S., et al.	2010	Responding to the challenge of financial sustainability in Estonia's health system. Executive Summary.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D88
13.	Estonia	Tomson, S., et al.	2010	Responding to the challenge of financial sustainability in Estonia's health system.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D89
14.	Estonia	Tomson, S., et al.	2011	Responding to the challenge of financial sustainability in Estonia's health system: one year on.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D90

15.	Estonia	Võrk, A., & Habicht, T.	2018	Can people afford to pay for health care? New evidence on financial protection in Estonia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D91
16.	Estonia	Võrk, A., et al.	2009	Income-related inequality in health care financing and utilization in Estonia 2000–2007. Health Financing Technical Report.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D92
17.	Estonia	Võrk, A., et al.	2010	Income Related Inequality in Health Care Financing and Utilization in Estonia Since 2000.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D93
18.	Estonia	Võrk, A., et al.	2010	Out-of-pocket payments and health care utilization in Estonia, 2000-2012.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D94
19.	Estonia	WHO Regional Office for Europe.	2006	The economic consequences of ill-health in Estonia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D95
20.	Estonia	WHO Regional Office for Europe.	2010	Estonia. Health system performance assessment. 2009 Snapshot.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D96
21.	Estonia	WHO Regional Office for Europe.	2015	Pay-for-Performance in Estonia: A transformative policy instrument to scale up prevention and management of noncommunicable diseases.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D97

22.	Estonia	WHO Regional Office for Europe.	2018	Estonia. Regions for Health Network.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D98
23.	Hungary	WHO Regional Office for Europe.	2018	World Health Organization in Hungary.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D99
24.	Latvia	Gulis, G., et.al.	2012	Strengthening the implementation of health impact assessment in Latvia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D100
25.	Latvia	Taube, M., et.al.	2018	Can people afford to pay for health care? New evidence on financial protection in Latvia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D101
26.	Latvia	WHO Regional Office for Europe.	2018	Financial protection in high-income countries: a comparison of the Czech Republic, Estonia and Latvia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D102
27.	Lithuania	Murauskiene, L., & Thomson, S.	2018	Can people afford to pay for health care? New evidence on financial protection in Lithuania.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D103
28.	Lithuania	Murauskiene, L., & Thomson, S.	2018	Can people afford to pay for health care? New evidence on financial protection in Lithuania. Summary.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D104

29.	Montenegro	WHO Regional Office for Europe.	2017	Governing for Health Equity and Sustainable Development in Montenegro. Current progress and opportunities for cross-sectoral action on social determinants to improve equity in health.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D105
30.	North Macedonia	WHO Regional Office for Europe.	2015	Making Things Happen 2014-2015. Implementing the European policy framework for health and well-being Health 2020 in the former Yugoslav Republic of Macedonia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D106
31.	Poland	Dubas-Jakóbczyk, K., et al.	2018	Health as an investment in Poland in the context of the roadmap to implement the 2030 Agenda for Sustainable Development and Health 2020.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D107
32.	Poland	Nagy, B.	2015	Improving the allocation of health care resources in Poland.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D108
33.	Poland	WHO Regional Office for Europe.	2009	Assessment of health systems' preparedness. Poland.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D109
34.	Romania	WHO Regional Office for Europe.	2000	Investment for Health in Romania. Draft Report of an Expert Group from the	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D110

				WHO Regional Office for Europe and the European Committee for Health Promotion Development.		
35.	Romania	WHO Regional Office for Europe.	2012	Evaluation of structure and provision of primary care in Romania. Primary care in the WHO European Region. A survey-based project.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D111
36.	Romania	WHO Regional Office for Europe.	2018	Romania. Regions for Health Network.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D112
37.	Serbia	WHO Regional Office for Europe.	2010	Evaluation of the organization and provision of primary care in Serbia. A survey-based project in the regions of Vojvodina, Central Serbia, and Belgrade.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D113
38.	Serbia	WHO Regional Office for Europe.	2015	Serbia: assessing health-system capacity to manage sudden large influxes of migrants. Joint report on a mission of the Ministry of Health of Serbia and the WHO Regional Office for Europe with the collaboration of the International Organization for Migration.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D114

39.	Slovakia	WHO Regional Office for Europe.	2012	Evaluation of the structure and provision of primary care in Slovakia. A survey-based project.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D115
40.	Slovenia	European Observatory on Health Care Systems and Policies.	2016	Analysis of the Health System in Slovenia. Evaluating Health Financing. Final Report.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D116
41.	Slovenia	European Observatory on Health Care Systems and Policies.	2016	Analysis of the Health System in Slovenia. Making Sense of Complementary Health Insurance. Final report.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D117
42.	Slovenia	European Observatory on Health Care Systems and Policies.	2016	Analysis of the Health System in Slovenia. Purchasing and payment review. Final report.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D118
43.	Slovenia	European Observatory on Health Care Systems and Policies.	2016	Analysis of the Health System in Slovenia. Optimizing Service Delivery. Final report.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D119
44.	Slovenia	European Observatory on Health Care Systems and Policies.	2016	Analysis of the Health System in Slovenia. Health System Expenditure Review. Final Report.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D120
45.	Slovenia	WHO Regional Office for Europe.	2008	Primary care quality management in Slovenia.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D121

46.	Slovenia	WHO Regional Office for Europe.	2017	Situation Analysis on Evidence-Informed Policymaking. EVIP Net Europe Series, N°1. Slovenia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D122
47.	The Czech Republic, Estonia, and Latvia.	Thomson, S., et al.	2018	Financial protection in high-income countries. A comparison of the Czech Republic, Estonia, and Latvia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D123
Country BCA´s						
1.	Albania	WHO Regional Office for Europe.	2010	Biennial Collaborative Agreement between the Ministry of Health of Albania and the Regional Office for Europe of the World Health Organization 2010/2011.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D124
2.	Bosnia and Herzegovina	WHO Regional Office for Europe.	2010	Biennial Collaborative Agreement between the Ministry of Health of Bosnia and Herzegovina and the Regional Office for Europe of the World Health Organization 2010/2011.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D125
3.	Bulgaria	WHO Regional Office for Europe.	2010	Biennial Collaborative Agreement between the Ministry of Health of Bulgaria and the Regional	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D126

				Office for Europe of the World Health Organization 2010/2011.		
4.	Croatia	WHO Regional Office for Europe.	2018	Biennial Collaborative Agreement between the Ministry of Health of Croatia and the Regional Office for Europe of the World Health Organization 2018/2019.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D127
5.	Estonia	WHO Regional Office for Europe.	2010	Biennial Collaborative Agreement between the Ministry of Social Affairs of Estonia and the Regional Office for Europe of the World Health Organization 2010/2011.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D128
6.	Hungary	WHO Regional Office for Europe.	2010	Biennial Collaborative Agreement between the Ministry of Health of Hungary and the Regional Office for Europe of the World Health Organization 2010/2011.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D129
7.	Latvia	WHO Regional Office for Europe.	2010	Biennial Collaborative Agreement between the Ministry of Health of Latvia and the Regional Office for Europe of the World Health Organization 2010/2011.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D130

8.	Latvia	WHO Regional Office for Europe.	2012	Biennial Collaborative Agreement between the Ministry of Health of Latvia and the Regional Office for Europe of the World Health Organization 2012/2013.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D131
9.	Poland	WHO Regional Office for Europe.	2010	Biennial Collaborative Agreement between the Ministry of Health of Poland and the Regional Office for Europe of the World Health Organization 2010/2011.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D132
10.	Slovak Republic	WHO Regional Office for Europe.	2008	Biennial Collaborative Agreement between the Ministry of Health of Slovak Republic and the Regional Office for Europe of the World Health Organization 2008/2009.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D133
11.	Slovak Republic	WHO Regional Office for Europe.	2010	Biennial Collaborative Agreement between the Ministry of Health of Slovak Republic and the Regional Office for Europe of the World Health Organization 2010/2011.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D134
12.	Slovak Republic	WHO Regional Office for Europe.	2018	Biennial Collaborative Agreement between the Ministry of Health of	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D135

				Slovak Republic and the Regional Office for Europe of the World Health Organization 2018/2019.		
13.	Slovenia	WHO Regional Office for Europe.	2010	Biennial Collaborative Agreement between the Ministry of Health of Slovenia and the Regional Office for Europe of the World Health Organization 2010/2011.	World Health Organization the Regional Office for Europe, Copenhagen, Denmark.	D136
Research publications						
1.	Kutzin, J., Cashin, C., Jakab, M., & World Health Organization.		2010	Implementing health financing reform: lessons from countries in transition.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D137
2.	Marakova, N., & Stanley, R.		2012	Behind the Estimates of out-of-pocket spending on health in the former Soviet Union.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D138
3.	Papanicolas, I., & Smith, P.		2013	Health system performance comparison: an agenda for policy, information and research: an agenda for policy, information and research.	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen, Denmark.	D139
4.	Thomson, S., Foubister, T., Mossialos, E., & World Health Organization.		2009	Financing health care in the European Union: challenges and policy responses.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D140

Meeting and conference notes					
1.	WHO Regional Office for Europe.	2007	First national seminar on strengthening public health services in Estonia. 9–10 October 2006 Tallinn, Estonia.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D141
2.	WHO Regional Office for Europe.	2015	Regional Committee for Europe 65th session Resolution (EUR/RC65/R5). Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness.	World Health Organization Regional Office for Europe, Copenhagen, Denmark.	D142
3.	WHO Regional Office for Europe.	2016	Regional Committee for Europe 66th session Resolution (EUR/RC66/R12). Action plan to strengthen the use of evidence, information, and research for policymaking in the WHO European Region.	World Health Organization Regional Office for Europe, Copenhagen, Denmark.	D143
4.	World Health Organization.	2005	Fifty-Eight World Health Assembly Resolution WHA58. Ninth plenary meeting, 25 May 2005, Committee A, eighth report. Sustainable health financing, universal	World Health Organization.	D144

			coverage, and social health insurance.		
5.	World Health Organization.	2006	The work of WHO in the European Region, 2004–2005: biennial report of the Regional Director.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	D145
Grey literature and background information sources					
1.	Arnaudova, A.	2004	10 health questions about the 10.	WHO Regional Office for Europe Publications, Copenhagen, Denmark.	S1
2.	European Observatory on Health Care Systems and Policies.		Home page, Section - About Us, Partners.	Last accessed: 05.01.2024. https://eurohealthobservatory.who.int/about-us/partners	S2
3.	European Observatory on Health Care Systems and Policies.		Home page, Section - Publications.	Last accessed: 23.01.2024. https://eurohealthobservatory.who.int/publications/health-systems-reviews	S3
4.	WHO Regional Office for Europe & South-East Europe Health Network.	2015	The Belgrade Statement.	WHO Regional Office for Europe & South-East Europe Health Network, Copenhagen, Denmark.	S4
5.	WHO Regional Office for Europe.	1988	Vienna Declaration on Nursing in Support of the European Targets for Health for All.	World Health Organization Office for Europe, Copenhagen, Denmark.	S5
6.	WHO Regional Office for Europe.	1994	The Copenhagen Declaration on Health Policy.	World Health Organization Office for Europe, Copenhagen, Denmark.	S6

7.	WHO Regional Office for Europe.	1996	The Ljubljana Charter on Reforming Health Care.	World Health Organization Office for Europe, Copenhagen, Denmark. Last accessed: 05.01.2024. https://iris.who.int/handle/10665/107873	S7
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9.	WHO Regional Office for Europe.	2008	The Tallinn Charter: Health Systems for Health and Wealth.	World Health Organization Office for Europe, Copenhagen, Denmark.	S9
10.	World Health Organization European Region.		Home page, Section- About WHO Europe.	Last accessed: 05.01.2024. https://www.who.int/europe/about-us/about-who-europe#	S10
11.	World Health Organization European Region.		Home page, Section- About WHO Europe.	Last accessed: 14.12.2023. https://www.who.int/europe/about-us/about-who-europe/technical-centresbarcelona	S11
12.	World Health Organization European Region.		Home page, Section- Groups and networks.	Last accessed: 14.12.2023. https://www.who.int/europe/groups/south-eastern-europe-health-network-(seehn)	S12
13.	World Health Organization European Region.		Home page, Section- Teams.	Last accessed: 14.12.2023. https://www.who.int/europe/teams/office-for-health-systems-financing-(barcelona)	S13

14.	World Health Organization.		Home page, Section - About WHO.	Last accessed: 14.12.2023. https://www.who.int/about/who-we-are/regional-offices	S14
15.	World Health Organization.		Home page, Section - Countries.	Last accessed: 05.01.2024. https://www.who.int/countries	S15
16.	World Health Organization.		Home page, Section - Data, Data Collections.	Last accessed: 05.01.2024. https://www.who.int/data/collections	S16
17.	World Health Organization.		Home page, Section - Health topics, Health Accounts.	Last accessed: 05.01.2024. https://www.who.int/health-topics/health-accounts#tab=tab_1	S17
18.	World Health Organization.		Home page, Section - Health topics, Universal Healthcare Coverage.	Last accessed: 05.01.2024. https://www.who.int/health-topics/universal-health-coverage#tab=tab_1	S18
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24.	World Health Organization.		Home page, Section – Health Topics, Health Accounts.	Last accessed: 23.01.2024. https://www.who.int/health-topics/health-accounts#tab=tab_1	S24
25.	World Health Organization.		Home page, Section – Health Topics, Universal Health Coverage.	Last accessed: 23.01.2024. https://www.who.int/health-topics/health-accounts#tab=tab_1	S25
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Contribution B: OECD's healthcare financing policy recommendations in CEE countries

Liva Stupele, Ante Malinar

1.Introduction

This chapter offers a detailed analysis of the content of policy advice on healthcare financing provided by the Organisation for Economic Co-operation and Development (OECD) to CEE countries in the period of 1989-2019. Moreover, the chapter lays the basis for a further analysis of whether and how the OECD has been influential in policymaking processes regarding healthcare financing in CEE countries. The latter questions are addressed in chapter XX of this edited volume that provides a case study of healthcare financing developments in Latvia and the role of IOs, including the OECD.

The OECD is an international organisation (IO) of primarily high-income countries, founded in 1961, with the goal of assisting member states in defining and developing economic policies while promoting growth and trade (Brunn, 2021). Over time, its focus has extended to include social policies and measures aimed at enhancing economic and social well-being worldwide (Dostal, 2004; Mahon & McBride, 2009a; 2009b; Duina & Nedergaard, 2010; Mahon, 2019). As a result, over the past decades, the OECD has established itself as a prominent actor in global social policy. Regarding health policy, although the OECD does not have a specific mandate in this field, its involvement in health-related policy issues was visible already in the late 1970. Since the early 2000s, the OECD has intensified its activities in healthcare policies in response to member states' requests, for example through the OECD Health Project (2001-2004)[21] (Kaasch, 2010; 2013; Kaasch & Deacon 2008). In parallel, the organisation has consistently engaged in collecting data on healthcare systems in both member and non-member countries,

[21] The OECD Health Project (2001-2004) was launched in response to requests from member countries. Its objectives were to develop quality indicators, enhance international comparability of health systems, identify best practices, and address key policy issues. The project was driven by rising concerns about healthcare quality, the lack of comprehensive international comparisons, the need for evidence-based policymaking, and shared health system challenges across OECD countries. As a result, it produced a conceptual framework and initial set of indicators for comparing health care quality internationally, laying the foundation for ongoing efforts to measure and improve health system performance (Arah et al., 2006; Kelley & Hurst, 2006; OECD, 2004b).

assessing system performance, and providing policy recommendations for reforms (Kaasch, 2009; 2015; Kaasch & Deacon, 2008).

Historically, the OECD has played a pivotal role in institutionalising and promoting neoliberal economic and financial policies, especially since the 1980s. Its policy advocacy has long emphasised liberalisation, deregulation, and privatisation (Uljens, 2007; Mahon, 2010; Middlebrook, 2012; Hong, 2024). In recent decades, however, scholarly debates have noted an evolution in the OECD's policy orientation. Some argue that the organisation has shifted from a rigidly neoliberal stance toward a more nuanced framework, often described as "inclusive liberalism" (Porter & Craig, 2004). This emerging paradigm incorporates concerns such as social cohesion and environmental sustainability into its narrative and recommendations and reflects broader trends in policy thinking that seek to balance market efficiency with social equity in response to financial crises and growing public scrutiny of purely market-driven models (Kaasch & Deacon, 2008; Mahon & McBride, 2009b).

However, other scholars remain sceptical of the depth and substance of this transformation: Despite the rhetorical inclusion of socially inclusive goals, critics argue that the organisation's policy advice continues to be rooted in neoliberal ideology, particularly in the areas of fiscal governance, labour markets, and welfare reform (Mahon & McBride, 2009a; Heinrich et al., 2021). While the discourse may incorporate socially inclusive language, in practice, OECD recommendations frequently privilege standardised, market-based solutions that prioritise competitiveness and cost-containment over redistributive or context-specific measures. This tendency has led to what critics describe as a "one-size-fits-all" approach, where policy advice is shaped by global benchmarks and economic orthodoxy rather than by the socio-economic realities of individual member states (Mahon & McBride, 2009a; Heinrich et al., 2021). These recommendations often risk deepening inequality or weakening welfare systems, indicating that the OECD's ideational power still advances a neoliberal agenda, despite its more socially conscious discourse. In a contribution to this debate in the literature, this chapter explores the alleged OECD's duality in healthcare financing reforms in CEE countries.

After the collapse of the communist regimes in the late 1980s, CEE countries actively pursued integration into Western institutional frameworks by joining various international forums and organisations. The CEE countries were driven by the desire for

recognition from “the West”, the economic development, and security considerations. The process of accessing OECD, among other, was seen as providing them with an additional momentum to “lock-in” the desired political and economic reforms aligned with liberal democratic and market-oriented principles (Mattli & Plümper, 2002; Carroll, 2014). This ambition aligned with the OECD’s broader strategy toward post-communist transitions of promoting liberal reforms to stabilize markets while mitigating the social consequences of economic transition (Deacon et al., 1997; Deacon & Hulse, 1997). Accordingly, the existing literature suggests that OECD’s policy, while homogenous at a paradigmatic level (see Hall, 1993) in promoting market-based reforms, varied across countries and reflected the specific reform priorities and socio-economic contexts of each applicant state (Deacon & Hulse, 1997). For instance, according to Deacon and Hulse (1997), Poland’s labour market assistance lacked a strong social component, whereas Hungary received detailed studies on social assistance and protection schemes (Deacon & Hulse, 1997:52).

Notably, there is limited empirical research assessing whether the above-mentioned broader findings extend to the domain of healthcare financing in CEE countries. This chapter addresses this gap by systematically analysing the OECD’s recommendations on healthcare financing reform across the region. This study uses original OECD documents to assess the ideological underpinnings and substantive focus of policy advice. The analysis follows the conceptual framework defined in the introduction to this edited volume that rests on the work by Kutzin et al. (2010) and Hall (1993). In particular, Kutzin e al. (2010) identify four sub-dimensions of healthcare financing, that is: revenue collection, pooling, purchasing and coverage. In his seminal article, Hall (1993) distinguishes between three levels of policy change—paradigmatic, instrumental, and parameter-level —allowing for a nuanced categorisation of reform content. Accordingly, the analysis below assesses whether OECD recommendations in the four dimensions of healthcare financing were aimed at the paradigmatic level (such as general taxation or social health insurance as a financing model) or focused on instruments and parameters (e.g., the structure of funding, single vs. multiple funds, or contribution levels).

Guided by the framework specified above and by the ambiguities detected in the existing literature, the chapter addresses three central questions:

4) Do OECD healthcare financing recommendations in CEE reflect a commitment to "inclusive liberalism," or do they primarily promote market-oriented reforms?

5) Do policy recommendations differ across national contexts and over time, or do they adhere to a standardized, one-size-fits-all approach?

6) At what level of policy—paradigmatic, instrumental, or parameters —are the OECD recommendations primarily targeted?

The chapter examines the content of OECD's policy advice in the period from 1989 to 2019, thus covering the three decades between the collapse of communist regimes in the region and the restoration of independence in CEE countries and the outbreak of the COVID-19 pandemic. During this period, eight CEE countries joined the OECD, namely the Czech Republic (1995), Hungary (1996), Poland (1996), Slovakia (2000), Slovenia (2010), Estonia (2010), Latvia (2016) and Lithuania (2018) (OECD, 2025). After a preliminary analysis had revealed that the OECD issued recommendations only for member states or those in the accession process, an in-depth document analysis of the healthcare financing recommendations was conducted only for these eight countries. [22]

The documents that build the corpus were collected from OECD's online archive website, using search filters including "healthcare financing," "health and finance," "spending and health," "funding and health," "health policies," and the names of CEE member countries. Documents containing statistical data and indicators without explicit healthcare financing recommendations or those with disclaimers stating they did not necessarily represent OECD opinions were excluded. The final corpus consists of 118 documents, including 74 Economic Surveys analysing each country's economic and health policies, 30 country or topic-specific research publications, e.g. *Health Care Reform Controlling Spending and Increasing Efficiency* (1994) (D102), *Health Care Systems Efficiency and Policy Settings* (2010) (D93), *Future Trends in Health Care Expenditure* (2017) (D86), and 14 conference meeting notes. The documents were coded and analysed through qualitative content analysis, using MAXQDA software. Four basic codes were defined deductively, corresponding to the four sub-dimensions of healthcare financing: revenue collection, pooling, purchasing and coverage (Kutzin et al., 2010).

The chapter is structured as follows: based on a review of the existing literature, the next section discusses OECD's governance instruments and the organisation's evolving position on health policy issues, including on healthcare financing, to offer a background

[22] However, the OECD does collect healthcare data and analyses healthcare financing policies in non-member states.

for the following empirical section. Section three presents the empirical findings on the content of OECD policy advice in CEE in the studies period. The final section provides discussions and conclusions.

2.The role of the OECD in global health policy

2.1. OECD's governance instruments

As one of the largest and most important intergovernmental forums, the OECD provides a platform for exchanging policy experiences, identifying common challenges, and developing solutions to enhance the well-being of the populations in member countries and beyond. The OECD functions both as a think tank and a policymaking body, positioned between academic and policy domains (Armingeon, 2003; Kaasch, 2009). According to the literature, the OECD's Secretariat operates as an expert-driven institution, aiming to provide neutral, evidence-based information, assessments, and policy improvement tools for national decision-makers, free from political influence (Kaasch, 2009; 2015; Mahon & McBride, 2009b; Martens & Jakobi, 2010; Kaasch & Martens, 2015). By facilitating discussions among civil servants from member countries, the OECD has successfully fostered an international epistemic community, ensuring that policy insights are disseminated at the countries' political levels (Armingeon, 2003).

The OECD is widely regarded as the leading international organisation diffusing market-oriented policy ideas (Armingeon, 2003; Niemann & Martens, 2018), shaping a specific vision of the world and promoting it among member states (Mahon & McBride, 2009a; 2009b; Duina & Nedergaard, 2010). Its institutional structure fosters close institutionalized ties with national governments (Brunn, 2021: 434), making it the most important and powerful platform for developing, standardizing, and disseminating transnational policy ideas at the national level (Kaasch, 2009; Mahon & McBride, 2009a; 2009b; McBride & Merolli, 2013).

Similarly to the WHO (see chapter xx), the OECD relies exclusively on soft governance, functioning as an institution for mutual learning, exchange of ideas, and the dissemination of good policy practices (Brunn, 2021). The OECD does not provide any financial support to member countries, nor does it have the authority to impose sanctions for non-compliance with its recommendations (Cerami, 2006; Armingeon, 2003). As a result, it

does not possess any hard or conditional power, such as financial or legal enforcement mechanism, and governments can choose to disregard its advice.

Scholars have identified three key soft governance instruments through which the OECD influences policymaking: idea and discourse production, policy evaluation (monitoring), and data generation (Kaasch, 2007a; 2007b; 2009; Mahon & McBride, 2009b; Martens & Jakobi, 2010; McBride & Merolli, 2013; Niemann & Martens, 2018). First, **idea and discourse production** involve generating and disseminating policy narratives and normative frameworks that define problems and prescribe solutions; by framing issues in a particular light, the OECD persuades national policymakers to adopt reforms that align with its globally endorsed models (Mahon & McBride, 2009a; Elfert & Ydesen, 2023). Second, **policy evaluations (monitoring)** include regular periodical country or topic-specific evaluations that present national experiences in comparative perspective, either relative to each other or to international best practice, leading to concrete policy recommendations (Armingeon, 2003). This systematic assessment leads to concrete policy recommendations and serves as a persuasive tool by highlighting areas of success or deficiency, thereby encouraging states to align with international benchmarks (Mahon & McBride, 2009b; Niemann & Martens, 2018). Finally, regarding the data generation, the OECD is particularly known for its use of "soft governance through putative hard facts" to persuade countries to reform certain policy areas (Niemann & Martens, 2018:267). Central to this strategy is the **production of comparative statistics**, indices, and extensive data collection, all of which enable the OECD to rank national performance, benchmark policy outcomes, and facilitate peer review among member states. These instruments—ratings, rankings, and benchmarking—serve not only as essential tools of soft governance (Mahon & McBride, 2009b; Niemann & Martens, 2018), but also as mechanisms of peer pressure and monitoring that can strongly incentivize compliance (Woodward, 2009:68). Both academics and national policymakers across various policy areas rely heavily on the OECD's comparative data. By providing an evidentiary basis for policy decisions through objective measurements and internationally recognized standards, the OECD subtly compels governments to reformulate policies in response to comparative performance assessments (Hajisoteriou & Neophytou, 2020; Niemann & Martens, 2018).

Collectively, all three OECD's soft governance instruments exemplify suasion as a key aspect of OECD's soft governance influence (see Marcussen, 2004; Woodward, 2007;

Mahon & McBride, 2009b) in that they work by influencing national discourses and decision-making processes rather than through coercive means, thereby promoting policy change through intellectual and normative persuasion. When member countries do not comply with its recommendations, the OECD can hope that domestic political opposition or the media amplify its critiques, increasing pressure on governments to align with its advice (Armingeon, 2003). While states are not obliged to implement OECD's advice, they often feel compelled to justify decisions that diverge from its recommendations (Niemann & Martens, 2018). Ultimately, the OECD's influence depends on its perceived legitimacy, which plays a crucial role in encouraging member countries to adopt its policy suggestions (Niemann & Martens, 2018). All these mechanisms apply equally to health-related policies.

In summary, the OECD's influence on international discourse stems from its strategic use of soft governance instruments. Its power lies in its ability to apply ideational influence, that is, to shape ideas, define policy problems and propose best practice solutions (Mahon, 2009; Niemann & Martens, 2018). At the core of its legitimacy and authority lies its reputation as a rational, impartial and apolitical IO, recognized for its technocratic expertise. This credibility allows the OECD to serve as a trusted source of information, expertise and evidence-based policy recommendations for national governments (Dostal, 2004; Mahon & McBride, 2009a; 2009b; Mahon, 2009; Merolli, 2015; Niemann & Martens, 2018). Some authors argue that the OECD's soft governance role as a "creator, purveyor and legitimator of ideas" can, in some cases, be even more powerful than traditional economic and military power (Mahon & McBride, 2009a:84). Its ability to shape policy debates and frame issues in ways that resonate with policymakers ensures its impact extends far beyond formal enforcement mechanisms.

2.2 OECD's approach to healthcare

In the healthcare field, the OECD employs all three of its soft governance instruments, i.e. idea and discourse production, policy evaluation (monitoring), and data generation, with a particular emphasis on comparison, mutual learning, and the identification of shared challenges and commonalities across member states' healthcare systems (Kaasch, 2007a; 2007b; 2009; 2010; Porter & Webb, 2008; Grek, 2009; Niemann & Martens, 2018). In essence, the OECD's soft governance instruments serve as the foundational

mechanisms that enable the specific healthcare-oriented strategies of comparison and collective problem identification, thus promoting mutual learning among member states.

In its early publications such as *Public Expenditure on Health* (OECD, 1977) and *Financing and Delivery of Health Care* (OECD, 1987), the OECD focused primarily on specific healthcare system functions, such as financing and provision, rather than analysing the healthcare system as a whole. The OECD's policy goal at that time was to decrease healthcare spending across member states, as it saw high healthcare expenditure as an obstacle to economic growth (Kaasch, 2015). However, these publications have been criticized for oversimplifying the complexity of healthcare systems and placing excessive emphasis on economic considerations.

Following the criticism, the OECD's policy goals in the healthcare sector have evolved, in line with what a share of the existing literature labels as "inclusive liberalism" (Porter & Craig, 2004). Thus, the OECD has adopted a balanced approach, integrating socio-economic and market efficiency perspective rather than acting as a "neoliberal stalking horse" (Kaasch & Deacon, 2008). Kaasch (2015:73,74) argues that the OECD advocates for accessible, high-quality healthcare that is both economically efficient in use and provision while also maintaining redistributive and income protection functions. Regarding healthcare financing, the OECD does not seem to endorse a specific reform blueprint or one-size-fits-all. Instead, it keeps a rather neutral stance, offering only balanced criticism of policy choices in individual countries (Kaasch, 2007b; 2009; 2013). Rather than imposing strict policy prescriptions, the OECD highlights areas for improvements and tailors its advice to national contexts. The only overarching recommendation across all countries has been the call for more and better data on healthcare systems (Kaasch, 2015). In healthcare policy, the OECD employs multiple channels to disseminate its recommendations. First, it is widely recognized for its comprehensive, internationally standardized, comparative set of indicators covering various aspects of healthcare, such as healthcare system performance and public health. These indicators enable a holistic analysis of healthcare systems from multiple perspectives (Arah et al., 2006; Kaasch, 2007b). Based on these data, the OECD publishes its annual *Health at a Glance* reports, which compare and rank member states' healthcare systems and policies according to their performance.[23] Second, the OECD has expanded

[23] https://www.oecd.org/health/health-at-a-glance/

its analytical work to address specific healthcare topics requested by member states, particularly in healthcare financing. This includes studies on the economics of prevention, care coordination, service purchasing methods, and the role of private health insurance (Kaasch, 2007a; 2015). For example, within the framework of the *Health Project* (2001-2004), the OECD published *Private Health Insurance in OECD countries* (OECD, 2004a) and *Towards High-Performing Health Systems* (OECD, 2004b). These reports examined the opportunities and risks of integrating private health insurance into national healthcare systems, particularly regarding coverage, healthcare access, quality of care, public expenditure, and overall system efficiency. The OECD concluded that private health insurance should not be viewed as a universal solution to all healthcare challenges but rather as one of many possible policy instruments that could contribute to system improvements (Dostal, 2004; Kaasch, 2007a; Martens & Jakobi, 2010).

Third, the OECD integrates its healthcare recommendations into periodical country evaluations, such as *Economic Surveys* (Armingeon, 2003; Kaasch, 2009; Mahon & McBride, 2009a; 2009b; Martens & Jakobi, 2010). Additionally, it relies on conferences, ministerial and state-bureaucrat meetings, and committee work as key platforms for disseminating its policy messages (Kaasch, 2009; 2015). OECD reports and conference proceedings are written in engaging and popular language to reach a broader audience, including policymakers, the public, and media outlets (Brunn, 2021). By simplifying complex policy issues, the OECD enhances the accessibility and expands the reach of its work, leading to significant media coverage and broader dissemination. However, this approach may also lead to oversimplifications, making the findings susceptible to varied interpretations by different stakeholders (Mahon & McBride, 2009b).

The early work of Deacon and colleagues (see Deacon et al. 1997 and Deacon & Hulse, 1997) examines the OECD involvement in CEE countries following the collapse of the communist regime. According to these studies, the OECD - similarly to other IOs such as the WB and IMF - primarily focused on economic reforms affecting the market transition. However, the existing literature on the OECD's role in shaping in healthcare policy – particularly healthcare financing – in CEE remains limited. Cerami highlights the OECD's concerns regarding Czech healthcare reforms that aimed at privatisation, citing the organisation's recommendations to reduce the importance of private insurers in the healthcare system (Cerami, 2006:16). Kaasch (2015) discusses the OECD's role in Poland where it drew attention to the high level of OOPP and suggested different cost-

sharing mechanisms, while also evaluating the pros and cons of each option. Additionally, the OECD prioritized the development of a standardized, comparable dataset, in line with its perspective on healthcare systems performance (Kaasch, 2015). This chapter, together with the chapter XX that analyses the involvement of OECD along with other IOs in Latvia's healthcare financing reforms, contributes to a more nuanced understanding of the role of IOs in the healthcare financing policy developments in CEE countries. The following section examines the OECD's policy advice on healthcare financing four sub-dimensions for the CEE countries.

3. OECD healthcare financing policy recommendations in CEE countries

3.1. Revenue collection sub-dimension

The OECD recommendations on revenue collection pertain to two domains: public and private resources for healthcare financing. OECD recommendations specifically addressing the model of revenue collection within the public domain were observed only in Hungary, Estonia and Poland. For Hungary, starting from 1997, the OECD published annual *Economic Surveys* recommending that the country should move away from social health insurance (SHI) and re-introduce a general taxation model. The 1997 and the subsequent *Economic Surveys* argued that the existing SHI system was inefficient due to under-reporting of workers' income, declining employment rates, high payroll tax, and a flat payroll tax component that discouraged employment of low-skilled and part-time workers (D9; D15; D18). Similar recommendations appeared in later OECD documents (e.g., D15; D18; D22; D35). For instance, the OECD explicitly advised Hungary to continue reducing payroll tax while shifting to general tax revenue (D18; D22; D28). Later, it recommended to *"phase out of the lump-sum employers' healthcare contribution"* (D35:17).

In Estonia, the OECD expressed concerns about the limited breadth of healthcare coverage which was tied to formal employment and recommended transitioning back to a general taxation system to ensure coverage for the entire population (D47; D49). Similarly, in 2002, Poland also received a recommendation to adopt a general taxation model for healthcare financing (D39). The OECD argued that Poland's healthcare system was *"only notionally insurance-based… with the state paying the contributions for large groups of non-workers and practitioners receiving payment from the state"* (D23:96-97). However, in the following years, the OECD appeared to accept that Poland was unwilling

to revert to a general taxation model. Consequently, its subsequent recommendations focused on improving the existing SHI system by suggesting an increase in payroll taxes - both generally and later for certain categories such as farmers, as well as broadening the contribution base (D51). These adjustments in policy recommendations highlight the OECD's flexibility and responsiveness to domestic circumstances.

Other CEE countries received recommendations to improve their existing public revenue collection policies. For instance, the recommendation to broaden the SHI contribution base[24] was observed in all countries except Lithuania and Latvia. In Lithuania and Latvia, the OECD only recommended a targeted, incremental increase in these countries' comparatively low share of public spending on health, to achieve levels closer to the OECD average but did not suggest any concrete steps (D59; D63; D66; D70; D73; D101). Concerning healthcare payroll tax rates, the OECD recommendations varied depending on the country[25].

In addition to policies related to SHI, the OECD recommended diversifying revenue sources in most countries (such recommendations were not observed in Latvia and Lithuania). In some countries, the OECD argued that additional public revenue should come from other tax sources, specifically recommending using "sin taxes" (D25) – such as an increased share of non-labour taxes or earmarked tax on tobacco products, alcohol and unhealthy foods and drinks[26]. Explicit recommendations to implement these measures were found in Poland, Slovakia, the Czech Republic, and Estonia (D51; D65; D67; D69).

In addition to public revenue sources, the OECD supported the use of private funds such as voluntary health insurance and OOPP as additional sources of healthcare financing. In the Czech Republic, Hungary, Poland, and Slovakia, the OECD noted a significant potential for establishing a voluntary private insurance market - either supplementary or

[24] Depending on the country, this recommendation applied to different groups: pensioners and self-employed workers in the Czech Republic, students in Slovenia, overall household income in Slovakia, and non-working spouses in Poland (D51). In Hungary, no specific groups were mentioned.

[25] For example: reducing the payroll tax rate in Slovakia and Hungary (D18; D25; D28), equalize the contribution rates across all population groups in Slovenia (D60), increasing contributions for the self-employed in the Czech Republic (D69), introducing a health insurance surcharge for non-working spouses in Slovakia (D36), and raising employee payroll taxes when a freely co-insured spouse does not work in Poland (D51), among others.

[26] Hungary was cited as a model for implementing an earmarked tax for tobacco, alcohol or unhealthy foods and drinks (D103).

complementary - that could generate additional revenue and improve access and equity if properly regulated to prevent cream skimming[27] (D18; D25; D26; D30; D42; D46; D51; D54; D61; D72). In Slovenia[28], the OECD initially recommended restructuring private complementary health insurance (CHI) by reducing the scope of covered services and adjusting the premiums based on age, which would allow greater use of co-payments (D53; D60). However, in 2017 the recommendation shifted to abolishing CHI completely (D68). This once more illustrates the OECD's flexibility in providing the policy recommendations that best suit the domestic context.

Regarding OOPP[29], the OECD recommended its use in all CEE member countries to moderate demand and acquire additional private revenue, but not at the expense of equity or access. Using its data collection, OECD established benchmarks to determine an adequate level of OOPP and how to implement them in single countries. On the one hand, the OECD recommended reducing OOPP in the countries where they negatively affected access, such as Poland and the Baltic States[30] (D63; D64; D65; D66; D70; D71; D101). On the other hand, it advocated for increasing OOPP in the countries where this would not compromise access, such as the Czech Republic and Slovakia (primarily for pharmaceuticals), and Slovenia (D42; D45; D46; D52; D53; D60). In Slovenia, the OECD specifically stated that "*there is scope to increase out-of-pocket health expenditure in Slovenia as its burden amounts to slightly above 2% of final household consumption, and is one percentage point lower than the OECD average"* (D53:29). Moreover, in Hungary, the OECD suggested mandatory OOPP in the form of formal patient co-

[27] Cream skimming can be defined as "selection by the insurer of so-called preferred risks, i.e. those insured for whom the insurer considers the risk-adjusted per-capita payment to be (far) above the expected cost level" (van de Ven & van Vliet,1992: 23).

[28] Healthcare financing system in Slovenia underwent significant reforms in the early 1990s and 2000s. The 1992 Health Care and Insurance Act introduced a social insurance system based on mandatory payroll taxes, managed by the Health Insurance Institute of Slovenia (HIIS). This marked a transitioning from a decentralized, budget-financed system to a Bismarckian social health insurance model. The reform introduced compulsory health insurance funded through payroll contributions from employers and employees, established co-payments for certain services, and allowed for voluntary complementary health insurance to cover these co-payments. However, the system faced challenges during economic crises due to its reliance on employment-based contributions (Albreh, et al., 2009; Albreht & Klazinga, 2009; Thomas, et al., 2015).

[29] OECD defines OOPP as *"expenditures borne directly by the patient where neither compulsory nor voluntary insurance cover the full cost of the health good or service"* (OECD, 2017:92). Thus, OOPP includes user fees and co-payments, as well as informal payments. When recommending the use of OOPP, the OECD does not refer to informal payments.

[30] For instance, in Lithuania, the OECD recommended curbing OOPP on drugs by providing financial incentives to clinicians and pharmacies to prescribe generic drugs (D70).

payments and user fees to curb widespread informal payments (D35; D43; D50). Other recommendations aimed at reducing reliance on informal payments included introducing legal sanctions and clearly defining a basic healthcare service package in Hungary (D43), implementing voluntary private insurance in Slovakia (D30), and increasing public healthcare funding in Poland (D19). In Lithuania, while the OECD acknowledged the problem of widespread informal payments, it did not provide a specific policy solution (D63; D70).

In summary, the OECD rarely recommended a specific healthcare financing model. However, in some cases - such as Estonia, Poland, and Hungary - it advised switching to a general taxation model due to challenges these countries were facing with their SHI systems during the early reform phase. For the most part, later OECD recommendations on revenue collection focused on improving existing systems of revenue collection (e.g., broadening the SHI contribution base, diversifying the revenue collection, adjusting the payroll tax rate, adjusting OOPP policy) rather than advocating for SHI or general taxation. Additionally, countries with similar healthcare financing systems and challenges tended to received similar recommendations. Moreover, countries that joined the OECD earlier (e.g., Hungary, Poland, Slovakia, and the Czech Republic) received more detailed recommendations compared to those that joined later (e.g., Latvia, Lithuania). Overall, OECD recommendations on revenue collection were highly country-specific, tailored to each nation's unique context and circumstances at different points in time.

3.2. Pooling sub-dimension

OECD recommendations on pooling were observed in four countries: Hungary and Slovenia, where OECD provided limited advice, and the Czech Republic and Slovakia, where its recommendations were more extensive over a longer period. In Hungary, the OECD supported a single pooling agency and endorsed the government's decision to maintain it. In 2000, it stated that *"the centralized single purchaser regime appears appropriate for Hungary and the decision to remain with it will free up intellectual and political resources for finding solutions to the many other difficulties that remain"* (D18:151). In Slovenia, the OECD recommended separating pooling funds for SHI and long-term care, along with introducing a "*dedicated source of funding for long-term care"* to *"better monitor and control the expanding costs due to ageing"* (D60:39). As for the Czech Republic and Slovakia, in the 1990s, the OECD advised reducing the

number of health insurance funds and regulating their operations to limit cream skimming (D7; D8; D12). Later, both countries received similar recommendations aimed at increasing competition among health insurance funds, implementing risk-weighting for different client groups, e.g., based on health parameters (in Slovakia) or morbidity (in the Czech Republic), and promoting centralisation in various aspects (D25; D26; D45). Specifically, the Czech Republic was advised to transfer the payroll tax collection responsibilities to tax authorities, centralize tax administration, and streamline revenue collection by creating a single agency responsible for collecting taxes, excise duties, social insurance contributions, and health insurance contributions (D42). In Slovakia, the OECD suggested either transitioning to a single insurance fund (D25) or improving the existing multiple insurance fund system by increasing competition (D45). This could be achieved by *"allowing the distribution of profits, reducing barriers to entry, such as reconsidering the upper limit for administrative costs, allowing selective contracting with providers, and allowing contributions to vary"* … and considering *"splitting up and partial privatization of the dominant publicly owned insurer"* (D45:16).

As evident, OECD recommendations on pooling sub-dimension were relatively limited. Most were directed at Slovakia and the Czech Republic, focusing on the challenges posed by their multiple-payer systems which created more equity-related issues, such as risk selection by competing insurers (Kutzin et al., 2010), compared to single-payer systems present in other countries. Similarly to its approach to revenue collection, the OECD did not advocate for a particular pooling model. It did not express preference on whether countries should opt for a single fund or multiple healthcare insurance funds, whether these funds should be territorially distinct or overlapping, or whether pooling agencies should be vertically integrated with revenue collection and purchasing agencies. Instead, the OECD tailored its recommendations to each country's specific context, advising on ways to improve the existing pooling policy.

3.3. Purchasing sub-dimension

In the hospital sector, the OECD advised CEE countries to either implement or optimize Diagnosis-related Groups[31] (DRGs) as a payment mechanism, with no recommendations

[31] Sometimes the OECD uses a different term, e.g., Homogeneous Diseases Groups (D31).

observed in Estonia[32]. Once DRGs were introduced, the OECD emphasized the importance of regular evaluation and updates to ensure accurate coding and prices, prevent upcoding, and establish appropriate penalties for fraud. However, the OECD did not express a preference for a specific DRG model, such as the Australian or Nordic groupings. Other hospital care recommendations were more country-tailored. In the Czech Republic and Slovakia, the OECD recommended fostering competition among healthcare providers by allowing insurance funds to negotiate individual contracts with service providers and establishing a pay-for-performance scheme for hospital doctors (D26; D45; D67; D69). In Hungary, the OECD recommended introducing budget caps for hospitals in 1999 (D15). Later recommendations focused on improving Hungary's DRG policy by *"introducing a payment scale between HDGs (Homogeneous Diseases Groups) performance units, outpatient points and chronic-care points*" (D31:70). Lastly, the OECD advised Latvia and Lithuania to implement selective hospital contracting based on minimum volume thresholds and quality indicators (D66; D70; D73).

In primary healthcare, the OECD consistently recommended a mixed payment system combining capitation and fee-for-service models, noting that this approach was *"becoming the norm in OECD countries"* (D45:61). Specifically, in countries with a capitation-based model, the OECD advised complementing it with a fee-for-service model, and vice versa. Such recommendations were observed in Slovakia, the Czech Republic, and Poland (D7; D17; D25; D44; D45; D69). In contrast, no related recommendations were made for Slovenia, Estonia, Lithuania, Latvia, and Hungary, as these countries had already implemented a mixed capitation and fee-for-service system (Kutzin et al., 2010). Additionally, the OECD encouraged Hungary, Slovakia, the Czech Republic, Slovenia, and Lithuania to introduce or enhance pay-for-performance schemes in primary care (D53; D67; D69; D70; D72). However, it rarely specified which performance indicators should be used.

The OECD recommendations in the purchasing dimension are the most consistent compared to the other three healthcare financing policy dimensions. It clearly preferred DRGs in the hospital sector and a mix of capitation and fee-for-service models in primary care as the main methods of healthcare service purchasing. Additionally, the OECD

[32] However, in Estonia, the OECD repeated WHO's observation that *"although the provider pay system has been reformed and improved substantially, some perverse incentives remain. For example, case-based purchase of inpatient care doesn't encourage continuity of care among providers or levels of care"* (D47:86).

tailored its service purchasing policy recommendations to specific country contexts, especially in the hospital sector, where it recommended measures such as budget caps or selective contracting.

3.4. Coverage sub-dimension

The OECD recommendations in the coverage dimension were observed in all countries except Lithuania. The only country that was recommended to expand the breadth of coverage to the entire population was Estonia (D58; D65). In 2014, Poland received a recommendation to *"disconnect health-insurance entitlement from unemployment registration"* (D56:37). Regarding the scope of coverage, the OECD recommended explicitly defining the basic or minimum package of services (no recommendation was observed for Lithuania and Latvia). The Czech Republic, Slovakia, Slovenia, Estonia, Hungary (after 2000), and Poland were advised to narrow the definition of the basic healthcare services package and exclude non-essential services (D17; D18; D25; D47; D53). The OECD suggested that non-essential services could be covered by voluntary private insurance or OOPP. However, it emphasized that the scope of coverage should not be reduced for certain population groups, such as those unable to pay or individuals suffering costly diseases (e.g., D26; D53; D74).

Regarding the depth of coverage, the OECD maintained a balanced position on OOPP. As previously mentioned in the section on revenue collection, the OECD recommended the use of OOPP in all countries. However, to ensure access and equity, it advised using OOPP with caution and in combination with other policies, such as means-tested caps on OOPP (in Estonia, Poland, the Czech Republic, and Slovakia) (D26; D45; D47; D51), voluntary private insurance (in Poland, Slovakia, the Czech Republic, Hungary) (D18; D26; D30; D51), and exemptions for vulnerable and low-income populations (in Slovenia, the Czech Republic, Slovakia, and Latvia) (D26; D53; D66; D74).

Compared to revenue collection and pooling, the OECD recommendations in coverage policy were more uniform. As nearly all OECD member states in CEE have formally universal coverage, there were few considerations regarding the breadth of coverage. Concerning the scope and depth of coverage, in most cases, the OECD recommended reducing both, while insisting on the need to avoid significant disruption in access to services, especially for the most vulnerable population. However, the OECD's

recommendations did reflect country-specific circumstances, particularly when addressing potential limits to the scope of coverage or the use of OOPP.

4.Discussion and conclusions

This chapter offers an examination of the OECD's healthcare financing recommendations for CEE countries. Unlike previous studies that have primarily focused on broader global health governance (Porter & Craig, 2004; Kaasch & Deacon, 2008; Mahon, 2009) our analysis provides a systematic, comparative, in-depth assessment of OECD recommendations over time and across different national contexts, distinguishing between paradigmatic shifts, policy instruments, and specific policy parameters. It contributes to the existing literature by illustrating how OECD recommendations have been predominantly delivered through its periodic *Economic Surveys*, with a particular focus on reform trajectories based on past achievements. Moreover, it sheds light on the extent to which these recommendations align with the principles of "inclusive liberalism" or emphasize market-oriented reforms.

Our findings show that the OECD has issued healthcare financing recommendations exclusively to its member states and those undergoing formal accession. As a result, the earlier the country entered the accession process and became a member of the OECD, the more healthcare financing recommendations have been issued so far. For example, Latvia and Lithuania received fewer healthcare financing recommendations than other CEE countries due to their later OECD accession, respectively in 2016 and 2018. Thus, we provide new empirical evidence on how the OECD has evaluated healthcare systems and financing structures in all eight CEE member countries, covering all four-healthcare financing sub-dimensions.

Regarding revenue collection policy, we identify an important evolution in the OECD's recommendations. Initially, in the early transition years, the organisation proposed a paradigmatic shift (see Hall, 1993), advocating a return to general taxation-based models in Poland, Hungary, and Estonia. Indeed, the OECD argued that most of the healthcare sector problems these countries were facing would be alleviated by switching from SHI back to a general taxation model. This finding contributes to the literature examining whether the paradigmatic change of SHI model across the CEE can be attributed to direct pressure from IOs (see Deacon et al. 1997; Müller, 1999; Cerami, 2006; Kaasch, 2015,

Kamniska et al., 2021) and clearly shows that not only did the OECD not pressure CEE countries to introduce SHI, but it was actually opposed to it. However, since Poland, Hungary, and Estonia did not follow on that recommendation, the OECD adjusted its approach, shifting from recommendations on fundamental system changes to advice on refining the SHI models in place through incremental policy instruments and specific parameters. This finding is consistent with findings for other IOs that operated in the CEE region, e.g. the World Bank (e.g., Kaminska et al., 2021; chapter XXXX in this volume). Specifically, these later OECD recommendations included broadening the SHI contribution base, adjusting the payroll tax rate, etc. Depending on the situation in single countries, recommendations on specific settings of these policies varied, e.g., which groups should be eligible to have their SHI contributions covered, or whether the payroll tax should be lowered or increased, etc. Besides, the OECD recommended diversifying the revenue sources by including other revenue (both public and private) in addition to SHI, such as earmarked taxes for tobacco, private insurance, as well as OOPP.

Furthermore, our results show that while the OECD does see private insurance as a policy that can complement SHI, it does not favour private health insurance as a primary funding mechanism. Accordingly, the OECD often recommended reliance on private voluntary health insurance such as supplementary or complementary health insurance to address coverage of non-essential healthcare services. The OECD argued that if regulated correctly (e.g., to avoid cream skimming) private voluntary health insurance could serve multiple purposes: raise additional revenue, improve access and equity, and reduce informal payments. This confirms the findings of previous research which states that the OECD considers private health insurance as a complementary policy instrument that can be used to improve the healthcare system (Dostal, 2004; Kaasch, 2007a; Martens & Jakobi, 2010). Moreover, our findings on OECD's specific recommendations for different national contexts (how exactly it should be implemented or whether it should be avoided altogether) clearly show that the organisation did not apply a one-size-fits-all approach. Instead, the OECD adjusted its policy advice across countries and sometimes over time. For instance, in Slovenia, the OECD initially endorsed improving private CHI but later called for its abolition due to its negative effects. In contrast, it recommended developing CHI in the Czech Republic, Hungary, Poland, and Slovakia to reduce reliance on OOPPs.

Considering the OOPP, we provide insights into how, across all CEE countries, the OECD has consistently endorsed them as an additional revenue source and as means to

moderate demand for healthcare services, while at the same time (again) tailoring recommendations to national contexts. Prior research has not fully accounted for the OECD's dual approach of advocating both increases and reductions in OOPP levels, depending on OECD benchmarks and broader fiscal strategies. Depending on the country, the OECD recommended increasing or lowering the level of OOPP or using them in combination with other policies such as voluntary private insurance or means-tested caps. On that note, in the coverage dimension, the OECD generally advocated for limited scope and depth of coverage, mostly through narrowing the basic package of healthcare services and the use of OOPP, but never at the expense of vulnerable groups. While the OECD promoted limited coverage expansion and cost containment, it rarely specified which services should be excluded—suggesting a deliberate strategy of leaving politically sensitive decisions to national policymakers.

Another key contribution of this study is the identification of OECD recommendations regarding pooling policies which have been relatively sparse but highly targeted. Our findings highlight how the OECD selectively engaged with the Czech Republic and Slovakia due to their complex multi-insurance fund systems. As with revenue collection, the OECD tailored its advice to the specific issues the countries were facing and never advocated for any specific pooling model such as single or multiple healthcare insurance funds. This is another finding which indicates that the OECD's approach to pooling has remained notably flexible and pragmatic, reinforcing its adaptive and non-prescriptive policymaking style. This aspect has received little attention in previous research.

However, in some cases, the OECD did promote certain policy ideas as best practice solutions. This is evident in the purchasing sub-dimension, where our analysis found a strong OECD's preference for specific provider payment models across all CEE countries, particularly a mix of capitation and fee-for-service purchasing models in primary care and DRGs in hospital care. This finding links these recommendations to the OECD's broader role in promoting global best practices through cross-country data analysis and comparative policy evaluations. By demonstrating how OECD guidance on purchasing has remained relatively uniform, we contribute to the understanding of its role as a disseminator of best practice solutions defined in global healthcare policy by analytical work relying on data comparison between countries (Mahon, 2009; Niemann & Martens, 2018).

Another significant finding of this study is our identification of how the specificity of OECD recommendations has evolved over time. We reveal that early OECD member states (Poland, Hungary, and the Czech Republic) received detailed, directive recommendations in the 1990s, likely due to the complexity of their post-communist healthcare transitions, for example the need to rebuild their healthcare systems during this period while experiencing increased problem pressure. In contrast, later accession countries, such as Latvia and Lithuania, often received more general recommendations, only identifying the problems and areas where national reforms should be focusing. This shift from detailed policy prescriptions to broader strategic guidance could be explained by the fact that, the two countries became member states most recently (in 2016 and 2018, respectively), after the initial post-communist transition problems had already been alleviated.

Based on the content of the OECD advice on healthcare financing in CEE countries, it can be argued that the main goal of OECD in the region across the time was to achieve financial sustainability and efficiency of the healthcare system and at the same time preserve equity and access to the services. This is consistent with the conclusions of other scholars in other policy fields and other regions (Kaasch, 2007a; 2007b; 2010; Kaasch & Deacon, 2008; Mahon, 2009) who have noted that rather than relying only on the neoliberal framework in its healthcare policy advice, OECD practices "inclusive liberalism" instead, in that it consistently balances considerations on financial sustainability, system efficiency, equity and the role of the state which in the view of the OECD has to protect vulnerable groups such as the poor (see also chapter XXXX in this volume discussing the respective position of WHO on the state's responsibility). This is particularly visible in OECD's advice for revenue collection and coverage dimensions e.g., means-testing for OOPP, exempting those unable to pay from co-payments, voluntary private insurance etc. In this sense, the OECD appears or tries to appear as a rather neutral organisation that provides healthcare policy expertise, on which its member states can choose to rely on. Findings also demonstrate that the OECD does not impose a standardized, one-size-fits-all approach, but rather applies a nuanced perspective and adapts its policy advice to country-specific contexts and evolving conditions. This is consistent with the findings of Kaasch (see 2007a; 2007b; 2010). This adaptability is evident in the organisation's responsiveness to national healthcare transitions (e.g., to the processes of transitioning from general taxation to SHI in Hungary, Estonia and Poland)

and its adjustment over time (e.g., to the issue related to CHI in Slovenia). Even when the OECD promoted best practice models such as purchasing policy reforms or optimal OOPP levels, its recommendations remain context-sensitive, thus considering political and economic developments and particular issues single countries were facing. In the purchasing dimension, OECD's recommendations were further differentiated for single countries beyond the best practice models. Besides a mixed payment system in primary care or DRGs in hospitals, the OECD recommended the introduction of budget caps in Hungary, selective hospital contracting in Latvia and Lithuania, and pay-for-performance schemes in the Czech Republic and Slovakia.

This suggests that the OECD has been reactive rather than proactive in its recommendations. In other words, the OECD did not try to force its ideas upon countries, but rather offered alternative policy ideas which could resolve the problems countries were facing at that specific time. One of the plausible explanations is related to the OECD's unique nature and institutional setup. As already discussed above, the OECD was created to assist member states in their policy choices, and it functions as a platform that provides the possibility to exchange policy experiences, find common issues and possible solutions, and identify good practices. As the OECD does not have any coercive instrument at its disposal, its only option to influence countries is to provide them with up-to-date advice that is relevant to the problems countries are experiencing. In this way, countries are more likely to decide to follow its advice, since it devises possible solutions for the domestically chosen policy paths.

This study is the first to systematically map these tools in the context of CEE healthcare financing, filling a gap in the literature on the OECD's role in healthcare reforms in the region. While OECD cannot rely on hard governance instruments, this chapter shows that the organisation has resorted to all three of its soft governance instruments discussed above, i.e., the idea and discourse production on healthcare financing, policy evaluation (monitoring) and data collection in the CEE region. *Economic Surveys* (as policy evaluation and monitoring) serve as a key vehicle for explicit healthcare financing recommendations. Within the policy monitoring instrument, OECD applies the following principle: first, it examines the country-specific context and evaluates the interaction of the healthcare system with other policy fields, then it identifies the problem areas and, based on those, recommends possible solutions. Besides policy evaluation (monitoring), the OECD also resorted to other two non-coercive governance instruments in the

healthcare financing policy in the CEE region: other collected documents contained large amounts of statistical data and descriptions of the healthcare financing systems in the member countries. It can be argued that even though periodical publications like the *State of Health* in the EU and *Health at a Glance* did not contain explicit healthcare financing recommendations, they can influence healthcare financing indirectly by offering large and easily comparable statistical data, best practice models (specifically in purchasing sub-dimension) and benchmarks (for OOPP) that can be seen as a powerful incentive and push nations to adopt the OECD's advice (see Kaasch, 2007a; 2009; 2015).

In conclusion, the findings of this research offer empirical insights into the OECD's healthcare financing recommendations in CEE countries, demonstrating its evolving, context-sensitive, and learning-based approach to policymaking. By systematically analysing the OECD's recommendations over time and across national contexts, we contribute to a more nuanced understanding first, of the organisation's ideas on healthcare systems and health policies, and secondly, of its potential influence in global health governance. A detailed analysis of how national policymakers internalize and implement OECD recommendations is provided in the chapter XX in this volume, presenting a case study on Latvian healthcare financing policy developments.

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Appendix 1

Analysed documents

No.	Author	Year	Name of the Document	Link/ Source	Document Code
OECD Economic Surveys					
1	OECD.	1991	OECD Economic Surveys: Czech and Slovak Federal Republic.	OECD Publishing, Paris.	D1
2	OECD.	1991	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D2
3	OECD.	1992	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D3
4	OECD.	1993	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D4
5	OECD.	1994	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D5
6	OECD.	1994	OECD Economic Surveys: The Czech and Slovak Republics.	OECD Publishing, Paris.	D6
7	OECD.	1996	OECD Economic Surveys: The Czech Republic.	OECD Publishing, Paris.	D7
8	OECD.	1996	OECD Economic Surveys: The Slovak Republic.	OECD Publishing, Paris.	D8
9	OECD.	1997	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D9
10	OECD.	1997	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D10
11	OECD.	1997	OECD Economic Surveys: Slovenia.	OECD Publishing, Paris.	D11
12	OECD.	1998	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D12
13	OECD.	1998	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D13

14	OECD.	1998	OECD Economic Surveys: Romania.	OECD Publishing, Paris.	D14
15	OECD.	1999	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D15
16	OECD.	1999	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D16
17	OECD.	2000	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D17
18	OECD.	2000	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D18
19	OECD.	2000	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D19
20	OECD.	2001	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D20
21	OECD.	2001	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D21
22	OECD.	2002	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D22
23	OECD.	2002	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D23
24	OECD.	2002	OECD Economic Surveys: Romania.	OECD Publishing, Paris.	D24
25	OECD.	2002	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D25
26	OECD.	2003	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D26
27	OECD.	2004	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D27
28	OECD.	2004	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D28
29	OECD.	2004	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D29
30	OECD.	2004	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D30
31	OECD.	2005	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D31
32	OECD.	2005	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D32
33	OECD.	2006	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D33
34	OECD.	2006	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D34
35	OECD.	2007	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D35

36	OECD.	2007	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D36
37	OECD.	2008	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D37
38	OECD.	2008	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D38
39	OECD.	2009	OECD Economic Surveys: Estonia.	OECD Publishing, Paris.	D39
40	OECD.	2009	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D40
41	OECD.	2009	OECD Economic Surveys: Slovenia.	OECD Publishing, Paris.	D41
42	OECD.	2010	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D42
43	OECD.	2010	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D43
44	OECD.	2010	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D44
45	OECD.	2010	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D45
46	OECD.	2011	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D46
47	OECD.	2011	OECD Economic Surveys: Estonia.	OECD Publishing, Paris.	D47
48	OECD.	2011	OECD Economic Surveys: Slovenia.	OECD Publishing, Paris.	D48
49	OECD.	2012	OECD Economic Surveys: Estonia.	OECD Publishing, Paris.	D49
50	OECD.	2012	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D50
51	OECD.	2012	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D51
52	OECD.	2012	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D52
53	OECD.	2013	OECD Economic Surveys: Slovenia.	OECD Publishing, Paris.	D53
54	OECD.	2014	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D54
55	OECD.	2014	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D55
56	OECD.	2014	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D56
57	OECD.	2014	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D57

58	OECD.	2015	OECD Economic Surveys: Estonia.	OECD Publishing, Paris.	D58
59	OECD.	2015	OECD Economic Surveys: Latvia.	OECD Publishing, Paris.	D59
60	OECD.	2015	OECD Economic Surveys: Slovenia.	OECD Publishing, Paris.	D60
61	OECD.	2016	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D61
62	OECD.	2016	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D62
63	OECD.	2016	OECD Economic Surveys: Lithuania.	OECD Publishing, Paris.	D63
64	OECD.	2016	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D64
65	OECD.	2017	OECD Economic Surveys: Estonia.	OECD Publishing, Paris.	D65
66	OECD.	2017	OECD Economic Surveys: Latvia.	OECD Publishing, Paris.	D66
67	OECD.	2017	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D67
68	OECD.	2017	OECD Economic Surveys: Slovenia.	OECD Publishing, Paris.	D68
69	OECD.	2018	OECD Economic Surveys: Czech Republic.	OECD Publishing, Paris.	D69
70	OECD.	2018	OECD Economic Surveys: Lithuania.	OECD Publishing, Paris.	D70
71	OECD.	2018	OECD Economic Surveys: Poland.	OECD Publishing, Paris.	D71
72	OECD.	2019	OECD Economic Surveys: Hungary.	OECD Publishing, Paris.	D72
73	OECD.	2019	OECD Economic Surveys: Latvia.	OECD Publishing, Paris.	D73
74	OECD.	2019	OECD Economic Surveys: Slovak Republic.	OECD Publishing, Paris.	D74
Research publications					
a	Auraaen, A., et al.	2016	How OECD health systems define the range of good and services to be financed collectively. OECD Health Working Papers, No. 90.	OECD Publishing, Paris.	D75

2	Boulhol, H., et al.	2012	Improving the Health-Care System in Poland. OECD Economics Department Working Papers, No. 957.	OECD Publishing, Paris.	D76
3	Colombo, F., & Tapay, N.	2004	The Slovak Health Insurance System and the Potential Role for Private Health Insurance: Policy Challenges. OECD Economics Department Working Papers, No. 11.	OECD Publishing, Paris.	D77
4	de la Maisonneuve, C., et al.	2016	The drivers of public health spending: Integrating policies and institutions. OECD Economics Department Working Papers, No. 1283.	OECD Publishing, Paris.	D78
5	Drechsler, D., & Zimmermann, F.	2006	New Actors in Health Financing: Implications for a Donor Darling. OECD Development Center, Policy Brief No. 33.	OECD Publishing, Paris.	D79
6	Eris, M.	2012	Improving Health Outcomes and System in Hungary. OECD Economics Department Working Papers, No. 961.	OECD Publishing, Paris.	D80
7	Girouard, N., & Y. Imai.	2000	The Health Care System in Poland. OECD Economics Department Working Papers, No. 257.	OECD Publishing, Paris.	D81
8	Hurst, J.	2010	Effective Ways to Realise Policy Reforms in Health Systems. OECD Health Working Papers, No. 51.	OECD Publishing, Paris.	D82
9	Kawiorska, D.	2004	SHA-Based Health Accounts in 13 OECD Countries - Country Studies - Poland: National Health Accounts 1999. OECD Health Technical Papers, No. 10.	OECD Publishing, Paris.	D83
10	Koechlin, F., Lorenzoni, L., & Schreyer, P.	2010	Comparing Price Levels of Hospital Services Across Countries: Results of Pilot Study. OECD Health Working Papers, No. 53.	OECD Publishing, Paris.	D84

11	Lorenzoni, L., et al.	2017	Cyclical vs structural effects on health care expenditure trends in OECD countries. OECD Health Working Papers, No. 92.	OECD Publishing, Paris.	D85
12	Marino, A., et al.	2017	Future trends in health care expenditure: A modelling framework for cross-country forecasts. OECD Health Working Papers, No. 95.	OECD Publishing, Paris.	D86
13	Morgan, D. & Astolfi, R.	2013	Health Spending Growth at Zero: Which Countries, Which Sectors Are Most Affected?. OECD Health Working Papers, No. 60.	OECD Publishing, Paris.	D87
14	Morgan, D., & Astolfi, R.	2014	Health Spending Continues to Stagnate in Many OECD Countries. OECD Health Working Papers, No. 68.	OECD Publishing, Paris.	D88
15	OECD.	2002	Measuring Up. Improving Health System Performance in OECD Countries.	OECD Publishing, Paris.	D89
16	OECD.	2004	Private Health Insurance in OECD Countries. OECD Health Project.	OECD Publishing, Paris.	D90
17	OECD.	2008	Pharmaceutical Pricing Policies in a Global Market.	OECD Publishing, Paris.	D91
18	OECD.	2009	Achieving Better Value for Money in Health Care.	OECD Publishing, Paris.	D92
19	OECD.	2010	Health Care Systems: Efficiency and Policy Settings.	OECD Publishing, Paris.	D93
20	OECD.	2010	Health care systems: Getting more value for money. OECD Economics Department Policy Notes, No. 2.	OECD Publishing, Paris.	D94
21	OECD.	2011	A System of Health Accounts 2011. Revised edition.	OECD Publishing, Paris.	D95

22	OECD.	2011	Where is the money and what are we doing with it? Creating an evidence base for better health financing and greater accountability. A Strategic Guide for the Institutionalization of National Health Accounts.	OECD Publishing, Paris.	D96
23	OECD.	2013	Public spending on health and long-term care: a new set of projections. A Going for Growth Report.	OECD Publishing, Paris.	D97
24	OECD.	2014	Geographic Variations in Health Care: What Do We Know and What Can Be Done to Improve Health System Performance?. OECD Health Policy Studies.	OECD Publishing, Paris.	D98
25	OECD.	2015	Fiscal Sustainability of Health Systems: Bridging Health and Finance Perspectives.	OECD Publishing, Paris.	D99
26	OECD.	2016	OECD Reviews of Health Systems: Latvia 2016.	OECD Publishing, Paris.	D101
27	OECD.	2017	Tackling Wasteful Spending on Health.	OECD Publishing, Paris.	D100
28	Oxley, H., & MacFarlan, M.	1994	Health Care Reform Controlling Spending and Increasing Efficiency. OECD Economics Department Working Papers, No. 149.	OECD Publishing, Paris.	D102
29	Sassi, F., Belloni, A., & Capobianco, C.	2013	The Role of Fiscal Policies in Health Promotion. OECD Health Working Papers, No. 66.	OECD Publishing, Paris.	D103
30	Scherer, P., & Devaux, M.	2010	The Challenge of Financing Health Care in the Current Crisis: An Analysis Based on the OECD Data. OECD Health Working Papers, No. 49.	OECD Publishing, Paris.	D104
Conference and meeting notes					
1.	Lau, E.	2012	Presentation- Arrangements for managing health expenditures. Joint OECD/WHO Meeting on	OECD Publishing, Paris.	D105

			Financial Sustainability of Health Systems. June 28, 2012. OECD.		
2.	OECD.	1989	Agenda item: 12 A system of health accounts for international data Collection. OECD Meeting of National Accounts Experts. September 22-25, 1998, Paris.	OECD Publishing, Paris.	D106
3.	OECD.	2000	Summary Record of the Workshop on Insurance in the Baltic States. December 14-15, 2000, Riga, Latvia**.**	OECD Publishing, Paris.	D107
4.	OECD.	2002	Working Party on Social Policy. Health Policy Statistics. Meeting of Experts in National Health Accounts. The State of Implementation of the OECD Manual A System of Health Accounts (SHA). October 10-11, 2002, Paris.	OECD Publishing, Paris.	D108
5.	OECD.	2003	Working Party on Social Policy. Health Policy Statistics. Summary Record of the Meeting of Experts in National Health Accounts. October 27-28, 2003, Paris.	OECD Publishing, Paris.	D109
6.	OECD.	2004	Health, Economy and Trade Feature at OECD Forum 2004. Ministerial Meetings. May 12-14, 2004, Paris.	OECD Publishing, Paris.	D110
7.	OECD.	2008	Health Accounts Experts. 10th Meeting of Health Account Experts. Next Steps to Further Improve the Methodology for Development PPPS in the Healthcare Sector. October 8-9, 2008, Paris.	OECD Publishing, Paris.	D111
8.	OECD.	2010	Meeting of the Health Committee at Ministerial Level. Meeting of the Health Committee at Ministerial Level Final Communique. October 7-8, 2010, Paris.	OECD Publishing, Paris.	D112

9.	OECD.	2011	A System of Health Accounts 2011. 13th Meeting of Health Account Experts. October 4-5, 2011, Paris.	OECD Publishing, Paris.	D113
10.	OECD.	2011	Health Sector Innovation and Partnership: Policy Responses to the New Economic Context. OECD 50th Anniversary Conference on Health Reform: Meeting the challenge of ageing and multiple morbidities**.** June 22, 2011, Paris.	OECD Publishing, Paris.	D114
11.	OECD.	2012	Session 1: The Financing Framework Under SHA 2011. Technical Workshop on the Implementation of the Health Financing Framework under SHA 2011. October 9, 2012, Paris.	OECD Publishing, Paris.	D115
12.	OECD.	2013	Expenditure by Disease, Age & Gender. 15th Meeting of Health Account Experts. 2013, Paris.	OECD Publishing, Paris.	D116
13.	OECD.	2016	Synthesis Note. Health Network. 5TH Meeting of the Joint Network on Fiscal Sustainability of Health Systems.	OECD Publishing, Paris.	D117
14.	OECD.	2017	Ministerial Statement. THE NEXT GENERATION of HEALTH REFORMS. OECD Health Ministerial Meeting. January 17, 2017, Paris.	OECD Publishing, Paris.	D118

Contribution C: The role of international organizations in the healthcare financing reforms in Latvia

Liva Stupele, Monika Ewa Kaminska Visser

1. Introduction

The collapse of the communist regime in Central and Eastern Europe (CEE)[33] in the late 1980s and early 1990s triggered profound political, economic, and social changes that severely affected healthcare financing systems (Cerami, 2006; Rechel & Mckee, 2009) and resulted in their underfunding (Davis, 2010). While struggling internally with the crisis that accompanied the post-communist transition, the CEE countries were pursuing the idea of "(re-)joining" the West and aspiring to membership of several international organisations (IOs) anchored in the Western structures, thus becoming subject to their influence (Laurel & Arellano, 1996; Deacon, 1997). In the last three and a half decades, IOs such as the World Bank (WB), the World Health Organization (WHO), the Organisation for Economic Co-operation and Development (OECD), and the European Union (EU) have been active in the region to assist the CEE countries in – among other things – social policy reforms, including social protection, pensions, and healthcare, by offering financial assistance, policy recommendations, and technical advice.

As for healthcare, and its financing in particular, one strand of the existing literature suggests that IOs, particularly the WB, defined the content of the reforms by coercing CEE countries to abandon the tax-based Semashko system in favour of a Social Health Insurance (SHI) model (Müller, 1999; Deacon, 1997; 2007; Deacon et al., 1997; Cerami, 2006) and that their policy advice was imbued with neoliberal, free-market approaches (Orenstein 2008). Other sources argue that the inspiration for adopting SHI was primarily endogenous, driven by domestic actors, with IOs playing a minor role in defining the new healthcare paradigm (Radin, 2003; Sitek, 2008; Rechel & McKeen 2009; Roberts, 2009; Kaminska et al. 2021).

This chapter contributes to the discussion on the extent and mode in which IOs have shaped social policies in post-communist CEE countries. It draws on three other chapters included in this edited volume that examine the content of policy recommendations

[33] The Central and Eastern European countries in this research are: Albania, Bosnia & Herzegovina, Bulgaria, Croatia, Estonia, Estonia, Hungary, Kosovo, Latvia, Lithuania, Montenegro, North Macedonia, Poland, Romania, Serbia, Slovakia, Slovenia, and the Czech Republic.

formulated by the WHO, the OECD, and the WB in the context of healthcare financing reforms in post-1989 CEE. It provides a case study (Gerring, 2008; Seawright & Gerring, 2008) of the involvement and role of IOs in healthcare financing reforms in Latvia from 1989 to 2019. The chapter answers multiple questions:

1) When and at whose initiative did cooperation between Latvian stakeholders and IOs materialize?
2) Which healthcare financing dimensions (see Kutzin et al., 2010) did IOs address?
3) Did IOs exert influence on the policy process?
4) Which policy level (paradigm, instrument, or parameter, see Hall 1993) did their recommendations target?
5) Did IOs promote SHI in Latvia, and how committed were they to neoliberal approaches?
6) How aligned were their recommendations with domestic ideas on reform, and did IOs use coercion to enforce changes?

Latvia, with one of the lowest shares in CEE of GDP allocated to healthcare in the early transition period (estimated at 3.9%–4.4%) (S10), faced critical challenges in funding healthcare. As a former Soviet republic, Latvia faced additional challenges compared to other CEE countries in the first decades of the transition, namely the daring task of state and nation-building in a socio-economic and political context that was imbued with post-soviet legacies (Stark & Bruszt, 1998; Sitek, 2010; Bohle & Greskovits, 2012). Moreover, Latvia was one of the EU countries hardest hit by the 2008 financial crisis, with a 25% GDP contraction and a 24% reduction in the healthcare budget (D67; D68; D71). These factors made Latvia particularly vulnerable and dependent on international support, making it an ideal case study for examining the potential influence of IOs.

The chapter focuses on the influence of the WHO, OECD, and WB on Latvian healthcare financing policies. No evidence of direct EU involvement was found, and therefore it is not included in this analysis. To ensure the reliability of the analysis, extensive data was collected from multiple sources, including legal acts, government strategies, position and press statements, and IOs' documentation (reports, assessments, publications, and presentations). The documents were obtained from IOs' online archives, Latvian government and parliament archives, the Ministry of Health (MoH), the Latvian Medical

Association (LMA), and the National Library. Documents not publicly available were obtained through personal correspondence with the WHO and OECD representatives (see Appendix No. 2). This set of data was complemented by twenty 25 depth semi-structured interviews conducted between June 2019 and September 2020 with domestic and international experts, including former ministers, state bureaucrats, and representatives from civil society and IOs (see Appendix No. 3). The data was coded using MAXQDA software, followed by a content analysis.

This chapter covers the period from 1988 to 2019. Following an overview of the initial attempts to reform healthcare financing under Soviet rule, the analysis traces five distinct periods (1991–1995; 1996–2001; 2002–2008; 2009–2010; 2011–2019), each corresponding to successive reform phases up to the outbreak of the COVID-19 pandemic.

2. IOs´ involvement and policy advice in Latvian healthcare financing

2.1. Healthcare system in Latvia before 1991

After Latvia declared independence in 1918, the Bismarckian SHI model became a blueprint for the healthcare system. By 1930, compulsory health insurance was introduced[34] for employees, including farmers, soldiers, and sailors. By 1938, thirty sickness funds covered 18.2% of the population (S3; S9; Arāja & Krūzs, 2016; Reshetnikov et al., 2019). The funds were financed by employer and employee contributions, along with state allocations. In most cases, sickness funds both purchased and provided healthcare services, owning or renting healthcare facilities, while private practitioners and hospitals operated in parallel. During the Soviet occupation (1940-1991), the SHI system was replaced by a highly centralized etatist Semashko system, financed through state budget allocations (Kutzin et al., 2010; 2010a; 2010b; Rechel & McKee, 2009; S8).[35]

By the late 1980s, Latvia's healthcare system was experiencing mounting problems. With healthcare spending between 2.6% (1980) and 3.4% (1990) of GDP (D54), access to care was limited, medical equipment was outdated, and healthcare facilities were in a state of

[34] This included regulation on sickness fund structure, medical treatment obligations, cash benefits, fund revenues and governance (S3; S8; Arāja & Krūzs, 2016).

[35] See more Rechel & McKee, 2009; Thomson et al., 2009; Davis, 2010.

severe disrepair. Poorly remunerated medical personnel were highly dissatisfied with the situation (D4; D54; S10). Amid the collapse of the Soviet Union, the first domestic reform initiatives emerged in the Latvian Soviet Socialist Republic (SSR). As indicated by our earlier research, following its re-establishment in 1988, the LMA began pressuring the MoH of the Latvian SSR to reintroduce the pre-Soviet SHI system (D4; D5; Kaminska et al., 2021). In 1989, the LMA developed a detailed reform concept, proposing a new social insurance system, combining pension, social, and health insurance, inspired by the German SHI system (D4; D5; I-3; I-5; I-6; I-13; I-14; I-16; I-18). However, under Soviet rule, no reforms were implemented, and due to Latvia's isolation from international contacts, no IOs were involved at that time.

2.2. 1991-1995: Domestically driven healthcare financing reforms and indirect involvement of IOs

After Latvia regained independence in 1991, a window of opportunity opened for healthcare financing reforms and international cooperation, allowing for Latvia's membership in various IOs and their involvement in healthcare reforms. In 1991, Latvia joined the WHO, whose advice initially focused on public health, access to pharmaceuticals, immunization, and the development of primary healthcare (PHC). In 1992, the country also became a member of the WB, and amid a severe socio-economic crisis, the new government sought the WB's guidance in most problematic areas, including the transition to a market economy, privatization, and the promotion of entrepreneurship. The WB became the main IO supporting Latvia with stabilization programs, loans, and technical expertise (D52; D54; D55; D56; D64; Orenstein, 2008).

The first rehabilitation loan from the WB helped Latvia secure crucial technical assistance and imports (including pharmaceuticals, vaccines, and medical supplies) that had been disrupted after the Soviet Union's collapse (D52; D53; D54). Although this loan did not target social issues directly, it paved the way for WB involvement in broader policy reforms, including social policies, since "*it would allow to sit down with the government and talk about reforms*" (I-11). A 1993 WB report, while focusing on micro- and macroeconomic stabilization, privatization, and banking system reforms, also addressed social policy by recommending reforms to the social safety net to accommodate the anticipated rise in unemployment (D54), which fully aligned with domestic policymakers´ concerns over potential social unrest. Accordingly, priority in social policy

was given to pensions and social protection reforms, while healthcare continued, for the time being, to be financed and organized according to Soviet principles (Arāja & Krūzs, 2016; I-3; I-5; I-6; I-13; I-14; I-15; I-16).

However, in newly independent Latvia, the overarching political objective was to break away from the Soviet legacy across all policy areas, with domestic policy efforts directed at distancing the country from the previous system (Bohle & Greskovits, 2012; I-13; I-6; I-15; I-16; see Kaminska et al. 2021). In the healthcare sector, doctors became key players in this process, advocating for the shift to a market-driven system. On one hand, the LMA had already established itself as an expert group in the 1980s, on the other hand, individual doctors transitioned into policymaking roles, assuming key positions in parliament and government (S3). Medical professionals utilized these access channels to promote the ideas outlined in the LMA 1989 reform proposal, thus aiming to diminish the role of the state and replace it with market-driven initiatives and emphasise individual responsibility. They advocated for the establishment of a decentralized SHI network providing only a basic package of services for the entire population, complemented by voluntary health insurance (VHI) for complementary and supplementary healthcare services (I-3; I-5; I-6; I-13; I-14; I-16; see Kaminska et al. 2021).

As already mentioned, the WB did not initially focus on healthcare financing, and the early reform ideas for a return to SHI were primarily domestically driven (I-3; I-5; I-6; I-13; I-14; I-16; see Kaminska et al. 2021). However, a WB's report on the transition to a market economy included a section on healthcare, emphasizing the need for decentralizing decision-making to improve efficiency and effectiveness (D54). Domestic policymakers interpreted this recommendation as an endorsement of the SHI model, even though the WB did not explicitly advocate for SHI or provide specific guidance on how to implement the decentralisation process.

By 1993, these domestically defined healthcare reforms were set in motion, aiming to overhaul all four sub-dimensions of the healthcare financing system: revenue collection, pooling, purchasing, and coverage. In 1994, the first step towards establishing SHI was the creation of over thirty local account funds, known as "sickness funds") (D21; D22) which, despite their name, did not collect insurance premiums but instead received and redistributed state and municipal resources. The next phase of the reform was expected to introduce insurance-based revenue collection (I-3; I-5; I-6; I-13; I-14; I-15; I-16).

At this stage, the healthcare financing system was based on the 1989 LMA reform proposal, which outlined two revenue streams, each designated to cover a specific package of services (D5). The first stream, sourced from the state budget, financed specialized health services under the State Healthcare Program. The second, funded through municipal budgets and state subsidies, supported local account funds managed by municipalities, which covered primary and secondary care services within the so-called Basic Care Program (D57). Health service coverage in Latvia extended to all citizens and residents[36], a policy that remains in place today, with no additional access criteria such as employment status, income, ethnicity, or place of residence. However, the generosity of service packages varied across municipalities and over time. On the one hand, the packages were approved annually based on state budget allocations; on the other hand, their actual content and quality of provision in each municipality depended on the resources that municipalities could allocate to the local account funds, in addition to state subsidies (D57; S3; I-3; I-5; I-11; I-14; I-15; I-16).

Although the WB did not directly focus on healthcare in its policy studies, it addressed healthcare financing in two documents on local government and public expenditure (*Latvia Public Expenditure Review*, 1994 (D56), and *Latvia Local Government Expenditures and Resource Transfers,* 1995 (D57)), as healthcare was the largest expenditure category for municipalities. While the WB did not formulate explicit recommendations regarding revenue collection and pooling, it did propose changes in service payment mechanisms and composition of the healthcare expenditure, to increase the efficiency of the system given the limited availability of resources. As for service payments in the hospital sector, the WB recommended shifting from bed-day-based payments with patient co-payments to a payment model based on capitation or the number of patients treated relative to the population served (D56).

Regarding the overall composition of healthcare expenditure, the WB recommended moving away from inpatient care towards outpatient (mainly primary) care. Additionally, it advocated for equalizing the quality of services and their provision across municipalities (D56; D57; I-11).

[36] After the proclamation of independence, Latvia had a relatively high proportion of permanent residents (around amount of 27% of the population in 1996) who were not citizens of Latvia, or of any other country. The number of non-citizens decreased to 12% of the population in 2017 (S12).

Alongside IOs' involvement, Latvia also developed cooperation with Western countries, particularly Germany. An extensive cooperation network was established with German medical personnel and state and regional authorities, with exchange visits, clinical internships, and capacity-building activities, with the aim to introduce Latvian stakeholders to the German SHI system (I-3; I-4; I-5; I-6; I-7; I-10; I-14; I-16). German assistance was publicly portrayed as support for Latvia's efforts to introduce SHI.

In summary, early healthcare financing reforms in Latvia were primarily driven by domestic actors, with a focus on decentralization, market-based incentives, and the introduction of SHI. While the WB did not pursue a strong healthcare reform agenda, its recommendations on decentralization, macroeconomic stabilisation, and fiscal policy indirectly influenced healthcare financing and included detailed suggestions in the sub-dimension of purchasing. Although the WB did not express direct support for the SHI model, its emphasis on decentralization was interpreted by domestic policymakers as an endorsement of SHI. Meanwhile, the WHO's concentrated its efforts on public health and PHC, without directly engaging in healthcare financing reforms during this period.

2.3. 1996-2001: WB is invited to take part in healthcare financing policy

The first wave of healthcare reforms in Latvia resulted in extreme fragmentation of the healthcare financing system, leading to inefficiencies and significant regional inequalities in service quality. These system failures prompted a consensus among domestic actors - politicians, representatives of the Ministry of Welfare (MoW) (which oversaw the healthcare system), and the LMA - that a decentralized healthcare model was unsuitable for a country with such a small population, limited territory, and constrained resources (I-4; I-5; I-6; I-15). Consequently, in 1996, the Latvian government decided to pursue a re-centralization of the healthcare system (D23; D24; D63; D65; I-4; I-5; I-6; I-11; I-15).

Initial steps included the introduction of patient fees for doctor appointments and co-payments for certain services, aiming to limit healthcare utilisation and generate additional revenue (S10; I-3; I-17; I-24). These out-of-pocket payments quickly came to account for approximately 30% of total health expenditure (THE). Additionally, VHI was introduced, initially covering user charges but later expanding to include complementary and supplementary services (D63; S10). However, VHI's contribution to THE remained marginal (S1) (see Appendix No. 1).

Recognizing the challenges ahead and building on successful cooperation in other policy areas, particularly pension reforms, the Latvian government decided to involve the WB in healthcare reforms. Accordingly, the MoW approached the WB to extend its involvement into healthcare financing and re-centralization of the healthcare system (D59; D62; I-9; I-11; I-12; I-15). Cooperation with the WB was seen as an opportunity to gain policy expertise, financial support and solutions for addressing the healthcare system's challenges. The former State Secretary of the MoW stated:

"It was not the World Bank's plan to get involved in healthcare reforms in Latvia. The World Bank was involved in the reform of the pension system which was a success. But then they [the World Bank] could see that we were struggling with the reform [of the healthcare system] and recognized that we needed it [the WB's help]" (I-15).

The parties agreed to initiate a comprehensive Healthcare Reform Project, which took two years to develop (1996-1998) as its objectives and activities were extensively negotiated among domestic stakeholders and international aid donors throughout the preparation stage. The WB coordinated bilateral foreign aid from the Swedish International Development Agency and the Japanese government, aiming to develop a Social Insurance Reform Project (D60; D61; D62; I-23). The possible solutions were domestically discussed and agreed upon, later facilitating domestic ownership of the implementation process (D58; D60; D65; I-11; I-15). Since the idea to reverse the changes at the paradigm level and re-centralize the healthcare system was already formulated by the domestic actors, the WB's role was to identify the best possible instruments and parameters (see Hall, 1993) that aligned with this vision (I-11). The WB relied only on pro forma conditionalities related to the agreed project activities and refrained from imposing any hard conditionalities.

The two-phase Healthcare Reform Project was approved, with a loan contract signed between the Latvian government and the WB in 1998. The first phase, starting in January 1999 and initially planned to end in December 2001, was completed with delays in 2004. The USD 12 million loan for the first phase comprised four components: a) implementing healthcare financing reforms (healthcare administration, finance allocation, health investment policy, and payment mechanisms); b) restructuring the healthcare delivery system (hospital sector restructuring, building primary healthcare, and strengthening public health and disease prevention programs); c) health reform communication strategy;

and d) project management. The second phase was planned for the period 2005-2010 with a loan of USD 20 million (D65).

Given the need for immediate reforms and alignment between the WB and the government's positions on policy solutions, several project activities began in 1997 before the official contract was signed in 1998. A key reform addressed the fragmentation of healthcare funding, merging the two separate funding streams into a "single pipe" managed at the national level by the newly established State Sickness Fund. This fund, later renamed the State Compulsory Health Insurance Fund (SCHIF), continued to distribute state budget resources to the local level (D30; D61; D63). Moreover, between 1997 and 1998, the 33 local account funds were merged into eight, creating larger risk pools (minimum 200,000 people) for more efficient risk management. These reforms introduced the purchaser-provider model (World Bank, 1998). Municipalities were no longer responsible for financing service provision but maintained responsibility for healthcare facilities and ensuring access to care (D61; D62; D63; D65; I-1; I-3; I-5; I-8; I-14; I-17). The two service packages were also merged into one, covering primary, secondary and specialized services.

For revenue collection, to guarantee a predictable and stable healthcare budget, the Project required that "*between 1999 and 2001, the Borrower will ensure that the earmark of the income tax revenue for healthcare services remains not less than 28.4% of total revenues*" (D61; D63).

Several Project activities built on earlier WB advice to shift focus from inpatient care to outpatient care and PHC to improve resource allocation and control costs (D61; D63). However, this transition proved complex. Reaching a consensus among multiple domestic (national and local) and international (particularly the WHO) stakeholders was challenging. Local politicians, in particular, resisted hospital closures due to concerns over losing the support of their electorate (I-3; I-4; I-5; I-8; I-11; I-15).

The Project specifically addressed the purchasing sub-dimension of healthcare financing and payment methods for healthcare providers. In PHC, the payment model shifted in 2001 from the German point system to a mixed capitation model, with general practitioners (GPs) holding funds for ambulatory specialists (World Health Organization, 2001). In inpatient care, preparatory work towards introducing Diagnosis-related Groups

(DRGs) and global budgeting for hospitals, which was to be piloted in the second Project phase (D61), aimed to replace the existing mix of several methods.

Additionally, the first component of the Project focused on capacity building, training, and skills development for healthcare administration staff at the ministerial and hospital levels. This was key in building competencies in health economics and system management, leaving a lasting impact on Latvian healthcare policy (I-3; I-6; I-11; I-13; I-16; I-17; I-18). The Project also funded software and hardware for health service purchasing and reimbursement, which is still in use by Latvia's National Health Service (NHS) (I-2; I-17; I-18).

To conclude, while the WHO was not directly involved in healthcare financing reforms, the WB's Healthcare Reform Project marked a turning point in Latvian healthcare financing policy. Following the Latvian government's initiative, the WB focused on healthcare policy, identifying it as one of the five priority areas for its advice, technical involvement, and lending that would bring the most added value (D62; D63). Consequently, between 1996 and 2000, the WB played a significant role in the Latvian healthcare reforms not only by providing financial support but also by assuming the role of an epistemic community (Haas, 1992) to facilitate policy learning and transfer. Rather than imposing a specific reform model, the WB adapted its focus to Latvia's needs, supporting the domestically driven paradigmatic change (re-centralization of the healthcare system) and provided the requested advice and financial support at the level of instruments and parameters within the healthcare sector.

2.4. 2002-2008: Departing from the WB and further healthcare financing centralization

The parliamentary elections in fall 2002 produced a major shift in Latvian politics. The "Jaunais Laiks" (New Era) party, with a highly neoliberal program, emerged victorious and assumed key positions, including those of Prime Minister (PM) and Finance Minister. In healthcare, the new government made two major decisions: first, it established a separate MoH, distinct from the MoW, appointing a New Era party member as its head (D25). Second, it disengaged from the WB in the healthcare sector by cancelling the second phase of the WB's Healthcare Reform Project, which was supposed to introduce the Master Plan "Program of Development of Primary and Hospital Care Services" aimed

at restructuring the hospital network, hospital closures, and changing payment mechanisms for secondary healthcare services (D65).

The cancellation of the second phase of the Healthcare Reform Project had several reasons. First, local governments, as owners of hospitals, opposed the restructuring of the hospital network restructuring, fearing that hospital closures and downsizing would cost them votes in the upcoming local elections (I-2; I-3; I-5; I-8; I-11; I-15; I-16, I-17; I-18; S8). Second, the new government and the freshly created MoH did not have an understanding and a sense of ownership of the Project. Instead, they were generally critical of any endeavours of the previous government and claimed that the project focused too much on technical assistance, domestic capacity, and institution building instead of promoting sweeping neoliberal reforms in the sector, in line with the overall political program of New Era (D25; D65; I-9).

The WB was keen to stay in the game and continue the project, and emphasized that *"not proceeding with the next phase of this project would significantly reduce the effectiveness of the reforms supported under the first phase, and may leave key components of the reform agenda unfinished"* (D65:36). It sought to convince the New Era-led government of the need for reform consistency, offering other forms of cooperation, including a Technical Assistance Loan and continued policy dialogue, reflecting the WB's flexibility. Yet, the government refused any further cooperation, and the second phase with its corresponding loan was cancelled (D61; D65; D26; I-2; I-8; I-15; I-17; I-18). In the project's Completion Report, the WB noted that some interventions, such as the Master Plan and the consolidated health investment strategy, required domestic actors to shift priorities, as "*competing pressures on the government budget, a focus on impending accession of Latvia into the EU, and economic and security issues, are currently eclipsing health as a major government priority*" (D65: 34). The WB also pointed out that "*the implementation of the Master Plan [..] depends on long-term government commitments to making the tough decisions that must be made in this area*" (D65:16).

In 2004, following another political turnover, a discussion on state budget composition developed in the domestic arena (S6) with the Ministry of Finance arguing for more flexibility in allocating resources across policy areas, including healthcare. In line with that argumentation, given that the conditions of the Healthcare Reform Project's first phase were fulfilled and the commitments with the WB were terminated, the earmarked portion of 28.4% of income tax revenue for the healthcare budget was discontinued in

2005 (I-2; I-8; I-17; I-18; I-19). Healthcare financing was fully shifted to general taxation through the annual state budget, with funds transferred (via the State Treasury) to the State Compulsory Health Insurance Agency (SCHIA) that had replaced SCHIF in 2003 (S8; I-8; I-17; I-18; I-19).

By 2005, local account funds—the number of which was meanwhile reduced to five—were turned into territorial branches of SCHIA, which became the main healthcare financing institution and acted as a service purchaser on behalf of the entire population (Cabinet of Ministers; 2004).

Interestingly, despite having discontinued its cooperation with the WB in the healthcare sector, the government followed the reform course outlined in the Master Plan and began implementing individual elements of it without the WB's technical and financial assistance (D26; D61; D65; I-2; I-8; I-15; I-17; I-18). Specifically, the government focused on introducing the DRGs which the WB had been consistently recommending since the beginning of the transition. During the first phase of the Healthcare Reform Project, an analysis was conducted to identify the most suitable DRG system for Latvia, accompanied by preparatory work for piloting. Moreover, in 2004, the government began reforming the hospital network, although it chose a gradual restructuring approach rather than the rapid, large-scale hospital closures envisaged in the World Bank's Master Plan (D26).

Two conclusions can be drawn. First, the WB's cooperation with Latvia was shaped by the domestic political landscape, with the new government choosing to reverse previous reforms and selectively engage with IOs. Despite considerable efforts, the WB was unable to establish a working relationship with the new leadership. This demonstrates that even in politically and economically vulnerable countries, domestic actors can assert agency over the terms of cooperation with IOs, including initiating cooperation or terminating project activities based on their own agendas and needs. Second, although IOs were not directly involved in Latvian healthcare policymaking at the time, the WB's ideational influence endured. While the government rejected certain elements of the WB's Master Plan, it adopted and adapted others, which illustrates that the WB's non-coercive approach allowed its influence to persist even in the absence of financial or technical assistance.

2.5. 2009-2010: Global financial crisis and active support from the WB and WHO

Latvia was one of the EU countries hardest hit by the global financial crisis in 2008-2009, with GDP falling by nearly 25% in 2009 (Purfield & Rosenberg, 2010; Åslund & Dombrovskis, 2011; Austers, 2014), making the country heavily dependent on international support. Harsh consolidation measures were introduced across all policy areas, with drastic cuts in public expenditure – particularly affecting the social sector and healthcare. At the same time, tax increases[37] and structural and public administration reforms, including the reduction of the number of ministries and public agencies, also impacted the healthcare sector[38]. The MoH and its agencies experienced a 55% reduction in staff[39], with several functions merged into the remaining institutions[40]. The overall health budget decreased by 24% in 2010 compared to 2008 (D67; D68; D69; D71; Åslund & Dombrovskis, 2011).

In response to the crisis, the healthcare financing system was reorganized multiple times over the following years, including the transformation of the SCHIA into an independent NHS. This new institution was tasked with implementing health policies, managing financial resources, and ensuring the provision of healthcare services, including "*determining the contents of the benefits package, contracting with providers, implementing the e-health system and registering clinical guidelines and medical technologies*" (S7:18).

To contain the crisis, Latvia requested a €7.5 billion support package from the European Commission and the International Monetary Fund[41] (S4), which included a short-term loan from the WB (World Bank, 2010f). At that time, Latvia's relationship with the WB

[37] Value added tax (VAT) was increased from 18% in 2008 to 21% in 2011; some excise taxes were also increased (Åslund & Dombrovskis, 2011; S7).

[38] Previous efforts to centralize the provider network and shift from hospital care to outpatient care were drastically accelerated. Thought the shock-type overnight reforms, the excessive hospital numbers (from 72 to 43 in 2009 and to 39 in 2012), and bed capacity were reduced, while prioritizing primary care, services for children and pregnant women, with additional emergency and pharmaceutical assistance, to mitigate the negative consequences on population's health as much as possible (S7; D67; D68; D70; D71).

[39] From 1319 in January 2009 to 593 in October 2009 (S7).

[40] Under MoH in 2009 following agencies were closed: The State Agency of Health Statistics and Medical Technologies, the State Centre of Medical Professional Education and Public Health Agency in which earlier in the year the Centre of AIDS Prevention, the Narcology State Agency, the Mental Health State Agency and the Health Promotion Agency was incorporated. Several others were re-organized and functions merged (S7; D67; D68; D69; D70; D71).

[41] See more S2; S4; S5.

was limited to fee-for-service technical assistance, as all WB-financed projects had been completed and Latvia had graduated from WB financial support in 2007. Nevertheless, the WB agreed to provide a loan on special lending terms (World Bank, 2010c; 2010d), with funds transferred in two separate streams. The first stream aimed to strengthen the financial sector, while the second supported the Public Administration Reform and the domestically developed Social Safety Net Strategy (SSNS). The former aimed at *"reforming and strengthening public administration, by reducing the number of central government ministries, improving human resource management and internal auditing structures, and increasing transparency in the management of state-owned enterprises"* (D66:2), which covered the healthcare sector. As for the SSNS, one of its goals was to shield vulnerable groups from the effects of the crisis and ensure their access to health services (D66; D69; D70; D71). While the SSNS was designed by domestic policymakers, the WB provided support in selecting operational measures, particularly emphasizing the protection of vulnerable groups, showcasing the WB's flexibility in cooperation with recipient countries, with limited coerciveness.

Starting in October 2009, the SSNS, supported by a €100 million loan from the WB, exempted individuals with low income from user charges for all healthcare services and financed overnight stays after day care. The SSNS also introduced home-care services for the chronically ill, day-care centres, additional nurses in GP practices, and a family doctor telephone advisory service, supporting the shift away from hospital care (World Bank, D66; D69; D70; D71). In February 2010, further exemptions were introduced for low-income individuals (D51; D66; D68; D69; D71). The WB emphasized the need to protect vulnerable groups and stipulated that, following the end of its loan financing, the government would need to readjust the eligibility criteria and continue the SSNS using funds from the general state budget (D66; D69). This marked the first instance of the WB enforcing loan conditionalities in Latvia's healthcare financing.

During this period, the WHO was also actively involved in Latvian healthcare reforms. While continuing to focus on public health (e.g., providing technical assistance and educational trainings across different healthcare fields), the WHO, for the first time, expanded its activities to include healthcare system strengthening (I-8; I-12; I-20). Between 2009 and 2011, the WHO's main message was that "*the government should give higher priority to health within the limited fiscal space*" (D43:1) and that "*if the Latvian government kept cutting the public spending on health, and relying even more on OOPPs,*

it would lead to dramatic consequences" (D43:1). The WHO engaged in parliamentary discussions, provided recommendations on managing the impact of the crisis, and assisted in drafting the healthcare budget. Moreover, the Regional Director (RD) of WHO Europe communicated not only directly with the Latvian PM but also through conferences, to convey the WHO's position at the highest political level (D42; D43; I-8; I-12; I-14; I-18; I-20). Through these efforts, the WHO disseminated its ideas to key stakeholders in government, parliament, and civil society.

In 2010, in response to the critical situation in healthcare financing and following the WHO's advice to avoid further spending cuts, Member of Parliament and former HM Circene[42], supported by PM Dombrovskis, revived the idea of introducing SHI with the aim of attracting additional funds to the system. A working group at the MoH explored reform options, including the expansion of VHI and the introduction of a state insurance system that would link healthcare entitlements to income tax status, potentially excluding some social groups from access (D10; D11; D12; D68; I-2; I-18). However, the incumbent HM Rozentāle criticised these ideas, condemning them as an attempt to balance the state budget at the expense of healthcare and claiming that increasing healthcare funding required political will rather than systemic change (D10; D11; D12; I-2; I-18).

Both the WHO and the WB, already active in mitigating the crisis's impact on the healthcare system, expressed their views on introducing SHI in Latvia. Under the 2010-2011 Biennial Collaborative Agreement between Latvia and WHO Europe, the WHO issued "Comments on the Informative Report on the Usefulness of Introducing Compulsory Health Insurance in Latvia", concluding that the healthcare financing system in place was sound and "*there [was] no compelling argument in favour of the introduction of a payroll-tax-based social health insurance system in Latvia*" (D42:2, D43; I-12; I-14). It advocated for strengthening the general-tax-based system and prioritizing healthcare by allocating a larger share of government revenue to the sector (D42).

Similarly, the WB, in its 2010 "Public Expenditure Review of Government Administration and the Social Sectors", published as part of its technical support to the Latvian government, concluded there was "*no compelling argument for structural reform*

[42] Ingrīda Circene was HM from April 2003 until March 2004 and then from October 2011 until July 2014 (see below).

of health finance in Latvia at this juncture, such as a shift to a social insurance model, mandatory private insurance or a mix of public and private insurance beyond what exists today" (D67:9). Both IOs cautioned that introducing SHI would incur administrative costs that could outweigh the benefits of a system change, and opposed abandoning the principle of universal coverage (D42; D67; D68). Since both the incumbent HM and the two IOs opposed the introduction of SHI, the idea was temporarily dropped from the public debate.

In its public expenditure report (D67), the WB offered additional healthcare financing recommendations, grounded in the belief that, given limited financial resources, efficiency and effectiveness were crucial for the healthcare system's sustainability. First, the WB focused on service provision and access. While Latvia still used a negative list of services, the WB recommended defining a positive list within the state-financed benefit package to establish clear rules and enable providers to offer services on the open market (D67). Responding to co-payment increases introduced in 2009 to reduce demand, the WB also suggested that the *"co-payment policies can be adjusted further so that those who can pay more, while the poor are better protected"* (D67:9). While in 2010 some co-payments were indeed reduced, out-of-pocket payments still accounted for 37.8% of THE (see Appendix No. 1) (D67; D68; D71). Second, in the purchasing sub-dimension, the WB recommended competitive contracting for providers and stressed the need to adopt a DRG system in inpatient care to improve efficiency. The WB proposed piloting the DRG-based payment system, aiming for implementation in 2013/2014 (D67).

In conclusion, both the WB and the WHO supported the Latvian government with technical advice and financial assistance during the crisis. Notably, this marked the first time the WHO actively engaged in healthcare financing reforms, advising on the healthcare budget and urging policymakers to prioritize healthcare financing over other policy fields. The WB recommended efficient use of the limited resources and shielding the most vulnerable populations from the crisis' impact. Its loan and the related conditionalities proved crucial in ensuring healthcare access for the poorest. The WB recommendations clearly deviated from a strict neoliberal approach. Importantly, both IOs criticised a possible introduction of SHI, stressing the importance of preserving universal health coverage in Latvia, which ultimately contributed to the idea being discarded.

2.6. 2011-2019: SHI revival and IOs objection to the reform proposal

In 2011, healthcare expenditure in Latvia amounted to 5.6% of GDP, reflecting severe underfunding (S11). In response, two new initiatives to introduce elements of SHI were launched—first between 2011 and 2014, and again between 2016 and 2018—based on the argument that SHI would provide more stable and increased financial resources to the system.

The first initiative followed the emergency parliamentary elections in October 2011, when PM Dombrovskis reappointed Circene as HM (Cabinet of Ministers, 2014). Circene declared healthcare financing reform a priority (D3; D13; D14; I-1; I-2; I-5; I-9). Under her leadership, a draft law was prepared in March 2013 (D15; D16), proposing a departure from universal health coverage. Instead, it recommended earmarking a portion of existing individual social contributions specifically for healthcare and linking entitlement to health services to the payment of income tax or designated individual contributions (D14; D15; D16; Mitenbergs et al., 2014; I-1).

Although the draft law was developed domestically, IOs found themselves drawn into the policymaking process. In an effort to gain support for her ideas and bolster her position amid growing opposition, Circene approached both the WHO - already active in Latvia - and the OECD, which had just decided (in May 2013) to open accession discussions with the country.

Similarly to other CEE countries (see Chapter xx on OECD), Latvia's main motivation for joining the OECD was the fact that *"it provided an international seal of quality for the level of economic development"* (D1, n.p). Additionally, the OECD membership was promoted as an "*opportunity to improve the existing policies, the efficiency of the state administration, the state's competitiveness, and the general level of the population's well-being"* (D7; D1, n.p.). During the accession process, structured cooperation on healthcare financing policy did not take place. Rather, it was sporadic, based on the HM requests, as the one mentioned above (Stupele 2025, forthcoming).

Although both IOs expressed criticism of the draft law in their assessments, Circene publicly claimed that they supported her plans to introduce SHI, in an attempt to leverage their authority to advance her reform agenda in the face of political opposition during the approval stage (Stupele 2025, forthcoming). However, this clear misrepresentation of the IOs' positions was exposed by the opposition (D8; D9; Mitenbergs et al., 2014).

Ultimately, the draft law was rejected by Parliament in 2014, and healthcare continued to be financed through general taxation, administered by the NHS.

Following the failed reform attempt, the state of healthcare financing remained critical, with government spending on health lagging behind other European countries, covering only around 60% of THE. While VHI contributed 5% of THE, the remaining share was financed by OOPPs (D38; D41; S1) (see Appendix No. 1). In 2016, the newly appointed HM Čakša[43] declared her commitment to addressing the system's chronic underfunding (D2; I-22) by "*developing and implementing a new healthcare financing model to attract a significantly larger amount of financing for healthcare*" (D27).

Since the WHO had already established itself as a source of policy advice and technical expertise on healthcare financing after the crisis, it was the first IO that HM Čakša contacted, requesting consultation with the WHO Europe Barcelona Office for Health Systems Strengthening (WHO Europe Barcelona Office) to discuss possible policy solutions.[44] A senior MoH representative remarked, *"the cooperation was always good with the WHO [..] also with the Barcelona office. We knew that [the Barcelona office] experts could offer their expertise [on healthcare financing reforms]"* (I-23). A consultative meeting took place in Barcelona in early 2016, organized by the WHO Europe Barcelona Office, with the support of the European Observatory on Health Systems and Policies (Observatory). It focused on discussing reform proposals and analysing relevant experiences from other European countries. As a follow-up, in July 2016, the WHO issued its third assessment (D45), evaluating the challenges and reform options. While the WHO consistently emphasized the need for sufficient funding, recommending that up to 12% of the state budget be allocated to healthcare (D45), it strongly criticized the specific solutions proposed by the HM, reaffirming the importance of a tax-based healthcare system with universal coverage (D45). Thus, while the WHO aligned with the framing of the problem, it did not endorse the proposed solutions.

The HM also approached the OECD, which Latvia had officially joined in July 2016 (D35). Just before the accession, the OECD published the first comprehensive evaluation

[43] Anda Čakša was HM from June 2016 until January 2019.

[44] The WHO Europe Barcelona Office is responsible for providing expertise on health system strengthening. Such a request was possible based on WHO's cooperation framework with member states, where technical consultations are available to members upon request (I-8; I-12; I-20) since WHO's mission and mandate is to assist member countries in all of the health-related topics (see Chapter xx in this edited volume).

of Latvia's healthcare system, part of the pre-accession evaluation (2016) (D35). The *"good cooperation established during the preparation phase of the report"* paved the way for the OECD's close involvement in Latvia's healthcare reforms (I-23). The OECD report stressed that, with public spending at merely 3.2% of GDP, the healthcare system was underfunded. It recommended improving access to healthcare by reducing OOPPs through cost-sharing exemptions for vulnerable and low-income groups (D37:51-52). This recommendation aligned with the policies already being implemented within the SSNS framework, which had been financially supported by the WB during the 2008-2009 financial crisis.

The HM´s direct approach to IOs demonstrated the initiative and capacity of domestic actors to actively involve IOs in the policymaking process. The HM sought to leverage IO support to legitimize its framing of the issue—that the healthcare system was critically underfunded—and to persuade Parliament that

The HM's direct requests for IOs' advice demonstrate the initiative and capacity of domestic actors to involve IOs in the policymaking process. The MH sought to leverage IOs' support to legitimise her framing of the issue (the need for more funds) and to persuade Parliament that *"the government had to act responsibly and allocate an appropriate budget (to the healthcare system). The WHO's opinion that the sector was under-resourced and needed more money [...] was very important [in this debate]"* (I-23).

In September 2016, the PM and MoH organised a high-level conference to present reform scenarios developed by the MoH to both domestic and international stakeholders. During the event, the MoH State Secretary outlined three options, clearly favouring a scenario that once again envisaged introducing elements of SHI. Specifically, the MoH suggested: first, increasing the share of individual income tax allocated to social insurance purposes by one percentage point and earmarking it for healthcare; second, dividing statutory healthcare services into two baskets - a "basic" and "full" one; and third, making the entitlement to the "full" basket conditional upon individuals' actual payment of the earmarked healthcare tax.

The last provision meant that only the "basic" healthcare basket would be accessible to individuals who did not—or could not - pay the designated share of taxes earmarked for

healthcare (D18; D19; D31; S1; Pētersone et al., 2019), which would translate into effectively abandoning the principle of universal coverage.

The goal of the conference was to convince domestic policymakers to prioritize healthcare and allocate more funding to the sector, while also gaining support for the proposed reforms (I-22; I-20). Additionally, the HM sought IOs' endorsement of her preferred reform scenario (I-17; I-18; I-19; see Stupele, 2025, forthcoming). During the conference, both the WHO and the OECD representatives who were invited to the event (D17; I-19; I-20; I-21; I-22; I-25) reiterated that Latvia's healthcare system was critically underfunded and suggested increasing public spending on health and improving access by reducing OOPPs (D17; D33; D36; D37:51-52; D42; D44; D45). The WHO again recommended allocating 12% of the annual state budget and 5% of GDP to healthcare (D33; D42; D44). However, both IOs again opposed abandoning the principle of universal coverage, with the WHO explicitly urging lawmakers not to implement reforms that would jeopardize it (D33; D36). The OECD did not offer any specific recommendations regarding the HM's proposal (D36; I-19; I-20; I-25). In the aftermath of the conference, the Health Minister once again falsely claimed that the WHO and OECD supported her proposal (I-8; I-19; I-23; see Stupele, 2025, forthcoming).

Despite the WHO's explicit criticism, the HM once again approached WHO representatives in early 2017 to discuss a draft of a Healthcare Financing Law that included the previously formulated measures (earmarking income tax payments for healthcare, splitting services into two baskets, and linking entitlement to the "full" basket to individual tax payment status). After her meeting with the WHO RD for Europe, the WHO agreed to re-evaluate the proposed reforms (D20; D46). This illustrates that, despite its critical stance, the WHO chose to "stay in the game" rather than withdraw from cooperation. Importantly, the WHO was aware of growing political opposition in Latvia to the reforms, and these actors may have intended to rely on the new WHO assessment to bolster their position - as had occurred during the 2011-2014 reform attempt (I-8; I-20; I-22; see Stupele, 2025, forthcoming).

In its fourth reform assessment, the WHO once more criticised the plans to split healthcare services into two baskets and tie the entitlement to the "full" basket to tax payments. The WHO argued that reforms should focus on reducing the financial burden on patients and ensuring universal access to healthcare by increasing healthcare spending. The organization was particularly critical of the potential exclusion of approximately 300,000

people from access to healthcare (D39; D40; D47; I-11). Simultaneously, the OECD published its periodic Economic Survey (D38), reiterating the need to reduce OOPPs by expanding co-payment exemptions for low-income populations and increasing public healthcare spending (D38; D39; D40).

Shortly before the WHO and the OECD submitted their assessments, the WB released its evaluation of various aspects of the Latvian healthcare system. Published in late 2016, the report was part of a 2015 contract for reimbursable advisory services and had been requested by the NHS in 2014 (D6; D50; I-8). The request was motivated by the WB's authority among domestic stakeholders, rooted in its long-standing role in conducting comprehensive studies of social and healthcare systems across the CEE region since the early 1990s— an effort unmatched by any other IOs at the time (I-8). The evaluation offered policy solutions for a comprehensive national health strategy to address key healthcare system challenges (D48). Consistent with its earlier stance, the WB's evaluation concluded that the health budget in Latvia was not likely to increase in the short-to-medium term, and that improvements in health sector performance were needed to spur efficiency gains from the existing funds (D49:2). The WB also suggested that the NHS implement strategic purchasing based on quality benchmarks and minimum service volume thresholds for healthcare providers (D48).

Despite growing domestic opposition and the lack of support from the WHO and OECD for her reform agenda, HM Čakša moved forward with the planned reforms (see Stupele, 2025, forthcoming). The Healthcare Financing Law came into effect in January 2018 as part of broader tax reforms (D31; I-8; I-9; 1-10). In addition to the previously mentioned measures, the law included several provisions aligned with recommendations from the WB's 2016 evaluation, such as strategic purchasing (D28).

In June 2018, the OECD issued a follow-up note on the 2016 pre-accession recommendations, welcoming the government's efforts to increase public healthcare funding while also highlighting risks in the reform's design and warning that linking contributions to entitlements, while perhaps politically is appealing, can also have unintended—and ultimately costly—consequences on equity and efficiency (D39; D40). The report also criticized the failure of the reform to address high OOPPs and the introduction of two-basket system that had the potential of adding *a considerable degree of administrative complexity* and increasing costs (D39).

Following the parliamentary elections in October 2018, a new governing coalition committed to developing a *"sustainable healthcare financing system ensuring a compulsory inclusion of all Latvian residents*" (D29). The newly appointed HM Viņķele[45] pronounced herself against the introduction of a two-basket system (I-17; I-18; I-20; I-21). To gain the support of the new Parliament, she invited Tamas Evetovits, Head of the WHO Barcelona Office, to once again present the WHO's position to a parliamentary committee in April 2019. In his presentation, Evetovits reiterated the WHO's criticism of the two-basket system and the contribution-based model of healthcare financing (D34; I-18; I-20; I-21). In June 2019, the introduction of the two-basket system was suspended and eventually abandoned in the following years. The allocation of one percentage point of the individual income tax to healthcare was retained (D32; S1; Pētersone et al., 2019). However, further adjustments to healthcare financing were postponed due to urgent challenges, including a shortage of human resources in the sector and the onset of the COVID-19 pandemic.

In summary, the healthcare financing reforms implemented between 2011 and 2019 primarily concentrated on reforming revenue collection to secure additional and stable funding for the system. Moreover, the composition principles of the benefits package were adjusted in the coverage sub-dimension. However, the reforms did not address the pooling sub-dimension. In the service purchasing dimension, a service reimbursement method based on a DRG system and promoted by the WB was implemented between 2014 and 2016 (S1).

Between 2011 and 2019, Latvia engaged in intensive cooperation with three IOs, namely the WB, the WHO, and the OECD. Domestic stakeholders perceived these IOs as external sources of legitimacy that could be strategically "used" to gain political advantage in domestic policymaking. In practice, various domestic actors instrumentalized the IOs to bolster support for their respective positions within the national arena. Notably, but not exclusively, three health ministers—Circene, Čakša, and Viņķele—relied on the authority of the IOs in their attempts to advance their reform agendas. At the same time, representatives of reform-opposing groups, particularly the LMA and the Latvian Rural

[45] Ilze Viņķele was Minister for Welfare from October 2011 to January 2014, and Health Minister from January 2019 to January 2021.

General Practitioners' Association, also cited the IOs to strengthen their arguments (see Stupele, 2025, forthcoming).

At the paradigmatic level, starting from 2010, the WHO and the OECD consistently expressed their criticism of a potential shift towards SHI in Latvia, advocating for the retention of tax-based financing, which they saw as essential for ensuring universal health coverage. However, their objections were mostly ignored by the HMs Circene and Čakša who pushed for reforms that defied IOs' recommendations. The recommendations by the WB did not target the paradigmatic level. **At the instrument level,** the focus of IOs differed. The WHO and the OECD primarily concentrated on the sub-dimension of resource collection, stressing the need for increased budget allocations to healthcare, but these recommendations were largely ignored by Latvia. In contrast, the WB focused on efficiency in the healthcare system and provided recommendations for the service purchasing sub-dimension, which were partially implemented. **At the parameter level,** the WHO repeatedly emphasized the need to increase THE to at least 5% of GDP and 12% of the annual state budget. However, these recommendations were not followed, either.

3. IOs role in Latvian healthcare financing policy

Between 1991 and 2019, Latvian healthcare financing policy underwent massive changes. This chapter documents and analyses IOs' role in these processes and illustrates the evolving nature of cooperation between domestic actors and IOs. In the early transition years, domestic actors, particularly doctors, were the primary sources of reform ideas and the driving force behind the changes, supported by contacts with their German counterparts. This confirms earlier findings about the endogenous nature of the early reform ideas, especially the attempts to introduce SHI in Latvia (see Kamiska et al. 2021). This finding aligns with the conclusions of other scholars, who argue that the diffusion of SHI across CEE countries was driven by endogenous factors (Marrée & Groenewegen, 1997; Lawson & Nemec, 2003; Jacoby, 2004; Rechel & McKee 2009:1187; Roberts, 2009; Kutzin et al., 2010b).

Even after Latvia joined the WHO and the WB (in 1991 and 1992, respectively), these IOs did not directly engage in healthcare financing reforms. The WHO focused on public health issues, and the WB concentrated on economic and financial policies outside the

healthcare sector. While its influence on domestic healthcare policy ideas and agenda-setting were limited, the WB's policy advice in other areas indirectly informed healthcare financing (Radin, 2003) through its emphasis on decentralized decision-making, which domestic actors interpreted as support for re-establishing SHI in Latvia. Furthermore, the WB's focus on public finances led to explicit recommendations on service purchasing, laying the groundwork for later cooperation in the healthcare sector.

Following the initial, turbulent, and endogenously driven reform efforts, the Latvian government, in 1996, requested direct WB's involvement in healthcare, viewing it as an opportunity to implement comprehensive reforms across the healthcare sector. The WB contributed policy knowledge, technical expertise, and financial assistance, thereby lending credibility to the domestically defined agenda of re-centralization. Notably, the WB did not impose its own policy agenda or preferred healthcare financing models. Instead, its input served as a foundation for negotiation among the domestic stakeholders, resulting in mutually agreed-upon, pro forma conditionalities (see Killick, 1998).

Until 2002, the WB influenced Latvian healthcare financing through non-coercive means, providing evidence-based policy options derived from its knowledge and experiences in other countries. It also acted as an international aid coordinator and intermediary in horizontal policy transfer (see Rechel & McKee, 2009), connecting the Latvian side with international experts and consultants from countries such as Sweden, the Netherlands, and Japan. In this capacity, the WB helped identify valuable policy lessons applicable to the Latvian context, which aligns with existing literature portraying the WB as an epistemic community – an actor that frames problems, goals, and solutions (Robertson, 1991; Killick, 1998; Orenstein, 2000; Larmour, 2002; Deacon, 2007).

At the start of the new millennium, despite multiple internal challenges, the new political leadership distanced itself from direct WB involvement in healthcare financing. The WB's efforts to "stay in the game" and continue cooperation with the Latvian government by adjusting its offer were unsuccessful, and the cooperation was unilaterally terminated by the Latvian government.

However, even without direct involvement, the domestic reform trajectory reflected WB's recommendations, particularly in the areas of service purchasing and hospital restructuring. Thus, the WB's influence continued shaping the policy (Robertson, 1991; Killick, 1998; Orenstein, 2000; Larmour, 2002; Deacon, 2007).

Following the financial crisis, Latvia's deteriorating economic situation, prompted the government to renew cooperation with IOs, namely the WB and the WHO, to support healthcare policy reforms. During this period, the WB's technical and financial support played a crucial role in addressing healthcare financing challenges. The WB agreed to fund domestically developed policy measures, again attaching largely pro forma conditionalities that reflected its protecting the most vulnerable by ensuring access to healthcare services. Additionally, the WB once more served as an external source of legitimacy for domestic policy measures.

During this period, the WHO also expanded its involvement in Latvia, engaging in healthcare financing reforms. It employed healthcare system assessments, technical consultations on the healthcare budget composition, and presentations at various events to advocate for prioritizing healthcare financing over other policy areas. From this point onward, the WHO assumed a leading role among the IOs, offering consultancy and ad-hoc expertise on healthcare financing reforms in Latvia.

The most intensive cooperation with IOs on healthcare financing occurred between 2011 and 2019. The WHO continued to play a prominent role, providing advice in response to Latvia's requests in the 2010/2011 Biennial Collaborative Agreement. In this period, the WHO's main message for Latvia focused on the need to ensure universal health coverage, aligning to the *Sustainable Development Goals* and *Health for All* framework (see Chapter xx on WHO), which translated into consistent recommendations to increase public spending within the existing system.

In 2013, Latvia began the OECD accession process, which allowed for initiating cooperation on healthcare financing policy. The OECD contributed advice on healthcare financing issues through its regular publications only and did not offer ad-hoc evaluations or recommendations as such activities fell outside the scope of the cooperation framework (Kaasch & Martens, 2015; see Chapter xx on OECD).

During the three decades under investigation, the three IOs maintained different foci in their recommendations. The WHO emphasized prioritizing healthcare among other policy fields, repeatedly advocating for an increase in public spending (see Chapter xx on WHO). Similarly, the OECD's evaluations, based on comparisons with other member countries, called for an increase in public funding. Both the WHO and the OECD focused on the sub-dimensions of resource collection and coverage, advocating for a shift in

domestic political priorities. In contrast, the WB provided recommendations primarily in the sub-dimensions of pooling and purchasing, emphasizing the optimization of existing healthcare spending patterns and improving system efficiency. The WB, unlike the WHO and the OECD, refrained from emphasizing the need to increase public spending and reach certain benchmarks.

It can be argued that all three IOs - rather than promoting a strictly neoliberal agenda - adopted a balanced approach integrating socio-economic and market efficiency perspectives, which can be labelled as "inclusive liberalism" (see Porter & Craig, 2004). While this is consistent with the WHO long-standing position that governments bear responsibility for organising healthcare through provision of adequate health and social measures (Lee & Goodman, 2002; Kaasch, 2009; 2015; Hanrieder, 2016), it is more notable in the cases of the WB and the OECD which have historically been associated with promotion of neoliberal policy. Nonetheless, this finding is in line with more recent scholarship on the OECD, which shows that over the past decades it has also advocated for healthcare systems that are not only economically efficient but also accessible, high-quality, social protective - preserving redistributive and income-protection functions (Kaasch & Deacon, 2008; Mahon & McBride, 2009; Kaasch, 2015).

In their attempts to shape the preferences and priorities of domestic actors and influence policymaking, the WHO and the OECD relied on their soft power, using knowledge production and technical support (see Deacon, 1997; Cerami, 2006; Orenstein, 2008; Béland & Orenstein, 2013; Kaasch, 2015; Sending, 2015) and providing ideas in form of evaluations based on best practices and international comparison, thus serving as epistemic communities (see Haas, 1992) and facilitating ideational transfer (see Rechel & Mckee, 2009). They also participated in domestic conferences, as well as direct meetings and correspondence with high-level political leaders (see Kaasch & Martens, 2015). Since the WHO and the OECD operated with soft governance only, it was possible for Latvian stakeholders to ignore their advice. As for the WB, in addition to soft governance, it also provided financial assistance, which traditionally is associated with hard governance instruments. However, the WB only relied on pro forma conditionalities (Killick, 1998) and consistently refrained from applying hard conditionalities, despite having the option to do so (Kelley, 2004; Cerami, 2006; Deacon, 2007; Orenstein, 2008; Kaasch, 2015).

4. Conclusions

This study sheds light several aspects in the relationship between IOs and their member states. First, it demonstrates that even weak and vulnerable countries can retain agency as they initiate and terminate cooperation with IOs, and select forms of collaboration that align with their domestic agenda and needs. The relationship with the WB clearly illustrates this dynamic: domestic actors requested the WB's involvement in 1996, then discontinued the cooperation when its approach diverged from national policy priorities, only to later reinstate it upon recognizing that no other IO could offer similarly comprehensive system evaluations (Kaasch & Martens, 2015). Furthermore, domestic stakeholders were able to negotiate the content and terms of the cooperation in line with their own policy visions.

Second, the last two reform attempts reveal not only the limitations of IOs in shaping policy ideas and setting the government's agenda, but also the ways in which domestic actors were able to instrumentalize the IOs. Between 2011 and 2018, domestic actors strategically engaged with the WHO and the OECD to leverage their authority and legitimize their reform agendas in the face of political opposition (see Stupele, 2025, forthcoming). In doing so, they selectively utilized IOs' recommendations, effectively "cherry-picking" elements that supported their positions (see Stupele, 2025, forthcoming).

Third, this study shows the flexibility and responsiveness of the IOs in their relations with receiving countries. Even when their recommendations were ignored, IOs continued to engage. The WHO, for example, did not terminate cooperation with Latvia despite its concerns being consistently dismissed. Instead, it continued to provide assistance, in an effort to "stay in the game" and maintain an opportunity to persuade domestic counterparts to adopt its policy ideas. This engagement can be explained by the WHO's institutional mandate to advise member states (see Chapter xx on WHO) and its long-term vision of achieving universal health coverage globally (see Chapter xx on WHO). Similarly, the WB exhibited flexibility, agreeing to financially and technically assist Latvia through the financial crisis, even after the Healthcare Reform Project was discontinued by the government. Clearly, as an international bank, the WB was eager to continue cooperation with Latvia to be able to reinstate its lending activities in the country. This finding resonates with conclusions in the studies on the WB's involvement in Croatia, Albania and in the Pacific (see Larmour, 2002; Druga, 2022; Malinar, 2022).

This research also demonstrates that IOs, in their policy advice, aim to strike a balance between economic efficiency and the protection of vulnerable groups through redistributive and income protection functions. All three IOs were actively involved in advocating for the protection of these groups. While the WHO's emphasis on equity is expected, it was particularly noteworthy in the case of the WB, which only once employed hard loan conditions, requiring the Latvian government to safeguard low-income groups and ensure access to healthcare services. Such instances of "inclusive liberalism" (see Porter & Craig, 2004), were visible also in the case of the OECD, which aligns with existing literature (see Lee & Goodman, 2002; Kaasch & Deacon, 2008; Mahon & McBride, 2009; Kaasch, 2009; 2015; Hanrieder, 2016; see Chapter xx on OECD).

Lastly, the chapter reveals the varying degrees to which Latvia implemented IOs' recommendations. While almost all the WB's recommendations were implemented, the advice of the WHO and the OECD was repeatedly ignored. Existing literature suggests that lack of implementation can be attributed to the absence of executive or veto powers for IOs and the fact that decision-making lies with domestic politicians (see Orenstein, 2008). However, our research uncovers two additional factors contributing to this outcome: the alignment of IOs' policy advice with domestic agendas and the specificity of the advice. The more an IO's recommendations aligned with domestic priorities and solutions, the more likely were they to be implemented (see Noy, 2017; 2018). For example, the WB's non-coercive approach in the Healthcare Reform Project and the SSNS provided the basis for negotiating policy content and corresponding loan conditionalities. This collaborative interaction led to domestic ownership of the reforms and the successful implementation of the WB's ideas. This confirms that aligning policy solutions between IOs and domestic actors is crucial for policy transfer (see Killick, 1998; Wireko & Beland, 2017; Bazbauers, 2018). On the other hand, several instances in Latvia's healthcare financing reform show that the recommendations by the WHO and the OECD did not align with domestic priorities, even contradicting them at times (see Stupele, 2025, forthcoming). Particularly during the 2016 reform, the discrepancy between domestic solutions and IOs' recommendations was significant, resulting in Latvia disregarding IOs' advice. As for the level of specification, this research found that the granularity of policy advice played a role in the implementation of IOs' policy prescriptions in the domestic setting. The more specific the advice at the instrument and parameter levels (see Hall, 1993), the greater the likelihood of it being followed. For

instance, the WB's specific recommendations at the level of instruments and parameters could be easily implemented without the need to politicise these measures. In contrast, the advice of the WHO and the OECD to increase public funding from the state budget required a paradigm shift, which necessitated political will, stability and continuity, public debate, and consensus among stakeholders. Additionally, the WHO and the OECD recommended changes in domestic priorities and mindset, without specifying it at the level of instruments and settings, thus leaving them open to domestic interpretation and leading to varying levels of politicization in implementation.

In summary, this chapter shows that changes in Latvian healthcare financing resulted from a complex interplay of domestic political and economic factors, alongside interactions between domestic stakeholders and IOs, thus confirming that domestic policymaking interacts with international interdependencies (see Obinger et al., 2013). It also demonstrates that weak and vulnerable countries can exercise agency in their relationships with IOs, selectively choosing when, how, and with whom to cooperate, and which recommendations to implement.

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Appendix No. 1

Total Health Expenditure (THE) in Latvia

Indicators	1995	1998	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
THE in % Gross Domestic Product (GDP)	5,8	6,4	5,5	5,8	5,8	5,5	6,2	5,9	5,7	5,5	5,6	6,1	6,1	5,6	5,4	5,4	5,5	5,7	6,2	6,0	6,2	6,7
Domestic General Government Health Expenditure (GGHE-D) in % THE	66,3	60,0	50,8	48,7	49,6	49,8	56,2	55,7	61,5	60,9	60,3	59,6	60,2	63,5	60,3	60,0	59,7	58,7	55,8	57,2	59,7	61,5
Out-of-pocket (OOPS) in % of THE	33,7	40,0	47,7	48,9	47,6	48,6	40,6	41,7	35,6	36,8	37,3	38,8	37,2	34,3	37,8	38,5	39,1	40,5	43,4	42,0	39,3	37,1

Source: Authors' compilation of World Health Organization's Global Health Expenditure Database (the year 2000-2018) and OECD Stat Database (the year 2019).

Appendix No. 2

Analysed documents

No.	Author	Year	Name of the Document	Link/ Source	Document Code
Domestic actors´ press publications					
1.	Ārlietu Ministrija (Ministry of Foreign Affairs).	2019	OECD un Latvija (OECD and Latvia).	https://www.mfa.gov.lv/lv/oecd-un-latvija?utm_source=https%3A%2F%2Fwww.google.com%2F	D1
2.	Čakša, A.	2016	Veselības aprūpes ārstēšanas plāns (Healthcare treatment plan).	The Latvian Doctor, (10), 1-4.	D2
3.	Circene, I.	2013	Gudra veselības aprūpe (Smart healthcare policy).	In P. Apinis (Ed.). Veselības aprūpe Latvijā [Healthcare in Latvia] (pp. 10-13). Riga, Medicīnas apgāds.	D3
4.	Meikšāns, J., Strazdiņš, V.	1989	Latvijas ārstu biedrības LPSR veselības aizsardzības organizācijas pārveides projekts republikas saimnieciskā aprēķina koncepcijas ietvaros (Latvian doctors' association project of health protection organization transformation within the republic of Latvia economic conception).	Latvijas Ārsts (Latvian Doctor). (1), 88-94.	D4
5.	Meikšāns, J., Strazdiņš, V.	1990	Latvijas PSR likums par veselības un sociālo aprūpi. Projekts (Latvian SSR Law on Health and Social Care. Project).	Latvijas Ārsts (Latvian Doctor). (2), 93-96.	D5

6.	Nacionālais Veselības Dienests (National Health Service).	2015	Amendment to the Agreement for Reimbursable Advisory Services.	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/838171468047406811/official-documents-amendment-to-the-reimbursable-advisory-services-agreement-with-the-national-health-service-of-latvia-ref-p152481	D6
7.	Public broadcasting of Latvia.	2016	Latvija paraksta līgumu par pievienošanos OECD (Latvia signs an agreement on joining the OECD).	https://www.lsm.lv/raksts/zinas/ekonomika/latvija-paraksta-ligumu-par-pievienosanos-oecd.a185800/	D7
8.	Tiesībsargs (The Ombudsman of Latvia).	2014	ANO Augstā Komisāre Cilvēktiesību jautājumos un veselības aprūpes finansēšanas modelis (UN High Commissioner for Human Rights and the healthcare financing model).	http://www.tiesibsargs.lv/news/lv/ano-augsta-komisare-cilvektiesibu-jautajumos-un-veselibas-aprupes-finansesanas-modelis	D8
9.	Tiesībsargs (The Ombudsman of Latvia).	2014a	Atklāta vēstule Saeimai: par "Veselības aprūpes finansēšanas likumu" (Open Letter to the Parliament: On the draft "Healthcare Financing Law").	http://www.tiesibsargs.lv/uploads/content/legacy/veselibas_aprupe_ANO_augstas_komisares_atbilde_Saeimai_13022014_ieskanets.pdf	D9
10.	Veselības Ministrija (The Health Ministry).	2010	Veselības ministre: ienākuma nodokļa sasaiste nomaksas sasaiste ar veselības aprūpes pieejamību nav risinājums (Minister of Health: Linking the payment of income tax to the availability of healthcare is not a solution).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/2653_veselibas_ministre_ienakumu_nodokla_nomaksas_sasaiste_ar_veselibas_aprupes_pieejamibu_nav_risinajums/	D10
11.	Veselības Ministrija (The Health Ministry).	2010	Veselības ministre: adekvāts veselības aprūpes finansējums ir politiskas gribas jautājums (Minister of Health: Adequate	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/2673_veselibas_ministre_adekvats_veselibas_aprupes_finansejums_ir_politiskas_gribas_jautajums/	D11

			funding for health care is a matter of political will).		
12.	Veselības Ministrija (The Health Ministry).	2010	Veselības ministre: veselības aprūpes pieejamības sasaistīšana ar nodokļu nomaksu pretnostatīs ārstus un pacientus (Minister of Health: Linking access to health care to the payment of taxes will contrast doctors and patients).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/2630_veselibas_ministre_veselibas_aprupes_pieejamibas_saistisana_ar_nodoklu_nomaksu_pretnostatis_arstus_u/	D12
13.	Veselības Ministrija (The Health Ministry).	2011	Veselības ministre ar sociālajiem partneriem pārrunā nepieciešamību sasaistīt plānveida medicīnisko palīdzību ar nodokļu nomaksu (Minister of Health discusses with social partners the need to link planned medical care with tax payments).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/3198_veselibas_ministre_ar_socialajiem_partneriem_parruna_nepieciesamibu_sasaistit_planveida_medicinisko_/	D13
14.	Veselības Ministrija (The Health Ministry).	2012	Darba grupa veselības obligātās apdrošināšanas koncepcijas izstrādei (Working group for the development of a draft concept of compulsory health insurance).	https://www.vm.gov.lv/lv/ministrija/darba_grupas/darba_grupa_veselibas_obligatas_apdrosinasanas_koncepcijas_p/	D14
15.	Veselības Ministrija (The Health Ministry).	2013	Veselības nozares stratēģiskā padome atbalsta ministrijas virzīto koncepciju par veselības obligāto apdrošināšanu (The Strategic Council for the Health Sector supports the concept of health insurance promoted by the Ministry).	http://www.vm.gov.lv/lv/aktualitates/4104_veselibas_nozares_strategiska_padome_atbalsta_ministrijas_vi/	D15
16.	Veselības Ministrija (The Health Ministry).	2013	Veselības aprūpes finansēšanas likuma projekts (Healthcare Financing Law Project).	https://www.vm.gov.lv/lv/veselibas-aprupes-finansesanas-likumprojekts?utm_source=https%3A%2F%2Fwww.google.com%2F	D16

17.	Veselības Ministrija (The Health Ministry).	2016	Konference “Veselības aprūpes sistēma Latvijā- strukturālās reformas un finansēšanas modeļi” [Conference "Healthcare system in Latvia -structural reforms and financing models"].	http://www.vm.gov.lv/lv/ministrija/konferences_un_seminari/konference_veselibas_aprupes_sistema_latvija__strukturalas_r/?pri	D17
18.	Veselības Ministrija (The Health Ministry).	2017	Apspriež Veselības aprūpes finansēšanas likumprojektu (The Healthcare Financing Bill is discussed).	https://www.vm.gov.lv/lv/aktualitates/preses_relizes/5501_apspriez_veselibas_aprupes_finansesanas_likumprojektu/	D18
19.	Veselības Ministrija (The Health Ministry).	2017	Veselības aprūpes finansēšanas likumprojektu virza apstiprināšanai uz Ministru Kabinetu (The Healthcare Financing Bill is submitted to the Cabinet of Ministers for approval).	https://www.vm.gov.lv/lv/aktualitates/preses_relizes/5506_veselibas_aprupes_finansesanas_likumprojektu_virzis_apstipri/	D19
20.	Veselības Ministrija (The Health Ministry).	2017	Veselības ministre darba vizītē apmeklēs PVO Eiropas Reģionālo biroju [The Minister of Health will pay a working visit to the WHO Regional Office for Europe].	https://www.vm.gov.lv/lv/aktualitates/preses_relizes/5417_veselibas_ministre_darba_vizite_apmekles_pvo_eiropas_regiona	D20
Domestic Laws, Parliament and Cabinet of Ministers Regulations					
21.	Ministru kabinets (The Cabinet of Ministers).	1994	Par veselības aprūpes sistēmas finansēšanas reformu. Ministru kabineta noteikumi Nr. 63. (On the reform of the financing of the healthcare system. Regulations of the Cabinet of Ministers No. 63).	https://likumi.lv/ta/id/58049-par-veselibas-aprupes-sistemas-finansesanas-reformu	D21
22.	Ministru kabinets (The Cabinet of Ministers).	1994	Slimokasu izveides un darbības noteikumi. Ministru kabineta noteikumi Nr. 360. (Rules for the establishment and operation of sickness funds. Regulations of the Cabinet of Ministers No. 360).	https://www.vestnesis.lv/ta/id/45552-slimokasu-izveides-un-darbibas-noteikumi	D22

23.	Ministru kabinets (The Cabinet of Ministers).	1996	Veselības aprūpes finansēšanas noteikumi (Healthcare Financing Regulation).	https://www.vestnesis.lv/ta/id/41779-veselibas-aprupes-finansesanas-noteikumi	D23
24.	Ministru kabinets (The Cabinet of Ministers).	1996	Latvijas veselības aprūpes attīstības stratēģija (Latvian Healthcare Development Strategy).	https://likumi.lv/ta/id/16617-par-primaras-un-sekundaras-veselibas-aprupes-sistemas-attistibas-strategiju	D24
25.	Ministru kabinets (The Cabinet of Ministers).	2002	Deklarācija par Einara Repšes vadītā Ministru kabineta iecerēto darbību (Declaration on the Cabinet of Ministers headed by Einars Repše intended operation).	https://www.mk.gov.lv/sites/default/files/editor/repse-deklaracija.pdf	D25
26.	Ministru kabinets (The Cabinet of Ministers).	2005	Par Ambulatorās un stacionārās veselības aprūpes pakalpojumu sniedzēju attīstības programmas ieviešanas plānu 2005.-2010.gadam (On the implementation plan for the development program of outpatient and inpatient health care service providers for 2005-2010).	https://likumi.lv/ta/id/124962-par-ambulatoras-un-stacionaras-veselibas-aprupes-pakalpojumu-sniedzeju-attistibas-programmas-ieviesanas-planu-2005-2010-gadam	D26
27.	Ministru kabinets (The Cabinet of Ministers).	2016	Māra Kučinska Valdības deklarācija (Declaration on the Cabinet of Ministers headed by Maris Kucinskis).	https://www.mk.gov.lv/sites/default/files/editor/20160210_mkucinskis_vald_prior_gala_vers_0.pdf	D27
28.	Ministru kabinets (The Cabinet of Ministers).	2017	Par konceptuālo ziņojumu "Par veselības aprūpes sistēmas reformu" (On the conceptual report "On the reform of the health care system").	https://likumi.lv/ta/id/292718-par-konceptualo-zinojumu-par-veselibas-aprupes-sistemas-reformu	D28
29.	Ministru kabinets (The Cabinet of Ministers).	2019	Deklarācija par Artura Krišjāņa Kariņa vadītā Ministru kabineta iecerēto darbību (Declaration on the leadership of Arturs Krišjānis Kariņš the intended activities of the Cabinet).	https://www.mk.gov.lv/sites/mk/files/media_file/kk-valdibas-deklaracija_red-gala-1.pdf	D29

30.	Saeima (The Parliament of Latvia).	1997	Par valsts sociālo apdrošināšanu (On state social insurance). Law edn.	https://likumi.lv/ta/id/45466-par-valsts-socialo-apdrosinasanu	D30
31.	Saeima (The Parliament of Latvia).	2017	Veselības aprūpes finansēšanas likums (Healthcare Financing Law).	https://likumi.lv/ta/id/296188-veselibas-aprupes-finansesanas-likums	D31
32.	Saeima (The Parliament of Latvia).	2019	Grozījumi Veselības aprūpes finansēšanas likumā (Amendments to the Health Care Financing Law).	https://likumi.lv/ta/id/307619-grozijumi-veselibas-aprupes-finansesanas-likuma	D32
IOs produced documents and publications					
1.	Evetovits, T.	2016	Health financing in Latvia: analysis of expenditure and financial protection. WHO Europe Barcelona Office for Health Systems Strengthening.	Unpublished. Obtained in personal correspondence	D33
2.	Evetovits, T.	2019	WHO perspective on health financing reforms in Latvia. WHO Europe Barcelona Office for Health Systems Strengthening.	Unpublished. Obtained in personal correspondence	D34
3.	OECD.	2016	Latvia's accession to the OECD.	https://www.oecd.org/latvia/latvia-accession-to-the-oecd.htm#:~:text=1%20July%202016%20%2D%20Latvia%20deposited,full%20member%20of%20the%20Organisation	D35
4.	OECD.	2016	Latvia faces important challenges to improve the performance of its health system.	https://www.oecd.org/newsroom/latvia-faces-important-challenges-to-improve-the-performance-of-its-health-system.htm?	D36
5.	OECD.	2016	Reviews of Health Systems OECD Reviews of Health Systems.	https://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-systems-latvia-2016_9789264262782-en	D37

6.	OECD.	2017	Economic Surveys: Latvia.	https://www.oecd-ilibrary.org/economics/oecd-economic-surveys-latvia-2017_eco_surveys-lva-2017-en	D38
7.	OECD.	2018	Secretariat Note on Latvia's Implementation of the Health Committee Recommendations.	Unpublished. Obtained in personal correspondence	D39
8.	OECD.	2018	Summary of Latvia's OECD Post-Accession Progress.	https://www.oecd.org/content/dam/oecd/en/about/legal/post-accession-report/latvia-oecd-post-accession-report-2018.pdf	D40
9.	OECD.	2019	Economic Surveys: Latvia.	https://www.oecd-ilibrary.org/economics/oecd-economic-surveys-latvia-2019_f8c2f493-en	D41
10.	WHO Europe.	2010	WHO comments on the "Informative Report on the Usefulness of Introducing Compulsory Health Insurance in Latvia". WHO Barcelona Office for Health System Strengthening, WHO Europe.	Unpublished. Obtained in personal correspondence	D42
11.	WHO Europe.	2010	WHO/Europe contributes to health budget discussions in Latvia.	https://www.euro.who.int/en/countries/latvia/news/news/2010/09/whoeurope-contributes-to-health-budget-discussions-in-latvia	D43
12.	WHO Europe.	2012	WHO notes on the informal meeting on sustainable health financing: European experience with specific attention to opportunities and challenges for Latvia. WHO Barcelona Office for Health System Strengthening, WHO Europe.	Unpublished. Obtained in personal correspondence	D44

13.	WHO Europe.	2016	WHO notes on health system financing policy in Latvia: opportunities and challenges in light of international experience. WHO Barcelona Office for Health System Strengthening, WHO Europe.	Unpublished. Obtained in personal correspondence	D45
14.	WHO Europe.	2017	Policy dialogue proposed during visit of Minister of Health of Latvia to WHO/Europe.	https://www.euro.who.int/en/countries/latvia/news/news/2017/04/policy-dialogue-proposed-during-visit-of-minister-of-health-of-latvia-to-whoeurope	D46
15.	WHO Europe.	2017	WHO notes on health system financing policy in Latvia: opportunities and challenges in light of international experience. Summary of key messages. WHO Barcelona Office for Health System Strengthening, WHO Europe.	Unpublished. Obtained in personal correspondence	D47
16.	World Bank Reimbursable Advisory Services.	2016	Health Sector Reform Options for Latvia.	https://www.vmnvd.gov.lv/lv/pasaules-banka-konference-prezente-latvijas-veselibas-aprupes-sistemas-izvertejumu	D48
17.	World Bank Reimbursable Advisory Services.	2016c	Prospects for Health Sector Reform in Latvia.	https://www.vmnvd.gov.lv/lv/media/276/download?attachment	D49
18.	World Bank Reimbursable Advisory Services.	2016	Inception Report.	https://www.vmnvd.gov.lv/lv/media/303/download	D50
19.	World Bank.	2010	The Status of Projects in Execution (SOPE) Report.	https://documents1.worldbank.org/curated/en/518261468056423016/pdf/573850AR0SOPE0101public10BOX353754B.pdf	D51

20.	World Bank.	1992	Conformed Copy - Loan Agreement Loan Number 3525 LV (Rehabilitation Loan) between Republic of Latvia and International Bank for Reconstruction and Development.	http://documents.worldbank.org/curated/en/357741468300291882/Conformed-Copy-L3525-Rehabilitation-Loan-Loan-Agreement	D52
21.	World Bank.	1992	Announcement of World Bank Approves First Loan to Latvia.	http://documents.worldbank.org/curated/en/934021628676311789/Announcement-of-World-Bank-Approves-First-Loan-to-Latvia-on-October-22-1992	D53
22.	World Bank.	1993	Latvia The Transition to a Market Economy.	http://documents.worldbank.org/curated/en/892111468758735453/Latvia-The-transition-to-a-market-economy	D54
23.	World Bank.	1994	Latvia - Country Assistance Strategy.	http://documents.worldbank.org/curated/en/634531468266155321/Latvia-Country-assistance-strategy	D55
24.	World Bank.	1994	Latvia Public Expenditure Review.	http://documents.worldbank.org/curated/en/625941468774261054/Latvia-Public-expenditure-review	D56
25.	World Bank.	1995	Latvia Local Government Expenditures and Resource Transfers.	http://documents.worldbank.org/curated/en/977841468774310714/Latvia-Local-government-expenditures-and-resource-transfers	D57
26.	World Bank.	1996	Latvia - Structural Adjustment Loan Project.	http://documents.worldbank.org/curated/en/723131468265757767/Latvia-Structural-Adjustment-Loan-Project	D58
27.	World Bank.	1997	Latvia - Welfare Reform Project.	http://documents.worldbank.org/curated/en/202811468772215633/Latvia-Welfare-Reform-Project	D59

28.	World Bank.	1997	Conformed Copy - L4408 - Health Reform Project - Japanese Grant Agreement.	http://documents.worldbank.org/curated/en/193421468278120263/Conformed-Copy-L4408-Health-Reform-Project-Japanese-Grant-Agreement	D60
29.	World Bank.	1998	Latvia - Health Reform Project (English).	http://documents.worldbank.org/curated/en/859301468772216611/Latvia-Health-Reform-Project	D61
30.	World Bank.	1998	Report No. 17706-LV Latvia - Country Assistance Strategy.	http://documents.worldbank.org/curated/en/584941468045857753/Latvia-Country-Assistance-Strategy	D62
31.	World Bank.	1999	Report No: 18968 Implementation Completion Report Republic of Latvia Structural Adjustment Loan (Loan No. 4126-LV).	http://documents.worldbank.org/curated/en/651391468303035886/Latvia-Structural-Adjustment-Loan-Project	D63
32.	World Bank.	2003	Latvia Country Brief 2003.	http://web.worldbank.org/archive/website00978/WEB/OTHER/1E8E5F8B.HTM	D64
33.	World Bank.	2004	Report No: 27521 Implementation Completion Report (TF-20376 SCL-44080) on a Loan in the Amount of US$11.46 Million to the Latvia for a Health Reform Project.	http://documents.worldbank.org/curated/en/253731468752999775/Latvia-Health-Reform-Project	D65
34.	World Bank.	2009	Program Information Document (PID). Concept Stage. Report No.: AB4945.	https://documents1.worldbank.org/curated/en/540401468056936876/pdf/LV0SSPAR0PID010Concept0Stage.pdf	D66
35.	World Bank.	2010	Latvia From Exuberance to Prudence. A Public Expenditure Review of Government Administration and the Social Sectors. (In	https://documents.worldbank.org/en/publication/documents-	D67

			Two Volumes) Volume I: Overview and Summary.	reports/documentdetail/462981468265795002/overview-and-summary	
36.	World Bank.	2010	Latvia From Exuberance to Prudence. A Public Expenditure Review of Government Administration and the Social Sectors. (In Two Volumes) Volume II: Analytical Report.	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/225041468045881507/analytical-report	D68
37.	World Bank.	2010	Loan Number 7863-LV. Loan Agreement (Safety Net and Social Sector Reform Program First Development Policy Loan) between Republic of Latvia and International Bank for Reconstruction and Development.	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/336981468090561136/loan-agreement-for-loan-7863-lv-conformed	D69
38.	World Bank.	2010	Report No. 5 1434-LV. International Bank for Reconstruction and Development Program Document for the First Special Development Policy Loan in the Amount of Euro 100 Million as Part of a Proposed Lending Program, of Two Loans to the Republic of Latvia to Support a Safety Net and Social Sector Reform Program.	https://documents1.worldbank.org/curated/en/794501468045236197/pdf/514340PGD0P115101Official0Use0Only1.pdf	D70
39.	World Bank.	2010	Latvia: Protecting Poor and Vulnerable Groups in the Wake of the Global Economic Crisis.	https://documents.worldbank.org/en/publication/documents-reports/documentdetail/484501468188931592/protecting-latvia-s-poor-and-vulnerable-groups-in-the-wake-of-the-global-economic-crisis	D71
Gray literature and background information sources					

1.	Behmane, D., Dudele, A., Villerusa, A., Misins, J., Klavina, K., Mozgis, D., ... & World Health Organization.	2019	Latvia: Health system review.	https://eurohealthobservatory.who.int/publications/i/latvia-health-system-review-2019	S1
2.	Finanšu ministrija (Ministry of Finance).	2008	Convergence Programme of the Republic of Latvia 2008-2011.	https://ec.europa.eu/economy_finance/economic_governance/sgp/pdf/20_scps/2008-09/01_programme/lv_2009-01-14_cp_en.pdf	S2
3.	Glāzītis, A.	2003	Rīdzinieku veselības aprūpe 1201-2002 (Healthcare for the population of Riga 1201-2002).	Riga: Author.	S3
4.	International Monetary Fund.	2009	IMF Announces Staff-Level Agreement with Latvia on a €1.7 Billion Stand-By Arrangement as Part of Coordinated Financial Support.	https://www.imf.org/en/News/Articles/2015/09/14/01/49/pr08332	S4
5.	International Monetary Fund.	2010	IMF Survey: After Severe Recession, Stabilization in Latvia.	https://www.imf.org/en/News/Articles/2015/09/28/04/53/socar021810a.	S5
6.	Ministru kabinets (The Cabinet of Ministers).	2020	Ministru kabineta vēsture (The History of the Cabinet of Ministers).	https://www.mk.gov.lv/lv/ministru-kabineta-vesture?utm_source=https%3A%2F%2Fwww.google.com%2F	S6
7.	Mitenbergs, U., Taube, M., Misins, J., Mikitis, E., Martinsons, A., Rurane, A., & Quentin, W.	2012	Latvia: Health system review. Health systems in transition.	https://eurohealthobservatory.who.int/publications/i/latvia-health-system-review-2012	S7

8.	Tragakes, E., Brigis, G., Karaskevica, J., Rurane, A., Stuburs, A., Zusmane, E., ... & World Health Organization.	2008	Latvia: health system review.	https://eurohealthobservatory.who.int/publications/i/latvia-health-system-review-2008	S8
9.	Vīksna, A.	1994	Slimo kases Latvijā (Sickness funds in Latvia).	Riga: A/S Slimo Kase (Corporation Sickness Fund).	S9
10.	World Health Organization.	2001	Health care systems in transition: Latvia.	https://eurohealthobservatory.who.int/publications/i/latvia-health-system-review-2001	S10
11.	World Health Organization.	2021	Global Health Expenditure Database.	https://apps.who.int/nha/database/ViewData/Indicators/en	S11
12.	Zvidriņš, P.	2022	Iedzīvotāju valstiskā piederība Latvijā (Nationality of the population in Latvia).	https://enciklopedija.lv/skirklis/5163-iedz%C4%ABvot%C4%81ju-valstisk%C4%81-pieder%C4%ABba-Latvij%C4%81	S12

Appendix No. 3

Conducted interviews

No.	Name of the interviewee	Position	Interview data	Interview code
1.	Ģirts Briģis (MD)	Professor and Head of the Department of Public Health and Epidemiology, Faculty of Public Health and Welfare, Rīga Stradins University. Co-author of HiT reports, co-author of publications about the Latvian healthcare system.	June 10, 2019. Face-to-face interview, Rīga, Latvia.	I-1
2.	Ingrīda Circene (MD)	Minister of Health (April 2003 – March 2004, October 2011 – July 2014), Member of Parliament, external advisor to the Prime Minister in health questions.	June 10, 2019. Face-to-face interview, Rīga, Latvia.	I-2
3.	Dzintars Mozgis (MD)	Deputy Director for Prevention and Public Health, Centre for Diseases Prevention and Control, Associate Professor at Rīga Stradins University, Department of Public Health and Epidemiology, Member of the Board of the Latvian Medical Association.	June 11, 2019. Face-to-face interview, Rīga, Latvia.	I-3
4.	Indra Dreika	The Head of the Health Inspectorate, was directly involved in developing the idea of sickness funds under the research institute in Stradins Hospital.	June 17, 2019. Face-to-face interview, Rīga, Latvia.	I-4
5.	Pēteris Apinis (MD)	Head of the Latvian Medical Association (1991–1992, 2006–2018), Minister of Health (February–December 1995) and Member of Parliament (6th and 7th Saeima), External advisor to the Prime Minister (2009–2010).	June 18, 2019. Face-to-face interview, Rīga, Latvia.	I-5
6.	Ivars Krastiņš (MD)	The first President of newly established Latvian Medical Association, Member of Parliament (1990-1993).	June 19, 2019. Face-to-face interview, Liepāja, Latvia.	I-6

7.	Inga Kalviša	Former state employee in the healthcare sector, participant in the study visits in Germany	June 21, 2019. Email correspondence.	I-7
8.	Māris Taube (MD)	The former head of NHS, co-author of WHO HiT reports and the publication "Can people afford to pay for healthcare? Latvia".	June 25, 2019. Face-to-face interview, Rīga, Latvia.	I-8
9.	Laila Ruškule	Coordinator at the Ministry of Welfare of WB project in 1998.	June 27, 2019. Face-to-face interview, Rīga, Latvia.	I-9
10.	Otmar Kloiber (MD)	Foreign relations advisor to the German Medical Association (1991 – 1997) Secretary of the German Medical Association (1997 – 2002), Deputy Secretary-General of the German Medical Association (2002 – 2005), Secretary-General of the World Medical Association (since 2005).	September 16, 2019. Phone interview.	I-10
11.	Toomas Palu	Advisor, Global Coordination at World Bank Group, team leader for the World Bank "Project Appraisal Document on a proposed adaptable program lending (loan) in the amount of US$ 12.0 million equivalents to the Republic of Latvia for a health reform project, October 14, 1998".	September 20, 2019. Online interview.	I-11
12.	Aiga Rūrāne	Head of the WHO Euro Country Office in Latvia, 1995–2019.	September 24, 2019. Online interview.	I-12
13.	Vladimirs Strazdiņš (MD)	Member of the Latvian Medical Association, author of the first healthcare financing reform proposal in 1989.	October 1, 2019. Face-to-face interview, Jūrmala, Latvia.	I-13
14.	Pēteris Apinis (MD)	Head of the Latvian Medical Association (1991–1992, 2006–2018), Minister of Health (February–December	October 07, 2019.	I-14

		1995) and Member of Parliament (6th and 7th Saeima), External advisor to the Prime Minister (2009–2010).	Face-to-face interview, Rīga, Latvia.	
15.	Vladimirs Makarovs and Maija Poršņava	Minister of Welfare (1995-1999), Minister of Economy (1999-2000), Minister of Environment and Regional Development (2000-2002). State Secretary of the Ministry of Welfare (early 1990s - 2002).	October 15, 2019. Face-to-face interview, Saulkrasti, Latvia.	I-15
16.	Jānis Meikšāns (MD)	CEO of Teva Pharmaceuticals Ltd in Hungary, Former member of the Latvian Medical Association, co-author of the first reform proposal in 1989.	January 13, 2020. Online interview.	I-16
17.	Dzintars Mozgis (MD)	Deputy Director for Prevention and Public Health, Centre for Diseases Prevention and Control, Associate Professor at Rīga Stradins University, Department of Public Health and Epidemiology, Member of Board of Latvian Medical Association.	June 29, 2020. Online interview.	I-17
18.	Pēteris Apinis (MD)	Head of Latvian Medical Association (1991–1992, 2006–2018), Minister of Health (February–December 1995) and Member of Parliament (6th and 7th Saeima), External advisor to the Prime Minister (2009–2010).	July 21, 2020. Online interview.	I-18
19.	Rinalds Muciņš	Former Minister of Health (March 2004 – December 2004), former State Secretary at the Ministry of Health.	September 7, 2020. Online interview.	I-19
20.	WHO Europe Barcelona Office representative	Requested anonymity	September 25, 2020. Online interview.	I-20
21.	Ilze Viņķele	Minister of Health (since 2019), Member of the Parliament (2014–2017), Minister of Welfare (2011–2014), Parliamentary Secretary at the Ministry of Finance (2010–2011).	September 15, 2020. Online interview.	I-21

22.	Anda Čakša	Minister of Health (June 2016 – January 2019).	September 4, 2020. Online interview.	I-22
23.	Kristīne Kļaviņa	Head of the Human Resources Development Department at the Ministry of Health.	March 4, 2020. Online interview.	I-23
24.	Andris Glāzītis,	Former Head of the Riga Sickness Fund	June 18, 2019. Face-to-face interview, Riga, Latvia.	I-24
25.	OECD representative	Requested anonymity	October 9, 2020. Online interview.	I-25

Contribution D: Misusing international organizations' authoritative resources; The case of the Latvian healthcare financing reforms

Liva Stupele

Introduction

The role of international organizations (IOs) in shaping domestic policies has been recognized in the global social policy literature as well as in policy transfer studies (Dolowitz & Marsh, 2000; Deacon, 2007; Orenstein, 2008). The influence of IOs on domestic policymaking and policy outcomes depends on various interconnected factors, such as the type of resources IOs can offer and the 'strength' of individual countries vis-à-vis concrete IOs.

The literature identifies three types of IOs resources. First, some IOs offer **financial** resources like aid or loans, at times upon conditionality (Woods, 2006; Noy, 2017). Second, **ideational** resources are ideas, norms, and policy advice utilized by domestic actors in policymaking processes (Martens & Jakobi, 2010). Third, **authoritative** resources refer to IOs lending their authority to domestic actors, enhancing their legitimacy in policymaking processes (Zürn, 2018; Tallberg & Zürn, 2019). While ideational and authoritative resources are common across all IOs operating in the social policy sector (e.g., World Health Organization (WHO), Organization for Economic Co-operation and Development (OECD), World Bank (WB), and International Monitory Fund (IMF), as well as European Union (EU)), financial resources are limited primarily to the WB, IMF and the EU.

Domestic actors may be interested in these resources for numerous reasons. Countries in an economically challenging situation may need financial support for reform implementation (Stone, 2011; Kentikelenis et al., 2016). Domestic actors may rely on IOs external expertise, policy advice, and impartial evaluation of a policy issue (Fang & Stone, 2012; Kentikelenis et al., 2016). Finally, domestic actors may use IOs as an external source of authority to justify their actions, and legitimize decisions and policy preferences, thereby "borrowing credibility" from international stakeholders (Cortell & Davis, 1996).

In terms of the strength of a country vis-à-vis IOs, literature suggests that large and wealthy countries may exert influence over IOs agenda, decisions, policy priorities and content, in line with their national agenda (Drezner, 2003; Woods, 2006; Stone, 2011;

Kentikelenis et al., 2016). Conversely, countries with limited economic resources[46], limited institutional capacity, high exposure to risks and crisis, and dependent on external assistance[47] are assumed to be in a weak position vis-à-vis IOs and as a result to be (passive) recipients of IOs conditions and advice (Finnemore & Sikkink, 1998; Mosley, 2003; Woods, 2006; Kentikelenis & Seabrooke, 2017; Corbett et al., 2018).

However, other studies question this assumption. While weak countries cannot dictate the agenda of IOs (Mosley, 2003, p.103), they have agency and may display defiance vis-à-vis IOs by, for example, not complying with conditions attached to financial loans, disregarding policy advice (Woods, 2006, p.178; Kentikelenis & Seabrooke, 2017, p.1068; Malinar, 2022) or misusing "borrowed credibility". IOs may tolerate such conduct, adjusting their policy advice and accepting the misuse of their resources, as they seek to remain relevant in the policy process and "stay in the game" (Barnett & Finnemore, 2004; Park & Vetterlein, 2010; Squatrito et al., 2019; Tallberg et al., 2020; Malinar, 2022).

Weak countries´ reliance on IOs ideational and financial resources has been extensively studied. Literature on financial resources focuses on the WB and IMF and on the interplay between financial resources and ideological influences, such as policy loans accompanied by specific reform conditions, across diverse geographical regions and different policy fields, e.g. pension reforms (see Orenstein, 2008), healthcare (Abbasi, 1999; Ruger, 2005; Tichenor & Sridhar, 2017), and other policy areas (see Woods, 2006). In this context, weak countries' defiance against the WB has been documented (Malinar, 2022). Reliance on ideational resources has been studied across different social policy fields (e.g., OECD's role in education policy, see Niemann & Martens, 2018, and the role of WHO and OECD in healthcare, see Kaasch, 2015), including in weak countries (see Deacon et al., 1997; Heinrich, 2021).

However, the use of IOs authoritative resources by weak countries has received less attention. This article contributes to closing this literature gap by investigating the development of Latvian healthcare financing policy between 2010 and 2019.

[46] Countries with lower GDP, high debt levels, or struggling economies (Barrientos et al., 2005).

[47] Heavy reliance on foreign aid, loans, or technical assistance (Barrientos et al., 2005).

After the country regained independence in 1991, reforms of the centralized communist healthcare system started with attempts to introduce social health insurance (SHI); yet, by mid by the mid-90s, the country opted for general taxation to finance healthcare (Kaminska, et al., 2021; Stupele, Kaminska, 2025). The 2008/2009 global financial crisis severely impacted the country's economy, further undermining the strained healthcare financing system. The search for a solution was limited to either re-introducing SHI or further relying on general taxation (see Kutzin et al., 2010); private healthcare insurance was not ideologically acceptable in Latvia (D62; I-9). Domestic stakeholders were deeply divided over these two options, with no clear consensus and majority. Between 2010 and 2019, three reforms of healthcare financing were attempted, wherein domestic supporters and opponents of re-introducing SHI in Latvia engaged with the IOs that were present in the country, namely the WHO, OECD and OHCHR (Office of the United Nations High Commissioner for Human Rights), to garner a majority among stakeholders and in the parliament. While seeking IOs' support for their respective policy agendas, domestic actors drew on IOs' authoritative resources and were able to instrumentalize, and in some cases, intentionally misuse IOs resources. However, the IOs continued to provide their assistance with the aim of preserving long-term cooperation possibilities. The puzzle here is that, on the one hand, in pursuit of their political agendas, domestic actors demonstrated instrumentalization of the IOs, and on the other hand, such instrumentalization has not triggered retaliatory measures from the IOs.

Accordingly, the following research questions are addressed in the paper:

A) How did domestic actors utilize IOs' authoritative resources?

B) How did IOs react to these activities of domestic actors?

The following section presents the paper's conceptual framework, focusing on the IOs authoritative resources, and on why and how domestic actors utilize these resources. It also discusses the potential responses from IOs and explores the dynamics of interaction between weak countries and IOs. Subsequent sections discuss methods and data, and present empirical findings from the three reform attempts between 2010 and 2019. The final section offers a discussion and overall conclusions.

1. Conceptual framework

1.1. Authoritative resources

IOs offer ideational, financial and authoritative resources that countries may be interested in. While authoritative resources are emphasized here, it is important to note that IOs authority is partially executed and strongly interlinked with its ideational resources, for example by providing policy advice to the countries.

Authority is a key resource of IOs, derived primarily from legal mandates granted by member states (Barnett & Finnemore, 1999) and IOs' expertise (Deacon, 2007; Kaasch, 2015; Béland & Orenstein, 2013; Sending, 2015). While IOs' policy advice is not legally binding, governments tend to follow it or justify deviations from it (Kelley, 2004; Niemann & Martens, 2018). A large body of literature has discussed the authority of IOs (see Hurd, 1999; Hooghe, 2017; Zürn, 2018; Tallberg & Zürn, 2019). In this article, authority is defined as institutionalized power to make decisions, set standards and impose the rules that influence state behavior (Barnett & Finnemore, 2004). The literature identifies several types of IO authority. **Political (normative) authority** allows IOs to shape member states' policies by establishing norms and rules, labelling issues, socializing actors, and distributing best practices (Barnett & Finnemore, 1999; Gostin & Katz, 2016; White, 2020). Political authority relies heavily on legitimacy, and both are rooted in trust and recognition that are critical to securing compliance and effectiveness (Buchanan & Keohane, 2010; Tallberg & Zürn, 2019). **Expert authority** is based on IOs' technical knowledge and possess data not immediately available to other actors. Seen as apolitical and evidence-based, it allows IOs – inter alia - to influence global health governance (Barnett & Finnemore, 1999; Deacon, 2007; Kaasch, 2015; Fang & Stone, 2012; Béland & Orenstein, 2013; Sending, 2015; White, 2020). Finally, **moral authority** stems from IOs ethical standing and commitment to humanitarian principles. Within the health policy field, it is often rooted in IOs mission to improve global health and protect vulnerable populations, strengthening IOs' legitimacy and effectiveness (Barnett & Finnemore, 2004; Tallberg & Zürn, 2019).

All three IOs included in this study (WHO, OECD and OHCHR) assert authority in the healthcare domain. The WHO stands out with all three forms of authority and is often described as a "global Health Ministry" serving as the central advisor to national health ministries (Deacon, 2007; Hanrieder, 2015; Kaasch, 2015). The WHO's authority in

setting health standards is reinforced by its legitimacy as an apolitical organization dedicated to normative, informational, and technical work (Ecker-Ehrhardt, 2018; Scholte & Tallberg, 2018). Although lacking financial and material resources, it leverages its authority to mobilize other IOs and NGOs for research, surveillance, and technical assistance (Hanrieder, 2015, p.19). The WHO works in dialogue with member states to develop medium- and long-term strategies executed by regional or national offices. It aims to strengthen domestic health systems while respecting national ownership. This includes responding to requests for technical expertise, supporting health program planning, and aligning with country cooperation strategies (Buse & Gwin, 1998; Siddiqi et al., 2009; Stupele, 2025).

The OECD plays a pivotal role in healthcare policy, leveraging its political and expert authority. The OECD provides a platform for policymakers to exchange solutions, develop policies using its extensive health system indicators database, and engage in mutual accountability through peer scrutiny and high standards, fostering expertise, mutual learning, and the shaping of global norms (Kaasch, 2015; Martens & Jakobi, 2010; Kaasch & Martens, 2015; White, 2020). Renowned for its high-quality policy analysis (White, 2020; Dakowska, 2022), the OECD has an expert authority, since it identifies and frames policy problems. Like WHO, the OECD does not offer financial assistance to the member states (Martens & Jakobi, 2010). Engagement with member states takes place primarily through its committees and specialized networks dedicated to a specific policy area or issue, rather than building one-on-one relationships. Unlike the WHO, the OECD has no country offices, nor does it handle ad-hoc requests. Instead, it adheres to a pre-planned schedule of publications, peer reviews, and assessments evaluating national policies against international standards (Fang & Stone 2012; Eckhard & Jankauskas, 2019; Stupele & Malinar, 2025).

The OHCHR, as the leading UN's human rights agency, wields significant political, expert and moral authority. It supports member states in meeting human rights obligations through technical cooperation, monitoring, advocacy, and fostering accountability (Oberleitner, 2007, pp.119-120; Alston & Goodman, 2013, pp.740-741). In health policy, the OHCHR collaborates closely with the WHO to integrate human rights principles such as accessibility and poverty reduction into national health policies and programs (Hunt, 2007, p.370; Meier & Gostin, 2018, p.155). Its operational approach aligns with the WHO's, reflecting their shared UN framework.

1.2. Leveraging authoritative resources

The involvement of IOs in domestic policymaking often reflects the motivations and strategies of domestic actors seeking to leverage different types of IO resources. By leaning on IOs **authority**, domestic actors can invoke international rules and norms to shape domestic debates and formulate policy options (Haas, 1989, pp.398, 401; Moravcsik, 1994, p.6; Drezner, 2003, p.2), and legitimize their decisions and strengthen their policy preferences through "borrowed credibility" (Cortell & Davis, 1996, pp.457, 453; Boswell, 2009; Sending, 2015; Grittersova, 2017). IOs´ authority can also be used to challenge the legitimacy and appropriateness of opposing policy proposals, blocking rival concepts and actors (Haas, 1989; Cortell & Davis, 1996, p.453; Boswell, 2009).

Domestic actors may rely on different strategies – including instrumentalization and misuse – to draw on IOs resources. In this paper, instrumentalization refers to deliberate use of IOs resources by domestic actors to achieve specific political and policy objectives (Barnett & Finnemore, 1999). This phenomenon can be observed in domestic actors´ **selective use IOs expert authority** by adapting technical expertise and policy advice to fit domestic agendas, e.g. by cherry-picking guidance that aligns with pre-existing preferences while ignoring more stringent recommendations (Lake, 2013; Diprose et al., 2019; Tallberg & Zürn, 2019). Domestic actors can also instrumentalize IOs resources by **invoking international norms and commitments** to justify difficult or unpopular reforms (Lake, 2013; Zaum, 2013; Tallberg & Zürn, 2019; White, 2020, p.73). Furthermore, **"forum shopping"** can be used to find specific IOs' advice supporting a domestic actors' position, to fend off opposition at home (Coen et al., 2021; Rautalin et al., 2021; Ficek, 2022). Domestic actors can also **signal commitment** to IO initiatives but maintain a level of flexibility with compliance (Drezner, 2003; Zaum, 2013; Tallberg & Zürn, 2019). Apart from that, referring to IO's **monitoring, benchmarking, and public assessments** in domestic debates can help delegitimize opponents and exert pressure for reforms (Tallberg & Zürn, 2019; Diprose et al., 2019; White, 2020). Lastly, a long-term strategy involves **socializing other domestic actors into new norms** via repeated interactions with IOs, gradually shifting the policy landscape (Drezner, 2003; Kelley, 2004; Zaum, 2013).

Misuse, in contrast, pertains to the wrongful, unethical, or illegal use of IOs authoritative resources, involving actions by domestic actors that pervert the intended goals of the IOs. This phenomenon is particularly evident when domestic political entities seek to consolidate power, garner legitimacy, or undermine political opponents (Barnett & Finnemore, 1999; Matanock, 2020).

Importantly, the ability of domestic actors to rely on these strategies varies (Moravcsik, 1994, p.12), with top officials generally being better positioned due to their access to information and decision-making forums. This "gatekeeping" power allows them to influence policies while sidelining other stakeholders (Moravcsik, 1994).

In summary, in their relationships with IOs, domestic actors can act not merely as passive recipients of external influence, but as strategic actors that advance their policy goals by leveraging IOs authoritative resources.

1.3 IOs´ reactions to instrumentalization and misuse of authoritative resources

The ability and willingness of IOs to respond to instances of instrumentalization and misuse of their authoritative resources are conditioned by their institutional capacity, organizational setup, and cooperative frameworks with member countries.

When countries instrumentalize IOs' authority, those often respond with persuasion, dialogue, peer pressure, and, in some cases, naming and shaming tactics to enforce norms. IOs may reiterate advice, engage in diplomatic discussions, or escalate concerns within international forums (Barnett & Finnemore, 2004; Park & Vetterlein 2010; Squatrito et al., 2019; Tallberg et al., 2020). Monitoring tools like assessments, peer reviews, and reporting are employed to ensure accountability and highlight non-compliance (Tallberg, 2002, Grigorescu, 2007; 2010; Martens & Jakobi, 2010). IOs may also leverage media and public reports to create reputational threat for non-compliant countries, potentially affecting their international standing and investor relations (Tallberg, 2002; Kelley & Simmons, 2015).

In cases of misinterpretation or even misuse of their resources, IOs often clarify their stance through public statements, reports or press releases, while re-engaging diplomatically to correct misunderstandings (Ecker-Ehrhardt, 2018; Tallberg & Zürn, 2019). While IOs can highlight instances of misuse, they typically tend to avoid

confrontation or withdraw completely, as the interest to ensure long-term cooperation and preserve diplomatic relations as well as their relevance in global governance prevails (Dakowska, 2022). IOs often opt for quiet diplomacy, gradual pressure, and norm socialization, and prioritize engagement over enforcement while avoiding public escalation (Finnemore & Sikkink, 1998; Tallberg & Zürn, 2019). This approach allows IOs to "stay in the game" and sustain their influence in the long term, even when short-term compliance is not achieved (Heinkelmann-Wild & Jankauskas, 2020; Hirschmann, 2021).

Crucially, the effectiveness and feasibility of these approaches depend not only on the institutional capacity of IOs, but also on the strength and specific characteristics of the non-compliant country, as discussed below.

1.4.Weak countries and interaction with IOs

As mentioned above, weak countries are defined by limited economic resources, weak institutional capacity, vulnerability to risks, and reliance on external assistance (Barrientos et al., 2005; Grittersova, 2017). The literature often suggests that weak countries are susceptible to IOs' influence and portrays them as passive recipients of IOs policy advice, as power imbalances make such national settings vulnerable to international policy prescriptions (Finnemore & Sikkink, 1998; Mosley, 2003, p.103; Woods, 2006, p.70; Kentikelenis & Seabrooke, 2017, p.1068; Corbett et al., 2018). It is assumed that weak countries are unable to independently develop policy ideas (Finnemore & Sikkink, 1998; Corbett et al., 2018) and to resist IOs advice (Barnett & Finnemore, 2004; Béland & Orenstein, 2013). In complex policy areas like social policy, IOs expert authority may seem indispensable, pressuring weak countries to comply with global standards, to maintain legitimacy and status within the global community, and avoid international isolation (Acharya, 2004; Barnett & Finnemore, 2004; Haas, 2004).

However, some studies have found that weak countries, despite their perceived vulnerability, employ strategies to defy IOs and can actively push back against policy prescriptions, even if they remain economically dependent on IOs. In Latin America, Weyland (2009) observed how El Salvador, Bolivia, Brazil, and Costa Rica, maintained agency in health policy decisions despite IOs' involvement. Similarly, Noy (2017; 2018) showed how Peru, Argentina, and Costa Rica influenced the World Bank to adapt its

health strategies to local initiatives. In Africa, Wireko and Béland (2017) documented how Ghana persuaded the WB to support its preferred SHI model. In Europe, Malinar (2022) revealed Croatia's ability to contest IMF and WB prescriptions, despite economic challenges. Beyond social policy, Bolkvadze (2016) illustrated Georgia's selective compliance with EU conditionality, while Eihmanis (2018) described Latvia's strategic cherry-picking of EU economic targets.

These studies reveal that weak countries can resist IOs pressures and maintain control over policy decisions. For example, weak countries can leverage IOs resources while implementing policies that have been developed domestically. They can also re-shape programs developed by IOs to align them with domestic priorities, or adopt IOs recommendations only selectively, to better fit local contexts. These findings suggest a nuanced relationship between IOs and weak countries, where even under challenging conditions, the latter can assert policy autonomy and negotiate IOs influence. This complexity calls for a better understanding of IOs-country dynamics.

2. Case selection, methods and data

Latvia serves as a prime example of a "most likely case" (Gerring, 2008; Seawright & Gerring, 2008), testing the assumption that weak countries are passive recipients of IOs resources. In the researched period (2010–2019), Latvia faced several challenges. It was one of the EU countries hardest hit by the 2008/2009 financial crisis and was heavily dependent on external support[48]. Its GDP declined by nearly 25% in 2009 (Åslund & Dombrovskis, 2011). Fiscal tightening led to significant cuts in social policies[49], including a 55% reduction in Health Ministry (HM) personnel and a 24% drop in the health budget by 2010 compared to 2008[50] (Åslund & Dombrovskis, 2011). Latvia's healthcare system struggled with underfunding, resulting in high out-of-pocket payments

[48] To contain the crisis, the government requested a €7.5 billion support package from the European Commission and IMF (S1; S3), plus a €100 million as a short-term loan from the WB (S11).

[49] Efforts to centralize the provider network and shift from hospital to outpatient care accelerated, reducing hospitals from 72 to 43 by 2009 and 39 by 2012. Bed capacity was cut, while primary care, children's services, maternity care, emergency services, and pharmaceutical aid were prioritized to mitigate health impacts (S8; S9; S10; S12; Mitenbergs et al., 2012).

[50] This involved cutting funding to hospitals, raising user fees, sharply reducing health worker salaries, and lowering pharmaceutical prices (S8; S9; S10; S12; Mitenbergs et al., 2012).

and poor health outcomes (Behmane et al., 2019; D62). The 2008/2009 crisis prompted reforms aiming to shift from general taxation to SHI between 2010 and 2019.

The IMF and EU did not play a direct role in healthcare financing reforms, and the WB focused on system efficiency (Stupele & Kaminska, 2025), therefore these IOs are excluded from the scope of this article. Focus is on WHO, OECD and OHCHR as Latvia became especially reliant on these IOs in reforming healthcare financing.

This article presents a single case study (Gerring, 2017) using qualitative methods, including document analysis, focusing on the content and reform developments, and semi-structured interviews, to explore argumentation and motivation of the stakeholders. The documentation includes forty-five statements from websites, nine parliamentary regulations, eighteen IOs publications, and eighteen gray literature sources. Data collection involved searching physical and online archives of the Latvian government bodies and the Latvian Medical Association (LMA) (see Appendix 1), with key search terms including 'healthcare financing reforms', and 'international organizations'. Non-public documents were obtained via communication with WHO and OECD representatives, covering the 2008-2019 period.

Additionally, seventeen semi-structured interviews were conducted between June 2019 and September 2020 with domestic and international actors, including former ministers, government officials, and representatives from WHO and OECD (see Appendix 2). The textual material was analyzed through qualitative content analysis following Kuckartz (2014) using MAXQDA, with a coding scheme covering six areas: (1) reform ideas; (2) actors; (3) reform positions of different actors; (4) domestic strategies vis-à-vis IOs; (5) IOs resources used; and (6) IOs reactions.

3. Instrumentalization and misuse of IOs' resources during healthcare financing reforms in Latvia

3.1. Main developments of Latvian healthcare financing policy since 1991

After 1991, healthcare reforms focused on breaking away from the Soviet-era centralized Semashko system (I-13; I-14; I-15; I-16), which proceeded in waves. In 1994, the system was decentralized and an institutional framework for SHI was established, without fund pooling (D50; D51; S16), leading to fragmented and inefficient healthcare with high

inequalities (D48; D49; S6; S7). Between 1996 and 2011, the system underwent re-centralization, culminating in the creation of the National Health Service (NHS) which introduced a tax-based system with a purchaser-provider split (D9; Mitenbergs et al., 2014). Revenue collection continued to be based on general taxation, with annual budget allocations (Stupele & Kaminska, 2025).

Historically, Latvia's healthcare financing system struggled with underfunding and inadequate coverage, and the 2008/2009 crisis further weakened the system[51], prompting domestic actors to seek reform options, particularly regarding revenue collection (Kutzin et al., 2010). Between 2010 and 2019, two attempts were made to introduce SHI, followed by a reversal of an approved SHI law in 2019.

Both attempts at introducing SHI proposed earmarking a portion of individual social contributions for healthcare. In addition, the 2016 proposal suggested dividing healthcare services into "basic" and "full" packages. Access to health services would depend on income-related tax or designated contributions, limiting full services to contributors, while offering only basic services to non-contributors, thereby challenging universal coverage (D30; D34; D42; D43; D53; I-1; I-2; I-4; I-5; I-6; I-8; Pētersone et al., 2019; Behmane et al., 2019). The proposals did not address institutional changes to reduce out-of-pocket payments.

Involved in these reform processes were state officials and civil society organizations (medical societies, academia), divided into proponents and opponents of SHI. Proponents included Ministers of Health (MoH), namely Ingrīda Circene (2011), Anda Čakša (2016), and Ilze Viņķele (2018)[52], with support from subsequent Prime Ministers (PM) and Ministers of Finance (MoF) (D47; I-1; I-5; I-7; I-8). The Strategic Council for Healthcare[53] and the Latvian Employer's Confederation also consistently supported

[51] Total healthcare expenditure dropped from 6.6% of GDP (2008) to 6.5% (2010), below the EU average of 8.3% (S5). Government health expenditure as a percentage of total health expenditure dropped from 59.5% (2008) to 57.1% (2010), much below than EU levels, while out-of-pocket spending grew from 39.1% (2008) to 41.0% (2010), significantly higher than the EU average of 19% (S18). Unmet health needs due to financial reasons doubled from 10.5% (2008) to 21.5% (2010) (S2).

[52] Party affiliation is irrelevant here, as the idea of introducing SHI has not been associated with party politics (Kreuzer & Pettai, 2003; Pabriks & Štokenberga, 2017).

[53] Since 2007, the Strategic Council for the Healthcare Sector is a consultative body under the HM. It aims to involve health sector associations and state and municipal institutions in health

introducing SHI (D34; D39; D40; D43; I-1; I-8; I-9). Opponents included healthcare sector actors, such as the LMA, the Latvian General Practitioners´ Association (LGPA), and the Latvian Rural General Practitioners´ Association (LRGPA). In 2011, the Latvian Health and Social Care Workers' Trade Union and the Latvian Hospital Association opposed the reforms (D11), and in 2016, the Association of Healthcare Management Specialists joined the opposition (D2; D13; D14; D15; I-4; I-5; I-6). The Ombudsman was the only non-healthcare actor opposing the introduction of SHI (D18; D19; D20). None of the domestic actors involved were able to build a majority for their preferred option, making IOs' resources especially influential in these reform processes.

3.2.2010-2014 (WHO, OHCHR and OECD)

In January 2010, the PM's health adviser and a former MoH (April 2003 – March 2004) Ingrīda Circene started working on a proposal to introduce SHI in Latvia (D24; D25; D26; I-1; I-5). Yet, the incumbent MoH (June 2009–March 2010) Baiba Rozentāle opposed changing the healthcare financing model, effectively stalling the SHI proposal (D24; D25; D26; I-1; I-5). As the WHO[54] was advising Latvia on overcoming healthcare challenges exacerbated by the 2008/2009 financial crisis (D68: I-1; I-2; I-9; I-11), Circene requested analytical insights from the IO. Indeed, WHO issued "*WHO Comments on the Informative Report on the Usefulness of Introducing Compulsory Health Insurance in Latvia"* (December 2010) (D68). In that document, WHO positioned itself against Circene's ideas and concluded that "there is no compelling argument in favor of the introduction of a payroll tax-based social health insurance system in Latvia" (D68, p. 2). The report was not publicly available or cited at the time of its publication.

Following the 2011 emergency elections, Circene returned as MoH for a second term (October 2011–July 2014). Although, as discussed above, the National Health Service (NHS) was launched in November 2011 following the reforms prepared under MoH Rozentāle and signaling Latvia's commitment to a tax-financed healthcare system (D10;

policy development and implementation, and promotes collaboration and information exchange between all stakeholders (S15).

[54] In 1991, Latvia joined the WHO, which initially focused on public health, access to pharmaceuticals, immunization programs, and developing primary healthcare during the early transition period (Stupele & Kaminska, 2025; I-4; I-5; I-17).

Mitenbergs et al., 2014), Circene claimed that SHI was "the only way to resolve healthcare sector problems in the long term" (D6; D27; D30; I-1; I-2; I-5; I-7; I-11).

To overcome domestic resistance to her ideas, Circene again sought WHO's backing for an introduction of SHI (D28; I-1; I-11). In January 2012, as customary for new MoHs in WHO member countries, she met with the WHO Europe Regional Director and other WHO representatives to align healthcare priorities. A central topic was strengthening the health system, including SHI implementation (D28; D66; I-1; I-11; I-17).

Later that year, leveraging the involvement of WHO EURO experts in Latvia's healthcare financing since the financial crisis[55], Circene requested additional technical support and organized a working visit to the WHO Barcelona Office for Health Systems Financing (WHO BO)[56] to discuss SHI reforms (D29; D65; I-1; I-9; I-11). Before the visit ended and before an official report was finalized, Circene published a press release, selectively citing arguments favoring SHI introduction, while omitting criticism expressed by WHO BO during the talks (I-1; I-9; I-11; D29).

A few days later, WHO prepared a report from the meeting, "*WHO Notes on the Informal Meeting on Sustainable Health Financing: European Experience with Specific Attention to Opportunities and Challenges for Latvia"* (D71). The report was confidential and only accessible to a few individuals. Echoing the WHO report of 2010*,* the 2012 report warned that "linking entitlement to payment of contribution means a move away from universal population coverage, which has to be carefully managed to avoid adverse effects" (D71, p.4). Instead, WHO recommended increasing public healthcare spending to 12% of the annual state budget and 5% of GDP, to ensure universal coverage, equity in access, and minimizing the out-of-pocket payments. It also concluded that implementing SHI would entail significant costs outweighing the potential benefits (if any) and reducing equity (D68, p.2; D71, p.6).

[55] Under the Biennial Collaborative Agreement, WHO provided consultation and technical assistance in drafting annual healthcare budgets for the HM and Parliament in 2010 and 2012, to address the impact of the 2008/2009 financial crisis on the health sector (D8; D11; D12; D25; D68; D72).

[56] The WHO Barcelona Office for Health Systems Financing provides technical support on health systems financing to WHO European Region Member States. It also conducts analytical work and offers training on health financing for universal coverage and strengthening health systems for better outcomes (S17).

Aware of the domestic tensions surrounding the SHI proposal, WHO drafted its statements carefully, recognizing their potential of being weaponized by both sides in Latvia's internal discourse (I-11). However, the 2012 WHO report was leaked, and the domestic opposition seized on it, publicly criticizing Circene for falsely representing the WHO's position. The president of the LMA cited findings from the leaked report in a letter to the MoH and PM, challenging the SHI proposal and exposing the misrepresentation of the WHO's conclusions (D4; I-5; I-6). Despite recognizing Circene's misuse of the WHO's political and expert authority in the press release (I-11; D29), neither the WHO BO nor the WHO Country Office clarified their stance publicly. Instead, to prevent further misinterpretation and ensure access to the full text for both sides, the WHO released its 2012 report to the public.

> *"We were very keen to make [our report] available for the public, but even before we could publish it, it was already leaked by someone from the government opposition. So, the opposition used it as well. I mean, this was one of those carefully formulated texts that both sides were using, making references to WHO's recommendations"* (I-11).

By March 2013, Circene's team had drafted a law to introduce SHI (D35), sparking more domestic opposition (D12). The Latvian Ombudsman, among others, criticized the draft, arguing it violated human rights by excluding certain groups from healthcare access (D16). In response, Circene sought support from the OHCHR, the UN agency for human rights. In June 2013, a bilateral meeting occurred between OHCHR representatives and Circene to discuss SHI (D17). During the meeting, OHCHR emphasized the need to retain an equal, non-discriminatory access to healthcare services (D17). Yet, Circene issued a press release stating that "[*T]he UN High Commissioner and Human Rights Experts support the concept of the MoH"* (D31), falsely claiming that OHCHR endorsed her proposal.

By late 2013, despite fierce opposition, the draft law passed its first reading in Parliament (D3; D54). Circene continued seeking international validation by holding a bilateral meeting with the Head and the Deputy Director of the OECD Directorate for Labor and Social Affairs in December 2013. Although the OECD did not endorse the reform (I-11; I-12), Circene issued another misleading press release claiming that *"[T]he OECD was interested, and expressed support for the implemented reforms in Latvian healthcare (...)*

including the new healthcare financing model" (D32; I-1). The OECD did not react to this misrepresentation.

Meanwhile, between 2012 and 2013, the LMA sought collaboration with the WHO BO to consolidate opposition against the draft law on SHI introduction (I-5; I-11). However, WHO declined direct interaction, indicting that its counterpart in the country was the MoH (I-11).

In early 2014, domestic tensions escalated as societal actors exposed Circene's misrepresentation of IOs´ positions. The Ombudsman wrote an open letter to the PM and Parliament members, revealing that OHCHR had not endorsed the draft law as claimed by Circene (D18). OHCHR clarified its position through correspondence with the Ombudsman, but it did not take any additional action, leaving further interpretation of its stance to domestic actors. Additionally, an LMA member translated the 2012 WHO report into Latvian and shared it publicly, bolstering opposition to the reform (D1; I-5; I-6). The Ombudsman again criticized Circene's actions as unethical and contrary to good governance and the rule of law (D17; D18). The LGPA demanded her resignation, citing mistrust in her leadership (D13; D15).

Following a government collapse at the beginning of January 2014, Circene resigned in June due to disagreements with the new PM and officials over healthcare priorities (D36), which effectively halted efforts to introduce SHI.

3.3. 2016–2017 (WHO and OECD)

In early 2016, Latvia's new government committed to "develop[ing] and implement[ing] a new healthcare financing model, attracting a significantly larger amount of financing for healthcare*"* (D47). Following MoH turnovers between 2014 and 2016, the PM handpicked Anda Čakša[57] as MoH in June 2016, tasking her with a healthcare financing reform (D5; I-8). Čakša began exploring policy options to address underfunding (D38; D40). In mid-2016, she requested another evaluation from WHO BO (I-8; I-11). WHO's third report, this time translated into Latvian and published by HM on its website, *"WHO notes on health system financing policy in Latvia: opportunities and challenges in light*

[57] Anda Čakša (HoM June 2016- January 2019), was a former Head of the Board of the Children's Clinical University Hospital without prior experience in politics (S14).

of international experience" (July 2016) (D69) referred to the two previous reports and reaffirmed the need to increase state funding for healthcare and warned that introducing compulsory health insurance without additional public spending would harm financial protection (D41; D68; D71; I-3; I-8; I-11). Meanwhile, three reform scenarios were developed within the HM, one scenario proposing an introduction of SHI. (D38; D40), for which Čakša had a preference (I-8). To garner support for SHI introduction, she selectively interpreted the 2016 WHO report in public statements, emphasizing potential funding increment and presenting the idea of introducing SHI as aligned with WHO guidance, while downplaying WHO's broader concerns (D5; D41; I-3; I-7; I-8; I-9).

The domestic debate on healthcare financing reform gained momentum, culminating in a high-level conference in September 2016 titled *"Healthcare System in Latvia: Structural Reforms and Financing Models"* co-organized by the MoH and PM. While the event was supposed to discuss the three reform scenarios, it was effectively aimed to gather domestic and international support for the reform introducing SHI, which proposed linking healthcare entitlement to tax payments and splitting services into two baskets (I-5; I-9). WHO and OECD representatives provided input, with the Head of OECD Health Division[58] (D37; D38; D60; D62:51-52; I-12) focusing on comparing the three scenarios and recommending increased public healthcare funding, rather than directly endorsing or criticizing the proposed reforms[59]. WHO BO Head warned that SHI without sufficient public funding could reduce financial protection and widen inequities (D56; I-11), urging lawmakers to increase funding within the existing system instead (D56; I-2; I-5; I-6; I-11). The PM and MoH publicly acknowledged WHO's concerns and stated they would not pursue the idea of introducing SHI (I-2; I-4; I-5; I-6; I-9; I-10).

Despite these assurances, in early 2017, the MoH and PM presented a draft of a "Healthcare Financing Law" that provided for SHI introduction (D46; D53). WHO representatives were surprised by this reversal given the conference's conclusions (I-2; I-11; I-17), but issued no official response or clarification.

In early 2017, Čakša intensified her engagement with IOs, to secure their support and counteract growing domestic opposition. She met with OECD and WHO representatives,

[58] On May 11, 2016, the OECD Council invited Latvia to join the OECD Convention (D61). In preparation, the OECD released the "Economic Survey LATVIA" and the healthcare-focused report "Reviews of Health Systems: Latvia 2016" (D59; D62; D64).

[59] Presentation based on OECD's *"Reviews of Health Systems: Latvia 2016"* report (D60; D62).

requesting further evaluations (D44; D45; D67). While the OECD declined to evaluate the specific reform proposal (I-8; I-11; I-12), the WHO BO issued a fourth report, *"Notes on health system financing policy in Latvia"* (D70). This report, translated and published by the HM, explicitly disapproved of the proposed Healthcare Financing Law. It left no room for misinterpretation, warning that without increased public funding, the reform could exacerbate existing problems rather than solve them:

> *"The WHO experts do not support this approach to reforming health insurance in Latvia. Without the commitment to increase public spending on health, the introduction of compulsory health insurance is unlikely to lead to improved performance of the health system and financial protection may further deteriorate"* (D70:1).

Subsequently, the OECD released its periodical *"Economic Survey of Latvia,"* acknowledging the government's efforts to improve healthcare access (D58), without explicitly endorsing or disapproving of the SHI reform. This allowed domestic actors to selectively interpret the report based on their interests.

In October 2017, a conference titled *"The new Healthcare Financing Law: Challenges and Opportunities"* was held in the Latvian Parliament to discuss integrating the proposed law – which had passed its first reading (D53) – into the existing general taxation-based system. The Ombudsman's criticized the law for excluding certain groups and lacking clarity regarding service baskets, urging revisions and questioning its social responsibility (D19; D20). The opposition argued that the law failed to address social justice and the rule of law, emphasizing that tackling the shadow economy and increasing tax compliance should not be the task of the healthcare financing system (D2; D14; D19; D20; D22; I-6; I-9). Despite domestic and international concerns, the Parliament approved the new Healthcare Financing Law in December 2017. The law, which established a statutory health insurance system with two separate service baskets, was scheduled to take effect in January 2019 (Behmane et al., 2019; Pētersone et al., 2019).

3.4. 2018-2019 (WHO)

Despite the adoption of the Healthcare Financing Law introducing SHI, domestic opposition persisted. In August 2018, the Head of the LGPA criticized the law for contradicting the WHO's 2016 recommendations and urged compliance with WHO

guidelines (D14; I-6). The LMA and Ombudsman highlighted the exclusion of 60,000 people from healthcare and referred to the criticism by WHO to strengthen their stance (D7; D21). It also published an open letter urging the HM, the Parliament, and the government to revoke the law, quoting WHO's advice (D14).

Following the 2018 parliamentary elections, Ilze Viņķele, a known opponent of introducing SHI and advocate of a tax-based system during her time as Minister of Welfare (2011–2014), replaced Čakša as MoH (D4; I-2; I-9; I-10; I-11). Reversing the Healthcare Financing Law became one of her priorities (I-10). In January 2019, the law's implementation was postponed for a year due to growing pressures from medical associations and the Ombudsman (D20), aligning with Viņķele's view that the financial model was unsuitable for Latvia (I-2; I-5; I-6; I-9; I-10; I-11). To strengthen her stance, she invited the WHO BO to present their position on healthcare financing to Parliament, to persuade Parliament members to revoke the Healthcare Financing Law (D55; I-10; I-11). On April 30, 2019, the Head of the WHO BO presented the WHO's position on Universal Health Coverage, reaffirmed the need for increased state funding and opposed the two-basket system, consistent with WHO evaluations since 2010. (D55; I-10; I-11).

By June 2019, Parliament delayed the implementation of the two-basket system until 2021 (D52), largely due to continued societal pressure and Viņķele's strategic engagement with the WHO. The 2020 COVID-19 pandemic shifted healthcare priorities, halting debates on financing reforms, and effectively leaving the issue unresolved, as proponents of the original reforms were no longer in power.

4. Discussion and conclusions

The empirical findings show how societal and governmental actors in Latvia strategically engaged with IOs to leverage their authoritative resources, which were seen as decisive by both supporters and opponents of SHI. MoHs, in particular, leveraged IOs' authority and "borrowed credibility" to advance their agendas. These findings converge with the literature pointing to other instances of domestic actors leveraging IOs' authority to shape policy debates and legitimize decisions (see Cortell & Davis, 1996; Grittersova, 2017) and highlighting the instrumental role of IOs in domestic policy (see Béland & Orenstein, 2013; Martens & Jakobi, 2010).

In the case of WHO as the “global Health Ministry”, domestic actors drew on its political, expert, and moral authority derived from WHO technical advice. The OECD's reputation as an expert authority made its endorsement highly desirable, boosting the credibility and political standing of the reforms pursued by ministers. Meanwhile, the OHCHR was consulted primarily for its moral authority to address ethical concerns raised by opponents. These engagements reflect how crucial IOs' specific authority types are for domestic actors, aligning with existing research on how IOs shape national policy through their various forms of authority (see Barnett & Finnemore, 1999; 2004; Tallberg & Zürn, 2019).

All IOs consistently advised increasing public health spending. The WHO highlighted the shortcomings of the proposed reforms, offering international comparisons. The OECD provided comparative data and welcomed efforts to improve healthcare financing, without endorsing specific policy solutions. The OHCHR emphasized the discriminatory aspects of the reform proposal, consistent with its moral authority. Notably, none of the IOs supported an introduction of the SHI model, which is in line with the newest literature on this topic (see Kaminska, et al., 2021; Stupele, 2025; Stupele & Malinar, 2025). The IOs´ stance on Latvian healthcare reforms reflects their distinct approaches, roles and expertise in healthcare policy, as discussed by Oberleitner (2007), Siddiqi et al. (2009), Martens and Jakobi (2010), Hanrieder (2015), and Kaasch (2015).

The empirical analysis reveals a consistent leveraging IOs’ assessments and selective references to technical expertise to support the respective positions of domestic actors. These findings are consistent with the observations provided in the existing literature that identified similar tactics in the context of authoritative power and IOs policy influence (see Lake, 2013; Diprose et al., 2019; Tallberg & Zürn, 2019). Particularly, MoH Circene and MoH Čakša frequently cherry-picked IOs statements to fit their agendas, ignoring critique, and misrepresenting the IOs’ overall messages. Circene falsely claimed IOs’ support in press releases after meetings with WHO, OECD, and OHCHR. Čakša selectively cited WHO recommendations to increase healthcare funding while ignoring criticism of her reform proposal. Additionally, Čakša openly ignored WHO's advice and proceeded with reforms despite publicly stating she would not do so. Opponents of introducing SHI employed similar tactics: e.g., the LMA president only cited WHO criticism of the idea to tie health service entitlements to tax payments, and an LMA member criticized the reform relying on WHO's 2012 recommendations. The behavior of

MoHs is consistent with the findings provided by Bolkvadze (2016) and Eihmanis (2018) in the context of Georgian selective compliance with EU conditionality and Latvia's strategic cherry-picking of EU economic targets, respectively. Moreover, the MoH's "gatekeeping" role allowed selective information use, sidelining other stakeholders, which is consistent with findings by Moravcsik (1994) who discussed how international cooperation provides national top officials additional resources to enhance their domestic power. In summary, cherry-picking was prevalent during the 2011-2014 and 2016-2018 reform attempts, while misrepresentation marked Circene's tenure only. Reliance on these tactics diminished after 2018, as the reform debate shifted to other priorities under the new leadership of Viņķele and there was no need to draw on IOs authority, since there was no domestic opposition.

Further, the study revealed the practice of "forum shopping," used by MoH Circene (2011-2014) and MoH Čakša (2016-2017) to gain external support for their SHI proposals. Circene initially approached the WHO but turned to the OECD when WHO's support for introducing SHI was lacking, leveraging Latvia's membership application and OECD's political and expert authority. The OECD declined to evaluate the reform proposal, which is consistent with its operational framework (see Stupele & Malinar, 2025). Circene further approached the OHCHR to address human rights concerns related to introducing SHI, relying on its moral, political and expert authority. Similarly, Čakša sought support from both the WHO and OECD for her reform. Both ministers leveraged Latvia's history of collaboration with the WHO, and worked with the OECD following Latvia's accession, using its reports in an attempt to generate support for their reform. In contrast, Viņķele (2018-2019) did not employ forum shopping. With diminished domestic support for SHI, her engagement with IOs was limited to the WHO that aligned with her policy priorities, which reduced the need for any additional backing. This is consistent with findings from other studies which have shown that states often approach IOs strategically to bolster their position in domestic policy debates (Coen et al., 2021; Rautalin et al., 2021; Ficek, 2022). The reliance on multiple IOs, such as WHO, OECD, and OHCHR, reflects a deliberate effort to draw on IOs' authority to amplify political legitimacy of reform proposals and generate support for them in the domestic context.

The study also explores how IOs responded to the instrumentalization and misuse of their resources. While the OECD and OHCHR appeared largely unaware of the misuse, the WHO was aware of domestic political tensions since 2011. Instead of confronting the

MoHs, the WHO pursued a long-term strategy of maintaining a "seat at the table" through continued engagement. A similar approach by the WB was discovered by Malinar (2022) in Croatian healthcare reform developments. In Latvia, the WHO continued issuing advice, participating in meetings, conferences and discussions, using various other formats[60] and making reports public to minimize misinterpretation. Both the WHO and OECD continued to provide assessments and monitoring, maintaining accountability and transparency, but neither of them issued clarifications or formal rebuttals. This approach reflects the need for IOs to balance expertise with maintaining constructive relationships in policymaking. This aligns with the existing literature on IOs' tendency to favour diplomacy and engagement over confrontation, thus prioritizing their long-term relevance (see Finnemore & Sikkink, 1998; Tallberg & Zürn, 2019).

It was observed that IOs may be susceptible to misuse of their resources due to their institutional structure and interaction patterns with member countries. For example, the WHO, with its broad health mandate, responds to domestic requests through the HM. This is consistent with Moravcsik's (1994) observation that top officials are better positioned to utilize IOs' resources due to their "gatekeeping" power. The OHCHR operates similarly as a technical agency addressing human rights concerns (Oberleitner, 2007; Alston & Goodman, 2013). The OECD, with pre-planned publication schedules (see Stupele & Malinar, 2025), ensures transparency, minimizing misuse risks through public reports and other monitoring tools (Tallberg, 2002; Grigorescu, 2007; 2010, Martens & Jakobi, 2010). Additionally, the confidentiality of IOs' recommendations increases the risk of misrepresentation. Confidential recommendations or broad, general advice are more susceptible to selective interpretation, as demonstrated by WHO reports, while the OECD's public and detailed outputs reduce such risks. These findings echo the findings of other studies (e.g., see Kelley & Simmons, 2015; Tallberg et al., 2020) arguing that IOs' influence depends heavily on their internal and institutional governance mechanisms.

The findings in this article are consistent with the literature suggesting that domestic actors often draw on IOs' authority with the purpose of legitimatizing policy decisions,

[60] Like the WHO EURO Regional Committee, World Health Assembly, the WHO Barcelona course on health financing for universal health coverage and the Baltic Policy Dialogue (D8; D9; D11; D12; D25; D71; I-17).

rather than improving policy design or implementation (as in Boswell, 2009). Crucially, however, this paper challenges the predominant perception (as in Finnemore & Sikkink, 1998; Mosley, 2003; Woods, 2006; Kentikelenis & Seabrooke, 2017; Corbett et al., 2018) of weak countries as passive recipients of IO advice. Crucially, this article reveals that domestic actors initiate contacts with IOs to engage in cherry-picking, forum shopping, and occasional misuse (e.g. misrepresentation of content) of IO resources, with the purpose of advancing domestic agendas, which is consistent with research by Weyland (2009), Noy (2017; 2018), Bolkvadze (2016), Wireko and Béland (2017), Eihmanis (2018) and Malinar (2022). In Latvia's healthcare reform debates, both proponents and opponents strategically cited IOs' reports to legitimize their respective stances, often misrepresenting IOs' views. This demonstrates how IOs' authority, derived from expert and normative status, can be manipulated in domestic debates, given IOs' limited monitoring capacities. On the other hand, this study finds no evidence of invoking international norms, commitments signaling credible commitments to reform or socializing domestic actors into new norms – tactics that have been reported by the existing literature (see Drezner, 2003; Kelley, 2004; Lake, 2013; Zaum, 2013; Tallberg & Zürn, 2019; White, 2020).

In summary, this study provides insights into the strategic use of IOs' authoritative resources in Latvia's healthcare reforms. It challenges the prevailing notion that weak countries are passive recipients of IO advice and provides clear evidence that even states with limited resources can instrumentalize IO authority for domestic purposes. The study also shows that while IOs offer expertise and legitimacy, their influence is often undermined by domestic actors´ strategic usage of IOs' resources. It also demonstrates that in such cases, IOs tend to prioritize long-term relevance over immediate compliance, often opting for continued engagement rather than withdrawal, which highlights the potential fragility of IOs' authority.

Although this study provides valuable empirical evidence, its limitations must be mentioned. The paper focuses on a single country and one policy area, with a time frame of ten years only. Thus, future research should explore how other weak countries interact with IOs across different policy areas, focusing on misuse of IO resources and IO responses.

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Appendix 1

Analysed documents

No.	Author	Year	Name of the Document	Link/ Source	Document Code
Domestic actors´ press publications					
1.	Aizsilniece, I.	2014	Atkal par veselības aprūpes finansēšanu (Again on healthcare financing).	The Latvian Doctor, (2), 2-3.	D1
2.	Aizsilniece, I.	2016	Latvijas Ārstu biedrība- vēlme ieviest veselības obligāto apdrošināšanu sliktāk gan iedzīvotājiem, gan mediķiem (Latvian Medical Association - the desire to introduce compulsory health insurance is worse for both the population and the medical profession).	https://medicine.lv/raksti/lab-velme-ieviest-veselibas-obligato-apdrosinasanu-sliktak-gan-iedzivotajiem-gan-medikiem.	D2
3.	Ancane, G.	2013	Jaunumi medicīnas nozarē 2013. gada oktobrī (News in Latvian medicine in October 2013).	The Latvian Doctor. (10), 3-5.	D3
4.	Apinis, P.	2013	Redaktora sleja (Editor's column).	The Latvian Doctor, (4), 3-4.	D4
5.	Čakša, A.	2016	Veselības aprūpes ārstēšanas plāns (Healthcare treatment plan).	The Latvian Doctor, (10), 1-4.	D5
6.	Circene, I.	2013	Gudra veselības aprūpe (Smart healthcare policy).	In P. Apinis (Ed.). Veselības aprūpe Latvijā [Healthcare in Latvia] (pp. 10-13). Riga, Medicīnas apgāds.	D6

7.	Jansons. J.	2018	Par veselības aprūpes finansēšanas likumprojektu un veselības apdrošināšanas ieviešanu kopumā (On the draft law on health financing and the introduction of health insurance in general).	The Latvian Doctor. (1), 80-81.	D7
8.	Keris, V.	2013	Uz pierādījumiem balstīts viedoklis par veselības nozari tuvākajā nākotnē (Evidence-based views on the health sector in the near future).	The Latvian Doctor, (1), 71-74.	D8
9.	Latvijas Ārsts (The Latvian Doctor).	2011	Notikumi medicīnā (Events in the medicine).	The Latvian Doctor. (10), 70.	D9
10.	Latvijas Ārsts (The Latvian Doctor).	2011	Informācija (Information).	The Latvian Doctor. (11), 76-77.	D10
11.	Latvijas Ārsts (The Latvian Doctor).	2011	Informācija (Information).	The Latvian Doctor. (5), 12.	D11
12.	Latvijas Ārsts (The Latvian Doctor).	2013	Notikumi medicīnā (Events in the medicine).	The Latvian Doctor. (3), 79.	D12
13.	Latvijas ģimenes ārstu asociācija (The Latvian General Practitioners´ Association).	2014	Latvijas Ģimenes ārstu asociācijas biedru sapulces paziņojums (Announcement of the meeting of the members of the Association of Latvian General Practitioners).	Obtained in personal correspondence	D13

14.	Latvijas ģimenes ārstu asociācija (The Latvian General Practitioners´ Association).	2018	Par Veselības aprūpes finansēšanas likuma atcelšanu (On the abolition of the Healthcare Financing Law).	Obtained in personal correspondence	D14
15.	Latvijas ģimenes ārstu asociācija un Latvijas lauku ģimenes ārstu asociācija (The Latvian General Practitioners´ Association and the Latvian Rural General Practitioners´ Association).	2014	Par veselības aprūpes finansēšanas likumu (On the draft law "Healthcare Financing Law").	Obtained in personal correspondence	D15
16.	Tiesībsargs (The Ombudsman of Latvia).	2014	Par likumprojektu “Veselības aprūpes finansēšanas likums” (About the “Healthcare financing law").	http://www.tiesibsargs.lv/uploads/content/legacy/veselibas_aprupe_ANO_augstas_komisares_atbilde_Saeimai_13022014_ieskanets.pdf	D16
17.	Tiesībsargs (The Ombudsman of Latvia).	2014	ANO Augstā Komisāre Cilvēktiesību jautājumos un veselības aprūpes finansēšanas modelis (UN High Commissioner for Human Rights and the healthcare financing model).	http://www.tiesibsargs.lv/news/lv/ano-augsta-komisare-cilvektiesibu-jautajumos-un-veselibas-aprupes-finansesanas-modelis	D17

18.	Tiesībsargs (The Ombudsman of Latvia).	2014	Atklāta vēstule Saeimai: par "Veselības aprūpes finansēšanas likumu" (Open Letter to the Parliament: On the draft "Healthcare Financing Law").	http://www.tiesibsargs.lv/uploads/content/legacy/veselibas_aprupe_ANO_augstas_komisares_atbilde_Saeimai_13022014_ieskanets.pdf	D18
19.	Tiesībsargs (The Ombudsman of Latvia).	2017	Par "Veselības aprūpes finansēšanas likumu" (About the "Healthcare financing law").	https://www.tiesibsargs.lv/news/lv/veselibas-aprupes-finansesana	D19
20.	Tiesībsargs (The Ombudsman of Latvia).	2018	Veselības aprūpes finansēšana (Healthcare Financing).	https://www.tiesibsargs.lv/news/lv/veselibas-aprupes-finansesana	D20
21.	Tomsone, S., Evetovits, T., Sailass, Dž.	2018	Pasaules Veselības Organizācija- 70. gadi. Finansiālā aizsardzība Čehijā, Igaunijā un Latvijā- trijās valstīs ar augstu ienākumu līmeni. Trīs dažādas pieredzes (World Health Organization - 70s. Financial protection in the Czech Republic, Estonia and Latvia - three countries with a high level of income. Three different experiences).	The Latvian Doctor. (4), 67-70.	D21
22.	Veide, S.	2018	Kā tiek iznīcināta veselības aprūpes sistēma? (How the national healthcare system is being crushed?).	The Latvian Doctor. (8), 4-5.	D22
23.	Veselības Ministrija (The Health Ministry).	2003	Par veselības aprūpes finansēšanas nākotni (About the Future Organization of Health Care Financing).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/86_par_veselibas_aprupes_finansesanas_turpmako_organizaciju/	D23
24.	Veselības Ministrija (The	2010	Veselības ministre: ienākuma nodokļa sasaiste nomaksas sasaiste ar veselības aprūpes pieejamību nav risinājums	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/2653_veselibas_ministre_ienakumu_nodokl	D24

	Health Ministry).		(Minister of Health: Linking the payment of income tax to the availability of healthcare is not a solution).	a_nomaksas_sasaiste_ar_veselibas_aprupes_pieejamibu_nav_risinajums/	
25.	Veselības Ministrija (The Health Ministry).	2010	Veselības ministre: adekvāts veselības aprūpes finansējums ir politiskas gribas jautājums (Minister of Health: Adequate funding for health care is a matter of political will).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/2673_veselibas_ministre_adekvats_veselibas_aprupes_finansejums_ir_politiskas_gribas_jautajums/	D25
26.	Veselības Ministrija (The Health Ministry).	2010	Veselības ministre: veselības aprūpes pieejamības sasaistīšana ar nodokļu nomaksu pretnostatīs ārstus un pacientus (Minister of Health: Linking access to health care to the payment of taxes will contrast doctors and patients).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/2630_veselibas_ministre_veselibas_aprupes_pieejamibas_saistisana_ar_nodoklu_nomaksu_pretnostatis_arstus_u/	D26
27.	Veselības Ministrija (The Health Ministry).	2011	Veselības ministre ar sociālajiem partneriem pārrunā nepieciešamību sasaistīt plānveida medicīnisko palīdzību ar nodokļu nomaksu (Minister of Health discusses with social partners the need to link planned medical care with tax payments).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/3198_veselibas_ministre_ar_socialajiem_partneriem_parruna_nepieciesamibu_sasaistit_planveida_medicinisko_/	D27
28.	Veselības Ministrija (The Health Ministry).	2012	Veselības ministre Ingrīda Circene tiekas ar Pasaules Veselības Organizācijas Eiropas reģiona biroja vadītāju Zuzannu Jakabu (Minister of Health Ingrīda Circene meets with Zuzanna Jakab, Head of the World Health Organisation Regional Office for Europe).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/3256_veselibas_ministre_ingrida_circene_tiekas_ar_pasaules_veselibas_organizacijas_eiropas_regionala_biro/	D28
29.	Veselības Ministrija (The	2012	Veselības ministre Ingrīda Circene no 4. līdz 6. jūnijam tiekas ar PVO Barselonas biroja pārstāvjiem, lai apspriestu veselības	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/3753_veseli	D29

	Health Ministry).		aprūpes finansēšanas modeļus (Minister of Health Ingrīda Circene meets with representatives of the WHO Barcelona Office from 4 to 6 June to discuss health financing models).	bas_ministre_ingrida_circene_no_4lidz_6junijam_piedala/	
30.	Veselības Ministrija (The Health Ministry).	2012	Darba grupa veselības obligātās apdrošināšanas koncepcijas izstrādei (Working group for the development of a draft concept of compulsory health insurance).	https://www.vm.gov.lv/lv/ministrija/darba_grupas/darba_grupa_veselibas_obligatas_apdrosinasanas_koncepcijas_p/	D30
31.	Veselības Ministrija (The Health Ministry).	2013	Circene: ANO Augstā Komisāre un cilvēktiesību eksperti atbalsta Veselības ministrijas koncepciju (Circene: The UN High Commissioner and human rights experts support the concept of the Health Ministry).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/4201_circene_ano_augsta_komisare_un_cilvektiesibu_eksperti_atbals/	D31
32.	Veselības Ministrija (The Health Ministry).	2013	Ingrīda Circene veselības nozares attīstību pārrunā ar augsta līmeņa starptautiskajiem ekspertiem (Ingrīda Circene discusses health sector development with high-level international experts).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/4363_ingrida_circene_veselibas_nozares_attistibu_parruna_ar_augst	D32
33.	Veselības Ministrija (The Health Ministry).	2013	Sabiedriskās organizācijas pauž atbalstu veselības obligātās apdrošināšanas koncepcijas ieviešanai (Public organizations express support for the approval of the concept of compulsory health insurance).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/4139_sabiedriskas_organizacijas_pauz_atbalstu_veselibas_obligatas/	D33
34.	Veselības Ministrija (The	2013	Veselības nozares stratēģiskā padome atbalsta ministrijas virzīto koncepciju par veselības obligāto apdrošināšanu (The	http://www.vm.gov.lv/lv/aktualitates/4104_veselibas_nozares_s	D34

	Health Ministry).		Strategic Council for the Health Sector supports the concept of health insurance promoted by the Ministry).	trategiska_padome_atbalsta_ministrijas_vi/	
35.	Veselības Ministrija (The Health Ministry).	2013	Veselības aprūpes finansēšanas likuma projekts (Healthcare Financing Law Project).	https://www.vm.gov.lv/lv/veselibas-aprupes-finansesanas-likumprojekts?utm_source=https%3A%2F%2Fwww.google.com%2F	D35
36.	Veselības Ministrija (The Health Ministry).	2014	Veselības Ministre Ingrīda Circene iesniegusi demisijas rakstu (Minister of Health Ingrida Circene has submitted a resignation letter).	http://www.vm.gov.lv/lv/aktualitates/preses_relizes/4514_veselibas_ministre_ingrida_circene_iesniegusi_demisijas_raks/	D36
37.	Veselības Ministrija (The Health Ministry).	2016	Konference "Veselības aprūpes sistēma Latvijā- strukturālās reformas un finansēšanas modeļi" (Conference "Healthcare system in Latvia -structural reforms and financing models").	http://www.vm.gov.lv/lv/ministrija/konferences_un_seminari/konference_veselibas_aprupes_sistema_latvija__strukturalas_r/?print	D37
38.	Veselības Ministrija (The Health Ministry).	2016	Diskutē par veselības aprūpes iespējamajiem finansēšanas modeļiem (Discuss possible financing models for healthcare).	https://www.vm.gov.lv/lv/aktualitates/preses_relizes/5164_diskute_par_veselibas_aprupes_iespejamajiem_finansesanas_mod/	D38
39.	Veselības Ministrija (The Health Ministry).	2016	Pārrunā sadarbības jautājumus ar sociālajiem partneriem (Discuss cooperation issues with social partners).	https://www.vm.gov.lv/lv/aktualitates/5186_parruna_sadarbibas_jautajumus_ar_socialajiem_partneriem/	D39
40.	Veselības Ministrija (The	2016	Nozares stratēģiskā padome atbalsta veselības ministrijas virzīto veselības	https://www.vm.gov.lv/lv/aktualitates/preses_relizes/5166_noza	D40

	Health Ministry).		aprūpes finansēšanas modeli (Strategic Sector Council supports the health financing model promoted by the Health Ministry).	res_strategiska_padome_atbalsta_veselibas_ministrijas_vi/	
41.	Veselības Ministrija (The Health Ministry).	2016	Pasaules Veselības Organizācija iesaka būtiski palielināt valsts finansējumu veselības aprūpei (The World Health Organization recommends a significant increase in public funding for healthcare).	https://www.vm.gov.lv/lv/aktualitates/5163_pasaules_veselibas_organizacija_iesaka_butiski_palielinat_no	D41
42.	Veselības Ministrija (The Health Ministry).	2017	Apspriež Veselības aprūpes finansēšanas likumprojektu (The Healthcare Financing Bill is discussed).	https://www.vm.gov.lv/lv/aktualitates/preses_relizes/5501_apspriez_veselibas_aprupes_finansesanas_likumprojektu/	D42
43.	Veselības Ministrija (The Health Ministry).	2017	Veselības aprūpes finansēšanas likumprojektu virza apstiprināšanai uz Ministru kabinetu (The Healthcare Financing Bill is submitted to the Cabinet of Ministers for approval).	https://www.vm.gov.lv/lv/aktualitates/preses_relizes/5506_veselibas_aprupes_finansesanas_likumprojektu_virzis_apstipri/	D43
44.	Veselības Ministrija (The Health Ministry).	2017	Veselības ministre piedalīsies OECD veselības ministru sanāksmē (The Minister of Health will participate in the OECD Meeting of Health Ministers).	https://www.vm.gov.lv/lv/aktualitates/preses_relizes/5342_veselibas_ministre_piedalisies_oecd_veselibas_ministru_sanak/	D44
45.	Veselības Ministrija (The Health Ministry).	2017	Veselības ministre darba vizītē apmeklēs PVO Eiropas Reģionālo biroju (The Minister of Health will pay a working visit to the WHO Regional Office for Europe).	https://www.vm.gov.lv/lv/aktualitates/preses_relizes/5417_veselibas_ministre_darba_vizite_apmekles_pvo_eiropas_regiona	D45
Domestic Laws, Parliament and Cabinet of Ministers regulations					
1.	Ministru kabinets (The	2017	Par konceptuālo ziņojumu "Par veselības aprūpes sistēmas reformu" (On the	https://likumi.lv/ta/id/292718-par-konceptualo-zinojumu-par-	D46

	Cabinet of Ministers).		conceptual report "On the reform of the health care system").	veselibas-aprupes-sistemas-reformu	
2.	Ministru kabinets (The Cabinet of Ministers).	2016	Māra Kučinska Valdības deklarācija (Declaration on the Cabinet of Ministers headed by Maris Kucinskis).	https://www.mk.gov.lv/sites/default/files/editor/20160210_mkucinskis_vald_prior_gala_vers_0.pdf	D47
3.	Ministru kabinets (The Cabinet of Ministers).	1996	Veselības aprūpes finansēšanas noteikumi (Healthcare Financing Regulation).	https://www.vestnesis.lv/ta/id/41779-veselibas-aprupes-finansesanas-noteikumi	D48
4.	Ministru kabinets (The Cabinet of Ministers).	1996	Latvijas veselības aprūpes attīstības stratēģija (Latvian Healthcare Development Strategy).	https://likumi.lv/ta/id/16617-par-primaras-un-sekundaras-veselibas-aprupes-sistemas-attistibas-strategiju	D49
5.	Ministru kabinets (The Cabinet of Ministers).	1994	Par veselības aprūpes sistēmas finansēšanas reformu. Ministru kabineta noteikumi Nr. 63. (On the reform of the financing of the healthcare system. Regulations of the Cabinet of Ministers No. 63).	https://likumi.lv/ta/id/58049-par-veselibas-aprupes-sistemas-finansesanas-reformu	D50
6.	Ministru kabinets (The Cabinet of Ministers).	1994	Slimokasu izveides un darbības noteikumi. Ministru kabineta noteikumi Nr. 360. (Rules for the establishment and operation of sickness funds. Regulations of the Cabinet of Ministers No. 360).	https://www.vestnesis.lv/ta/id/45552-slimokasu-izveides-un-darbibas-noteikumi	D51
7.	Saeima (The Parliament of Latvia).	2019	Grozījumi Veselības aprūpes finansēšanas likumā (Amendments to the Health Care Financing Law).	https://likumi.lv/ta/id/307619-grozijumi-veselibas-aprupes-finansesanas-likuma	D52

8.	Saeima (The Parliament of Latvia).	2017	Veselības aprūpes finansēšanas likums (Healthcare Financing Law).	https://likumi.lv/ta/id/296188-veselibas-aprupes-finansesanas-likums	D53
9.	Saeima (The Parliament of Latvia).	2013	11.Saeimas sēžu transkripti (Transcripts of 11th Saeima meetings).	https://www.saeima.lv/lv/transcripts/view/215	D54
IOs produced documents and publications					
1.	Evetovits, T.	2019	WHO perspective on health financing reforms in Latvia. WHO Europe Barcelona Office for Health Systems Strengthening.	Obtained in personal correspondence	D55
2.	Evetovits, T.	2016	Health financing in Latvia: analysis of expenditure and financial protection. WHO Europe Barcelona Office for Health Systems Strengthening.	Obtained in personal correspondence	D56
3.	OECD.	2019	Economic Surveys: Latvia.	https://www.oecd-ilibrary.org/economics/oecd-economic-surveys-latvia-2019_f8c2f493-en	D57
4.	OECD.	2017	Economic Surveys: Latvia.	https://www.oecd-ilibrary.org/economics/oecd-economic-surveys-latvia-2017_eco_surveys-lva-2017-en	D58
5.	OECD.	2015	Economic Surveys: Latvia.	https://www.oecd-ilibrary.org/economics/oecd-economic-surveys-latvia-2015_9789264228467-en	D59

6.	OECD.	2016	Latvia faces important challenges to improve the performance of its health system.	https://www.oecd.org/newsroom/latvia-faces-important-challenges-to-improve-the-performance-of-its-health-system.htm?	D60
7.	OECD.	2016	Latvia's accession to the OECD.	https://www.oecd.org/latvia/latvia-accession-to-the-oecd.htm#:~:text=1%20July%202016%20%2D%20Latvia%20deposited,full%20member%20of%20the%20Organisation	D61
8.	OECD.	2016	Reviews of Health Systems OECD Reviews of Health Systems.	https://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-systems-latvia-2016_9789264262782-en	D62
9.	OECD.	2018	Secretariat Note on Latvia's Implementation of the Health Committee Recommendations.	Obtained in personal correspondence	D63
10.	OECD.	2018	Summary of Latvia's OECD Post-Accession Progress.	https://www.oecd.org/content/dam/oecd/en/about/legal/post-accession-report/latvia-oecd-post-accession-report-2018.pdf	D64
11.	WHO Europe.	2012	Latvian Minister of Health discusses policy at WHO Barcelona Office for Health System Strengthening.	https://www.euro.who.int/en/countries/latvia/news/news/2012/06/latvian-minister-of-health-discusses-policy-at-who-barcelona-office-for-health-system-strengthening	D65

12.	WHO Europe.	2012	Minister of Health of Latvia signs agreement with WHO/Europe.	https://www.euro.who.int/en/countries/latvia/news/news/2012/01/minister-of-health-of-latvia-signs-agreement-with-whoeurope	D66
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Appendix 2

Conducted interviews

No.	Name of the interviewee	Position	Interview data	Interview code
1.	Ingrīda Circene (MD)	Minister of Health (April 2003 – March 2004, October 2011 – July 2014), Member of Parliament, external advisor to the Prime Minister in health questions.	Face-to-face interview, Riga, Latvia. June 10, 2019.	I-1
2.	Māris Taube (MD)	The former head of NHS, co-author of WHO HiT reports and the publication "Can people afford to pay for healthcare?; Latvia".	Face-to-face interview, Riga, Latvia. June 25, 2019.	I-2
3.	Kristīne Kļaviņa	Head of the Human Resources Development Department at the Ministry of Health.	Online interview. March 4, 2020.	I-3
4.	Assoc. Prof. Dzintars Mozgis (MD)	Deputy Director for Prevention and Public Health, Centre for Diseases Prevention and Control, Associate Professor at Riga Stradins University, Department of Public Health and Epidemiology, Member of Board of Latvian Medical Association.	Online interview. June 29, 2020.	I-4
5.	Pēteris Apinis (MD)	Head of Latvian Medical Association (1991–1992, 2006–2018), Minister of Health (February–December 1995) and Member of Parliament (6th and 7th Saeima), External advisor to the Prime Minister (2009–2010).	Online interview. July 21, 2020.	I-5
6.	Ilze Aizsilniece (MD)	Head of the Latvian Medical Association (since 2018), General Practitioner, Lecturer at University of Latvia.	Online interview. August 27, 2020.	I-6

7.	Liene Cipule	Parliamentary Secretary at the Ministry of Health (2011–2013).	Online interview. September 4, 2020.	I-7
8.	Anda Čakša	Minister of Health (June 2016 – January 2019).	Online interview. September 4, 2020.	I-8
9.	Rinalds Muciņš	Former Minister of Health (March 2004 – December 2004), former State Secretary at the Ministry of Health.	Online interview. September 7, 2020.	I-9
	Ilze Viņķele	Minister of Health (since 2019), Member of the Parliament (2014–2017), Minister of Welfare (2011–2014), Parliamentary Secretary at the Ministry of Finance (2010–2011).	Online interview. September 15, 2020.	I-10
10.	WHO Europe Barcelona Office representative	Requested anonymity	Online interview. September 25, 2020.	I-11
11.	OECD representative	Requested anonymity	Online interview. October 9, 2020.	I-12
12.	Vladimirs Strazdiņš (MD)	Member of the Latvian Medical Association, author of the first healthcare financing reform proposal in 1989.	Face-to-face interview, Jūrmala, Latvia. October 1, 2019.	I-13
13.	Ivars Krastiņš (MD)	The first President of newly established Latvian Medical Association, Member of Parliament (1990-1993).	Face-to-face interview, Liepāja, Latvia. June 19, 2019.	I-14

14.	Jānis Meikšāns (MD)	CEO of Teva Pharmaceuticals Ltd in Hungary, Former member of the Latvian Medical Association, co-author of the first reform proposal in 1989.	Skype interview. January 13, 2020.	I-15
15.	Vladimirs Makarovs and Maija Poršņava	Minister of Welfare (1995-1999), Minister of Economy (1999-2000), Minister of Environment and Regional Development (2000-2002). State Secretary of the Ministry of Welfare (early 1990s - 2002).	Face-to-face interview, Saulkrasti, Latvia. October 15, 2019.	I-16
16.	Aiga Rūrāne	Head of the WHO Euro Country Office in Latvia, 1995–2019.	Online interview. September 24, 2019.	I-17

General declaration

I declare that I have autonomously completed my dissertation without seeking any unauthorized aid. All sources and aids employed in the dissertation are properly referenced, with clear acknowledgment and citation. Any ideas, excerpts, or citations not originating from my own work are explicitly identified. I will also allow the dissertation to be checked with qualified software in the event of allegations of plagiarism. I have used artificial intelligence programs for language editing, improving readability, and shortening the text. No part of this thesis has been accepted or is currently being submitted for any other degree or qualification at this university or elsewhere

Isernhagen, 18.07.2025 Liva Stupele