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Contesting focality in global health governance: The World Health Organization-World Bank relationship in historical perspective

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Abstract

Focal organisations are typically seen as the undisputed leaders in addressing specific cooperation problems. However, as global governance becomes increasingly fragmented and contested, even well-established organisations are now facing challenges to their traditionally unquestioned focality. Drawing on new theoretical insights, the article contends that the contestation of focal organisations is not a new phenomenon. On the contrary, most focal organisations experience challenges to their focality from their very establishment. At the same time, focal organisations are likely to respond to these challenges with tailored, ad hoc strategies. The article tests these expectations in the case of the global health governance complex, where the initial focality of the World Health Organization was contested by various actors since the outset. Among those contesting the World Health Organization's focality, a prominent position was gained by the World Bank. By examining the interinstitutional relationship between the World Health Organization and the World Bank from the 1970s onwards, the article shows how this dynamic impacted the World Health Organization's focality and influenced the broader evolution of the global health complex over the past decades.

Keywords

global governance, global health governance, international organisations, regime complexity, World Bank, World Health Organization, United Nations

Introduction

In a speech held at the World Economic Forum in 2019, the United Nations (UN) Secretary-General Guterres expressed his concern about the state of the multilateral order by lamenting that 'We are in a world in which global challenges are more and more integrated, and the responses more and more fragmented'.[1] In his remarks, Guterres was

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alluding to a phenomenon long recognised by International Relations (IR) scholars, namely the fragmentation (or complexity) of contemporary multilateral cooperation efforts (Raustiala and Victor, 2004). While international institutions were once viewed as isolated actors, this notion of 'singular institutionalism' is no longer viable (Henning and Pratt, 2023). Instead, scholars increasingly agree that 'the creation, evolution and effectiveness of international institutions are fundamentally shaped by how they relate to other institutions operating within their policy domains' (Eilstrup-Sangiovanni and Westerwinter, 2021: 1). These 'other institutions' extend beyond formal international organisations (IOs) to include a wide array of governance actors, such as ad hoc coalitions (Reykers et al., 2023), civil society and nongovernmental organisations, informal organisations (Roger, 2020), multi-stakeholder initiatives (Reinsberg and Westerwinter, 2021), philanthropic foundations (Partzsch and Fuchs, 2012), public–private partnerships (Andonova, 2010), and trans-governmental regulatory networks (Abbott and Faude, 2021a), among others. Far from operating in isolation, contemporary organisations thus function within global governance complexes, that is, 'system[s] of governance composed of at least three international or transnational institutions or actors whose mandates, functions and memberships overlap, and that jointly address a specific policy problem' (Eilstrup-Sangiovanni and Westerwinter, 2021: 6).

In the last decade, IR scholars have intensified their efforts to understand the causes and consequences of such institutional proliferation.[2] On one hand, states' behaviours and material and ideational shocks – such as the end of the Cold War – have been identified as key *drivers* behind this trend (Benvenisti and Downs, 2007; Biermann and Koops, 2017; Panke and Stapel, 2022). On the other hand, attention has been paid to grasp the impact of complexity on governance *outcomes*. The more pessimistic analyses have emphasised the role of complexity in exacerbating policy incoherence (Breen et al., 2020), institutional shallowness (Rüland, 2018), interinstitutional competition (Betts, 2013), and power asymmetries (Drezner, 2009). More optimistic accounts have instead highlighted the potential complementarities between institutions (Gehring and Faude, 2014), their collaborative and adaptive relationships (De Búrca, 2016; Faude and Parizek, 2020; Pratt, 2018), and the flexibility and normative legitimacy provided by dense systems (Faude and Groβe-Kreul, 2020). More recently, Henning and Pratt (2023) have shown how patterns of cooperation within a governance complex are influenced by specific structural features of the complex itself, particularly its authority relations and institutional differentiation.

While these works provide valuable insights into the causes and consequences of institutional complexity, they exhibit three shortcomings. First, they give limited attention to the impact of complexity on a specific class of organisations, namely *focal organisations* (FOs). While these organisations are conventionally portrayed as the exclusive, natural, and leading authorities of their reference domains (Jupille et al., 2013), they too have had to adapt to a changing and more competitive environment. However, the strategies they have used in this regard have not been thoroughly researched.[3] Second, most existing scholarship emphasises the role of *states* as the main actors driving institutional complexity (Gómez-Mera, 2020). In contrast, the question of how IOs themselves navigate the political dynamics of the complexes in which they operate has received inadequate attention[4] (Margulis, 2021). Third, works on governance complexity often suffer from a *recency bias*, in that they assess present patterns without references to past developments and path-dependent mechanisms.[5]

This article addresses two research questions. First, how should focal organisations be understood in a scenario characterised by growing complexity? Second, how do focal organisations navigate this complexity, particularly when faced with contestation from *other* institutions? In answering these questions, the article makes three contributions. First, it offers an improved understanding of focal organisations, unveiling the limits of current characterisations. Second, it introduces a new framework to study how focal organisations try to adjust to external challengers. This framework shows how focal organisations react to contestation by tailoring their strategies to the specific characteristics of the challenges posed by rival institutions. Third, the article provides a first application of this framework, discussing how the World Health Organization (WHO) – the supposed focal organisation in global health – was challenged by the rising influence of the World Bank since the 1970s. The case of the global health complex is particularly intriguing. When it first emerged in the mid 1940s, this complex was characterised by strong hierarchy (with WHO being the 'peak', or 'focal', institution) and rather differentiated institutions. While this would suggest limited adaptive pressures (Henning and Pratt, 2023), the regime for global health has significantly changed throughout time. Specifically, WHO's initially uncontested focality has been immediately challenged by the rise of new diversified actors (Hoffman et al., 2015), including other international institutions (as the United Nations Children's Fund (UNICEF)), public–private partnerships (Andonova, 2018), and even fully private entities such as the Bill and Melinda Gates Foundation (Levich, 2015). Among those institutions that have challenged the post-Second World War 'status quo' in global health, the World Bank has played a particularly prominent role. Leveraging its financial and intellectual capabilities, the Bank frequently contested WHO's leading position. While this prompted important adjustments on WHO's side, it nonetheless contributed to the unfolding of a less hierarchical global health regime. For this reason, analysing the changes in the WHO-World Bank interinstitutional relationship from the 1970s onwards may offer valuable insights into the broader evolution of global health governance over the past decades. The article proceeds as follows. The next two sections propose a renewed understanding of focality and an original framework to support the subsequent empirical analysis. The fourth section applies the developed insights to the health complex, and specifically to the intricate relationship between WHO and the World Bank. The last section summarises the discussion and concludes.

Problematising focality and focal organisations

Within IR scholarship, the term focal organisations was initially used to indicate organisations that were central to their members and around which expectations converged (Pfeffer and Salancik, 1978; Schelling, 1960). Since these early mentions, references to focal organisations have become more frequent. In their theory of institutional choice, Jupille et al. (2013: 27) define focal organisations as 'the natural fora for dealing with a particular cooperation problem'. A similar interpretation is found in Abbott and colleagues' work on orchestration (Abbott et al., 2015: 24). There, focal organisations are portrayed as 'the single and uncontested governance leader[s]' of their domains, so that 'no other actor is recognized as occupying the same position'. Accordingly, institutions as the United Nations Security Council (UNSC), the World Trade Organization (WTO), and the International Monetary Fund (IMF) are cited as focal organisations in the domains of international security, trade, and financial stability, respectively.[6]

While this interpretation of focal organisations is intuitive, it clashes with the fact that 'a steady increase in the number, breadth, and diversity of international institutions [. . . has] been a persistent feature of many domains of international cooperation since the early twentieth century' (Eilstrup-Sangiovanni, 2021: 295). Such fragmentation has had two consequences for focal organisations. First, it has multiplied the number of possible 'focal points' around which states' expectations may converge (Henning and Pratt, 2023). Second, it has presented focal organisations with potential competitors – what I term institutional substitutes – that have progressively chased FOs' mandates, members, and resources (Abbott and Faude, 2021b). In different fields, prominent institutions that once faced little challenge to their recognised roles now find it increasingly difficult to justify their entitlement to a focal and privileged position.

Several works have explored these trends. In their ground-breaking article, Morse and Keohane (2014) coined the term 'contested multilateralism' to describe situations where states, multilateral organisations, and non-state actors use multilateral institutions, existing or newly created, to challenge the rules, practices, or missions of existing focal organisations. Building on this concept, some studies have specifically examined instances where focal organisations have faced contestation from *other* international institutions. For instance, Güven (2017) has unveiled the 'competitive pressures' placed upon the focal IMF and World Bank by the creation of rival institutions as the New Development Bank (NDB) and the Asian Infrastructure Investment Bank (AIIB). Similarly, Van de Graaf (2013) has explained how Western countries established the International Renewable Energy Agency (IRENA) to counter the focal International Energy Agency's (IEA) normative bias towards fossil and nuclear energy industries. Other works have investigated the competition between the focal United Nations High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM) in the refugee regime complex (Betts, 2013), or the contestation of WTO's agriculture rules from the United Nations (Margulis, 2018). In the field of global health, Hanrieder (2009, 2015b) has unveiled the competitive pressures placed upon the focal WHO by WTO's entry in the health regime, as well as by the proliferation of public–private partnerships in development assistance to health (DAH). These accounts present three shortcomings. First, their study of focal organisations' contestation does not contribute to a broader *reevaluation* of traditional understandings of focal organisations. In other words, the characterisation of FOs as 'single and uncontested governance leaders' of specific domains resists, despite evidence of its analytical inadequateness. Second, most of these works lack an analysis of focal organisations' *responses* to external institutional threats. While all focal organisations have had to adapt to changed and more competitive environments, the strategies they have employed vary widely. Third, existing research mostly focuses on *contemporary* events, thereby missing the insights stemming from a more longitudinal study of FOs. In this section, I address the first of these weaknesses by advancing a more nuanced understanding of focality and focal organisations.

I start by proposing a new definition of focal organisations, according to which *an organisation is focal when it is recognised as the principal actor matching, shaping, and delivering on the evolving expectations of its governance complex.* While this definition builds on existing formulations (including Abbott et al., 2015 and Fioretos and Heldt, 2019) that acknowledge a 'central' role for FOs, it problematises common understandings of focality, and it raises the threshold for actual focality to be present. For example, the WTO is traditionally regarded as the focal organisation for trade governance. However, the Genevan institution is today significantly failing with respect to each of its core

competencies, from negotiating to monitoring agreements and settling disputes (Low, 2022). Partly for this, alternative regional and bilateral trade agreements have proliferated in the last years. In this context, whether the WTO can still be recognised as 'the principal actor matching, shaping, and delivering on the evolving expectations of [the trade] complex' is at best an empirical question. Based on the definition provided, four features of focality can be identified. First, focality is a matter of degree. Stated differently, focality is rarely absolute or entirely absent, as it often varies across sub-issue areas and competences. For example, Moon (2021) portrays WHO as being more focal in performing stewardship duties than in developing new health tools. Second, focality is dynamic, as it is a non-static feature. While it may initially arise by first-mover advantages, focality can be reduced over time, or regained following periods of crisis. For instance, the Food and Agriculture Organization (FAO), the first and focal institution in the anti-hunger regime, underwent significant contestation in the 1970s, to the point that two alternative fora[7] were created to overcome its shortcomings (Johnson, 2016). Third, focality is relational, meaning it should be conceived in relation to the specific governance complex in which an actor operates. While the General Agreement on Tariffs and Trade (GATT) was the focal actor in the complex for trade in goods, other institutions – as the Organization for Economic Cooperation and Development (OECD) – initially played a more central role in the complex for trade in services (Cohn, 2017). Fourth and last, focality is a contestable and contested attribute. If organisations fail to match, shape, and deliver on the expectations of their complexes, focality is endangered. When this occurs, new or existing actors – 'institutional substitutes'[8] – may gain influence and attempt to take over, or contend, the position granted to the focal organisations.

This definition and conceptualisation show that focality is neither an exclusive nor an 'inalienable' trait of particularly powerful institutions. Instead, understanding focality as nuanced, dynamic, relational, and contestable helps explain why focal organisations may continuously face challenges to their role from the moment of their creation. The next section delves deeper into the challenges posed by institutional substitutes and the counterstrategies that focal organisations may employ to maintain their focality.

How focal organisations navigate complexity

Institutional substitutes intuitively constitute a hindrance on focal organisations' ability to match, shape, and deliver on expectations. However, substitutes are not identical, and neither is the character of their challenges. In fact, substitutes should be evaluated based on (1) their *level of overlap* with the focal organisations' competencies and (2) their adopted *issue framing*[9] vis-à-vis the focal organisations' adopted issue framing.

To begin with, focality is affected differently depending on whether the institutional substitute encroaches in a peripheral or core competence of the focal organisation. In most cases, the latter will state its core competences in official documents and statements. For example, the IMF's website reports how the organisation 'promotes international financial stability and monetary cooperation, facilitates international trade, promotes employment and sustainable economic growth, and helps to reduce global poverty'. If organisations do not explicitly outline their core competences, these can be inferred by looking at founding documents and annual budgets. As a general rule, the focality of a given organisation is more significantly impacted if one of its *core* competences is credibly challenged by a specific institutional substitute. Conversely, a substitute targeting more flanking activities unlikely disrupts the main 'focal elements' of the organisation (Haftel and Lenz, 2021).

Table 1. Focal organisations' responses to institutional substitutes.

		Issue framing	
		Consistent framing	*Inconsistent framing*
Level of overlap	*Peripheral competence*	Collaboration	Cooptation
	Core competence	Coopetition	Retrenchment

Next, focality is affected differently, depending on whether the institutional substitute adopts a consistent or inconsistent framing (on a specific issue) vis-à-vis the issue framing adopted by the focal organisation. This acknowledges that institutions 'may have epistemic or normative differences, [. . .] producing disagreement over the best ways to address governance problems' (Abbott and Faude, 2021b: 8). These differences can stem from variations in member states' preferences and/or powers, but also from antithetical bureaucratic cultures (Haas, 1992). In this context, an inconsistent issue framing is one that conflicts, at least in part, with the 'principled beliefs' of the focal organisation (Margulis, 2021). For instance, Moe and Geis (2020) discuss how the UNSC and the African Union (AU) adopted an opposite approach to African security in the post-Cold War years, respectively, advocating an external intervention *versus* a sovereignty-based framing. To be sure, substitutes may also promote a framing entirely consistent with that of the focal organisation. Heldt and Schmidtke (2019) show how the NDB and the AIIB frame development finance challenges in a relatively coherent way with the approach adopted by the World Bank, the focal organisation in the field. As a general rule, the focality of a given organisation is more significantly affected if a specific institutional substitute adopts an *inconsistent* framing on how to address existing governance problems.

As the present framework is dynamic, it can be supposed that core (periphery) issues do not necessarily remain so through an organisation's life. For instance, after the 1986 Chernobyl disaster, the International Atomic Energy Agency (IAEA) doubled its efforts in the field of nuclear safety, until then a relatively minor activity in its portfolio. Similarly, whether a substitute's framing is considered consistent (inconsistent) can vary depending on the historical context. When WTO was established in the mid 1990s, its approach to intellectual property rights protection was quite inconsistent with that promoted by the World Intellectual Property Organization (WIPO). Over time, however, the two organisations developed a more coherent and integrated interinstitutional relationship (Abbott, 2000).

With threats from institutional substitutes being a function of the substitutes' level of overlap and adopted issue framing, responses from focal organisations are accordingly modulated on the characteristics of the challenge faced. Four possible strategies implemented by focal organisations in response to external pressures are discussed (Table 1).[10] Importantly, I assume that focal organisations act strategically, but also boundedly rational (Simon, 1957). While they aim to maximise their potential and immediate benefits, focal organisations often operate in environments marked by informational scarcity and asymmetry, time pressure, and urgency. As a result, they may choose strategies that satisfice them in the short term, even if these come at the expense of more advantageous long-term options.

If faced with a substitute targeting a peripheral competence in a consistent way, focal organisations may seek to collaborate with it. *Collaboration* enables organisations to work together towards shared goals that could not be achieved independently (Gutner, 2022). As such, it is easier when organisations converge on the framing of a policy issue, and when they do not overlap on 'core' prerogatives, as they can draw

from distinct resources. Elie (2010) recalls how collaboration between the focal UNHCR and the Intergovernmental Committee for European Migration (ICEM) was crucial during the 1956 Hungarian refugee crisis, where the ICEM acted under UNHCR's lead to jointly manage the situation. This case suggests that focal organisations tend to develop collaborative relations when these support their objectives and acknowledge their leadership position.

If faced with a substitute targeting a core competence in a consistent way, focal organisations may seek to coopete with it. A concept derived from management studies (Walley, 2007: 12), *coopetition* refers to situations where 'competitors simultaneously cooperate and compete'. While usual examples pertain to the business world, the notion translates to the study of interinstitutional relationships. Here, coopetition occurs between actors overlapping in core competencies and sharing similar long-term, coherent approaches. In these cases, focal organisations attempt to create synergies with the substitute to enable an efficient division of labour and ensure a 'collective legitimation of [their common] governance complexes' (Haftel and Lenz, 2021: 20). For instance, Brosig (2010) studies how the Organization for Security and Cooperation in Europe's (OSCE) High Commissioner on National Minorities (HCNM) and the Council of Europe's Advisory Committee (AC) developed a division of labour assigning them different tasks within the European complex of minority rights protection. This was possible because the two organisations shared congruent interests (the protection of minority rights) but had different 'primary aims' (the HCNM is an instrument of early warning, while the AC monitors the implementation of minority rights norms ex-post). Hence, the HCNM and the AC could profit from a structured coordination of their activities, as this did not significantly disrupt their respective influence within the minority rights complex.

If faced with a substitute targeting a peripheral competence in an inconsistent way, focal organisations may seek to coopt it. *Cooptation* is 'the process of absorbing new elements into the leadership or policy-determining structure of an organization as a means of averting threats to its stability or existence' (Selznick, 1949: 34). More broadly, the notion applies to strategies implemented by lead organisations to absorb recalcitrant external actors, without a substantial transferral of power or leadership to the latter. By co-opting substitutes that adopt inconsistent framing, focal organisations can leverage their centrality to maintain control. This not only preserves their leadership, but can also strengthen it as focal organisations leverage the resources and legitimacy of the coopted partners (Holdo, 2019). For instance, in the 1980s, the GATT successfully coopted the antagonistic United Nations Conference on Trade and Development (UNCTAD) into its orthodox liberal economic logic. As a result, UNCTAD shifted from being a 'serious counterweight to the economic policy prescriptions of [Western . . .] organisations' (Diekmann, 1996: 223) to playing a subordinated role in GATT-led trade negotiations. However, as Mattli and Seddon (2015) note, cooptative strategies are double-edged swords. Being the potential for transfers of leadership from the initiator to the cooptee present, the possibility of backfiring is significative.[11] Accordingly, focal organisations are likely to pursue cooptation only when it is perceived as cost-effective and relatively riskless.

Finally, if faced with a substitute targeting a core competence in an inconsistent way, focal organisations may retrench. Generally, *retrenchment* can be understood as an adaptive mechanism to manage competitive pressures (Costa, 2017). I further differentiate between two types of retrenchment. On one hand, *proactive* retrenchment involves recognising the presence of a potential substitute and adjusting accordingly. This may help minimising

interinstitutional contradictions and gain legitimacy in the substitute's eyes. For instance, when the WTO tried to incorporate a social clause into the promotion of liberal trade agreements, the International Labour Organization (ILO) launched the alternative Decent Work Agenda (DWA) to mediate between the demands of global capital and the need to improve the lives of marginalised workers (Vosko, 2002). On the other hand, focal organisations may engage in a more dysfunctional form of retrenchment, which I term *passive* retrenchment. In these cases, focal organisations respond to external threats by perching on their own positions and hardening their organisational culture. For example, Barnett and Coleman (2005) show how Interpol was slow to adjust to the rise of competitors in the realm of police cooperation,[12] despite these increasingly encroaching on its core mandate.

At this point, it is worth considering the likely impact of each strategy on final levels of focality. It is sensible to separate *short-run* and *long-run* impacts. In the short run, collaboration preserves or increases focality, provided that the focal organisation stresses its lead position. Similarly, coopetition maintains, or better redefines, focality because of the division of labour determined by the actors involved. The outcome for cooptative and retrenchment strategies is less predictable in the short run. When considered in the long run, these strategies may lead to different outcomes. Long-term collaboration may result in two distinct scenarios. Specifically, a focal organisation may attempt to incorporate the substitute's activities in its own portfolio, or it may decide to forego its peripheral tasks, thereby contemplating a limited loss of focality. Long-term coopetition can similarly weaken focality. If the focal organisation becomes overly dependent on the substitute, for example, if the latter provides funding to the focal organisation's activities, its ability to 'deliver' on expectations can be impaired. In addition, an initially agreed division of labour can end up unbalancing the relative powers within a governance complex, costing the focal organisation part of its influence. In the long run, the impact of cooptation strategies becomes clearer. If successful, cooptation shifts the position of the substitute closer, fostering a more collaborative relationship. If cooptation backfires, it can cause the incorporation of the focal organisation's tasks from the substitute, hence, making future cooptative strategies riskier. A similar logic applies to retrenchment. In the long run, a proactive retrenchment implies a greater awareness of the substitute's positions from the focal organisation. Hence, the two move closer, possibly shifting to a coopetitive relationship. Conversely, passive retrenchment can determine a long-term decline in focality. With the focal organisation perched on rigid positions, the substitute can gain traction by positioning itself as the only possible 'go-to organization' for dissatisfied stakeholders.

Before moving on to the empirical section, a recap of the theoretical arguments hitherto developed is in order. Three main points have been made. First, focal organisations do not necessarily embody the concept of 'exclusive, natural, and leading authorities'. Instead, being focality nuanced, dynamic, relational, and contestable, focal organisations are often challenged since their very creation. Second, challenges to focal organisations are not identical, but rather depend on (1) whether a core or peripheral competence of the focal organisation is being targeted, and (2) whether a substitute adopts a consistent or inconsistent framing vis-à-vis the focal organisation's preferred framing. Third, focal organisations tentatively respond to substitutes by modulating their strategies on the specific characteristics of the challenge faced.

The next section applies these arguments to the case of the WHO-World Bank interinstitutional relationship. Several factors make this specific case interesting. To start with, WHO constitutes a 'least-likely' case for presenting focality as a contestable and contested attribute. The UN agency was established in 1948 as the only 'directing and coordinating authority' in all matters relating to international health, a mandate that recalls the

idea of an ‘exclusive fora’ advanced by Jupille et al. (2013). Accordingly, the regime complex for health was initially perceived as hierarchical, as also evidenced by the fact that WHO reunited under its umbrella the functions previously performed by three distinct institutions.[13] Despite these initial conditions, WHO’s focal role was contested since the immediate postwar decade, as the proliferation of various institutional substitutes gradually led to a more fragmented and horizontal complex. In this context, the World Bank represented since the 1970s one prominent substitute endowed with the (financial and operational) capacity to partially displace WHO as the focal health organisation. That said, the type of threat that the World Bank entailed for WHO significantly shifted over time. While it initially concentrated on peripheral issues, the Bank became a central global health actor in the 1990s, before returning to a secondary role after the mid 2000s. In this sense, the case presented is particularly illuminating to assess the evolution of focal organisations (and their associated complexes) *across time*, going beyond the diffuse recency bias of most regime complexity scholarship.

The following analysis should be understood as a theory-guided idiographic case study which aims at reinterpreting the WHO-World Bank historical relationship through the lens of focality (Levy, 2008). Methodologically, the study adopts a ‘theory testing’ approach to process tracing (Beach and Pedersen, 2011). As for data, the analysis draws on documents publicly available in WHO’s online repository of the World Health Assembly (WHA) and Executive Board meetings. Similarly, official policy papers and reports from the World Bank’s Documents & Reports (D&R) site are used throughout the case study.

Contesting focality in global health: The WHO-World Bank historical relationship

Until the late 1960s, the strategies adopted by the World Bank and other economic agencies to promote global development were heavily influenced by Walt Rostow’s (1960) book *The stages of economic growth*. Rostow posited that economic progress was a sequential process, where advancement from an initial phase of underdevelopment could be achieved through gradual capital accumulation and industrialisation. Relying on this theory, World Bank officials had focused their investments on physical capital and heavy infrastructure. However, by the end of the 1960s, it became evident that ‘[such approach] had produced growth without development. Dams, highways, hospitals, and factories were being built, but the basic needs of the people were not being met’ (Packard, 2016: 235). Faced with this reality, economic organisations abandoned their fixation on large-scale infrastructures to embrace different, poverty-alleviation programmes. This new emphasis on meeting ‘basic needs’ led to a greater focus on health initiatives. At the World Bank, this concern for health intensified under the Presidency of Robert McNamara (1968–1981). Starting in the 1970s, the Bank thus emerged as one of the most influential players in international health governance, leveraging its fiscal and policy capacity to challenge WHO’s focality in the field. The way it did so, as well as the responses it provoked from WHO, are at the centre of the next three subsections.

Starting from the periphery: The World Bank’s early steps and WHO’s reaction (1970s to 1980s)

The first step of the World Bank in international health governance dates back to 1970, when it began financing some population control programmes and established its Population Projects Department. While most officials had hitherto excluded a role for the

Bank in curbing population growth, the arrival of McNamara as President changed these assumptions. McNamara's focus on population issues could be understood as part of a broader strategy to prioritise the provision of basic services within the Bank's operations. Building on its funding capacities and its connections with finance ministries, the Bank began collaborating with other actors (as the newly created United Nations Fund for Population Activities (UNFPA[14])) to support family-planning activities in African and Asian countries. In addition to its population policies, the Bank expanded its efforts into other health areas. In 1972, an internal paper (Berg et al., 1972) identified widespread malnutrition as a critical issue affecting people in low-income countries. The article advocated for greater involvement by the World Bank,[15] arguing that its analytical capabilities could provide a valuable assistance in planning national nutrition programmes. As a result, a nutrition unit was established in 1972.

Building on these early initiatives in population control and nutrition, the World Bank further formalised its position in international health. A turning point materialised in 1975, when the organisation adopted its first formal health policy (World Bank, 1975) and began financing water supply and sanitation activities. In doing so, the Bank recognised the limits of its previous financing approach – which had limited health operations only to components of projects in *other* sectors – and decided to lend directly to standalone health initiatives. This shift was certified by the 1980 World Development Report (WDR; World Bank, 1980a: 64), which underlined how the 'significant involvement in the health sector [was] an important element of the Bank's concern for alleviating poverty in the developing countries'. During this period, the Bank also established its Health, Nutrition, and Population (HNP) Department[16] to coordinate the work previously handled by separated branches. Born as a peripheral unit, the HNP grew to become one of the World Bank's largest departments by the mid 1980s (Sridhar et al., 2017). Its early efforts focused on developing basic health infrastructures, supplying essential drugs, promoting nutrition, providing maternal and child healthcare, and preventing and controlling endemic and epidemic diseases (World Bank, 1980b). Within a few years, the number of approved projects with a HNP sector code significantly increased. After granting its first loan to expand basic health services in Tunisia in 1981, the Bank approved 45 projects by 1988, with half of these concentrated in the Sub-Saharan region.

As the World Bank multiplied its health-related activities throughout the 1970s, it came to gradually encroach on WHO's areas of expertise and operations. However, these early efforts by the Bank were not intended to displace WHO's focal role in international health. On the contrary, during this period the Bank expanded its activities as a complement, rather than a substitute, of WHO. Partly for this reason, the UN agency decided to support the World Bank's activities by promoting a more formal *collaborative* relationship. For instance, the two organisations initiated a joint programme on water supply and sanitation in 1971 (Fair, 2008). Operating until 1984, the programme completed nearly 200 activities in 86 countries and became known for its sector studies. These studies, which combined the expertise of both organisations, provided national planners and funding bodies with comprehensive guides to the water supply and sanitation priorities of the assessed countries (WHO, 1985). WHO and the Bank also collaborated on rural development programmes, with the agency contributing a technical report on the health impacts of rural policies to a Bank-led task force (WHO, 1976). In the area of disease control, a major example of *collaboration* was the joint launch of the Onchocerciasis Control Program (OCP). The OCP, which covered 11 countries and a population of 30 million people in West Africa, was created to eliminate onchocerciasis and was regarded as an

unprecedented public health success. As WHO served as the main executive agency, the initiative marked a high point in the WHO-World Bank relationship (Samba, 1994). Finally, the two organisations collaborated on the fight against tropical diseases, as well as in the context of the WHO-led Programme for the Control of Diarrheal Diseases.[17]

The most significant divergence between WHO and the World Bank emerged in the field of population control. WHO's framing of population issues was shaped by a 1966 resolution in which the World Health Assembly '[had] redefined fertility control as a health problem' (Finkle and Crane, 1976: 375). This resolution emphasised that 'the role of WHO [was] to give technical advice, upon request, in the development of activities in family planning as part of an organized health service' (WHO, 1966). Two important caveats were thus placed on WHO's initiatives. First, the agency had to focus on the more technical aspects of population control, avoiding involvement in political decisions. Second, proposed policies were to be integrated into the broader provision of basic health services. In contrast, most of the early population programmes sponsored by the World Bank, often in collaboration with UNFPA, did not follow these two core principles. In fact, the Bank's programmes frequently overlooked local health conditions and were disconnected from broader efforts to strengthen health services. For instance, a Bank's programme launched in Indonesia in 1972 to expand family-planning efforts effectively provided buildings, vehicles, and equipment, and training for non-medical family-planning workers (International Development Association (IDA), 1972). However, the programme's heavy emphasis on family-planning activities led to a lack of integration with the broader development of local health services. Therefore, WHO criticised it for draining resources away from domestic health ministries and overshadowing WHO's influence with local governments (Finkle and Crane, 1976). Confronted with an institutional substitute approaching a peripheral activity (population control) with an inconsistent framing, WHO's Secretariat implemented a *cooptative* strategy. Specifically, WHO sought to retain the Bank's resources allocated to population programmes while redirecting them towards the more general development of domestic health services. After extensive negotiations, the two organisations signed a memorandum of understanding (MoU) in 1973, wherein 'the Bank agreed not only to include WHO representatives in its project preparation missions but to respect WHO's judgments on health structures and needs' (Crane and Finkle, 1981: 384). Following the MoU, WHO expanded its role in the previously peripheral area of population control, strengthening its influence over the population agenda. By the mid 1970s, the agency was responsible for family-planning projects in around 60 countries, consolidating its focal position especially in the African, Latin American, and Western Pacific regions.

Moving to the centre: The World Bank as a substitute to WHO (1980s to 1990s)

The end of McNamara's Presidency marked significant shifts in the scope and target of the World Bank's activities. In 1979, the organisation led a global coalition of various stakeholders, including UNICEF and the Rockefeller Foundation, to promote a new approach to international health, known as Selective Primary Health Care (SPHC). This approach was largely *inconsistent* with WHO's then advocacy for Primary Health Care (PHC). The concept of PHC – as articulated in the 1978 Alma-Ata conference convened by WHO – emphasised a whole-of-society approach to health aimed at ensuring the highest possible level of health and well-being and their equitable distribution. In contrast,

SPHC advocated for selecting and prioritising health interventions based on factors such as prevalence, morbidity, risk of mortality, and feasibility of control. Accordingly, it proposed a package of four interventions (immunisation, oral rehydration, antimalarial drugs, and breastfeeding) that could be delivered in a cost-effective and timely way (Walsh and Warren, 1979). If the emphasis on quick, technical, and measurable solutions appealed to donors, the SPHC approach diverged sharply from WHO's values and aspirations. Primary Health Care emphasised community participation and bottom-up mobilisation, allowing countries to determine their own priorities. In contrast, SPHC promoted top-down (vertical), disease-specific interventions that largely ignored local specificities (Gish, 1982). In addition, the haste to implement these programmes often overlooked the need for sustained and coordinated actions, whereby advances in health sectors were to be matched by efforts to strengthen industrial, education, agricultural, and housing infrastructures. Finally, the SPHC approach largely diluted the 'political' and 'social' dimensions of PHC by failing to recognise the connection between health and socioeconomic policies. Instead of addressing the social determinants of health, SPHC proponents attributed the origins of health diseases to 'natural'; that is, non-socially constructed, poverty. In turn, this led to a preference for technological solutions over more challenging societal transformations (Wisner, 1988). This perspective aligned with the neoliberal policies emerging in the 1980s. In Washington as in London, Reagan and Thatcher were campaigning for limited government programmes and expenditures to stimulate economic growth. In this respect, '[WHO's] call for the public provision of primary care, together with social and economic measures, threatened the emerging, [. . .] ideological paradigm of neoliberalism' (Birn et al., 2016: 739).

Given these developments, it becomes evident why the World Bank consolidated as a significant threat to WHO during the 1980s. The Bank promoted its alternative framing of health promotion through a two-pronged strategy. First, it disseminated the principles of SPHC in key reports, including *Financing Health Services in Developing Countries: An Agenda for Reform* (World Bank, 1987) – the first Bank's document solely focused on health – and *Strengthening Health Services in Developing Countries through the Private Sector* (Griffin, 1989). These reports downplayed the role of governments to mere funders and regulators of health services, disregarding the emphasis on self-determination and societal transformation central to the Primary Health Care movement. Second, the Bank leveraged its financial influence over low-income countries to advocate for health sector reforms aligned with the core principles of SPHC. For instance, the 1981 report *Accelerated Development in Sub-Saharan Africa: A Plan for Action* (World Bank, 1981) outlined recommendations for restructuring African countries' public sectors to enhance efficiency and liberalisation. The report identified several concerns with existing health services, including 'allocation – insufficient spending on cost-effective health programs; inefficiency – wasteful public programs of poor quality; and inequity – inequitable distribution of the benefits of health services' (World Bank, 1987). From the 1980s onwards, the World Bank then used structural adjustment lending to compel low-income countries to reform their domestic health systems. Specifically, the Bank made its loans conditional on the adoption of private health insurance coverage, increased drug utilisation, the contracting of private hospitals and providers, outsourcing of public management, and the charging of user fees for state-delivered health services. In addition, donors were encouraged to focus their efforts on self-sustained, high-impact projects, making decisions based more on cost-effectiveness principles rather than equity and community participation considerations.[18] The implications of these adjustment programmes for low-income

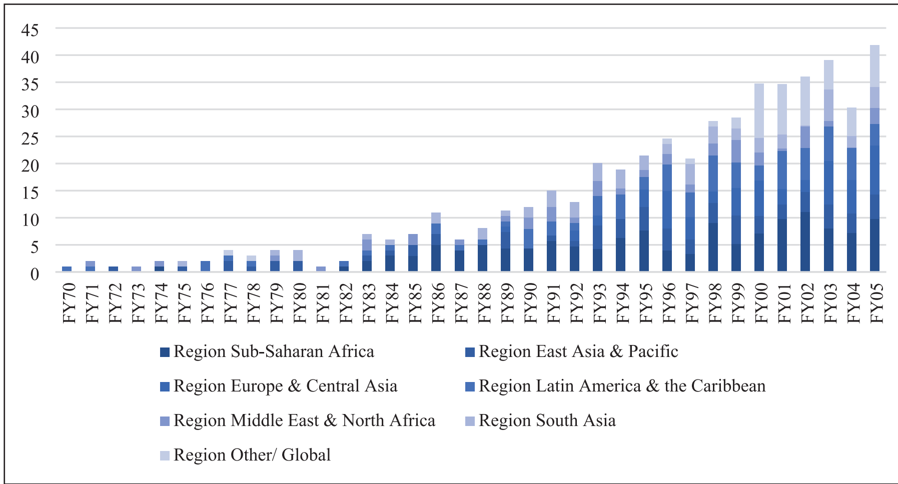

Figure 1. Number of newly approved projects with an HNP sector code by FY and region.
Source: World Bank's Health, Nutrition and Population Data Portal.

countries were profound. Often, the Bank's short-term solutions evolved into longer term adjustment plans, with significant economic and health consequences (WHO, 1988). Specifically, these programmes led to severe medical poverty traps resulting from untreated morbidity, reduced access to healthcare, long-term impoverishment, and excessive use of drugs (Whitehead et al., 2001).

The presidential terms of Barber Conable (1986–1991) and especially Lewis T. Preston (1991–1995) marked a further shift in the World Bank's health activities. During this period, the Bank faced growing criticism, as its role was considered redundant in a world with abundant private capital. In addition, the social, political, and environmental consequences of structural adjustment programmes were becoming increasingly evident. In response, Conable first and later Preston identified poverty reduction as the Bank's overarching goal. This led to a renewed commitment to basic social services as education, nutrition, and health (World Bank, 1995). HNP operations gained even greater importance within the Bank's portfolio, representing 11% of total lending by the end of Preston's mandate. As the Bank continued leveraging its fiscal span to sway low-income countries' spending decisions, its lead over WHO became more pronounced. By the mid 1990s, total HNP commitments, amounting to around US$2350 million, doubled the grants awarded by WHO. The Bank had become the world's largest external funder of health, relegating WHO to the lesser role of providing medical expertise and technical support[19] (Ruger, 2005). An illustration of these trends is provided in Figures 1 and 2 (p. 14), respectively, showing the rise in the number of the World Bank's HNP projects and HNP sector commitments from the 1970s onwards.

The Bank's growing influence in global health governance extended beyond financial contributions. In 1993, the organisation published its first World Development Report entirely dedicated to health (World Bank, 1993). Titled *Investing in Health*, the report identified four major shortcomings of international healthcare systems, namely the misallocation of resources, the inappropriate deployment of medical staff, the unequal access to basic healthcare, and rising healthcare costs (Abbasi, 1999). The Bank's proposed solutions relied on two complementary strategies. First, health markets had to be expanded by

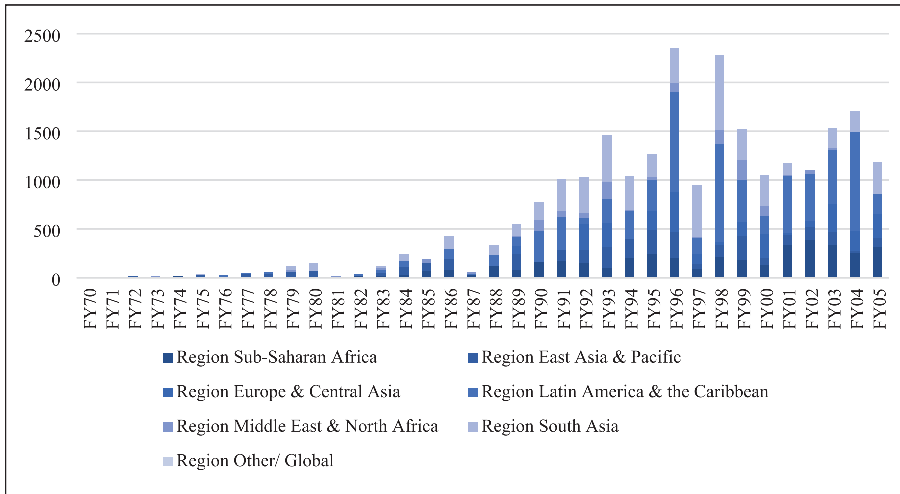

Figure 2. New HNP sector commitments by FY and region (in current US$ million).
Source: World Bank's Health, Nutrition and Population Data Portal.

shifting the provision and financing of health services from the public to the private sector, with a view to promoting diversity and competition. Second, states were urged to limit their involvement to providing a restricted number of public goods and relief measures (Laurell and Arellano, 1996). These were to be selected based on two principles, cost-effectiveness and the burden of disease. Cost-effectiveness emphasised the importance of directing states' resources towards health problems where cost-effective interventions were available. The burden of disease was measured using an innovative metric, the disability-adjusted life year (DALY). The DALY combined two different indicators, the loss of life due to premature death and the loss of healthy life due to disability (Haines et al., 2008). Together, these concepts introduced a 'performance-based' approach to guide decision-makers in setting spending priorities (Gaudilliére et al., 2022). The 1993 World Bank Report thus marked the umpteenth step towards an economistic understanding of health. While WHO's officials contributed to drafting the document, this was widely seen as a statement from the Bank, as evidenced by the claim that 'spending on health [could] be justified on purely economic grounds' (World Bank, 1993: 17). By framing health as a private good rather than an inalienable right, the World Bank successfully promoted a model of healthcare provision that was fundamentally opposed to WHO's principles. This approach negatively affected the living conditions of those affected and, in turn, diminished WHO's focality.

To begin with, the Bank's use of structural adjustment programmes contributed to exacerbate existing health problems in low-income countries. From Latin America (Silva et al., 2011) to South-Asia (Nuruzzaman, 2007) and Africa (Owoh, 1996), the approach advocated in *Investing in Health* led to aggravated health outcomes, reduced access to and quality of care for the poorest populations, and left structural flaws unaddressed (Birn and Dmitrienko, 2005). By 1997, the Bank itself acknowledged that only 17% of its HNP projects had contributed to development objectives, and only 44% were likely to be sustainable (World Bank, 1997). For WHO, the increased Bank's assertiveness was equally consequential. The Bank's policies intensified earlier calls for selective primary health

care, promoting a narrow understanding of public health that marked a complete departure from WHO's PHC approach. The impact of this was recognised by WHO in an internal study in the early 1990s (WHO, 1993). The study highlighted that in many countries 'the government's financing role in health [was] becoming more reactive and less programmatic', a trend exacerbated by 'the movement of human resources to the private sector [and] the [deterioration of] building and equipment' (*ivi*: 14). Similarly, the effects of privatisation on levels of health funding, allocative efficiency, and equity were found to be at best mixed.

Besides criticising the World Bank's approach, WHO struggled to propose adequate solutions. Faced with a rival institution advocating inconsistent policies, the agency failed to present a credible alternative framing for health interventions throughout the 1990s (*passive retrenchment*). This outcome was somewhat predictable, given that WHO was grappling with a financial, authority, and leadership crisis (Chorev, 2012). The agency's decline during this period was indeed exacerbated by the troubled leadership of its director-general Hiroshi Nakajima and, more critically, by its failure to effectively address the dramatic HIV/AIDS Pandemic. In fact, the response to HIV/AIDS served as a telling example of the gradual leadership transition from WHO to the World Bank. While WHO had established its Global Programme on AIDS (GPA) already in 1986, the programme came under criticism by the mid 1990s for its inefficiency in coordinating activities among UN agencies (Knight, 2008). As a result, leadership on HIV/AIDS was transferred to a new entity, the Joint United Nations Programme on HIV and AIDS (UNAIDS). Moreover, the Bank itself started to finance its own campaigns and became one of the largest funders of HIV/AIDS treatment, further sidelining WHO. The shift from the GPA to UNAIDS highlighted the significant difficulties – financial, political, and normative – faced by WHO during the 1990s. In this context, the agency found itself passively yielding to the World Bank's influence and preferences. When the two organisations renewed their MoU in 1994, WHO representatives expressed this frustration, noting that the 'Bank's perception of WHO's role insufficiently recognize[d] WHO's full range of contributions' (WHO, 1995). With the end of Nakajima's mandate, however, the WHO-World Bank relationship was poised to change once again.

The WHO-World Bank relationship in constant change (2000s to present)

The past two decades in the WHO-World Bank relationship have been marked by a mutual rapprochement. While the initial years (1998–2007) saw WHO actively aligning with the World Bank's economistic approach (shifting from *passive* to *proactive retrenchment*), the later period has witnessed a reversal in the balance of influence between the two institutions, possibly signalling a new era of interinstitutional *coopetition*.

Following the conclusion of Nakajima's tenure, WHO sought to reclaim a focal role in global health. As this required a more engaged approach vis-à-vis prominent substitutes, particularly the World Bank, a strategy of *proactive retrenchment* was promoted by the Secretariat. This strategy was particularly evident during the tenure of Gro Harlem Brundtland (1998–2003), Nakajima's successor as director-general. Leveraging her diplomatic clout,[20] Brundtland spearheaded important reforms to align WHO more closely with the then prevailing neoliberal consensus (Leon, 2015). Within the agency, Brundtland oversaw a restructuring of the organisational apparatus (the 'One WHO' process) to promote a more integrated approach to planning, resource mobilisation, and performance assessment

(Hanrieder, 2015a). In line with the principles of New Public Management (NPM), Brundtland's reforms prioritised oversight and transparency in budget allocation and called for enhanced management accountability and performance-based regulation. On the external front, Brundtland worked to expand WHO's global reach and affect and strengthen collaboration with the organisation's main partners, including the World Bank (Cueto et al., 2019). By promoting an innovative multi-stakeholder approach to health challenges, WHO orchestrated the creation of new alliances bringing together different actors, including other multilateral agencies, private foundations like the Gates Foundation, and pharmaceutical companies. This strategy allowed WHO to reduce competitive pressures from other institutions, while positioning itself as a necessary partner in multilateral health initiatives. Notable initiatives launched during this period include the Global Alliance for Vaccines and Immunization (GAVI) and the Roll Back Malaria (RBM) campaign.

From a normative standpoint, the major documents published under Brundtland's tenure reflected the renewed approach adopted by WHO. For instance, the controversial 2000 *World Health Report* (WHO, 2000) closely mirrored the assumptions and logic outlined in the World Bank's *Investing in Health* (Chorev, 2012). As its title, *Improving Performance*, suggested, the Report resumed the Bank's emphasis on measurement and cost-effectiveness, as evidenced by the assertion that 'if services are to be provided for all, then not all services can be provided' (WHO, 2000: 14). During her tenure, Brundtland also facilitated the full integration of economists into WHO's agenda setting and decision-making processes. This culminated in the establishment of a Commission on Macroeconomics and Health (CMH), chaired by former IMF advisor Jeffrey Sachs. While the *Commission's Report* (WHO, 2001) supported WHO's call for increased investments in public health, it did so by framing good health as a prerequisite for economic growth.

Specific policy initiatives also demonstrated WHO's commitment to adapting to the imperatives of cost-effectiveness and prioritisation (*proactive retrenchment*). One of the most notable accomplishments during Brundtland's tenure – the Framework Convention on Tobacco Control (FCTC) – is illustrative in this respect. The FCTC was sponsored by WHO within the framework of its 'new universalism' strategy. Under this approach, governments were encouraged to shift their focus from serving those most in need to implementing cost-effective interventions that could benefit the broader population, regardless of individual socioeconomic conditions (Brown, 1999). Within this context, tobacco control appeared to WHO as a rewarding area of intervention. Importantly, the FCTC negotiating process also gained the World Bank's attention, giving way to an unforeseen case of interinstitutional *collaboration*. Specifically, the Bank played a crucial role in building cross-sectoral consensus on the harmful effects of tobacco. While the medical community had long acknowledged these effects, it was a Bank's report, *Curbing the Epidemic: Governments and the Economics of Tobacco Control* (World Bank, 1999), that positioned tobacco control as a highly cost-effective policy. By 'threaten[ing] the tobacco companies' ability to use economic arguments to dissuade governments from enacting tobacco control policies' (Mamudu et al., 2008: 1690), the Bank's report laid the groundwork for the later negotiation of the FCTC, the first binding treaty ever adopted under WHO (2009).

Following Brundtland's tenure, WHO's more engaged posture coincided with a gradual shift in the World Bank's neoliberal orientation, further bringing the two organisations closer. Specifically, the Bank began to reassess its previous support for controversial practices, as user fees, as well as its strong advocacy for market-oriented mechanisms (Birn et al., 2016). Reflecting this changed perspective, the Bank's 2000/2001 World Development Report, *Attacking Poverty*, stressed that 'while markets are a powerful force for poverty

reduction, institutions that ensure that they operate smoothly and that their benefits reach poor people are important' (World Bank, 2000: 191). Consistently, the Bank dropped the language of structural adjustment to embrace the less contentious one of poverty reduction, and it began to promote a new understanding of development as a more multidimensional, holistic process (Leon, 2015). This approach closely aligned with WHO's major initiatives since the mid 2000s, such as the Commission on Social Determinants of Health and the Universal Health Coverage (UHC) agenda. These initiatives shared the view of health as a universal, non-negotiable right whose provision could not be subordinated to economic considerations. The concept of UHC[21] was well received by the World Bank, which has supported it since the early 2010s. For instance, WHO and the Bank *collaborated* on developing a common UHC monitoring framework (WHO and World Bank, 2014) and later applied it to the creation of an action plan for Africa (WHO, 2016).

On a general level, the recent years of WHO-World Bank relationship have seen a gradual resurgence of WHO's prominent role, as certified by an improved division of tasks in accordance with the two institutions' respective comparative advantages (*coopetition*). While the Bank has narrowed its focus to a limited set of priorities (especially budgetary support for poverty reduction activities[22]), WHO has reclaimed its constitutionally mandated role as global health coordinator. This renewed division of labour was evident in the global response to the COVID-19 pandemic, where WHO and the World Bank *collaborated* on several initiatives, most notably the multi-stakeholder Access to COVID-19 Tools (ACT) Accelerator.

Conclusion

Contemporary international organisations do not exist in a vacuum. While this notion is now well acknowledged, the idea that organisations can be studied in isolation remains prevalent in IR scholarship (Henning and Pratt, 2023). Although there are remarkable accounts of WHO's (Chorev, 2012; Hanrieder, 2015a) and World Bank's (Kapur et al., 2011; Sharma, 2017; Weaver, 2007) individual histories, only a few scholars have effectively integrated the two (Ruger, 2005). In this context, the limited attention paid by IR works to the notions of focality and focal organisations is perplexing.[23] In fact, focal organisations could serve as a valuable tool to connect two distinct levels of analysis; the *individual* – that is, the single organisation's one – and the *systemic* – that is, the regime complex's one. Using the lens of focality, studies of individual organisations could be enriched by examining the parallel (but related) development of their reference governance complexes. The article has made three contributions. First, it has problematised the conventional understanding of focal organisations found in much of the existing literature. Specifically, focality has been portrayed as a nuanced, dynamic, relational, and contestable trait of organisations, in contrast with accounts presenting it in a simplistic and dichotomic way. Second, the article has introduced a new framework for analysing how focal organisations respond to institutional substitutes that may threaten their focality. Overcoming the traditional focus on collaborative *versus* competitive dynamics, the article has offered a more nuanced taxonomy of interinstitutional relationships (Gutner, 2022). The third contribution of the article is empirical. Specifically, the article has evaluated the explanatory potential of the framework by analysing the relationship between the World Health Organization, the focal actor in global health, and one of its major competitors, the World Bank. In so doing, the article has unveiled the significant impact of the Bank on the development of health governance over recent decades. Relatedly, it has

discussed how WHO has adjusted its response to the specific challenges posed by the World Bank, alternating different engagement strategies over time. Based on an extensive and historically informed case study, the article has thus showed how the WHO-World Bank interinstitutional relationship played a crucial role in shaping the development of the global health complex, making it increasingly fragmented and less hierarchical.

The article's contributions provide answers to the two research questions outlined in the introduction. First, the refined understanding of focality advanced here facilitates a more nuanced appreciation of contemporary global governance institutions. Scholars and practitioners often express pessimism about the current state of global governance. Well-established institutions as the UN and WTO are perceived as weakened by internal divisions, resource constraints, and external contestation (Debre and Dijkstra, 2021; Yang, 2022). While this is partly inevitable, a more sober consideration of focality can help temper our expectations regarding the successes and failures of global cooperation, as well as its gridlock and innovations. If focal organisations are not seen as the sole and default options to all global problems, alternative and innovative ways of cooperating can be envisioned. The article has also offered new insights into the relationships between focal organisations and institutional alternatives. Beyond emphasising the need to avoid a collaboration *versus* competition dichotomy, the article has unveiled the dynamic nature of these interactions. By adopting a long historical perspective, the article has identified three subsequent 'stages' in the WHO-World Bank relationship. In this way, it has showed how the Bank's stance vis-à-vis WHO shifted, and how WHO's reactions influenced (or tried to influence) these shifts. These observations contribute to the growing body of scholarship on practices of contested multilateralism enacted by revisionist actors (He, 2019; Zhao, 2018). In partial contrast with such accounts, the article has discussed how focal organisations (as WHO) have traditionally faced competition due to the inherent contestability of their focality. Nonetheless, the article has underscored WHO's relative success in defending its position and mitigating external pressures through different strategies. While these have not always succeeded, as evidenced by WHO's decline in the 1990s, their implementation is a possible indicator of the broader resilience of global governance structures (Dijkstra et al., 2024).

Given its theoretical and empirical contributions, the article serves as a starting point for grasping how focal organisations adapt to deep structural changes in their broader environments. Building on it, future research could explore the specific determinants of focal organisations' behaviour, as well as the possible factors enhancing (or limiting) the effectiveness of their counterstrategies. For instance, the allusion to the different leadership qualities under Nakajima and Brundtland suggests a possible avenue for further investigation. Similarly, new studies could examine the potential path dependency patterns behind focal organisations' strategies. By way of example, effort could be devoted to investigating how initial responses to external threats (for instance, proactive *vs* passive retrenchment) may facilitate (or constrain) future reactions to similar or different challenges. More broadly, the article lays the ground for a more systematic assessment of the nature and historical evolution of focal organisations, with a view to better understanding their current shortcomings and strengths.

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Notes

1. Full speech retrievable at: https://www.weforum.org/agenda/2019/01/these-are-the-global-priorities-and-risks-for-the-future-according-to-antonio-guterres/.
2. See Alter and Meunier (2009), Betts (2013), Eilstrup-Sangiovanni (2019), Gómez-Mera (2015), Haftel and Hofmann (2019), Henning and Pratt (2023), Hofmann (2009), Kranke (2021), Margulis (2021), and Westerwinter (2021).
3. For a recent exception, see Fuß (2023).
4. For exceptions, see Abbott et al. (2015), Betts (2013), Clark (2021), Delreux and Earsom (2023), Holzscheiter (2017), Langlet and Vadrot (2024).
5. For exceptions, see Eilstrup-Sangiovanni (2021), Fioretos and Heldt (2019), Hofmann and Yeo (2023), and Kijima and Lipscy (2023).
6. From a different angle, scholars applying social network approaches (SNA) to the study of international organisations (IOs) have coined the term 'centrality' to indicate the degree to which a single node within a network is connected to all others (Hafner-Burton et al., 2009).
7. The World Food Council and the International Fund for Agricultural Development.
8. Institutional substitutes are not limited to formal, highly structured IOs. On the contrary, they encompass all those actors that overlap with the focal organisation on at least one dimension between governance tasks, membership, and policy domains (Reinsberg and Westerwinter, 2023; Schuette, 2023). While this accommodates for the inclusion of different actors, it restricts the study to analytically meaningful substitutes.
9. For issue framing, I refer to the portraying of an issue from one perspective to the necessary exclusion of alternative perspectives.
10. The four strategies are not comprehensive of possible patterns of inter-organisational relationships. Scholarly works have discussed equally credible mechanisms – as boundary maintenance (Holzscheiter, 2017; Kranke, 2021), intervention (Margulis, 2021), and task expansion (Littoz-Monnet, 2017) – through which IOs attempt to deal with institutional rivals.
11. For instance, Johnson (2016) discusses how the Food and Agriculture Organization (FAO) was coopted by agri-business industries in the mid 1970s, as these successfully fostered their commercial objectives through the FAO-hosted Industry Cooperative Programme (ICP).
12. As the Trevi Group (or TREVI), an informal body for intergovernmental cooperation in the field of law and order set up by the European Council in 1975.
13. The League of Nations Health Organization (LNHO), the Office International d'Hygiène Publique (OIHP), and the United Nations Relief and Rehabilitation Administration (UNRRA).
14. The United Nations Fund for Population Activities (UNFPA) was established in 1969 as the United Nations (UN) sexual and reproductive health agency.
15. The article also suggested expanding staff-level relationship with World Health Organization (WHO).
16. The Health, Nutrition, and Population (HNP) superseded the Bank's Population Projects Department.
17. The programme also saw the participation of the United Nations Children's Fund (UNICEF) and the United Nations Development Program (UNDP).
18. Within the Bank, a Disease Control Priorities (DCP) group was created to develop new tools for measuring the effectiveness of health investments (Gaudilliére et al., 2022).
19. According to WHO representatives, 'the World Bank [was] the new 800 lb. gorilla in world health care' (Abbasi, 1999).
20. Before joining WHO, Brundtland had been the prime minister of Norway and the chair of the UN World Commission on Environment and Development.
21. UHC implies that 'all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care' (WHO, 2016).
22. As of 2010, the Bank provided the 32% of the global health systems support budget and promoted innovative financing mechanisms to ease the access to equitable and sustainable health services (Tichenor and Sridhar, 2017).

23. Some recent exceptions exist. See Baroncelli (2021) and Hofmann and Yeo (2023).

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