

Sridhar, Devi Lalita; Batniji, Rajaie

Working Paper

Misfinancing global health: The case for transparency in disbursements and decision making

GEG Working Paper, No. 2007/35

Provided in Cooperation with:

University of Oxford, Global Economic Governance Programme (GEG)

Suggested Citation: Sridhar, Devi Lalita; Batniji, Rajaie (2007) : Misfinancing global health: The case for transparency in disbursements and decision making, GEG Working Paper, No. 2007/35, University of Oxford, Global Economic Governance Programme (GEG), Oxford

This Version is available at:

<https://hdl.handle.net/10419/196298>

Standard-Nutzungsbedingungen:

Die Dokumente auf EconStor dürfen zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden.

Sie dürfen die Dokumente nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, öffentlich zugänglich machen, vertreiben oder anderweitig nutzen.

Sofern die Verfasser die Dokumente unter Open-Content-Lizenzen (insbesondere CC-Lizenzen) zur Verfügung gestellt haben sollten, gelten abweichend von diesen Nutzungsbedingungen die in der dort genannten Lizenz gewährten Nutzungsrechte.

Terms of use:

Documents in EconStor may be saved and copied for your personal and scholarly purposes.

You are not to copy documents for public or commercial purposes, to exhibit the documents publicly, to make them publicly available on the internet, or to distribute or otherwise use the documents in public.

If the documents have been made available under an Open Content Licence (especially Creative Commons Licences), you may exercise further usage rights as specified in the indicated licence.

Misfinancing Global Health: The Case for Transparency in Disbursements and Decision-Making

Devi Sridhar and Rajaie Batniji

September 2007

GEG Working Paper 2007/35



DEPARTMENT OF
POLITICS
AND
INTERNATIONAL
RELATIONS



Global Economic Governance Programme

Centre for International Studies | Department for Politics and International Relations



The Global Economic Governance Programme was established at University College, Oxford in 2003 to foster research and debate into how global markets and institutions can better serve the needs of people in developing countries. The three core objectives of the programme are:

- to conduct and foster research into international organizations and markets as well as new public-private governance regimes;
- to create and maintain a network of scholars and policy-makers working on these issues;
- to influence debate and policy in both the public and the private sector in developed and developing countries.

The Programme is directly linked to Oxford University's Department of Politics and International Relations and Centre for International Studies. It serves as an interdisciplinary umbrella within Oxford drawing together members of the Departments of Economics, Law and Development Studies working on these issues and linking them to an international research network. The Programme has been made possible through the generous support of Old Members of University College.

Devi Sridhar

Dr Devi Sridhar is a Senior Researcher at the Global Economic Governance Programme at the University of Oxford where she directs the GEG's Global Health Governance Project. She is also a Senior Research Associate at Oxford's Centre for International Studies and a Research Associate of the Institute of Social and Cultural Anthropology, Oxford. From October 2007, she will be a postdoctoral fellow in politics at All Souls College, Oxford. She has worked at the Kaiser Family Foundation, on the Oxfam GB Policy Team, as a contributor to the UNDP Human Development Report, and as a consultant to Save the Children UK and the World Health Organization. Dr Sridhar is the editor of *Anthropologists Inside Organisations: South Asian Case Studies* (Sage, forthcoming, 2007) and author of *The Politics of Hunger: The World Bank and Nutrition* (forthcoming, 2007). She holds a DPhil in Social Anthropology ('The Art of the Bank: Nutrition Policy and Practice in India'), an MPhil in Medical Anthropology ('The Political Economy of Child Hunger and the Green Revolution in India') and a bachelors degree in biology and pre-medicine from the University of Miami.

Rajaie Batniji

Rajaie Batniji is an MPhil candidate in international relations at the University of Oxford, studying global health governance and global cooperation on non-communicable disease. He is on leave from his final year of medical school at the University of California, San Francisco, where he focused his clinical studies on poverty medicine. Rajaie Batniji graduated Phi Beta Kappa and with distinction from Stanford University in 2003, where he earned BA and MA degrees in History (Middle East) and served as a Junior and Senior Class President. He has worked as a consultant to the World Health Organization, authoring papers on mental and social health.

Acknowledgements

We would like to acknowledge the exceptional and continual input from Ngaire Woods, Harold Jaffe, and Shunmay Yeung, of our collaboration at the Oxford Global Health Network. Our work would not have been possible without conversation with, and feedback from Ashok Alexander, Drew Altman, Tim Evans, David Fidler, Kara Hanson, Claes Johansson, Kelley Lee, Ruth Levine, Marie-Claude Martin, Jeffrey Mecaskey, Michael Merson, David Nabarro, and Christina Schneider. They are not responsible for, nor have they endorsed, the contents of this document, but have provided helpful guidance. The John Fell Fund at Oxford has supported this project.

Misfinancing Global Health: The Case for Transparency in Disbursements and Decision-Making

Devi Sridhar and Rajaie Batniji

Introduction

Global health is high on the international agenda of policy-makers, civil servants and philanthropists. At the turn of the century, the Millennium Summit increased interest in global health with the creation of the Millennium Development Goals, which serve as the benchmark of international attention and finance. Recently health has moved higher on the policy agenda as it has integrated into security and foreign policy agendas and priorities (1-3). The increased attention given to global health since 2000 is reflected in the mobilisation of international political actors on global health issues. An unprecedented amount of money is being pledged and mobilized to fund research and services in global health. Although estimates are hard to come by, a recent estimate for 2004 approximated that international funding for global health reached \$14 billion, and this figure is rapidly rising, due largely to the emergence and growth of the Bill and Melinda Gates Foundation, and the U.S. government's AIDS initiative (4). In parallel to increased financial commitment, there seems to be a growing consensus on technical strategies for global health(5), and an emerging, though controversial, epidemiological evidence-base that may inform the disbursement of global health funds(6).

We examine the relative (mis-)match between what needs to be done, according to public health evidence, and financial commitments by considering all disbursements made in 2005 among the major financiers relative to mortality. Decisions about disbursements and priority areas in global health are shaped by institutional mandate and direct political influence. This is consistent with a much-cited study on foreign aid, which showed that political and strategic relationships, including colonial past and political alliances, explain foreign aid allocations better than economic need(7). By relating disbursements to mortality, we create a baseline from which we can assess deviations in priority that may be due to political influence in each of the major global health financiers.

The increased political and financial commitments supporting global health are complemented by a growing consensus on strategies to prevent and treat the illnesses afflicting the poor (8). An enormous bank of information on 'what works' in reducing morbidity and mortality has been accumulated; this body of knowledge is best embodied by the publication of the Disease Control Priorities in Developing Countries which was supported by the World Health Organisation, the World Bank, and the Bill and Melinda Gates Foundation(5). The Lancet has published series on issue areas in global health, building consensus on both technical and social strategies for disease prevention and treatment. In international development, some scholars argue that we have the solutions to end ill health and poverty; we only need (international) financial commitment to deliver them (9). Such clarity on strategies, though perhaps flawed, can facilitate cooperation and political commitment. The articulation of shared objectives, scientific consensus on the means to these objectives(10), and the financial commitment which can begin to facilitate their realization makes this a more promising time than any for effective cooperation and coordination among the major institutions in global health.

Potentially restraining cooperation is a lack of knowledge on the current investments of the major financiers of global health. Previous efforts have been focused on tracking funding by disease (e.g. HIV/AIDS), by country (e.g. OECD DAC), and in-country (e.g. National Health Accounts) (11-17). For example, Shiffman's 2006 article is an excellent examination of the donor funding priorities for communicable disease control from 1996 to 2003 (11). However, as has been noted in recent Center for Global Development and RAND reports, no information source exists to provide the "big picture" of health resource flows, leading to a lack of credible estimates of donor commitments and actual funds (18, 19). Due to the difficulties of tracking health-relating funding(19), no systematic effort to track all disbursements of the major global health financiers has been conducted. Such work is needed to inform and facilitate coordination. This paper, as discussed in the methods, uses the limited available sources to analyse global health disbursements. A primary objective of this paper is to prompt further disclosure of resource flows from major global health institutions which may challenge these findings.

I. Global Health Financiers

There is some consensus on what needs to be done in global health. The question then is, who is going to do it and how? Out of many different possible candidates (e.g. governments, NGOs, World Health Organisation), four institutions have come to the fore: the World Bank, the U.S. Government, the Gates Foundation and the Global Fund for HIV/AIDS, TB and Malaria (Table 1). These four play the largest role in terms of magnitude of funding, though it is estimated that they comprise only about one-third of all international spending for global health (20). The specific mandate, capacity and decision-making mechanisms of each significantly may affect their disbursements, thus it is important to understand the structures of each institution.

World Bank

The World Bank is a multilateral 'bank' which makes low-interest/concessionary (International Development Agency) and normal loans (International Bank of Reconstruction and Development). These loans must be given over a specified timetable with a measurable rate of return. Loans are prepared and analysed by professional staff according to guidelines set within the Bank. In contrast to the other institutions, the Bank is a lender, not a donor. The Bank is the largest international financial contributor to health-related activities in the developing world and loans exclusively to governments and state enterprises. Although the Bank is a multilateral institution, because of its physical location in Washington, D.C., and the U.S. influence on its governance, it is perceived as borrowers countries as dominated by non-borrower country interests. Given the changing nature of global health financing over the past ten years, the World Bank has refocused its strategic directions in health. Its objectives are to improve health outcomes for the poor, to protect households from the negative effects of illness, to work within country on sustainable financing mechanisms, to strengthen health systems, and to improve health sector governance.

The criteria for selection of priorities areas (Table 1) were that they must reflect the Bank's comparative advantage in health, particularly the expertise it can offer for multi-sectoral and health system development at the country level because of its strong country presence. In addition, it has operations in many different areas that affect health such as macroeconomic

and fiscal management, public sector management, private sector development, education, transport, environment, rural development, and financial management and procurement just to name a few. The majority of the Bank's priorities reflect the health objectives described in the Millennium Development Goals.

It is important to observe that the Bank's health disbursements are not the only way to assess or achieve the Bank's stated health priorities. These priorities are executed in several ways. First, they are integrated into Country Assistance Strategies (CAS) and Poverty Reduction Strategy Papers (PRSPs), a translation of knowledge into programme design and implementation. Second, these priorities influence the international community's approach to health through the Bank's role as a development leader. In this way, the Bank increases advocacy and awareness around these health areas. Third, these priorities are used to assess the Bank's impact on health systems strengthening. Fourth, these priorities are the focus of Bank staff analytic and advisory activities. The Bank has moved away from specific health project funding (vertical) and works at the government level to increase inter-sectoral strengthening of health systems (horizontal). It has also started to collaborate with bilateral agencies and private foundations using a 'buy-down' strategy. The basis for this strategy is that these other partners of the Bank will buy down the cost of a loan for a country if the results are achievement.

United States Government

The U.S. government gives money bilaterally and predominantly vertically, through the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative, its development agency (USAID), and the Millennium Challenge Corporation (MCC). This money is given as grants. USAID receives funding from the Secretary of State to help advance U.S. national security, foreign policy and most recently, the war on terrorism. To address these areas, USAID addresses poverty and the lack of economic opportunity in developing countries as these are viewed as the underlying causes of violence. Within USAID, the Bureau for Global Health is responsible for protecting human health in developing countries and has the twin objectives of improving lives and advancing U.S. interests for regional stability. To achieve these goals, the Bureau provides global leadership to improve the 'quality, availability and use of essential health services.'

USAID has no official statement on their website regarding how priority areas were selected. It can be inferred from the website that the main criteria for disease area selection is that USAID addresses areas that will ensure U.S. taxpayer's money is used 'efficiently, effectively, and strategically to guarantee security through global stability and prosperity(21).' In addition, top priorities are selected based on the support given by the Administration and Congress.

These priorities are executed in three main ways. First, USAID through the Bureau for Global Health provides global leadership in these areas by influencing the worldwide health agenda and encouraging the global health community to follow USAID priorities and goals. Second, the Bureau undertakes innovative research in biomedicine, social science and operations. Finally, it provides technical support in the field either through programme evaluation tools or through addressing humanitarian emergencies. USAID works in partnership with the 2003 President's five-year \$15 billion PEPFAR to address prevention, treatment and care of HIV/AIDS, the President's Prevention of Mother-to-Child Transmission Initiative (PMTCT), the 2005 President's five-year \$1.2 billion Malaria Initiative to control malaria in Africa, and

the MCC which has committed \$573.8 million for health in 8 countries(22). On 30 May 2007, President Bush announced a plan, awaiting congressional approval, to provide \$30 billion over 5 years to further the U.S. government's assistance on HIV/AIDS(23).

Bill and Melinda Gates Foundation

The Bill and Melinda Gates Foundation is a private philanthropic foundation, which employs a venture capital approach to investments in health. It is the largest philanthropic foundation in the world with an endowment of approximately \$33 billion, with another \$37 billion pledged by Warren Buffett. One of the main areas of work within the foundation is global health. To date, the foundation had made grants worth U.S. \$7.8 billion for global health. The two objectives of the global health programme are to fund research into low-cost and practical health solutions as well as to increase access to existing drugs and technologies for the world's poorest(24). The grants given to creative, new and sometimes risky , scientific research, and private sector approaches in health delivery play to the organisations comparative advantage.

Priority disease areas were determined according to set criteria that reflect a general concern with equity. The three criteria, as the Foundation states, are that disease areas must cause widespread morbidity and mortality in developing countries; they must have a heavier burden and higher prevalence in developing countries relative to developed; and they must receive inadequate attention and funding at the global level. The Foundation's website offers no information if decisions on priorities are made according to a quantitative calculation, or if they reflect the judgement of Bill and Melinda Gates.

Global Fund for HIV, Tuberculosis and Malaria

Finally, the Global Fund is an innovative public-private partnership that receives administrative support from the WHO and fiduciary support from the World Bank as a trustee. It was created to serve as a financing mechanism for HIV/AIDS, TB, and malaria, and thus, priority areas are built into the institutional mandate. Since its inception in 2002, it has committed over U.S.\$7.1 billion to more than 540 grants in 136 countries, though disbursements lag behind these commitments, as evidence of progress is required for continued funding. The Global Fund does not directly work in country or implement programmes. Rather it serves as a financial instrument, managing and disbursing resources through an independent and technical process. Countries submit proposals to the Global Fund through a Country Coordinating Mechanism (CCM). Proposals are reviewed by a Technical Review Panel and assessed based on fulfilling the eligibility criteria.

Governance of the Four Financiers

The multilateral institutions have more robust systems in place for democratic decision-making than private and bilateral institutions. For example, the World Bank is governed by an Executive Board in which all member states are represented. It should be noted that representation on the Board is not equal; large donor countries have more voting power. Health-related projects are in the Human Development network with a related Vice-Presidency. This network is directly under the President and Managing Directors. The President in turn is responsible to the Executive Directors and the Board of Governors. Thus ultimately health-related disbursements are governed by the Executive Board, a multi-state body. Similarly, an independent Board is responsible for the overall governance of the Global

Fund including the approval of disbursements. The Global Fund is unique in having a board that includes significant developing country representation(25). The Board includes representatives of donor and recipient governments, NGOs, private companies and foundations and affected communities. Ultimately disbursements of the Global Fund are under the supervision of the Board.

In contrast, the Gates Foundation's governance structure reflects the private nature of the initiative. The Foundation has co-chairs that oversee operations, Bill Gates, Melinda Gates, William Gates Sr., and Warren Buffet. The executive team consists of a CEO, a COO, and Presidents for each of the initiatives (Global Development, Global Health, the U.S. Programme). Ultimately disbursements made by the Foundation in global health are authorised by the four co-chairs.

The U.S. government, the bilateral donor, executes initiatives under the direction of the State Department. Through its location in the Executive Branch of government, the State Department is ultimately responsible to the President of the U.S. and his supporters. In the current system the multilaterals are united in having independent governing bodies with membership drawn from a diverse range of actors in contrast to the private and bilateral financiers which have a much less diverse set of interests represented on decision-making bodies.

II. Methods

Using information gathered from the annual reports and budgets, we created a database of disbursements categorized by financier, priority area, regional focus, type of investment, and type of receiving agency for 2005. We relied exclusively on public sources. Health was broadly conceived to include grants for nutrition, water and sanitation, emergency relief, etc. We chose the year 2005 because this was the last year in which all four financiers had budgetary information publicly available. While this method provides a valuable snapshot of global health financing, we recognize that the one-year time period examined, which offers standardization, does impose a constraint on examining funding. The database is organised in Microsoft Excel and is available upon request.

In total, we considered 429 grants or loans made by the World Bank (65), the U.S. government (94), the Global Fund for HIV, TB and Malaria (92) and the Bill and Melinda Gates Foundation (178). It should be noted that due to an absence of accessible data on disbursements, for the Gates Foundation we considered commitments. Disbursements were studied for the other institutions. Combining disbursement and commitments in this analysis is problematic, as they are not equally comparable, and the relative lag of commitments to disbursements is obscured(17). To classify according to priority area and type of investment, the authors independently categorized according to relevant disease areas and then conferred to reach consensus. For multi-priority or multi-region grants, we divided funding equally across categories. For regional analysis, the World Bank regions were used as morbidity and mortality data is available based on these regions. To distinguish research from services, the authors placed all funds specified for exploratory purposes to research (including large-scale trials), and all funds specified for the provision of health services to service.

For each disease grouping, we included mortality estimates in low- and middle-income countries according to the Global Burden of Disease Study(6), with all the limitations thus

entailed, and with the following points of clarification. To compute mortality for child health, we used all cause under-5 mortality, including deaths due to vaccine-preventable causes. For this reason, we merged funding on vaccines, and child health. We have also conducted an analysis (Appendix 1) in which vaccine-preventable mortality was considered independent of child mortality, and this included measures on deaths due to measles, diphtheria, pertussis, tetanus, Japanese Encephalitis, and hepatitis B. Maternal mortality includes mortality related to maternal conditions and mortality due to cervical cancer. This grouping is justified by the merging of these two areas in disbursements from financiers. We included all World Bank grants made through the health sector, and other sectors related to health. For example, we included grants for improved quality and quantity of roads in computing funding for injury prevention. To consider deaths due to poor nutrition, we considered all deaths due to under-nutrition as a risk factor. To calculate deaths related to water and sanitation, we included all deaths due to diarrhoeal disease. It should be noted that the categories presented here are not mutually exclusive. For example, a child death due to measles would be counted both under the heading child health (all cause), and may likely be associated with under-nutrition.

We used STATA 9.2 for computation of correlation coefficients, using the `pwcorr` function, and SPSS 14.0 and Microsoft Excel for presentation of the data. In computing correlation of mortality and disbursements, we excluded all fields for which there is no clearly measured mortality; these are: emergency/disaster, general infectious diseases, global health strategy, and health systems. The omission of health systems funding is prominent, as it excludes approximately 1/3 of all World Bank disbursements from the regression, and these funds may be most important in considering World Bank disbursements for non-communicable disease (26). We include in Appendix 1a a correlation that assumes that 1/3 of health systems disbursements are for non-communicable disease. Since the Global Fund has a mandate only for HIV, TB and malaria, we considered disbursements vs. mortality for those diseases only. Though PEPFAR has a narrow mandate, we included all categories in regressions for U.S. government funds because USAID has an inclusive mandate. It should be noted that mortality data from the Global Burden of Disease study is for 2001, while disbursements are for 2005.

The most obvious limitation is the poor, and un-standardised data on disbursements that is available from global health financiers. Of equal importance, mortality data is incomplete for many funded areas, leading to potentially imprecise assessments of disease burden. Finally, as elaborated in our discussion, relating mortality to disbursements suggest that in an ideal world, they would be correlated. For technical and political reasons elaborated in the discussion, disbursements from global health financiers should not necessarily match mortality. Rather than considering a perfect match of disbursements to mortality as an ideal, in this analysis, it is considered as a baseline from which deviations should be explained.

III. Global Health Disbursements

Surprisingly little attention has been given to analysis of global health disbursements. Advocates for particular disease areas or interventions often cite the abysmal funding for their area of priority, without the context of the “big picture” of global health funding. Where is funding for global health being allocated by each international financier? We look at the World Bank, the U.S. Government, the Global Fund and the Gates Foundation each in turn (see Tables 3 and 4).

Financing of Priority Areas

In 2005, the World Bank disbursed \$3.9 billion dollars in both IBRD and IDA loans for health (Table 2). The main areas of investment (health systems, non-communicable disease and injury prevention, water and sanitation) are integrated into general support loans to low and middle-income countries. The Bank's funding focuses on services for disease prevention, rather than research or disease treatment (Table 2). Loans for injury prevention are specifically to improve road quality and quantity in country. Given its role as a 'bank' for countries, 93.4% of its total funding in 2005 was disbursed directly through Ministries of Finance or Health. The remaining 6.6% was given to state-owned enterprises (e.g. Manila Water Company). Funding was roughly equal across the developing world with no special focus on any one region (Table 4).

The U.S. Government disbursed \$1.3 billion dollars through the USAID Bureau for Global Health, PEPFAR, and the President's Malaria Initiative in 2005. The U.S.'s disbursements favored vertical programmes to address HIV/AIDS and malaria (Table 3). Approximately 30% of funding went towards prevention activities while the remaining 70% was for treatment. 8% of all funding was for abstinence-only programmes(27). Similar to the World Bank, the U.S. funded services (98.4% of funding) rather than research. While complete information on the recipients of funding in developing countries is not available, the funds are shared with a number of partner organisations, which are a combination of civil society organisations (e.g. faith-based NGOs), the private sector, and government ministries(27). These organisations are listed, but no breakdown of how much funding reaches each organisation is made publicly available. The U.S. gave over 99% of its total global health funding to Sub-Saharan Africa (Table 4).

In 2005, the Gates Foundation disbursed approximately \$1.8 billion dollars, through 178 grants (Table 3). The main areas of investment for 2005 were in vaccines, and research conducted by organisations based in North America and Western Europe. The Foundation's disbursements focus on basic and clinical science research on infectious disease. No grants were made for non-communicable disease and injury, and one grant (.005% of disbursements) was made for health systems research. Gates has focused on prevention of disease, with 71.2% of dollars on prevention programmes and research.

In 2005, the Global Fund disbursed \$292 million dollars with 92 grants (Table 3). The investments in HIV/AIDS and malaria are similar, at 37.5 and 33.2% of disbursements, while the investment in TB is not far behind at 24.3% of dollars disbursed. The Global Fund does not directly fund research initiatives and 100% of dollars disbursed were for services, though many grants include provisions for monitoring and evaluation of programmes. The Global Fund focused most dollars on Sub-Saharan Africa, which received 73% of disbursements (Table 4). Notably, in 2005, disbursements to South Asia were low, especially relative to disease burden. South Asia received only 3 grants, accounting for 1.3% of all dollars disbursed.

Comparisons of aggregate spending with mortality (Figure 1) demonstrate the mis-match between mortality in low- and middle-income countries, and the focus of disease-specific funding. When we examine total disbursements from all studied financiers (Figure 2), there are three notable deviations in funding trends: HIV/AIDS receiving more funding relative to mortality while child health and non-communicable disease and injury receive less funding relative to mortality.

IV. Discussion

Our analysis does not allow informed comment on the magnitude of funding needed for global health. Instead, the data presented only allow comment on the distribution of funds. Three critical points emerge from our findings, each of which is elaborated in the discussion below. First, the publicly available data on global health disbursements is incomplete and not standardized. A clear understanding of the work and disbursement of global health institutions is a prerequisite for coordination, and we hope that these findings encourage institutions to fully disclose and standardize the methods of communicating disbursements. Second, the discussion on priority-setting in global health has focused on technical debate, particularly regarding the DALY(28), and has not sufficiently addressed the selection of political priorities, such as the MDGs, which appear to have great influence on health disbursements. Third, the data suggests that there may be a role for multilateralism in creating a priority agenda to guide global health investments.

The correlations we perform imply that mortality and disbursements should, in an ideal world, be perfectly correlated. This is based on two problematic assumptions, one technical and the other political. First, the statistical assessment assumes that the cost per year of life-saved is equal for all causes of mortality. We know this not to be true from important work on cost-efficacy of critical interventions(29). Second, the statistical assessment assumes that international funding should be directed equally at all disease areas. This neglects the comparative advantage of these international institutions relative to national governments (e.g. procurement of anti-retrovirals). Each of these two assumptions corresponds to a justifiable reason for deviation from matching disbursements to mortality. In the former, technical knowledge of cost efficacy justifies a deviation of funding from mortality. In the latter, political and institutional niche of the funding organisation may justify a deviation from mortality. Below, we discuss how improved recognition of these deviations, through data to inform technical priorities, and research to understand the setting of institutional priorities may lead to a more equitable distribution of global health funding.

No good data on disbursements

The task of tracking, then standardizing, global health disbursements from the major financiers is a difficult one. A two-years project on resource tracking in global health, conducted by the Center for Global Development, determined that there are substantial information gaps, including a lack of credible data on commitments and funds available to global health, and a gap between the rhetoric of transparency and accountability, and the data systems to provide this(19). The report, like an earlier report by the RAND Corporation(18), makes recommendations to improve standardization and access to data on global health funding. Neither report, nor any other we have identified, attempts to track the resources committed by the major global health financiers.

Our effort to analyse disbursements is based on imperfect and incomplete data, on both mortality and disbursements. Mortality is the metric by which we have considered the match between technical evidence and allocations. Mortality estimates are based often on hospital deaths, and extrapolations, rather than real measures. Further, we do not have good estimates for non disease-specific deaths. For example, we do not know how many people die because of a lack of access to health systems, and thus are unable to consider health system allocations on the same basis which we consider allocations for HIV/AIDS. The insufficiency of current health metrics, particularly in determining community (as well as national and

regional) needs has been widely recognized. The recently launched Gates-funded Institute for Health Metrics and Evaluation at the University of Washington, which will work closely with WHO, holds promise for further progress on assessing investments in health.

Second, we lack good data on the disbursements made by the major global health financiers. We do not account for disbursements that may have been withheld or withdrawn, nor do we have information about what the recipients used the funding to accomplish. Our attempt to standardize the categorization of funds is based on our reading of the available grant information. The data has substantial limitations, but this first attempt to consider the full range of disbursements informs our understanding of trends in global health funding, including the power of the political over the technical in allocations, and the relative allocative efficiency of multilateral institutions. We hope that this analysis will lead financiers to challenge our conclusions by making more complete and standardized data available. Increased financial transparency may make coordination possible as institutions will have a clearer picture of the efforts of others, and they may better define their comparative advantage.

Political neglect and technical debate

Political statements and priorities, such as the U.S. government's commitment to HIV/AIDS, the Gates Foundation's quest for new technologies(30), and the United Nation's Millennium Development Goals, may better explain global health disbursements than technical evidence. While this observation comes as no surprise to observers of global health, the rigorous debate on the technical process of priority setting is met with a dearth of knowledge on the creation of political priorities in global health institutions. In place of empirical political analysis of influence on priorities and health strategies in these institutions, public discussion has been informed by commentaries and editorials(31-34), which offer important observations but lack political analysis on which to base institutional reform. Plans for mediating, or harnessing, this political influence on health priorities have not been offered, with few exceptions(35). Using deviation from mortality as a baseline from which to consider disbursements offers a standard method for considering political influence on health priorities.

Much of the discussion on the setting of global health priorities has focused on the validity of technically-based metrics for priority setting, while neglecting the political influences on disbursements. The DALY has been scrutinized by epidemiologists, economists, and philosophers concerned with equity for the reasons that, if used for policy, the metric would disfavour the disabled and women(35, 36), and if blinded to socio-economic issues, would not give attention to issues of equity(28). Political commitments within global health institutions, which appear to better explain the relative distribution of health funds, are not held to the same level of scrutiny. Why are the technicalities of the DALY debated, while the acceptance of the MDGs – formed from a series of international agreements among rich countries – is taken for granted? By relating disbursements to mortality, we provide a baseline from which to assess the magnitude of political influence on health priorities.

The political and ideological influences shaping health disbursements may be mediated and harnessed by the articulation of a clear priority agenda based on objective indicators of need. Political influence is not necessarily undesirable. Indeed, health has gained prominence on the global agenda due largely to political commitments from the G-8 to the U.S. government. The deviation of political priorities from technically based evidence (and here, we match this imperfectly to mortality) warrants explanation that has not been offered. Indeed, the

difference between political and technical has been muddled in global health as technical agencies, including the WHO, have adopted politically, rather than technically, constructed priority agendas. This observation mirrors the finding that WHO guidelines rely on expert opinion, sometimes in place of evidence(37). The WHO's "Global Health Agenda," published in its Eleventh General Programme of Work is not based on technical expertise, but like the MDGs, the agenda is based on international agreements (38). Similarly, while we consider the Global Fund's comparatively better (though not significantly) match to mortality, this is due to a political decision to narrow the mandate of the institution. To achieve equitable distribution of funding, regionally and by disease area, political influence on health priorities need to be critiqued, then mediated, with the same rigor that has met technical approaches to priority setting.

There may be justifiable, politically guided, deviations from even the best technical evidence in global health finance. Our exploration of the institutional mandates, process of priority setting and governance of the global health financiers suggests that each has selected priorities based on perceived comparative advantage. For the World Bank, the advantage is in infrastructure (which explains the focus on health systems); for the Gates Foundation, it is technology and innovation. There may be comparative disadvantages at play too. Multilateral institutions, because of their inclusion of low and middle income countries in their governance structures and their interaction with government, may be better placed to lead efforts supporting a country in developing a health system. It is less politically complex, and requires shorter commitment, to deliver and develop drugs and health technology, which has been the focus of the bilateral (U.S. government) and private (Gates Foundation) actors we studied here. Global health will not be devoid of politics, but the politics of each of these institutions and their interaction with governments deserves consideration when creating a shared global health priority agenda.

The role for multilateralism in creating a shared priority agenda

Our review of funding patterns and institutional mandates suggest that a shared, multilateral, priority agenda may reduce facilitate a closer matching of need and disbursements. Multilateralism can be understood as "institutionalized collective action by an inclusively determined set of independent states(39)." Among the financiers examined, two can be considered "multilateral" to varying degrees: the World Bank and the Global Fund. Both share the core feature of multilateralism, which is the coordination of policies in groups of three or more states(40). Three key benefits of multilateralism are a more inclusive decision-making processes, adherence to global "principles of conduct", and allocative efficiency.

First, multilateral institutions have structures in place for more inclusive decision-making, and indeed, their legitimacy depends partially on this inclusiveness. Keohane, a scholar of international relations, notes that, "output legitimacy depends on input legitimacy," and thus, in global health finance, legitimacy depends both on the quality of information and evidence guiding decisions as well as an acceptable process of including relevant parties. As noted earlier in this paper, the World Bank and the Global Fund, both multilateral institutions, have more robust systems in place for transparent and democratic decision-making than private and bilateral actors.

Second, "principles of conduct," central to multilateral institutions, may facilitate a closer matching of disbursements to mortality. John Ruggie, in a seminal consideration of multilateralism, writes, "What distinguishes the multilateral form from other forms is that it

coordinates behavior among three or more states on the basis of generalized principles of conduct(40).” Such principles of conduct in global health finance may be priorities, based on technical evidence and cognizant of political and institutional niche and capability. A shared priority agenda, based on international norms should be agreed upon and communicated to global health financiers in order to more efficiently allocate funds. While none of the financiers correlate disbursements significantly to mortality (Table 5), the descriptive statistics (Table 3-4), and the correlation assuming that 1/3 of health systems spending is for NCDs (Appendix 1, a), suggest that the Global Fund’s and, to a lesser extent, the World Bank’s, 2005 disbursements more closely match mortality of diseases than do the Gates Foundation (private) and the U.S. government (bilateral). Again, it is not assumed that funding will correlate with mortality, for the technical and political reasons described above, but it should at least bear some resemblance to our best measures of death by disease and region.

The third benefit of multilateralism is allocative efficiency. Our analysis has identified areas of neglect and inefficiency in global health finance. These include a relative lack of investment in priority disease areas such as non-communicable disease and child health. Further, only the World Bank made substantial investments in health systems in 2005, which are especially needed in addressing these neglected opportunities for the advancement of health. In a coordinated system, each financing institution need not match the measured burden of mortality (or any other metric for resource allocation), but the aggregate disbursements should reflect the demonstrated need. This does not appear to be the case (Figure 2). Rather than complementing each other, financiers seem to work in the same area, un-competitively and redundantly, as the efforts on HIV/AIDS have shown. Institutional coordination and a multilateral approach to global health governance may reduce this inefficiency.

Despite the benefits of multilateralism, states have increasingly less incentive to partake in a multilateral approach to global health. While global health advocates have often emphasized the links between health and national security to place health issues on the agenda (1-3, 41), it may be precisely this link to national security that leads states to favour a bilateral approach(42, 43).

Toward more equitable global health financing

The billion-dollar health institutions vary in their distribution of funding by geographical focus, investment in service or research, and support of government or civil society and private groups. Global health governance can be viewed as a patchwork of donors, UN agencies, governments, civil society organisations, and the private sector(44). This paper has mapped the investments of the major global health financiers, the World Bank, the U.S. Government, the Gates Foundation and the Global Fund. The pluralism of global health institutions and the informal alliances on which power in global health rests make a unified and fully coordinated global health system politically unrealistic (44, 45). Instead of a grand architecture for global health, attention should be turned to mechanisms for multilateralism in selection of priority areas, which may lead to a more equitable distribution of funds. Multilateralism in a private and bilateral system can be facilitated by the creation of a technically sound and politically acceptable priority agenda that can guide donor investments to meet the needs of the poor. The World Health Organisation, with its demonstrated success in technical advice, may be best placed to articulate a clear priority agenda, and serve as a forum for informal coordination. Our analysis demonstrates a clear role to be played in

improving the information gap, and moving towards decision-making based on objective indicators of need.

Based on our findings, we have three recommendations for global health policy:

1. Global health financiers must provide complete and standardised data on disbursements and commitments to facilitate coordination.
2. Scholars and policymakers should seek to explicitly explain deviations from mortality in global health disbursements, thus discarding the false pretence of technical neutrality, and explicitly recognizing political influence.
3. The WHO should lead, with partners, in the development and dissemination of a global health priority agenda based on objective indicators of need. This agenda may harness and mediate political influence and facilitate cooperation by creating normative “principles of conduct” in global health finance.

TABLE 1: Stated Priorities of Global Health Financiers

Global Health Financier	Stated Priorities
The World Bank	<ul style="list-style-type: none"> ▪ Childhood mortality reduced (MDG 4, Target 5 and MDG 7, Target 10), ▪ Childhood malnutrition improved (MDG 1, Target 2), ▪ Avoidable mortality and morbidity from chronic diseases and injuries reduced, ▪ Improved maternal, reproductive and sexual health (MDG 5, Target 6), ▪ Reduced morbidity and mortality from HIV/AIDS, TB, malaria and other priority pandemics (MDG 6, Target 7 & 8), ▪ Improve financial protection (reduce the impoverishing effects of illness for the poor or near poor), ▪ Improve funding sustainability in the public sector from both domestic and external sources, ▪ Improved governance and transparency in the health sector (MDG 8, Target 12)
U.S. Government Priorities	<ul style="list-style-type: none"> ▪ PEPFAR: HIV/AIDS ▪ President's Malaria Initiative ▪ USAID: Environment Health, Family Planning, Health Systems, HIV/AIDS, Infectious Disease, Maternal and Child Health, Nutrition
The Gates Foundation	<ul style="list-style-type: none"> ▪ Acute diarrhoeal disease ▪ Acute lower respiratory infections ▪ Child Health ▪ HIV/AIDS ▪ Malaria ▪ Poor nutrition ▪ Reproductive and Maternal Health ▪ Tuberculosis ▪ Vaccine-preventable diseases ▪ Other infectious diseases
Global Fund	<ul style="list-style-type: none"> ▪ HIV/AIDS ▪ Tuberculosis ▪ Malaria

TABLE 2: Key Aspects of the Major Global Health Financiers (in 2005)

Key Dimensions	World Bank	U.S. Government	Gates Foundation	Global Fund
Funding Source	IDA: Members capital subscriptions; IBRD: Private capital markets, members capital	U.S. Taxpayers	Bill and Melinda Gates (private assets)	Donations from governments and private actors
Accountable to	Executive Board	Congress	Co-Chairs (Bill, Melinda and William Gates)	Board
Leadership Structure	President, Managing Director, Vice-Presidency of Human Development	Executive Branch (White House, State Dept., USAID)	Co-Chairs, CEO, COO, Presidents for each Initiative (Global Health)	Executive Director, small Secretariat in Geneva
Funding Type	Loans (IBRD, IDA)	Grants	Grants	Grants
%of Funding to Service v. Research	Research: .26 Service: 99.5 Both: .21	Research: 1.6, Service: 98.4	Research: 46.4 Service: 6 Both: 47.7 ¹	Research: 0 Service: 100
% of Funding to Prevention v. Treatment	Prevention: 77 Treatment: .1 Both: 22.9	Prevention: 30 Treatment: 70	Prevention: 71.2 Treatment: 12.8 Both: 9.1 NA: 6.9	Funding integrated; not specified
Region of Recipients	SSA, SA, SEA, and L. America, Caribbean, Central Asia, Middle East, N. Africa	Sub-Saharan Africa (99%)	North America and Western Europe (95%)	Sub-Saharan Africa (73%)
Primary Recipients of Funds	Government	Civil-Society Organisations, Government	Private Research, Universities, Civil society, Public-Private Partnerships	Government/ Country Coordinating Mechanism (CCM)
Financier has major field staff presence	Yes	Yes	No	No, in-country CCMs
2005 Disbursement	\$3.9 billion	\$1.3 billion	\$1.8 billion	\$292 million
Total Endowment/ Commitment	NA	\$46.2 billion ²	\$67 billion ³	\$10.4 billion

¹ The GAVI Alliance, which received more than 750,000,000 in support from GMGF in 2005 accounts for 41.6% of all dollars given. GAVI has been categorized as funding targeted for both research and service.

² Pending congressional approval of proposed PEPFAR renewal

³ Pending transfer of Warren Buffet's pledge to the Bill and Melinda Gates Foundation

TABLE 3: 2005 Disbursements (millions), 2001 Deaths (millions) by Disease Area

Disease Group	World Bank (%)	U.S. Government (%)	Gates Foundation (%)	Global Fund (%)	Deaths in Low and Middle Income (%)	Total funding per death, dollars
Child Health (excluding vaccines)	140.4 (3.6)	.025 (<.001)	34.2 (1.9)	0	10.25 (21.2)	17.04
Child Health (including vaccines)	140.4 (3.6)	.025 (<.001)	801 (44.5)	0	10.25 (21.2)	91.89
Emergency/Disaster	0	0	3.6 0.2	0	NA	NA
General ID	159.9 (4.1)	.068 (<.001)	13.1	0	NA	NA
Global Health Strategy, Partnerships	0	0	8.2	0	NA	NA
Health Systems	1287 (33.0)	0	0	0	NA	NA
HIV/AIDS⁴	202.8 (5.2)	1232.4 (94.8)	136.8 (7.6)	108.8 (37.5)	2.56 (5.3)	656.22
Injury	705.1 (18.1)	0	0	0	4.71 (9.75)	150.02
Malaria	78.0 (2.0)	67.6 (5.2)	232.2 (12.4)	96.3 (33.2)	1.21 (2.5)	384.96
Maternal Health	187.2 (4.8)	.015 (<.001)	131.4 (7.3)	0	0.73 (1.5)	435.27
NCD	83.5 (2.1)	0	0	0	26.03 (53.8)	3.21
Nutrition	74.1 (1.9)	.025 (<.001)	77.4 (4.3)	0	5.89 (12.2)	25.75
Polio	51.7 (1.4)	0	35.1 (.019)	0	0 ⁵	> 1 million
TB	3.9 (.1)	0	37.8 (2.1)	112.18 (24.3)	1.60 (3.3)	70.35
Vaccines	0	0	766.8 (42.6)	0	1.48 (3.1)	518.10 ⁶
Water and Sanitation	854.1 (21.9)	0	.18 (.01)	0	1.78 (3.7)	479.94

⁴ The links between HIV/AIDS and TB treatment make it difficult to categorize these independently. Thus some HIV/AIDS funding might be spent indirectly on TB prevention and treatment as well.

⁵ In 2001, there were no reported deaths due to polio in low- and middle income countries, and one death in high-income countries, according the GBD 2006, p.445

⁶ This high figure is likely to be unique to 2005, and is due to Gates Foundations \$750,000,000 grant to the GAVI Alliance.

TABLE 4: 2005 Disbursements (in millions of dollars) by World Bank Region

Region	World Bank	U.S. Gov	Gates Foundation	Global Fund	Total Funds	Deaths in millions(27)	Total funding per death, dollars
E. Euro and Central Asia	550 (14.1)	0	0.72 (0.04)	16.4 (5.6)	567	5.7	99.46
East Asia, and Pacific (incl S.E. Asia)	694 (17.8)	<.013 (.001)	3.6 (0.2)	46.1 (15.8)	744	13.0	57.22
Latin America, Caribbean	905 (23.2)	<.013 (.001)	7.2 (0.4)	17.8 (6.1)	930	3.2	290.57
Middle East, N. Africa	312 (8.0)	<.013 (.001)	0	2.04 (0.7)	314	1.9	165.29
South Asia	710 (18.2)	<.013 (.001)	55.8 (3.1)	3.8 (1.3)	769	13.6	56.57
Sub-Saharan Africa	729 (18.7)	1287 (99.0)	19.8 (1.1)	213 (73.0)	2249	10.8	208.26
High-Income Countries	0	0	1714 (95.2 ⁷)	0	1714	7.9	216.91

⁷ 134 of 178 grants were made to organisations with headquarters only in North America or Western Europe. An additional 24 grants were made to organisations with dual headquarters or specified a recipient/beneficiary outside of high-income countries. For these 24 grants, the total dollar amount was divided equally among regions to come to the figure of 95.2%

TABLE 5: Correlation of 2005 disbursements (millions) vs 2001 mortality (millions)

	World Bank	U.S. Government	Gates Foundation	Global Fund	Total Disbursement
Correlation coefficient (p-value)	-0.163 (0.65)	-0.1417 (0.69)	0.0878 (0.81)	0.5685 (0.62)	-.1920 (0.595)

Note: in this correlation, NCD and injury are separate, and child health includes vaccines. Alternatives, in which a) it is assumed that 1/3 of health systems funding is for NCDs, b) NCD and injury are merged and c) child health and vaccine are separate can be found in Appendix 1.

FIGURE 1: Distribution of mortality in low- and middle-income countries and funding from major global health financiers

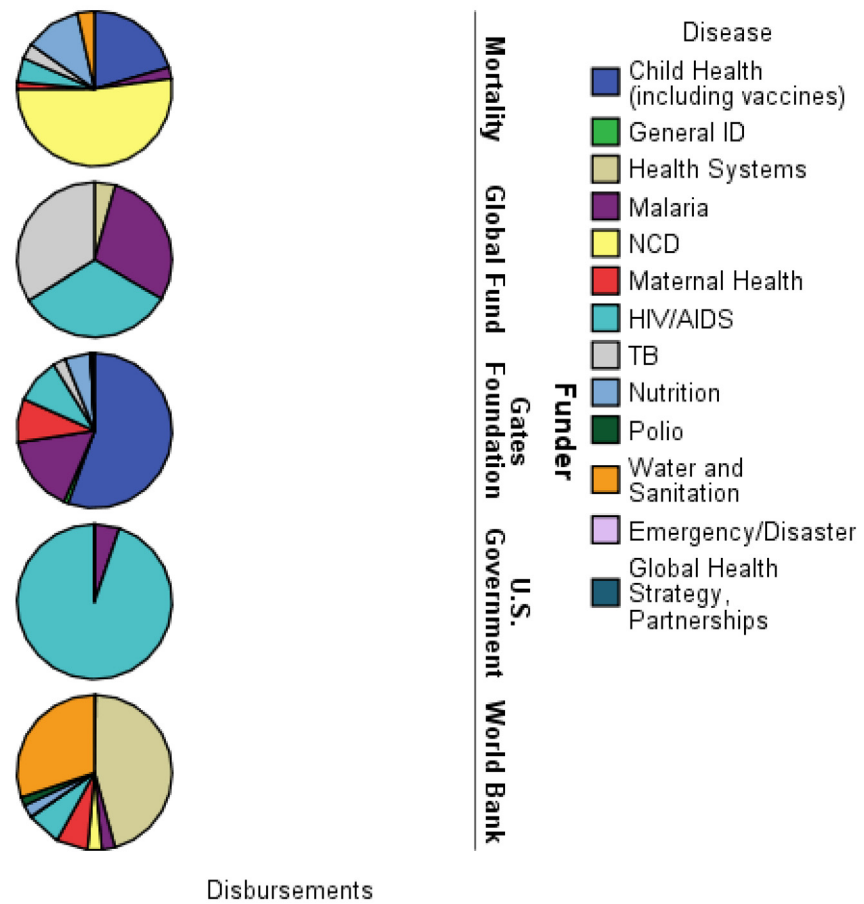


FIGURE 2: 2001 Mortality (%) vs. 2005 Disbursements of World Bank, U.S. Gov, BMGF, GFHTM

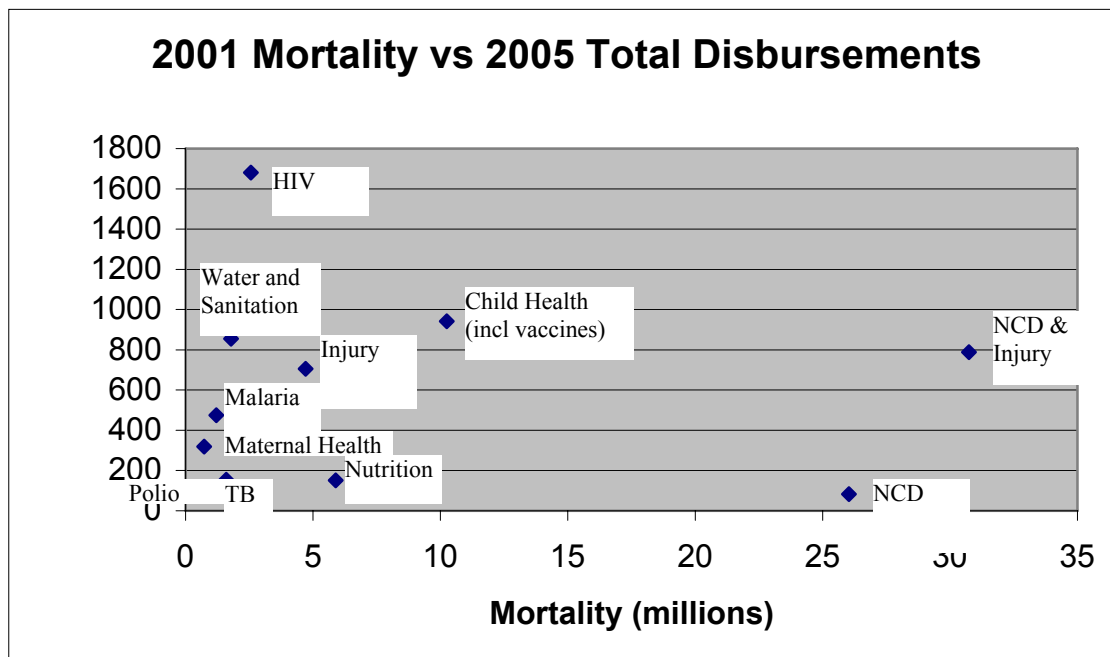
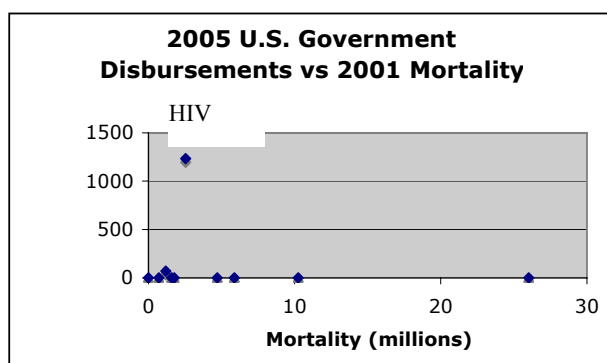
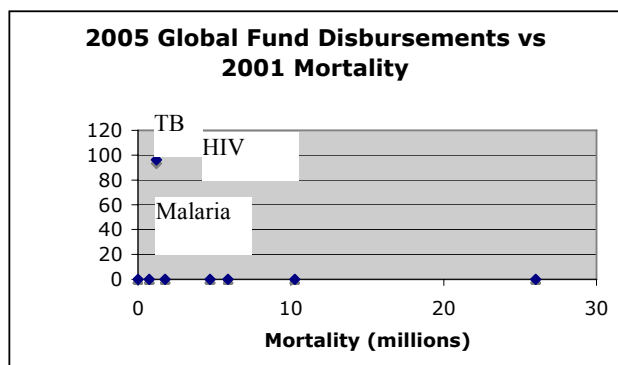
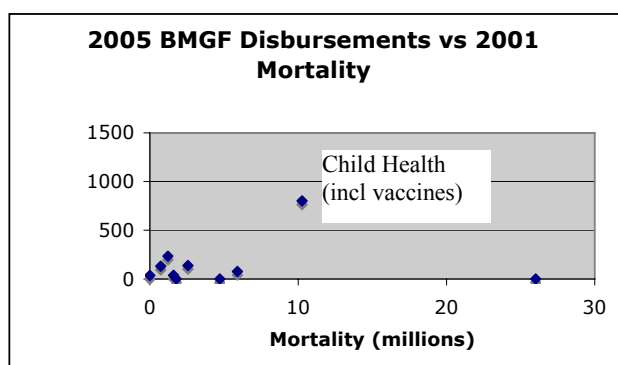
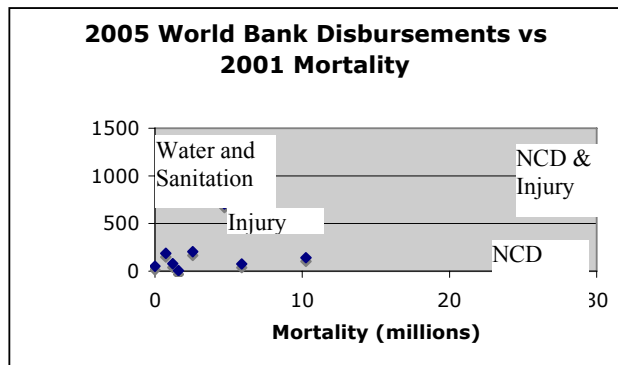


FIGURE 3: 2005 disbursements of each financier vs. 2001 mortality



Appendix 1

a. 2005 disbursements (in millions) vs. 2001 Mortality (millions): assuming 1/3 of health systems funding for NCDs (all else equal to Table 5)

	World Bank	U.S. Government	Gates Foundation	Global Fund	Total Disbursement
Correlation coefficient (p-value)	.226 (0.47)	-0.142 (0.69)	0.087 (0.81)	0.5685 (0.62)	0.054 (0.881)

b. 2005 disbursements (in millions) vs. 2001 Mortality (millions): NCD and injury merged

	World Bank	U.S. Government	Gates Foundation	Global Fund	Total Disbursement
Correlation coefficient (p-value)	0.55 (0.12)	-0.1461 (0.71)	0.032 (0.94)	0.5685 (0.62)	0.159 (0.69)

c. 2005 disbursements (in millions) vs. 2001 Mortality (millions): separate child health and vaccine

	World Bank	U.S. Government	Gates Foundation	Global Fund	Total Disbursement
Correlation coefficient (p-value)	-0.116 (0.73)	-0.122 (0.72)	-.28 (0.41)	0.5685 (0.62)	-0.319 (0.339)

-
1. Donaldson L, Banatvala N. Health is global: proposals for a UK Government-wide strategy. *Lancet*. 2007 Mar 10;369(9564):857-61.
 2. (U.S.). IoM. America's Vital Interest in Global Health. Washington DC: Institute of Medicine; 1997.
 3. Oslo Ministerial Declaration--global health: a pressing foreign policy issue of our time. *Lancet*. 2007 Apr 21;369(9570):1373-8.
 4. Kates J, Morrison JS, Lief E. Global health funding: a glass half full? *Lancet*. 2006 Jul 15;368(9531):187-8.
 5. Jamison D, World Bank., Disease Control Priorities Project. Disease control priorities in developing countries, 2nd edition. New York; Washington, DC: Oxford University Press; World Bank; 2006.
 6. Lopez AD, Disease Control Priorities Project. Global burden of disease and risk factors. New York Washington, DC: Oxford University Press ; World Bank; 2006.
 7. Alesina A, Dollar D. Who Gives Foreign Aid to Whom and Why? *Journal of Economic Growth*. 2000;5(1):33-63.
 8. PEPFAR and the fight against HIV/AIDS. *Lancet*. 2007 Apr 7;369(9568):1141.
 9. Sachs J. The End of Poverty: Economic Possibilities for Our Time: Penguin Press; 2005.
 10. Cooper RN. Can nations agree? : issues in international economic cooperation. Washington, D.C: Brookings Institution; 1989.
 11. Shiffman J. Donor funding priorities for communicable disease control in the developing world. *Health policy and planning*. 2006 Nov;21(6):411-20.
 12. OECD. OECD Development Assistance Committee. [cited 2007 4 July]; Available from: www.oecd.org/dac/
 13. WHO. National Health Accounts. 2007 [cited 2007 4 July]; Available from: <http://www.who.int/nha/en>
 14. Kates J, Lief E. International Assistance for HIV/AIDS in the Developing World: Taking Stock of the G8, Other Donor Governments and the European Commission. Washington, D.C.: Kaiser Family Foundation; 2006 July 2006.
 15. MacKellar L. Priorities in global assistance for health, AIDS, and population. *Population and Development Review*. 2005;31(2):293-312.
 16. Lane C, Glassman A. Bigger and Better? Scaling up and innovation in health aid. *Health Affairs*. 2007;26(4).
 17. Michaud C. Development Assistance for Health (DAH): Recent Trends and Resource Allocation. Geneva; 2003.
 18. Eiseman E, Fossum D. The Challenges of Creating a Global Health Resource Tracking System: Rand Corp; 2005.
 19. Levine R, Blumer K. Following the Money: Toward Better Tracking of Global Health Resources. Washington, D.C.: Center for Global Development; 2007 May 2007.
 20. Kates J, Morrison J, Lief E. Global health funding: a glass half full? *Lancet*. 2006 Jul 15;368(9531):187-8.
 21. USAID. 2007 [cited 2007 17 July]; Available from: www.usaid.gov
 22. Millenium Challenge Corporation. 2007 [cited 2007 19 June]; Available from: <http://www.mcc.gov/features/worldhealth/index.php>
 23. President Bush Announces Five-Year, \$30 Billion HIV/AIDS Plan. White House 2007 [cited 2007 June 3, 2007]; Available from: <http://www.whitehouse.gov/news/releases/2007/05/20070530-6.html>
 24. Gates. 2007 [cited; Available from: www.gatesfoundation.org/GlobalHealth
 25. GlobalFund. Composition of the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria. 2007 Fifteenth Board Meeting. 25-27 April 2007; 2007.
 26. Adeyi O, Smith O, Robles S. Public Policy and the Challenge of Chronic Noncommunicable Diseases. Washington, D.C.: World Bank; 2007.
 27. PEPFAR. Emergency Plan for AIDS Relief, Fiscal Year 2005 Operational Plan. Washington D.C.; 2005.
 28. Anand S, Hanson K. Disability-Adjusted Life Years: A Critical Review. In: Anand S, Peter F, Sen A, editors. *Public Health, Ethics, and Equity*. New York, N.Y.: Oxford University Press; 2004.
 29. Laxminarayan R, Mills AJ, Breman JG, Measham AR, Alleyne G, Claeson M, et al. Advancement of global health: key messages from the Disease Control Priorities Project. *The Lancet*. 2006;367(9517):1193-208.
 30. Birn A. Gates's grandest challenge: transcending technology as public health ideology. *Lancet*. 2005 Aug 6;366(9484):514-9.
 31. Kerr T, Kaplan K, Suwannawong P, Jürgens R, Wood E. The Global Fund to Fight AIDS, Tuberculosis and Malaria: funding for unpopular public-health programmes. *The Lancet*. 2004;364(9428):11-2.
 32. Bass E. The two sides of PEPFAR in Uganda. *Lancet*. 2005 Jun 18-24;365(9477):2077-8.
 33. McCarthy M, Das P. PEPFAR and the fight against HIV/AIDS. *The Lancet*. 2007;369:9568.
 34. Ollila E. Global health priorities—Priorities of the wealthy. *Global Health*. 2005;1(6).
 35. Shiffman J. Generating Political Priority for Maternal Mortality Reduction in 5 Developing Countries. *American Journal of Public Health*. 2007;97(5):796.

36. Mont D. Measuring health and disability. *The Lancet*. 2007;369:9573.
37. Oxman AD, Lavis JN, Fretheim A. Use of evidence in WHO recommendations. *Lancet*. 2007.
38. WHO. Engaging for Health: Eleventh General Programme of Work, 2006-2015, A Global Health Agenda Geneva, Switzerland: World Health Organization; 2006.
39. Keohane RO. The Contingent Legitimacy of Multilateralism. *Multilateralism Under Challenge? Power, International Order, and Structural Change*. 2006.
40. Ruggie JG. Multilateralism: the Anatomy of an Institution. *International Organization*. 1992;46(3):561-98.
41. Garrett L. HIV and National Security: Where are the Links?: Council on Foreign Relations; 2005.
42. Ikenberry GJ. Is American Multilateralism in Decline? *Perspectives on Politics*. 2003;1(03):533-50.
43. Woods N. Reconciling effective aid and global security: Implications for the emerging international architecture. *Global Economic Governance Programme*, University College, Oxford. 2005.
44. Chen L, Evans T, Cash R. Health as a Global Public Good. In: Kaul I, Grunberg I, Stern MA, editors. *Global public goods: international cooperation in the 21st century*: Oxford University Press; 1999.
45. Fidler DP. Architecture amidst Anarchy: Global Health's Quest for Governance. *Global Health Governance*.1.



Global Economic Governance Programme

Centre for International Studies | Department for Politics and International Relations



Working Papers

The following GEG Working Papers can be consulted at www.globaleconomicgovernance.org/papers.php

2007

Devi Sridhar and Rajaie Batniji	WP 2007/35 'Misfinancing Global Health: The Case for Transparency in Disbursements and Decision-Making'
Louis W. Pauly	WP 2007/34 'Political Authority and Global Finance: Crisis Prevention in Europe and Beyond'
Mayur Patel	WP 2007/33 'New Faces in the Green Room: Developing Country Coalitions and Decision Making in the WTO'
Lindsay Whitfield and Emily Jones	WP 2007/32 'Ghana: Economic Policymaking and the Politics of Aid Dependence'
Isaline Bergamaschi	WP 2007/31 'Mali: Patterns and Limits of Donor-driven Ownership'
Alastair Fraser	WP 2007/30 'Zambia: Back to the Future?'
Graham Harrison and Sarah Mulley	WP 2007/29 'Tanzania: A Genuine Case of Recipient Leadership in the Aid System?'
Xavier Furtado and W. James Smith	WP 2007/28 'Ethiopia: Aid, Ownership, and Sovereignty'
Clare Lockhart	WP 2007/27 'The Aid Relationship in Afghanistan: Struggling for Government Leadership'
Rachel Hayman	WP 2007/26 "'Milking the Cow": Negotiating Ownership of Aid and Policy in Rwanda'
Paolo de Renzio and Joseph Hanlon	WP 2007/25 'Contested Sovereignty in Mozambique: The Dilemmas of Aid Dependence'

2006

Lindsay Whitfield	WP 2006/24 'Aid's Political Consequences: the Embedded Aid System in Ghana'
Alastair Fraser	WP 2006/23 'Aid-Recipient Sovereignty in Global Governance'
David Williams	WP 2006/22 "'Ownership," Sovereignty and Global Governance'
Paolo de Renzio and	WP 2006/21 'Donor Coordination and Good Governance: Donor-led

Sarah Mulley	and Recipient-led Approaches'
--------------	-------------------------------

2005

Lindsay Whitfield	WP 2006/24 'Aid's Political Consequences: the Embedded Aid System in Ghana'
Alastair Fraser	WP 2006/23 'Aid-Recipient Sovereignty in Global Governance'
David Williams	WP 2006/22 "'Ownership,'" Sovereignty and Global Governance'
Paolo de Renzio and Sarah Mulley	WP 2006/21 'Donor Coordination and Good Governance: Donor-led and Recipient-led Approaches'

2005

Andrew Eggers, Ann Florini, and Ngaire Woods	WP 2005/20 'Democratizing the IMF'
Ngaire Woods and Research Team	WP 2005/19 'Reconciling Effective Aid and Global Security: Implications for the Emerging International Development Architecture'
Sue Unsworth	WP 2005/18 'Focusing Aid on Good Governance'
Ngaire Woods and Domenico Lombardi	WP 2005/17 'Effective Representation and the Role of Coalitions Within the IMF'
Dara O'Rourke	WP 2005/16 'Locally Accountable Good Governance: Strengthening Non-Governmental Systems of Labour Regulation'.
John Braithwaite	WP 2005/15 'Responsive Regulation and Developing Economics'.
David Graham and Ngaire Woods	WP 2005/14 'Making Corporate Self-Regulation Effective in Developing Countries'.

2004

Sandra Polaski	WP 2004/13 'Combining Global and Local Force: The Case of Labour Rights in Cambodia'
Michael Lenox	WP 2004/12 'The Prospects for Industry Self-Regulation of Environmental Externalities'
Robert Repetto	WP 2004/11 'Protecting Investors and the Environment through Financial Disclosure'
Bronwen Morgan	WP 2004/10 'Global Business, Local Constraints: The Case of Water in South Africa'
Andrew Walker	WP 2004/09 'When do Governments Implement Voluntary Codes and Standards? The Experience of Financial Standards and Codes in East Asia'
Jomo K.S.	WP 2004/08 'Malaysia's Pathway through Financial Crisis'
Cyrus Rustomjee	WP 2004/07 'South Africa's Pathway through Financial Crisis'

Arunabha Ghosh	WP 2004/06 'India's Pathway through Financial Crisis'
Calum Miller	WP 2004/05 'Turkey's Pathway through Financial Crisis'
Alexander Zaslavsky and Ngaire Woods	WP 2004/04 'Russia's Pathway through Financial Crisis'
Leonardo Martinez-Diaz	WP 2004/03 'Indonesia's Pathway through Financial Crisis'
Brad Setser and Anna Gelpern	WP 2004/02 'Argentina's Pathway through Financial Crisis'
Ngaire Woods	WP 2004/01 'Pathways through Financial Crises: Overview'



The Global Economic Governance Programme was established at University College in 2003 to foster research and debate into how global markets and institutions can better serve the needs of people in developing countries. The three core objectives of the programme are:

- to conduct and foster research into international organizations and markets as well as new public-private governance regimes
- to create and develop a network of scholars and policy-makers working on these issues
- to influence debate and policy in both the public and the private sector in developed and developing countries

The Global Economic Governance Programme
University College, Oxford OX1 4BH

Tel. +44 (0) 1865 276 639 or 279 630

Fax. +44 (0) 1865 276 659

Email: geg@univ.ox.ac.uk

www.globaleconomicgovernance.org