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

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Summary

Background

Global health has received increasing international attention and funding. Yet there is a dearth of information on global health financial flows. To address this gap, we aim to identify the patterns in allocation of funds in the four largest global health financiers in 2005- the World Bank, Bill and Melinda Gates Foundation, the U.S. government, and the Global Fund for HIV/AIDS, TB and Malaria.

Methods

Using information gathered from the annual reports and budgets, we created a disbursement database categorised by donor, priority area, regional focus, type of investment, and type of receiving agency for 2005. We included all health-related grants and loans, 1006 in total, made by the four studied financiers.

Findings

Financiers adopt disease-area foci that are inconsistent with burden of disease. Funding per death varied widely by disease area, from $1029.10 for HIV/AIDS to $3.21 for non-communicable disease. The World Bank, U.S. government, and Global Fund dedicated more than 98% of their funds to service, while BMGF directed most funds to research. 95% of BMGF grants in 2005 went to organisations based in rich countries, while the U.S. government and Global Fund disbursed their grants predominantly to Sub-Saharan Africa. The World Bank is unique in providing substantial funds to governments, with other donors funding predominantly private and civil-society initiatives.

Interpretation

Three critical points emerge from our findings. First, publicly available data on global health disbursements is incomplete and not standardised. Second, the discussion on priority-setting in global health has focused on technical debate, particularly regarding the DALY, and has not sufficiently addressed the selection of political priorities, such as the MDGs, which appear to have greater influence on health disbursements. Third, there needs to be continual attention to developing country ownership, particularly the need for planning and priority-setting to be driven through country-led processes.

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 (Donaldson, 2007; IoM, 1997; Oslo Ministerial Declaration, 2007). 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 mobilised 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 (Kates, Morrison and Lief, 2006, 187-188). In parallel to increased financial commitment, there seems to be a growing consensus on technical strategies for global health (Jamison, 2006), and an emerging, though controversial, epidemiological evidence-base that may inform the disbursement of global health funds(Lopez, 2006).

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 burden of disease. We also attempt to examine whether 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 (Alesina and Dollar, 2000). By relating disbursements to mortality and burden of disease, we create a baseline from which we can assess deviations in priority that may be due to other influences 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 (McCarthy and Das, 2007). 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 (Jamison, 2006). Although the DCPP study has been criticised for an excessive focus on technical, disease-specific strategies, it is a flawed, but useful, tool for analysis. *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 (Sachs, 2005). Such clarity on strategies, though perhaps flawed, can facilitate cooperation and political commitment.

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 strategic approach (e.g. eradication vs control), by country (e.g. OECD DAC), and in-country (e.g. National Health Accounts)[1]. For example, Shiffman's 2006 article is an excellent examination of the donor funding priorities for communicable disease control from 1996 to 2003[2]. 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 (Eiseman and Fossum, 2005). Due to the difficulties of tracking health-relating funding (Levine and Blumer, 2007), no systematic effort to track all disbursements of the major global health financiers has been conducted. 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.

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 (Kates, Morrison and Lief, 2006, 187-88). The specific mandate, capacity and decision-making mechanisms of each may significantly affect their disbursements, thus it is important to understand the structures of each institution.

World Bank

The World Bank makes low-interest/concessionary (International Development Agency) and normal loans (International Bank of Reconstruction and Development). 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 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. It is worth noting that the Bank has been criticised by groups, such as Global Health Watch, for weakening health systems through the imposition of structural adjustment packages(Global Health Watch, 2005). 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 grant 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). 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'(USAID, 2007). 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(Millennium Challenge Corporation, 2007). 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[3].

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 (Gates, 2007). 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 Four Financiers

The governance structures of the four financiers may explain decision-making and priority-setting processes. The World Bank is governed by an Executive Board in which all member states are formally represented. It should be noted that representation on the Board is not equal; large donor countries have more voting power (Woods, 2000). 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 and private sector representation (Global Fund, 2007). The U.S. government executes initiatives under the direction of the State Department. The State Department is ultimately responsible to the President of the U.S. and Congress. The Gates Foundation, a private initiative, 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.

Methods

Using information gathered from the annual reports and budgets, we created a database of disbursements categorised by financier, priority area, regional focus, type of investment, and type of receiving agency for 2005. We define health financing, to include funding from the four studied agencies that had the improvement of public health as its primary stated goal. Thus, we include within this study funding for vaccines, clinical treatments, improvements in

water and sanitation, emergency relief and public health advocacy. While this method provides a valuable snapshot of global health financing, we recognise that the one-year time period examined, which offers standardisation, does impose a constraint on examining funding. The database is organised in Microsoft Excel and is available upon request.

In total, we considered 1006 grants or loans made by the World Bank (65), the U.S. government (115), the Global Fund for HIV, TB and Malaria (543 payments) and the Bill and Melinda Gates Foundation (283). To classify according to priority area and type of investment, the authors independently categorised according to relevant disease areas and then conferred to reach consensus. For multi-priority grants we divided funding equally across categories. 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.

It should be noted that due to an absence of accessible data on disbursements, for the U.S. government we considered commitments. Disbursements were studied for the other institutions (Table 2). Combining disbursements from the World Bank, Bill and Melinda Gate Foundation and the Global Fund with commitments from the US government in this analysis is problematic, as they are not equally comparable, and the relative lag of commitments to disbursements is obscured (Michaud, 2003).

For each disease grouping, we included morbidity and mortality estimates in low- and middle-income countries according to the Global Burden of Disease Study (Lopez, 2006), with all the limitations thus entailed, and with the following points of clarification. It should be noted that mortality data from the Global Burden of Disease study is for 2001, while disbursements are for 2005. 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. Maternal morbidity and mortality includes DALY burden and death related to maternal conditions and to cervical cancer. This grouping is justified by the merging of these two areas in disbursements from financiers.

We included all grants made through the health sector, and other sectors related to health, which had the improvement of public health as a primary stated goal. 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. Further, there are interactions between categories, as many health interventions are mutually reinforcing. As in the example above, improving the child's nutritional status would decrease the risk for a death from measles. A vaccination campaign would also reduce measles deaths. The mutually reinforcing nature of health interventions has been widely recognised, and this has led many to call for health systems support, and also for 'packages' of interventions, as in the Disease Control Priorities Project. Since categories are not mutually exclusive, there is some double-counting of disease burdens. We control for double-counting of financial commitments by excluding disbursements made from one financier to another. Thus, we excluded US contributions to the Global Fund from the US Government data ($335 million in 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.

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 (Tables 3 and 4, Figures 1 and 2).

Financing of Priority Areas

In 2005, the World Bank disbursed $3.9 billion dollars in both IBRD and IDA loans for health (Table 3 and 4). 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 4). 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).

The U.S. Government committed $3.49 billion dollars through the USAID Bureau for Global Health, PEPFAR, and the President's Malaria Initiative in 2005. The U.S.'s commitments favoured vertical programmes to address HIV/AIDS and malaria (Table 3). 8% of all funding was for abstinence-only programmes (PEPFAR, 2005). 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 (PEPFAR, 2005). These organisations are listed, but no breakdown of how much funding reaches each organisation is made publicly available.

In 2005, the Gates Foundation disbursed approximately $827 million dollars, through 283 grants (Table 3 and 4). 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 disbursed for non-communicable disease and injury, and one grant was disbursed for health systems research. Gates has focused on prevention of disease, with 75.5% of dollars on prevention programmes and research.

In 2005, the Global Fund disbursed $1.05 billion dollars with 543 payments (Table 3 and 4). The investments in HIV/AIDS and malaria are at 56.3% and 29.2% of disbursements, while

the investment in TB is at 13.8% 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.

Comparisons of aggregate spending with mortality (Figure 1) and disability (Figure 2) demonstrate the mis-match between burden of disease 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.

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 standardised. We hope that these findings encourage institutions to fully disclose and standardise the methods of communicating disbursements. We suggest what information a health financing standardisation system should include to be relevant and accessible to policy-makers and researchers. Second, the discussion on priority-setting in global health has focused on technical debate, particularly regarding the DALY (Anand and Hanson, 2004), and has not sufficiently addressed the selection of political priorities, such as the MDGs, which appear to have great influence on health disbursements. Third, there needs to be continual attention to developing country ownership, particularly the need for planning and priority-setting to be driven through country-led processes.

We do not intend to suggest that mortality and disbursements should be perfectly correlated. There are two reasons to expect deviation, one technical and the other political. First, we do not assume 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 (Laxminarayan et al., 2006). Second, we do not assume that international funding should be directed equally at all disease areas. This neglects the comparative advantage of these institutions relative to national governments (e.g. procurement of anti-retrovirals, investment in water and sanitation infrastructure).

No Good Data on Disbursements and Disease-Burden

The task of tracking, then standardising, 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 (Levine and Blumer, 2007). The report, like an earlier report by the RAND Corporation (Eiseman and Fossum, 2005), makes recommendations to improve standardisation 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.

This analysis is based on imperfect and incomplete data on the global burden of disease. We

use DALYs and mortality to consider the match between technical evidence and allocations. These data, as has widely been recognised, are often 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, information is not available on mortality caused directly or indirectly by lack of access to health systems, and thus are unable to consider health system allocations on the same basis in 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 recognised. 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, there is a variable public access to data on the disbursements made by the major global health financiers. While the Global Fund and the World Bank have full data publicly available on disbursements, the U.S. Government and the Gates Foundation do not. However, among the major financiers, there is no standardisation in the organisation of funding data making any analysis of global health funding difficult. Based on this research, we suggest that all health financiers provide data in a standardised format which should include the date and dollar-amount of financial commitment, the organisation to be receiving the funding, the purpose and function of the funding, the date and dollar amounts of financial disbursements, and a notice of any irregularities including withdrawal or decrease in the funding. Such standardisation and transparency may help in facilitating developing country input into health financing as it decreases the uncertainties and confusion about financing which have often stifled this input. We hope that this analysis will lead financiers to challenge our conclusions by making more complete and standardised data available.

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 (Birn, 2005), and the United Nation's Millennium Development Goals, may better explain global health disbursements than technical evidence. It should be noted that the political-technical debate is a false dichotomy as the technical tools for analysis, such as the DALY, are inherently political due to the assumptions they make. Rather than naively calling for a move to reduce the role of politics, we instead call for more attention to be paid to documenting and understanding the politics of decision-making.

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 burden of disease) warrants explanation that has not been offered. Indeed, the difference between political and technical has been muddied 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 (Oxman, Lavis and Fretheim, 2007).

While this observation comes as no surprise to policy-makers working in global health, the rigorous technical debate on priority setting is met with a dearth of knowledge on the creation of political priorities in global health institutions. The DALY has been scrutinised by epidemiologists, economists, and philosophers concerned with equity for the reasons that, if used for policy, the metric would disfavour the disabled and women (Shiffman, 2007, Mont,

2007), and if blinded to socio-economic issues, would not give attention to issues of equity (Anand and Hanson, 2004).

Why are the technicalities of the DALY debated, while the MDGs are taken for granted (Clemens, Kenny and Moss, 2007)? 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 (Kerr et al., 2004; Bass, 2005; McCarthy and Das, 2007; Ollila, 2005), 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 (Shiffman, 2007). 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. The World Bank's new Health, Nutrition and Population strategy notes that its advantage is in infrastructure (which explains the focus on health systems)(World Bank, 2007); for the Gates Foundation, it is technology and innovation (Birn, 2005). 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.

Developing Country Ownership in Health

As noted in the overview, all four financiers do not explicitly incorporate the demands of developing country governments or citizens, or articulate the concept of 'ownership' in priority-setting but rather choose their priority area based on what the organisation defines as important. Even those who point to the inclusive Board of the Global Fund or its Country-Coordinating Mechanism must acknowledge that the priorities of the Global Fund, namely HIV/AIDS, TB and malaria, were built into the mandate.

In non-health sector aid, after many years of debate, there has been recognition of the importance of ownership, as demonstrated by the endorsement of the 2005 Paris Declaration. Ownership was defined in the Declaration as developing countries exercising 'effective leadership over their development policies, and strategies' and coordinating development actions (OECD, 2005)**.** Small steps are being made in this direction in global health. The International Health Partnership (IHP) launched in 2007 by eight donor countries and 11 donor agencies aims to provide better coordination among donors; focus on improving health systems as a whole; and develop and support countries' own health plans (DFID, 2007). Yet, there are concerns that coordination will decrease the policy space of developing countries by shifting the balance of power towards the 'consortium of donors acting in unison,' and thus there could be an inherent contradiction in the partnership (Murray, Frenk and Evans, 2007).

It is time for the global health community to learn from the aid effectiveness debates and move towards incorporating the concept of 'ownership' into health assistance. Without systematic attention to the articulated needs of developing countries, financiers for global health will fall short of informed and inclusive decision-making.

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 (Chen, Evans and Cash, 1999). 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 highly unlikely (Chen, Evans and Cash, 1999; Fidler, 2007). Instead of a grand architecture for global health, our analysis demonstrates a clear role to be played in improving the information gap through a health financing standardisation system, in increasing attention to the politics of global health finance, and in moving towards decision-making based on the articulated needs of developing countries.

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.
2. Scholars and policymakers should seek to explicitly explain deviations from burden of disease in global health disbursements, thus discarding the false pretence of technical neutrality, and explicitly recognising political influence.
3. More space should be created at the global level to incorporate the needs of developing countries and facilitating genuine 'ownership' of the priority-setting process

Table 1: Stated Priorities of Global Health Financiers

Global Health Financier	Stated Priorities
The World Bank	▪ 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	▪ 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	▪ 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	▪ HIV/AIDS ▪ Tuberculosis ▪ Malaria

Table 2: Sources for Commitment and Disbursement Data for Four Financiers

Financier	Source of Data
World Bank	*Commitment data:* Not Available *Disbursement data:* IBRD, IDA loan database, http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/0,,menuPK:115635~pagePK:64020917~piPK:64021009~theSitePK:40941,00.html
Global Fund	*Commitment data*: (http://www.theglobalfund.org/en/funds_raised/commitments/). *Disbursement data:* http://www.theglobalfund.org/en/files/disbursementsindetail_raw.xls
U.S. Government	*Commitment data:* Congressional Budget Allocation, PEPFAR, Global Health Council, (http://www.usaid.gov/policy/budget/cbj2005/, http://www.pepfar.gov/progress/76936.htm, http://www.globalhealth.org/public_policy/funding/ *Disbursement data:* not available
Gates Foundation	*Commitment data:* http://www.gatesfoundation.org/GlobalHealth/Grants/default.htm?showYear=2005 *Disbursement data:* made available by Gates Foundation staff

Table 3: 2005 Disbursements ($ millions), 2001 Deaths (millions), 2001 DALYs (millions) by Disease Area

Disease Group	World Bank (%)	U.S. Government (%)	Gates Foundation (%)	Global Fund (%)	Deaths[1] in Low and Middle Income	DALYs in Low and Middle Income	Total funding per death, dollars
Child Health (excluding vaccines)	140.4 (3.6)	466.0 (13.4)	14.4 (1.7)	0	10.25 (21.2)	132.2	60.5
Child Health (including vaccines)	140.4 (3.6)	570.8 (16.4)	240.9 (29.1)	0	10.25 (21.2)	132.2	92.7
General ID	159.9 (4.1)	230 (6.59)	76.9 (9.3)	0	NA	NA	NA
Global Health Strategy, Partnerships and General Budget	0	96.1 (2.8)	62.5 (7.5)	0	NA	NA	NA
Health Systems	1287 (33.0)	0	0	8.2 (0.8)	NA	NA	NA
HIV/AIDS	202.8 (5.2)	1719 (49.3)	119.3 (14.4)	593.4 (56.3)	2.56 (5.3)	70.8	1029.1
Injury	705.1 (18.1)	0	0	0	4.71 (9.75)	155.9	149.7
Malaria	78.0 (2.0)	156.6 (4.5)	239.7 (28.9)	308.2 (29.2)	1.21 (2.5)	39.9	646.7
Maternal Health (including family planning)	187.2 (4.8)	406.1[2] (11.6)	29.6 (3.6)	0	0.73 (1.5)	26.4	853.28 / 295.9 excluding FP
NCD	83.5 (2.1)	0	0	0	26.03[3] (53.8)	678.8	3.2
Nutrition	74.1 (1.9)	29.7 (0.9)	15.7 (1.9)	0	5.89 (12.2)	29.6	20.3
Polio	51.7 (1.4)	127.3 (3.6)	35.1 (4.2)	0	0[4]	0	> 1 million
TB	3.9 (.1)	124.0 (3.5)	41.9 (5.0)	146.1 (13.8)	1.60 (3.3)	35.9	197.8
Vaccines (excluding specific disease areas above)	0	104.8 (3.0)	191.4 (23.1)	0	1.48 (3.1)	43.2	200.1
Water and Sanitation	854.1 (21.9)	0	0	0	1.78 (3.7)	58.7	479.8
Total	3823.9	3490.1	826.7	1055.9			

[1] Mortality and DALY figures from Global Buren of Disease (2006) pp. 445, 448 respectively

[2] Note that this entire sum was for family planning

[3] See GBD (2006), 10 for all deaths due to child and maternal under nutrition as a risk factor

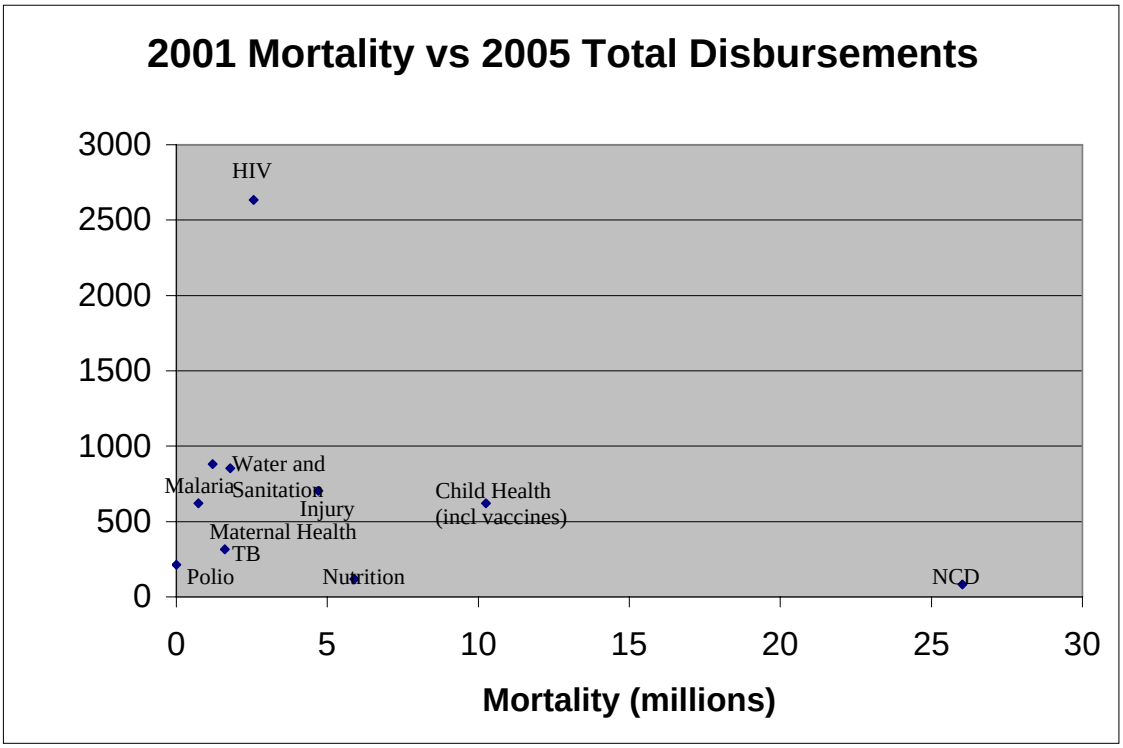
[4] In 2001, there were no reported deaths due to polio in low- and middle income countries, and one death in high-income countries, according the Global Burden of Disease (2006), 445

Table 4: 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: ~5, Service: ~95	Research: 60.6 Service: 33.5 Both: 3.5 NA: 2.3	Research: 0 Service: 100
% of Funding to Prevention v. Treatment	Prevention: 77 Treatment: .1 Both: 22.9	Not specified, but for PEPFAR ~30 for prevention and ~70 for treatment	Prevention: 75.5 Treatment: 5.9 Both: 16.2 NA: 21.3	Funding integrated; not specified
Region of Recipient Agency	SSA, SA, SEA, and L. America, Caribbean, Central Asia, Middle East, N. Africa	Sub-Saharan Africa	North America and Western Europe	Sub-Saharan Africa
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	$3.8 billion	$3.5 billion (Commitment)	$827 million	$1.05 billion
Total Endowment/ Commitment	NA	$46.2 billion	$67 billion[5]	$10.4 billion

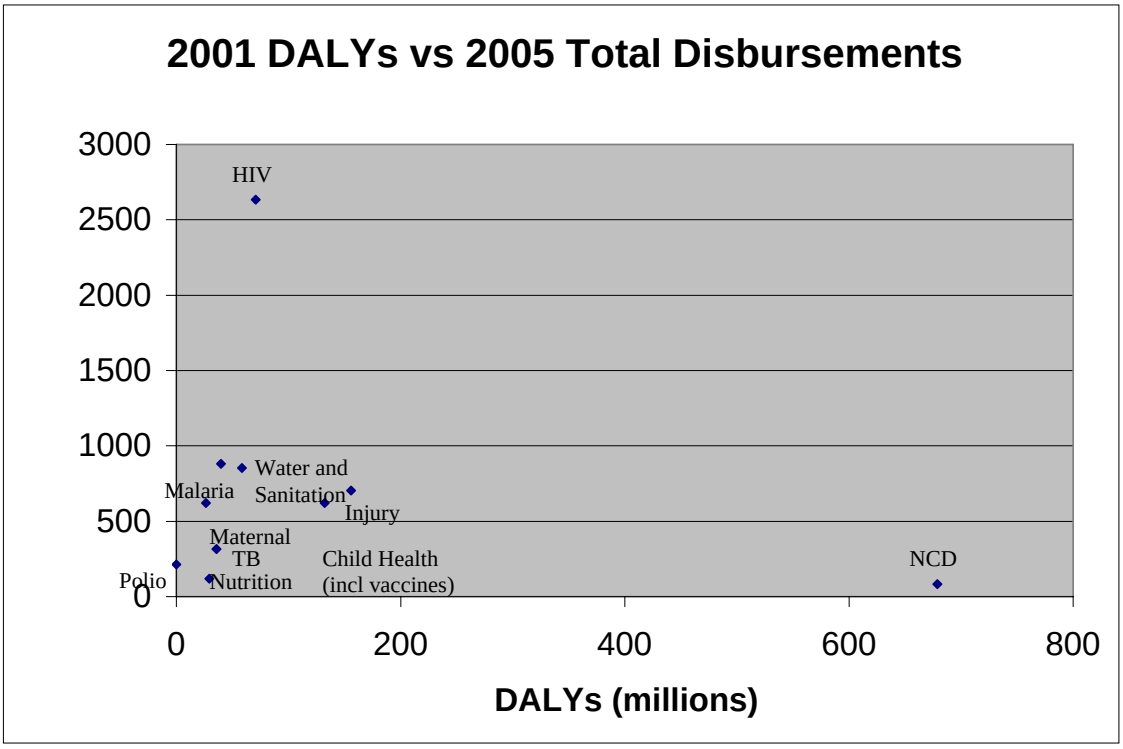
[5] Pending transfer of Warren Buffet's pledge to the Bill and Melinda Gates Foundation

Figure 1: 2001 Mortality (millions) vs. 2005 Disbursements of World Bank, U.S. Gov, BMGF, GFHTM (millions of dollars)



Note: Health systems funding cannot be graphed as there is no reliable measure of mortality and disability due to a lack of a good health system. The omission of health systems funding excludes approximately 1/3 of all World Bank disbursements from Figures 1 and 2.

Figure 2: 2001 DALYs (millions) vs. 2005 Disbursements of World Bank, U.S. Gov, BMGF, GFHTM (millions of dollars)



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