Who pays for cooperation in global health? A comparative analysis of WHO, the World Bank, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance

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In this report we assess who pays for cooperation in global health through an analysis of the financial flows of WHO, the World Bank, the Global Fund to Fight HIV/AIDS, TB and Malaria, and Gavi, the Vaccine Alliance. The past few decades have seen the consolidation of influence in the disproportionate roles the USA, UK, and the Bill & Melinda Gates Foundation have had in financing three of these four institutions. Current financing flows in all four case study institutions allow donors to finance and deliver assistance in ways that they can more closely control and monitor at every stage. We highlight three major trends in global health governance more broadly that relate to this development: towards more discretionary funding and away from core or longer-term funding; towards defined multi-stakeholder governance and away from traditional government-centred representation and decision-making; and towards narrower mandates or problem-focused vertical initiatives and away from broader systemic goals.

Introduction

Whether it is confronting and containing an Ebola outbreak originating in Guinea or a Zika outbreak originating in Brazil, deploying vaccines to rural India, or getting insecticide-treated bednets to Malawi, governance matters. It is through institutions that nations have long organised and focused efforts to protect and improve the health of their citizens. Today, however, health governance has gone global. Global governance is formally conducted by and across national governments and non-state actors through international institutions, underpinned by both financing to enable them to fulfil their missions, and rules to structure interaction.

Key messages

1. Three major trends in global health governance over the past two decades have been: towards more discretionary funding and away from core or longer-term funding; towards multi-stakeholder governance and away from traditional government-centred representation and decision making; and towards narrower mandates or problem-focused vertical initiatives and away from broader systemic goals sought through multilateral cooperation.
2. These shifts are reflected in the creation of partnerships such as the Global Fund to Fight HIV/AIDS, TB and Malaria and Gavi, the Vaccine Alliance, as well as in the increased voluntary contributions to WHO and the World Bank. These mechanisms allow donors to finance and deliver assistance in ways that they can more closely control and monitor at every stage.
3. WHO's volatile financial state is a reflection of a lack of donors' trust in the agency. Reform should focus on improving the agency's relationship to monitoring and accountability through addressing membership, including voting rights for non-state actors, and transparency to the public and member states.
4. The past few decades have seen the consolidation of influence across three of our four case study institutions in the roles the USA, the UK, and the Bill & Melinda Gates Foundation have all had in financing. Despite a proliferation of initiatives in global health, much of the financing for global cooperation comes from a few powerful donors.

The essential functions of health governance, which historically have been the purview of the WHO and its governing board, and now are stretched across a broader spectrum of actors, include: convening key stakeholders, defining shared values, establishing standards and regulatory frameworks, setting priorities, mobilising and aligning resources, disease surveillance and health emergency and outbreak response, and promoting research and development.[1] All of these functions are crucial to mounting responses to prevent and treat infectious diseases and non-communicable diseases (NCDs) alike.

To understand institutions means delving into how they are governed, how they make decisions, and how they are financed. In this Health Policy report, we take a closer look at WHO, the chief coordinator and director of international health within the UN, and compare its financing and governance with three of the most important global institutions, as determined by resources commanded and disbursed (figure 1): the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance.

We focus on three research questions: how are WHO, the World Bank, the Global Fund, and Gavi financed? How does their financing possibly affect their agendas? And third, what explains the financing flows and new governance of global health? To answer the first question, we rely on data from each institution itself as well as data aggregated by the Institute for Health Metrics and Evaluation at the University of Washington (IHME).

For the second, we look for evidence as to how changes in financing flows have affected the institutions' agenda over time. Finally, we offer our own thoughts and reflections about what explains these various shifts and what this means for the future of WHO.

Financing WHO

In 1948, WHO was established "to direct and coordinate" international public health efforts as a normative and technical agency.[3] WHO receives funding from two tranches: assessed contributions from its 194 member states (previously called regular budget funds) and voluntary contributions (previously called extrabudgetary funds) from its member states, philanthropic foundations, corporations, non-governmental organisations (NGOs), and private individuals.[4] The former are the monies WHO has full discretion to use as its leadership decides, and the World Health Assembly (WHA), a body comprised of all its member states, approves. In practice, core funds are used to support the administrative costs of running WHO and programmes that might not have received funding through other channels. Individual states' membership dues are calculated in conjunction with WHO's biennial budget process and based on the UN's standard scale of ability to pay as determined by a country's gross national product (ie, size of economy) and population.

In 1980, the WHA voted to freeze its membership assessments in real dollar terms; in other words, only inflation and exchange rates would affect membership assessment adjustments.[5,6] This change took effect with the 1982–83 budget. Throughout the 1980s and 1990s, the failure of member states to pay even their frozen levels of contributions presented a big challenge for WHO. The USA in particular withheld funds, a move largely interpreted as expressing dissatisfaction with WHO's list of essential medicines,[7] in line with public opposition from US pharmaceutical companies.[5,8] In 2014, the collection rate was 86% across members.[9,10] WHO has little leeway to force states to pay even their membership dues; loss of voting rights is the most extreme step it can take, but this approach is rarely taken unless a state is in significant arrears.[11]

A larger challenge for WHO has been the steady rise of extra-budgetary funding as a percentage of the WHO's overall budget, steadily approaching 80% (appendix p 3). Over time, the rearrangement of WHO's priorities to align with funds was inevitable, with donors earmarking 93% of voluntary funds in the 2014–15 budget.[12–14] Influence is heavily concentrated among the top donors (figure 2).[14] Undeniably then, a direct link exists between financial contributions and WHO focus.

Financing the World Bank

Alongside using voluntary contributions as a mechanism of control over WHO activities, donors also turned to other institutions, first the World Bank and then later

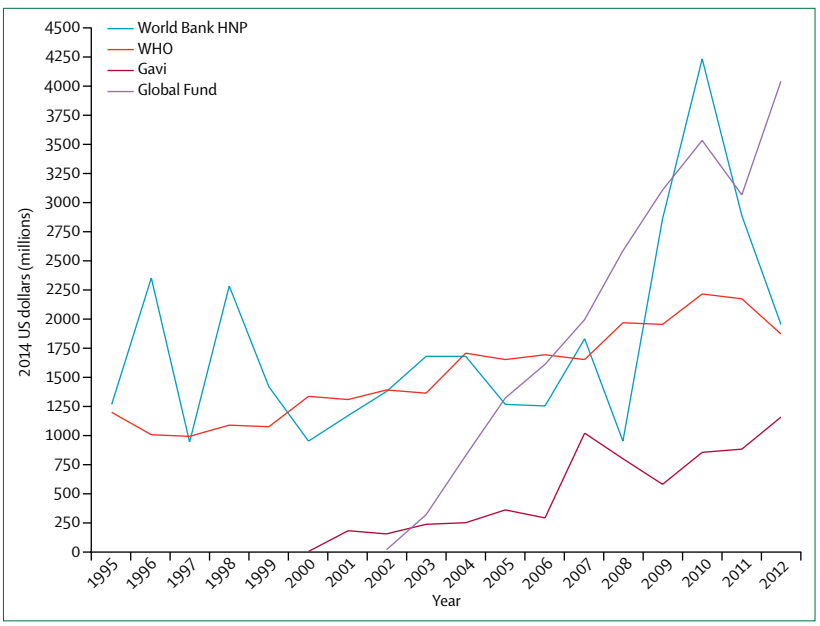

Figure 1: **Annual Disbursements for the WHO, World Bank HNP, Gavi and the Global Fund 1995–2012**
Data from Institute for Health Metrics and Evaluation.[2]

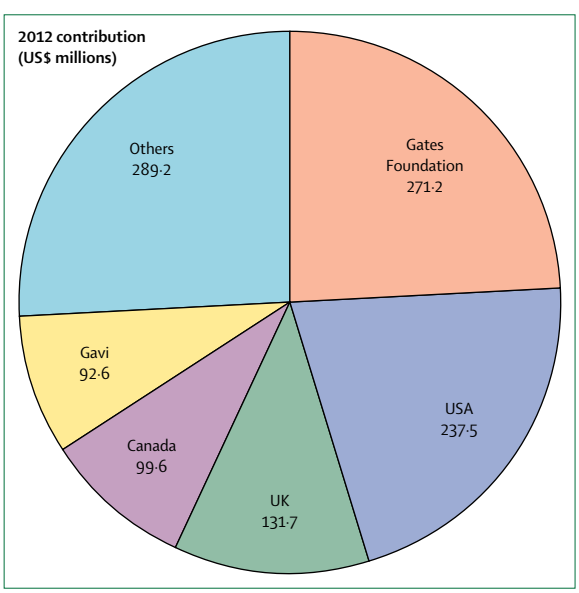

Figure 2: **Main contributors to the WHO in 2012**
Data from Institute for Health Metrics and Evaluation.[2]

See Online for appendix

Gavi and the Global Fund, to further exert influence in global health and over their use of funds. In the past 40 years, the World Bank has become increasingly important in health through its lending for health-related projects, and its role as an advisory body, an intellectual research institute, and a training centre for developing country civil servants.[15] The Bank's legacy in health is controversial in view of its former support of structural adjustment and user fees, which the current Bank President Jim Yong Kim has recanted.[16] However, within

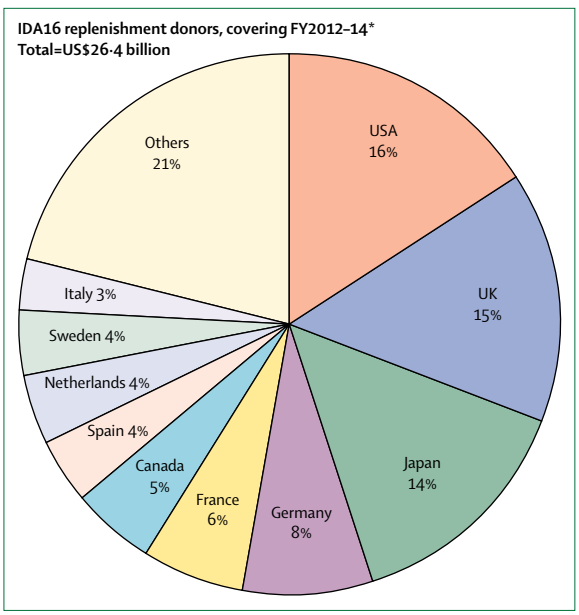

Figure 3: **Main donors to the World Bank IDA replenishment FY2012–14**
Data from World Bank.[20]

the Bank, health itself claims a relatively small share of attention. For its 2014 fiscal year, loans in the health and other social services space stood at less than US$3·4 billion, out of a total loan pool of more than $40·8 billion.[17,18] Health loans accounted for less than 10% of the Bank's portfolio that year, barely edging above 8% of total loan volume.

From 1990 through 2011, the World Bank, according to its own data,[2,17] disbursed close to $20 billion in grants and loans throughout its health, nutrition, and population portfolio. When a broader definition of health is used (eg, inclusive of HIV/AIDS), $33·8 billion over the same period in loans and grants was disbursed, plus $2·8 billion of in-kind support.

The World Bank generally refers to the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA), the two largest parts of the Bank. The IBRD is funded by capital contributions from its members and is effectively owned by its 188 member states. As votes are allocated based on capital subscription, there is clearly an incentive for member states to meet, and even seek to increase, their capital commitments. This pressure is evident in the recent intransigence of the US Congress to cede a portion of its current 16·1% voting share (which allows it to effectively block any decision it does not agree given most of the Bank's key decisions require 85% of all votes outstanding to approve) and in China's efforts to invest more into the Bank to gain a commensurate rise in voting power. However, most of IBRD's funding comes from the issuance of World Bank bonds that are sold into capital markets across the world. However, in view of the broad market for such bonds, it is the capital contributors, not the bondholders, who exert more influence over the Bank's agenda.

By contrast, IDA is funded by replenishments, or donor commitments made at specific intervals, generally every 3 years. Since its launch in 1960, IDA has convened 17 replenishment meetings, securing increasing IDA commitments from World Bank members almost every round. Only Bank members can contribute to IDA; for example, there is no mechanism for the Gates Foundation to contribute to IDA, although the Gates Foundation and others have invested alongside IDA in health-related areas, for example in polio eradication.[18] IDA's first replenishment raised $750 million, with the USA accounting for more than 40% of total funds pledged. In 1984, in advance of IDA's 17th replenishment, the USA said it would not account for more than 25% of IDA at any point in time, in line with similar arguments expressed throughout the UN system, including at WHO.[19] While the World Bank convenes the replenishments, in practice, they are overseen by donors, not the Bank or IDA recipients. Looking at the 16th replenishment provides a more complete picture of IDA donors (figure 3). It is clear a finite number of donors account for most of IDA's coffers, and it is a similar list to those most prominent to WHO's budget.

However, unlike with WHO, evidence is scarce of greater donor control in the patterns of IBRD and IDA funding—or in how the Bank then chose to allocate those funds. In fact, it is only through trust funds that donors can earmark funding for specific uses; in 2012, roughly $5 billion, or more than a third of donor contributions were earmarked.[21] Trust funds are a financial arrangement set up with contributions from one or more donors and in some cases from the World Bank Group itself for a particular purpose. A trust fund can be country-specific, regional, or global in its geographic scope, and it can be stand-alone or integrated into a programme.

Financing the Global Fund to Fight AIDS, Tuberculosis and Malaria

A core difference between the so-called "old" institutions, WHO and the World Bank, and the "new" ones, the Global Fund and Gavi, is the latters' focused mandates. The Global Fund is a financing mechanism targeting efforts to end HIV/AIDS, tuberculosis, and malaria while Gavi also marshals funds toward a goal of equitable access to vaccines for children living in the world's poorest countries. Unlike WHO or the Bank, the Global Fund relies entirely on voluntary contributions. Even for its de-facto permanent Board members, like the USA, China, and the Gates Foundation, there is no formalised expectation of funds contributed annually. Similar to IDA, the Global Fund relies on replenishment as its main fundraising mechanism. At replenishment time the donors alone take centre stage. Aside from the Gates Foundation, the composition of the Fund's major donors closely resembles IDA's major donors (figure 4).

In its first 13 years, the Fund received $29·6 billion in financial contributions, with $27·9 billion coming from donor countries, including both board members and non-members, and from a small number of implementing countries largely through debt swap arrangements with donor governments. These were not common arrangements, accounting for less than 0·3% of total funds over the period.[22] When swap agreements were struck, donor governments would forgive part of a loan repayment if developing countries would invest a commensurate amount in Global Fund grant arrangements in their countries. Through the end of 2013, the Fund had received $75·8 million from five swap agreements across four implementing countries and two donors. For purposes of our analyses, we include those debt swap arrangements as donor contributions under the relevant donor. As was true for many public health concerns in the early 21st century, the only significant non-bilateral donor to the Fund was the Gates Foundation. The Gates Foundation donated more than $1·1 billion to the Fund in its first 13 years, accounting for two-thirds of all non-bilateral funds the Global Fund received over that period.[22]

From 2000–13, bilateral donors accounted for 94·3% of the monies the Global Fund raised.[22] Unlike the World Bank's IBRD or Gavi, the Global Fund Board never seriously considered and certainly never approved raising funds through the capital markets.[23] Neither did the Global Fund Board ever decide, despite significant debates inside the Board and outside the Fund, to introduce expected contributions levels from donor countries.[24] Additionally, the Board's inability for much of its first decade to establish protocols for accepting in-kind donations because of generic market concerns might also explain why private support never materialised at substantial levels.[25] Yet even for WHO, which has long-standing protocols governing in-kind donations, such donations have never proven meaningful as a percentage of budget.

Irrespective, the Global Fund funding base is similar to the WHO and the World Bank's IDA. The USA in particular has strong presence on the Global Fund Board, and in its coffers. Most years, America has accounted for a third of the Fund's total received contributions, and is not a passive or quiet investor. For years now, following every Global Fund Board meeting, the USA publishes its points of view on Board decisions and debates. Analysis of every such document through the first 28 Board meetings, against the Board decision points, yields few disagreements and no significant ones between the decisions of the Global Fund Board and the organisation's largest funder.[26] The USA also directs members of its UN Mission in Geneva, Switzerland, to liase directly on its behalf to the Global Fund. The greater density of interactions that probably result from such an arrangement might help to explain the congruence between the Fund and the USA, a dynamic amplified by the more frequent meetings that Global Fund donors have often held between Board meetings than have implementing countries (the Fund's terminology for recipient countries) or civil society organisations involved with the Fund, including those that serve on its Board.[27] Alternatively, the explanation could lie in the dependence of the Fund on US funds. Looking solely through a financing lens, it is clear that donors, and notably the Fund's largest donor the USA, work hard to ensure their voices are coordinated when possible and heard well beyond the boardroom.

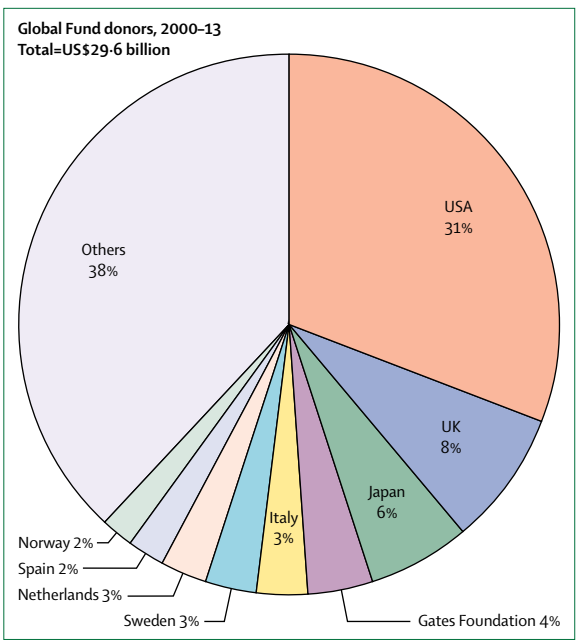

Figure 4: **Main contributors to the Global Fund 2000–13**
Data from The Global Fund.[22]

Financing Gavi, the Vaccine Alliance

Gavi, and particularly the Global Fund, benefited from the robust development assistance for health environment coincident with their first years (what IHME termed the Golden Age).[28] Although Gavi raised much smaller amounts than the Global Fund, its experience of how it raised those funds contrasts sharply—even if the source of those funds does not differ. Unlike the Fund and World Bank/IDA, Gavi came relatively late to replenishment as a means to marshal donor funds. Before its first pledging conference in June, 2011, all donor contributions to Gavi were made on an ad-hoc basis.

Through December 2013, Gavi received $8·3 billion in direct donor contributions (figure 5). Its most significant source of funds by far was the Gates Foundation, which contributed $2·1 billion. Notably, the Gates Foundation's contributions were effectively synonymous with non-bilateral support. Contributions from the Gates Foundation, both through direct unconditional funds and through matching funds, comprised 97% of non-governmental and non-intergovernmental (eg, the OPEC

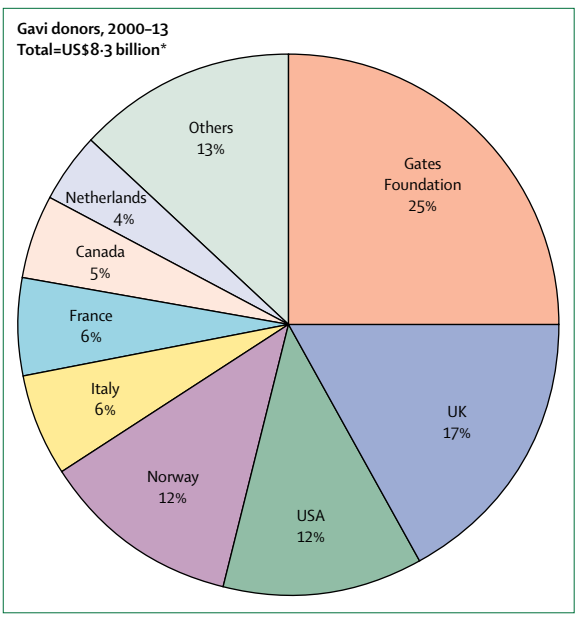

Figure 5: **Main contributors to GAVI 2000–13**
Data from Gavi, The Vaccine Alliance.[29]

Fund and the European Union) support.[29] Yet the Gates Foundation's support, and by extension non-bilateral support, became less important on a percentage basis in Gavi's early second decade than had been true in its first 10 years.

Additionally, one of Gavi's innovative mechanisms accounted for an additional 15% of the monies raised in its first 13 years. Gavi received $1·24 billion from the International Financing Facility for Innovation mechanism, which effectively securitises long-term pledges from bilateral donors, converting the pledges into usable cash resources by selling bonds in the capital markets. Through the end of 2013, the UK, France, Sweden, Norway, the Netherlands, Spain, Italy, and South Africa had provided support to Gavi through the purchase of long-term International Financing Facility for Innovation mechanism bonds. Collectively they had pledged $6 billion over 20 years that had translated into $4·5 billion of bonds sold.[29] In the same period, Gavi raised $581·8 million through the Advance Market Commitment, a mechanism through which donors committed to purchase new pneumococcal vaccines at a price that covers development costs and provides some profit for the drugs' manufacturers with the provision that they only be distributed in low-income and middle-income countries.[30–32] The donor composition for the Advance Market Commitment differs slightly from that of Gavi as a whole, with Italy accounting for more than 40% of total Advance Market Commitment-related funds through early 2015.[33]

Still, for all of its mobilisation of funds through innovative mechanisms and the strong, even foundational support of the Gates Foundation, Gavi is largely dependent on a conventional bilateral donor list and is even more dependent on the Gates Foundation than the Global Fund is. Gavi and the Fund are hardly alone in continuing to rely on bilateral donors. Even the International AIDS Vaccine Initiative and related HIV/AIDS-vaccine initiatives are largely funded by governments, despite the strong business case for the private sector investing in this work; 83% of aggregate funding for a HIV/AIDS vaccine in 2011 came from the public sector, 13% from the philanthropic/foundations sector, and only 4% from the private sector.[34]

It is harder to discern the likely influence at Gavi as neither the Gates Foundation nor the UK or the USA, the three largest donors to Gavi, publish their views on Gavi Board decisions in the way the USA does after Global Fund Board meetings. This decision by donors not to publish their views might be because of the strong influence they exert quietly, or because Gavi conforms to the views of its donors, especially the Gates Foundation, have for it. Additionally, Gavi has long provided support to its developing country Board members to meet before Board meetings, investments the Global Fund started only to make more recently. We are unable to discern whether such facilitation might have led to a greater harmonisation of interests across diverse constituencies, or convergence to donor preferences.

Why has so much investment been made in the new partnerships, and why are the four institutions financed in this way?

The move towards the partnership model in global health and voluntary contributions to WHO and the World Bank allows donors to finance and deliver assistance in ways that they can more closely control and monitor at every stage. The shift towards partnerships like the Global Fund and Gavi illustrates three major trends in global health governance more broadly: towards more discretionary funding and away from core or longer-term funding; towards multi-stakeholder governance and away from traditional government-centred representation and decision-making; and towards narrower mandates or problem-focused vertical initiatives and away from broader systemic goals sought through multilateral cooperation.[35]

By using financing and governance mechanisms within the old institutions, as well as by creating new agencies, donors can more likely achieve their goals for a few reasons. First, they have structurally aligned the objectives of global agencies with their own objectives. Individual governments (or small groups of governments and like-minded others) can use new funding mechanisms, agencies, or initiatives as a way to define and pursue a separate mandate, for example with HIV/AIDS (appendix pp 1–3).

Second, funders have created and enforced incentives for performance. As already mentioned, governments and other donors can use budget as rewards and

punishments in their attempts to induce international institutions to achieve particular outcomes. This approach has taken two forms: an increase in discretionary contributions to conventional multilateral organisations (as seen at WHO) while not increasing core budget support; and the establishment of new organisations funded through a replenishment model (as seen with the Global Fund and Gavi). Additionally, from inception, the Global Fund has linked grant performance to fundraising.[36] Gavi also has long promised results as proof of concept to its donors.

Third, donors have more directly reduced the technical knowledge gap between themselves and the global health institutions they support. In WHO and the World Bank, it is the senior management of the organisation who present proposals to the Board, thus ensuring that the management and staff of the organisation retain considerable influence and agenda-setting power (even if they are unable secure the funds for this agenda). By contrast, the decision-making Boards of the Global Fund and Gavi instead take advice from panels composed of independent experts that make recommendations to them directly (at Gavi the Independent Review Committee recommendations go first to the Chief Executive but then are passed along to the Board).

Fourth, key donors can more closely monitor what global agencies are doing. As technology has enabled closer monitoring (at least in theory), this has become a major preoccupation of donors in recent years, placing emphasis on organisations providing results through results-based management systems, comprehensive results frameworks, an increased use of evaluations (both independent and in-house), and increasing transparency for donors and the public. When contrasted to the Global Fund and Gavi, the World Bank and WHO look particularly difficult to monitor: for example, their activities are broader and more diffuse, their budgets are more complex, and their regional and country offices make complete oversight impossible. By contrast, the Global Fund provides detailed financial information about its grant commitments and disbursements, donor pledges and contributions, and, importantly, grant progress reports. It also discloses the independent Technical Review Panel recommendations and then Board decisions. Additionally, most major donors have people on the ground in countries receiving funds from the Global Fund who at times are members of the country coordinating mechanisms charged with overseeing grant implementation. This approach translates into more real-time monitoring for certain donors than even the Global Fund Secretariat could claim. Gavi has a Transparency and Accountability Policy that governs the management of all cash-based support to Gavi eligible countries and similarly discloses all Independent Review Committee recommendations and Board decisions related to Gavi applications and approved grants. Donors have pushed the World Bank in this direction. For example, in 1993 the Board, driven by the USA, created the Independent Inspection Panel: an institution investigating Bank decisions and actions and reporting directly to the Board.[37,38] This setup is similar to what the USA pushed for, and achieved, 15 years later with the introduction of the Inspector General at the Global Fund and what we, and others, have recommended, without successful adoption, for WHO.[39]

Effect of financing flows on global health

The irony that our analysis brings to the fore is that states form and join global institutions such as WHO recognising the need for collective action that does not always mesh with their own individual national interests. Yet, as the shifts in global governance over the past two decades show, they largely resist providing the adequate support and investment necessary for the institutions to succeed on delivering against collectively determined priorities.

Three important risks emerge from varied, and unpredictable, financing flows.[35] A first concern is normative. Critics allege that global health pursued through coalitions of the willing (either in vertical initiatives or in discretionary special funds in international organisations) impose the priorities of powerful donor states and philanthropic organisations on poorer countries, whose populations have little recourse to demand accountability or to affect these priorities in view of their inability to contribute funds or affect donor decision making.

A second concern is efficiency.[35] The risk is that the new health funding approaches might be creating mechanisms that encourage donors to favour short-term priorities, even important ones, over longer-term public health goals: the rationale for creating WHO was to ensure that nations would "compromise their short-term differences in order to attain the long-run advantages of regularized collaboration on health matters".[40]

A third consequence of the shifts in global health financing and governance is the consequent erosion of and underinvestment in important capacities in global public health. For example, the knowledge and information derived from global monitoring today to help plan for and prevent epidemics and other health crises in the future, historically the purview of WHO. The dissipation of donor support for WHO broadly, and in these areas specifically, led to the now well-documented collapse in funding for its pandemic preparedness and response functions.[41] Global monitoring can be a casualty of the new health funding if real or perceived donor influence erodes the capacity of multilaterals effectively to monitor and disseminate information. The impartiality of the international agency pooling information is vital for monitoring. Countries need to trust an international agency to give it information and to respect the integrity of the information it, in turn, provides its members.

The chronic underinvestment by donors in health systems relative to other priorities provides our second example here.[42] Donors have been reticent to invest significantly in what is broadly known as health systems strengthening, either through traditional multilaterals, vertical funds, or their own bilateral mechanisms, despite the broad-based recognition that health systems are vital to achieving durable progress in vertical and horizontal prerogatives alike. This reticence is also there for the monies needed to invest in building core capacities to prevent, detect, and respond to new infectious disease outbreaks.[43] Not until 2012 did donor funds targeting health systems broadly surpass $2 billion per year, a level it stayed above in the subsequent 2 years.[42] In 2014, the USA was the largest provider of development assistance for health in this arena at $425 million. These are not insignificant sums on an absolute basis although they are significantly lower than the almost $36 billion in development assistance for health disbursed in 2014 or the more than $14 billion through bilateral and multilateral channels, such as the Global Fund, given to fight HIV/AIDS, tuberculosis, and malaria. The relative sense of priorities is clear although we acknowledge that some of the rationale for these trends is donor mind-set that countries should finance health systems through domestic sources.

On a more positive note, the new health funding has filled historic underinvestment in other areas (eg, HIV/AIDS throughout the 1980s and 1990s with the Global Fund) or regained recently lost ground (eg, with vaccines in the 1990s through Gavi). They have encouraged social mobilisation and strong civil society participation at all levels from the boardroom to the field. Further, new mechanisms have focused attention on how and where more traditional international organisations, such as the World Bank and WHO, might do better, while also maintaining pressure on the Global Fund and Gavi to live up to their founders' expectations, including their nimbleness to reform when necessary. Additionally, it is conceivable that the greater control donors have over their funds and the heightened ability to monitor how those funds are used have led to more funds being contributed, funds that otherwise might not have gone to global health at all.

The future of global health governance

In terms of the future of global health governance, WHO's volatile financial state is a reflection of a lack of trust in the agency. The agency's reform agenda proposes broadening the funding base by attracting donations from foundations, emerging economies, and the private sector. Although worthwhile, these stakeholders are unlikely to behave differently than traditional donors, and will prefer to control their funds through earmarks, especially if they are not offered a meaningful say in how their funds will be used. Moreover, reliance on philanthropic and corporate funding further opens the agency to the charge that it is not fully independent. The Global Fund's experience shows that hoping for and even investing in recruiting broad private sector and philanthropic support does not necessarily yield substantial financial support.

Rather than simply asking for more money, the agency needs to work toward a new deal with donors. In return for flexibility and predictability, the agency would scale back on activities agreed by the Executive Board so that it focuses on making gains where it has unique comparative advantage in global health today and not working in areas where it does not.

Additionally, membership, including voting rights, and transparency, which both tie into monitoring and accountability, needs to be explicitly addressed. Because non-state actors have not been given a voice within WHO, they have redirected their energies elsewhere. This process has hollowed out WHO, as resources and influence move to partnerships such as the Global Fund and Gavi where non-state actors have more input. The World Bank recognised this problem and launched the Civil Society Forum, convened in advance of its Annual Spring Meetings every year.

Transparency is also key. Stakeholders demand clarity on how their resources will achieve improved health outcomes. Yet, an independent evaluation graded WHO as weak on key parameters, such as cost-consciousness, financial management, public disclosure, and achievement of development objectives.[44] The 2011 reform agenda promised to establish independent evaluations of WHO's work.[45] This would then be in line with the independent evaluations the Global Fund has periodically both commissioned and participated in, as well as the increasing openness of both Gavi and even the World Bank, around the grants and loans each finances. For example, in 2010, the Bank introduced a formal access to information policy which detailed that information would be disclosed unless it is on the policy's exceptions list.[46,47] Additionally, the Bank publishes extensively on the results of its programmatic investments, certain internal assessments, and through the Bank's Independent Evaluation Group. WHO has not yet introduced regular independent evaluations or a public information policy.

Conclusion

The past few decades have seen the consolidation of influence across all four of our case study institutions in terms of the roles that the USA, UK, and the Gates Foundation have all had. This consolidation is clearly evident in the creation of Gavi and in the disproportional role each have from a financing perspective in Gavi, the Global Fund, and WHO. Additionally, the Gates Foundation has changed how institutions are held accountable, given that it is a philanthropic body substantively different from government representatives. The persistence of a small group of funders to the World

Bank's IDA raises concerns that the institution is also beholden to a small number of donors. The large part the Gates Foundation plays in global health makes it imperative that all four major global health institutions engage with it. It continually puts pressure on performance and results, and when unhappy, pushes for quick reform in whatever ways that it can, including withdrawal or provision of funds.

How institutions maintain autonomy and discretion when relying entirely or mainly on voluntary donor commitments is a key question, particularly as we look to more diagonal interventions complementing developing country governments' own efforts rather than vertical interventions funded by donors alone. Additionally, recent trends suggest that the monies available for global health will decease as limited growth has come to characterise development assistance for health.[48] In this environment of limited funds and competing priorities, it is now more important than ever for attention to be paid to what institutions global health donors are willing to pay for, for what reasons, and with what broader consequences.

Contributors

Both authors contributed equally to the design, data collection, analysis, interpretation and writing of the report.

Declaration of interests

CC discloses that the Clinton Health Access Initiative (CHAI) has worked with the Global Fund as well as served on a few Country Coordinating Mechanisms for Global Fund grants and additionally has worked with the World Bank on health systems strengthening and rebuilding, among other areas, and also has had various interactions with WHO and Gavi. DS declares no competing interests.

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