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# Trojan Multilateralism: Global Cooperation in Health

Devi Sridhar and Ngaire Woods
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# Trojan Multilateralism:

# Global Cooperation in Health

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# Abstract

This paper argues that recent global health cooperation has been marked by two trends. First, there has been a highly successful proliferation of vertical funds to fight specific diseases. These are characterised by narrower problem-based mandates; multi-stakeholder governance; voluntary and discretionary funding; no in-country presence for the delivery of assistance; and an output-based legitimacy (based on effectiveness, not process). The rise of new initiatives with these characteristics has dovetailed with an increase in the funding of international organizations. However, the latter has not necessarily strengthened multilateralism. Instead rapid increases in discretionary earmarked funding to the WHO and World Bank, which we call Trojan multilateralism, has replicated features of the vertical funds. With what consequences for international cooperation? Using principal-agent theory, we find a mixed picture. International organizations are being redirected by specific incentives. However, two constraints on bilateral control are not shifting. There is a persistent asymmetry of information between the WHO or the World Bank and individual member states which gives the former a degree of autonomy. Equally, there are persistent obstacles to tightening bilateral monitoring of multilateral action. We conclude that the positive lessons to be drawn from vertical initiatives need to be balanced by the risks posed from a convergence of vertical initiatives and Trojan multilateralism

## Policy Implication

There are several policy implications from this analysis. Donor governments are rightly attracted by the model of vertical funds which can deliver clearly measurable outcomes and do not require long-term funding commitments. However, they must now properly identify the ways these funds rely upon wider elements of global health cooperation (including global regulation, monitoring, and crisis management) and ensure that their funding is aimed at both sets of goals. The senior management in international organizations need to use their autonomy and more robustly demonstrate and make the case for how and why governments should support 'core' global cooperation rather than being lured yet further into the shorter-term, issue-specific interventions. Finally, countries in receipt of the new global health funding, need more strongly to identify and express their own health priorities, and to build health strategies which prioritize the building of their own effective health systems.

# Introduction

International cooperation in global health seemed to increase markedly during the decades up to 2010 (IHME 2010). Widespread popular concerns about HIV/AIDS, maternal mortality, and the H1N1 or avian flu pandemics brought more money and new mechanisms of delivery into global health. New 'vertical' initiatives in health proliferated, offering a powerful complement to traditional multilateralism. Focussed on narrow goals, mobilizing a variety of stakeholders, and delivering through a light management structure, the Global Fund and GAVI demonstrate what vertical funds can do. Meanwhile, the multilateral infrastructure of global health cooperation – delivered by the WHO and the World Bank - has also enjoyed an increase in its funding.

On the face of it, then, global health cooperation has enjoyed a couple of decades of strengthening. There is however another possibility. It could be that the new and successful vertical initiatives have created a model which is tempting powerful states to import a new and greater control into traditional international organizations. Rather like the Greeks who built the famous Trojan horse as a stratagem to gain entry into Troy, wealthy governments might be using their 'gifts' to multilateral organizations to further more purely bilateral initiatives.

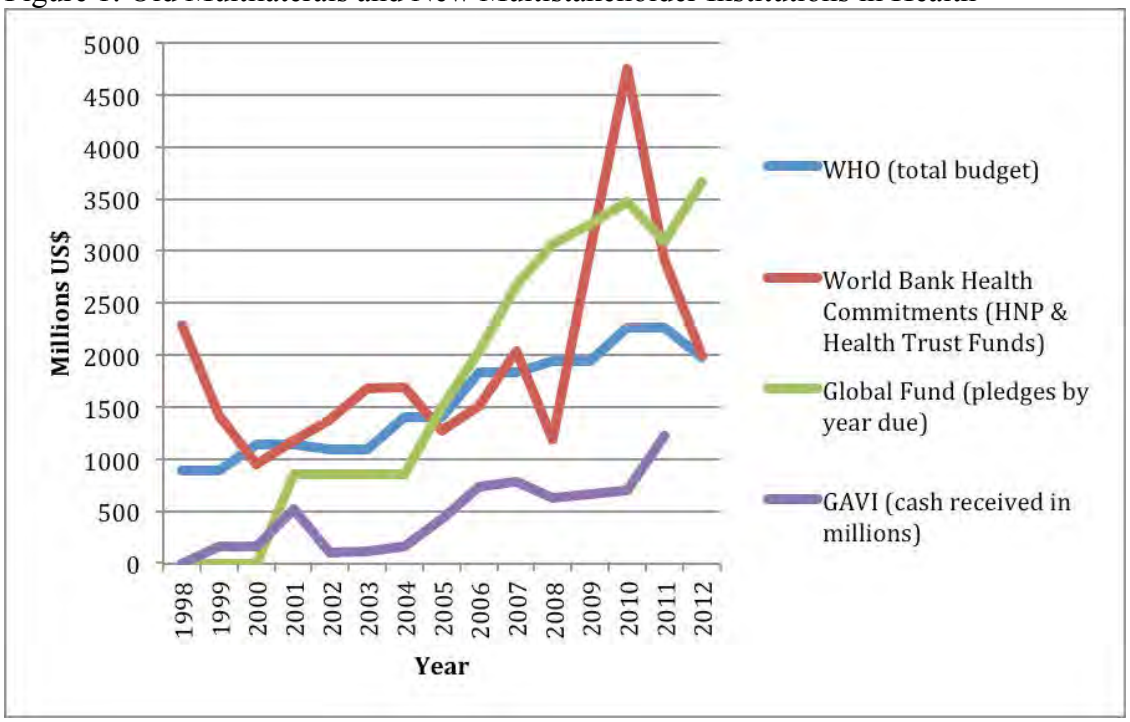
The special influence of powerful states has, of course, always been a feature of international organizations. This paper investigates whether an increasing intensity of such influence is being introduced in global health cooperation. It is worth briefly defining our terms. Multilateralism describes groups of states coordinating their policies and/or acting together to achieve specified goals. Multilateralism is supported by institutions which are created to facilitate cooperation. Since cooperation is pursued when states cannot achieve particular goals through individual actions, it necessarily requires mutual adjustments among states. Institutions make this easier by providing a way to reduce transactions costs, to increase information, and to monitor and constrain free-riding or cheating (Keohane 1984). For international institutions to function, they need to balance the 'buy-in' of the powerful (who are often given a special degree of influence), against the need to assure all other members that each of their interests are best served by continuing to belong and to participate in the organization. An increased intensity of unilateral or bilateral control or influence puts at risk the original purposes of cooperation, the efficacy, and the legitimacy of an international organization.

Section one examines the rise of vertical funds, giving evidence of their success, and elaborating five features which distinguish them from traditional international organizations. Section two dissects the much-touted increase in multilateral funding for global health, analysing to what extent it either mirrors or complements the new vertical initiatives. It gives evidence of the rise of what we call Trojan multilateralism whereby increased funding to multilateral institutions is creating the illusion of multilateral intent, whereas it is covertly introducing bilateral goals and interests into multilateral institutions. These overlap with vertical initiatives and have the potential to corrode multilateralism. Section three explores the limits of Trojan multilateralism, probing empirically how structures within international organizations prevent individual governments from controlling an agency. Section four returns to the converging forces of proliferating vertical initiatives and Trojan multilateralism and elaborates the possible consequences for global health.

# I. The rise of vertical funds in global health

The decade from 2000 to 2010 witnessed the emergence of new multistakeholder institutions for global funding such as the Global Fund to Fight HIV/AIDS, TB and Malaria and the GAVI Alliance (see Figure 1). The Global Fund is fast becoming the largest multistakeholder donor in health with pledges rising from US$852 million in 2001 (its creation) to US$3.6 billion in 2012. GAVI is also picking up pace from its initial start of US$164.7 million in 1999 to US$1.2 billion in 2011. In short, the decade has been an exciting new era of proliferating, competitive initiatives which "get things done" because they focus on one problem at a time (they are "vertical") (WHO Maximizing Positive Synergies Collaborative Group 2009).

Figure 1: Old Multilaterals and New Multistakeholder Institutions in Health




The Global Fund has successfully delivered on two donor objectives: it has become a rapid disbursement mechanism for funds relative to other agencies, and it is successfully lending to fragile states.

To give an idea of disbursement times, it is useful to compare the Global Fund to its equivalent in education, the Fast Track Initiative housed in the World Bank. In contrast to the Global Fund which has raised over US$18 billion, the FTI has disbursed less than US$500 million. One of the major problems has been the long delay between commitment and disbursement due to the application of IDA rules. The Global Fund is much more agile able to disburse funding roughly 9-11 months after commitment.

In fragile states the Global Fund is also claiming success. The World Bank struggles in fragile states given its mandate to lend to governments. By contrast, the Global Fund has disbursed US$2.9 billion in fragile and conflict-affected states since its creation in 2001 (Sridhar & Tamashiro 2009). In its first four rounds of funding, the Global Fund

has invested one-third of committed funds in 45 fragile states, financing a total of 123 programmes. According to the Global Fund's 2008 Progress Report, 70 percent of programmes in fragile states are performing well, and the overall effective performance of all countries supported by the Global Fund is only slightly higher at 75 percent. There have also been reports of corruption in countries such as Mali and Zambia that have raised questions about the Fund's effectiveness; however, the total amount involved is US$34 million which is less than 0.3% of the total amount the fund has disbursed since 2007 (Boseley 2011). Despite some reputational harm from this fraud, the Global Fund is still being looked at as a model within which other donors can engage with fragile states in health and other sectors.

Vertical initiatives like the Global Fund and GAVI differ from traditional multilateral institutions such as the WHO and the World Bank in a number of ways.

A first distinguishing feature of vertical funds is that they have narrowly defined goals. Unlike the broad mandates of the WHO ('the attainment by all people of the highest possible level of health') and the World Bank (to alleviate poverty and improve quality of life), both the Global Fund and GAVI have narrowly defined mandates that are problem-focused. The Global Fund mandate is to attract and disburse additional resources to prevent and treat HIV/AIDS, TB and malaria. GAVI's mandate is to save children's lives and protect people's health by increasing access to immunisation in poor countries. Achieving these specific purposes, or course, always relies to some degree on broader efforts to ensure the necessary health, education and infrastructure systems are in place to support disease specific interventions and to sustain their impact on human wellbeing.

A second distinguishing feature of vertical funds lies in their governance. Traditional multilateral institutions bring governments together so as to regulate (eg the World Health Assembly's International Health Regulations) and to coordinate their policies. For example, in the World Health Assembly each member government has one vote (some decisions require a simply majority, others a two-thirds majority of those present and voting). Together these governments determine the WHO's policies and recommendations (e.g. the implementation of the International Health Regulations (2005), the monitoring of the achievement of the health-related Millennium Development Goals and strategies to reduce the harmful use of alcohol and counterfeit medical products). The Assembly also approves the WHO's work programme, selects and directs its Executive Board and Director General, and reviews and approves the WHO's budget and financial policies.

By contrast, the Global Fund and GAVI bring together diverse stakeholders. For example, the Global Fund's Board includes representatives from civil society (3, including one person afflicted by at least one of the diseases), the private sector (1), the Gates Foundation[1] (1) who sit alongside representatives from developing countries (7) and donor countries (8). It also includes key partners (as non-voting members) : the WHO, UNAIDS, the World Bank, and a Swiss citizen (as the Fund is legally a Swiss

[1] The Bill & Melinda Gates Foundation has been an important new principal. It is currently the largest philanthropic foundation in the world with an endowment of approximately US$33 billion, with another US$37 billion pledged by Warren Buffett. The Gates Foundation has put huge amounts of money into GAVI (US$1.5 billion), its largest recipient, the Global Fund (US$651 million), the WHO (US$336 million) and the IBRD of the World Bank (US$135 million) (McCoy et al. 2009).

foundation). This Board, is responsible for the governance, development of new policies and the approval of grants within the Global Fund.

GAVI also has a multi-stakeholder board which includes 4 permanent seats for representatives from the Gates Foundation, UNICEF, WHO and the World Bank. In addition, there are 18 rotating Board members who represent various constituency groups: developing country governments (5 seats), donor governments (5 seats), research and technical institutes (1 seat), industrialized country vaccine industry (1 seat), developing country vaccine industry (1 seat), and civil society organisations (1 seat). The Board also includes unaffiliated Board members (10 seats) with no professional connection to GAVI's work in order to bring independent and balanced scrutiny to the Board's deliberations. This Board establishes all policies, oversees operations and monitors programme implementation.

A third attribute of the new initiatives is that they are funded by voluntary contributions. While the WHO and World Bank have moved towards discretionary funding (see above section), they still both have financial models based on assessed contributions. The new multi-stakeholder institutions rely entirely on voluntary contributions. The Global Fund receives voluntary contributions from governments (largest contributor), individuals, businesses and private foundations. These are usually not for specific projects but to replenish the core fund. A notable exception is the three year US$30 million donation from Chevron Corporation which is specifically for programmes in Nigeria, Indonesia, Angola, Thailand and South Africa.[i] GAVI also relies on donor contributions through direct donations, long-term pledges, and pledges to support the development and manufacture of vaccines. Private industry has donated about a third with the remaining contributions drawn from government.

A fourth difference between new initiatives and more traditional multilateral approaches concerns the way relations with recipients of funds are structured. Unlike the WHO and World Bank which work through government agencies and have offices and personnel in recipient countries, neither the Global Fund nor GAVI work directly in-country.

The Global Fund relies on Country Coordinating Mechanisms (CCMs) to develop and submit grant proposals based on priority needs at the national level. CCMs usually consist of representatives from governments, NGOs, donors, people living with diseases, faith-based organisations, the private sector and the academic community. For each grant, CCM nominates one or two organisations to serve as Principal Recipient. Since the CCM is a committee and not an implementing agency, it allocates the oversight and responsibility to the Principal Recipient who is responsible for local implementation of the grant. About two-thirds of all Principal Recipients are government institutions, but most recently the Global Fund has allowed 'dual track financing' where grants are split across different Principal Recipients.

GAVI provides funding directly to national governments based on country income (countries with gross national income per capita below US$1000). There are currently 72 countries eligible to apply for GAVI support.

Finally, the legitimacy of the new initiatives differs from the state-centric model of representation and interaction in traditional multilateral organizations. Both the Global

Fund and GAVI derive their legitimacy from their effectiveness in improving very specifically defined health outputs and outcomes. Each also makes a claim better to represent those affected by the particular diseases they are working to overcome.

The new global health initiatives have narrower mandates and expected to address specific problems rather than broader, systemic goals. Their multi-stakeholder membership does not attempt to offer universal representation to governments, and they rely on discretionary funding and have no claim to automatic core or longer-term committed funding. These attributes have enabled vertical funds to succeed. At the same time, however, their success may also be leveraging multilateral cooperation in the broader area of health, supported by traditional international organizations such as the WHO and the World Bank. Neglected in analyses of the rise of new vertical funds has been an attention to their relationship with multilateralism, and specifically to what roles of international organizations they cannot and do not attempt to replicate.

# II. The increase in funding of global health

To some extent the success of vertical funds relies on the activities of multilateral organizations in at least three realms:

- regulation (eg International Health Regulations) which requires a forum of governments;
- global monitoring, aggregating, and sharing among governments information on health more broadly than, say, individual diseases;
- providing a forum for cooperation among governments in the face of unexpected pandemics and crises.

For these reasons, an increase in the funding of multilateral organizations alongside the new vertical initiatives may well be vital to the strengthening of cooperation and to the success of the vertical initiatives themselves.

On the face of it, multilateral funding increased sharply over the period the new vertical funds were being established (Figures 2, 3). Existing analyses of global health spending and development assistance focus on multilateral versus bilateral spending and programs. For example, the Institute for Health Metrics and Evaluation - divides up contributions to international programmes in this way. From this data we see that the past 15 years have witnessed an increase in the budget and commitments of the WHO and World Bank respectively.

Figure 2: Total DAH for Health: Bilateral v. Multilateral (IHME 2009)

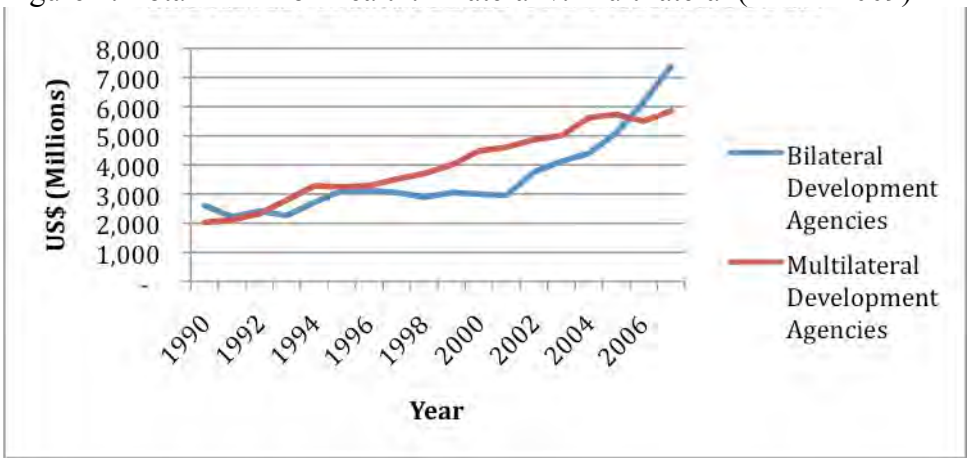
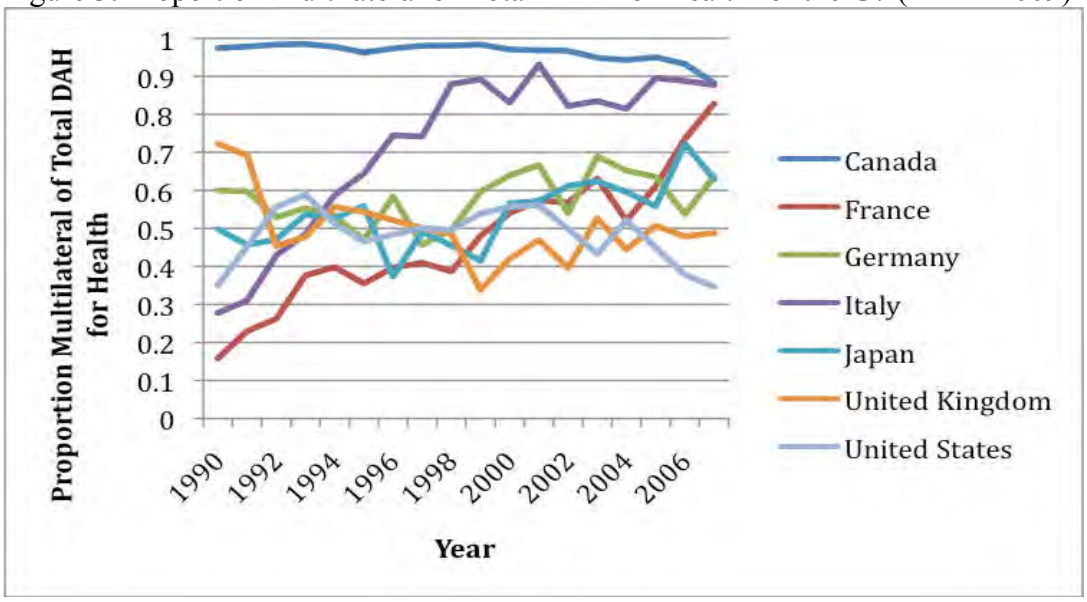



Figure 3: Proportion Multilateral of Total DAH for Health for the G7 (IHME 2009)




The story of increasing multilateral funding for global health does not end here. As a recent OECD/DAC report noted, about 30% of multilateral funding is given through, what it calls, "multi-bi" aid (OECD 2010; OECD 2012). This refers to the practice of donors choosing to route non-core funding, earmarked for specific sectors, themes, countries or regions through multilateral agencies. At first glance the funding looks multilateral but upon investigation, it is more bilaterally controlled.

Changing fastest is the discretionary funding of programmes in existing multilaterals. Voluntary contributions are increasing while core budgets are flat or fluctuating (see Figure 4). The key difference lies in the distinction between "trust funds" or "discretionary or voluntary contributions" on the one hand, and core funding for multilateral health cooperation on the other.

Within the WHO, the biennial budget has more than doubled in the past decade from US$1647 million in 1998-99 to US$4227 million in 2008-09. Most of the growth, however, has been in extrabudgetary funding which has risen from 48.8% in 1998-99 to 77.3% in 2008-09. In 2007, the top six donors of extra budgetary funding were the U.S. (25%), the UK (24%%), the World Bank- GAVI affiliate- (16%), Canada (12%), the Bill & Melinda Gates Foundation (11.8%) and the Commission of European Communities (10.2%).

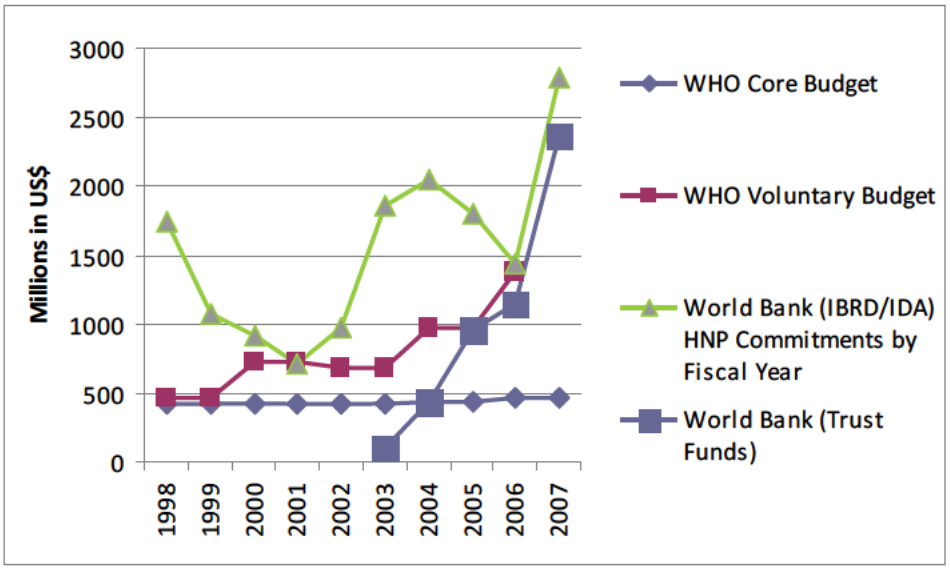
Within the World Bank's activities in health, total commitments have increased from US$1.7 billion in 1998-99 to US$5.2 billion in 2006-07. While growth has occurred in both types of funding, it is the trust fund portfolio for health has experienced the most dramatic growth from US$95 million in 2003-2004 to US$2.4 billion in 2006-07 which is almost equal to the core funding provided by IBRD/IDA (US$2.8 billion).[ii]

Why does this matter? The increase in discretionary and additional funding to multilateral organizations is an important feature, not least because it replicates rather than complements the expansion of vertical funds. This may well corrode the longer term capacity of international organisations and their sustainability since contributions to trust funds are discretionary. Countries can choose (or not) to contribute, decide how much and for what purpose.

The core funding of the WHO is used for the purposes decided by member states at the World Health Assembly while the use of extra-budgetary funding is decided by specific donors. In 2008-09 of WHO's regular budget, 25% of funds were allocated to infectious disease, 8% for non-communicable diseases and roughly 4.7% for injuries. These purposes align roughly with the global burden of disease. By contrast, the extrabudgetary funding of the WHO for 2008-09 was used for infectious diseases (60%), while only 3.9% was for non-communicable diseases and 3.4% for injuries.

In the World Bank a similar picture emerges. In 2005, the core budget (Health, Nutrition, Population) was focused on infrastructure in health with the major priorities being health systems (34%), water and sanitation (22%), injury (18%) with disease-specific strategies following with infectious disease (15%) and non-communicable disease (2%) (Sridhar & Batniji 2008). In contrast, the trust fund portfolio is largely focused on disease-specific strategies with funds including the Global Partnership to Eradicate Poliomyelitis, Programs for Onchocerciasis Control, the Avian and Human Influenza Facility, and the Global Partnership for TB Control. The Global Fund is the largest trust fund and received 35% of 2008 contributions to trust funds (World Bank 2008).

Figure 4: Funding Patterns of the WHO and World Bank




The above analysis highlights that a significant proportion of increased funding for global health has been by contributions which are discretionary (in terms of amount and timing of payment) to fund a specific activity (as opposed to the general purposes of the organization), and to fund implementation through a third party.

Far from strengthening multilateralism (groups of states coordinating their policies on health), our analysis suggests that increased funding to multilateral institutions is covertly introducing bilateral goals and interests into multilateral institutions (created by governments for purposes they cannot achieve through bilateral means). The risk is that this could undermine the capacity of international organizations to deliver much-needed cooperation and the delivery of collective action in global health.

## III. How deep might Trojan Multilateralism go?

In this section we explore how far Trojan Multilateralism might go towards corroding elements of international organizations which are crucial to their capacity to facilitate cooperation. Using principal-agent literature, we explore three ways in which governments using "Trojan Multilateralism" might entrench and deepen bilateral controls (Nielson and Tierney 2003; Hawkins et al 2006; Pollack 2007).

(1) realigning the objectives of international organizations using material (and other) incentives to reward actions and behaviour they approve and to punish that which they don't;

(2) reducing the asymmetry of information between them and the agency (such as by contracting out expertise or information gathering activities);

(3) tightening their monitoring over the agency's work and outcomes, such as through the governance and decision-making rules of the agency.

1. *Sharpening incentives and realigning objectives*

Classic agency literature draws our attention to incentives, and more specifically to how incentives might be structured better to induce an agent to carry out the principal's interests faithfully. "High-powered incentives", for example, are those which tie an agent's payoffs tightly to realized outcomes, delivering a large reward to the agent when the principal's desired outcome is realized.

New cooperative initiatives such as the Global Fund and GAVI take financial incentives to a new high. They reflect higher powered and more precise incentives on agencies to achieve outcomes specified by principals. For example, the Global Fund and GAVI explicitly link performance to replenishment and must show results to attract donor interest. In 2004, the Global Fund Board decided that resource mobilization should use a periodic replenishment model on a voluntary basis for all public donors, complemented by additional ad hoc contributions for all donors. The replenishment provides a forum for donors to exchange views on the operations and effectiveness of the Global Fund, consider its funding needs and make pledges in respect of their financial contributions for the next three years.

Similarly, GAVI launched its first replenishment process in New York in October 2010. GAVI donors met to agree on how to fund programmes to avert an estimated 4.2 million future deaths through immunisation..

What makes sharper incentives work in vertical funds? Such incentives are notoriously difficult to deliver when it comes to public sector agencies (Dixit 2002). This is because public sector agencies are involved in delivering complex tasks, with multiple stakeholders and tiers of management. Yet vertical funds obviate these problems because their task is narrowed to a specific problem, their stakeholders are marshalled around that problem and their management is kept light.

Can this work in international organizations? Yet more difficult is the use of incentives in multilateral organizations with multiple principals (Hawkins et al 2006). This is not least because of an assurance problem. If any one principal (ie government) were seen to be able unilaterally to manipulate incentives, the participation of others would be difficult to assure. For this reason, multilateral institutions such as the WHO and World Bank are structured deliberately to limit the power of individual governments to set incentives for the management and staff. The result is a structure designed to ensure a degree of autonomy which permits the agencies to act as genuinely "multilateral" organizations. For example, countries have obligations to provide the core budget regardless of performance.

Nevertheless, governments can (and do) use financial and other incentives to induce international institutions to act in particular ways. For example, the United States threatened and then quit UNESCO in 1984 due to "a growing disparity between U.S. foreign policy and UNESCO goals" (US State Department 2002). When the United States rejoined the institution 18 years later, it noted that radical internal reforms had taken place. A second example is the UK government in 2011 announcing, as a result of the Multilateral Aid Review cited above, to withdraw its membership of UNIDO (DFID 2011).

A much more common incentive governments use to influence international organizations is finance; governments threaten or promise changes to the budget of an organization. For example, in the UK government follow-up to their review they declare their intention to stop all extra-budgetary funding to UNISDR and UN-HABITAT, and for the UK's Department for International Development to stop contributing core funding to the ILO (leaving the UK's core contributions to be made by the Department of Work and Pensions).

Constraining governments from using financial leverage is their obligation to pay into core budgets. For example, as noted (with some implicit frustration) in the UK DFID follow-up report cited above, the UK has a Treaty obligation to the European Commission to contribute to its development assistance budget. Likewise the UK has a membership duty to the WHO to contribute a proportion of the core budget reflecting the UK's wealth and population size. The use of that budget is decided by all countries in the World Health Assembly which must unanimously approve the budget. If a country does not pay their contribution, the Assembly is authorized to suspend voting privileges and services to which a member is entitled, although no provision is made for expulsion.

Tighter incentives are made possible (as noted above) when governments, or others, provide extra-budgetary resources. In the WHO this is significant, constituting almost 80% of the total budget. This requires the WHO to work more in the interests of a few states and principals rather than its wider membership (WHO 2010). Thus, through providing tied funding to specific departments, donors can ensure that their funding is used to influence the activities and direction of the organization.

In the World Bank a similar structure of core capital and discretionary contributions exists. The World Bank's main lending agency is the IBRD which is funded from three sources. It raises money on private capital markets by selling bonds which are underwritten by the full membership, it earns money on its interest-bearing loans to members, and it earns income from its investment portfolio (since it invests part of the money it earns from its lending). These sources are independent of members' control.

Discretionary contributions to the World Bank became significant from 1960 when the members of the Bank created a trust fund called the International Development Association to make concessional loans to the poorest countries. The funding for IDA is negotiated every few years in an intensely political process during which governments agree how much they will contribute. A result of this process has been to open up a new channel through which the Bank can be directly influenced by its wealthier government members, and in particular the United States.

The United States has always been an important contributor to IDA, in 1998, for example, contributing 20.8 per cent of IDA funds, as compared with Japan at 18.7 per cent, and the United Kingdom and France at 7.3 per cent (IDA 1998). On the basis of these figures one would expect some degree of US leverage within the IDA itself. However, US influence exerted through IDA replenishment negotiations has gone further. Even though the IDA itself accounts for only about 25 per cent of IBRD/IDA total lending, historically, the US has used threats to reduce or withhold contributions to the IDA in order to demand changes in policy, not just in the IDA but in the World Bank as a whole. For instance, during the late 1970s the Bank was forced to promise

not to lend to Vietnam in order to prevent the defeat of IDA 6, and in 1993, under pressure from Congress, the US linked the creation of an Independent Inspection Panel in the World Bank to IDA 10 (Gwin 1997).

*2. Reducing asymmetries of information*

A powerful rationale for cooperation in global health is the need for information to be drawn together and disseminated (by the WHO) among governments. Built into this rationale is an assumption that the WHO will have more information than any one member state. In principal-agent terms, this gives the agent (the WHO) an important autonomy from the principals.

Classical agency theory suggests that a principal (consider here one government) wishing to tighten its control over the agent (e.g. the WHO) would seek to reduce the information asymmetry (as between the government and the WHO). But is this occurring so as to drive and deepen Trojan multilateralism? And what model is emerging in the new vertical initiatives?

Our first observation is that both traditional multilateral organizations and the new initiatives out-source information. The WHO, for example, while possessing considerable in-house technical expertise, relies on expert advisory panels and committees to support its work. Most often these are established for the purpose of reviewing and making technical recommendations on a subject of interest to the organization, such as food safety, response to the H1N1 pandemic, or counterfeit medicines.

Crucial to our analysis of the principal-agent relationship is the fact that it is the Director-General who appoints members of the panel based on technical ability and experience, although consideration is also given to the broadest possible international representation in terms of diversity of knowledge, experience and approaches in the fields for which the panels are established. The panel reports to the Director-General, thus the management of the WHO, who must submit to the Executive Board a report on meetings of expert committees. The report contains observations on the implications of the expert committee reports, recommendations on follow-up actions to be taken and the texts of the recommendations of the exert committees are provided in annexes. Two points are worth underscoring here. First the outside experts are putting information into the hands of management and staff ie. the potential asymmetry of information persists. Second, the information provided by outside-experts is not being used directly in decisions about what to fund and on what conditions.

Both the Global Fund and GAVI rely on out-of-house expertise that reports directly to the Board. In these agencies, the out-of-house expertise is used to aid decision-making in terms of which proposals and programmes to fund. The Global Fund has a Technical Review Panel. The panel reviews proposals based on certain eligibility criteria and makes recommendations to the Board. The panel consists of a Chair and two Vice Chairs and a maximum of 40 experts who are appointed by the Board for up to four Rounds. Vacancies on the Panel arise annually and members are selected form a pool of approximately 100 experts called the Technical Review Panel Support Group. Recruitment for this larger Group typically occurs every two years and is managed by the Portfolio and Implementation Committee using an open, transparent and criteria-

based process through a public call for applications. Criteria include broad expertise, both scientific and programmatic, in HIV/AIDS, tuberculosis and malaria prevention, care and treatment as well as broader health systems.

Similarly, GAVI relies on an Independent Review Committee (IRC) comprised of experts drawn from a broad geographic base. The committee is independent and makes its recommendations in an environment free from political considerations. The IRC is divided into three teams to reflect GAVI's core areas: new proposals team, health systems team, and the monitoring team. Each team has a membership varying from 8 to 18 with members serving for a team of 3 years. When new members are required, GAVI issues a call for nominations to its partners specifying the skills needed. IRC members are not connected with GAVI and are selected (primarily from low and middle income countries) for their expertise in public health, epidemiology, development and economics and specific knowledge of vaccines and immunisation. Once nominations are received, the final decision is taken by the Executive Secretary.

International organizations such as the WHO and World Bank have sustained an asymmetry of information between the principals (countries represented on the governing body of an organization) and the management and staff of the agency. It is the senior management of each organization who presents proposals to the Board thus ensuring that the management and staff of the organization retain considerable influence and agenda-setting power. By contrast, the decision-making Boards of the Global Fund and GAVI take advice from panels composed of independent experts. This reduces the agency slack afforded to senior management and staff of the agencies concerned.

*3. Tightening monitoring*

A fundamental problem of all principal-agent relationships lies in how to monitor the agent. Typically, agency models assume that the principal cannot directly observe an agent's actions (Bendor et al. 2001). Instead, all the principal can observe is outcomes, which are correlated with an agent's effort but not perfectly so. Reward and punishment schemes are thus constructed around outcomes (such as share prices in the business world) rather than actions taken. If outcomes are only weakly linked to agent effort, such incentive schemes may have minimal effects. A general problem is that effective monitoring might demand an investment of resources so large that it overwhelms the rationale for delegation.

When governments and foundations cooperate on global health by delegating actions to a global fund or agency, how can they know precisely what their agent is doing on their behalf? The desire to know has become a major preoccupation of donors who have focussed heavily in recent years on demonstrating results typically through results based management systems, comprehensive results frameworks, an increased use of evaluations (both independent and in-house), and on a tightening and deepening of reporting requirements and transparency. This focus can be seen in the UK DfID's 2011 review of multilateral aid, in which there is a specific focus on (a) measuring strategic and performance management in multilateral agencies; and (b) improving transparency and accountability. The review asked whether organizations make comprehensive information about their policies and projects readily available to

outsiders, and whether they are accountable to their stakeholders, including donors, development country governments, civil society organizations and direct beneficiaries.

Traditional multilateral organizations have established structures for their member states to monitor their activities. In the World Bank, a permanent Board on which all member countries are represented (some in groups) sits permanently in Washington DC. Members of the Board have access to large amounts of information about what the Bank is doing, enabling them (in theory) closely to monitor the activities of the staff and management of the organization. The Board has sometimes sought more actively to monitor the activities of the management and staff. For example, the 1990s the Board created the Independent Inspection Panel; an institution investigating Bank decisions and actions and reporting directly to the Board (Nielsen & Tierney 2003).

The WHO is governed by the World Health Assembly and by an Executive Board. The World Health Assembly is the main way that member states monitor the activities of the organization. Its functions are to review and approve the budget, approve the general programme of work and given instructions or directives to the Executive Board and Director General. Member states can also monitor the WHO through the Executive Board which is composed of 34 individuals technically qualified in the field of health elected for three-year terms. The Board meets at least twice a year where it works to realize the decisions and policies of the World Health Assembly, to advise it and to generally facilitate its work.

Despite the Assembly and Board, one of the main challenges in monitoring the WHO relates to its regional structure. The WHO is composed of the main secretariat, in Geneva, and six regional organizations which are unique in the UN system for their independence and decision-making power. Each member state is allocated to a regional office which is governed by a Regional Committee - a plenary body largely composed of Ministers of Health. Each office is headed by a Regional Director who serves as chief technical and administrative officer for WHO in that region. Regional Directors are elected by their constituent countries and then formally appointed by the Executive Board. They have full power over personnel in their region including the appointments of country representatives. Regional Committees meet annually to formulate policies, review the regional programme budget and monitor the WHO's collaborative activities for health. These decisions are formally approved by the World Health Assembly and Executive Board, but in practice, tight policy and budgetary control is not possible. This creates challenges in monitoring the organization (Yamey 2002).

When contrasted to the new multistakeholder initiatives such as the Global Fund and GAVI, the World Bank and WHO look particularly difficult to monitor: for starters, their activities are broader and more diffuse, and their budgets are more complex. By contrast, the Global Fund provides detailed financial information about commitments and disbursements, as well as donor pledges and contributions. GAVI has a Transparency and Accountability Policy that governs the management of all cash-based support to GAVI eligible countries.

The review of multilateral organizations conducted by UK DfID in 2011 rated only two of 43 organizations as "strong" on transparency and accountability, both were global funds, of which a further three were rated as satisfactory. GAVI is praised for "strong financial oversight including a proactive Finance and Audit Committee, and

internal Auditor appointments and a robust Transparency and Accountability Policy". The Global Fund is praised because its decision "to publish/require recipients to publish procurement data has been a major driver for a range of innovations in transparency". By contrast the report notes "the WHO has no formal disclosure policy and does not publish enough specific programme or policy details", even though "partners are well represented in governance mechanisms".

In sum, Trojan multilateralism is permitting donors to finance and deliver assistance in ways which they can more closely monitor.

# IV. Possible consequences for multilateral cooperation in health

In this paper, we have argued that cooperation in global health was achieved in the period 1986-2010 through new vertical initiatives, and through increased multilateral funding. However, our analysis of the increased funding of international organizations suggested to us that Trojan multilateralism might be on the increase, by which we meant the importation of individual country goals and governance in ways which may corrode multilateralism.

We see three important risks in the convergence of new vertical initiatives in global health with Trojan Multilateralism. Coming to the fore is an approach to cooperation which is:

- disease or issue-specific;
- controlled by a small group of stakeholders;
- funded in a discretionary way (as opposed to long-term commitment).

A first important concern is normative. The convergence of new disease or issue-specific initiatives and Trojan multilateralism creates enormous momentum behind treatments (or preventions) of specific diseases. But not all diseases, or causes of premature mortality are included. Some international partnerships and campaigns are more successful than others. Critics allege that global health pursued through coalitions of the willing (either in vertical initiatives or in discretionary special funds in international organizations) imposes the priorities of powerful states and actors on poorer countries, whose populations have little recourse to demand accountability or to influence these priorities. Down the road, there is no commitment to continue funding such actions. Put simply, the democratic deficit of global governance could be deepened by this confluence of vertical initiatives and Trojan multilateralism. By contrast, at the core of traditional multilateralism is a representation of governments who are at least (mostly) directly or indirectly accountability to those they govern, coupled with long term commitments to fund.

A second possible consequence concerns efficiency. The risk is that the new health funding may be creating mechanisms which encourage donors to favour short-term political gains over longer-term public health goals. The advantage of traditional multilateral organizations is that their relative autonomy permits them to bring a transparency and discipline to difficult choices: the rationale for creating the 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' (Allen 1950). Multilateral forums have been important in the area of HIV/AIDs treatment to ensure that evidence-based policies are put to the fore, rather short-term politically popular policies. The general proposition is that multilateralism offers governments a chance to delegate authority to an international institution to take political heat off themselves or to tie their hands in a way which is conducive to long-term goals but not to short-term political interests. An example of this is the international Framework Convention on Tobacco Control which strengthens the hand of Health Ministries to fend off the more short-termist agendas of those who would prioritize commercial interests.

A third consequence of the combination of vertical initiatives and Trojan multilateralism is that it may erode important public capacities in global health: in terms of knowledge and information derived from global monitoring. By channelling expertise and staffing into in-favour areas, and depleting areas of expertise which may be needed in the future, or needed in order to maintain a strategy for dealing with global health. Where donors use discretionary funding to conduct bilateral (or multi-bi) activities under multilateral cover, they are working off the back of several decades of core multilateral funding. They are benefitting from a wider, previously built, technical expertise in agencies such as the World Bank or the WHO.

Global monitoring may be a casualty of the new health funding if it erodes the capacity of multilaterals effectively to monitor and disseminate information. Here, the relative autonomy or independence of global agencies is important. One reason why states form international agencies is so that they can pool or analyse information. Subsequently, this internationally-gathered and analysed information enables more effective multilateral action. In health we see this sharing of information, such as the global incidence and trend of an infection, and collaboration in analysis, such as among highly trained epidemiologists. The benefits of sharing and pooling information and expertise accrue to all countries including to governments who enjoy expertise and information, such as the US and the countries of the European Union.

The impartiality of the international agency pooling information is vital for monitoring. Countries need to trust an international agency in order to give it information and to use its information. The International Health Regulations offers one example. The IHR, which were launched on 15 June 2007 require countries to report certain disease outbreaks and public health events to WHO. They were agreed upon by consensus among WHO Member States as a balance between their sovereign rights and shared commitment to prevent the international spread of disease. Building on WHO's competence in global disease surveillance, alert and response, the IHR define the rights and obligations of countries to report public health events, and establish a number of procedures that WHO must follow in its work to uphold global public health security. The IHR also require countries to strengthen their existing capacities for public health surveillance and response. Here again, WHO draws on its technical expertise to work closely with countries and partners to provide technical guidance and support to mobilize the resources needed to implement the new rules in an effective and timely manner. Importantly, the IHR do not include enforcement mechanisms for states which fail to comply, but it is thought that the potential consequences of non-compliance are a sufficient incentive.

The importance of international collaboration on disease control was highlighted in

2007 when the Indonesian Health Minister drew attention to the fact that developing countries were supplying H5N1 virus to WHO Collaborating Centres for analysis and preparation for vaccine production, but that the resulting vaccines produced by commercial companies were likely to be unavailable to developing countries such as Indonesia (Sedyaningsih et al. 2008). She called this system "unfair." Her point was that actions taken by developing countries for the public good were being exploited by commercial companies for subsequent profit. If developing countries were to withhold viruses from WHO Collaborating Centres, a threat would be posed to global public health security and the ongoing risk assessment for influenza, conducted by WHO Collaborating Centres.

For all these reasons, the design of international institutions for collating and sharing information and knowledge is vital. Likewise, the expertise of international organizations and their capacities to compile, analyse, and monitor information are information. These could be corroded by the combined force of vertical initiatives and Trojan multilateralism.

On the more positive side, the positive impact of new health funding has been to shine a clear light on how and where international organizations, such as the World Bank and WHO, might do better. Both organizations have been criticized for being slow to act and overly bureaucratic. Trojan multilateralism is forcing these institutions to start reflecting on how to reform to remain more appealing to the wider set of principals.

# V. Conclusion

In this paper, we have argued that recent global health cooperation has been marked by two trends. First, there has been a highly successful proliferation of vertical funds to fight specific diseases. These are characterised by narrower problem-based mandates; multi-stakeholder governance; voluntary and discretionary funding; no in-country presence for the delivery of assistance; and an output-based legitimacy (based on effectiveness, not process). The rise of new initiatives with these characteristics has dovetailed with an increase in the funding of international organizations. However, the rise in funding has not necessarily strengthened multilateralism. Instead rapid increases in discretionary earmarked funding to the WHO and World Bank which we call Trojan multilateralism has replicated features of the vertical funds. With what consequences? We tested our concerns about how states might deepen the bilateral control suggested by Trojan multilateralism, using propositions derived from principal-agent theory. We found a mixed picture. Certainly, new incentives can and have been used to redirect international organizations. However, two constraints on bilateral control are not shifting so as to strengthen Trojan multilateralism. The first is the asymmetry of information between the WHO or the World Bank and individual member states which gives the former a degree of autonomy. The second is the difficulties which arise in monitoring multilateral action which have not been transformed in the era of Trojan multilateralism. We conclude that the positive lessons to be drawn from vertical initiatives need to be balanced by the risks posed from a convergence of vertical initiatives and Trojan multilateralism.

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[i] http://www.chevron.com/chevron/pressreleases/article/10052010_chevronincreasestotalinvestmentto55millionintheglobalfund.news

[ii] The World Bank trust funds include: "Bank-Executed Funds", which support a particular work program of the Bank and over which the Bank has spending authority ; Recipient-Executed Trust Funds, where the Bank passes the funds to a third party and usually appraises and supervises activities; Financial Intermediary Funds over which the Bank acts as trustee but typically has no operational role (two-thirds of the funds held in Trust by the World Bank group at the end of the financial year 2009).

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