



GLOBAL HEALTH CENTRE WORKING PAPER NO. 21 | 2020

HOW EUROPEAN COUNTRIES FUND GLOBAL HEALTH: UNPACKING DECISION-MAKING AND PRIORITY-SETTING PROCESSES

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EXECUTIVE SUMMARY

Covid-19 has significantly altered the global health funding landscape. This study seeks to improve understanding of factors driving global health funding decisions in Europe. Relatively little academic research has focused on European global health funders, though collectively their financial contribution is on par with the US.

This study explores how the ten largest European contributors to development assistance for health (DAH) – the UK, Germany, France, the Netherlands, Sweden, Norway, Spain, Italy, Belgium and Denmark – decide upon priorities and channel funding for DAH and the WHO. It asks:

- How much have European governments contributed, for what, and how?
- What factors influence European governments' funding decisions?
- How has funding been evolving over the years?

This study draws upon quantitative and qualitative data. It analyses publicly available data on DAH and WHO to describe financing trends over time. It uses semi-structured interviews with 16 global health policymakers from relevant ministries in all ten countries to understand the rationales behind the numbers.

We found four main factors influencing funding priorities and decisions. These factors interact with each other, and operate both within and across governments:

- (1) The division of political and financial responsibilities across ministries of foreign affairs/development and ministries of health;
- (2) The political preferences of Heads of State/government, Ministers, and members of parliaments;
- (3) The technocratic preferences within the civil service, such as path dependence of longstanding funding arrangements and the performance of agencies; and
- (4) Peer-pressure and tacit coordination between European governments.

This study further found that despite the changed rhetoric of the UN Sustainable Development Goals (SDGs), which shifted emphasis away from disease-specific programmes and towards health systems strengthening (HSS), European governments have not significantly changed the way they finance DAH or WHO. Interviewees attributed this lack of change to:

- (1) The difficulty in gaining visible and tangible results with the HSS agenda;
- (2) The 'stickiness' of vertically-oriented organizations, which hampers horizontalization; and
- (3) The privileged access to information and influence that comes with earmarked or vertical funding.

Our findings lead to several recommendations. *First*, many ministries appear to continue functioning in silos. Institutionalising and improving intra- and inter-ministerial dialogue across both technocratic and political levels, for example through structured processes such as developing national global health strategies, may improve coherence and overall impact. *Second*, if European governments wish to move beyond informal peer pressure or tacit coordination alone, creating structured spaces for intentional, meaningful coordination is still required. In addition to the obvious potential role for the European Union (EU), a forum that also involves non-EU European governments may be useful. *Finally*, overcoming inertia on longstanding challenges – such as increasing the proportion of unearmarked funding to WHO or shifting funding towards HSS – will require a few leading countries to set precedents, thereby clearing the path for others to more easily follow. European governments, individually and perhaps collectively, may play a much more central role in global health funding in the future.

1. INTRODUCTION

European countries have been playing an important role in funding global health organisations and initiatives. Notable financial contributions from European governments include support from the United Kingdom (UK), France, and Germany, Europe's top funders of development assistance for health (DAH) from 1990 to 2018.¹ These countries account for large portions of funding to agencies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) and Gavi, the Vaccine Alliance (Gavi).² These funding streams are supported and reinforced by the institutions of the European Union (EU) who have been contributing to DAH through, amongst others, the Global Fund, Gavi, the Global Polio Eradication Initiative (GPEI) and the Global Financing Facility (GFF).³

The Covid-19 pandemic has witnessed European countries and EU institutions taking a more central role in global health, including but not limited to their role in financing development assistance and WHO. The European Commission (EC) organized the first major international pledging conferences for the Covid-19 response in May and June 2020, during which the EC, the European Investment Bank (EIB), and EU Member States pledged a total of 11.9 billion EUR (approx. 14 billion USD).⁴ Individual European countries – such as the UK,⁵ Germany,⁶ Ireland⁷ and Finland⁸ – stepped up their funding to the WHO after the US announced its withdrawal in May 2020.

¹ IHME: Financing Global Health|Viz Hub, "Flows of Global Health Financing," 2020, <https://vizhub.healthdata.org/fgh>.

² The Global Fund, "Government Donors Overview," 2019, <https://data.theglobalfund.org/donors/partners/France>.

³ Donor Tracker, "EU – Global Health," 2020, <https://donortracker.org/eu/globalhealth>.

⁴ European Commission, "Coronavirus Global Response: Breakdown of the Pledges Made Today in the 'Global Goal' Summit," June 27, 2020, https://ec.europa.eu/commission/presscorner/detail/en/qanda_20_1216.

⁵ "UK Leads Global Fight to Prevent Second Wave of Coronavirus."

⁶ WHO, "Partners in Health: Germany and France Commit to Increased Support to WHO Affirming the Organization's Crucial Role in Global Public Health."

⁷ "Ireland to Quadruple Its WHO Contribution after US 'Halts' Funding."

⁸ "Finland Pledges 5.5 Million Euros More to Help Cover Donald Trump's WHO Funding Gap."

However, there has been relatively little academic research on how European governments make global health funding decisions. Existing research on funding decisions concentrates on national health care systems;⁹ and specific issue areas such as non-communicable diseases (NCDs),¹⁰ antimicrobial resistance (AMR)¹¹ or sexual and reproductive health.¹² In terms of global health funding, some studies include European actors in a descriptive mapping of the funding landscape¹³ or the specific relationship with certain global health initiatives such as the Global Fund.¹⁴

While these studies provide valuable insights, they do not specifically seek to explain how European governments make global health funding decisions, individually or collectively. Although some studies make reference to specific financial contributions, they do not reconstruct the rationales behind these decisions. One can, therefore, identify an underexplored question that could yield an improved understanding of Europe's role in funding global health: How do governments arrive at funding decisions? These questions concern, amongst others, how they choose to fund intergovernmental organisations such as the WHO or specific programmes.

Since funding decisions on global health remain largely in the hands of European capitals, this study focuses on individual European governments rather than EU institutions per se. This approach, furthermore, allows for including the UK and Norway, two non-EU countries that play a significant role in DAH and WHO. We do briefly examine the EU's coordinating role, in the past and future. The main objective of this study, nevertheless, is to analyse global health funding decisions of European governments.

⁹ Elias Mossialos, ed., *Funding Health Care: Options for Europe*, European Observatory on Health Care Systems Series (Buckingham; Philadelphia: Open University Press, 2002).

¹⁰ M. Begum et al., "European Diabetes Research and Its Funding, 2002-2013," *Diabetic Medicine* 34, no. 10 (October 2017): 1354–60, <https://doi.org/10.1111/dme.13411>; Hans Törnblom et al., "Funding for Gastrointestinal Disease Research in the European Union," *The Lancet Gastroenterology & Hepatology* 3, no. 9 (September 2018): 593–95, [https://doi.org/10.1016/S2468-1253\(18\)30203-6](https://doi.org/10.1016/S2468-1253(18)30203-6).

¹¹ Máire Geoghegan-Quinn, "Funding for Antimicrobial Resistance Research in Europe," *The Lancet* 384, no. 9949 (September 2014): 1186, [https://doi.org/10.1016/S0140-6736\(14\)61723-2](https://doi.org/10.1016/S0140-6736(14)61723-2).

¹² Sara Seims, "Maximizing the Effectiveness of Sexual and Reproductive Health Funding Provided by Seven European Governments," *International Perspectives on Sexual and Reproductive Health* 37, no. 3 (2011): 150–54.

¹³ D. McCoy, S. Chand, and D. Sridhar, "Global Health Funding: How Much, Where It Comes from and Where It Goes," *Health Policy and Planning* 24, no. 6 (November 1, 2009): 407–17, <https://doi.org/10.1093/heapol/czp026>.

¹⁴ Lies Steurs et al., "EU Donors and Health System Strengthening: The Love-Hate Relationship with the Global Fund," *Development Studies Research* 5, no. sup1 (December 17, 2018): S1–13, <https://doi.org/10.1080/21665095.2018.1511378>.

We began by selecting the ten largest DAH contributors: the UK, Germany, France, the Netherlands, Sweden, Norway, Spain, Italy, Belgium and Denmark. We then asked:¹⁵

- (1) How much have European governments contributed, for what, and how?
- (2) What factors influence European governments' funding decisions?
- (3) How has their funding been evolving over the years?

The paper begins by briefly touching upon the main debates in DAH to situate this study's discussions and put its findings into perspective. It then provides an overview of the DAH and WHO funding patterns of the concerned countries. It next offers an explanation for these funding patterns by analysing interviews conducted with global health policymakers in their respective countries. Finally, it offers conclusions for global health scholars and policymakers.

Methodology

Quantitative section:

The countries covered in this study were selected by ranking the financial contributions of all 17 European countries included in the IHME database for global health financing between 1990 and 2018, and selecting the ten highest (the "E10") for the sake of feasibility. The E10 in total comprise approximately 90% of total DAH from all 17 European countries (see Annex: *Figure A*).

Data for WHO financing was extracted from the WHO Budget Portal, covering the three biennia: 2014–2015, 2016–2017 and 2018–2019.¹⁶

Qualitative section:

Semi-structured expert interviews were carried out between February and July 2020 with 16 global health policymakers covering all ten countries. The interviewees were selected on the basis of organizational charts, namely the relevant units of the Ministries of Foreign Affairs, Departments of Development Cooperation, and Ministries of Health. To maintain the

¹⁵ See in the "A Note on the Methodology" section to determine how these countries were selected.

¹⁶ The website currently has an additional biennium (2020–2021) which was not available when the quantitative analysis was conducted for this study.

anonymity of the interviewees, quotes are presented without country-specific or identifying information, and all interviewees are referred to as 'they'.

Due to the Covid-19 pandemic, most interviews were conducted telephonically and via Zoom. The interviews were recorded, transcribed, and coded. Furthermore, interviews conducted during the pandemic may have been influenced by developments related to Covid-19, such as the US government's announcements regarding WHO.

The pandemic is likely to change DAH and WHO funding patterns significantly in the years to come. However, we argue that the factors driving decision-making within European governments are likely to endure, and therefore these findings may still offer relevant insights for a post-Covid-19 global health landscape.

2 | DEVELOPMENT ASSISTANCE FOR HEALTH (DAH): A BRIEF BACKGROUND

To situate the findings of this study, this section briefly summarizes the main relevant issues surrounding DAH arising in the literature, namely the role of donors in priority-setting and fragmentation.

Countries set their priorities in DAH for various reasons. They may select priorities that serve their economic and political interests.¹⁷ Their preference formulation may also be guided by socialization and not solely calculated interests. A decision-maker's repeated participation in meetings and negotiations can lead to '*a process of policy [and priority] diffusion*'.¹⁸ Donors do not necessarily set and fund their priorities '*in a rational way*',¹⁹ for example, priorities are not necessarily established based on the pathogens or countries that account for the highest disease burden.²⁰ In other words, preferences are also guided by motivations beyond metrics.

An enduring debate in DAH has been whether programmes should be organized 'vertically' or 'horizontally'. Vertical programmes usually refer to targeted disease- or intervention-specific programmes – such as HIV/AIDS, malaria and polio – whereas horizontal programmes refer to efforts to strengthen health systems. Vertical programmes have been popular amongst donors as they can easily and relatively quickly track how their money is being spent.²¹ This approach was particularly prevalent during the UN Millennium Development Goals (MDGs) era and is reflected in the establishment of agencies such as the Global

¹⁷ Ilona Kickbusch, "Influence And Opportunity: Reflections On The U.S. Role In Global Public Health," *Health Affairs* 21, no. 6 (November 2002): 131–41, <https://doi.org/10.1377/hlthaff.21.6.131>.

¹⁸ J. Shiffman, "Donor Funding Priorities for Communicable Disease Control in the Developing World," *Health Policy and Planning* 21, no. 6 (August 30, 2006): 411–20, <https://doi.org/10.1093/heapol/czl028>.

¹⁹ Devi Sridhar and Ngairé Woods, "Are There Simple Conclusions on How to Channel Health Funding?," *The Lancet* 375, no. 9723 (April 2010): 1326–28, [https://doi.org/10.1016/S0140-6736\(10\)60486-2](https://doi.org/10.1016/S0140-6736(10)60486-2).

²⁰ Suerie Moon et al., *Development Assistance for Health: Critiques and Proposals for Change*, 2012, http://www.chathamhouse.org/sites/default/files/public/Research/Global%20Health/0413_devassistancehealth.pdf.

²¹ Moon et al.

Fund and Gavi.²² The UN Sustainable Development Goals (SDGs) have shifted the rhetoric and focus, arguably, away from vertical programmes towards health systems more broadly. Yet, the global health community appears to remain in the ‘MDG-mindset’, continuing to establish new health financing mechanisms such as the Global Financing Facility for Women, Children and Adolescents (GFF) to finish the unfinished business from the MDG era.²³ Whilst there have been efforts to address this issue through a ‘diagonal approach’ – or the prioritization of ‘*certain interventions to strengthen the overall structure and functions of health systems*’²⁴ – analysts have argued that only through the backing of donors can such an approach be feasible.²⁵

DAH has also seen a proliferation of actors, particularly after the inception of the MDGs, with one study suggesting over 200 major actors are engaged in global health.²⁶ This proliferation has produced a fragmentation of efforts in the global health landscape, characterized by ‘*poor, or lack of, coordination*’.²⁷ Fragmentation, furthermore, has led to a competitive environment marred by increased transaction costs and inconsistencies.²⁸ Efforts to increase coordination amongst donors have been challenging as actors are disinclined to cooperate due to the ‘*competition for visibility and leadership roles*’.²⁹

This fragmentation poses perennial challenges for health systems strengthening (HSS) and the achievement of universal health coverage (UHC), which require more holistic and comprehensive approaches.³⁰ This study seeks to contribute to understanding why fragmentation and vertical funding persist, by offering a nuanced account of governmental decision-making processes.

²² Robert Marten et al., “Shifting Global Health Governance towards the Sustainable Development Goals,” *Bulletin of the World Health Organization* 96, no. 12 (December 1, 2018): 798–798A, <https://doi.org/10.2471/BLT.18.209668>.

²³ Marten et al.

²⁴ Frenk, Gómez-Dantés, and Knaul, “The Health Systems Agenda.”

²⁵ Gorik Ooms et al., “The ‘diagonal’ Approach to Global Fund Financing: A Cure for the Broader Malaise of Health Systems?,” *Globalization and Health* 4, no. 1 (2008): 6, <https://doi.org/10.1186/1744-8603-4-6>.

²⁶ Steven J. Hoffman and Clarke B. Cole, “Defining the Global Health System and Systematically Mapping Its Network of Actors,” *Globalization and Health* 14, no. 1 (December 2018): 38, <https://doi.org/10.1186/s12992-018-0340-2>.

²⁷ Neil Spicer et al., “‘It’s Far Too Complicated’: Why Fragmentation Persists in Global Health,” *Globalization and Health* 16, no. 1 (December 2020): 60, <https://doi.org/10.1186/s12992-020-00592-1>.

²⁸ David Held et al., “Gridlock, Innovation and Resilience in Global Health Governance,” *Global Policy* 10, no. 2 (May 2019): 161–77, <https://doi.org/10.1111/1758-5899.12654>.

²⁹ Anna Holzscheiter, Gill Walt, and Ruairi Brugha, “Monitoring and Evaluation in Global HIV/AIDS Control-Weighing Incentives and Disincentives for Coordination among Global and Local Actors,” *Journal of International Development* 24, no. 1 (January 2012): 61–76, <https://doi.org/10.1002/jid.1705>.

³⁰ Spicer et al., “‘It’s Far Too Complicated.’”

3 | SETTING THE SCENE: HOW HAVE THE E10 CONTRIBUTED FINANCIALLY TO DAH & WHO?

This section describes European financial contributions to global health, beginning with a general overview of the funding trends of the 17 European countries included in the IHME database for DAH (hereafter 'European countries'). It then presents the E10's contributions to DAH and the WHO. Both sections also situate European countries' financial contributions within the wider global context, including a comparison with the US.

3.1. General overview of European countries' funding patterns

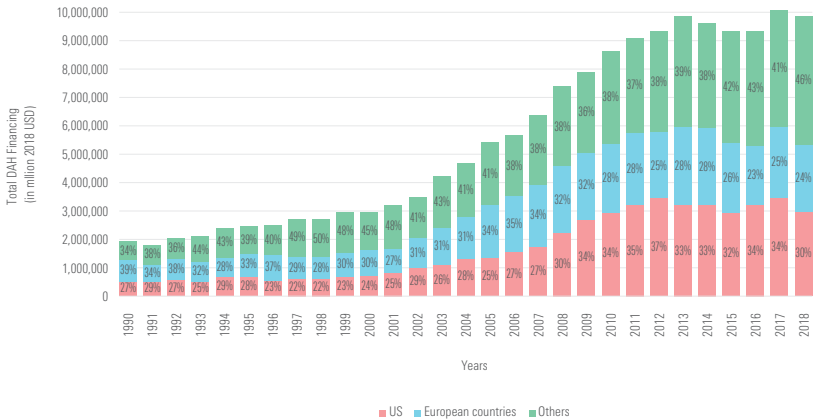
Before delving into European countries' funding patterns, it is worth briefly looking at the overall DAH financing landscape and trends over the last thirty years. Between 1990 and 2018, DAH financing increased fivefold from 7.8 to 40 billion USD (Figure 1).³¹ While growth was relatively gradual until the end of the 1990s, from the early 2000s there was a significant increase until 2013, after which it levelled off. The increase in the early 2000s may be attributed to the launch of the MDGs, which increased political attention to health.³²

³¹ IHME: Financing Global Health|Viz Hub, "Flows of Global Health Financing."

³² Charles Kenny and Andy Sumner, "More Money or More Development: What Have the MDGs Achieved?" (Center for Global Development, December 2011), https://www.cgdev.org/sites/default/files/1425806_file_Kenny_Sumner_MDGs_FINAL.pdf.

European countries have been steady contributors to DAH, funding between a quarter to a third of total DAH over the period under review (Figure 1). From 2008 to 2018, the US contributed an annual average of 12.4 billion USD, while European governments contributed 9.9 billion USD – on average, 80% of the US’ annual contribution during this period.

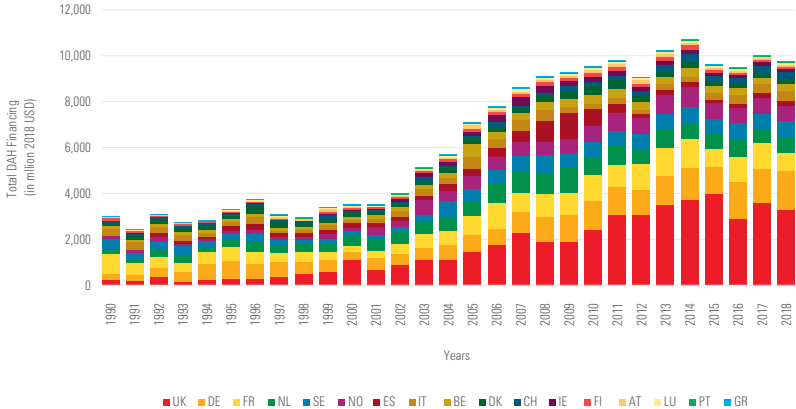
Figure 1: Proportional DAH financing by the US, European Countries & Others, 1990–2018



Note: 'Others' refers to the following: Other sources (debt repayments, un-allocable, other sources); Gates Foundation; Non-OECD DAC countries; China; Japan; New Zealand; South Korea; other OECD countries; private philanthropy; Australia; and Canada (refer to IHME database for global health financing for further details).

Looking at specific European countries (Figure 2), the UK, Germany and France stand out as the top three contributors to DAH, though their contributions have fluctuated, especially from 2015 onwards. DAH from many of the countries explored in this study show similar trends, with some more extreme than others. Italy is perhaps one of the few countries whose contributions has been on the rise since 2012, followed by Denmark from 2016 onwards.

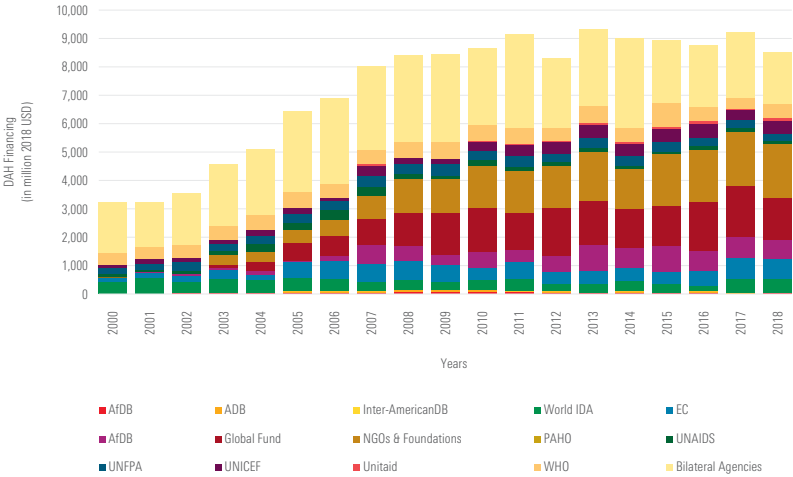
Figure 2: DAH financing by 17 European countries, 1990–2018



Note: The country codes are as follows (from left to right; bottom to top): United Kingdom of Great Britain and Northern Ireland (UK), Germany (DE), France (FR), Netherlands (NL), Sweden (SE), Norway (NO), Spain (ES), Italy (IT), Belgium (BE), Denmark (DK), Switzerland (CH), Ireland (IE), Finland (FI), Austria (AT), Luxembourg (LU), Portugal (PT), and Greece (GR).

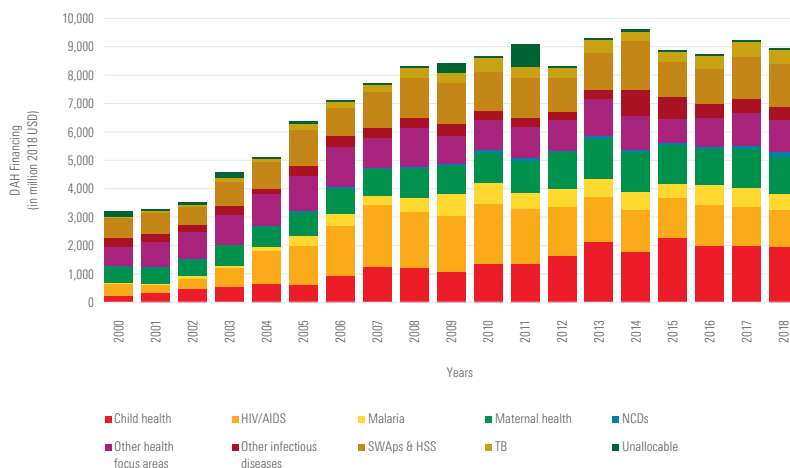
When looking at the channels the E10 have been using to finance DAH between 2000 and 2018 (Figure 3), there does not appear to be a drastic change for most channels. Looking specifically from 2015 onwards, when the SDGs began, the channels remain constant overall. However, two observations can be made: *first*, channeling through bilateral agencies decreased from 2.2 billion USD in 2015 to 1.8 billion USD in 2018; and *second*, channeling through the WHO nearly halves, from 854 million USD in 2015 to 452 million USD in 2018. Figures B and C in the Annex show in detail which channels each individual E10 country has been using to finance DAH and which health areas they have been focusing on from 2000 to 2018, as well as their trends over the years.

Figure 3: DAH channels used by E10 (aggregated), 2000–2018



There also does not appear to be a significant change in the issue areas the E10 have been investing in over the last ten years (Figure 4). In 2018, child health received the highest amount (1.98 billion USD), followed by SWAps & HSS (1.54 billion USD), maternal health (1.32 billion USD) and HIV/AIDS (1.29 billion USD). NCDs, though slowly gaining traction from 2015 onwards, receives the least funding, with only 142 million USD invested in 2018.

Figure 4: DAH health areas of E10 (aggregated), 2000–2018



3.2. Financial Contributions to WHO by E10

WHO Member States can fund the WHO through assessed contributions (AC) and voluntary contributions (VC), which come in two forms: core voluntary contributions (CVC) and specified voluntary contribution (SVC). ACs are membership fees that must be paid in order to remain a Member State of WHO – they are calculated relative to a country’s economy and population.³³ CVCs are fully flexible funds (unearmarked) which the WHO can decide how to allocate – these funds are often used for activities and programmes that are less well-funded. SVCs, as the name suggests, are funds that are tied to specific programmes (earmarked) and must also be ‘spent within a specified timeframe’.³⁴ In the biennium 2018–2019, ACs covered below 20% of the total WHO budget, CVCs 3% and SVCs 77%.³⁵

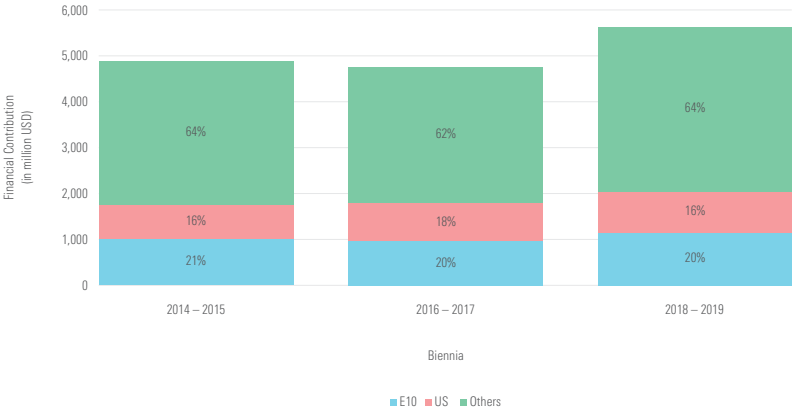
³³ WHO, “Assessed Contributions,” 2020, <https://www.who.int/about/finances-accountability/funding/assessed-contributions/en>.

³⁴ WHO, “Voluntary Contributions,” 2020, <https://www.who.int/about/finances-accountability/funding/voluntary-contributions/en>.

³⁵ WHO, “WHO Budget Portal.”

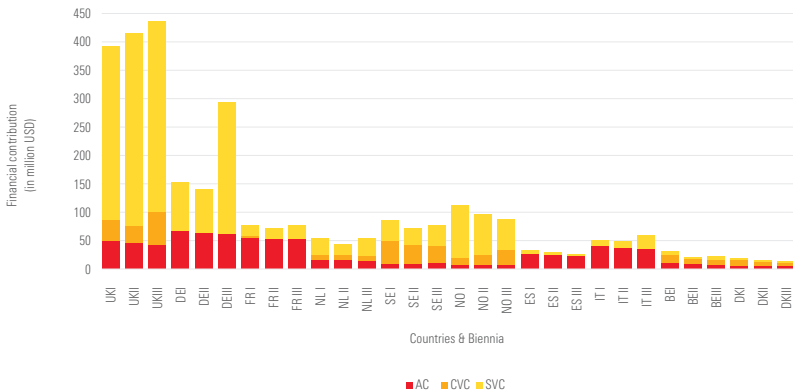
Overall, across the three biennia (biennium I: 2014–2015, biennium II: 2016–2017 and biennium III: 2018–2019), the proportion of the E10's funding contributions to the WHO has remained constant at approximately 20% (Figure 5). In comparison, the US contribution has remained between 16% and 18%. The E10 contributed on average 1.03 billion USD each biennium, the US contributed 835 million USD – on average 81% of the E10s contribution per biennium.

Figure 5: Proportional WHO financing by E10, the US & Others to the WHO, 2014–2019



Of the E10, the UK, Germany and Norway are the top three contributors to the WHO (Figure 6), financing between approximately 65% to 70% of the E10's total contribution from biennium I to biennium III. Their main contribution goes through the form of SVCs.

Figure 6: Trends in ACs, CVCs and SVCs by E10, 2014–2019



Note: I represents the biennium 2014–2015; II represents the biennium 2016–2017; and III represents the biennium 2018–2019. The acronyms used in the figure stand for the following terminologies: Accessed Contribution (AC), Core Voluntary Contribution (CVC) and Specified Voluntary Contribution (SVC).

When looking at the trends of the E10's contributions to the WHO vis-à-vis ACs, CVCs and SVCs, a number of observations can be made. First, ACs for all E10 remained relatively constant throughout the three biennia, as is to be expected given the nature of how ACs are calculated.³⁶ Second, regarding CVCs, not all countries have been contributing through this form. Germany and Italy are two such countries that have not paid any CVC in all three biennia. The countries who have been paying CVCs are split into three categories: (a) increasing, (b) decreasing and (c) constant. Countries in (a) include the UK and Norway with the former increasing its contribution by 20 million USD from biennium II and biennium III and the latter by twofold, from 12 million USD in biennium I to 24 million in biennium III.

³⁶ WHO, "Assessed Contributions."

Countries in (b) include France, which contributed 4 million USD in biennium I and less than 1 million in biennium III, and Belgium, which paid 17 million USD in biennium I and 7 million in biennium III. The Netherlands and Denmark fit in category (c) with their CVCs remaining stable over the course of the three biennia – the Netherlands remained between 9 and 11 million USD, and Denmark at 6 million. Sweden contributed the greatest CVC in biennium I (24 million USD) and II (34 million USD) followed by the UK, 22 million and 32 million respectively. The UK surpassed Sweden as the largest contributor to CVCs in biennium III.³⁷

Third, concerning SVCs, most countries' contributions have remained constant over the course of the three biennia. However, select countries' funding patterns are worth mentioning. For instance, Germany increased its SVCs from 84 million USD in biennium I to 231 million in biennium III. The UK slightly increased its SVCs between biennium I and biennium III by 30 million. Italy's SVCs doubled from I to III from 10 million to 24 million USD. In the meantime, Norway is one of the few countries that has gradually been decreasing its SVCs from 92 million in biennium I to 24 million USD in biennium III, while simultaneously increasing its CVCs.

Overall, we found that the E10's contribution to DAH financing in general has been stable, with some fluctuations from larger countries such as the UK, Germany and France. Regarding WHO financing, most money is channeled through SVCs with countries either increasing or maintaining their contributions through this channel. Furthermore, CVCs are low, with the majority of countries either paying a small amount or none, and only a select few countries contributing a significant amount. These findings underscore WHO's continuing heavy dependence on voluntary earmarked contributions (SVCs).

³⁷ WHO, "A69/INF/3: Voluntary Contributions by Fund and by Contributor, 2015," May 13, 2016, https://www.who.int/about/finances-accountability/reports/A69_INF3-en.pdf?ua=1; WHO, "Core Voluntary Contributions: All CVC Contributors (2016–2017)," 2020, <http://open.who.int/2016-17/cvc>; WHO, "Core Voluntary Contributions: All CVC Contributors (2018–2019)," 2020, <http://open.who.int/2016-17/cvc>.

4 | WHAT'S THE STORY BEHIND THE NUMBERS?

The previous section provided a broad descriptive overview of the E10's financing trends for DAH and WHO financing. This section offers an explanation of how these trends came about by examining how governments decide on their global health funding priorities. Through the use of interview data, this section explores two main questions:

- (1) What factors influence European governments' funding decisions?
- (2) How has funding been evolving over the years?

Figure 7: Summary of findings in Section 4

4.1: Factors influencing European governments' global health funding decisions
Intra-governmental factors
<ul style="list-style-type: none">■ The division of political and financial responsibilities across ministries of foreign affairs/development and ministries of health■ The political preferences of Heads of State/Government, Ministers, and Members of Parliament■ The technocratic preferences within the civil service, such as path dependence of longstanding funding arrangements and the performance of agencies
Inter-governmental & organizational factors
<ul style="list-style-type: none">■ Peer-pressure and tacit coordination between European governments
4.2: Obstacles that hinder change in European global health funding
<ul style="list-style-type: none">■ The difficulty in gaining visible and tangible results with the health systems strengthening (HSS) agenda■ The 'stickiness' of vertically-oriented organizations, which hampers horizontalization■ The privileged access to information and influence that comes with earmarked or vertical funding approaches

4.1. Factors influencing European governments' global health funding decisions

The interviews revealed four main factors that influence E10 governments' funding priorities. These factors operate on two levels: intra- and inter-governmental. Intra-governmentally, the division of political and financial responsibilities across ministries as well as the differing logics on the political and technocratic level are influential factors in decision-making processes. Inter-governmentally, coordination and peer pressure are factors that can influence decision-making within governments. This level can also include inter-organizational coordination, which implies discussions between governmental representatives and officials from international organizations.

4.1.1 Intra-governmental decision-making processes

The governmental structure: Division of political and financial responsibilities

In all E10 countries, two to three ministries were particularly involved in global health matters: the Ministry of Foreign Affairs and International Development Cooperation (here onwards referred to as 'MFA' for brevity), and the Ministry of Health (MOH) (Table A). It is important to note that some countries, such as Germany, have individual Ministries for Foreign Affairs and Development Cooperation, whereas in others, development sits inside foreign affairs.

Table A: Ministries and departments engaged in global health matters in E10

Note: The figure is not exhaustive and provides only a broad overview of the ministries' responsibilities in each country.

* DFID combined with FCO in June 2020 ** AICS was part of the MFA until 2015

	UK*	DE	FR	NL	SE	NO	ES	IT	BE	DK
Ministries of Foreign Affairs/ International Development Cooperation (MFA)	Dept for International Development (DFID) Foreign & Commonwealth Office (FCO)	Federal Min for Economic Cooperation & Development Federal Foreign Office	Min of Europe and Foreign Affairs	Min of Foreign Affairs	Min for Foreign Affairs	Min of Foreign Affairs	Min for Foreign Affairs & Cooperation	Min of Foreign Affairs & International Cooperation Italian Agency for Development Cooperation (AICS)**	Federal Public Service Foreign Affairs	Min of Foreign Affairs
Ministries of Health (MOH)	Dept of Health and Social Care	Federal Min of Health	Min of Social Affairs & Health	Min of Health, Welfare & Sport	Min of Health & Social Affairs	Min of Health & Care Services	Min of Health, Consumer Affairs & Social Welfare	Min of Health	Min of Health	Min of Health

While the responsibilities of each ministry vary from country to country, the interviews highlighted the following general observations with regards to each ministry's political and financial responsibilities:

(1) Political responsibilities

Regarding political responsibilities – issues concerning which ministries are in charge of preparing statements, positions, or policy proposals for the decision-making bodies of international health organizations – the MFA and MOH are responsible for different agencies, namely the Global Fund, Gavi and the WHO.³⁸ In many countries, the MFA is in charge of the Global Fund and Gavi, whereas the MOH leads in the World Health Assemblies (WHAs). These divided responsibilities were attributed to two factors:

³⁸ Many other agencies engage in global health issues besides the Global Fund and Gavi. However, the interviews referred to mainly these two agencies. Hence, this section focuses mainly on these two agencies, together with the WHO.

First, the MFA and MOH appear to have different understandings of the terminology 'global health'. As one interviewee from the MFA said, *'(t)he MOH is very much focusing on the impact of global health on their domestic health, so they very much look at global health as a way to protect their own citizens... whereas from the development perspective, we see global health very much as a contribution to the global groups and to the SDGs.'* Another interviewee added that their MFA sees global health as *'a key part of human development'*. This diverging understanding of the terminology between the two ministries reflects varying interests and, consequently, different policy foci. For instance, the MOH often focuses on specific issues such as NCDs and AMR, and the MFA on broader aspects, such as Sexual and Reproductive Health and Rights (SRHR).

It should be noted here that not all ministries use the term 'global health'. According to one interviewee, their MFA uses the term 'global health' while their MOH uses the term 'international health': *'Our MFA was among [the first countries] to draft a global health strategy... that strategy is very much MDG oriented, as is our country's understanding of global health, which is very much North, South, even if it's in a partnership spirit... International health, that is, the relationship with WHO particularly, and therefore some issues of global health such as let's say AMR or polio eradication because they are very much WHO-driven, would be handled by the MOH'*. This distinction reveals that while 'global health' is a term that is often embedded in the larger development field, 'international health' is still used to refer to health issues under the auspices of the WHO.

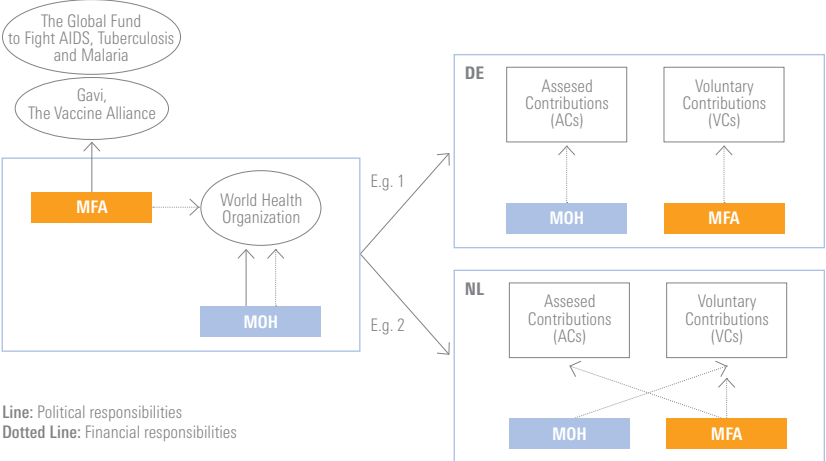
Second, all interviewees highlighted the distinct nature of the WHO in contrast to other agencies such as the Global Fund and Gavi. WHO has historically been, and to this day, perceived as a technical organization that is an important partner in setting evidence-based normative guidelines. Meanwhile, the Global Fund and Gavi are perceived as more *'politically charged'* as they are more publicly visible funding mechanisms. For this reason, in many of the countries studied, those responsible for analysing and supporting briefings around political issues on global health sit with the MFA, while the MOH's role lies in strengthening the WHO. As noted by an interviewee, *'(t)he MFA gives its policies a sort of political direction (whereas) the MOH has a very technical approach to their issues'*. This is not to say that the WHO is not political or disengaged with governance-related issues – the MOH is engaged in the governing bodies and participate in the World Health Assembly (WHA), but the political direction is provided by the MFA. In other words, it appears that the MFA generally decides upon the broad direction according to larger foreign policy objectives and the MOH implements the more technical details accordingly. Nevertheless, variation and nuanced differences across countries also exist.

Another reason for the distinct responsibilities lies in the historical backgrounds of the agencies. As one interviewee indicated, the Global Fund and Gavi were established in a different era: *‘The MOH is responsible for more “traditional” players – such as the WHO and UNAIDS – whereas the MFA is in charge of organizations developed under the MDG era.’* This observation implies a certain path dependence, namely that responsibilities are determined by the initial historical and political context during which an initiative or agency is set up, and these are not necessarily adjusted over time.

(2) Financial responsibilities

Though the MFA and MOH have political responsibilities in different organizations, when it comes to WHO financing, both ministries are often involved and contribute to financing through different funding streams. In some countries – such as Germany – the MOH contributes to ACs and the MFA to the voluntary contributions (VCs). In others, the MFA and MOH contribute to both ACs and VCs. For example, in the Netherlands, the MFA funds ACs, the majority of CVCs and a few earmarked contributions (SVCs), and the MOH provides only very specific highly earmarked contributions to WHO Headquarters, EURO and PAHO offices (Figure 8).

Figure 8: Political and financial responsibilities of the MFA and MOH for the Global Fund, Gavi and the WHO



Note: The left part of the figure illustrates a general overview of the distinct responsibilities of the MFA and MOH vis-à-vis the Global Fund, Gavi and the WHO. The right part of the figure uses the example from Germany and the Netherlands to illustrate the ways in which the MFA and MOH contribute to different funding streams of the WHO.

The observations thus far imply a fragmented intragovernmental decision-making process regarding global health issues. Coordination across ministries is important for policy coherence. Interviews revealed divided opinions regarding the extent to which the two ministries coordinate on global health related matters domestically. Some governments appear to have good coordination between their ministries, with regular meetings occurring every few weeks. One interviewee, for example, said that their government has an exchange of staff between the ministries regularly *'(b)ecause it ensures that policy is not shifting 360 degrees every year, but there is some continuity in knowledge and in the people dealing with the subject'*.

Others highlighted the divide between their ministries, particularly in the capitals. In one interviewee's words: *'(I)n capitals, one [each ministry] doesn't speak to the other.'* The divide between the ministries presents challenges, particularly in the context of WHO funding which, as observed above, involves both the MFA and MOH. According to an interviewee from the MOH, whilst the MOH has an understanding of the WHO, the other ministries simply see the WHO as *'an implementing agency which they want to use to implement their own goals... but they don't want to strengthen the WHO in its core mandate, which is our [MOH] goal.'*

Differing understandings of the WHO's role and the lack of inter-ministerial exchanges can lead to misunderstandings. The example of the polio programme provides a useful illustration. According to one interviewee, their MFA has been contributing to the polio programme without being fully aware of how exactly the money was being spent. The MFA learned about the potential programmatic and financial consequences of the polio programme's 'sunset' to the WHO only when the MOH raised this issue with them.

The role of the political level:

Personification, coalition building and buffers against change

Interviewees underscored the role of the political level – including Heads of State/Government, Ministers, or Members of Parliament – as the ultimate decision-makers that can effect change in both global health and WHO funding priorities. One interviewee highlighted that Ministers are *'(a)lways trying to give their own flavor to the policy the ministry is embarking on.'* For the WHO specifically, Ministers in power prioritize certain programmes to show their constituencies their commitment to the cause. One interviewee summarized the

situation, *'They [the Ministers] want to show their priorities and prove to their government that they are staying true to their priorities'*.

In addition to the prioritization of certain themes, Ministers can also decide whether they want to pledge bi- or multi-annually to programmes and agencies. Here, some interviews revealed the presence of disagreements between the Ministers and civil servants. As one interviewee said: *'(W)e've had some Ministers who want to have multi-year agreements which the organizations of course prefer. And I would say also, us, the civil servants, we also prefer that because we see that there's a lot of work just renewing bilateral agreements every year. And it doesn't necessarily bring you that much, you know, anything in terms of more effectiveness or efficiency at all and, in fact, it goes a little bit against all the principles of good aid. But the longer you make an agreement, the less kind of leverage, or power you have, and this is up to our politicians to decide.'* These disagreements underline the presence of differing logics and interests within a ministry, namely between the political and technocratic level.

The legislature, or Parliament, is also able to exert influence on priorities through its voting rights and oversight regarding the allocation of budgets. In some countries, the policy and budget proposals by the government are often adjusted, or as one interviewee said, *'over-ruled'*, by the Parliament through amendments. Such amendments, consequently, provide the opportunity to influence the way a ministry spends their money. This is true particularly when amendments are made regarding the specific allocations within a ministry's yearly budgets.

While priorities can change with a new party or Minister in power, the extent to which the priorities can be shifted is subject to existing mechanisms that serve as buffers. Within some countries, expenditures are planned and budgeted for a multi-year period which keeps funding fluctuations in check. In other words, multi-year commitments prevent incoming Ministers from significantly shifting budget priorities within a short period of time. In addition, drastic shifts in funding priorities are less likely if budget decisions are made on a bi- or multi-partisan basis. Some of the countries in this study are characterized by coalition or minority governments which require broad support from their respective Parliaments to get their global health funding priorities approved. In Norway, for example, development policy has been *'stable and constant'* as Norway's political system is characterized by coalition governments. Similarly, Denmark usually has minority governments and a *'long tradition for broad agreements across Parliament in terms of the government reaching out to others and doing ... more long-term priority discussion.'*

In other countries which are generally governed by single-party governments, funding may shift more drastically from one administration to another. In France, for instance, global health remains high on each government's agenda, but priorities '*vary from one administration to another*'. Such shifts may also be explained by the degree of responsibilities assumed by the President of the Republic, exemplified in Emmanuel Macron's personal efforts towards the Global Fund replenishment process in 2019. As one interviewee said, France's contribution to the Global Fund was '*formerly vehicled by the MFA, but [today] it's very much with the presidency. So last year... France hosted the replenishment conference of the Global Fund in Lyon that brought 14 billion USD. And that was [all] Macron, personally [pushing for the money]*'.

The technocratic level:

Longstanding commitments, foreign policy influence & performance

Funding priorities for global health-related issues and priorities are also decided based on longstanding commitments. For instance, countries that played a role in the establishment of the Global Fund and/or Gavi will contribute to these agencies given their deep-rooted relationship. A number of interviewees said that new aid budgets are often based on previous aid projects, and thus governments are '*(j)ust building upon what [they] used to do.*'

However, according to one interviewee, this 'building upon what they used to do' approach taken by many countries is not holistic: '*(I)it's looking at what we have done in the past and seeing whether we make some adjustments to that. We do not really have a bigger picture process where we look at the totality and where we look at what are our needs, where we need to make some shifts... that does not exist, and I think that's unfortunately the situation with very many organizations*'. This statement reinforces previous observations, namely that intragovernmental coordination and the analysis of the bigger picture, is lacking at times. In addition, it demonstrates that bureaucratically driven funding decisions are subject to path dependencies and that an impulse to change direction would need to come from the political level.

Global health priorities are also influenced by governments' broader foreign policy agendas, which may react to international developments. Over the years, for instance, there has been growing international attention to gender issues. One interviewee whose government's foreign policy is shaped '*very much by the feminist agenda*' explained: '*... [we] apply a sort*

of gender perspective on development cooperation... so applying a gender lens on development I think that's key, but also as regards to global health, I think also aligned with that thought, a lot of money goes to maternal health and newborn health, SRHR...'

The performance of agencies and programmes was highlighted as another criterion for global health funding. Many countries use their own review systems and/or existing evaluation mechanisms of which they are a part – such as the Multilateral Organization Performance Assessment Network (MOPAN) – to assess their multilateral partners based on their overall effectiveness and fit with their domestic priorities. As highlighted by an interviewee, this review process is crucial, particularly today where competition for limited development assistance resources is high.

The performance criterion is also important when it comes to funding decisions regarding the WHO. One interviewee noted that in their government's assessment of the WHO in 2016, the organization was judged to be *'in the middle of the pack'* in terms of effectiveness – as a result, the government placed an emphasis on reforming and strengthening WHO by contributing more flexible funding.

These views were mirrored by other interviewees who highlighted that their government *'provide(s) core voluntary contribution which is un-earmarked resources for the organization at large... That's our core strategy. Being part of governing bodies, taking responsibility, influencing strategic direction, but then supporting the totality of what the organizations are doing, and then keeping the organization accountable for the totality of [what the] organization is doing'*. This perspective underlines that governments may value the WHO's work and hence support the agency's core functions while simultaneously remaining vigilant to influence and scrutinize its activities.

4.1.2 Inter-governmental and -organizational decision-making processes

Tacit 'coordination' and peer pressure

In addition to the factors affecting intra-governmental discussions, deliberations across governments and international agencies can also influence decision-making processes. All interviewees underscored that their governments work with 'like-minded' countries – defined by one interviewee as those that *'have a common interest and common goals'* – and

major multilateral groups such as the EU and other multilateral groups and institutions of which they are a part (i.e. G7, G20, the Group of Western European and Other States Group (WEOG)...). In other words, their partners do not seem to be solely determined by health considerations, but rather by the larger foreign policy outlooks of their governments and the institutions in which they are embedded.

The extent to which they work together, however, varies according to the specific issue at hand. For instance, in the lead up to replenishments for the Global Fund and Gavi, countries 'liaise' with each other. As one interviewee said, governments are in constant dialogue regarding replenishments and decisions around whether or not changes should be made to existing contributions and the reasons behind such changes: '*... we are always aware of what other countries are doing before the replenishment, because that's also [what] our Minister's asking. So if I advise my Minister to reduce our contribution, they want to know what other countries are doing. So I always have to provide the Minister with a table [of what their like-minded countries are planning on contributing]... and so if you want to do something different than the like-minded, that's always very hard [because] no Minister really likes to stand out, in the negative sense at least*'. Governments, therefore, do not necessarily engage in active coordination, but reach out to others to avoid being isolated.

One interviewee called this form of relationship between countries '*peer-pressure*': '*(w)hen it comes to these big initiatives [i.e. Global Fund and Gavi], I think there's kind of a peer pressure... if you know that all the other Heads of States and governments are going to come to this replenishment conference and say this and that, then you want to be part of that club ... We want to be part of that group you know, so yes, there's kind of at the highest political level, I feel some kind of coordination sometimes, and peer pressure or whatever. And I mean it's very smart to have a host country for each replenishment because then that Head of State or government takes it upon him or herself to be in touch with his or her peers and that creates pressure*.' This form of peer pressure can ultimately lead to contributions that appear to be coordinated. However, the coordination seems to be more a product of social pressures rather than a result of clear strategies or health-based resource allocation.

It should be noted that during pressing issues such as pandemics, countries '*look at each other*'. As noted by an interviewee, during Covid-19, they have been looking at other countries in terms of what levels of attention they are placing on the issue. This is because countries that are part of the EU tend to engage in burden-sharing, which implies that Member States should contribute to common actions according to their weight. In other words, they engage in 'responsibility-sharing' and look towards other EU Member States to

see and determine the extent to which they contribute to an issue.³⁹ The leadership role of larger countries was highlighted in the context of burden-sharing, with smaller countries often following decisions made by larger ones.

Notably, no interviewee referred to the EU as an actively and systematically used coordination body. One interviewee provided a potential explanation for this: *'The EU, they have a strength... but they also have kind of a weakness because they have one person giving the opinion of 28 countries... sometimes, [countries that are not part of the EU] can have a stronger opinion than the EU because some countries in the EU don't necessarily support the most progressive or radical point of view on certain issues like SRHR.'* Governments may refrain from coordinating decisions within the EU because the consensus achieved may reflect the lowest common denominator. If governments hold positions not shared by their counterparts, they may prefer to go it alone with their funding.

With the exception of issues pertaining to replenishments, interviewees underscored that though they are in constant dialogue with partner countries on global health issues, the extent to which these interactions directly influence their own global health strategies is debatable. One interviewee said, *'[whether] we work with them [other countries] to sort of shape our own decisions on what priorities to pursue or where to put our money, I'm not sure.'* One interviewee added, *'We are for multilateralism, but we make our decisions ourselves'*. These points reveal the presence of a tension of multilateralism: on the one hand, governments look towards each other and consult each other for certain issues; on the other hand, they seek to remain autonomous and make decisions according to their own priorities. Furthermore, for funding decisions specifically, there appears to be little to no coordination present between countries. An interviewee said, *'... I at least am not aware of... national development agencies sitting together and strategizing together on where to put their money. At least I don't think that's how it works.'* Another claimed, *'... the final decision with regards to finances, how much everybody provides, that is not heavily coordinated... to some extent it's not coordinated.'* One interviewee highlighted that decisions on financing ultimately *'remains the national or domestic decision'*.

Whilst there appears to be some form of dialogue and indirect coordination at the Global Fund and Gavi, particularly for replenishments, the interviews revealed the absence of any form of coordination at the WHO level, neither with regards to political priority-setting, nor

³⁹ Eiko Thielemann, *Burden-Sharing* (Oxford University Press, 2012), <https://doi.org/10.1093/oxfordhb/9780199546282.013.0056>.

the allocation of financial resources. As one interviewee said, *'No one coordinates at the WHO level... countries coordinate with the WHO, but not with each other'*. Similarly, specifically concerning funding priorities, another interviewee said, *'(I) wouldn't say that there is real coordination with regards to the question on what to fund among partners. Rather, we ask the WHO whether they still [have] funding gaps, and then we would bring the funding for these specific areas.'* This absence of coordination between WHO Member States for financing poses issues for certain countries that must earmark to obtain their government's financial support. One interviewee said that providing earmarked funding to the WHO would be perceived more positively if all WHO Member States coordinated: *'(I) if you have to earmark your funding and you earmark it through the funding needs of the organization and you're not coming up with a concrete plan, but rather ask the organization, "So, for what specific areas do you want the funding? Give us your plan and we will earmark it to your plan," then there's nothing wrong with earmarking... The problem... is that it's uncoordinated.'*

Several interviewees stated that the absence of coordination between WHO Member States can, at least partly, be explained by the absence of an organizational space provided by WHO for such coordination to take place. As noted by an interviewee, *'(t)here's not a very strong coordination mechanism around WHO. There's a much better organized [mechanism] around Gavi, Global Fund... even UNAIDS I think is better organized.'* Another interviewee said, *'WHO doesn't create space for coordination'*. One interviewee explained this absence of coordination space at the WHO due to the agency's *'old-fashioned'* nature. Traditionally, the WHO has been engaging largely with a specific group of actors (such as the MOH and MFA depending on the country), and mostly for earmarked funding. Today, such a working relationship is outdated – the increasing recognition of the importance of flexible funding requires *'more strategic dialogue'* between WHO Member States. In other words, intergovernmental coordination is also shaped by the institutional design and *'way of doing things'* that prevails in the recipient organization.

Though *'coordination'* per se may not be happening formally vis-à-vis WHO, countries appear to – or at least try to – influence other countries to follow suit in certain funding decision-making. For instance, some countries try to *'convince'* others through dialogue: *'What we try to do though is to convince other countries that they should also contribute to the unearmarked pool for WHO. And this is something that we discuss with other Member States... but since we cannot even keep our own promises and we also fund earmarked, it's kind of a mix I think, a mix trying to convince that we should spend as less earmarked as possible, and when we have to earmark, we look at our added value.'* This approach reflects

the previous findings that coordination remains tacit, building rather on social and peer pressure instead of pre-agreed strategies and agreements.

Others carry this general approach further by trying to convince indirectly through the *'symbolic'* soft-earmarking of certain programme areas. Soft-earmarked funds are funds loosely earmarked for a particular programme but that WHO can reallocate for other purposes.⁴⁰ According to one interviewee whose government soft-earmarked the NCD programme in the biennium 2018–2019, *'(b)y softly earmarking, we were sending a signal that we want the WHO to strengthen efforts in this field [NCDs]. We had some concern that [...] the whole health architecture is a bit influenced by very many different actors and we tend to create a new mechanism whenever there is a specific problem, like we did with the UNAIDS and the Global Fund and some of these in the early 2000s... We didn't want to see another NCD fund, a new mechanism. So that was also partly why we said we want to set the signal by soft-earmarking.'*

The absence of coordination platforms at the WHO may be addressed through recent developments. One interviewee raised the Strategic Partnership Portal (SPP), a digital mechanism that was recently developed which aims to enhance communication between WHO and countries and donors.⁴¹ However, they said that their government does not use it at the moment as they lack the time to dive into a new mechanism. Whether it provides a useful platform that can enhance active coordination, therefore, remains to be seen.

Overall, interviewees were hesitant to describe the working relationships for global health-related matters as being characterized by active coordination and collaboration. Whilst there seem to be intensive exchanges and consultations, governments seek to retain sufficient space to maneuver and set their own priorities. At the same time, the overall close relationship between European countries creates a form of peer pressure which could be described as a form of indirect and diffuse coordination. The hesitancy of describing working relationships as coordinated may, furthermore, be explained by the specific usage of the term amongst EU countries where *'coordination meetings'* are held to actively search for common positions.

⁴⁰ Cheryl Cashin, Susan Sparkes, and Danielle Bloom, "Health Financing Working Paper No.5: Earmarking for Health, from Theory to Practice" (WHO, 2017), <https://apps.who.int/iris/bitstream/handle/10665/255004/9789241512206-eng.pdf?sequence=1>.

⁴¹ WHO, "Strengthening Health Security by Implementing the International Health Regulations (2005): Strategic Partnership Portal," 2020, <https://www.who.int/ihr/donors-partners-collaboration-portal/en>.

4.2. The evolution of funding: Linear or bumpy paths to change?

How have European governments' funding priorities evolved over time? In general, interviewees revealed that, over the years, there appears to be a shift with regards to the issue areas governments are engaging in. For instance, some governments have been increasing their political and financial support for work on NCDs, AMR, and climate change and health.

Furthermore, at the policymaking level, there appears to be a shift in the language and discourse as HSS is increasingly perceived as a priority. This shift has been influenced by SDG 3 on health. As one interviewee said, *'You could never have a meeting now with any organization and not talk about HSS.'* It should be highlighted however, that there are inconsistencies in the relevance of the SDGs, and consequently HSS, between ministries: *'The SDGs, in our ministry – the MOH – it's not so prominent. It's more discussed in frameworks of our ministry of development... they work a lot more with the SDGs. It's not so relevant for our policy domains. But we know them. And of course, we relate to them, but it's not an important topic in our ministry.'* These differences across ministries, once more, reflect the different organizational logics and foci which prevail depending on a ministry's general area of work.

Despite this change in discourse and the increased focus on horizontal programmes, the data revealed that these shifts do not necessarily translate into revisions of funding streams. For instance, albeit rhetorically recognizing that the WHO as an agency should be strengthened through more flexible and less earmarked funding, governments continue to rely heavily on earmarked contributions. Similarly, despite the SDGs' focus on horizontal programmes, governments continue financing mainly through programmes or agencies that focus on specific diseases – as one interviewee noted, the global health community is *'still very much in the MDG thinking'*. Another interviewee said, *'It's like the new cliché right... We moved from the MDG to the SDG era, and it makes for a great kind of rhetorical point. But in terms of realities, I mean, our objectives [HSS] have always been the same.'*

The interviews identified three obstacles that hinder translating rhetorical change into rewired funding: the preference to invest in vertical programmes as they provide visible results; the stickiness of vertically oriented organizations and existing agencies; and the privileges coming along with certain funding mechanisms.

Investing in the visible: 'Vertical is traction' and enjoys action

The political level – referring to Heads of State/Government, Ministers, or Members of Parliament – have an interest in investing in areas or programmes where they can see and demonstrate tangible results while they are in power. Prevention, which is central to the HSS agenda, is more politically challenging to sell than a reaction to an emerging crisis situation – such as a disease outbreak – because results can only be seen in the long term or in the absence of a problem. Furthermore, with limited resources in a competitive global health landscape, *'people have to have in mind how many million children have been saved and all this kind of stuff'* because *'it makes donors feel better'*. Hence, governments prefer investing in agencies such as, amongst others, the Global Fund and Gavi, because these agencies are perceived as more *'visible'* due to their replenishments and their much narrower and clearer agenda in contrast to the WHO's wide mandate.

One interviewee shared their frustration when trying to raise the importance of the WHO to their government to obtain increased funding: *'(P)eople [referring to their Ministers] will always say, "Well, you know, if you give more money to the WHO, what will they do? It's all so invisible, their agenda is so wide, the direct impact for our policies is limited. They are a normative organization, so why do they need the money anyway?"'* As a result, governments resort to earmarking their money to the WHO so they can at least see the results of their contributions. These observations, potentially, provide one part to the answer why governments channel funding largely through SVCs (see Section 3.2.).

Given the difficulty in gaining political traction for HSS, interviews underscored the necessity to continue using the current financing mechanism, or, in other words, contribute to HSS through financing vertical programmes. As one interviewee said, *'vertical interventions are needed sometimes to get some things moving while you try to solve the whole picture'*. Prioritizing horizontal programmes over vertical approaches is, furthermore, hampered by a prevailing understanding that HSS is a national priority and not the responsibility of the international community. Quoting one interviewee: *'To me, a health system is a national priority. Just like a government has to build roads, ensure access to water and essential services, it has to bring the essential package of health and health systems. . . the international community can bring support [to HSS]. But the fundamental issue is a political choice of the country.'* At least some donor governments may not favor such programmes as such foundational structures are seen as a national responsibility.

The stickiness of existing agencies: Adaptability and path dependencies

The prevailing focus on vertical programmes – despite rhetorical commitments to HSS – provides an explanation why governments prefer to channel funds to agencies that have been *'traditionally'* focused on vertical programmes, such as the Global Fund. Yet, the same governments are pushing such agencies to integrate HSS into their work. One interviewee said that their government is *'asking these organizations to focus on HSS... so it's not a one-size-fits-all approach that we're trying to pressure these organizations to shift away from the traditional MDG disease specific protocols, but rather to integrate into the theme of HSS.'*

These attempts to use vertical programmes and organizations to contribute towards HSS points to the stickiness of existing organizations: instead of redirecting funds, actors actively seek to work through the existing agencies. Furthermore, as one interviewee noted, *'(N)o organization wants to put itself out of work... you will never have any of the representatives of any of these global health organizations say, "Well we're a typical MDG organization, we should just, you know, stop working." [...] [That's why] they're opening up their portfolio to kind of stay relevant.'* This quote elucidates that organizational logics and orientations are often shaped by the historical context in which they were created. In the context of changing narratives and priorities, they also seek to adapt.

In addition, civil servants often face push back when they advocate for more horizontalized funding, whether they raise it in board meetings or towards their Ministers: *'... the push from all different sides to continue our funding in the way that we are currently funding is enormous. And what is difficult is that a part of this push is being paid for by ourselves. I mean we pay a Secretariat at the Global Fund and we pay a Secretariat at Gavi, and it's those people who are organizing meetings with our Parliaments to make sure our Parliamentarians push for more money. So there are many perverse incentives in the way we have set up our own funding mechanisms to keep it as it is'.* In other words, the existing mechanisms have locked in a certain way of doing things which hampers horizontalization. Similarly, another interviewee said that in many countries, organizations such as the Global Fund and Gavi *'are very powerful'* not only financially, but also with regards to the lobby groups they established: *'They [the Global Fund and Gavi] created major civil society groups, which, to a large extent, whose mandate depend on these players who are even to some extent funded by them. So, to change that, it's really burdensome and difficult, because you would not only have to change these organizations, but there's a big lobbying machinery behind it... which is also linked to the Parliament. And I think often the civil society organizations and NGOs involved*

don't even realize that'. In short, the agencies created in the context of the MDGs remain 'sticky,' which inhibits a substantial change to existing funding approaches.

The stickiness of organizations, once more, underlines the observation that changes in discourse does not necessarily translate into substance and funding. The SDGs may have revised the language and goals, but must still rely on the actors and institutions created during the MDG era for implementation. As one interviewee said, *'(W)hat the Member States of the UN, who more or less approved the SDG agenda, didn't do was, they clarified the goals, but they didn't clarify the means how to reach those goals. And in particular, they didn't change the global landscape... so what we have is new goals. But we still have the same actors. And the actors, they have, to a large extent, been established in the MDG era, which was disease specific. So we are practically asking the wrong actors to implement new goals, and one could argue, from my point of view, that these are potentially the wrong actors.'*

The stickiness of vertical approaches is, furthermore, aggravated by the prevailing status quo of limited ACs, which would provide more flexibility to the UN. Since the agreement to effectively freeze ACs in the 1990s, any push towards this direction is seen as unpromising. As one interviewee said, *'(W)e really would like to advocate for an increased AC to the WHO, but even such a statement within our own organization is seen as a bit... naive, because, in general, a decision has been made in New York not to increase the ACs to any of the UN organizations. So it's also the position of WHO in the broader UN family that makes it [change] hard because there is a consensus that the UN gets enough money, and that we should not spend more on the UN.'*

The privileges of funding: Incentives on parade

There are a number of existing incentives that prevent governments from changing the way they have been financing global health. This is evident particularly at the WHO as governments are incentivized to continue channeling payments through specific funding streams. For example, though the WHO calls for more flexible funding, the existing funding system within the WHO encourages WHO Member States to continue earmarking. According to one interviewee, *'If you don't earmark and if you're not [...] funding this project in these countries, then you tend to know less about what's going on, you tend to have less access to the Secretariat information... So that's interesting because in one way, they (WHO) say, "Please give us less earmarked money," and then on the other hand, if you have this*

programme on maternal health that is a high priority of theirs, only those who give specific money are invited [to the meetings]. It appears that as long as earmarked funding goes hand in hand with specific privileges, governments are incentivized to favor such contributions.

This is further reinforced as countries that do not earmark are less able to wield influence on specific issues. As one interviewee noted, they're *'(n)ot the right [ones] to ask because [they] don't earmark'*. This implies that earmarking funding is a prerequisite to obtain information and to have credibility within the WHO. This means that as long as earmarking comes with certain informal but substantive privileges and benefits within the organization, there is and will be an incentive for governments to continue providing earmarked contributions.

The decisions of larger countries, such as the US, also guide smaller countries. Without the leadership of large countries to provide more flexible funding to the WHO, smaller countries are likely to continue providing earmarked funding. One interviewee explained this phenomenon: *'(W)hether it's because of the US' approvals process and how their politics plays out. . . they're just never going to move away from that approach because if you can come to these meetings [board meetings] and just say, "Look, you've seen how hard our political system is, we buy into the idea of holistic approaches to systems but we just can't do this. . . we have to stay vertical" and that makes other countries, sort of smaller donors, feel like, "Well, if the US isn't going to change, then why should we change anything?"'* Whilst this resembles peer pressure, it also indicates that such incentives will not change unless leading contributors are willing to change their prevailing modus operandi.

5. CONCLUSION

This study attempted to better understand how the ten highest European contributors to DAH decide upon priorities and channel funding for global health and the WHO. It found four main factors that influence decision-making processes: (1) the division of political and financial responsibilities across ministries of foreign affairs/development and ministries of health; (2) the political preferences of Heads of State/Government, Ministers, and Members of Parliament; (3) the technocratic preferences within the civil service, such as path dependence of longstanding funding arrangements and the performance of agencies; and (4) peer-pressure and tacit coordination between European governments.

This study further found that despite shifting rhetoric with the SDG 3 framework placing greater emphasis on HSS, governments have not significantly changed the way they finance DAH and the WHO due to: the difficulty in gaining visible and tangible results with the HSS agenda; the ‘stickiness’ of vertically-oriented organizations which hampers horizontalization; and existing incentives, such as privileged access to information and influence that comes with earmarked or vertical funding approaches, that encourages governments to continue financing the way they have been financing.

Moreover, this study found fragmentation at both intra- and inter-governmental levels. On the intra-governmental level, fragmentation within ministries arises as the political and technocratic level have different interests. Between ministries, particularly the MFA and MOH, fragmentation is the result of different logics and preferences. On the inter-governmental level, the absence of formalized coordination arrangements inhibits more effective collaboration. Although governments appear to follow each other, coordinated patterns appear to be the product of informal peer-pressure rather than intentional practices. As such, this study highlights that any analysis of global health funding patterns needs to go beyond a unitary understanding of states. Intra-governmental fragmentation further demonstrates that funding decisions are not necessarily the product of deliberate and strategic calculations.

The conclusions of this study suggest action in three main areas:

First, this study suggests a need for more intra- and inter-ministerial dialogue across all levels. Whilst such a dialogue already exists in some governments in the form of formalized inter-ministerial coordination bodies or the exchange of civil servants between ministries, many ministries appear still to function in silos. Working towards a coherent approach could be facilitated by, for example, the inclusive drafting of a national Global Health Strategy that takes the interests and preferences of all governmental actors into account (as has already been done in a few countries). Such a document, in turn, could improve coherence across issue areas, and overall impact.

Second, if European governments wish to move beyond informal peer pressure or tacit coordination alone, creating structured spaces for intentional, meaningful coordination is still required. At the WHO level, countries can make increased use of existing spaces for coordination. In addition to the obvious potential role for the EU, a forum that also involves non- EU European governments may be useful.

Third, leadership seems to be crucial for effecting change. Current funding patterns were built in the MDG era, which continues to drive funding approaches today. Changing these patterns requires purposive action. This study found that larger countries play an important role in setting precedents that other countries may follow. Overcoming inertia on longstanding challenges – such as increasing the proportion of unearmarked funding to WHO or shifting funding towards HSS – will require a few leading countries to set precedents, thereby clearing the path for other governments to more easily follow.

European governments have played a central leadership role at the global level since the start of the Covid-19 pandemic, upholding multilateral approaches to addressing the pandemic amidst a near collapse of international cooperation. This development suggests that European governments, individually and perhaps collectively, may play a much more central role in global health funding in the future. Deepening our understanding of how these decisions are made will be increasingly relevant.

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Figure A: Proportional DAH financing of 17 European countries (E17) and the top ten European contributors to DAH (E10)

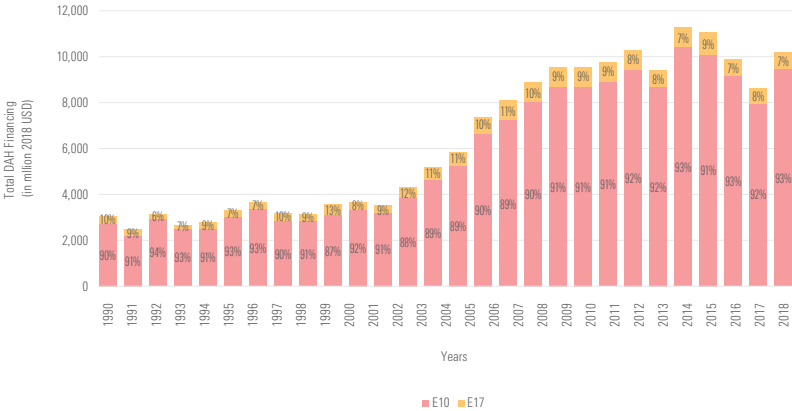
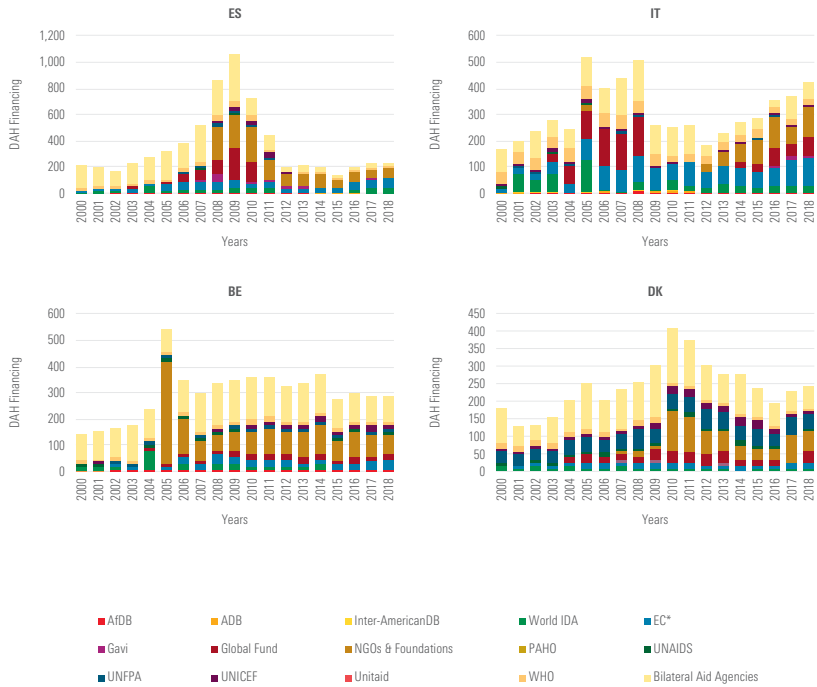


Figure B: DAH Financing Channels for Top 10 European DAH Contributors between 2000–2018
(in million 2018 USD dollars)



Figure B: continued



*EC is EEA for NO

The acronyms for the organizations are as follows: World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS), Pan American Health Organization (PAHO), Non-governmental organizations (NGOs), European Commission (EC), World International Development Bank (World Inter-American Development Association), Inter-American Development Bank (DB), American Development Bank (ADB), and African Development Bank (AfDB).

Figure C: Health Focus Areas by Top 10 European DAH Contributors between 2000–2018
(in million 2018 USD)



Figure C: continued





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