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## **Title**

Innovative Financing of Global  
Public Goods for Health

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## Innovative Financing of International Public Goods for Health

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### Globalization of Public Goods

Globalization brings expanded access to information, communications, trade, and travel and, along with these, new opportunities for human development. This unprecedented interconnection and interdependency among human communities also introduces newly shared risks of epidemic communicable disease, accelerating global spread of resistance to antibiotics, and emerging environmental health hazards. A threat to health anywhere in the world is, increasingly, a threat to every member of the human community. Since productivity and economic development in poor countries are hampered by a larger burden of illness, the resulting inequities threaten peace and international financial stability as well as global health.

Just as public health threats are of concern to the global community, the knowledge and technologies necessary to achieve their eradication or control are “public goods”. Public goods can be distinguished from private goods in two characteristics: non-rivalry (i.e., consumption of the good by one individual does not lessen the amount of the good available to another individual) and non-excludability (i.e., once produced, the consumption of the good cannot be restricted to certain individuals). As Cooper (2001) points out, “those are

#### **Smallpox Eradication: It's Not Action but Inaction That Costs**

The eradication of smallpox was perhaps the consummate international public good. Since final eradication in 1979, an estimated 30 million lives have been saved. The total cost of this achievement was US\$25 million per year over 12 years. Global savings from eradication amount to approximately US\$275 million per year in direct costs alone, with a cumulative total of over \$168 billion globally (Nelson, 1998). It is estimated that US taxpayers are thereby repaid for their investment in smallpox eradication every 26 days. Smallpox eradication illustrates that some global public goods should be understood not in terms of their “cost”, but in terms of the social and economic costs of delaying their

strong conditions, and few pure public goods exist”. But there are many goods with a mixture of public and private characteristics.

Social scientists have long recognized that, because of these characteristics of non-rivalry and non-excludability, public goods are undersupplied (Samuelson, 1954). The incentives to finance them are also weak or absent, since the willingness to pay for these goods does not approach the price to

produce them. Within nations, the solution to this “market failure” for production and financing of public goods has been left to governments.

When public goods are truly international or global in scope, or when goods are associated with substantial cross-border externalities, their production and financing becomes even more complex. Individual governments are unable to produce most international public

**TB Treatment: Defining the “Privateness” and “Publicness” of Health Benefits**

Analysis of the reach of benefits of health interventions can be used to guide allocation of responsibility for financing those interventions. Treatment of tuberculosis (TB), for example, yields substantial private benefits, making the direct costs of drugs (approximately US\$ 84) and/or health services (US\$ 112) a “good buy” for an individual or a government seeking to regain productivity lost due to chronic illness, even in countries with a low per capita GDP.

Each person with TB can be expected to infect another 14 persons (WHO, 2000), and perhaps five of those (or more, in a setting with a high prevalence of HIV/AIDS) will eventually develop active clinical infections. Treatment of each individual therefore also yields significant public benefits through containment of future service costs. Within months, by preventing further spread of the infection, treatment of a single individual (at a cost of \$196) might avert more than 3000 times that amount in direct costs alone. Where multiple drug resistance makes TB more expensive to treat, treatment of each case could avert millions of dollars in later costs.

Effective treatment of a single individual with tuberculosis provides a cascade of benefits, both within his community and beyond. More analysis is needed to define the proportion of public benefit that is purely national and the proportion that accrues across international boundaries. However, better understanding of the “reach” of such externalities will help to accelerate negotiations to finance and achieve both local public

goods (IPGs), since they require inputs and actions outside national boundaries and jurisdiction. Politicians and policy makers also have little incentive to allocate resources for interventions that offer substantial benefits outside their own constituencies. Nations, especially the poorest, have been content with being “free-riders”, leaving costs to be borne by neighboring countries. Because there is little incentive for any one nation to produce them, IPGs generally require international collective action for both their production and financing.

Because both of these present challenges for financing, this paper addresses both “pure” public goods and health interventions with substantial cross-border

externalities, such as communicable disease control. Two further characteristics of public goods are examined below because of their implications for financing; these include the “reach” and the “patterns of aggregation” of public goods.

**Geographic Reach of Externalities and the Implications for Financing**

The “domain of coverage” (Cooper, 2001) or the “reach” of goods helps to define the responsibility for financing. Private goods can and should be financed privately; but local, national, international, and global public goods will generally require action at the

corresponding level for their financing and production. When the reach of benefits is regional, such as with surveillance and control of tropical diseases endemic in only a few countries, the costs of producing this “club good” are more appropriately borne by the endemic countries than by countries unaffected by the disease.

The epidemiologic realities suggest that each intervention might be placed on a continuum of the “privateness” and “publicness” of the health benefits it produces. Immunization, for example, provides substantial benefit to the individual when the prevalence of the prevented disease is high. At low prevalence of disease, the chances of individual infection become small and a higher proportion of the benefit accrues to the public instead of to the immunized individual.

It is likewise possible to estimate, based on the the geographic reach of externalities, the proportion of the benefit of an intervention that is a local public good and the proportion of the benefit that is international. The reach of benefits of infectious disease control, for example, is determined by such factors as the transmission dynamics of the infectious agent and the cross-border mobility of affected populations. In the case of the elimination or eradication of a communicable disease, especially if there is potential for global spread, the local payoff is clearly dwarfed by the cross-border externalities. Several developing countries, the last havens of endemic polio, are paying a substantial price in the final stages of polio eradication, despite diminishing returns as the fewer and fewer cases become progressively more expensive to detect and contain. In fact, the poorest nations are bearing an inequitably larger burden for producing this IPG with each day that passes before the international community successfully finances and executes the eradication of polio. The valuation of contributions to the production of such IPGs will help to rationalize negotiations between developing and industrialized countries, and between creditors and debtor nations.

**Recommendation:**

*While developing countries should be encouraged to invest national resources in public goods for health, no poor country should indebt itself to finance the final stages of eradication when eradication will produce positive externalities with broad international reach.*

**Aggregation of Public Goods and the Implications for Financing**

Incentives and strategies for the pursuit and financing of IPGs are also affected by the way in which they accumulate. Sandler (2001) points out that goods may have “summative”, “weakest link”, or “best shot” patterns of accumulation or aggregation.

Most IPGs exhibit a mixture of patterns of aggregation. For example, vaccine development research has both summative (each contribution enhances the likelihood of successful development of an effective product) and best-shot (once a product is found, other efforts may become redundant) aggregation patterns. IPGs with summative patterns of aggregation

are often those that provide substantial national benefits. These are generally best financed with traditional country-focused ODA to augment or accelerate national investment, including through loans from multilateral development banks (MDBs). Disease elimination or eradication programs display weakest-link patterns of aggregation in that the smallest effort fixes the level of the IPG for the group. IPGs with weakest-link and best-shot patterns of aggregation are those most appropriate to grants, transnational alliances or global efforts for collective financing.

### **Sources and Current Levels of Financing for IPGs**

The expanding use of IPGs as a conceptual framework has made it increasingly possible to disaggregate development assistance expenditures by whether the public goods they produce are predominately national or international. Although funding for health IPGs is not quantified separately, the World Bank (May 2001) has recently summarized all-source funding for pursuit of IPGs, distinguishing activities as “core” (aimed specifically to produce IPGs) or “complementary” (preparing countries to consume IPGs). These estimates, summarized in the table below, are based on figures from OECD DAC and the Foundation Center and do not reflect recent increases in foundation giving, but provide a rough indication of the predominance of concessional funding in financing IPGs.

#### **Sources of Funding for Core and Complementary Activities Related to IPGs**

(Annual averages, 1994–1998, billion of US dollars)

Purpose of funds	Global and regional funding		Country-based finance		Total
	Foundations	Trust Funds	Concessional	Non-concessional	
Core activities	1	2	2	-	5
Complementary	-	-	8	3	11
<b>Total</b>	<b>1</b>	<b>2</b>	<b>10</b>	<b>3</b>	<b>16</b>

Though it is difficult to define and disaggregate spending on IPGs as a share of ODA, Cook (1999) and Morrissey (2000) offer data to suggest that the proportion of ODA committed to IPGs is on the rise, from about 4% in 1980 to around 10% today. Kaul (1999) estimates that the larger proportion of “one aid dollar in four supports global public goods rather than just the purely national concerns of poor countries”. The World Bank’s recent report (World Bank, May 2001) on Development Finance offers a substantially higher, though less credible, estimate that 30% to 40% of aid flows are dedicated to the pursuit of IPGs. Despite the broad variation in these estimates, the very limited aid to regional and global initiatives clearly reflects the paucity of financing effectively targeted to generate IPGs.

### **Donor Coordination and IPGs**

Historically, individual donors have operated relatively independently in each developing country, recognizing unmet local needs and addressing them as they can, within the

constraints of agency policies. “In general, goods with public attributes are provided when a single decisionmaker backed by adequate financing has strong enough interest in providing them” (Cooper, 2001). This haphazard “mosaic” approach to production and financing of public goods has sufficed historically, but has become increasingly inadequate as both the global problems have increased in size and the necessary solutions have increased in cost.

The accelerating spread of diseases such as AIDS and growing gaps between the health of the rich and the poor have made the lacunae in this mosaic more and more intolerable. Globalization has made the public “bads” increasingly international in their reach. National, regional, and even global coordination have become ever more important to ensure that aid is targeted to contribute optimally to the public good. Sharing and integration of information will require unprecedented national transparency and harmonization of surveillance systems in order to track infectious disease threats as well as to control terrorist threats to human health.

Despite this need, there are still few effective international mechanisms to identify and prioritize IPGs, to agree upon arrangements for shared financing of those goods, or to coordinate the necessary collective action that spans national and regional boundaries. National sovereignty and the economic and political interests of the nation-state have been daunting obstacles to the pursuit of IPGs. “The international public goods agenda opens up new and heretofore little explored dimensions of aid coordination that relate to issues of timing, balance, and synergy (World Bank, May 2001). While globalization is inevitable, human collaboration to mitigate its drawbacks and harness its benefits for human development is not.

The past few years have brought a new sense of global community and unanimity of purpose among many stakeholders groups. Demonstrations in Seattle, Washington and Genoa are evidence of the globalization of civil society. Although many civil organizations have not yet identified constructive mechanisms to voice their concerns, the ascendancy of global issues on their agenda is heartening. The “Call to Action” by the Secretary General also offers new hope of cooperation to address the global epidemics of AIDS, tuberculosis, and malaria. These and other recent trends that are the subject of this paper could herald new expectations and new success in the pursuit of IPGs for health.

This paper addresses the innovative financing of IPGs for health by source of funding. The paper does not simply focus on aid, but all modes of support and finance for global goods for health. It summarizes several innovative strategies for mobilization of new funds and more effective application of existing support from domestic sources in developing countries (Section 1), through bilateral aid (Section 2), multilateral development banks (Section 3), UN agencies (Section 4), and private sources (Section 5). Private funding is further divided into private philanthropic, civil society and NGO, and corporate sources of finance. Finally, strategic alliances among combinations of these partners are addressed (Section 6).

## 1. Developing Country Financing of IPGs

Global trends in the last decade have provided developing countries with increasing access to technology, ideas, and human resources for development in the health sector. Successful development and improved health will depend primarily on the mobilization and management of these domestic resources.

Most domestic expenditures for health are of private resources and yield private goods. Even those expenditures that yield public goods provide benefits that are primarily local or national in reach. This section of the paper confines itself to the discussion of domestic financing of IPGs and goods that provide substantial cross-border benefits.

### Strengthen National Social Architecture to Achieve IPGs for Health

Developing countries can, usually with little cost, recognize and manage public goods for health using legal and regulatory instruments. Policy, legislation, and regulation can be “engineered” to foster public goods and provide disincentives to creation of public “bads”. For example, creation of a policy environment that discourages misuse of antibiotics and reduces the spread of antibiotic resistance will provide a public good, yielding cross-border benefits in addition to national benefits.

The benefit to the globe of such policy reform in a single small country would be important, but limited in scope. However, introduction of harmonized legislation in a bloc of countries or a region would offer substantial positive externalities. But the global community has done little to promote constructive change in legislation and regulations that affect health. Traditional country-focused development assistance has been a barrier and the UN agencies have been reticent to promote legislative change. But the barriers to any single developing nation acting alone to introduce legislation and regulation to improve health are substantial.

#### Recommendation:

*Invest more global resources in regional efforts to develop prototype policies and model legislation and to harmonize these (including for intellectual property rights, trade, labor, and environmental protection) regionally to promote equitable improvement in health.*

### Enhance National Incentives to Pursue IPGs

Many publicly funded health interventions in developing countries have substantial cross-border spillover effects and contribute to production of IPGs. But few countries understand their willing or unwilling contributions to international public goods well enough to articulate these and “trade” them or use them in ODA negotiations as a *quid*

#### Recommendation:

*Developing nations should use the IPG framework to negotiate “exchanges” of contributions to IPGs for increased support for the national development agenda.*

*pro quo*. More widespread use of the concept of public goods should help developing countries to strengthen their hand in negotiating “conditionalities”, and in assuring that national priorities are also addressed. As Kaul (1999) suggests, “by establishing objective criteria for defining a global public good, the Northern and Southern development agendas that frequently seem to be in conflict become more comparable – and therefore negotiable”.

Since most IPGs have a local good component, the use of epidemiologic data to define the international or global benefits of each intervention will assist Northern and Southern nations in allocating the relative burden for financing those goods. This information will also help make the case for global or regional approaches to financing IPGs and will strengthen the hand of developing countries in negotiating increases in ODA and “softened” lending terms to finance health interventions with an IPG component. This increased transparency in negotiating development priorities will, itself, enhance developing countries’ willingness to collaborate in production of IPGs. Without such transparency and empowerment of developing countries, efforts to finance IPGs might be perceived as another effort to recoup the benefits of development assistance budgets for the industrialized countries. The IPG conceptual framework should accelerate the empowerment of developing countries, for as Kaul (2001) points out, “in the case of global public goods, there are typically no donors or recipients, but partners coming together to cooperate in the mutual interest of all” (Kaul, 2001).

Compensatory payments could be used to accelerate production of IPGs where the policy preferences and priorities of developing countries diverge. For example, global collective financing might be used to compensate countries for the excess cost of shifting from a cheaper antibiotic as a first line treatment to one that will inhibit the emergence of resistance. Such compensatory payments are analogous to those used by the Multilateral Development Fund established under the Montreal Protocol for the Global Environment Facility.

### **Shift the Focus to Regional Approaches**

A principal obstacle to the pursuit of many IPGs is the small size of the less and least developed countries. Many of these nations simply do not have large enough populations and economies to warrant the development of the necessary institutions to generate IPGs. Forced to make hard choices with limited resources, policy makers in the smallest countries defer investment in public goods such as research or even infectious disease prevention in favor of the perceived “emergency” of curative care for those now ill. A failure to invest in public goods for health may be ascribed to the temptation to “free ride” because of the investments of other countries. Though this may be a factor, especially among the poorest countries, many of these countries wisely refrain from investing in some

#### **Recommendation:**

*Accelerate and complement traditional country-focused aid programs through targeted financing for regional cooperation among developing nations in producing IPGs.*

public goods because the national benefit is simply too small to justify the expenditure.

Regional cooperation, analogous to that within the European Union or ASEAN, could be instrumental in overcoming this obstacle to national financing of public health institutions and interventions. Pursuit of development goals, as well as IPGs, will require regional or global alliances among nations in the developing world. National sovereignty is often offered as a reason to preserve the current situation, despite its adverse consequences for economic and social development. It may also be in the interests of the industrialized nations to preserve this *status quo*.

Donor nations should structure ODA to promote regional “club” approaches to produce IPGs, where those that benefit from a good share the largest proportion of the costs. For example, countries in a region might adopt harmonized or standardized policies and practices for surveillance and treatment of infectious diseases and in exchange for having access to regional resources for epidemic investigation and control.

## 2. Bilateral Development Assistance and IPGs for Health

### Enable Developing Nations to Create Public Goods

A highly leveraged use of bilateral (as well as multilateral) ODA to produce international public goods lies in technical assistance to developing countries for optimizing policy, legislation, and regulations to “internalize externalities”. LDCs need help in modulating incentives and managing market forces for the public good. The “policy environment” is widely acknowledged to be critical in producing IPGs, but the aid community has little expertise or experience in helping countries to improve it in a way that is consistent with local ownership.

### Transcend Traditional Country-Focused Aid

There is nearly universal agreement that overall ODA is less than adequate, in effectiveness as well as quantity, to pursue IPGs. Kanbur (1999) points out that two recent trends indicate the need for a reassessment of ODA strategies. These include “the rise of transnational problems” and “disenchantment with conventional country-

#### Recommendation:

*Target bilateral aid, through an initiative implemented with UN agencies, to create a “menu” of policy and legislative options from which developing countries can draw to create both national public goods and IPGs.*

#### Recommendation:

*Accelerate and complement traditional country-focused aid programs through targeted financing for regional cooperation among developing nations in producing IPGs. Regional cooperation to address public needs hitherto neglected, including human resource development and health research, should receive special attention.*

focused assistance”.

These two trends are undoubtedly linked. While bilateral aid packages are still negotiated on a country-by-country basis, donors often use single-country ODA as an instrument to address more global issues. The development priorities of countries are therefore rarely financed “as is”, despite the stated intentions of sector-wide approaches (SWAPs) and poverty reduction strategy papers (PRSPs). Conditionality or “joint” design teams may be used to ensure that bilateral aid programs help to address global priorities, generating IPGs such as health research results and progress in eradicating or eliminating communicable diseases.

Since few IPGs are truly global in scope, development assistance to regional organizations and programs would also be an obvious strategy to pursue many IPGs. There have, however, been few such regional programs or organizations. The Onchocerciasis Control Program, which was established in 1974 to control river blindness in 11 countries in Africa, has been the pre-eminent example of a regional effort to pursue an IPG. This highly successful program was developed and funded primarily by the US, the Netherlands, the World Bank and WHO. In 1987, Merck & Co. made a commitment to provide financial resources and its drug Mectizan for as long as it is needed. Further discussion of such multidonor alliances for the pursuit of IPGs is presented in section VI below.

With globalization, country-focused aid has become inadequate to fully achieve national development goals and it is thoroughly ineffective in the pursuit of IPGs. New strategies are needed for delivery of bilateral development assistance, including through provision of new funds for initiatives that feature inter-country or regional alliances.

### **Account for ODA to Enhance Incentives to Finance and Produce IPGs**

Although hardly an “innovative” approach to financing, there must be an absolute increase in the total of ODA and the relative proportion of ODA dedicated to health. This will be critical in addressing the inequitable burden of illness in developing countries and in order to expand the envelope available for financing IPGs for health. As Ernesto Zedillo (2001) points out, “the challenge is to persuade the politicians and citizens of industrial countries that aid expenditures to build a more secure world are a vital investment – and certainly less onerous and more efficacious than military expenditures.”

It can be argued, however, that the more global the public good, the less rational it is to tap ODA to finance its production. Kaul (1999, 2001) has suggested two separate “streams” of ODA, one for traditional bilateral aid to finance national or local goods, with a separate account for “global priorities” and IPGs. Developing countries would thereby be released to fully apply their conventional development assistance funding to achieve their national health goals. This adjustment in procedures for public finance to recognize the cross-border externalities to both national interventions and ODA would enhance public and policymaker awareness of the important distinction between national and supra-national uses for aid. The

“dual streams” idea has growing support within the UN and among its member states (PrepCom on Financing for Development, Feb 2001). Because the OECD definition of ODA requires that the donor country receive nothing in return (van Kesteren, 2001), some caution is warranted to assure that funding targeted for IPGs is accounted as ODA from the donor country.

More recently, Kaul (2001) has suggested that the costs of producing IPGs “should be partly borne by the national health sector budgets of industrialized countries, rather than by their aid budgets alone”. The UK and the US both have made progress in “mainstreaming” their investments in IPGs by providing regular budget support for institutions with international mandates and through tax incentives for research and development targeted for “orphan” diseases.

**Recommendation:**

*Mobilize additional resources to complement traditional ODA, by adding a separate account for IPGs and by leveraging more national resources within industrialized countries for IPGs for health.*

**Promote Global Collective Action**

IPGs are perhaps most appropriately pursued through assistance that transcends national boundaries. Historically, contributions to the multilaterals, including WHO and UNICEF, have been the principal mechanism used by the bilateral aid agencies to pursue IPGs for health. A most recent and encouraging trend has been the new leadership and activism among G-8 donors in accelerating control efforts for HIV/AIDS, tuberculosis and malaria. G8 bilateral AID agencies have already seen increases in their health budgets (G8 Communiqué, 2000). These donors have expressed financial commitments to the newly established Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), though it will be important to assure that these resources are truly additional rather than “repackaged” announcements of previous appropriations or diversions of funds from other health ODA. The GFATM is discussed in further detail in Section 6.

**Recommendation:**

*Donor nations should sustain and expand their efforts to promote global collective action for the financing and production of IPGs.*

### 3. Multilateral Development Banks and IPGs for Health

The first regional development banks were created 150 years ago to accelerate economic development by providing long-term loans to support new industries when the commercial banks were unable to fulfill this need. After the Great Depression and World War II, there was again a global sense of failure of the international economic order that led to creation of the Bretton Woods institutions. These institutions, including the World Bank Group and the International Monetary Fund (IMF) were designed to pursue IPGs, constructing “a new international economic order that would provide for economic stability, promote economic growth and facilitate the development of the poorest countries” (Stiglitz, 1998).

But like the bilateral aid agencies, the MDBs are organized by country relationships. Only sovereign nations are permitted to guarantee the loans that are the MDBs’ principal instrument for development assistance. In addition to the constraint of working primarily country-by-country, the MDBs have lacked the organizational culture to take action at regional or global levels in the public interest.

An even more important constraint to the pursuit of IPGs by the MDBs has been the lack of flexible financial instruments for financing projects with benefits that are international or global in their reach. The MDBs are designed to provide loans. Within the World Bank Group, loan rates depend on the per capita GDP of the debtor nation, with the poorest qualifying for low-interest IDA (International Development Association) loans while richer countries must borrow at higher IBRD (International Bank for Reconstruction and Development) interest rates. Countries that “graduate” to IBRD rates must borrow at the higher rates regardless of whether the project produces benefits that are private or public, national or international.

#### Target Loans for Optimum Impact

Recently, however, the MDBs have begun to take an expanding role in financing IPGs and interventions with substantial cross-border externalities. The Inter-American Development Bank (IDB) has provided grants and loans for regional initiatives for agricultural research and regional electrification. The World Bank’s Development Committee has already endorsed the pursuit of “global public goods”, with control of communicable diseases specifically identified as a “particular” priority (WB/IMF Development Committee, 2001).

As evidence of this new priority, the World Bank has made recent commitments to triple the availability of International Development

#### Recommendation:

*The MDBs should continue to expand their already important role in financing IPGs for health, including through introducing new financial instruments to better address transnational problems and to provide rewards or incentives for countries that contribute to the production of IPGs.*

Association (IDA) lending for communicable disease control, including HIV/AIDS, tuberculosis, and malaria. Using IDA, the Bank has recently provided intensive support for development of a broad response to AIDS in Africa. By the end of FY 2000, the Bank had committed more than US\$ one billion for 99 AIDS-related projects in 56 countries under IDA's Multi-Country HIV/AIDS Program for Africa (MAP).

Partly in response to the growing recognition of the need for international action and financing for IPGs, the World Bank established the Development Grant Facility (DGF) in 1998. The DGF combines bilateral donor funds with a smaller contribution from the Bank's

#### **Softening Lending Terms for IPGs**

In partnership with several bilateral donors and the Bill & Melinda Gates Foundation, the World Bank has recently designed a new program to finance IPGs for health. Modelled on a tuberculosis control project funded by the UK's Department for International Development in China, this initiative:

- Rewards achievement of health outcomes by using pooled donor funds to "pay down" interest rates on loans for projects only if they achieve mutually agreeable performance targets;
- Supports special assistance to improve the technical quality of projects using the new financing mechanism; and,
- Incorporates developing country and other donor participation in the approval and governance of new projects.

The program offers new incentives to developing countries to invest in IPGs and new hope to donors that these investments will produce results.

administrative budget, facilitating the expenditure of about \$1.1 billion a year. It has supported multi-institutional partnerships to address "transnational development challenges not adequately supported through country lending operations" (World Bank, May 2001).

Although the World Bank has historically evaluated "performance" solely in terms of disbursement of funds, there is a new and encouraging commitment to achievement of improved health outcomes and willingness to link loan terms to these results. As evidence of this, the World

Bank has established a new instrument for Adaptable Program Lending (APL), which releases tranches of funding only upon achievement of mutually agreeable performance targets (Batson, personal communication, 11/July/01).

#### **Increase Concessional Resources for IPGs**

The World Bank is already "cautiously exploring a possible role for IDA grants" to support the pursuit of IPGs (WB/IMF Development Committee, 2001). But there is considerable "debate", both within and outside the Bank regarding the appropriateness of this emerging role as a development assistance grantmaker (Piercy, June 2001).

The World Bank also has a history of contributing some of its own resources, primarily

through technical and administrative support to these trust funds, to pursue IPGs for agriculture and the environment. Its support of the Consultative Group for International Agricultural Research (CGIAR), and the Global Environmental Facility (GEF) are the preeminent examples. Other recent Bank contributions to global initiatives in the health sector include the International AIDS Vaccine Initiative (IAVI), the Global Program to Eradicate Lymphatic Filariasis and the Dracunculiasis (Guinea Worm) Eradication Program.

The World Bank has also had an expanding role as a depository and trustee for funds pooled by multiple donors or used by multiple implementing agencies to pursue IPGs. This role for the World Bank, in which it provides fiduciary “savings and checking” services for transnational programs, is likely to expand in the future. This role for the Bank should be formalized and the services provided at little or no cost for the financing of IPGs. Such global initiatives with financing pooled from multiple sources are discussed further in section VI.

#### **4. United Nations Agencies and IPGs**

In the interest of the sovereignty of the nation-state, the global community has constrained the function of the UN agencies so that they cannot fully undertake the pursuit of IPGs. The UN is structured to make decisions through consensus among its 185 member states, and is therefore faced with considerable political obstacles to substantial change. Because it reports to these member states, it is designed to give less heed to the interests of civil society, including NGOs, and to the business community. The UN agencies have, therefore, been less likely to harness these potentially powerful forces to improve the health of the poor. The UN has also been constrained financially, as the rich nations have withheld their scheduled contributions as a mechanism to control UN actions. Emerging changes, however, especially within the World Health Organization (WHO) suggest that the UN may be newly willing and able to innovate.

##### **Prioritize Interventions for Pursuit of IPGs**

Most would cite the UN agencies as the most obvious mechanism to identify, prioritize and pursue global public goods or IPGs at the international level. Although the UN agencies do not directly finance major new initiatives to produce IPGs, they have the capacity (though often not the political will) to identify priorities among IPGs and mobilize funds for new initiatives from bilateral donors. Once the funds have been allocated, UN agencies have the comparative advantage of being able to act transnationally or engage directly in multi-country programs.

##### **Recommendation:**

*WHO and the other UN agencies should receive increased support to identify and prioritize needs for IPGs, and to strengthen policy and legislation for IPGs in member states.*

The UN agencies are uniquely well positioned to analyze IPG priorities, define the distributional characteristics of the benefits of each public health intervention, and make recommendations regarding the proportion of each intervention that should be privately or publicly financed (and, if publicly financed, whether the costs should be borne at local, regional, or global levels). The UN is also able to ensure developing country participation in the process, articulate the global consensus about these funding priorities, and support in-country efforts to meet global standards for policy and program implementation.

### **Facilitate New Partnerships for IPGs**

WHO has organized several global programs, including the Tropical Diseases Research Program and the Polio Eradication Initiative, to address the need for global collective action for financing and production of IPGs. To fund these and other “extrabudgetary” programs for the pursuit of IPGs, WHO relies primarily upon donor voluntarism.

Many of these global initiatives rely on interagency partnerships and alliances with the private sector. And increasingly, these efforts to mobilize international collective financing have taken place outside the UN system. At present, collective action by the UN is hampered by the fact that it remains multinational, rather than truly international or global in its interests and actions. Partnerships formed outside the UN have had the further advantages of a greater sense of ownership by donors and more substantial participation by the private sector.

Even defenders of WHO acknowledge that “partnerships that are housed outside the UN bureaucracy are viewed as a way of getting things done, and, when industry is involved, getting things done efficiently (Buse and Walt, 2000[1]).” Widespread “concerns about the effectiveness of the UN, including increasing evidence of overlapping mandates and interagency competition” have further stimulated the establishment of partnerships outside the UN system to pursue IPGs for health.

There is a sense that the UN has been forced to concede or share leadership with other agencies because of its lack of control over the financing. Buse & Walt (2000a) point out that “the under-resourced UN’s resolute drive toward collaboration with the private sector derives, at least in part, from a position of financial weakness.” But Sigrun Møgedal, Norway’s Secretary of International Development, insists that these “innovative partnerships...should not be seen as undermining the authority of the UN”. While they may not be ideal as prime movers in organizing the collective financing of these efforts, WHO and the other UN agencies are critical players in establishing priorities and fostering global cooperation to produce IPGs for health.

## **5. Private Finance of IPGs for Health**

The globalization of economies and of civil society has led to a “partial eclipse” of government influence in producing IPGs. “As long as national governments held sway over the commanding heights of the economy, the development system was bound to be focused

on project financing and country-based plans. But it is now clear that the weakening of national public bureaucracies to make room for a burgeoning civil society – as well as far-flung multinational businesses – calls for fundamental adjustments in the modalities of development assistance” (World Bank, June 2001).

Most of the globe’s financial resources lie in the private, not the public sector. In addition to these financial resources, the products and expertise controlled by private industry must be tapped to contribute to the health and well being of the public. Private commitment to public health must be better encouraged not only within nations, but also at the international and global levels.

Already the private sector has been increasingly recognized as a powerful ally in the pursuit of IPGs (World Bank, 1998). The private sector also has the comparative advantage of being less constrained by national identities and interests. Though multilaterals are accountable only to nation-states, international civil society and corporations might report to a truly global constituency. Developing country governments, however, often object to the “anointing” of civil society leaders who may have questionable representative legitimacy. There is broad agreement, in any case, that transparency and accountability still remain much too limited in the private sector, including among NGOs and foundations.

Although there are concerns about their governance, no one has eschewed the new resources brought by the private sector for financing IPGs. Globalization of civil society has brought encouraging new commitments of private resources to global public health from philanthropies, industry, and NGOs alike. But as these new resources have been injected, these newly important stakeholders have a larger voice in defining the processes and outcomes in the pursuit of IPGs. It may be that “the most important political implication of globalization is the shift of power from government and intergovernmental agencies to private actors – to non-governmental organizations (NGOs), private business and the press and media” (Matthews, 1997).

This section addresses three sources of private finance that are emerging as increasingly important for the financing and pursuit of IPGs: a) private philanthropies, b) civil society, including non-governmental organizations, and c) corporations.

#### **a. Philanthropy and IPGs**

Private charitable foundations have become an increasingly important source of social venture capital for public goods, including IPGs for health. It is estimated that foundations provide “about 2 percent of official development assistance and about 20% of international resource transfers on public goods” (World Bank, May 2001). As reflected in the recent recession, however, resources flows from the private sector are sometimes less predictable, due to their vulnerability to changes in economic growth patterns.

During the last century, US Foundations such as those established by the Carnegie,

Rockefeller and Ford families, have made substantial investments in knowledge generation and medical research as public goods. A “tacit division of labor” has emerged wherein foundations undertake higher risk research and development while their successful ideas are then embraced by governments and handed over to public agencies for their widespread implementation (Letts, Ryan, and Grossman, 1997). Foundations also have the comparative advantage of being perceived as “honest brokers”, without the political agendas that often underlie government programs, including ODA.

By 1998, there were more than 47,000 foundations in the US holding assets of over \$385 billion (Foundation Center, 2000). Giving by these foundations doubled in five years, from \$11.3 billion in 1994 to \$22.8 billion in 1999. While only a small proportion of this has been disbursed for international programs, virtually all of it is dedicated to the pursuit of public goods. The proportion that is international is increasing as globalization has brought a geographically broader sense of social responsibility (Smith, 1994).

In addition to this increase in international grantmaking, the Foundation Center (<http://fdncenter.org>) sees trends toward more partnerships among funders, and increased emphasis on grants that educate the public about international issues, promote citizen philanthropy and leverage other donors. It is estimated that only 2% of US philanthropy is committed to international health grants, much of which is programmed through US institutions.

### **Strengthen Incentives for Private Citizens to Finance IPGs**

While private philanthropic giving is an increasingly important resource for IPGs, not all of those who are willing and able to give have done so. The real wealth of millionaires has grown by 375% in the last 15 years. There are more than 57,000 individuals whose fortunes exceed US\$30 million, garnering a cumulative worth of \$8.37 trillion (Report of the UNSG, 2000). Though most of these potential philanthropists are not yet ready to relinquish the work of expanding their personal wealth, many are increasingly aware of the 1.2 billion people living on less than a dollar a day, and might be persuaded – if given financial incentives and technical support - to commit substantial resources to reduce the growing inequities.

Cooper (2001) points out that, “it’s worth asking why private philanthropy is well developed in a few countries but poorly developed in other countries that are equally well off economically.” Engineering of laws and regulations is perhaps the most effective incentive for such generosity. The 1986 reform of US tax code has allowed wealthy individuals to contribute to “improve public welfare” to avoid a wealth tax of 60% or more (Schervish, 2000). The UK, Japan, and the EU

#### **Recommendation:**

*Promote increased private giving for IPGs, including through technical support for philanthropists and corporate foundations and strengthened tax incentives for philanthropic and corporate contributions.*

have all seen recent increases in both individual and corporate contributions for IPGs due to changing norms and legislation. More developing countries are also noting the rise of indigenous philanthropy (Foundation Center, 2000), a trend that should be further encouraged.

## **b. Civil Society and IPGs**

### **Promote the Globalization of Civil Society for IPGs**

Civil organizations are “increasingly important in the supply of global public goods” (Malik,

#### **Rotary International and Polio Eradication**

Rotary International has been instrumental in both the financing and the implementation of polio eradication. The organization has raised over \$450 million and mobilized countless volunteers for an effort that will yield health benefits and cost savings for all time. Eradication of polio, which is now imminent, will prevent an estimated 10 million cases over the next 40 years, with a global cost savings of US\$ 33.2 billion in treatment and vaccine costs alone.

Because of the higher costs of immunization and illness care in industrialized countries, the lion’s share of this estimated cost savings accrues to rich countries, including US\$200 million a year to Western European countries and US\$230 million a year to the United States.

There has been no formal “global alliance” to achieve this goal, but the leadership of WHO and Rotary have elicited broad collaboration among developing countries, multilateral agencies, bilateral donors, NGOs and foundations. Traditional country-focused assistance would have been inadequately fast and flexible to ensure rapid response to the last few outbreaks to prevent their spread.

2001). Most use funding from donors to implement their programs, though a few raise “new” money for these programs from individual and corporate sources. Private voluntary contributions, such as through NGOs and community foundations, could be exploited to greater advantage in pursuit of IPGs for health. Community groups in developing countries, such as women’s groups and churches, already provide massive, though difficult to quantify, resources for local public goods. Many of these organizations, in addition to financing and supplying IPGs, play an important role in advocacy to strengthen demand for IPGs and pressing the public sector to respond to emerging needs for IPGs.

These organizations have been quick to adapt their behavior in the emerging context of globalization. International alliances of non-governmental organizations (NGOs) have emerged to provide transnational support for other civil society efforts, including for monitoring emerging infectious diseases, combating AIDS, and providing organizational development support for indigenous NGOs in developing countries.

In addition to Rotary International and its well-known contribution to polio eradication, Kiwanis Clubs have been instrumental in global efforts to eliminate iodine deficiency through iodization of salt, and the International Red Cross has helped to address the transnational needs of refugees and responses to disasters. In healthy societies, civil society is instrumental in ensuring transparency and accountability in government institutions. Though global civil society is new and still testing its voice, it has successfully brought world attention to issues of equity, including in the distribution of the benefits of globalization and access to drugs for treatment of AIDS. “As we saw at Seattle, many protesters see the international financial architecture as it presently exists as a club good. The more civil society expresses social concerns, the more likely it will be that these concerns are taken into account” (Kaul, 2001).

**Recommendation:**

*Make fuller use of the grass roots organizing power of civil society to promote, finance, and implement programs to produce IPGs for health.*

**c. Global Corporate Citizenship and IPGs**

**Enable Industry’s Contributions for IPGs**

There has been enormous growth of private business in the past decade; and the private-for-profit sector has exhibited its characteristic agility, identifying the changes of globalization as an unprecedented opportunity for business development. Through artful design of legislation and regulation, private investment could be encouraged to “flow into channels that lead to ‘high quality growth’, that is, growth that supports sustainable human development and reduces poverty (Culpepper, 1999).”

Though multinational corporations have often been cast as villains, the past lack of constructive contribution by industry for achieving social goals reflects a lack of leadership in the international public sector to guide this contribution. The international public sector has so far largely failed to provide incentives for the private sector to contribute to IPGs or improvements in public health. It is an expectation that the IPG discourse will accelerate progress toward rectifying that failure.

Broader access to information, coupled with improvements in governance could also help to drive improvements in the health and well-being of the poor and make marginalization of less privileged groups unsustainable. But international civil society and the public sector must recognize these opportunities and form new alliances with private business in order to pursue them. The Global Business Council for AIDS, with the leadership of Richard Holbrooke, represents a development that promises to better harness the resources of the private sector for the public good. Many corporate leaders have contributed to the UN Secretary General’s “Global Compact” for control of HIV/AIDS, while others have even called for a new “Marshall Plan” to rectify inequities and accelerate development in the poorest

countries (Schrempp, 2001).

The number of transnational corporations is now estimated at 37,000 globally. They control a third of all private-sector assets and have sales of \$5.5 trillion, comparable to the US gross national product. In the US, where tax laws favor corporate philanthropy, there are more than 2000 corporate foundations holding approximately \$13 billion in total assets (Foundation Center, 2001).

Net private capital flows (including foreign direct investment, bank lending, bond lending and portfolio equity) to developing countries, now recovering toward their 1997 level of \$220 billion, are about four times as large as official aid flows. It is estimated that a 50% reduction in trade barriers (which could be provided in exchange for increases in national investment in health) could further increase private capital flows to developing countries by more than USD 100 billion a year (Köhler, 2001). The EC has shown encouraging leadership in this area, launching an initiative to provide free access for the exports of the poorest countries.

The public sector must exhibit the leadership to enhance incentives for constructive engagement of private funds and institutions. “The large resource requirements can only be met by leveraging scarce official and philanthropic funds with additional private resources. In particular, official funds should be used strategically to mobilize or ‘pull in’ private finance for activities that offer the continual prospect of a commercially run business...” (World Bank, May 2001).

But many public sector leaders have raised alarms about collaboration with industry. In its eagerness to address market failures and pursue IPGs, public-private partnerships are often structured so that the public sector absorbs the lion’s share of the risk and the costs, while

#### **Medicines for Malaria Venture (MMV)**

MMV was developed to “discover, develop, and commercialize antimalarial drugs at a rate of one new product every five years and at prices that are affordable to populations worst hit by the disease”. It uses a social venture capital model and treats patenting and licensing rights as an “essential element of project deals”, in an effort to ensure a reasonable profit and sustainable mechanisms for production and distribution of drugs (Wheeler, 2001). Developed within WHO, the MMV was “spun off” when it was recognized that it could operate more effectively in a role that is more independent of the international public sector.

the private sector absorbs a disproportionate share of the profit. The Medicines for Malaria Venture (MMV) and the International AIDS Vaccine Initiative (IAVI) are both recent public-private partnerships for health in which the public sector assumes the risk and provides the capital to develop new products for which market forces have failed. But many would argue that the public sector lacks knowledge of the private sector’s real costs and is likely

to yield too much to the private-for-profits, committing more resources than necessary to generate IPGs for health. Others see all private sector goals as a

one-dimensional commitment to maximizing profits at all costs and in conflict with the goal of better health (Hancock, 1998).

While values may not be fully shared, there remain substantial opportunities to capitalize on the shared objectives between public and private sectors, such as for development of products to address diseases of public importance in developing countries. Especially in the pharmaceutical industry, there is growing interest in contributing to the pursuit of IPGs. For example, Merck's positive experience in donation of ivermectin (Mectizan®) to combat onchocerciasis has been cited as stimulating further "pharmaco-philanthropy" (Wehreim, 1999). More recent important drug donations have included Malarone® for treatment of drug-resistant malaria (Glaxo Wellcome), albendazole to accelerate elimination of lymphatic filariasis (GlaxoSmithKline), and Zithromax® to eliminate blinding trachoma (Pfizer, Inc). GSK's donation alone is likely to top US\$1 billion. Merck, Bristol-Myers Squibb, and other pharmaceutical corporations are beginning to take steps to make antiretroviral treatments more accessible for treatment of HIV/AIDS patients in developing countries.

These promising signs of good corporate citizenship have been seen at the global level. But within individual developing countries, corporate responsibility is more uneven. Little of the foreign direct investment and other private flows to developing countries have been successfully harnessed to achieve local or global public goods. There is a need for more innovative mechanisms to strengthen incentives for both local and multinational corporations to assume a constructive role in the pursuit of public goods for health. As noted above, development assistance should be targeted to assist developing countries and to achieve regional harmonization of policies to enhance private participation in pursuit of public goods.

Several other promising strategies have been identified to enhance private industry's incentives to contribute toward IPGs for health. Other papers have addressed the use of publicly funded research and access to venture capital to address the market failure and to "push" the development of vaccines and drugs for diseases of the poor world. Subsidizing or developing new facilities for research, development, and manufacturing of drugs and vaccines within the public sector or in developing countries also offers hope of overcoming the current barriers to provision of tools for prevention and treatment of important diseases in the poor world. Creative mechanisms for public financing of these facilities should be considered, including accelerated

**Recommendation:**

*Strengthen financial incentives for industrial contribution to IPGs using multiple strategies, including tax credits, awards for development of critical products, exchanges or extensions of patent and marketing rights for price concessions, pre-commitments or trust funds to purchase new products, and improving the effectiveness of systems for delivery of key health products and interventions.*

depreciation or issuance of revenue bonds for construction.

“Pull” incentives have also recently shown promise. Favorable changes in patent and marketing rights, tax credits and pre-commitments to purchase products have all been proposed to strengthen private sector participation in pursuit of public goods. For example, the Millennium Vaccine Initiative in the US announced up to \$1 billion in tax credits to corporations to promote the delivery of existing vaccines and accelerate development of new vaccines for developing countries. Public policies that link financial incentives to the achievement of results will help assure increased convergence of public and private goals.

The most effective “pull” mechanisms, however, will be the effective delivery and marketing of products such as vaccines and drugs in developing countries. A strategic combination public and private partners using both “push” and “pull” financing mechanisms will be needed to overcome the market failures and ensure development of such public goods as vaccines and drugs effective against HIV/AIDS (Batson, 2001; Sagasti, 2001), malaria, tuberculosis, and other infectious diseases prevalent in developing countries (Wheeler, 2001).

More distant possibilities for raising more revenue for IPGs include introduction of taxes on international trade and currency exchange flows (Tobin tax), or for use of global commons (such as for ocean freight, air traffic, deep-sea mining, fishing in international waters, or “parking” of geostationary satellites). Tanzi (2000) has proposed creation of a World Tax Organization, as a forum for coordinating national tax policies for IPGs and, perhaps less realistically, to levy and collect taxes on international financial transactions. Such taxes could be used not only to raise revenue for public goods, but as corrective or Pigovian taxes providing disincentives for public “bads”. They might be used, for example, to deter speculative transactions that are most destabilizing for the global economy (Michalos, 1997) or discourage international trade in specific commodities (such as arms or toxic pesticides) that are damaging to health. Other less feasible proposals using international monetary measures include the use of special drawing rights (SDRs) and the sales of International Monetary Fund’s gold reserves (valued at around \$37 billion) to achieve development goals.

## **6. Transnational Alliances and Collective Financing of IPGs**

The global AIDS epidemic brings the greatest pressure to date to solve the undersupply of IPGs. “A supranational government backed by the power to tax could remedy this mismatch of demand and supply. But because no such entity exists, the commitment of public and private resources to international public goods requires the coordination of efforts across national borders” (World Bank, May 2001). But with the nations of the world still unready to cede sovereignty to any global government, the pressing need for collective action has engendered a recent profusion of transnational “alliances”, “partnerships”, and “funds”. Many are designed to pursue specific public goods such as vaccine development

and immunization (Global Alliance for Vaccines and Immunization), development of a vaccine to prevent HIV/AIDS in least developed countries (International AIDS Vaccine Initiative) or improved drugs for treatment of tuberculosis (Global Alliance for TB Drug Development).

These alliances are assembled quickly and the rumor that the “train is leaving the station” brings donors to the table with uncharacteristic speed. Participation is voluntary, but there is

#### **The Global Fund for AIDS and Health**

The new Global Fund for AIDS, Tuberculosis and Malaria (GFATM) represents the convergence of several collective efforts, including the pursuit of the health goals identified in the recent G-8 meetings in Okinawa and Genoa. They have pledged \$1.7 billion, although little of this has been deposited to date. It is scheduled to have operational governance structures early this year and to begin disbursing funds in April or May. The process of structuring this Fund has already brought many lessons about the transaction costs of alliance formation and the challenges of tracking contributions despite earmarking, fungibility and questionable additionality.

substantial pressure on the G8 governments to contribute. Some have suggested that a “common pool” of blended funds should discourage or even forbid “earmarking” for specific purposes (Kanbur, 1999). However, to proscribe donor governments from complying with their respective political constraints would clearly be a deal breaker.

Especially in the case of the GFATM, it has been a challenge to achieve consensus regarding governance and the priorities for use of the Fund. While some partners have an expectation that the resources will be used for IPGs, others envision

financing country health development plans or provision of private goods such as medical services. Public sector agencies emphasize the importance of “representative legitimacy” and “due process”, and express concern that “private sector representation is ad hoc and based on personal contacts” (Buse, 2000[2]). Meanwhile, private partners seek credible and flexible leadership that is de-linked from organizational or national representation.

Since these alliances provide mechanisms to mobilize new funds, the governments of rich nations have dominated the early phases of their development. There is broad commitment to ensuring substantial participation of developing nations in their governance, but there is still no consensus regarding the mechanisms to shift the balance of power and ownership toward the developing world.

There is growing consensus that the international community should reserve its resources not for what individual countries can do for themselves, but for tasks that require international collective action (World Health Report,

#### **Recommendation:**

*Use transnational financing to achieve transnational goals. Structure the collective financing mechanisms, such as the GFATM, to provide incentives for mobilizing domestic resources and for regional cooperation for pursuit of IPGs.*

1999). The Global Fund for AIDS and Health represents a highly visible and important experiment in international collective action. Future success in such transnational pursuit of IPGs for health will depend on the experience of the next few years with this effort. If these resources are used solely to finance “business as usual” through country-by-country programs, the world will likely deem it a failure. To fail to innovate, to fail to act transnationally, would squander the comparative advantage and potential added value of pooled resources. Although all local efforts to control these three diseases will have positive cross-border externalities, there should be a higher priority placed on financing interventions expected to provide international public goods with the broadest reach and largest impact. “Additionality” of these resources for IPGs should be assured by holding donors accountable for sustaining or increasing conventional bilateral ODA to address national development goals.

## 7. Conclusions

The discourse on IPGs has established a fresh view of the next steps for pursuit and financing of global health goals. As Faure (2001) suggests, the debate on IPGs has yielded “an array of innovative approaches to addressing the chronic under-funding of collective action in areas such as peace, health, and financial stability, in ways that cut cross established institutional boundaries and public and private sectors”.

### Prioritize IPGs to Accelerate Financing

Achieving and articulating consensus within the public health community regarding which IPGs to produce may be a greater challenge than determining how to finance them. The apparent lack of a focused and credible set of priorities and an operational plan for IPGs such as AIDS control, vaccine development, or global disease surveillance remains a principal barrier to securing financing. But new “ownership” of the public health agenda by leaders from outside the public health community has brought substantial progress in financing IPGs for health. This infusion of new leadership has created shifts in global consensus and brought hitherto unimaginable advances, for example, in implementation of treatment for tuberculosis and acceleration of interventions for AIDS in Africa. The public health community should contribute as it can to accelerate this trend.

#### Recommendation:

*Invest more resources in efforts to build political will and social momentum for the pursuit of IPGs among opinion leaders outside the health sector.*

There is an ever-present risk that finances will be diverted for the private good of illness care at the expense of the public goods of prevention and of research and development to continually develop new intervention technologies. Recent flurries of attention to provision of highly active antiretroviral therapy (HAART) for individuals with AIDS, for example, should not be allowed to undermine the sustained commitment to the public goods of

epidemic control and vaccine development. Vigilance is also needed to prevent under-investment in health research and generation of knowledge. Clear articulation and separation of streams of funding for public and private, local and global goods will help to preserve a rational balance in these investments.

### **Reform the International Development Architecture for the Global Context**

Neither the current quantity of financing nor the present structure of the “international development architecture” is adequate to fully enable global action for human health. The growing demand for international public goods provides the opportunity to make a case for additional aid resources. These resources must be truly additional, not diverted from conventional country-focused ODA budgets. National public goods must still be pursued, but “the new development paradigm will have to make room for support to global public policies and programs” (World Bank, June 2001).

Institutions as well as aid strategies must be redesigned to channel larger resources in new ways and to take account of the growing integration of the global economy. It has been suggested, “the international community requires an institutional and organizational framework for transnational problem solving on an ongoing basis” (World Bank, May 2001). While conventional ODA and participation in alliances will likely remain voluntary, there is an opportunity to use more automatic approaches to increase funding to strengthen critical institutions.

There is reason to hope that the pursuit of IPGs for health will establish a precedent for success in global collective action. With public health on the ascendancy in the global agenda, control of communicable diseases such as AIDS, tuberculosis, and malaria are goods that the world seems newly prepared to “purchase”. Disease elimination and eradication and research for global health may be the first IPGs around which the world is willing to mobilize, pool resources, and establish new mechanisms for global governance to guide cooperation. The best practices and “lessons learned” from this pursuit of IPGs for

#### **Summary of Key Recommendations:**

- *The development assistance community should become more explicitly concerned with identifying distinct strategies for prioritization and financing of IPGs.*
- *Valuation of contributions to the production of IPGs will help to clarify whether interventions should be financed through loans or through (fully or partially) concessional financing.*
- *Innovative financing mechanisms should include a host of reforms designed to enhance private sector contributions to IPGs and mechanisms to leverage or “soften” MDB financing using ODA or philanthropic dollars.*
- *ODA should be structured to enhance support for regional and global initiatives, including for regionally harmonized policy and legislative reform and development of regional institutions for research and training.*

health may then be extended to efforts in other sectors. Human health and security will finally require effective control of broader risk factors such as conflict, terrorism, trade and environmental safety. But we may be better prepared for the necessary economic and political concessions to contain these intersectoral threats with the experience gained from successes in global collective action for control of communicable diseases.

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