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Putting Aid in Its Place: Financing Common Goods

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Who should set priorities in global health? Last year CGD authors made the case for a greater role for country-led priority-setting, with a stronger influence on aid, referred to as a "New Compact" between countries and donors. However, national priority-setting institutions may rationally undervalue healthcare investments with cross-border impacts, since their primary focus is their constituent population, not those in other countries. Global public goods and other common goods, are, therefore, at risk of underinvestment in this framework, highlighting the need for complementary mechanisms of priority-setting and financing.

For example, global health security (a form of global public good) is created in part through country-level services such as disease surveillance systems. The role of the Pandemic Fund to set priorities and directly finance pandemic preparedness is therefore different from global health initiatives which focus principally on core health services, where there is a clearer case for country ownership. Efforts to act on the Lusaka Agenda and reform of the global health architecture should be guided by this distinction.

KEY MESSAGES

- Healthcare priority-setting led by national institutions can risk undervaluing investments with cross-border impacts.
- Supranational action through international relations and/or non-state actors (such as multilateral initiatives or private philanthropy) can mitigate this risk.
- Efforts to rework health financing in aid recipient countries by empowering country priority-setting institutions—including the New Compact—must recognise these common goods and ensure appropriate support to both country and supranational priority-setting systems and institutions.

The tragedy of the common goods: Why standard evidence-informed priority-setting risks underinvestment in services with cross border impacts

Good quality health policy means using evidence to maximise health and other outcomes we care about (such as financial protection, equity, and so on).1 The primary processes and institutions for this are national, and the field of health economics, including work from the Center for Global Development (CGD), has helped to strengthen such institutions in recent decades. An important feature of national institutions for health is the compact—implicit or explicit—with the constituent population. In short, ministries of health exist to champion good health for the people of their country. This clear mandate is important but comes with a challenge: many health concerns do not stop at a country's border. Accordingly, decisions on investments in health by national institutions do not only affect their constituent population but also people in neighbouring countries and beyond. In economics terms, this is an "externality" i.e., a service provided by A to B can also affect C. These spillover effects can lead to systemic failures to provide enough of the right kinds of healthcare services.

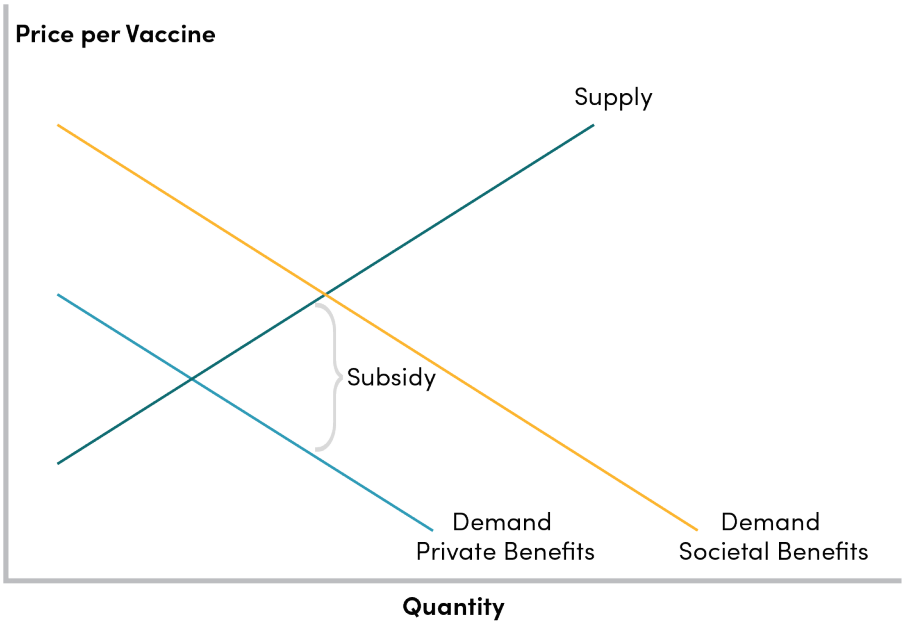
Let's unpack the externality issue through an analogy to vaccines and individual decision making. When an individual gets vaccinated against an infectious disease, there is a private benefit as their chance of getting the disease is reduced. In parallel, the wider population benefits as vaccination may also reduce the chances of other people getting the disease, as the individual is less likely to transmit it. Therefore, a positive externality arises when someone is vaccinated, as there are both individual and societal benefits.

Markets underprovide for goods with positive externalities because the balance between price and consumption depends largely on private benefits, rather than considerations of externality effects. Public health policy can correct this market failure by subsidising vaccines such that demand is increased to a sufficient level (Figure 1). In many cases vaccines are provided for free, reflecting practical challenges in getting the right subsidy and/or an equity-led approach to vaccine access.

This problem of relying on individual decision making for vaccine uptake is analogous to the problem of relying on national institutions for investment in healthcare with cross-border impacts. A ministry of health seeking to maximise health for its constituents will likely undervalue investments with cross-border effects, including regional or global public goods. The central example here is health security, particularly controlling the spread of infectious diseases. Global health security is a type of global public good, which is a type of common good. There are other examples as well. The use of a technological health innovation by one country is nonrival because it does not diminish its availability or effectiveness for others. For example, the knowledge of how to produce a vaccine or the protocol for a new surgical procedure can be used by multiple healthcare providers worldwide without being depleted.

1.. Going forward we use "health maximisation" as shorthand for maximising health and related outcomes.

Figure 1: Illustrative vaccine supply and demand considering private and societal benefits



There is not always a bright line between services for local populations and the production of global public goods. As with vaccination, some public goods are produced through the provision of services with a substantial private good component. Disease surveillance systems are another example where diagnostics services for local populations can, with additional investment in information management systems, facilitate early detection of pathogens with epidemic or pandemic potential.

The interplay between cross-border externalities and global public health goods, and the question of who is responsible for their governance and financing, is important for donor and country health service to consider in priority-setting. Health aid agencies contribute to the supply of global public goods, both directly and indirectly, and there is potential to provide unrealised benefits to public health, economies, and social systems worldwide.

Towards an integrated conceptual framework of global health financing

CGD has proposed a New Compact for reworking global health financing, which empowers national institutions in aid-recipient countries to set priorities on how health aid is spent. How does this fit with the existence of externalities in health and provision of global public goods?

In practice, cross-border impacts are often considered through diplomacy and multilateral collaboration. But how can this be integrated into a rational decision-making framework. More specifically, how can it be integrated into a New Compact decision framework?

Three policy approaches are available:

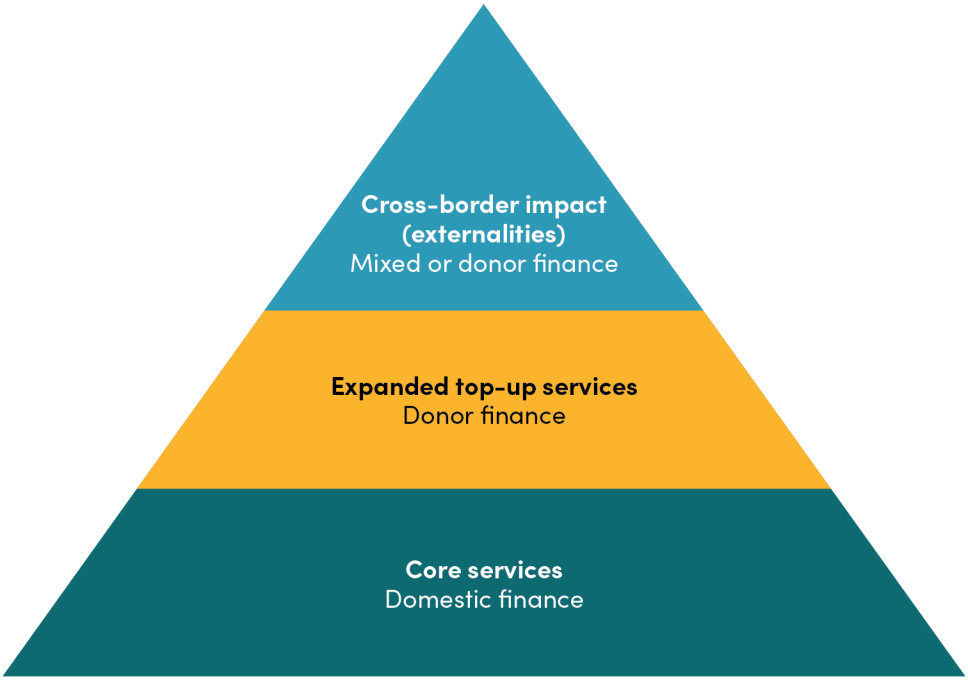
1. **Country decision makers adopt expanded spheres of responsibility.** That is, leaders and officials in ministries of finance and ministries of health are expected to account not only for benefits to their constituent populations but also for potential wider benefits to other countries. A strength of this framing is that it is morally intuitive and comports with an individual-level approach to ethics and community responsibility in many cultures. However, in practice, proximate pressures and incentives mean that such decisionmakers are more likely to prioritise benefits for their populations over others. Highly resource-constrained countries may understandably feel this pressure even more acutely.

2. **Collective action through health diplomacy.** Through international relations, states can and do agree to collaborate to ensure certain issues of cross-border concern are addressed. The International Health Regulations is an example of collective action. Though comprehensive agreements on shared financing obligations can be complex and challenging, organisations such as the Africa Centres for Disease Control (CDC) are financed in part by contributions from Africa CDC member states as well as high-income country donors.

3. **Donors subsidise regional or global public goods.** Here individual or groups of state or private donor organisations identify underinvested public goods and provide financial support. A conceptual model for this is outlined by Morton et al., whereby priorities are identified by donors and subsidies are offered to countries to make domestic investment more attractive. This is a neat theoretically optimal solution that is similar to the correction of vaccine market failure through subsidy. In practice it will be difficult to know the right subsidy level, and for high-value global public goods, donors may choose to finance in full or with only a nominal domestic contribution.

Decision making on health services, such as health benefits package design, can be appropriately influenced by cross border considerations through the above mechanisms but addressing these challenges cannot only be achieved through the individual country health maximisation lens. This highlights a limitation with the so called "bookshelf" model of evidence-informed priority-setting and with the version of the New Compact model as. This model outlined a simplified version of a potential reworking of health financing, through country-owned evidence-informed priority-setting. Efforts to address cross-border externalities potentially reintroduce some of the challenges the New Compact seeks to overcome with a degree of fragmentation, volatility, and potentially fungibility. However, there is a clear rationale for why there is a role for supranational priority-setting where cross-border externalities exist. In other words, while we note the challenges with the current health aid architecture and the need to simplify external financing support to aid-recipient countries, we also recognise a role for a degree of distortion to countries priorities, in order to adequately address regional and global challenges.

Figure 2: Layers of decision making for healthcare investment in aid-recipient countries



Case study: Who pays for pandemic preparedness (and who should)?

The shortcomings of the response to the COVID-19 pandemic emphasised the need for investing in pandemic preparedness. The concepts of global public goods are, at least in part, applicable here: everyone would benefit from pandemic preparedness as its benefits cannot be confined to specific countries, making these efforts nonexcludable. If the initial outbreak in Wuhan was prevented or controlled in an appropriate manner, the global burden of the COVID-19 pandemic may have been prevented. Further, the concept of nonrivalry would also apply as prevention of disease spread would be available to all without diminishing the benefits to any one country, whether they invest in pandemic prevention partnerships or not.

A disease surveillance system that could provide alerts globally, not just to the country that hosts the system, is a fitting example. Similar to the case of a vaccinated individual preventing disease transmission and providing benefits to the wider population, if a few countries have surveillance systems in place, this will benefit nations who do not. Recognising the importance of this, in 2023 the Pandemic Fund Governing Board allocated their first round of funding to strengthen disease surveillance, early warning laboratory systems, and relevant workforce development in 37 countries

across six regions. Notably, this effort to boost resilience to future pandemics funded 19 projects in the first call, with over 75 percent involving low- and lower-middle-income countries. Further, the Pandemic Fund aims to support multi-country projects that foster cross-border, regional collaboration. While not all nations will be able to prioritise investments in disease surveillance individually or through the initial funding call from the Pandemic Fund, they will still be able to reap the benefits of the disease surveillance systems if governed and coordinated appropriately.

When it comes to determining how to govern and who should manage supranational priority-setting and cross-border externalities, global and regional institutions such as the Pandemic Fund, Africa CDC, and the Coalition for Epidemic Preparedness and Innovations (CEPI) have a legitimate rationale to set relevant priorities. For example, they will rightly have disease surveillance as a priority for boosting pandemic resilience and may offer earmarked assistance without this being an unjustified undermining of national priority-setting. Governance in regional and global institutions which pursue common goods should of course sufficiently reflect the constituencies they intend to serve and indeed the Pandemic Fund's evaluation of proposals reports community involvement, inclusivity, and marginalised populations.

Conclusion

While the New Compact proposal highlights the various challenges with the current global health architecture and outlines an approach to "put aid in its place" by empowering country-led priority-setting, there is nevertheless a place for regional or global institutions to set priorities on regional or global common goods, with appropriate participatory governance mechanisms. Countries and donors should recognise this distinction while seeking reforms to global health financing.

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