

Global Common Goods for Health: Towards a New Framework for Global Financing

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Abstract

The COVID-19 pandemic, which has brought the world economy to an unprecedented synchronized recession, makes for a profound collective global experience. It should urge us to reshape our collective actions.

Human survival depends on shaping globalization for common well-being. Even as national governments retain authority for public health within their boundaries, the interconnectedness of global markets for capital and labor, including those for health systems, requires global cooperation.

Since the late 19th century, modern welfare states have developed increasingly mature institutions to finance health services using public funds, often in response to perceived shared threats. Yet lessons learned at the national level have been largely ignored in efforts to finance global health.

The paper examines the current architecture of global health financing using the framework commonly applied to assess the performance of modern states, based on three key health-financing functions: revenue raising, pooling, and strategic purchasing. Our analysis reveals global health functions to be underfunded, fragmented, and caught in a rigid disease-centered frame of reference.

Global health financing needs a full reset. We call for a transformation of global health funding in three major ways to reinforce the global community's resilience to health shocks:

1. Ensuring a sustained source of revenue for global common goods for health through a mix of national, global, and regional taxation.
2. Pooling resources under coordinated institutional mechanisms accountable to global citizens.
3. Strategic purchasing focused on global common good and function-based rather than disease-centric investments.

Global governance could provide a fourth pillar to ensure that global public goods are delivered, and global market failures are addressed. We call for transformation of the governance for global health financing by building a sense of global collective identity and developing new forms of

collective action and alliances to address the multiple interests affecting people's health.

The COVID-19 crisis is an opportunity to reset global health financing

The pandemic most public health experts had predicted for years has arrived and threatens to become far more devastating than any epidemic in the last hundred years. Epidemics are not new. They have shaped human societies from the earliest time. The plague that struck ancient Athens killed Pericles, weakening the city-state during its prolonged conflict with Sparta. In recent times, multiple outbreaks of Ebola have challenged governments in West Africa and have had severe socio-economic impacts. Some epidemics have altered the course of history of entire continents, such as the Black Plague in mid-14th century Europe and the smallpox epidemics during the early period of colonization of the Americas.

Today, COVID-19 has precipitated a global economic collapse, bringing the most interconnected global economy the world has known to its knees as country after country locked down to protect its people from the coronavirus (World Bank Group, 2020). The COVID-19 pandemic is a truly global event that has touched and altered lives around the world as people everywhere share the experience of fear of a common threat. This globalization of fear and anxiety is without precedent. And it is this shared fear that now links all of us in a rare global collective experience. Salient threats are always an opportunity as well as a danger (Savedoff, 2019):

People typically don't solve problems until they face a crisis, such as cholera outbreaks, natural disasters, political unrest, and wars . . . creating the US Center for Disease Control was not motivated by

the public interest in surveillance of domestic infectious disease. Rather it was the salience to government officials of the potential threat posed by biowarfare against American soldiers during the Korean War that carried the day.

Despite the global reach of COVID-19, the public health response to this collective global threat is still largely national. So far, countries have responded with well-tested national tools that became the institutional norm in the 20th century: fiscal policies, regulatory regimes, and information and communication outreach. Fiscal instruments used the flexibility of modern public finance systems to reallocate public funding to core public health services and intensive care units and to provide subsidies to households and small business to enable them to survive the societal and economic shocks of the epidemic.

Facing the global threat of COVID-19, the global community does not have the well-tested health system structures and fiscal instruments of a modern nation state and so finds it difficult to respond as one. Despite the evident need, it remains unclear how people around the world, with all their diversity of experience and perspectives, can come together to support a global mechanism to address the global common goods for health (Soucat, 2019), those essential public health functions that underpin effective prevention and constitute a comprehensive response to health threats, whether environmental, epidemic, or behavioral (Swinburn et al., 2019).

A collective global problem typically requires a common response to overcome the 'tragedy of the commons'—the suboptimal funding of common goods. In the health realm, common goods are population-based functions or interventions that require collective financing, either from governments or donors. Common goods for health meet three conditions:

1. They contribute to health and economic progress.
2. There is a clear economic rationale for the interventions based on market failures.
3. There is a clear focus on public goods (non-rival, non-exclusionary) or on large social externalities (Yazbeck and Soucat, 2019).

This paper examines the current architecture of global health financing using the health-financing framework that has long been applied to assess the performance of nation states. It examines three key functions:

1. Ensuring a sustained source of revenue for global common goods for health
2. Pooling resources under coordinated institutional mechanisms with transparency and accountability
3. Strategic purchasing of effective goods and services focused on functions rather than on individual diseases

Together, these three pillars can support a financing framework that can reinforce the global community's resilience to health shocks, preparing it for the next pandemic.

We also review the ways that global governance could establish a fourth pillar by providing the policy and regulatory systems needed to ensure that global common goods for health are delivered and that global market failures are addressed. We call for a governance transformation to end global fragmentation by strengthening systemic and regulatory governance through the development of appropriate multilateral leadership.

A new call to finance common goods for health

The first two decades of the 21st century have witnessed a major increase in global financing for health, driven by economic growth. Health spending rose from 8.5 per cent of global GDP in 2000 to about 10 per cent in 2017, reaching \$7.8 trillion (Xu et al., 2019). In low- and middle-income countries health funding increased more than five-fold over the period, driven by an increase in domestic financing, both public and private. At 6.3 per cent a year, growth in health funding outpaced global GDP growth of about 6 per cent a year.

Official development assistance for health also increased dramatically, to help low- and middle-income countries achieve the Millennium Development Goals by 2015. External funding for health going to developing countries increased from \$3.5 billion in 2000 to about \$16 billion in 2016. This funding was motivated largely by the desire to achieve greater inter-country equity and solidarity. It focused on the poorest countries and on reducing the gap in disease burden between poorer and wealthier countries, particularly for infectious diseases (such as HIV/AIDS, malaria and tuberculosis) and maternal and child health ailments.

Public support for these interventions, which generate large externalities, focused largely on improving equity of access to often narrowly defined disease interventions. Mostly neglected, however, was the fundamental rationale for stepping up collective global financing: to invest in global public goods and correct large market failures. These were not included among the Millennium Development Goals.

The successor Sustainable Development Goals corrected this omission and included critical common goods for health, such as preparedness, prevention of air pollution, and climate change mitigation. But little is known about how much of the funding goes to these global functions and how well the amount of funding matches needs.

One estimate of the funding for the global functions share of common goods for health put it at about \$4.3 billion in 2015 (Schäferhoff et al., 2019), or about a sixth of overall (country and global) funding for global health (\$25.5 billion), an amount that is clearly insufficient. At least 71 per cent of external funding for health goes to direct country support (OECD, 2020b). In 2013, the Lancet Commission on Investments in Health had already called for additional resources to be invested in global functions (Jamison et al., 2013). Post-Ebola 2014, the US National Academy of Medicine report estimated that an additional \$4.8 billion would

Table 1. Global Common Goods for Health in the COVID era

Common goods function	Examples of function/Activities (Soucat, 2019)	Example of global costs
1. Policy and Coordination	<ul style="list-style-type: none"> • Planning and management of emergency preparedness and response • Health security and environmental risk policies and strategies • Disease control policies and strategies • Animal health policies • Community engagement and management policies 	<ul style="list-style-type: none"> • Start-up costs related to creating a functional mechanism for the coordination of sectors in the implementation of [the WHO's International Health Regulations (IHR) (A multisectoral committee addressing requirements, setting up emergency information and communication capabilities between coordinating actors, creating standard operating procedures for coordination between sectors, creating National IHR Focal Points) • Construction and equipping regional Public Health Emergency Operation Centers, including a coordination specific vehicle • Overheads of revenue management agency
2. Taxes and subsidies	<ul style="list-style-type: none"> • Taxes on products with health impact to create market signals leading to behavior change • Subsidies to address market failures affecting use of public health interventions (such as tuberculosis, HIV, vaccines, tobacco control, air pollution) 	
3. Regulations & legislation	<ul style="list-style-type: none"> • Regulation of the safety of medicines and medical devices • Environmental regulations and guidelines (for example, for biodiversity, water, and air quality) <ul style="list-style-type: none"> • Global legislative frameworks to support implementation of the WHO's IHRs 	<ul style="list-style-type: none"> • Start-up costs for the establishment of legislation and regulation for the implementation of IHRs (establishment of legislative committees, a policy review committee)
4. Information collection, analysis, and research	<ul style="list-style-type: none"> • Human and animal disease, environmental degradation, and risk (such as antimicrobial resistance, chemicals and radiation) surveillance • Research and evaluation <ul style="list-style-type: none"> • Early warning systems 	<ul style="list-style-type: none"> • Capital goods for early warning systems for the detection and response to acute public health emergencies • Capital costs for the scale up of pandemic-related health information systems, such as health facility-based information systems, central surveillance teams within regional health authorities, and national authorities (ministries of health, national statistics offices of institutes of public health), composed mainly of information and communication equipment • Development and procurement of Covid-19 vaccines (including stockpiling); development of therapeutics for Covid-19 • Development of treatments for C19 patients

be needed for pandemic preparedness (Peters et al., 2019; Sands, Mundaca-Shah and Dzau, 2016).

In 2017, the WISH (World Innovation Summit for Health) Investing in Health Forum 2016 urged a shift of investments by global stakeholders towards funding global functions (Yamey et al., 2017), which are at the heart of the common goods for health agenda. More recently the authors of that report, in an article titled 'Financing Global Common Goods for Health: When the World is a Country,' made another plea to the global community to shift funding towards global goods to deal with emerging threats such as pandemics, antimicrobial resistance, and the impacts of carbon emissions on air pollution and climate change (Yamey et al., 2019). In 2019, a group of economists and public health experts called for a paradigm shift to prioritize financing common goods for health (Table 1), calculating a need to double current levels of global funding to adequately finance these common goods for health. In the context of COVID-19, a recent estimate of the global investment needed to end the acute phase of the pandemic calls for \$38 billion, which is a fraction of the cost (0.355%) of what governments have spent already on the first wave of response (WHO, 2020)..

The COVID-19 pandemic painfully vindicates this chorus of voices clamoring for more attention to global common functions. It is painful to observe that the amounts that have been estimated as needed to finance common goods for health have now been dwarfed by the dramatic economic losses due to COVID-19. Losses are currently estimated to exceed 4.9 per cent–7.6 per cent of global GDP (\$4–\$6 trillion), an amount that is 100 to 200 times greater than the estimated cost of investing in the needs for the COVID-19 response. It has resulted in the deepest recession in decades (International Monetary Fund, 2020; OECD, 2020a).

Options for consideration: clearly, we are being called on to acknowledge a common failure. It is time to fundamentally revisit how we collectively fund global common goods for health. In taking stock, we need to build on the experiences and lessons in health-financing policies implemented by national governments, many of which have built resilient health-financing systems and managed to improve both public health impact and the equity of health outcomes (Sriram et al., 2020).

Addressing a global problem requires reconfiguring health-financing functions at a global level. To redefine the global framework, we need to look at the core functions that health financing needs to encompass: raising revenues, pooling funds, and strategic purchasing. Additionally, as at other levels of human coexistence, these financing functions need to be embedded in solid governance mechanisms, not least with respect to the data underpinning policy decisions.

Raising revenues: The case for a global tax

Public finance textbooks identify public goods and large market failures as the first rationale for any government interventions. By now, most modern states have developed

long-established mechanisms that ensure the generation of revenues to fund common goods for health and other national priorities, as determined by citizens. During the 20th century, countries young and old built institutions to collect revenue and manage it for the collective good. Almost every country has a national treasury and an internal revenue service. Most countries can rely on taxation—mostly taxes on goods and income—to generate a common pool of resources for funding collective priorities. Institutionally, these funds are under the control of citizens through the oversight of national parliaments.

Curiously, no such mechanisms exist at a global level to fund the United Nations (UN) system, the closest institution we have to a global government. Revenues for global functions are not generated from global taxation, but rather from a combination of small compulsory and larger voluntary contributions, mostly to the UN and Bretton Woods institutions. Funding for global functions also flows to a few parallel global organizations, such as the Global Fund, Gavi, and – more recently – the Coalition for Epidemic Preparedness Innovations (CEPI).

Global revenue generation thus differs fundamentally from national revenue generation in that it lacks the core features of modern public finance management. Instead, it is mostly voluntary and does not flow into a single account from which funds can be disbursed in a coordinated way to implementing agencies operating under unified (parliamentary) governance control. Global revenue comes mostly from national budgets, ultimately from taxes generated at a national rather than a global level. For example, the World Health Organization (WHO) budget for 2020/2021 is about \$2.92 billion annually, of which about \$800 million is for global public goods (WHO Region Headquarters, 2020). The sustained flow of funding through assessed contributions totals only about \$480 million annually, just slightly over half of the WHO's global public goods budget. This of course does not include the financing required to respond to a pandemic such as COVID-19 (Edejer et al., 2020).

So, while globalization has largely been a global territorial extension of national markets, global governance has not adapted to the geographic unification of markets. Public institutions have responded only slowly. At the same time—as COVID-19 has made abundantly and devastatingly clear to all—a globalized world has urgent global problems to solve. Global markets have global market failures that require unified global interventions, which are possible only with targeted funding. The need to sustainably fund common goods for health has become increasingly evident in our globalized world. The COVID-19 pandemic is a clarion call warning us that we can no longer hide from such financing gaps and the need to reconfigure our global financing governance.

Options for consideration: there are several potential mechanisms for global revenue raising. A simple one is to increase and expand the compulsory contributions to the United Nations, giving priority to global common goods for health (which could include increasing the assessed contributions to the WHO for such functions). There does not

seem to be much political will to go down this road. A second option, frequently proposed in the literature (Global Policy forum, 2020), is a global tax, for instance on financial transactions and airlines (both likely progressive) or a carbon tax (Strand and Keen, 2006). While the primary rationale for a carbon tax is to shape markets and behaviors to slow the rapid environmental degradation caused by carbon emissions, it could also be constructed as a global revenue raising mechanism. In the short term, however, there might be little appetite for global taxation. A third option is regional taxes, implemented within a regional economic or political community, a mechanism that has already been proposed by some countries in the European Union and the Africa Union. Raising some \$25 billion a year for pandemic preparedness in a world whose GDP exceeds \$75 trillion would require a very minimal, and thus almost painless, level of taxation, making this a particularly feasible option.

Pooling funds: Unifying global financing

After raising global revenue, the next question is how to manage it. Which institution or agreed set of arrangements would be entrusted with holding the funds? The health-financing literature has consistently emphasized the importance of pooling funds within a single institutional frame (Kutzin, 2001) and allocating them under a single set of rules.

Pooled funds, whether within a single institution or in a multiagency structure operating under a unified risk adjustment and payment system, have a good track record at the country level for bringing together contributions from different segments of society, healthy and ill, rich and poor, employers and employees and distributing them effectively. Conversely, fragmentation of management of collective public financing for health has been shown to result in poor coverage of high-cost 'catastrophic' events and inequities in coverage (Mathauer et al., 2020). Again, the lessons from a century of national experience in health financing for the common good reveal the need for a strong global health institution or at least a common set of rules and a common accountability framework that brings the funding for global health functions under one governing logic of operation.

This is not currently the case. Funding for global functions is managed through a hyper-fragmented set of UN organizations, including the WHO and other agencies (United Nations Children's Fund, United Nations Fund for Population Activities, United Nations Development Programme, UNAIDS, and more), through the World Bank, and through non-UN partnership institutions such as the Global Fund, Gavi, and most recently CEPI. Each of these organizations manages small pools of funds that finance some elements of global common goods for health, but their functions and activities overlap and they do not operate under a common set of rules, incentives, or vision.

The fragmentation of resources for global common goods for health contradicts the purpose and very nature of the financing of public goods, which should be neither dividable

nor excludable. Fragmentation leads to wasteful duplication of functions; for example, the funding of global surveillance, laboratory capacity, and data systems is spread across multiple agencies, while the funding of public health programs with large externalities (such as vaccinations and communicable disease prevention) is split across UN organizations, the World Bank, GAVI and the Global Fund. In addition to inefficiencies, fragmentation leads to critical gaps in coverage of essential dimensions, such as research and development (R&D) and investments in stockpiles of critical inputs, as was exposed during the early days of the COVID-19 pandemic.

Options for consideration: a clearer delineation and synchronization of funding for global common goods for health and associated institutional accountability is needed. Several options can be envisioned. One is to entrust management of the funding of global common goods for health to a single UN institution; potential candidates include the WHO and the World Bank. A second option is to bring together under a single mechanism the multiple institutions involved in funding global common goods for health, for example, by establishing a trust fund for global common goods for health under Global Monitoring Board, assigning clear public oversight of funding. Some changes might be needed, such as stronger accountability of the fundholding function to global citizens and civil society. To ensure the coherence of investments in global common goods for health, people around the world need to see themselves as part of a new collective identity as global citizens willing to mobilize action beyond national boundaries (Savodoff, 2019). Finally, while creating a totally new institution is also an option, it is a less desirable one as it would compound the current fragmentation of global health institutions and partnerships rather than resolve it.

Strategic purchasing: From a disease focus to attention to functions

Strategic purchasing is the third core pillar of health financing. Its purpose is to align funding and incentives with promised health services. Strategic purchasing involves linking the transfer of funds to their outcome through information on their performance in meeting the collectively identified health needs of the population they serve (Mathauer et al., 2017).

At a country level, the objectives of strategic purchasing are to enhance equity in the distribution of resources, increase efficiency, manage expenditure growth, promote quality in health service delivery, and enhance the transparency and accountability of providers and purchasers to the population. Most mature national health systems have developed sophisticated institutional models to optimize the efficiency and equity of their resource allocation, using disciplines such as health technology assessment. They have also instituted democratic processes that enable citizens to guide the allocation of public money to various health services through the ongoing democratic debates that are part of a mature social contract.

At the global level, the concept of strategic purchasing has found expression within public finance management, including performance-based budgeting and financing. Attempts to guide global health policies have also emerged over the past three decades in these arenas. For example, the World Bank's *World Development Report 1993* proposed the concept of developing publicly funded cost-effective public health packages based on years of lives saved (World Bank, 1993). The 2013 report of the Lancet Commission on Investing in Health included similar recommendations but added the need to increase investments in global functions, including R&D and stockpiles of critical drugs and materials (Jamison et al., 2013). As recently as 2018, several papers called for a shift of global health funding to address global functions and public goods (Birdsall, 2018; Summers, 2016). The cost-effectiveness argument is also challenged by the COVID-19 pandemic as elderly are the ones requiring most expensive care while their fatality rates are the highest.

While national planning processes and health technology assessments rely on a broad set of criteria to develop recommendations for resource allocations, the global health discourse has relied almost exclusively on trends in disease burdens, using disease-linked mortality rates as the primary (and too often only) basis for estimating future needs. Most of the public health discourse on global strategic purchasing has had a disease focus and overlooks the public and common goods rational for public financing, including future risks related to environmental degradation and epidemic threats. This was the case of campaigns to eliminate smallpox and polio and the creation of Gavi, a fund dedicated to eliminating vaccine-preventable diseases, and the Global Fund, dedicated to eliminating AIDS, tuberculosis, and malaria. Nonetheless, the mandates of Gavi and the Global Fund also respond to market failures, and they fund significant amounts of global and national common goods for health. Even then, however, the focus is mostly on individual services at a national level, to the neglect of investments in health systems and global common goods for health.

Options for consideration: experience and theoretical studies suggest the value of moving away from viewing health as solely the absence of disease and returning to the WHO view of health as 'a state of complete physical, mental and social well-being'. That definition suggests a broad-based focus for global health actions on common goods for health as a common agenda for all global agencies, beyond diseases specific efforts. Under one scenario, this would require organizations active in the health arena, particularly those entrusted with pooling funds for global functions (see previous section), to focus determinedly on building the national institutions and capacities needed to ensure the fulfillment of global common functions. It would also require designation of an institution that could create ample space for the sharing of rich community experiences and hosting groups capable of outlining global priorities beyond those arising from analyses of disease patterns. An obvious candidate would be the WHO, which could host such a group as part of its core global role as convener and leader in providing normative guidance on global public health goods by

bringing together a broad range of knowledge institutions from communities onwards to national, regional, and global academic organizations to guide investments in global common goods for health.

Global governance: The necessary underpinning to change

Global governance is a complex affair. The UN system, the closest institution we have to a global government, is a product of the immediate post-Second World War order. As such, it is often ill-equipped, financially and instrumentally, to respond agilely to the formidable new challenges we face today, such as the COVID-19 pandemic.

Modern governments have been entrusted by their populations to address market failures, including in common goods for health. This governance role is typically led by a ministry or department of health in association with critical agencies such as food and drug administrations or accreditation and licensing agencies. Countries struggle with governance issues in ever more complex and dynamic arenas of a globalized world; these struggles are magnified at the global level (Sriram et al., 2020).

Calling for more investments in globalization in the form of the global commons is all the more difficult considering that the effects of recent decades of globalization have faced serious criticism (Stiglitz, 2002). True, the territorial globalization of markets has resulted in large efficiency and productivity gains and lifted billions of people out of poverty. But it also has to be acknowledged that globalization has contributed to rising inequality within countries and environmental degradation, which are increasingly threatening the viability of the social contract and the future of our planet. While COVID-19 has placed these problems in stark relief, long before this pandemic a growing number of people had called for a new approach to governing global common goods for health.

Options for consideration: the central challenge of global common goods for health is to ensure collective action at the global level (Smith et al., 2003). Without trust, transparency, and accountability, any arrangements, institutions, and practices will founder. One recommended step in that direction is for the UN General Secretary to appoint an independent, high-level advisory board to recommend a new concept of sovereignty and suggest ways to implement it through the financing, regulation, and governance of global public goods (Kaul, 2013). 'Regulation' in this sense means being trusted and entrusted by the people.

As the 'Ministry of Health of the World', the WHO's roles as standard setter and provider of normative guidance has gone largely unchallenged until recently. WHO's core credibility depends on providing evidence-based and scientifically vetted guidance to countries. This role probably still holds up as one of the more powerful instruments for shaping global spending on health, but it needs to be transformed and strengthened. Sustainable funding of core global public goods such as knowledge syntheses and dissemination as a basis for global policy guidance should be prioritized and funded through a global collective purse.

The geopolitical reverberations of the COVID-19 crisis have intensified scrutiny of the imperfections of the multilateral system. Given the dynamic complexity of health system financing and governance, multilateral institutions' roles in these pivotal domains need to be constantly scrutinized and upgraded to help them become the best that they can be. The interrelationships of global, national, and local levels and issues and the roles of citizens need to reconsider and clarified.

Global Governance is a continuing process that addresses global failures and dysfunctions through global or translocal collective action. Citizens, individually, in movements and in nongovernmental and civil society organizations as well as on social media are making their voices heard. It is in these interactions that something positive for global common goods for health could emerge. The COVID-19 crisis provides a rare if not frightening opportunity to advance the international community's interest in global common goods by sparking the type of collective action that has failed to take off before now. The engine of such collective action is the forging of new common identities built on perceived shared interests as world citizens and the formation of the supporting mechanisms needed to address competing interests (Savedoff, 2019). Already, we can observe a mobilization around the notion that developing a COVID-19 vaccine is a global common good for health (Ray, 2020).¹ Similar initiatives include the various movements under the umbrella of planetary health, (Whitmee et al.,), which embrace the importance of global common goods for health, as well as global platforms such as UHC2030, which identifies the funding of common goods for health as 'step 0' towards achieving universal health coverage by 2030 (Soucat, 2019) (UHC2030, 2020).

Where do we go from here?

The time for transformation is now. Looked at positively, the COVID-19 pandemic can motivate a collective revisiting of globalization to move us all to a better place. More direly, it foreshadows global crises to come if we fail to act on the evident urgency of transforming the global health-financing order.

COVID-19 has awakened us to our common humanity and to our need to address the common threats to human health. All stakeholders increasingly recognize the need to invest in global goods to address global market failures and to reshape the global landscape to ensure the financing of common goods for health.

Reform needs to build on the lessons from health-financing reforms at the country level that led to the development of instruments for financing common goods for health at the national level. The pillars of health financing need to find global expression through four main components:

1. A global or multinational taxation system
2. An institutional financing pool for global common goods for health managed in a way that is accountable to global citizens

3. A technical institutional arrangement that provides guidance on investments to address global common goods for health
4. A strong global policy and regulatory agency like the WHO that can strengthen the regulatory role of a multilateral body for health

Echoing the voice of the United Nations Secretary-General, we need to move from international chaos to the construction of an international global community that is capable of meeting and solving tomorrow's challenges.

Notes

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