

Intensified multilateral cooperation on global public goods for health: three opportunities for collective action

POLICY PAPER

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KEY MESSAGES

- **Global public goods (GPGs) for health are essential to achieving global health goals.** “GPGs for health” is shorthand for a set of collective action activities that address transnational health challenges. These activities are categorized as (i) traditional GPGs (e.g., global health research and development [R&D]), (ii) control of negative regional and global externalities (e.g., pandemic preparedness), and (iii) global health leadership and stewardship (e.g., global convening to build consensus). Our definition thus encompasses a broader set of investments that goes beyond the purely economic definition of a GPG.¹
- **There is substantial underinvestment in this critical area,** with only about one-fifth of all donor financing for health directed at GPGs. **The lack of investment was starkly exposed by the 2014-2016 Ebola outbreak** in West Africa where underfunding of global health R&D meant that there was no Ebola vaccine, therapeutic, or rapid diagnostic test; in addition, outbreak surveillance and preparedness systems performed poorly.
- **Multilaterals are well placed to deliver support for GPGs given their clear global or regional mandates.** To examine this potential role, we conducted a new analysis based on (i) a review of strategic and financing documents produced by the four multilaterals that provide the most development assistance for health (DAH): Gavi, the Vaccine Alliance (Gavi), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the World Bank, and the World Health Organization (WHO), and (ii) 42 key informant interviews with senior leadership in these and other organizations.² The analysis shows that **multilateral health agencies have all signaled their intention to step up investment in support of GPGs and intensify their cooperative activities** to collaborate more closely.
- Further, there is **significant convergence** in support of **three immediate opportunities for collective action**—by Gavi, the Global Fund, the World Bank (including the Global Financing Facility [GFF]) and WHO (including the Global Polio Eradication Initiative [GPEI])—to help address the global neglect of GPGs for health:



» Improving the production, quality, and use of health data



» Accelerating the development of and access to new health technologies, not just in low-income countries (LICs) but also middle-income countries (MICs)



» Strengthening global health security, particularly epidemic and pandemic preparedness.

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INTRODUCTION: WHY FOCUS ON GLOBAL PUBLIC GOODS FOR HEALTH?

In its *Global Health 2035* report published in 2013, the Commission on Investing in Health issued a “wake-up call” to the international community, arguing that **donors are neglecting critical GPGs for health**.³ The Commission highlighted the huge funding gaps for developing new health technologies, preparing for pandemics, and fostering global health leadership and stewardship. Shortly after *Global Health 2035* was published, these gaps were starkly exposed by the Ebola outbreak in West Africa. Underfunding of global health R&D meant that there was no Ebola vaccine, therapeutic, or rapid diagnostic test; in addition, outbreak surveillance and preparedness systems performed poorly.⁴

In the wake of Ebola and other recent outbreaks (e.g., Zika in Latin America and Nipah in India), along with other threats such as antimicrobial resistance that go beyond national boundaries, **there is growing realization that GPGs for health are essential to achieving global health goals**. Multiple studies have shown, for example, that the health-related Sustainable Development Goals (SDGs) will be difficult to achieve without new health technologies.^{5,6} Recent research has begun to quantify the size of the funding gap for GPGs for health and the impressive returns to investment in many different GPGs.

For example, a study led by Duke’s Center for Policy Impact in Global Health suggests that the annual funding gap for neglected disease product development is at least \$1.5-2.8 billion over the next five years.⁷ The study also found that the current pipeline is unlikely to produce several health tools that would be game-changing, such as highly effective vaccines for HIV, tuberculosis (TB), malaria, or hepatitis C. The returns to investing in GPGs for health, including R&D, are significant and wide-ranging (Box 1).

Box 1. The returns to investing in GPGs for health

- Developing a 70% efficacious HIV vaccine could reduce new infections by 44% over the first decade;⁸ every dollar invested in HIV vaccine development could return up to \$67.⁹
- In the United States alone, over 160,000 polio deaths and about 1.1 million cases of paralytic polio have been prevented by the polio vaccine, developed through an initial investment by the March of Dimes of about US\$26 million; the investment generated treatment cost savings of around \$180 billion.¹⁰
- The Framework Convention on Tobacco Control has prevented millions of deaths and averted large costs.¹¹

Yet delivering support for such GPGs is inherently difficult.¹² As the economist William Nordhaus notes: “if problems arise for global public goods, such as global warming or nuclear proliferation, there is no market or government mechanism that contains both political means and appropriate incentives to implement an efficient outcome.”¹³ Donor governments have not prioritized GPGs: **only about one-fifth of all donor financing for health is directed at GPGs for health.**¹⁴ Donor governments are also increasingly being more explicit about using bilateral funding to support their own foreign policy agendas and domestic objectives, an additional threat to global cooperation on transnational health concerns.^{15, 16}

A new agenda for the multilateral institutions

Multilaterals are well placed to deliver support for GPGs given their clear global or regional mandates.¹⁷ In the current climate of growing worldwide nationalism and populism, the multilateral institutions now find themselves well positioned to become a countervailing force in taking international collective action and supporting GPGs for health. **All the major multilateral health agencies have signaled their intention to step up their activities in support of GPGs** (Box 2).

Box 2. Examples of multilateral agencies' interest in GPGs for health

- **World Bank** President Jim Kim has made “a much expanded role for the World Bank Group in the Global Public Goods agenda” a priority for his second term (2017-2022).¹⁸ The Bank’s shareholders recently designated \$100 million in income or profit from its lending specifically to support GPGs, a decision by the bank’s shareholders “to spend ‘collective’ money for the collective or common good at the global level.”¹⁹
- **The World Health Organization (WHO)** decided on GPGs for health as one of three strategic shifts in its latest Global Programme of Work.²⁰
- **The Global Fund’s** 2017-2022 strategy includes \$194 million for “Strategic Initiatives”—catalytic investments that cannot be delivered through country grants, many of which are GPGs for health (e.g., malaria elimination and piloting malaria vaccine introduction).²¹
- **Gavi’s** deliberations about its 2021-2025 strategy include ways in which GPGs for immunization (e.g., market shaping to bring down vaccine prices) could be made available to benefit vulnerable children in a world where the divide between developed and developing countries becomes increasingly blurred.

In addition to signaling their intent to scale up investments in GPGs for health, the multilateral agencies also want to **intensify their cooperative activities**. For example, Gavi, the GFF, the Global Fund, and the World Bank Group have formed the “4G Initiative” to collaborate more closely on global health financing and transitions. Given these two important strategic shifts—towards greater support for GPGs and towards intensified cooperation—**there is a clear opportunity for the multilaterals to help address the global neglect of GPGs for health.**

Our policy analysis: aims and methods

Our policy analysis aimed to clarify this opportunity. We wanted to address the question: **to what extent do GPGs for health represent shared priorities across the multilaterals and present opportunities for increased collective action?**

We believe this analysis is timely, given that the multilaterals are currently redefining their roles in a changing global health landscape and in the face of multiple upcoming replenishments. One high-level panel convened by the Center for Global Development (CGD) argued that the multilaterals must “*recalibrate their missions, rethink their values, and work better as a collective system if they are to stay relevant.*”²²

We focused on the four multilaterals that provide the most development assistance for health (DAH): Gavi, the Global Fund, the World Bank (including the GFF), and the WHO (including the GPEI). We reviewed relevant published literature, and strategic and financing documents produced by the four organizations, and conducted 42 key informant interviews (see Annex 1 for a list of key informants).

Our study focuses on identifying ways in which GPGs can specifically be supported by DAH that is mobilized by the four multilaterals. We recognize, however, that delivering on the GPGs for health agenda will also require domestic resources and donor support beyond grant support (e.g., concessional loans). Indeed, the WHO’s new program of work on “common goods for health” recognizes the need for both DAH and national investments in support of critical public goods and investments with positive externalities.²³

How we defined GPGs for health

In this paper, we use the term “GPGs for health” as shorthand for a set of collective action activities that the Commission on Investing in Health calls the “global functions” or “core functions” of DAH (Table 1). Global functions are those that address transnational health challenges. These are categorized as: (i) traditional GPGs (e.g., global health R&D), (ii) control of negative regional and global externalities (e.g., pandemic preparedness), and (iii) global health leadership and stewardship (e.g., global convening to build consensus). We have thus adopted a looser definition of GPGs that goes beyond the purely economic definition of GPGs.²

Table 1. GPGs for health: three types of collective action

| FUNCTION | KEY EXAMPLES |
|--|--|
| Supporting global public goods | <ul style="list-style-type: none"> • Development of new health products • Setting of international norms, standards, and guidelines • Intellectual property sharing • Knowledge generation and sharing • Market shaping • Population, policy, and implementation research • Risk shifting and bearing |
| Managing cross-border regional & global externalities | <ul style="list-style-type: none"> • Control of cross-border disease movement • Curbing the cross-border marketing of addictive and other unhealthful goods • Outbreak preparedness and response • Responses to antimicrobial resistance |
| Fostering leadership & stewardship | <ul style="list-style-type: none"> • Agency for marginalized and neglected sub-populations • Convening for consensus building on policies and priorities • Health and cross-sectoral advocacy (e.g., education, environment, trade) |

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THREE OPPORTUNITIES FOR COLLECTIVE ACTION

Our study found significant convergence across the multilaterals in support of **three immediate opportunities for collective action** to help address the global neglect of GPGs for health:



» Improving the production, quality, and use of health data



» Accelerating the development of and access to new health technologies, not just in LICs but also MICs



» Strengthening global health security, particularly epidemic and pandemic preparedness.

These three areas reflect the common themes brought up by key informants across all the multilaterals interviewed. Given the focus of our study on *collective* action, this paper does not cover other critical topics that were brought up by just one agency, such as financing to support refugees and the operationalization of health technology assessments.



OPPORTUNITY 1: Improving the production, quality, and use of health data

KEY FINDINGS

- The multilateral agencies included in this study view data **quality and harmonization** as an important means for achieving advancements in global health.
- **More disaggregated and timelier global health data is needed** at all levels for more evidence-based decision-making.
- **Clearer guidance on and improved exchange of existing data resources would also facilitate better policy at all levels.** Such support can already be achieved by further **leveraging existing collaboration platforms.**

Defining the need

Global health multilaterals currently invest in data as a means for facilitating improved, evidence-based policies and fostering greater accountability (Box 3). The focus of this section is on multilateral investments in data initiatives that result in publicly available and accessible resources that can guide evidence-based decision-making across borders. In other words, investing in one country's health data systems can become a GPG **if the resulting data are shared and used for broader cross-national learning.** Such investments may be in the form of (i) one-off investments to strengthen national data systems to better collect data that is then made available publicly, or (ii) ongoing harmonization efforts to ensure that data that has already been collected by countries is quality assured and validated to allow for cross-country comparisons. Despite these investments, all the multilateral organizations interviewed acknowledge three major ongoing gaps or challenges **including that data are not granular enough, they are not timely enough, and there is a need for clearer guidance on—and improved exchange of—existing data resources.**

Box 3. How the multilaterals view health data

- **Gavi views** “improvement in the availability, quality and use of data” as one of its six strategic focus areas, critical for sustainable immunization coverage and equity.²⁴ Gavi’s investments include, for example, modernizing data systems as part of country grants.
- The **Global Fund** sees data as essential for achieving its aim of “investing for impact” – timely and accurate data can be used “to inform strategies, prioritize activities, ensure strategic investments, monitor coverage of high-quality services and measure impact.”²⁵ The Global Fund has invested, for example, in Tanzania’s first national TB prevalence survey.²⁶
- **Gavi and the Global Fund** have jointly invested in efforts to strengthen data systems, e.g., investing in the roll-out of the District Health Information System 2, which is used in more than 60 countries to collect and disseminate data on health programs.²⁷
- The **World Bank** sees global databases as a tool for supporting evidence-based policymaking, prioritizing them within its Global Engagement activities.²⁸ The World Bank’s Development Data Group, for example, manages the World Bank Open Data website, which includes HealthStats, the World Bank’s comprehensive database of Health, Nutrition and Population statistics.²⁹
- Data is a priority of the **WHO** at headquarters.³⁰ WHO’s health data resources include the Global Health Observatory, the Global Health Expenditure Database (GHED), the Global Health Estimates, the WHO Mortality Database, and the repository of health budgets.^{31, 32}

The need for more granular data

Despite these investments, the multilateral organizations acknowledge major ongoing gaps, including **lack of granularity in health data**, which impedes policy and investment decision-making. Informants highlighted that the production and quality of data must happen at the country level—however, disaggregation requires coordination at the province, district, and community levels.

This problem is particularly acute in national data processes, which are the basis for tracking progress at all levels (national, regional, global, and around specific themes).³³ Key informants consistently mentioned the need for an **improved national health accounts (NHA) process**. As one key informant at the Global Fund noted: “Health financing data is such an important piece of information – it is surprising to see how poor in quality it [NHA] can be.” Across the multilaterals, key informants mentioned two ways in which NHAs need to become more granular:

- More detailed data indicators are needed to better differentiate across the health sub-sectors (e.g., to distinguish spending on health security), as well as sub-nationally (i.e., to assess inequities in data burden and access to services and commodities).
- NHAs processes should be extended to include other sectors (e.g., capturing spending on the humanitarian sector).

This lack of granular health data is also **impeding the creation of accurate epidemic and pandemic risk profiles**, making it difficult, for example, for the World Bank to establish terms for pandemic bonds for the Pandemic Emergency Financing Facility (the PEF). It also affects **the ability of multilaterals to support investment cases for GPGs for health, such as for antimicrobial resistance (AMR)**. Health financing data is just one area that could be strengthened to guide better investment decisions. For example, one key informant at Gavi argued that collecting granular health data would be very helpful for Gavi to show the positive impact of vaccinations in curbing AMR.

The need for more timely data

Improving impact through informed decision-making also requires more timely data. For example, one of the weaknesses of the Global Fund's Price Quality Reporting (PQR) database, which aims to provide transparency on commodity prices and allow monitoring of the quality of purchases in Global Fund-supported programs, is a lack of timeliness.³⁴ As one key informant at the Global Fund noted: *"PQR data is outdated which makes it hard for buyers to get a common up-to-date market price."*

The need for clearer guidance on—and improved exchange of—existing data resources

Key informants stressed that efforts to produce more timely and granular data will not achieve impact unless greater emphasis is placed on how to improve the exchange and use of data for decision-making. Our study found that **the multilateral agencies want to support the production of clearer guidance on the use of health data.** A key informant at the Global Fund said: *"Health financing data is particularly relevant for the Global Fund's work. Currently, there are many types of development assistance to health data and it is difficult to make a decision on the most effective use of the data out there."* Guidance on the use of data should also include an assessment of the reliability and quality of each data source.

To help the community better respond to global health issues, there is also **a need to improve the exchange of data across organizations**, particularly to address current "data enclaves." As one key informant at WHO said: *"Data and innovation is at the heart of the WHO's Global Programme of Work, but the data needs to flow more easily."*

Looking ahead

All four multilaterals agreed that **there is an unmet need for higher quality and more harmonized data to inform decision-making at all levels.** With this common vision in mind, **the organizations voiced three opportunities:**



- » **Increase efforts to provide more granularity across databases in a timely fashion by supporting countries to develop national health data and information systems**
- » **Provide more guidance to the community on which data resources are best suited for which purposes**
- » **Prioritize data exchange efforts.**

The Consortium of Investors in Health Expenditure Tracking was established to support and further advance health expenditure tracking. Currently the Consortium partners include the Bill & Melinda Gates Foundation, the Global Fund, Gavi, the GFF, and USAID. The partners jointly fund the WHO program in expenditure tracking, and work to align their data efforts at the country level. It is anticipated that other partners may be interested in joining. The launch of the Consortium is a move that many key informants felt was in the right direction to address current data quality needs. Looking ahead, **this consortium could be further expanded to engage more potential funders.** One key informant called on the World Bank to consider becoming a donor of the NHAs and to drive the production of more disaggregated data.

If there is sufficient collective action across the multilaterals, several **other initiatives** could present additional opportunities to improve the production, quality, and sharing of health data. These include:

- The **Global Partnership for Sustainable Development Data**, launched in September 2015, is a consortium of organizations that aims to fill critical data gaps and ensure data is accessible and usable; several multilaterals, including Gavi and the World Bank, are members. Through the Partnership, the World Bank's Trust Fund for Statistical Capacity Building recently supported ten projects on data production, dissemination, and use, mostly in LICs and lower MICs.³⁵
- The new **memorandum of understanding signed by WHO and the Institute of Health Metrics and Evaluation** to strengthen country capacity to improve national health data systems and promote the use of both institutions' databases.³⁶ This effort is also intended to complement WHO's focus in the 2019-2023 Global Programme of Work to improve the definition of health data and harmonize its efforts, including through the creation of a new cluster.



OPPORTUNITY 2: Accelerating the development of and access to health technologies in LICs and MICs

KEY FINDINGS

- Multilaterals currently work in various ways to **promote access to affordable, high quality health technologies** for those that need it when they need it.
- Multilaterals are well positioned to **sustain access to medicines as MICs transition away from donor support** and to **expand access to such products in MICs that never received Gavi or Global Fund support to begin with.**

Defining the need

All the multilateral agencies included in this study support the global health access “ecosystem” in some way: even when they do not directly fund product development, they work to improve access to new products, such as through market shaping (Box 4). Although approaches to supporting access may vary, the end goal of all these efforts is the same: **access to affordable and quality health technologies for those that need it, when they need it.** The agencies recognize two major challenges to achieving this goal. The first is that **when MICs transition away from donor assistance, they find it harder to access high-quality products.** The second is that **MICs that never received Gavi or Global Fund support find it hard to afford new health products** (e.g., because they do not qualify for Gavi's vaccine prices).

Maintaining access to quality products after transition

The multilaterals included in this study have invested heavily in enhancing access to new and existing products, but when countries transition out of multilateral support **they can lose access to such products.** A major finding emerging from our study is that **multilaterals are deeply concerned about preserving the gains from their investments.** Transition means not only losing financial assistance—it can also mean losing technical assistance and access to mechanisms that enhance access to new health products, such as pooled procurement and market shaping.

Box 4. Examples of multilateral engagement in health R&D

- The **WHO and the World Bank** both have major health research portfolios. The World Bank, with other major donors—including the Bill & Melinda Gates Foundation, the European Union, the United Kingdom, and the United States—has funded HIV vaccine research through its support for the International AIDS Vaccine Initiative.³⁷ Both WHO and the World Bank, as well as UNICEF and UNDP, sponsor the Special Programme for Research and Training in Tropical Diseases (TDR), which is hosted by the WHO.³⁸
- The **Global Fund's** Pooled Procurement Mechanism provides access to competitive market terms and prices, largely for antiretrovirals, long-lasting insecticidal nets, and antimalarial medicines, by negotiating prices and delivery conditions directly with manufacturers.³⁹
- **Gavi's** Advance Market Commitment, supported by the World Bank, has helped to speed up the development and availability of pneumococcal vaccines for developing countries. Donors commit funds to guarantee the prices of vaccines once they have been developed.⁴⁰
- The **Medicines Patent Pool** is an organization backed by UNITAID and the Swiss Agency for Development and Cooperation (SDC) that works to expand access to HIV, TB, and hepatitis C treatments in LICs and MICs. Its partners include UNITAID, UNAIDS, WHO, and the Global Fund.⁴¹
- The **WHO** works on building the capacity of health research systems, setting research priorities and standards, and research translation.⁴²
- While neither **Gavi** nor the **Global Fund** has a mandate to finance product development directly, both work on shaping markets and pooled procurement, which serve as signals to product developers, including on target product profiles.

Improving access to new products in MICs that were never supported by Gavi or the Global Fund

Recent evidence shows that many Gavi-supported LICs outperform MICs in terms of achieving lower vaccine prices and higher vaccine coverage. **MICs that are not supported by Gavi pay much higher prices per dose compared to Gavi-supported MICs and LICs for pneumococcal, rotavirus, and human papilloma virus (HPV) vaccines.** For example, for HPV vaccine, non-Gavi lower-MICs pay on average 5 times the Gavi price and non-Gavi upper-MICs pay 6.5 times the Gavi price.⁴³ The high prices that MICs are asked to pay for life-saving health commodities is a major barrier to achieving global health goals.

Looking ahead

As countries' access to affordable and quality products change, there are **three key opportunities for enhanced collective action**:



- » **Help to sustain transitioning countries' access to quality products, such as through strengthening procurement and supply chains**
- » **Provide clear and actionable guidance to countries on accessing products as they prepare for transition**
- » **Improve access to new health products in MICs that are not receiving Global Fund/Gavi support.**

Building country procurement capacity and **strengthening national supply chains** are two important ways that the multilateral organizations can help to sustain country access to quality products after transition. One significant opportunity for collective action is to **help support the measurement of supply chain performance**. The multilaterals see the need for investments in procuring quality products through building strong data tracking systems **to ensure agile and strategic procurement strategies based on health product and population needs**. As one key informant from the Global Fund said: *“we are trying to move from just training individuals to making sure those individuals have the right tools and technologies.”*

The agencies included in this study identified a clear opportunity to better support countries by providing **concrete and actionable guidance to ensure sustainability of progress**. This guidance should span all key elements in the “product access chain,” from which products to purchase, particularly new products, to market assessment and market shaping. Some operational tools are available for country use but they often provide vague rather than clearly actionable guidance. Multilaterals acknowledged that it is important to *“recognize WHO’s leadership in delivering such guidance”* and technical support on health technologies. Key informants at WHO recognized, however, that WHO’s processes for developing recommendations and guidance remain slow.

Key informants shared ways multilaterals could help MICs to gain access to new health tools, such as vaccines or new HIV or TB drugs. For example, Gavi is “already passively engaged in shaping markets for post-transition countries and other MICs through the effect that its funding has on vaccine markets as a whole.”⁴³ In addition, investments by the World Bank show that there is potential in helping MICs to boost their own health product development industries. As one key informant at the World Bank noted: *“India has some very good ventures in R&D support, e.g., the Indian National Council has used IBRD loans to build biotech capacity – and now Turkey is interested in doing something similar.”*



OPPORTUNITY 3: Strengthening global health security, particularly epidemic and pandemic preparedness

KEY FINDINGS

- Several reforms and new initiatives are already underway to address gaps in global health security.
- Multilateral organizations see an opportunity to **strengthen the call for and mobilize increased investments for health security** by leveraging their collective voice.
- Multilaterals agree that they can help countries prevent and respond to cross-border disease threats by working more closely together to (i) **strengthen national health systems**, (ii) **improve capacities of regional networks**, and (iii) **address challenges caused by transition from donor financing, escalating humanitarian crises, and climate change**.

Defining the need

In recent years, the four multilateral organizations have led a number of strategic reforms and new initiatives to address gaps in global health security (Box 5). Despite these improvements, stakeholders at the organizations remain concerned about three gaps in health security: **an ongoing funding gap; poor national health system capacity to prevent and respond to emerging infectious diseases and other health emergencies; and the lack of a global, independent mechanism to coordinate decision-making on health security.**

Box 5. Examples of recent multilateral initiatives to improve global health security

- In 2016, the **WHO** established a new Health Emergencies Programme to coordinate the international health response to disasters, disease outbreaks, and conflicts.⁴⁴
- In 2017, the **Gavi** Board approved a new fragility, emergencies, and refugee policy that gives the organization flexibility in its processes “to take into account the needs of vulnerable populations, build resilience and maximize Gavi’s impact.”⁴⁵ WHO and UN classifications of emergencies are now used as “reference points and early warning signs to help identify Gavi-supported countries facing emergencies – natural or man-made.”⁴⁵
- In 2017 the Coalition for Epidemic Preparedness Innovations (CEPI) was launched at the World Economic Forum, with funding from the governments of India and Norway, the Bill & Melinda Gates Foundation, and the Wellcome Trust, to develop new vaccines for emerging infectious diseases.⁴⁶
- The Pandemic Emergency Fund (PEF) was launched in 2017, developed by the **World Bank** in collaboration with the **WHO**, with a \$500 million investment to provide countries with surge financing to respond to outbreaks from a defined set of viruses with pandemic potential.⁴⁷ Earlier this year, the PEF made its first commitment of \$12 million to the Ebola response in the Democratic Republic of the Congo.⁴⁸
- The **World Bank’s** Geospatial Operations Support Team housed in the Knowledge Management Unit is using geospatial data to better prepare for and respond to emerging infectious disease threats.
- Peter Sands, executive director of the **Global Fund**, recently signaled that he wants the organization to work more explicitly on health security and partner with others in this effort: “Taking a more integrated approach to health security, encompassing both endemic and emerging diseases, makes sense from a practical perspective. Too often the multiple agendas, initiatives and institutions that characterize the global health space compete rather than collaborate and sometimes only accidentally leverage the synergies between them.”⁴⁹

The funding gap for global health security

The efforts outlined in Box 5 go **only a very small way to closing the health security funding gap.** For example, the 2016 Commission on a Global Health Risk Framework for the Future (the GHRF Commission) estimated that an additional \$4.5 billion annually is needed to create a global pandemic preparedness system.⁵⁰ These investments are needed both to strengthen national health systems and at the global level (e.g., to strengthen regional and global surveillance systems).

Closing this gap is challenging. One key informant at the World Bank noted that “one of the biggest issues is how to get sustainable funding of the WHO emergency capabilities.” As of June 2018, the WHO’s Contingency Fund for Emergencies, launched in 2015, still fell \$31 million short of its \$100 million capitalization goal.⁵¹ In 2017, the WHO’s new Health Emergencies Programme and its Health Systems Preparedness Programme together faced an annual shortfall of \$225 million in funding their epidemic and pandemic prevention and control activities.⁵²

Key informants suggested that the World Bank’s Global Concessional Financing Facility (GCFF), which currently provides development support on concessional terms to MICs affected by the refugee crisis, could potentially be expanded to cover health system strengthening and pandemic preparedness in countries where systems are weak or they are particularly at risk of epidemics. The GCFF could also provide lessons for funding other GPGs beyond traditional grant financing, given its successful governance structure and resource mobilization approach. The GCFF example also raises the question of whether financing facilities for GPGs could be applied to *multiple* sectors. There may be value in developing financing mechanisms that can be applied to health, climate, humanitarian support, and other sectors. These sectors are sometimes competing for resources—thus developing an overarching, joined up “GPGs bank” to mobilize finance for multiple sectors may be a valuable direction.

National health system capacity for preparedness is often weak

The GHRF Commission found that **many LICs and MICs face substantial gaps in “skills, systems, and infrastructure” for pandemic preparedness.** Yet national health systems are the first line of defense against outbreaks. The Commission argued that reinforcing national health capabilities will require, among other strategies, rigorous assessment against agreed benchmarks, improved national accountability on and incentives for improved public health performance, and sustained financing. Attention also needs to be placed on improving the capacities of regional networks of institutions, such as the Africa Centres for Disease Control and Prevention, to prevent and respond to within-country threats.

The lack of an independent accountability mechanism to guide decision-making on health security

All four multilaterals are reviewing their organizational strategies and comparative strengths to address health security and cross-border challenges. However, **there is currently no independent global mechanism to coordinate and assess decision-making on efforts to manage outbreaks.** The multilateral organizations have an important opportunity to consider how they can best address health security needs in coordination with each other.

Looking ahead

The organizations included in this study all identified an opportunity to address health security needs in coordination with each other and work together to:



- » **Mobilize increased international financing for pandemic preparedness**
- » **Improve national health system capacity to prevent and respond to cross-border threats**
- » **Develop a mechanism to coordinate and guide decision-making on health security.**

The multilateral organizations acknowledged challenges in financing GPGs for health. In addition to epidemic and pandemic risks, the organizations emphasized **vulnerabilities countries face as they transition from external financing** and the **escalation of global humanitarian crises**. These crises include the 68.5 million people forcibly displaced by conflict, and climate change creating more extreme natural disasters.⁵³ With this in mind, multilaterals emphasized that **financing for pandemic preparedness must be a global priority**. If positioned the right way, pandemic financing could be used to make an investment case for continued development assistance provided through multilateral agencies.

The organizations see an opportunity to leverage and expand current investments in national health systems to help close health security gaps. For example, the Global Fund's investments in national surveillance and laboratory capacity to respond to AIDS, TB and malaria could be better leveraged for outbreak response. The GPEI has a strong infrastructure and network that could be leveraged for other public health needs. Our interviews with key informants at Gavi found that the organization is thinking through how to position vaccination more clearly as "a tool for epidemic control," including through stockpiling.

The agencies included in this study also emphasized a vision to help countries build strong systems for long-term sustainability. One key informant at the World Bank argued that "*pandemic preparedness is complex, it isn't just about funding. You need communities engaged and connected in countries.*" One key informant based outside the four multilaterals argued that during the next strategic period these agencies should explore where they are best positioned to fill the financing gaps in the broader health security agenda and how support can be better bundled. Many post-Ebola initiatives were launched to support countries to build strong systems. Looking ahead, multilaterals can provide the global accountability support that is needed to monitor these initiatives. An external key informant said that the emerging WHO/World Bank Global Preparedness Monitoring Board has the potential to fill this role if structured in the right way.

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CONCLUSIONS

The changing global health landscape—including country transitions from health aid, the complex health needs of MICs, and emerging global health threats—is spurring Gavi, the Global Fund, the WHO, and the World Bank to evaluate ways to intensify their joint activities. The upcoming replenishments and the highly ambitious health-related SDG targets are also feeding into this re-evaluation process.

Our analysis found that as part of this process, all four agencies see an important opportunity for **collective action in support of GPGs for health**. As one key informant shared with us: "*It is amazing how the issue of GPGs stands at the forefront of most discussions with the WHO's partners.*" By definition, GPGs for health can provide benefits to countries at all income levels, including post-transition countries, and they can help to reduce cross-border health threats.

There was a striking level of concordance between the agencies when it came to identifying **three priorities for collective action**: (1) improving the production, quality, and harmonization of health data; (2) accelerating the development of and access to new health technologies in both LICs and MICs; and (3) strengthening global health security, particularly epidemic and pandemic preparedness.

Investing in health data is an important way to facilitate improved, evidence-based policies and to foster greater accountability. When it comes to health data, the key opportunities for collective action include increasing efforts to provide more granularity across databases in a timely fashion; providing more guidance to the community on which health datasets to use for what purpose; and prioritizing greater sharing of data. Improvements in health data by these multilaterals may result in "spillover" benefits for other sectors—such as climate and humanitarian aid—that are also pushing for increased GPGs support.

All four of the multilateral agencies support **efforts to improve access to affordable, high quality products for those that need it, when they need it**. Looking ahead, the agencies see a need to help sustain transitioning countries' access to quality products, such as through strengthening procurement and supply chains. They want to find ways to provide clear and actionable guidance to countries on accessing products as they prepare for transition. In addition, they want to improve access to new health products in MICs that never received Global Fund or Gavi support.

In the wake of the devastating 2014-2016 Ebola epidemic in west Africa, several reforms and new initiatives are already underway to **address gaps in global health security**. However, there is still a massive shortfall in funding for global health security and many countries still face weak national health system capacity to prevent and respond to emerging infectious diseases and other health emergencies. The multilaterals see an important opportunity to **mobilize increased international financing for pandemic preparedness and to improve national health system capacity and global accountability to prevent and respond to cross-border threats**.

Action on the shared GPGs for health agenda identified by this study could have a transformative effect on global health. It will require advocacy by the organizations themselves to keep these opportunities at the top of the agenda and to devote attention and resources to them. And, as one key informant reflected, *"it will be a test of global solidarity to see if we can put this [agenda] together."*

ANNEX 1. LIST OF KEY INFORMANTS

Gavi

Johannes Ahrendts, Head of Strategy
Albane de Gabrielli, Senior Strategy Manager
Sophie Mathewson, Research Specialist, Policy and Performance (on secondment)
Minzi Lam Meier, Head, Financial Planning and Analysis
Wilson Mok, Acting Head, Policy
Aurelia Nguyen, Managing Director, Policy and Market Shaping
Anna Osborne, Senior Manager, Strategy Development and Tenders
Paolo Sison, Director, Innovative Finance

The Global Fund

Manjiri Bhawalkar, Strategy, Impact and Investment
Michael Borowitz, Head of the Strategic Investments and Partnerships
Carol D'Souza, Allocation Manager
John Fairhurst, Head, Private Sector Engagement
Johannes Hunger, Head, Strategic Information
Mariatou Tala Jallow, Head, Direct Procurement
George Korah, Senior Specialist, Development Finance
Sophie Logez, Manager, Health Product Management Hub
Peter Sands, Chair, World Bank's International Working Group on Financing Pandemic Preparedness (at time of interview; now Executive Director, Global Fund)

World Bank

Olusoji Adeyi, Director, Health, Nutrition and Population Global Practice
Ivar J. Andersen, Advisor
Daniel Balke, Strategy and Operations Officer, Global Concessional Financing Facility
Kimberli Boer, Senior Health Specialist, Global Financing Facility
Margot Brown, Director, Global Themes Knowledge Management
Tim Evans, Senior Director, Health, Nutrition and Population Global Practice
Lisa Finneran, Senior Advisor, Development Finance
Keith Hansen, former Vice President for Human Development (on sabbatical)
Olivier Lavinal, Program Manager, Global Concessional Financing Facility, Global Fragility and Conflict
Axel van Trostenburg, Vice President, Development Finance
Monique Vledder, Practice Manager, Global Financing Facility

World Health Organization

Bruce Aylward, Senior Advisor to the Director-General
Mariângela Simão, Assistant Director-General, Drug Access, Vaccines and Pharmaceuticals
Peter Singer, Senior Advisor to the Director-General
Bernhard Schwartländer, Chef de Cabinet
Agnés Soucat, Director, Health Systems, Governance and Financing
Ke Xu, Senior Health Financing and Expenditure Analyst
Robert Terry, Manager, Research Policy, TDR, the Special Programme for Research and Training in Tropical Diseases

Other Organizations (Think Tanks, Research Institutes, Private Sector, Bilaterals, and Non-Profits)

Cindy Huang, Co-director, Migration, Displacement, and Humanitarian Policy, Center for Global Development
Suerie Moon, Director, Research, Global Health Center, Graduate Institute of International Development Studies
Scott Morris, Director, US Development Policy Initiative, Center for Global Development
Sebastian Wienges, Team Leader, GIZ
Madita Wiese, Advisor, GIZ
Claire Wingfield, Senior Product Development Policy Officer, PATH (at time of interview; now Associate Director, Global Health Advocacy Incubator)
Simon Young, President, GeoSY Ltd

FOOTNOTES

- ¹ In the purely economic definition, a global public good is “non-rival” and “non-excludable”—its consumption by one person does not reduce availability to others and no one can be denied access to the good.
- ² This policy paper was written by a team of policy researchers under the leadership of Duke University’s Center for Policy Impact in Global Health (Gavin Yamey, Kaci Kennedy), in partnership with SEEK Development (Jessica Kraus, Hugo Petitjean, Christina Schrade), the Global Health Group at University of California, San Francisco (Sara Fewer, Naomi Beyeler), and Spark Street Consulting (Nina Schwalbe). The work was supported by a grant from the Bill & Melinda Gates Foundation to Duke University’s Center for Policy Impact in Global Health.
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