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The Evolving Role of the International Agencies in Supplying and Financing Global Public Goods for Health

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and
Global Public Goods for Health

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Abstract: Globalization places the international agencies (especially the World Health Organization and World Bank) in powerful roles. These include being: producers of global public goods; economic agents who facilitate national consumption of global public goods; and regulatory authorities to influence states who benefit from, but do not necessarily help produce, global public goods. Each of these roles is examined.

In these roles, the agencies face constraints and pressures. The most important of these are: baseline differences in knowledge or conceptual differences and gaps; relational constraints in the way that sovereign states use and interact with the agencies; financial pressures inherent in the way the agencies are financed; competitive constraints caused by the other factors; and environmental forces flowing from the international anarchy of globalization itself. These factors are determinant of the agencies' abilities to perform their roles to produce and encourage the use of global public goods. Improvements in global health status through greater emphasis on public goods would require states and agency management to change these factors to improve the agencies' performance of their roles.

The paper examines the way global public goods receive support, pays specific attention to WHO's role as a leading provider of global goods in health, looks at the supporting roles that other organizations, such as UNICEF, the charitable foundations and NGOs, play and ventures speculation on ways to expand provision and use of global public goods.

[**Keywords:** WHO, World Bank, UNICEF, global public goods, international health, competition, financing, partnership, NGOs, foundations]

1. Introduction

1. Global public goods are those that exhibit cross-border externalities, and are therefore likely to be under-supplied at the global level by governments and markets alike. Global public health goods are international policies, programs, and initiatives that promote global health and address health concerns that transcend national boundaries.

2. These go beyond the span of control or production of a single government (because of borders) just as national public goods are beyond the efficient production of individual firms. Globalization, replete with its anarchic characteristics in the absence of a world

government, has placed the international agencies (*1*) in historically unique and powerful positions relative to global public goods for which sovereign states are both producers and consumers.

3. Economic theorists long ago worked out the general case for public goods and the implications for prices and behaviors. "… [T]hirdly, the duty of erecting and maintaining certain public works and certain public institutions, which it can never be for the interest of any individual, or small number of individuals , to erect and maintain; because the profit could never repay the expense to any individual or small number of individuals, though it may frequently do much more than repay it to a great society.(*2*)" Protecting and improving the community's health is an endeavor long recognized as a public good.(*3*)

4. There is a parallel on the global level of the need for public goods where there is a need for development of health knowledge or programs that benefit a number of states, but that are of limited interest for any one to produce or pay for. Such knowledge or programs are needed because there are public "bads" that may exist (*4*) and must be acted against, and public goods that must be achieved.(*5*)

5. Public goods have two characteristics - they are non-rival and non-exclusive. A good is non-rival if the marginal cost of providing it to an additional consumer is zero.(*6*) A good is non-exclusive if consumers cannot be discouraged from using it.(*7*) In the case of global public goods, the concepts of non-rivalry and non-excludability apply to countries, not individuals or firms.

6. Public goods in health produced at the national level by many countries are not necessarily global public goods. Conversely, weakened national health systems may have

the unfortunate effect of contributing to global public "bads" - e.g., the export of drug resistant strains of tuberculosis.

7. Many of the activities of the international agencies ***aid the production, or assist in the consumption*** of national health goods with substantial global publicness in their benefits.(*8*) Agency activities that focus on disease surveillance, and eradication or elimination programs almost inevitably display a degree of global publicness in their benefits.

8. This demands attention to the question of how priorities for public goods in health are determined and to whom they are provided. **"*Who benefits*"** may be as important as **"*who pays*"** in determining which public goods in health are produced (*9*) and what subsidies encourage their consumption. However, this is not a simple calculus of economic efficiency versus wise humanitarianism. Operating with limited grants of authority from sovereign states, the international agencies have developed policies and tools that powerfully affect the production, the subsidies for access and the regulation of global public health goods. The roles of these agencies are described in detail in Section 2. The human, systemic and financial factors that constrain and influence the international agencies' performance of these roles are examined in Section 3. Section 4 looks at the potential for improvements in global health through emphasis of global public goods and the radical responses that may be required of the agencies and their owners.

2. Global Public Goods in Health – The Role of the International Agencies

9. With increased frequency and confidence in recent decades, the international agencies have acted, as a government agency might at the national level, to be:

- **producers** of global public goods,
- **economic agents** who facilitate national consumption of global public goods, and
- **regulatory authorities** to influence states who benefit from, but do not help produce, global public goods (so-called free riders) and to moderate appropriation of excessive returns to investment in such goods.

As Producers.

10. The central policy implication of the public goods concept is that the state must play some role in the provision of such goods; otherwise, they will be under-supplied.(*10*) But, there is no global government. The international agencies, acting on behalf of multiple states, have acted as the vehicle for collective action, and a proxy for global government in the provision of global public goods for health.

11. Knowledge is one of the pure forms of a public good. Knowledge about health used by one state does not take away anything from any other state and its use cannot be exclusive once it is released. The determination of normative standards, one of WHO's functions, for epidemiological surveillance, for example of malaria and TB, the services

of data aggregation and the dissemination of results at the global level are knowledge goods.(*11*)

12. Other institutions might act to produce similar knowledge products, but often lack the authority to unify the absence of government that prevails at the global level – academia for example, or a foundation or a departmental agency of a single state.(*12*) Often these academic or departmental agencies provide the human resources, or special facilities, used by the global institutions such as the WHO in developing or disseminating knowledge products or technical protocols for global public goods. However, unlike the state institutions, WHO provides an international forum, rules of operation and supporting secretariat, all of which improve the prospects of acceptance of the knowledge and of encouraging successful collective decisions.

13. Thus, while the international agencies are not the exclusive providers of global public goods, they are often the most important. Very often, they serve as a catalytic crossroads where many players contribute to the formulation of policy or supply of knowledge or activities with public goods characteristics. For health in general, and public health in particular, the WHO has many functions and leading roles as a global producer of public goods for health. These would include the "agreements" which WHO facilitates among states about standards to be achieved or maintained, or for collective action and response to important health problems.(*13*) Another example would include the aggregated epidemiological "knowledge" which results from the WHO's collection and analysis of individual state reports. The normative directives that WHO issues for guidance about disease control or health care are another example. Each of these involves a number of offices and levels of the organization, each often interacting intensively with particular

constituencies in member states or in professional associations or specialized non-governmental agencies.(*14*)

14. If WHO failed to establish norms and standards, and to competently collect and publish surveillance data on tuberculosis, for example, it could deprive state A of knowledge of an epidemic in its neighbors B or C. This could result in state A's TB program ignoring the immigration of persons with regular and drug resistant TB. Such a program would not succeed in reducing immigrant sources of new infections and an epidemic could persist and spread. Before standardization of TB surveillance criteria in 1993/4 by WHO, this kind of information was absent on a consistent global basis. Many countries had no regular source of information about the total size of the pool of infectious TB cases in their own jurisdiction, in neighboring states that accounted for their main sources of immigration.

15. The basis is now well established to identify which states have large numbers of TB cases and which among them are effectively reducing prevalence by producing TB cures, and ultimately reducing the incidence of TB. The basis for strategic targeting of health and foreign aid resources to provide better control of the TB epidemic was a form of global public good created by the WHO. Production of this good required international cooperation and yielded positive externalities to all states, not just those that participated. There are many other examples in WHO's operations.

16. UNICEF and World Bank are less frequently primary producers of global public goods in health. The Bank's mandate and instruments of lending are primarily for individual states, seldom encompassing multi-state or global funding. Although it is not an example in the health sector, the Bank's roles as the host and staff for the Global

Environmental Facility and the consultative Group for International Agricultural Research (CGIAR) have some characteristics of public good provision. The growing interest to directly execute functions needed for financing a global approach to the control of HIV/AIDS, TB and Malaria may emerge as a public good provided by the Bank or another UN agency. Through its financing of health projects that each affect an individual country, the Bank is probably the main "enabler/financier" of states to produce national public goods in health, some of which have regional or global effects. For example, the Bank has been the largest single financier of TB projects. Only if many states produce the national public good of TB control will control of the global epidemic be achieved, with benefit to all states for decades to come. To the extent that the Bank's lending accelerates the pace at which national TB control is achieved, it creates a smaller pool of infectious sources that perpetuate new infections. The reduced infection risk is a public good for all countries. It is non-rival and non-excludable.

17. The Bank's financing role expands the potential of states to produce public goods. To the extent that there is a subsidy element in the Loans of the Bank or IDA Credits, the Bank provides *a grant to stimulate the production* of a public goods. To the degree that it simply provides capital, *a Bank loan accelerates a state's production* of public goods beyond what the state was able to accomplish from its current resources. But such loans remain the purview of single states. It is only in the indirect, spillover effects of such national public good activities, or because of their collective impact, that global goods are aided or created. If the Bank developed lending instruments conditioned on collective action and participation, more direct, global public good impact could be achieved. Others agencies, for example, UNICEF to some degree, bilateral assistance donors, and

non-governmental organizations including foundations, provide a similar increase in potential global impact when financing local public goods in health.

18. The World Bank also produces knowledge public goods in its economic and sectoral analysis work on health. For example, the Bank's formative book on "Disease Control Priorities in the Developing World"(*15*) can easily be described to have been such a knowledge product. Similarly, the ideas and methodologies elucidated in its report "Investing in Health" (*16*) had an impact on global thinking about which interventions were best buys in health. The report also advanced understanding about how priorities in health could be determined and how outcomes of health spending could be reasonably compared. These knowledge goods, even in an imperfect form, assisted many countries to examine their own investments in health and to increase or improve efficiency of national and global effects. This knowledge also begot further research and development in these and related topics, producing yet further knowledge goods. To some extent the World Bank's analytical work influenced WHO's data gathering, analysis and reporting methodology, which in turn provided improved public knowledge for member states to use in prioritizing the use of Bank loans for health.

19. The UNICEF and others also produce knowledge on topics that can constitute global public goods in health. UNICEF distilled best practices and relevant country specific experience about diarrhea disease control, provision of immunizations, cold-chain management and safe motherhood practices into general knowledge and programmatic algorithms. These tools were applicable in multi-country settings, thereby achieving and accelerating accomplishment of national public goods, some of which had "global publicness" about them. The cumulative effect of such activities may have indirect

positive externalities at a global level through their impact on child survival, productivity and the status of women, with positive long-term consequences. Its cooperation with WHO to identify and advocate the best immunization strategy is a more direct example of a global public good. Nevertheless, UNICEF activities in health seem to have fewer cross border externalities and require fewer collective actions by states than work of the WHO. On the other hand, UNICEF produces considerable knowledge products of other kinds that constitute global public goods outside the health sector - on rights of the child, family life and education.

20. In general, however, there are very few global public goods for health produced by any single international agency in the way that happens in a state at the national level with national public goods. In large part, this is because states have not ceded their governance functions to the international agencies.

As Economic Agents.

21. That a public good is by its nature non-rival and non-excludable does not mean those who would use it can do so costlessly. It may be necessary for the consumer of a public good to undertake various expenditures before positive externalities of the public good can materialize.(*17*) A ship may have to be provisioned and crewed before the navigation benefits of a lighthouse are realized. A family may have to buy a radio or television before the benefits of public education broadcasts are enjoyed. Countries also need to make preparations to employ or benefit from public goods.

22. The ***cost*** to a Consumer State of a global public good may be beyond the financial or political commitment that a government is willing to make. There are many indicators of this in the current health programs of poor countries - smaller than optimal programs,

unserved population, inadequate resources, and practices that are cheap but inefficacious or inefficient. There also may be rejection, for reasons that are not clearly articulated, of technical standards and practices for public goods. These may include such considerations as the desire to protect employment of certain groups (e.g., hospital workers), protect local drug or other manufacturers from import competition.

23. This may mean that the Consumer State feels compelled to delay or ration access to global goods unless they can gain subsidies to help them meet the costs.(*18*) The international agencies can and do play multiple and critical roles in overcoming this reluctance.

24. For example, states often need to revise programmatic practices, clinical and diagnostic protocols, retrain staff and managers, and buy new equipment, drugs or other supplies before a new "knowledge" public health good can be utilized. Many of these preparations entail additional costs and some may require foreign exchange. The international agencies often provide or facilitate the investments needed to put public goods to work, or to reduce the cost of doing so.

25. WHO and UNICEF help in furthering the consumption of public goods, both directly (for example, through training programs) and by financing the cost of drugs and materials or supplying them in kind. This lowers the cost to the Consumer State of using the global public good (i.e., putting the knowledge to work). The technical assistance, training and publication dissemination functions of these agencies are important economic agent roles.

26. The World Bank finances the means of exploiting the benefits of public goods, usually national goods, but sometimes with considerable global public effect. Bank financing can be with either a small or very large subsidy element, depending on whether

the Bank or IDA (*19*) is the financing institution. The greater the subsidy element, the more the Bank Group's loan reduces the cost of acquisition or application of the public goods in question.

27. Funding by WHO and UNICEF to subsidize the consumption of global public goods is very limited. These two agencies often collaborate with bilateral donors to secure country-specific funding linked to the agencies' knowledge or best-practice dissemination activities. The external funding reduces the cost, expands the scope and accelerates the process of a country producing and using elements of global public goods. Similar linking of WHO and UNICEF operations with IDA resources also takes place. However, IDA funds are intended for the poorer countries and are limited. Moreover, like World Bank loans, IDA credits are country specific, not regional or global in purpose.(*20*)

28. By contrast, resources for health sector investment from the World Bank itself are essentially unlimited. However, up to now and because of its mandate, these resources have been restricted to financing the means of production or use of national and local public goods for health, only a few of which have strong global effects. Moreover, as explained, the loans involve only a small element of subsidy and would do little to facilitate the large-scale acquisition of public goods. However, there is an important caveat and potential to be recognized.

29. The main function of a loan is to ***accelerate*** the investment or the purchase of those assets or benefits, which would otherwise be affordable only over a long period, or by foregoing other presumably important current expenditures. The essentially unlimited pool of Bank loans could permit countries ***to act collectively to enjoy more rapidly*** (*21*)

global public goods – for example, TB cures, malaria prevention or HIV/AIDS prevention. A country could act individually to accelerate its realization of benefits, but would be likely to do so only if the national, rather than global, benefits were predominant. It makes economic sense to accelerate investment for predominantly global (cross border) benefits only when the other beneficiaries are willing to share this burden.

30. The Bank has extensive, unrealized potential for being the main economic agent to catalyze multi-state willingness to act collectively in the production and consumption of global public health goods.(*22*) Its owners would have to enable it to undertake lending to a collective of nations and mechanisms would have to be found to create and maintain multi-nation collectives for the achievement of public goods in health. The Bank's recognized strengths for sound economic and financia1 analysis, and relationships with authorities beyond the health sector, could place global public goods in health into the mainstream of long term national and international priorities.

31. Such developments would create large cross border benefits in human welfare and reduce economic loss. But it would require the better synchronization of the existing normative products of the WHO, the country delivery and advocacy capacity of UNICEF, and the Bank's formidable economic agent role. Existing and new global public goods could be produced and disseminated and their inexpensive consumption facilitated. These themes will be addressed further in the last section of this paper.

32. Further involvement of the international agencies in financing the consumption of public goods would also seem to be friendly to the growing trend of public-private partnerships. In these varied alliances, the global agencies and the institutions in civil society cooperate to facilitate the use of public goods in health.(*23*) Coalitions to

accomplish this already exist with the Bill and Melinda Gates Foundation fostered GAVI(*24*), and the Rockefeller Foundation's formative support for the Global Alliance for New TB Drug Development. The international agencies have joined, or are coordinating, with these new approaches for global common benefit.

33. The international agencies can also ensure that publications and protocols (knowledge that they or others produce) can be widely disseminated on a sustained basis. Both current and future generations of politicians and civil leaders, as well as health workers, thus become more aware of health strategy and practices and can accept them with less resistance. Strangely, the UN system agencies have in recent years begun to charge for many of their publications. This reflects perverse financial pressures on the agencies that inhibit their function to supply knowledge and assistance – thus putting a price on the information that should be a public good. WHO has recently moderated its practice of charging for publications. Other agencies may follow this lead, at least for important knowledge products.

34. In addition, the agencies sometimes act to lower the price of inputs for a public good, either through negotiated arrangements with suppliers (*25*) or more efficient collective procurement.(*26*)

As Regulatory Authorities.

35. It is easy to understand that any one state may feel that it should not bear the full financial burden of creating global public goods from one of its national health investments or programs. In addition, other states may rationally feel that if the first state is handling, for example, its tuberculosis epidemic problem successfully, they need do little or nothing with their own tuberculosis programs. They may correctly perceive that

they will benefit from the epidemic state's efforts, thus freeing some of their funds for use elsewhere.(*27*) Reliance on others to produce public good benefits enjoyed by all is called being a "free rider".

36. A state that produces global public goods would naturally expect that other states and the global community who enjoy the benefit of these goods should help pay for the costs. The investing state can reason that since other states are benefiting in some small way from fewer disease cases, or better surveillance data, they should share in the cost of production. Failing such sharing, it may try to exclude users from being users, or somehow ration the benefits or extract some reciprocity in another field.

37. As often pointed out in the economic literature on public goods, the very condition that gives rise to the need for a subsidy to correct negative externalities will cause users of the goods to misrepresent their preference for the public good.(*28*) If a state is one of many suffering the public "bad" it may be tempted to understate its desire/preference for the good (the cures or prevention, or the better data). It will hope that other states, agencies, or philanthropists will pay for a higher share of the costs without it forgoing any of the benefit.

38. The free rider phenomenon explains the poker-like bluffing and dissimulation intrinsic to the problem of sharing the cost of public goods that take place in a number of international venues. Countries sometimes request more grants from the WHO and more from their bilateral donors, often with the justification of poverty, while concurrently spending even larger sums on military hardware or infrastructure investments of dubious justification. It also characterizes the negotiations among states and their bilateral foreign assistance donors, and sometimes even the budget discussions *within* departments of

health.(*29*) States frequently plead poverty as constraining their pursuit of national and global public goods. This can be a real problem worthy of international subsidy or it can be a shield to deflect the need to prioritize within and across economic sectors. For example, Russia, Indonesia and Pakistan produce huge numbers of TB cases with cross border ramifications and global externalities. Each has displayed free rider behavior over the last few years by turning to others for the mobilization of funding for TB control. Yet, the degree to which poverty, in general and within the health sector, constrains them from meeting their own TB investment needs is obviously a vastly different among these countries.

39. In general, no state wants to overpay for public goods and many may like to underpay, providing they still receive their full share of benefits. Not only allocation by price but more elaborate systems of financing by voluntary contribution (*30*) will be grossly unreliable in fixing the balance between who pays for global and national public goods and who benefits therefrom. It would always be possible, most states would agree, that by changing the balance between production of global and national public goods everyone could be made better off.(*31*) The community could take communal responsibility for the balance between production and consumption of global and national public goods to optimize both. These thoughts must have underpinned some of the objectives of those who founded the World Bank and established the United Nations Specialized Agencies dealing with health, though it perhaps was not articulated in quite the same way. But the point is clear. When global public goods must be produced or encouraged, none other than the global community can take communal responsibility. Proxies for the global community or an international government, like the international

agencies, can only play partial roles and these are subject to the disruption and misallocation inherent in the present international anarchy, despite efforts by some states to make it more humane and fair in recent decades.

40. To summarize, the nature of global public goods (and "bads") and the decreasing cost phenomena associated with economies of scale for some health conditions may cause some national decisions, about what to invest in, to go wrong. The perceived costs to national governments for realizing the benefits of national and global public goods will be loaded with misinformation.(*32*) National benefit calculations will tend to neglect or discount much of the global benefit associated with public goods produced at the national level. National calculations will undervalue benefits of cooperative global production. In the use of their national budgets, states may perceive satisfactory rewards from less efficient (smaller) or alternative production of public goods in health.

41. In these circumstances, states may choose to under-invest in producing and consuming a public good, or try to recapture at least some of the costs of operation. This might be through user fees charged to those receiving services, thus creating a potential barrier to enjoyment of the goods produced.(*33*) Other barriers might include trade protection or other restrictions to ensure that all drugs, vaccines and equipment for production of the public good are purchased from domestic suppliers whether paid by foreign subsidies or local budgets.(*34*) Behaviors of states to become free riders may take the form of long delays, protestations of poverty and other forms of bargaining to maximize proceeds or minimize costs of foreign grants and loans.

42. Whether by design or practice, the international agencies have adapted their operations to provide some quasi-regulatory functions (*35*) that help moderate the free

rider and excess appropriations problems. We could characterize these functions as "taxes" of a sort, or non-monetary, but real, "costs" that states can be made to bear when they attempt to always be free riders, or to ration or appropriate excessively the returns to global public goods. Examples will help illustrate this. It is clear that states are well attuned to the practices of the agencies and have displayed regional and other solidarity in positioning themselves for maximum benefit and for influencing the international agencies.

43. The agencies have developed legal and quasi-legal pacts as instruments to induce states to declare their positions, agree to adhere to standards or principles and even set public benchmarks for themselves to be attained at specific dates. The Convention on the Rights of the Child (*36*) (largely outside the health sector), the Framework Convention on Tobacco, the Ministerial Conference on Malaria, the Amsterdam Conference on TB and Sustainable Development, contained elements of "public commitment" by states and their ministers. This provides the basis for review of performance and publicity. In designing these agreements and conferences the agencies fully intended to use the public commitments as tools to reward and to prod future performance of states.

44. All of the agencies have also developed technical databases of seemingly innocuous micro-level indicators which when published in aggregate, longitudinal form provide powerful "report cards" on performance. The World Bank's World Development Indicators, a variety of the WHO disease reports and UNICEF's Indicators of Child Health, are used to prod free riders and moderate greed in appropriation of returns. The 1993 World Development Report (*37*) was used to some extent in this way and changed much of the environment and concepts with which health issues were discussed.

Seemingly minor statistics published annually in WHO's *World Health Statistics* or other reports can stir protest by both industrialized and developing countries if their performance on some measure ranks lower than what they had expected.

45. Each of the agencies also use such data, together with detailed country reviews and reports, circulation of information among the donor community, global conferences and the like as forms of knowledge and sanction. Such reports can function both as rewards and as quasi "taxes". On occasion, release of information to the press has proven highly effective in changing national posture about public goods. In addition, performance information helps political leaders to be aware of developments on their watch and the remedial action recommended. Intensive dialogue between the agencies and individual ministries is fueled by such information and without doubt influences ministerial response. The release of information about free rides and excess appropriations can be used in public advocacy that builds global and national pressures for change. Development and equity-oriented NGOs often use the agencies' information, publicly and privately, with good effect.(*38*)

3. Constraints and Influences on the International Agencies

46. Like all human endeavors, the international agencies face a number of constraints and factors that affect their interaction and the provision of global public goods. The most important of these can be termed:

- ✓ Baseline (knowledge or conceptual differences and gaps)

- ✓ Relational (the way that sovereign states use and interact with the agencies), and
- ✓ Financial (forces inherent in the way the agencies are financed),
- ✓ Competitive, caused by the other factors above, and lastly
- ✓ Environmental (the international anarchy of globalization itself).

47. These factors interrelate and may reinforce each other. They can be explored only superficially here.

48. Baseline constraints. There are significant differences of opinions in the agencies about health interventions, their priorities and efficiencies. There is a lack of common technical knowledge among the staff of the international agencies about inputs and methods for many health sector interventions. If achieved, technical and strategic agreement could more readily produce global public goods or effects as part of country level projects or as core parts of coordinated institutional cooperation.

49. Even when WHO has defined technical approaches clearly and systematically, the process of acceptance of these norms has often been slow. The approaches may not coincide with beliefs already held by individuals – both international agency staff and health system staff in some countries. For example, it took five years before staff in the World Bank and in some health ministries accepted the principle parts of WHO's recommended strategy and practices for control of tuberculosis. Mythology and misunderstanding of disease processes and their consequences for control of TB had built up in public health circles to such an extent that acceptance of new advice was both slow and variable. The decline in the WHO's technical reputation during the late 1980s and early 1990s probably also contributed to new protocols being viewed skeptically.

50. It would seem obvious that WHO should take the lead in forging technical consensus, in partnership with the other agencies and with the main organizations of civil society that are strong global players. This consensus would have to be achieved with recognition of the perspectives and the knowledge that other agencies possess. This has been a difficult area in the past and is explored more fully under "competition" below.

51. Rationally, the medical or public health knowledge that WHO holds is the core with which to build on the broader experience of the other agencies with the objective of creating, supplying and encouraging the use of global public goods. The process would have to incorporate the economic and financial expertise of the World Bank, and the field experience and social knowledge of UNICEF and many non-governmental organizations active in the health and development fields. Such a process could be systematically undertaken, one topic at a time, until a whole range of knowledge products for public goods with global effects were accepted by the agencies, their staff, bilateral donors and most national governments. Some steps in this direction may have begun to emerge.(*39*)

52. **Relational constraints.** Bilateral agencies providing development assistance to the health sector exercise both positive and negative influences on the three public good roles (see above) of the international agencies. Some states have direct national interests in the global provision or achievement of specific public goods.(*40*) Others have developed extensive experience and tools and take the opportunity to synergistically further empower the WHO, the World Bank or UNICEF in creating public goods in health.

53. The influence of these bilateral agencies is exercised in at least four ways:

a) through the governing bodies of the institutions where matters of national interest or policy can shape global policy or consensus;

b) through participation in the technical and professional meetings and operational activities of the international agencies when national expertise can shape understanding, analysis and, ultimately, policy of the agencies;

c) by linking financial contributions to an agency's development of particular activities; and,

d) by directly contributing staff or management to the agencies so that they can supplement product or policy development.(*41*)

54. Each of these methods is employed on a regular basis by most bilateral agencies or their governments. The extent to which there is a carefully developed national policy agenda underlying the interactions in any one case or method varies greatly. Often there is just a general desire to strengthen the capability of the agency, to assist in a particular cause or to provide international experience to national staff for subsequent career development purposes.

55. Inevitably, there is a risk that bilateral political concerns unrelated to the public good objectives may become inserted in the process.

56. For example, the United States' concern with the perceived inefficiency of UN organizations has reduced its share of funding to some of the agencies in order to satisfy Congressional critics. For WHO, this was exacerbated by US dissatisfaction with WHO's direction under former its Director General, Nakajima. Other governments responsible, together with the U.S., for the majority of WHO's funding, shared some of these views

on substantive weak performance. To encourage reform, budget cutbacks (or non-growth) for the regular budget became the norm. Even under WHO's new Director General Brundtland this trend has persisted. This has two effects.

57. On one level, continued focus on specific bilateral concerns risks distortion or obscuring global policy formation. For example, in the 2001 World Health Assembly many plenum and committee discussions revolved around the theme of the US cost sharing or WHO budget reform. Among alternative topics that could have been discussed were which global health goods should be a priority for the world community? How and by whom should they be paid for? Over time the WHO's role may be weakened by the scarcity of ***health policy*** focus in its annual governance meeting.

58. On another level, it creates a unique dependency of WHO on a few bilateral financiers. This occurs because the regular budget finances all long-term staff. These staff naturally embody institutional memory, senior expertise and policy development knowledge. Funds for program activities and development of normative guidance have virtually disappeared with the budget restrictions. Many global public goods provision and formulation functions of WHO are at risk if bilateral donors do not finance them through extra-budgetary contributions. However, this makes the agency reliant on bilaterals agencies for new staff financing and programmatic funds.

59. Lack of agreement on some very basic concepts adds to this risk as the agencies have little choice but to accept certain ideological perceptions, even when there is not widespread agreement or even analytical effort to underpin them. For example, some bilateral donors insist that countries should become financially self-sufficient in support of health costs (should not depend on external resources; should not become

"dependent", etc.). At face value, this would seem to be an irrational position for the donors to adopt for global public goods. The more "pure" (*42*) the form and the more direct and immediate the global good (*43*), the more both an economic and a humanitarian rationale would dictate that poor countries not be self-sufficient. Indeed, they should be subsidized somewhat, perhaps for a very long time. There is no consensus on these topics at present.

60. Financial insecurity of the agencies is one of the main causes of competition among them and among departments within the agencies. The attitudes and behaviors accompanying the competition diminish potential impact and create inefficiencies.

61. Financial constraints. Most of the agencies in the UN system have regular budget resources derived from membership dues determined by treaty and extra-budgetary resources determined by external donors. In the last two decades these parallel budgets has dramatically affected both the size and strength of programs in the WHO. The World Bank has also supplemented its administrative budget with bilaterally contributed trust funds to which World Bank staff can apply for proceeds if their project preparation efforts and objectives meet the conditions of the trust fund donors. While the details are much different, the impact of the practice in the Bank is not dissimilar from that of the extra-budgetary funds received in WHO and described below.

62. In the WHO, extra-budgetary contributions allow additional staff to be hired, global, country and regional level activities to be financed, and the visibility and influence of the regular budget managers involved to be heightened. Extra-budgetary funds add to the temptation for staff and management to move away from any consensus that might be forged on the core mandates (for which all member states make regular budget money

available). It sets up competitive forces within the organization and between the international organization's staff and other actors in the international system – for example, NGOs that might have similar capacity or skills. It risks misallocation of resources to the extent that it involves the international agencies in activity for which they might not have existing competence and capacity. It also risks technical mistakes and inefficiency as lessons are learned. It necessitates acquiring special skills or staff who are outside of the agency's previously necessary competencies. Despite these drawbacks efforts to obtain extra-budgetary funding are a major activity in several of the agencies and in fact they could not operate without such contributions. In the case of WHO the extra-budgetary funds are approximately as large as the regular budget resources.(*44*)

63. On the positive side, external funding can provide a potent lever for donors to encourage agency management to do better and to take up topics which were neglected in the past but which are clearly "core" in nature. For example, it was external funding which help to revitalize WHO's attention to tuberculosis, malaria and anti-tobacco measures – all of which are important activities with public goods features. If the programs funded with external contributions are technically sound, well managed and efficient, they can produce national or global public goods that have considerable value. And of course, such externally funded programs compensate for the shortage of funds available from the regular budget.

64. The World Bank has been somewhat less susceptible to extra-budgetary funding influence in the past. The mission of the Bank had been relatively clearly defined by the earlier Presidents and Boards. The broadening of objectives and products to include social sectors was deliberately incremental. It was, for the most part, carefully planned,

subject to specific staff recruitment and training efforts and the subject of careful review and debate as each new feature or product emerged on the scene. The questions were usually asked – should the Bank be doing this? Why? What other capacity is there in the international system to do it?

65. However, the main reason that the World Bank remained insulated from a financial imperative, at least until the early 1990s, was that the Bank's administrative budget was not dependent on external grants of resources for staff or administrative costs directly associated with normal business. In general, Bank staff had sufficient budgets to carry out their work programs. Work outputs were (more or less) clear with specific products to be expected and budgets that could be managed to ensure some degree of efficiency and achievement. The staff was not, until very recent years, subject to budgetary maxims to mobilize their own external financing to meet operational costs of preparing or supervising projects.

66. With owner-driven pressure, particularly but not only from the United States, to reduce the administrative budget of the Bank, the situation changed dramatically. Additionally, the Bank had to respond to serious external challenges to improve its performance, to avoid negative externalities from its project, be more responsive to civil society and improve its project operations. Among other things, management had to cut the administrative budget to demonstrate greater efficiency. Consequently, the staff has had to spend a larger proportion of time trying to mobilize external funds to accomplish work, much as WHO staff had to do for the past two decades. While there are differences of detail between how the WHO and the World Bank staff were affected, the undesirable pressures to broaden their field and compete had not previously, on average,

distracted Bank staff and managers. More recently, adequate funding for project development activities, which ensure borrower participation and support, and high-quality project implementation assistance (supervision), has been alleged to be severely constrained. The results are said to be high transaction costs to the staff (thus inefficiency), severe demoralization, reported sub-optimal staffing of preparation and supervision missions and probably lower general quality of the Bank-Country project dialog.(*45*)

67. These examples suggest that, whatever their merits, financial pressures may have highly negative consequences for the agencies and their managers/staff. They may diminish the ability of the agencies to focus on core mandate and to provide or facilitate the use of national or global public goods. The compensatory financial mechanisms used by the agencies can substantially increase transaction costs, distract and destroy unity of management and organizational focus on objectives. They also establish incentives for non-productive competition within and among the agencies. These competitive forces and their consequences are examined in detail in the next section.

68. The extra-budgetary funding mechanisms also convey unusual indirect power to the mid-level officers in bilateral assistance agencies who control much of the funding provided to the international agencies. Depending upon their vision, competence and experience, such authority may be wielded with wisdom and powerful benefit or inexperience and myopia, incurring serious costs.(*46*) Either way, an extra-budgetary financing process avoids the formal governance process established collectively by the owners of the agencies and diverts power from the governing bodies. It adds to the international anarchy and muddles the specific grants of authority by member states to

the agencies. Since both non-donor (largely poor) governments and donor governments should reap substantial benefits from global public goods, the net effect of inadequate core financing of the agencies is probably detrimental to both rich and poor states. It suggests the need for common action to make reforms, to set and maintain objectives, to finance the budgets required, and to hold management fully accountable.

69. Competitive constraints. Close and persistent cooperation between international agencies increases their influence on states, and thus impact on policy. Inconsistency or competition between agencies has the opposite effect. Similarly, when differing technical advice or policy direction is given by the international agencies, or even by two units of the same agency, vested interests in the country can exploit the inconsistency for their own purposes. Lack of inter-agency consensus on basic technical and policy parameters can have a negative impact on national policy, project components, items to be externally financed and results achieved.

70. Competition in the production of ideas, or the accomplishment of work, may in general be a good thing, even among international bureaucracies. But competition for control or preeminence is often a negative-sum game, with the global (or national) good diminished no matter who succeeds. Assertions of international mandate can cause unnecessary disagreements about technical matters and pose serious barriers to agreement on priorities. Conversely, cooperation among the agencies potentially offers benefit to the agencies themselves, member states and global welfare.

71. Historically, the topics of cooperation and competition have been difficult areas for the main international agencies. Revisiting the details of the many and legendary

disagreements would gain little insight. It is better to acknowledge that management has made considerable progress in recent years to encourage collaborative work..

72. For example, today there is far more agreement than in the past on the need to prioritize investments in health and there is more acceptance of the criteria to be used. The 1993 World Development Report, the new series of World Health Indicators, other documents, and many meetings, have helped slowly to bring about improved dialogue and common understanding among the agencies.(*47*) It is also true that significant gaps remain.

73. The governance, budget processes, and the culture of each agency, help to maintain these gaps and determine whether competition or cooperation is encouraged. This deserves explanation in this paper because it is a determinant of the agencies' roles relative to global public goods. The financial imperatives examined in the preceding section fuel many of the actions that ultimately result in ineffective competition.

74. There are three reasons why the agencies (or individual departments within them) may want to position themselves for control or ownership of topics or causes related to global public goods in health:

- Firstly, as long as the base mandate and core objectives are not clearly and universally understood and financially supported by members, there is a risk that one agency's operational function may be eroded by another. There is fear that erosion indicates a lack of support or incompetence. Most importantly, erosion on details of expertise may pose a threat to future "core" funding in general.

- Secondly, leadership association with a cause (*48*) carries with it a tendency for the agency to strive for the lead position on all major aspects of that cause. Agencies, and individuals within them, protect such leadership for a variety of reasons, including economic ones. No agency wishes to see its prestige or financial power in a particular specialty eroded by another organization.(*49*)

- Thirdly, within an agency bureaucracy, the immediate managers (and in some cases their superiors) gain power, prestige, justification for securing more regular budget staff positions, and the very real probability of promotion by building and holding a broader operational portfolio and larger budget.(*50*)

75. These concerns are characteristic of private firms trying to protect their market share and reputation so that they can raise capital and ensure sales. That the concerns exist in the public agencies not dependent for their financing on capital markets or consumer demand seems surprising at first glance, but is logical upon reflection. When role and objectives are not clear, and when there are funds outside the control of management that can be competed for, a market develops between and within the agencies. Some of the aspects of the market have been described above. These competitive phenomena reflect the fact that the global community has not yet agreed that the public sector will pay for provision of public goods.

76. In the resulting vacuum of global community inaction, agency leaders and staff with vision and conscience try to fill the void where compelling inefficiencies or injustices prevail. However, they are doing so under conditions where the institutional owners are not yet ready to create the means for global resource mobilization and orderly allocation of subsidies to achieve betterment of the common good. Occasional preoccupation in the

agencies with control or prominence reflects these conditions, along with the desire to do good and more of it. But this preoccupation comes at a high cost. It creates further inefficiencies, conflicts and disruptions in priorities, thus causing misallocation in the creation and use of public goods. Surely, the public sector owners do not really want such phenomena. Yet, they do not act to correct the causes.

77. Environmental constraints. The primary cause behind these market share and specialty protection behaviors is that owners of the institutions (states) continue to allow the agency mandates to be less than clear. Only very limited grants of authority from the member states are made. WHO may have the normative authority to "direct and guide" member states in matters of health, but the states do not have to listen or accept. The World Bank can analyze inefficiencies in the health sector and use the encouragement of its financing to encourage improvement of strategy or practices. It cannot force states to accept either money or the reforms.

78. Indicators of fuzzy mandate and partial grants of authority abound. WHO is chronically under-funded for its core functions by donor/owner choice. The World Bank's administrative budget, even though not dependent on grants of public funding, has continued to be under severe, negative critique by some members for years. The extent to which agency management is specifically accountable to owners for monitorable achievement of specific core products varies among and within agencies.

79. As described above, in these conditions, organizational behaviors naturally turn to invention for survival and growth. New fields of activity are a means of additional mobilization of funds. New causes can be compellingly described and justified to donors

for financial support. The new activities can enhance career paths of individuals and the overall bureaucratic stature and power of those who gain additional revenues.

80. Often the new directions are stimulated by, or take advantage of particular national interests(*51*), ideology(*52*) or particular causes(*53*) of interest to key member states, or regional groupings that perceive the opportunity for action or benefit. In addition, new initiatives arise from the significant differences in objectives between donors and the poor countries that use many of the technical cooperation functions of the agencies.

81. These differences arise in the anarchical environment of globalization, in which states have not yet come fully to grip with orderly governance. The agencies' management and staff must operate in this partial vacuum. Human ingenuity and creativity for good, the best of public intentions and, sadly, sometimes self-serving behaviors, are the competitive forces within the agencies that underlie the growth of extra-budgetary funding mechanisms.

82. Lastly, there are no easy mechanisms in the present international system to appropriate even partial returns to those bearing the costs of global public goods in health. If those who produce the product of lowered disease risk could somehow capture its value from those who share in the benefits, more stable financial mechanisms and incentives could perhaps be developed. But since this is not so, global public goods in health are probably vastly under-produced and under-consumed relative to their potential or optimal supply.

4. Improving Global Health through Global Public Goods.

83. This concluding section tries to do four things:

- ✓ Briefly examine the way global public goods are chosen and receive support
- ✓ In light of this, revisit WHO's role as the leading provider of global public goods in health
- ✓ Briefly look at the supporting roles that other organizations can and do play
- ✓ Venture answers about what could be the next steps for the international agencies to take to improve their global public good roles.

84. The choice of global public goods. As we have seen, there is no extant consensus that the world community should bear the costs of improving global health for the community's own sake.(*54*) Moreover, that free riders might be permissible, even welcome, because the goods, or at least the global effects, are truly public is not yet an accepted idea. The question of who should pay for global public goods is clearly not resolved. The mechanisms of how to pay are just being explored.(*55*) The international agencies clearly feel that they must, somehow, be at the center of the mechanism and play some kind of directing roles. But, for what exactly - in which manner - with what restraint or license - with funds from which sources?

85. In the past, which goods and services to buy for health, and the methods of analysis to arrive at those choices, have been driven more by technology or humanitarianism than by economics. For some, it has been ideological – not wanting to see issues of health made subject to considerations of price and ability to pay. For others, the pace of technological change in medicine and potential impact on health has been so dramatic that it focused

thinking on which interventions were physically feasible in a given setting, with opportunity cost seldom discussed. On balance it may not have been a bad set of circumstances. The dedicated bureaucrats of Plato's Republic might be well satisfied had it been their watch for the last fifty years.

86. For example, the control and elimination of polio was both technically feasible and humane. However, it is doubtful if any international organization would have risen to the challenge and devoted sustained resources to elimination of polio if private charitable sources had not hastened the priority. The Rotary Foundation, with clubs in nearly every country to influence the local political environment, made a decision to buy this global good. This choice was not something states were collectively willing to do on their own, though foreign assistance agencies joined the financing effort once it emerged.(*56*)

87. Only within the last decade have there been serious global efforts to evaluate which health choices are the most affordable. This necessitated being able to identify which health programs have the greatest impact per unit cost. It then became useful to find ways to choose among interventions while taking into account quite different features of mortality, morbidity and risk in different countries.(*57*) These analytical tools have provided increased rational analysis and scientific testing of interventions and their achievements. This has enabled the international agencies to provide stronger normative guidance (WHO) and to design or negotiate better health investments (World Bank).

88. Progress has not been smooth or free of controversy. For example, a worsening global epidemic of tuberculosis was widely ignored by states and the international agencies. It was not a priority for the WHO in the 1980s.(*58*) A revitalized WHO effort (*59*) in 1992

used the new empirical indices and program results from poor countries. It showed TB to be both a serious global threat and manageable with an affordable technical package. World Bank staff first resisted rapid inclusion of TB control in projects mainly on the grounds of the technical package required.(*60*) There was resistance encountered at the country level.(*61*) Similarly, there was resistance and skepticism (*62*) within the bilateral assistance agencies.(*63*) Eventually, evidence at the country level of highly successful applications of the disease control approach and global advocacy about the public goods nature of TB control resulted in a growing consensus for action and acceptance of the strategy. The Bank became the world's largest financier of TB programs. The WHO had normative policies and technical cooperation resources that worked and made a difference

89. By the end of the 1990s about two million TB cases had been successfully treated and well over a million lives saved. However, these successful efforts met only about 20 percent of the world's need. This provided the chance for the global community to collectively make a choice to buy the rest of this global public good, as Rotary had done for polio.

90. Unfortunately, the constraints examined in section 3 had combined with sufficient friction to cause WHO's new Director General to reorganize in 1999 the agency's tuberculosis staff to accommodate various bureaucratic and political agenda. Momentum was lost and destructive competition emerged on several fronts. A second reorganization of the WHO's TB resources took place at the end of 2000. It remains to be seen whether WHO can lead an adequately resourced collective effort to control the TB epidemic with participation by other international agencies, member states and civil society for the two

or more decades required. Many of the constraints examined in section 3 still exist and will influence outcomes.

91. In general then, it is unlikely that the overall process by which public goods are chosen for support from existing financial resources will change radically. Beneficent opportunism to exploit technology changes or discoveries will still occasionally catapult public good interventions from obscure positions to the top of current priorities. Championship of particular causes by states, organizations and personalities will no doubt continue. Production of goods espoused by interest groups can be aided, and moderated, by use of empirical tools to verify merits and ensure focus on objective targets – the poor, for example. The use of empirical tools will be relatively more important when a source of financing is available and the operative question is "which public good should be chosen for investment?"

92. The international agencies, and WHO in particular, are also unlikely to be able to change their response very much when the pressure for public goods is determined mainly by "**who is willing to pay**" for them. The agencies in this scenario will remain the proxies of one or multiple states within their membership. Agency leadership will be confined to specific issues, as has been the established pattern in recent decades, but without any mandate for a radical shift in overall strategy, practices or effectiveness. Cooperation among and within agencies will be desirable but not easy to achieve despite exhortation from managers. The reasons for this continuation of the *status quo* will be that the competitive constraints outlined in section 3 will continue to be determinant of inter- and intra-organizational behaviors.

93. The situation might be quite different, as will be explored in the last section below, if the operative question is turned on its head and the political and financial choice of public goods revolves around "**who benefits**" from their provision and consumption? With this version of the question, the agencies, interested states and civil society have an opportunity to direct some of the processes of globalization.

94. Another look at WHO's role. It seems obvious that no matter how global public goods for health are defined, it is the WHO, among all the UN agencies that is best placed to work out the details of many of them, and to produce some of them. Much of WHO's work clarifies, encourages and assists the production of national public goods, some with substantial global publicness of effect. If the WHO did not exist at this time, it would have to be invented to moderate what would otherwise be anarchy in global cooperation and strategy on health.

95. The role of other UN agencies and the World Bank is much more limited to assisting countries achieve production of national goods with national, and perhaps, global public effects. Some further exploration of the WHO's role, with a view to the future, is therefore in order.

96. Some have proposed that WHO's constitutional list of 22 functions is far too many for organizational effectiveness.(*64*) They propose two types of international health functions -- core and support. Core functions should be aimed at promoting global public goods such as information, standards and regulations, health policy and research and development. All countries need these core functions. Support functions should be aimed at enhancing capacity and health sector performance -- objectives of special

importance for developing countries. "The analogy is that while core functions correct for global market failures, support functions overcome national weaknesses.... Where the constraining resource is knowledge, technical assistance should be provided, and where the bottlenecks are financial, development financing is indicated."(*65*) This framework clearly suggests naturally complementary roles for the WHO and World Bank.

97. Both functions -- core and support -- can result in the production of global public goods, or global effects. Both inputs -- technical assistance and finance -- can also result in these. The exercise of one function or input does not obviate or diminish the other -- indeed, they tend to be mutually enhancing, creating additional demand and improving efficiency. Normative guidance on surveillance policy and its methods, for example, generates country requests for technical assistance to apply surveillance guidance to country specific settings and to use the results obtained. This begets requests for financing, perhaps to the World Bank, to expand capacity for surveillance and to apply findings for better disease control or prevention. This in turn reduces risk of cross-border infection or development of drug resistance, thus providing regional or global public goods. It also generates data that enhance global knowledge, permitting better targeting, improved epidemiological research and further policy formation as corollary public goods.

98. There is nothing to suggest limiting the provision of functions or inputs for specific public goods to one particular agency. WHO, the World Bank, UNICEF and other UN agencies and some non-governmental organizations have all supplied technical assistance, training, medical supplies and other items to help control infectious diseases, conduct immunizations programs, support country adoption of improved policies and so

forth. The point is that in practice there is no necessary exclusivity for most things, nor need there be diminishment of any one agency's role, because other actors help to produce inputs or goods. However, for WHO's normative functions and the processes that underlie state concurrence with normative policies on health there is probably no other agency that can substitute for these functions.

99. It seems odd that appreciation of this in the past was not evidenced strongly in the bureaucratic cultural prevalent in WHO. Instead, there appeared to be a good deal of insecurity and doubt about role and function. As described earlier, this probably occurs for two very good reasons. Firstly, when the goals and strategy of an organization are unclear, managers and staff try to protect those fields of operation in which they perceive their own interests are at stake. Second, when agencies are under severe resource constraints just to perform their core functions, they may compete for turf in order to secure additional funding, even if it is not for core purposes.

100. For example, WHO's former management and staff gave a slightly prickly reception to preparation of the 1993 World Development Report. When a special committee formed itself and invited WHO leaders to collaborate in analyzing global priorities in health research (*66*), some in WHO initially stood aside and important external committees criticized the effort as misplaced, asserting that the topic was WHO's field of responsibility.(*67*) Establishment of The Global Forum for Health Research (*68*) was also questioned by WHO's former management and seen as perhaps another sign of loss of trust in the agency. Failing to absorb it during its creation, WHO temporarily became its physical host, as a way of contributing to it.

101. Still, WHO does claim many functions and its governance agenda is particularly complex. Within the WHO, emphasis by management on positive cooperation can help ensure that issues of turf do not arise among agencies. As a generalization, the relationships between the World Bank and WHO seem to have moved during the past decade from some distrust and competition, to increased collaboration with WHO pursuing some of the policy priorities earlier defined by the Bank's work. Conversely, Bank lending operations appear to follow the technical packages and advice of the WHO more than previously.

102. Nevertheless, as new health issues arise from globalization's pressures a continued "dominance effect" seems to be occurring even under new management. By this is meant that WHO seems to insist on being the senior partner, the hosting institution, or the agent whose imprimatur is prominently linked to each particular initiative. Probably these phenomena are the almost inevitable reaction of WHO's departments to the constraints examined in Section 3, which still prevail.(*69*) Events surrounding the creation of the GAVI, the Global Alliance for TB Drug Development, the STOP TB Partnership, the Global TB Drug Facility, the International AIDS Vaccine Initiative, and earlier, UNAIDS and other cases, have each manifested aspects of this possessive ownership behavior. In these cases WHO wanted to be the "home" for things, or to control things, whether it had obvious capacity or efficient mechanisms to do so, or not. It has been expensive for others and often required much patience and goodwill on the part of the other official and non-governmental organizations involved.

103. As an institutional response, this tendency to play the lead role on so many complex initiatives carries many risks, not the least of which is that performance must be truly

extraordinary, or image and credibility will be severely damaged. WHO, and its owners, must now place an extraordinary premium on making sure that the agency performs its core functions very well. The sheer volume and variety of normative guidance and technical work that must emerge from few, often relatively young, staff (*70*) could raise doubts about capacity. This could suggest consolidation of work, not expansion, in the minds of managers were it not for the pressures earlier described. Further, WHO does not have many well-defined, transparent processes for vetting and securing agreement from its partner agencies and constituencies to its normative and technical recommendations. The emergence of important policy documents without concurrence and commitment thereto by others may undercut its leadership role.(*71*)

104. Overall, as a provider of global public goods WHO is probably:

- best positioned, but not exclusively so among the agencies, to track events or conditions that have large cross border externalities (as public goods or bads).

- well positioned, but again not exclusively so, to supply some national and global public goods in ways that are non-rivalrous (takes nothing away from), and non-exclusive (cost nothing to other institutions or states). It is not, however, well-funded by its owners for these tasks.

- very well positioned, together with the World Bank, to encourage global arrangements to ensure that global public goods are produced and their use subsidized.

- technically best positioned to partner with others in arranging and implementing cooperative processes for common global or cross border action.(*72*) WHO is not adequately funded to play this role expansively.

105. However, in pursuing these purposes, WHO repeatedly must overcome the constraint of insufficient regular funding from its members and the negative consequences that all the related constraints entail. Further, it has no practical means to appropriate some of the returns from the provision of global public goods to help finance its own functions.

106. This makes the probability of failure or poor results quite high. These problems can only be addressed by its owners, probably only in response to strong management leadership in this direction.

107.Other Organizations. Two important groups of institutions have been mentioned only briefly in this paper. These are the growing number of organizations of civil society throughout the world which are concerned about health, justice, poverty and similar human welfare concerns – the non-governmental organizations (NGOs), and, the philanthropic institutions that by their nature often think and act far in advance of nation states to identify and influence progress in the human condition.

108.NGOs have been increasingly active and potent in critiquing and collaborating with the international agencies. They often perceive clearly the consequences of the anarchy accompanying globalization and have specific remedies they can offer. Because they mobilize human and sometimes financial resources additional to the capacity of the state they can be particularly valuable doing good at the local and national levels. Because

their members are also citizens they can play an important political role, helping to influence political will as well define its content.

109. These roles are no less valuable in providing and using global public goods than in other fields where NGOs have been successful. As a generality however, NGOs are not well prepared and certainly not organized collectively and effectively to exploit and assist the international agencies for common global good. They have to find ways to work collectively together without fearing erosion of their particular interests. They must address this weakness if they wish to have an influential seat at the table.

110. As organs of sovereign states, the agencies find it challenging to optimize relations and work with NGOs and foundations from within those same states. Legitimate issues of authority, representativeness, agenda and intention abound. Simultaneously the international agencies have come clearly to appreciate the potential of the NGOs and the risks of ignoring their concerns. What has not happened on a wide scale is for NGOs to devise mechanisms to systematically and collectively react on matters of global public good.(*73*) To change substantially the current reaction to globalization this has to happen or NGOs will remain instruments of society only at a national level.

111. Philanthropic institutions have historically been a product mainly of North American society. Globalization has also caused this to begin to change as the creation of wealth and its control, and thus responsibility for the consequences of its use become transnational. More philanthropy, and more of its institutions, not less, are probable with continued globalization.

112. Traditionally, philanthropic institutions have played fundamental catalytic roles at the national level in reforming social processes (e.g., education) and creating public goods (e.g., libraries, fire services and health services). On a global level, these institutions have already begun to play similar roles.(*74*) This process is also likely to continue. The foundations can push both the states and the agencies into conceiving and achieving public goods in health and correcting current market failures and social injustice.

113.A Possible Future for More and Better Global Public Goods. Nation states are not yet ready to grant authority to global agencies for striking the balance in global production and consumption of public goods in health. The thorny questions of which public goods, who pays and who benefits, are reserved to be answered only by states themselves thus far. Understandings about free riders, subsidies, and self-sufficiency, as yet, are not similar among states.

114. In recognition of this vacuum, the paper ends with proposals on some of the radical thinking that may be needed to make a truly significant difference in the way public goods are now pursued.

115. The issues of collective global security, and its achievement, have suddenly risen to the top of the international agenda and will remain there for some time. Its financial requirements will reduce public resources for other public concerns for an even longer period. Global health and inequities related thereto may be seen as part of a global security solution or as a simple parallel public cause. In either case, the world would

seem better served to change the way we look at the thorny questions of producing public goods according to **who pays** or **who benefits**.

116. This still leaves the question of how to pay for public goods. The main obstacle is the unwillingness of donor countries to put up most of the money. Obviously, there are many variations possible but some combination of rich, middle income and poor countries is the only possible answer. There can be different arrangements at different times for various countries or regions depending on global consensus about what is fair. Economic calculations of fairness and of benefit enjoyment may fail to provide guidance about what that sharing should be – because economic calculus does not address the core problem of what is right in human development. It may be that the rich world could decide to help the globe with better health just because it is right to do so and has positive externalities which current economic science cannot count.

117. Financial instruments such as debt can allow the world to consume more goods that are global sooner and pay for them over a longer period. For certain diseases, the risks that they pose and the consequences of poverty that they perpetuate, such instruments may make good sense. Stretching out the financial burden may also allow the world to afford more health in the near term with fewer long-term negative externalities while also attending to global security. Use of long term debt financing may also make the global subsidies politically more acceptable among the wealthy country constituencies, especially if the goods are seen to be just and humane. Buying time also allows the possibility that those countries, not able today to help pay for global public goods, borrow to do so in the future when their economies are more productive.

118. In a forthcoming book (*75*) addressing the impact of globalization, George Soros proposes an inventive approach that would permit the wealthy countries to buy global public goods in much greater amounts for the poor countries. He argues for the creation of Special Drawing Rights (SDRS, an internationally created currency issued in the form of debt) earmarked for providing and buying global public goods. As Soros explains, the concept could make a very substantial amount of money available almost immediately to finance the provision of public goods on a global scale as well as to provide assistance in structural reform to individual countries. He foresees that the rich countries would undertake all debt service for the SDRs. This might be just and financially feasible, but there is no legal reason why countries at different wealth levels at different points in time could not share in the debt service.

119. This is but one example of alternatives that could be chosen but it is a practical one and, for reasons which Soros eloquently documents, may be politically acceptable to the wealthy countries.

120. For public good consumption, the fundamental point proposed here is that the world should deliberately set out to purchase the global public goods that can benefit the greatest number (*76*), not those for which special pools of money are available.(*77*) This would give WHO's normative role in health the preeminence it deserves. WHO could can convene the expertise and the states to distill the agreements needed about the public goods and conditions of their production and subsidy. These it would formulate into global policy and protocols, the implementation of which, it would monitor and evaluate.

121. This approach also opens the door for better collaboration of WHO with the World Bank on the economic and financial policy analyses needed. These efforts would build directly on the results of the World Development Report, 1993 and the Report of the Ad Hoc Committee on Health Research and Development. The public good purchase approach provides a ready entry for the Bank to use its existing country-specific project interventions to finance supportive investments and to experiment with new multi-country and sectoral lending, or even new grant instruments.

122. Concurrently, the approach offers roles for both national and international NGOs to become directly involved with the agencies in the social and policy aspects of public good consumption, to mobilize domestic social support, and to ensure equity and enable minority participation.

123. Such an approach provides a rationale for member states to fund adequately each of the agencies fully to perform their public good roles. It would offer opportunity, by reducing the importance of cause-specific extra-budgetary funding for WHO, and of trust funds at the Bank, for suppression of the constraints creating competition and impeding effectiveness of the agencies. Thereby it would permit accountability to be better enforced (*78*) and for bureaucratic cultures to be radically improved.(*79*)

124. To give operational form to the proposal the world would have to identify a few key things as global health goods which would make a radical, fundamental difference to human welfare if achieved. An example, from an allied field, is the importance of universal primary education, with special emphasis on ensuring education of the girl child. An analogue in health might be sustained, effective prevention of HIV infection.

This should not be confused or combined with important measures for equitable AIDS care, but these have entirely different social, economic and political consequences and constituencies. There could be components of an HIV-prevention public good product to separately encompass, respectively, social campaigns and behavior change, and research for preventive vaccines or medicines.

125. Another example in health would be the accelerated, sustained global control of tuberculosis to levels where it no longer presented serious public risk. Malaria prevention and control probably constitutes yet another example. There will likely be a number of infectious diseases, which qualify on a regional basis, and for which existing technologies and country capacities permit useful action.

126. But who would get the world together to start this process? The door would appear to be wide open for the WHO and the World Bank to do so, fleshing out the proposal and adding the critical details necessary for any new concept to work. This could be done in concert with other agencies if the risk of diluting focus on the public goods agenda could be safeguarded against many competing special interests.

127. If the agencies would not be willing to do so (*80*), the philanthropic world could combine forces to create the nexus of a new private partnership for globalization of better health and catalyze public sector interest and direction. Those states who control the SDR creation process could use the private partnership for some or all of the public good delivery system.

(*1*) The World Health Organization (WHO) and the World Bank are mainly reviewed here. However, the United Nations Children's Emergency Fund (UNICEF) is also briefly mentioned and non-governmental organizations, especially philanthropic institutions, have also played prominent, forceful roles. They are likely to continue to do so as civil society discovers mechanisms to deal with globalization.

(*2*) **Smith A**. *Wealth of Nations*. (Cannan's edition), Vol. II: 184-185.

(*3*) Smith (Op cit., 272) observed, "…It would deserve its most serious attention to prevent leprosy or any other loathsome and offensive disease, though neither mortal nor dangerous from spreading itself…"

(*4*) For example, an epidemic like the swine flu or bubonic plague

(*5*) For example elimination of smallpox

(*6*) The cost of providing a public good such as safer navigation remains the same, with the erection of a lighthouse, whatever the number of ships that benefit from that lighthouse.

(*7*) Once knowledge of the role of germs was established, actions to benefit from that knowledge could not be stopped nor could royalties be extracted for its use.

(8) ***Publicness*** is an important concept. Examples of ***pure*** public goods in health are very few at both the national and global levels. Most things have an "if more for you than less for me" quality. But, and this is often missed in economic discussion, "if a commodity or a service has even a trace of "***publicness***", be it only in the form **of *by-product effects which impinge inseparably on many people*,** then profit-and preference-seeking market calculation will not efficiently mediate production and distribution". See-**Bator FM**. *Government and the Sovereign Consumer.* In: Private Wants and Public Needs: An introduction to a current issue of public policy. Phelps ES ed. New York, W.W. Norton & Company, 1962: 102B 117
(*9*) **Muraskin, WA**. Personal communication, November 2001

(*10*) **Stiglitz A.** Knowledge as a public good. In: Kaul I et al., eds. *Global Public Goods, International Cooperation in the 21st Century.* New York, Oxford University Press, 1999: 308B 325.

(*11*) **Zacher MW**. Global Epidemiological Surveillance, International cooperation to Monitor Infectious Diseases. In: Kaul Op cit. 266B-283.

(*12*) For example, the Centers for Disease Control and Prevention of the United States provides technical advice, knowledge and epidemiological tools to countries, and even related groups of countries, in a fashion similar to that of the WHO.

(*13*) For example, WHO's current efforts, in partnership with a number of national and international NGOs, as well as individual member states, to draft and seek support for an agreement on tobacco control.

(*14*) The International Union Against Cancer (IUAC), for example, or the International Clinical Epidemiology Network (INCLEN).

(*15*) **Jamison D et al**., eds. *Disease Control Priorities in the Developing World.* New York, Oxford University Press, 1993.

(*16*) **Jamison D et al,** *The World Development Report 1993, Investing in Health.* New York, Oxford University Press, 1993.

(*17*) Or before the negative consequences of a public bad can be avoided.

(*18*) There are two elements to this. Firstly, the compelling claim on budgetary resources in any country tends to be toward satisfaction of current illness-care in preference to prevention or control of medium-term disease risks. Many national and global public goods entail avoidance of future illness. These are often not as popular or defensible as shorter term measures. Secondly, some investments in public goods have long-term implications that preclude future budgetary flexibility. For example, procurement of vaccines, or research on viruses, may represent a small share of total resources in the health system. But, it may require a poor country to use hard currency, and to continue the research or to make the vaccines available for many years lest the benefits of earlier expenditures be lost. Perhaps, a country's leaders will reason, it is better not to start such things, especially if someone else may pay for such costs eventually (i.e., they may think it better to be a free or nearly-free rider). Governments may therefore be reluctant to make the

financial reallocations necessary to universalize consumption of a national public good. They may need some clear and continuing financial subsidy to help them do so.

It is worth noting that even if a leader makes a sustained commitment to production of a public good with global effects, there are difficult problems to overcome. Leaders must gain consensus within and outside of the health sector for earmarking financing to purchase inputs needed over a lengthy period. Such work is personally demanding and can have long-term, personal repercussions in political systems which are not stable or which involve high inter-personal transaction costs. Further, if resources for capital costs, are from different budgets than staff salaries or operational costs, or are subject to review by different agencies, the difficulty of the work is additionally complicated. Complex problems of contracting, potential corruption, and inconsistency in policies between different government administrations can discourage many health leaders.

(*19*) World Bank loans may have only a small subsidy element provided by the slightly less than market rate of interest charged and the longer loan term. IDA (International Development association) Credits have a large inherent subsidy in that only the principle of the credit needs to be repaid, and only over a typically long period.

(*20*) This feature is under study within the World Bank Group. Experiments through a Development Grant Facility may yield consensus on methods and concepts to broaden the beneficiaries and coverage targets of traditional lending activities to be regional or global in scope.

(*21*) There is significant misunderstanding and ideological dogma surrounding the use of debt for health sector investment. Somehow the economic returns to better health are viewed with skepticism relative to the probability that better health will permit debt to be repaid. Leaders in developing countries evidently apply high discount rates to potential health benefits when deciding whether to purchase them through deficit spending. In global circles, excessive indebtedness incurred for other causes is seen as evidence that borrowing for health is at best imprudent. Donors have developed political positions with domestic constituencies which oppose any but temporary funding of some health interventions because of the asserted need for poor countries to achieve financial self-sufficiency and avoid dependency on external financing.

(*22*) It is unlikely that the Bank could be the only agent, at least through use of its loan mechanisms. If the benefits of a good are truly global, payment of the costs of its realization will probably also have to be globally shared. Nonetheless, the Bank's loan tools could provide a fulcrum for broader financing arrangements and may be sufficient for accomplishment of some regional investments in public goods where states perceive fair sharing of the costs among them.

(*23*) For example, the Rotary Foundation's Polio Plus program, executed in partnership with and through both UNICEF and WHO, as well as by the national and local Rotary Clubs in a large number of countries.

(*24*) GAVI – Global Alliance for Vaccines and Immunizations, a partnership initiative including WHO, UNICEF, the World Bank, various foundations, non-governmental organizations, bilateral development assistance agencies and others, with an independent governing board for a new partnership entity – the Children's Vaccine Fund.

(*25*) Both WHO and UNICEF do this for a range of goods.

(*26*) As per the arrangements for access to anti-retrovirals for HIV/AIDS treatment in the first case and the use of UNICEF or WHO, or others, as a bulk procurement agent in the second case. For a range of drugs and basic health inputs, UNICEF has maintained for many years a global commodity facility that provides supplies with little or no mark-up over its cost.

(*27*) Mobility of labor and transmission of disease among mine workers in the 12 southern African states provide ample evidence of this phenomenon. It took many years before the states could agree to act even roughly in concert to provide disease control.

(*28*) **Bator** FM. Op cit. 117

(*29*) For example, departments of hospital facilities may plead poverty as the constraint keeping them from satisfying their investment requirements for which they know there is a politically vocal constituency. In

response, budget allocations made by financial authorities can mean that public health departments are deprived of modest increments in funding to bring public goods to poor segments of the population.

(*30*) For example, by international appeals for voluntary funding of a cause.

(*31*) Bentham's objective of the greatest good for the greatest number.

(*32*) This makes the price influencing role (subsidy of the cost of public goods consumption) of the international agencies critically important. The agencies have to consistently and cooperatively make benefit information known and exercise their economic agent role to overcome the misinformation inherent in an imperfect market for global public goods.

(*33*) This obviates the essential public nature of the good produced. Classically, in the case of a bridge built to serve the public at large, any positive price that would discourage even a single bridge crossing would result in allocation of the resources used to build the bridge to be inefficient. With imposition of any barrier to consumption of bridge crossings, there would be unexploited, costless crossings, which could make someone better off without hurting anyone else.

(*34*) This phenomenon is at the heart of an ongoing dispute between Russia and the World Bank over whether all TB drugs for control of Russia's serious epidemic, with frightful cross border consequences, must be purchased from national sources. Naturally, vested financial interests and political considerations always underlie such market barriers.

(*35*) Legal, analytical or advocacy products developed by the international agencies may constitute global public goods in and of themselves. These functions of the agencies are very like the regulatory or public policy formation functions within national agencies that affect the provision, safeguarding, quality or equity of access for public goods at a national level. Examples of such agencies are prevalent in almost every country – for food and water quality, consumer and labor safety, transportation or telecommunications standards.

While this kind of quasi-regulatory function was not specifically among the purposes of the World Bank, it takes place in many fields and the economic maxim of "efficiency" is the Bank's entry pass in almost all cases. By expressing its concern on efficiency in allocation of resources the Bank can justify examination into almost any feature of public expenditure and thereby can inspire governments to improve policies relating to production, equity and even stability.

Such functions can also be found when WHO's work involves harmonization and standard setting for vaccines, pharmaceuticals, surveillance and other activities.

(*36*) UNICEF was a driving actor. It has used elements of the convention to press states for greater investments and lesser appropriations even in aspects of its health work.

(*37*) Op cit., and subsequent papers on health research and development, health financing and health and poverty

(*38*) As noted earlier, action to influence the price of global public goods is not the exclusive purview of the international agencies. There are today more organizations that can affect the choice of priorities. These include non-governmental agencies who act on the international scene and philanthropic institutions, who by virtue of both the budgets, and the high level of the dialogue with which they engage governments, are able to influence the decisions of governments in accepting or ignoring the production of global public goods

(*39*) In mid-2001 the Director General announced a refocusing of work on health systems to better support scaling up of outcomes that bring benefits to the world'' poorest people. This involved organizational changes and better definition of the working mandate of several departments. Their work, if performed as envisaged, will add to the creation of new global goods – a better evidence base for policy formation, more systematic analysis of experience, and improved, consistent, health financing analysis and guidance. Whether this work will take full advantage of the expertise of the other agencies and create truly joint knowledge products remains to be determined, but the potential has been opened. Similarly, a mid-2001 initiative was launched to improve the links between WHO and civil society. It will require time before these efforts can be evaluated relative to WHO's role. It will be a considerable challenge for those

managing the effort to distill the lessons of recent and current linkages with civil society partners (such as those centered on TB and HIV/AIDS).

(*40*) Polio eradication, for example, will save the OECD countries billions of dollars of year in annual immunization costs.

(*41*) Excellent examples are the many expert staff seconded to WHO by the US Centers for Disease Control and Prevention (CDC) for specific technical program strengthening. Virtually every major disease program in WHO has benefited from this support. The World Bank and UNICEF have also enjoyed such external intellectual inputs. Other national agencies from the Netherlands, the UK and elsewhere have provided similar support to the agencies, enabling the human resources of national entities to have global impact and enrichment.

(*42*) Non-rival and non-excludable.

(*43*) For example, in descending order of purity and directness – elimination of polio, control of TB, immunization for measles, and immunization for hepatitis B.

(*44*) For WHO, these tendencies have been documented in several outside reviews. This includes reform groups who looked at WHO's operations in the period leading up to election of a new Director General in 1998, including the Oslo Group Report, the reports of the Transition Team established by the new Director General, and others.

(*45*) These topics have been covered at length in the Financial Times and other publications reporting on developments at the Bank during late 2000 and early 2001. The management of the Bank disagrees with many of the assertions.

(*46*) Some staff in the Agencies and in bilateral donor agencies would argue, with some justification, that the normal governance and budgetary processes of the Agencies are highly immune to real reforms and improvements within any reasonable period. The wise use of extra-budgetary imperatives have accomplished focus on global public goods and improved attention to organizational efficiency and diminishment of comp etitive behaviors. There are elements of truth in this position. Such progress is quickly undone, however, once donor interest or attention is diverted. With frequent staff changes in the donor agencies, the consistency of strategy is also at risk, and ultimately this exacerbates the problem by inducing confusion and new competitive forces.

(*47*) A closely allied topic is that of cooperation with non-governmental organizations and other institutions of civil society. UNICEF has a long record of success at the country in this area. The World Bank has made a remarkable shift in its willingness and ability to accept and cooperate with organizations of civil society, both nationally and globally. WHO has highly structured processes with mixed impact but has declared its intentions to do much better in this regard.

(*48*) For example, TB control, or effective care for women and children living with HIV

(*49*) Many examples could be cited from the last few years, relating to HIV/AIDS, strategy to deal with it, immunization policy and strategies, health and its relation to poverty, etc. In addition, whether or not the agency is already performing a particular function is not relevant in explaining this tendency. Capacity, or appropriateness, is rarely subject to analysis. Legendary struggles have taken place both within and among the international agencies about which (or which department within) has the lead or the mandate in a particular topic.

(*50*) Job grading in the UN system (not including the World Bank) is closely linked to the total budget controlled, the number and complexity of activities underway, and the number of staff (and their grade levels) supervised. Acquisition of a larger budget, with which to hire more staff, justifies not only higher grades for mid-level managers already in place, but also their superiors. Success in mobilizing funding also secures the stability of the successful manager, as administrators in a bureaucracy chronically short of funds are loath to replace those who are successfully bringing in the extra budgetary cash.

(*51*) For example, there was French insistence, linked in part to pharmaceutical firm interests, that HIV/AIDS treatment drugs be placed high on the international agenda for financing in the late 1990s. At that time there were not yet mechanisms for funding prevention interventions which were of proven higher

cost-effectiveness. The struggle about priority for funding of AIDS treatment versus HIV prevention continues.

(*52*) For example, that user fees and cost recovery measures are inherently undesirable in comparison to free public services and subsidization through general tax revenues.

(*53*) For example, to prove that sector wide approaches to planning (SWAPS) health services are inherently superior to other investment planning mechanisms.

(*54*) The evidence for this is incontrovertible. The WHO remains badly under-funded for its role. Foreign aid resources for health are not growing rapidly as they would need to do. Strategic collaboration among the agencies, states and civil society to change this environment is not evident. The constraints outlined in this paper and continuing squabbles over inadequate resources demonstrate clearly the continuation of global anarchy in this aspect of globalization.

(*55*) The G-8 approved, UN supported, Global Fund for HIV/AIDS, TB and Malaria is one example of this. The excruciatingly slow and convoluted process of states and international agencies working out its governance and operations indicates the difficulties present in the international system. The prospects of the Fund being a successful resource mobilization and allocation vehicles for the medium term will remain uncertain for some years as experience is gained.

(*56*) Rotary also made an astute choice to avoid offense of the WHO and to guarantee WHO's active cooperation and capacity to respond - by financing WHO staff positions. These same functional positions probably would not have been created or sustained from the regular WHO budget if extra-budgetary money not been made available by the Rotary Foundation for this purpose. Personal communication from Herb Pigman, General Secretary, Rotary (retired).

(*57*) For example, quantitative indices were used, such as DALYs, QALYs and other empirically based measures. These efforts originated with academia. They were applied in the 1993 World Development Report with considerable influence. Despite weaknesses inherent in such indices, they helped to focus thinking and empiricism in measurement of health outcomes and have been gradually adopted by WHO. Further refinement by the WHO of empirical measures and more focused thinking about health priorities may help to further free public health policy from influence of vested financial and political interests.

(*58*) WHO headquarters' staff dealing with TB was reduced to one person working within a general communicable disease division.

(*59*) This effort is attributable to a small handful of individuals inside and outside of the WHO. It was not a deliberate corporate decision by its management. It was even resisted actively by senior WHO managers of the time. Carefully constructed campaigns to build support from endemic states with high TB burdens and to attract extra-budgetary funding for TB from donors convinced of the effectiveness, efficiency and humanity of the TB control cause overcame this resistance.

(*60*) The package was not widely understood or believed by the Bank's staff. The WHO's credibility in advocating the package was not high initially. There were also multiple, conflicting messages of priority and response on many causes coming from the WHO. Many of the factors of competition and turf addressed in this paper were prevalent at the time. There was only loose central coordination within the Bank to disseminate understanding of the package. Internal agenda items related to Bank's new President and his reorganization priorities distracted from clear management signals.

(*61*) There was strong resistance in the medical and hospital establishments (and thus in parts of health ministries) against the technical approach which emphasized primary level, outpatient treatment with only four, already long-existent and inexpensive drugs. This low-tech, home-based approach threatened incomes, prestige and budgets of powerful interests at each level, including private practitioners.

(*62*) This was caused by: (i) lack of credibility at the time about WHO's technical advice in general; (ii) justified concern about furious political struggles inside the WHO bureaucracy; (iii) medical community resistance to the technical package; social prejudices about TB patients being non-compliant in treatment; and, (iv) doubt of economic justification and affordability.

(*63*) In addition, some bilateral donors raised ideological objections against "disease specific" programs, raising again the sterile debate about "vertical or horizontal" interventions in international health. Others wanted to emphasize only things that related to controlling costs, improving efficiency and aiding the narrow financial independence and cost recovery model that was in vogue at the time. Attention to buying cost effective global public goods with public money was simply not a topic that was considered. The 1993 World Development Report helped to change this general situation.

(*64*) **Lincoln C, et al**, *Health as a Global Public Good*. In: Kaul et al, Op cit. 284B 304. Also **Jamison D, et al**, International collective action in health: objectives, functions, and rationale. *Lancet*, 1990, **351,** 9101: 514-17.

(*65*) **Jamison D, et al**. Lancet. Op cit.

(*66*) **Ad Hoc Committee on Health Research Relating to Future Intervention Options**. *Investing in Health Research and Development.* World Health Organization, Geneva, 1996 (Document TDR/Gen/96.1).

(*67*) However, individual WHO staff were committee members and led key parts of the exercise. Eventually the product emerged under joint ownership that included WHO. The report has had an important impact in the parts of the health research community. Many of the WHO programs have adopted concepts suggested in both the World Development Report and the Ad Hoc Committee's Report to provide prioritization and justification of their activities. Movement of a number of staff and external authors associated with these two reports to become WHO officers under the new Director General assisted this process. The result was a WHO today better able to articulate normative policies, their prioritization and justification.

(*68*) A non-governmental organization created under Swiss law and supported and governed by a board of donor agencies, philanthropic institutions, other NGOs and officials from some of the international agencies.

(*69*) This "dominance effect" may also be partly a product of legalist interpretations within WHO driving its bureaucratic response.

(*70*) Many of these staff have only very short (one to eleven month) contracts of employment because of budget shortages as described in section 3. The uncertain tenure makes it hard to recruit seasoned, senior professionals into these positions.

(71) This suggests that WHO may want to develop well-defined review protocols, which substantively involve its partners at appropriate stages, to ensure that normative guidance is thoroughly critiqued and understood so that it will be accepted sufficiently to be acted upon. The process of technical meetings, secretariat synthesis and committee review of WHO's normative products, certainly does not now perform this function adequately for WHO's institutional partners and the many newly emerging public good contributors on the international scene.

(72) An excellent example is currently in the headlines with WHO's role for the Framework Convention for the Control of Tobacco.

(73) Naturally, there has been more opportunity and easier success for national NGOs to organize collectively and interact on matters of national public good with the international agencies than on matters which cut across many borders. The success of Doctors without Borders to become an important multi-national NGO with visible global impact is an example from the global level.

(74) For example, the Kellogg Foundation in education in Latin American, the Rockefeller Foundation in international health equity research, the Gates Foundation for various international health activities and the Soros Open Society Institutes for governance and civil participation.

(75) Publication is expected in early 2002.

(76) Presuming technical feasibility is assured, of course.

(77) Such monies should still be used of course. Special causes would still exist but they would not have the dominance of impact that they do now. Donors' interests to develop special interventions or focus on

special populations could still be pursued but these would not skew, as they do now, important elements of the agencies' agenda and international activity.

(78) If the agencies are responsible for production of specific, predefined products and services to meet their public good roles it would be relatively obvious if these were not produced.

(*79*) Staff engaged on the core business products would know exactly what they were to produce and why. Full funding of regular budgets to do the core activities would eliminate the negative aspects of managers and staff seeking external funding and taking on new responsibilities to maintain jobs and close financial gaps. Staff could focus on a take pride from specific accomplishment of core functions, managers could concentrate on strategy, and staff development to improve efficiency.

(*80)* There is a danger that the global bureaucracies would see themselves able to approach the topic only through convening of a global conference, with all of the delay and special interests that this would entail. If so, the foundations could play a catalytic role by convening a "virtual" conference with wide country visits, participation and consensus formation process. In this approach, the agencies could be invited guests, present to harvest consensus equitably but not dominate outcomes, choices and ownership of ideas. If the global public goods initially to be purchased are limited to just a handful, such an approach may be feasible.