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CENTRE ON GLOBAL HEALTH SECURITY WORKING GROUP PAPERS

Financing Global Health Through a Global Fund for Health?

Gorik Ooms and Rachel Hammonds

February 2014

WORKING GROUP ON FINANCING | PAPER 4

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EXECUTIVE SUMMARY

Low-income countries remain far from the $60 annual per capita expenditure on health that the 2009 High-Level Taskforce on Innovative Financing for Health Systems estimated was needed to deliver a limited set of key health services to their citizens by 2015. Although development assistance for health (DAH) almost tripled between 2000 and 2011, several studies suggest that this increase has, in some instances, displaced government health expenditure from domestic sources (GHE-D). This is clearly not in the interest of either donor or partner countries – to use the terminology of the Paris Declaration on Aid Effectiveness. This is but one example of why donor and partner countries need to re-examine aid delivery mechanisms and explore innovative approaches to achieving shared objectives. With that goal in mind, this paper addresses the desirability of a central international pool of DAH – called a Global Fund for Health for the exercise.

This paper analyses the desirability of a Global Fund for Health from a 'political realism' perspective, not from a normative one. The central question here is not whether the international community ought to create a Global Fund for Health, for ethical or human rights reasons. It is whether the international community would be willing to create such a fund and use it as the main channel for DAH because of the impacts such an approach would have on certain qualities of DAH – some desirable, some undesirable.

The option examined here uses the parameters that have been developed in other papers of Working Group 2 on Sustainable Financing for Health, namely that all countries should aim for a level of GHE-D equivalent to 5% of gross domestic product (GDP), and that high-income countries should provide DAH equivalent to 0.1% of GDP. We will not explain or defend the rationale of these parameters here, we simply refer to the relevant papers. However, we will suggest somewhat lower intermediate targets for GHE-D in low- and middle-income countries.

The idea of a Global Fund for Health is not new. Since 2006 we have proposed and discussed the idea in several academic journals, and the arguments described in this paper are largely based on feedback we received on earlier publications and on the discussions within Working Group 2 on Sustainable Financing for Health. We structured them, as much as possible, around the desired qualities of aid espoused in the Paris Declaration. We argue that:

Donor countries want:

- To preserve control over the DAH they provide,
- DAH to increase their standing and reputation,
- DAH to be focused on infectious disease control,
- DAH to be additional to the GHE-D,
- To share the burden of DAH for global public goods, and
- To discourage corruption.

Partner countries want:

- DAH to be aligned with their priorities,
- DAH to be reliable in the long run,
- The administrative burden of managing DAH to be as low as possible,
- Unconditional DAH,
- To overcome 'recipient' stigmatization, and
- More DAH.

For each of these statements, we evaluated the option of a Global Fund for Health compared with the option of maintaining the DAH status quo, i.e. mostly bilateral and a few global funds for infectious disease control.

From the perspective of partner countries, a Global Fund for Health is, on balance, more desirable than the option of keeping DAH as it is. From the perspective of donor countries, the picture is more mixed and the desirability of preserving control over the DAH they provide may well override all other considerations. Donor countries have so far accepted 'collective-choice arrangements' if and only if they cannot avoid them – for example, when there are global public goods like infectious disease control requiring financing.

However, we believe that political developments beyond global health may provide the impetus required to motivate donor and partner countries to look for new solutions to old and new common concerns. We suggest that the political motivation for supporting a Global Fund for Health may come from global warming. The necessity of capping greenhouse gas emissions from all countries may oblige donor countries to support at least the provision of subsistence rights in partner countries.

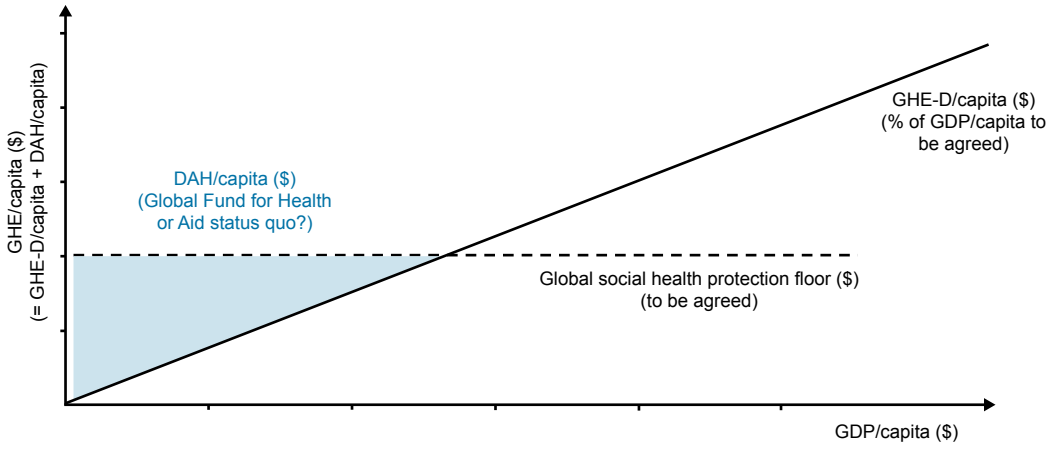
1. INTRODUCTION

This paper focuses on the desirability of a Global Fund for Health – a central international pool of development assistance for health (DAH). It is based on a few assumptions derived from the preamble of the Millennium Declaration, in which states confirmed that 'in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level'.[1] We assume that:

- The international community confirms that the primary responsibility for providing health care for their inhabitants rests upon each individual state, and that this primary responsibility can be expressed as a percentage of GDP;
- The international community accepts a shared responsibility for a minimum level of health care (a global social protection floor), and that this minimum level can be expressed as a monetary value per capita; and
- The primary purpose of DAH is to fill the gap between government health expenditure from domestic sources (GHE-D) and the agreed minimum level.

The assumed purpose of DAH is mapped out in Figure 1. The question is how to fill the gap between GHE-D and the agreed global minimum level of social health protection – which is represented by the grey triangle of Figure 1. Assuming that about 50 high-income countries would be expected to provide DAH and that about 50 low- and lower-middle-income countries would be expected to receive DAH – see Appendix – there are 2,500 potential bilateral arrangements to be monitored and coordinated. A Global Fund for Health would reduce that to about 100 arrangements – 50 between countries providing DAH and the Global Fund for Health, 50 between countries receiving DAH and the Global Fund for Health. At first sight, a Global Fund for Health seems to be a simple and convenient coordination tool.

Figure 1: The assumed purpose of DAH



States providing DAH and states receiving DAH have other objectives, however, in addition to filling the gap between agreed levels of GHE-D and an agreed global social health protection floor. The central question for this paper is not whether the international community ought to

1 United Nations General Assembly (2000), *United Nations Millennium Declaration*, http://www.un.org/millennium/declaration/ares552e.htm.

create a Global Fund for Health for ethical or human rights reasons (which we have addressed elsewhere).[2] It is whether the international community would be willing to create such a fund and use it as the main channel for DAH because of the anticipated impact of such an approach on certain qualities of DAH – some desirable, some undesirable.

2 Ooms, G. and Hammonds, R. (2008), 'Correcting Globalisation in Health: Transnational Entitlements versus the Ethical Imperative of Reducing Aid-Dependency', *Public Health Ethics*, 1(2).

2. METHODOLOGY

Selecting a methodology to test the desirability of two alternative options presents several challenges. If both options could be tested in a relatively small geographic area for a relatively limited time, we could organize clustered randomized controlled studies, for example as Banerjee and colleagues did for immunization campaigns with and without incentives.[3] For practical reasons, we cannot employ such a methodology to test the Global Fund for Health option; we cannot create a situation in which a few countries would receive development assistance for health from a global fund, while other comparable countries would continue to receive assistance as it is disbursed at present.

The obstacles are not only practical. Perhaps the main methodological challenge is that 'desirability' has a highly normative value: who decides what desirable means? As 'Hume's guillotine' explains, one cannot make normative claims solely on the basis of empirical findings. There is always a normative element or bridge needed.[4] When comparing immunization campaigns with and without incentives, the normative bridge is something like: 'the higher the resulting coverage rate, the better'. But it could also be: 'the higher the coverage rate at fixed costs, the better', and that could change the recommendations if there is a choice to be made between more expensive vaccines (protecting against more diseases) and offering incentives.

What would be the appropriate normative bridge for the question at hand, i.e. whether the international community would be willing to create a Global Fund for Health and use it as the main channel for DAH because of the anticipated impact of such an approach on certain qualities of DAH? To answer this we first have to determine what the members of the international community, namely sovereign countries, want to achieve when they provide or receive DAH.

The paper draws on our professional engagement with this issue over a number of years. Since 2006 we have proposed and discussed the idea of a Global Fund for Health in several academic journals[5] and numerous conferences. We have received a lot of feedback over the years, mainly from people who support the idea but argue that it is not politically feasible. To address this challenge we turned to the Paris Declaration on Aid Effectiveness as an expression of what countries desire from DAH, treating it as a proxy for political feasibility.[6]

The Paris Declaration provides us with a list of desired qualities of aid from the perspectives of donor and partner countries. However, it may be 'cosmetic' to some extent, listing the 'politically correct' qualities of aid, not the truly desired qualities of aid. For example, it is widely acknowledged that at least some DAH is motivated by donor countries' desire to control infectious diseases abroad. The World Health Report of 2007 explores this in depth and at length.[7] But that approach is only successful if a substantial part of DAH is actually used by the partner countries for infectious disease control, which may be at odds with the desired quality of alignment with domestic priorities. That tension is not mentioned in the Paris Declaration. Therefore, we added statements taken from an earlier literature review on the international political economy of global universal health coverage.[8]

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3 Banerjee, A.V., Duflo, E., Jameel, A.L., Glennerster, R. and Kothari, D. (2010), 'Improving Immunisation Coverage in Rural India: Clustered Randomised Controlled Evaluation of Immunization Campaigns with and without Incentives', *BMJ*, 340: c2220.

4 Castaneda, H.-N. (1973), 'On the Conceptual Autonomy of Morality', *Noûs*, 7(1): 67–77.

5 Ooms, G., Derderian, K. and Melody D. (2006), 'Do We Need a World Health Insurance to Realise the Right to Health?', *PLoS Medicine*, 3(12); Ooms G. and Hammonds R. (2008), 'Correcting Globalisation in Health: Transnational Entitlements versus the Ethical Imperative of Reducing Aid-Dependency', *Public Health Ethics*,1(2); Ooms G. and Hammonds R. (2010), 'Taking up Daniels' Challenge: The Case for Global Health Justice', *Health & Human Rights*, 12(1).

6 *Paris Declaration on Aid Effectiveness* (2005), http://www.oecd.org/development/effectiveness/34428351.pdf.

7 Prentice, T. and Reinders, L.T. (2007), 'A Safer Future: Global Public Health Security', *World Health Report 2007* (Geneva: World Health Organization).

8 Ooms G., Hammonds R. and Van Damme W. (2010), *The International Political Economy of Gglobal Universal Health Coverage*, http://www.pacifichealthsummit.org/downloads/UHC/The%20international%20political%20economy%20of%20global%20universal%20health%20coverage.PDF.

Starting from a rather long initial list, we regrouped statements about desired qualities and eliminated duplicates, ensuring that several very similar qualities were not repeated. (For example, ownership of aid-supported policies by partner countries and alignment with domestic priorities of partner countries largely refer to the same quality.)

For each of these statements, we evaluated whether a Global Fund for Health would contribute more to the desired quality, or whether DAH as it is at present provides that quality better. Some of these evaluations are very simple and therefore short; but some require a longer discussion.

Finally, we discussed the statements within Working Group 2 on Sustainable Financing for Health.

Statements about desired qualities of DAH

For the purposes of this paper, we distilled the following desired qualities of development assistance for health.

Donor countries want:

- To preserve control over the DAH they provide,
- DAH to increase their standing and reputation,
- DAH to be focused on infectious disease control,
- DAH to be additional to the GHE-D,
- To share the burden of DAH for global public goods, and
- To discourage corruption.

Partner countries want:

- DAH to be aligned with their priorities,
- DAH to be reliable in the long run,
- The administrative burden of managing DAH to be as low as possible,
- Unconditional DAH,
- To overcome ‘recipient’ stigmatization, and
- More DAH.

3. EVALUATION FROM THE DONOR COUNTRIES' PERSPECTIVE

Donor countries want to preserve control over the DAH they provide

In spite of all the rhetoric about partner-country ownership, most donors still consider the level and the duration of the aid they provide as discretionary. It is briefly mentioned in the Paris Declaration: 'Enhancing donors' and partner countries' respective accountability to their citizens and parliaments' means, from the perspective of donors, that their citizens and parliaments must maintain the liberty to increase or decrease aid, to change the beneficiaries or to change the objectives. Unlike domestic budgets, for which a substantial part is committed many years in advance simply because that is necessary for planning purposes, donors probably want their aid commitments to remain vague.

There are many reasons why donor countries want to preserve control over the development assistance for health they provide. It may be a matter of principle and accountability, but also a desire to 'instrumentalize' DAH – to make sure that it is used for infectious disease control (a desired quality that seems important enough to consider it in itself), or because it creates a new market for health goods and services, and donor countries want to promote the interest of companies under their jurisdiction to benefit from this market.[9] Another motivation may be the desire of donor countries to satisfy the demands of disease-focused activists among their constituencies.[10]

The recent trend towards increased 'multi-bi' funding, so termed by the Organization for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC), reinforces the interpretation that donor countries want DAH to align with their goals, whether delivered bilaterally or via multilateral channels.[11] Sridhar notes that 'multi-bi financing permits governments and other stakeholders to realign the objectives of multilateral initiatives with their own. […] [I]ndividual governments can use new funding mechanisms as a way to define a separate mandate and to push specific goals.'[12]

A Global Fund for Health would require governments to give up some of the control they now have over the DAH they provide. Its governance bodies would make allocative decisions concerning which countries and activities would receive funding. On the other hand, if these donor-country governments were duly represented in the governance bodies, each of them would have a say over the allocation of the DAH provided by other donor states. In as much as we can compare 'state sovereignty' with 'personal autonomy', the collective-choice arrangements that happen within every state ('the social contract') are generally not considered violations of personal autonomy, as long as individuals are duly represented. *Mutatis mutandis*, the Global Fund for Health should not be considered a breach of sovereignty as long as governments are duly represented.

However, although international collective choice arrangements on particular issues exist, they always seem to be born of a collective necessity: when achieving a global public good requires cooperation, countries are willing to give up some of their sovereignty in exchange for other countries doing the same. The preferred option at the international level remains individual choice, not collective choice.

9 Drage, N. and Fidler, D. (2007), 'Foreign Policy, Trade and Health: At the Cutting Edge of Global Health Diplomacy', *Bulletin of the WHO*, 85(3), p.162.

10 Garrett, L. (2007), 'The Challenge of Global Health', *Foreign Affairs*, 86(1).

11 OECD/DAC (2010), *2010 DAC Report on Multilateral Aid,* http://www.oecd.org/dataoecd/23/17/45828572.pdf.

12 Sridhar, D. (2012), 'Who Sets the Global Research Agenda? The Challenge of Multi-Bi Financing', *PloS Medicine* 9(9): e1001312.

Donor countries want DAH to increase their standing and reputation

Feldbaum and Michaud argue that 'countries are increasingly using health initiatives as a means to improve security, project power and influence, improve their international image, or support other traditional foreign policy objectives'.[13] A striking illustration of this is the difference between the 2000 American National Intelligence Council report on *The Global Infectious Disease Threat and its Implications for the United States*,[14] and its 2008 follow-up report on *Strategic Implications of Global Health*.[15] The follow-up report

> *expands the field of inquiry to fully encompass all aspects of global health – including maternal mortality, malnutrition, chronic diseases and other relevant non-infectious health issues. While these may not represent* direct threats *to US interests in the way that acute infections do, these health determinants can also have wide-ranging – if more slow-moving and subtle – impacts on the global scene.*[16] [emphasis in original]

Under the subtitle 'Health as Opportunity: A New Look at a Successful Paradigm', the final chapter of this report explores how 'efforts similar to that exerted by the US in the fight against HIV/AIDS – but focused on broader global health objectives – could simultaneously help advance economic development, foster diplomacy and improve overall health worldwide'.[17]

Pooling aid renders it somewhat anonymous. At first sight, a Global Fund for Health does not look desirable from the perspective of increasing standing and reputation, as the pooled DAH could no longer be easily attributed to any given government. For example: boxes with medicines would at best have a sticker stating 'Donated by the Global Fund for Health' on them, not 'Donated by the government of country X'. Before jumping to conclusions, however, we need to answer two crucial questions:

- Who exactly wants to increase their standing and reputation? Is it the donor countries individually, and some of them more than others? Or is it the donor countries collectively, the 'winners of globalization' who need to do something about globalization's 'discontents'?
- Who needs to know how much DAH each donor country provides (to yield the improved standing and reputation of the donor countries)? The direct beneficiaries of DAH? Or is it their leaders (who have other means of knowing how much each donor country contributes to a collective effort)? Could it be that leaders of partner countries prefer donor countries contributing to collective efforts, rather than donors displaying their generosity bilaterally (and with more strings attached)?

Contributing to a Global Fund for Health may well be perceived as a willingness to cooperate, whereas the present practice of DAH may be perceived as a willingness to display (and maintain) each donor country's individual strength.

Donor countries want DAH to be focused on infectious disease control

The evolution in thinking from the 2000 National Intelligence Council report[18] to its 2008 follow-up report[19] may signal that donor countries have 'discovered' indirect benefits of DAH for their

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13 Feldbaum, H. and Michaud, J. (2010), 'Health Diplomacy and the Enduring Relevance of Foreign Policy Interests', *PLoS Medicine*, 7(4): e1000226.

14 National Intelligence Council (2000), *The Global Infectious Disease Threat and its Implications for the United States* (Washington, DC: NIC), http://www.ahrn.net/library_upload/uploadfile/us0018.pdf.

15 National Intelligence Council (2008), *Strategic Implications of Global Health* (Washington, DC: NIC), http://www.state.gov/documents/organization/113592.pdf.

16 Ibid., p.1.

17 Ibid., p. 30.

18 NIC (2000), *The Global Infectious Disease Threat and its Implications for the United States.*

19 NIC (2008), *Strategic Implications of Global Health*.

own constituencies beyond infectious disease control, but that does not mean that they have abandoned the 'original' desired quality of DAH.

Both the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunizations (GAVI) are essentially global funds for infectious disease control. Those who think that it is not a coincidence that the international community 'failed' to create a global fund for mother-and-child health, for example, may consider this evaluation to be easy: a Global Fund for Health would inevitably remain focused on infectious diseases and therefore on a desirable option for donor countries. But we would argue exactly the opposite. A Global Fund for Health would have to establish criteria for comprehensive country health-sector plans, and it seems plausible that these criteria will be based on public-health prescriptions such as maximizing efficiency. It is not easy to predict whether this would lead to more DAH being used for non-infectious health issues because of the difficulty in assessing the long-term benefits of interrupting chains of infection; but at least priorities would be set in the function of local efficiency, not in terms of efficiency in reducing transnational threats.

The continuation of the present DAH practice allows donor countries to continue using the existing global funds focused on infectious disease control – they allow donor countries to earmark DAH for infectious disease control. From this perspective, a Global Fund for Health seems rather undesirable.

Donor countries want DAH to be additional to GHE-D

Through the Paris Declaration, partner countries commit to 'intensify efforts to mobilize domestic resources' (paragraph 25). Given the present financial crisis, it seems plausible that donor countries would like to make sure that DAH is additional to GHE-D. As Greenhill and Prizzon found when interviewing representatives of the OECD-DAC about the future of the Millennium Development Goals (MDGs):

> *Mutual responsibilities and burden-sharing emerged as important issues for the DAC donors, who no longer want to be taking on the full burden of providing the financing to meet the MDGs. Stronger commitments from both developing countries themselves and from non-DAC donors will be expected.*[20]

The desired quality of 'additionality' of DAH – or the undesired effect of 'displacement', if expressed the other way around – has been the subject of several studies already, and of serious controversy. A recent comment by Murray and colleagues probably reflects the current state of knowledge:

> *On average, the evidence is that a trade-off exists between development assistance channelled to the government health sector and health expenditure financed by domestic sources. To better understand this phenomenon, documentation of how governments spend their own resources by sector is an urgent priority.*[21]

When we plotted data about changes in GHE-D and DAH in low-income countries (using the World Bank classification) between 2000 and 2007, measured as a percentage of GDP (leaving out Liberia, Somalia and North Korea, because of unreliable data in 2000 or 2007 or both), we obtained the results shown in Figure 2.

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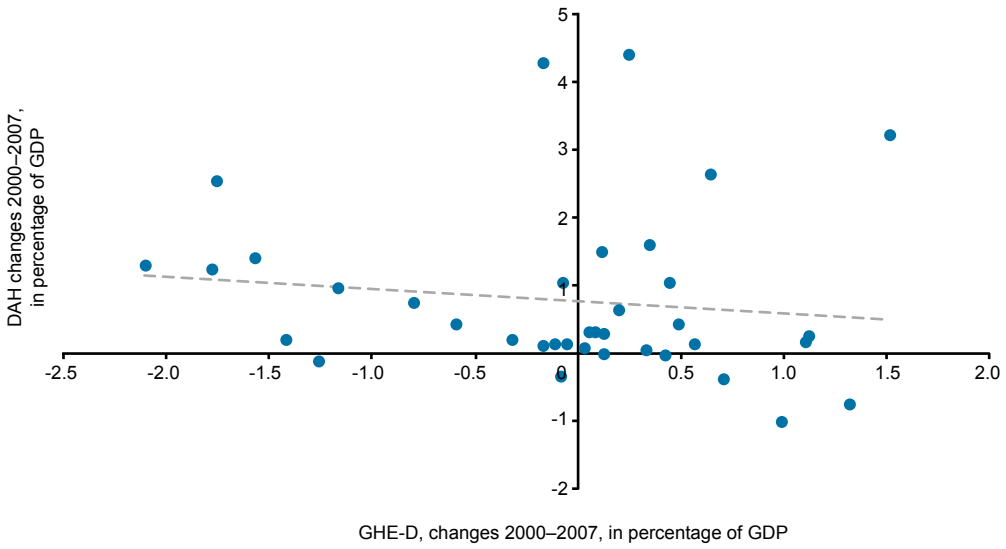
20 Greenhill, R. and Prizzon, A. (2012), *Who Foots the Bill after 2015? What New Trends in Development Finance Mean for the Post-MDGs* (Overseas Development Institute), p viii, http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7905.pdf.

21 Murray, C.J.L., Dieleman, J.L., Lu, C. and Hanlon, M. (2013), 'More Data and Appropriate Statistical Methods Needed to Fully Measure the Displacement Effects of Development Assistance for Health', *PLoS Med* 10(1): e1001365.

Figure 2: Changes in GHE-D and DAH in low-income countries between 2000 and 2007



Source: WHS2010.

This graphic tells us that neither displacement nor additionality should be assumed: the dots are 'all over the place'. But it also tells us that in many low-income countries, the increase of DAH during the first decade of the 21st century was offset by an even greater decrease in GHE-D. While some may argue that this is not problematic if the freed domestic resources were used well, in line with the principles of 'aid effectiveness' and national priority-setting across sectors, we would argue that donor countries would prefer to see no dots in the upper-left quadrant of Figure 2 – and there are quite a few.

How can aid channels influence additionality? First, it is important to note that aid that is unreliable in the long term encourages displacement. As aptly formulated by Foster,

> *donor commitments to individual countries remain short-term and highly conditional and do not come close to reflecting these global promises of increased aid, while donor disbursement performance remains volatile and unreliable […] governments are therefore understandably reluctant to take the risk of relying on increased aid to finance the necessary scaling up of public expenditure.*[22]

To understand that point, it is important to understand first how important DAH has become, in low-income countries in particular.

Table 1 tells us that total health expenditure (THE) in low-income countries, on average, increased from $10 per person per year in 2000, to $28 per person per year in 2010. This includes both government and private health expenditure. GHE increased from $4 per person per year in 2000 to $10 in 2010. That allows us to estimate that private health expenditure increased from $6 per person per year in 2000 to $18 in 2010.

22 Foster, M. (2005), 'Fiscal Space and Sustainability: Towards a Solution for the Health Sector', in *High-Level Forum for the Health MDGs, Selected Papers 2003–2005* (Geneva: World Health Organization and Washington, DC: World Bank), p.67, http://www.who.int/hdp/publications/hlf_volume_en.pdf.

Table 1: Health expenditure in low-income countries

	Total health expenditure (THE), pcpa, in US$ average exchange rate	Government health expenditure (GHE), pcpa, in US$ average exchange rate	Development assistance for health (DAH), as percentage of THE	DAH, pcpa, in US$ average exchange rate	GHE, as percentage of THE	Private health expenditure (PHE), as percentage of THE	Out-of-pocket (OOP) expenditure as percentage of PHE	OOP, pcpa, in US$ average exchange rate
2000	10	4	14.4	1.4	42.0	62.7	83.5	5.2
2010	28	10	26.3	7.4	38.5	61.5	77.7	13.4

Source: World Health Statistics 2013 http://www.who.int/gho/publications/world_health_statistics/en/index.html.

Table 1 also tells us that DAH increased from $1.4 per person per year in 2000 to $7.4 in 2010. But we do not know whether DAH is included in GHE or in private health expenditure. If we assume that all DAH went to GHE, then GHE-D increased from $2.6 per person per year in 2000 ($4 minus $1.4) to $3.6 in 2010 ($10 minus $7.4), while government health expenditure from aid (GHE-A) increased from $1.4 per person per year in 2000 to $7.4 in 2010. That would mean that the GHE-A share of GHE increased from 35% in 2000 to 74% in 2010 (in low-income countries).

We acknowledge that the accuracy of this figure is suspect because of our main assumption (that all DAH went to GHE) and note that a part of DAH may have supported private health expenditure. If we now assume that DAH supported all private health expenditure, except out-of-pocket (OOP) expenditure, this provides us with a lower boundary. Above, we estimated that total private health expenditure in 2000 was $6 per person of which, as Table 1 shows, $5.2 was private out-of-pocket expenditure. For 2010, we estimated that total private health expenditure was $18, of which $13.4 was private OOP expenditure. If we can assume that DAH did not support private OOP expenditure, then the maximum amount of DAH that supported private health expenditure was $0.8 in 2000 ($6–$5.2) and $4.6 in 2010. Thus we can assume that the GHE-A share of GHE increased from at least 15% in 2000 to at least 28% in 2009.

If we assume that our calculations are at least indicative of a real trend, and that the GHE-A share of GHE in low-income countries increased from somewhere in the range between 15% and 35% in 2000 to somewhere in the range between 28% and 74% in 2010, then it is understandable that the governments of these countries are reluctant to increase recurrent GHE. For low-income governments, it is too risky to expand recurrent GHE when GHE-A levels are unpredictable. GHE-A would have to be far more reliable in the long run, as a necessary precondition, not a sufficient precondition, to expect that partner countries increase GHE-D.

Lane and Glassman's 2008 study examining the reliability of aid flows supports the above interpretation. Their study, like Foster's in 2005, found that 'aid flows to the health sector are volatile in terms of observed outcomes and uncertain in terms of making and delivering future commitments'. They argue that 'aid is therefore poorly suited to fund recurrent costs associated with achieving the Health Millennium Development Goals, particularly funding of Primary Health Care'. However, they also found that 'parts of the new institutional architecture, such as the Global Fund, appear to deliver stable and predictable financing'.[23] A plausible explanation for their finding is that pooling DAH creates a buffer that absorbs shocks – windfalls and shortfalls combined. A Global Fund for Health that pools DAH would allow partner countries to increase GHE-D.

Therefore, if donor countries want to increase the additionality of DAH, they will first have to increase the predictability of DAH, and pooling DAH at the international level seems to be the best way to do that. From this perspective, donor countries may find the Global Fund for Health a desirable option.

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23 Lane, C. and Glassman, A. (2008), 'Smooth and Predictable Aid for Health: A Role for Innovative Financing?' (Washington, DC: Brookings Institution), http://www.brookings.edu/research/papers/2008/08/global-health-glassman.

Donor countries want to share the burden of DAH for global public goods

In 1997, Sandler predicted that 'a new form of foreign aid – *"free-rider aid"* – may come from the provision of transnational public goods and may increasingly replace traditionally tied and untied foreign aid of the post-World War II period'.[24] His term 'free-rider aid' meant that poorer countries would benefit from internationally financed efforts to provide global public goods without having to contribute resources. Although this qualification grossly downplays the domestic efforts, it highlights a problem: in as much as DAH is aid for global public goods, one can predict that the most attractive option for each individual country is to benefit from the efforts of all other countries.

Is health a global public good? Opinions vary, depending on how narrowly or broadly the definitions of public goods and of health are applied. Proponents of the narrower definitions – according to which public goods must be non-rival (once provided to some, a public good can be used by all) and non-excludable (nobody who wants to benefit from the public good can be excluded from benefiting) – argue that efforts to improve health are typically rival and excludable: a medicine taken by one person cannot be taken by someone else and any person can be excluded from health-care services, for example because he or she did not pay a health insurance fee.[25] Proponents of the broader definitions argue that the positive externalities of improving health for all people worldwide are typically non-rival and non-excludable.[26] Therefore, if one considers the externalities of improved global health, global health can be seen as a global public good.

Referring to 'prevention or containment of communicable disease', Woodward and Smith explain the problem in these words:

> *While communicable disease control is non-rival in its effect (one person's lower risk of contracting a disease does not limit the benefits of that lower risk to others), its production requires excludable inputs, such as vaccination, clean water or condoms, as well as non-excludable inputs, such as knowledge of preventive interventions and best practice in treatment.*[27]

They also refer to the global economic impact of improved health as an example of an externality of global health that may have value as a global public good.

Even if we accept that global health is a global public good, it is far from being a perfect one. Some elements of global health, such as infectious disease control, are acknowledged as global public goods, while others such as decreasing maternal mortality seem to have lesser global public-good value. But even if global health fits only imperfectly into the definition of global public goods, it contains at least some elements of such a good, and that requires one to be on the alert for free-riding behaviour. As Kanbur and colleagues phrased it, 'The presence of these international public goods raises free-riding considerations since, once provided, potential donor countries receive the benefits whether or not they fund these goods.'[28]All donor countries may understand that improved global health efforts will serve their interests; but if they can benefit from efforts made by other donor countries, they may try to avoid contributing.

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24 Sandler, T. (1997), *Global Challenges: An Approach to Environmental, Political, and Economic Problems* (Cambridge University Press), p. 183.

25 Long, D. and Woolley, F. (2009), 'Global Public Goods: Critique of a UN Discourse', *Global Governance*, 15(1).

26 Arhin-Tenkoran, D. and Conceição, P. (2003), 'Beyond Communicable Disease Control: Health in the Age of Globalization', in Kaul, I., Conceição, P., Le Goulven, K. and Mendoza, R.U. (eds), *Providing Global Public Goods: Managing Globalization* (Oxford University Press).

27 Woodward, D. and Smith, R.D. (2003), 'Global Public Goods and Health: Concepts and Issues', in Smith, R., Beaglehole, R., Woodward, D. and Drager, N. (eds), *Global Public Goods for Health: Health Economic and Public Health Perspectives* (Oxford University Press), pp.10–11.

28 Kanbur, R. and Sandler, T. with Morrison K. (1999), *The Future of Development Assistance: Common Pools and International Public Goods* (Washington, DC: Johns Hopkins Press for the Overseas Development Council).

An interesting attempt to avoid free-riding behaviour is the condition imposed by the US Congress on American contributions to the GFATM: they cannot exceed 33% of total contributions from all donor countries.[29] By doing so, Congress made sure that all other donor countries contribute at least 67%.

Of course, donor countries could avoid free-riding by simply agreeing that they will allocate a given percentage of their GDP to DAH. At present, however, examples of effective burden-sharing of aid are all attached to organizations.[30] This suggests that avoiding free-riding and sharing the burden of financing global public goods could be more easily achieved with a Global Fund for Health.

Donor countries want to discourage corruption

The importance of avoiding corruption in the use of DAH is mentioned in the Paris Declaration as a 'remaining challenge':

> *Corruption and lack of transparency, which erode public support, impede effective resource mobilization and allocation and divert resources away from activities that are vital for poverty reduction and sustainable economic development. Where corruption exists, it inhibits donors from relying on partner country systems.*

So there are two reasons why donor countries want to avoid corruption: it erodes public support for DAH within donor countries, and it decreases the level of financial resources available to improve health.

If donors want to discourage corruption it is important to consider the challenges posed by a Global Fund for Health. Mackey and Liang argue that 'large-scale, multilateral global health programs also present new opportunities for health corruption'.[31] They explain how the GFATM and the World Bank have been plagued by corruption – not within the organizations themselves, but through misuse of the grants they provided in several countries. It is beyond the scope of this paper to analyse whether multilateral aid is less or more susceptible to corruption than bilateral aid; but we believe that the solution Mackey and Liang propose – a 'Global Health Anti-Corruption Framework' – may work better for or with a Global Fund for Health than under the present practice of DAH. Their proposed framework would

> *involve multiple interventions and include: (1) transparency and audit policies; (2) a common framework for corruption monitoring and evaluation of public health programmes and funding; (3) codes of conduct for public and private sector actors; (4) minimum standards for member-state laws to specifically prevent and prosecute health-based corruption; (5) health financing improvements to curtail the need for an informal health sector; (6) a centralized surveillance and data repository system to report and investigate global health corruption; (7) multilateral processes to freeze proceeds from corruption and aid in recovery of diverted assets; and (8) commitment to earmark portions of seized assets to fund and develop these anti-corruption systems among members.*[32]

29 Henry J. Kaiser Family Foundation (2010), *The U.S. and the Global Fund to fight AIDS, Tuberculosis and Malaria* (Menlo), http://www.kff.org/globalhealth/upload/8003-02.pdf.

30 Addison, T., McGillivray, M. and Odedokun, M. (2003), *Donor Funding of Multilateral Aid Agencies: Determining Factors and Revealed Burden Sharing*, Discussion Paper No. 2003/17 (Helsinki: World Institute for Development Economics Research), http://unu.edu/hq/library/Collection/PDF_files/WIDER/WIDERdp2003.17.pdf.

31 Mackey, T.K. and Liang, B.A. (2012), 'Combating Healthcare Corruption and Fraud with Improved Global Health Governance', *BMC International Health and Human Rights*, 12: 23.

32 Ibid.

4. EVALUATION FROM THE PARTNER COUNTRIES' PERSPECTIVE

Partner countries want DAH to be aligned with their priorities

Under the donors' goal of controlling infectious diseases, we assumed that if a Global Fund for Health were used as the main channel for development assistance for heath, then it would have to consider comprehensive health-sector plans rather than disease-specific interventions. Logically, we then also assumed that DAH channelled via a fund would be more aligned with partner countries' priorities.

Partner countries want DAH to be reliable in the long run

Under the donor's goal of making health aid additional to partners' health spending, we explained how the GFATM and GAVI already seem to provide more reliable DAH than bilateral channels. The desired quality discussed there for donors was the additionality of DAH, and we argued that more reliable DAH was a necessary (albeit insufficient) precondition.

Partner countries may dislike the fact that donors want the DAH they provide to be additional to GHE-D, but it seems reasonable to assume that they would nevertheless prefer more reliable DAH.

Partner countries want the administrative burden of DAH to be as low as possible

We are assuming that all high-income countries provide or will be providing DAH, which means that for every partner country there are potentially 50 donor countries. Furthermore, in another background paper it is argued that some upper-middle-income countries should become donor countries: and in fact some of them already are.[33] On top of that, there are the already existing multilateral channels.

One of the key assumptions of this paper is that a Global Fund for Health would replace the present 'architecture' of DAH. While some bilateral DAH may continue to react to unforeseen situations, most assistance would go via the fund, which would thus substantially reduce the administrative burden.

Partner countries want unconditional DAH

We did not make detailed assumptions about the governance and the modalities of a Global Fund for Health, which makes it difficult to assess whether DAH channelled via such a fund would come with fewer or more strings attached. Under the donors' goal of retaining control over their health aid, we assumed that they would dislike a Global Fund for Health because it would reduce their control over the use of DAH, which implies that DAH via a Global Fund for Health would come with fewer conditions attached or with conditions that would be negotiated in a more transparent manner. However, under the donors' goal of additionality, we assumed that one reason for donor countries to support a Global Fund for Health would be the possibility to negotiate and monitor the additionality of DAH to GHE-D. Staying logically in line with that, we can assume that this is a reason for partner countries to rather dislike a Global Fund for Health.

33 Ottersen, T., Kamath, A., Moon, S. and Røttingen J.-A. (2014), *Development Assistance for Health: Quantitative Allocation Criteria and Contribution Norms* (Chatham House).

In July 2012, the African Union adopted a 'Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa', which calls on African governments and on the international community to fill the funding gaps together, proposing a 'fair share' approach based on 'ability' and 'prior commitments'.[34] The title of the roadmap may be somewhat misleading as the prior commitments referred to include the Abuja Declaration, which also had AIDS, TB and malaria in its title – 'HIV/AIDS, Tuberculosis and Other Related Infectious Diseases' to be precise – but which will be remembered for the commitment to allocate 15% of national budget to the entire health sector.[35]

The African Union does not represent all partner countries, and statements included in such declarations do not always reflect the true desire of the countries endorsing them. But it seems reasonable to assume that partner countries are willing to be held accountable for their GHE-D as long as there is a reciprocal commitment from donor countries. A Global Fund for Health would help to implement the Roadmap on Shared Responsibility and Global Solidarity.

Partner countries want to overcome 'recipient' stigmatization

'The hand that gives is above the hand that takes' is a truism commonly attributed to Napoleon Bonaparte, who did not want to be dependent on private bankers. It can be applied to countries receiving DAH as well.

Intriguingly, it is difficult for most people living in countries with sophisticated social-protection mechanisms to know or anticipate whether they will have been, at the end of their lives, net recipients from or net donors to their social protection schemes. It does not seem to matter: as long as one gives one's dues and takes no more than one's entitlements, there is no reason to feel like a recipient or a donor.

Leigh and Glennie propose a simple solution that would end donor–recipient relations in the world:

> *Splitting countries into 'developed' and 'developing' no longer makes sense. Nor does the simple division between donors and recipients. New middle-income countries are increasingly both recipients and providers of aid. Some kind of 0.7% target should soon apply to them, and the tentative reaching-out between OECD and non-OECD donors at Busan was a step in that direction.*[36]

Why would middle-income countries or even low-income countries become donors? According to Leigh and Glennie,

> *as rich countries quibble about how much they can spare to safeguard the planet and help people leave extreme poverty, the poorest countries would begin to shame richer countries into doing the right thing by allocating a proportion of their meagre resources for the common good [and] the countries that most need aid to work would at least have their feet under the table, arguing for their rights and interests from a position of fellow contributor not just recipient.*[37]

If all of the world's countries were to start acting as both donors and recipients, the result would be a big mess. But a Global Fund for Health would be an elegant solution. Even if the contributions for low- and middle-income countries were set at 0% of GDP, they would be

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34 African Union (2012), *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa*, http://www.au.int/en/sites/default/files/Shared_Res_Roadmap_Rev_F%5b1%5d.pdf.

35 Organization of African Unity (2001), *Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases*, http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

36 Leigh, C. and Glennie, J. (2013), 'Aid targets are aspirational – so let's apply them to every country', *The Guardian*, Poverty Matters Blog, 28 March 2013, http://www.guardian.co.uk/global-development/poverty-matters/2013/mar/28/aid-targets-aspirational-apply-every-country.

37 Ibid.

contributors in principle – and as soon as they reached the threshold of high-income countries, they would become contributors in effect.[38]

The creation of a Global Fund for Health could contribute to moving away from the stigmatizing division of countries into donors and recipients.

Partner countries want more DAH

One of our assumptions is that high-income countries should provide DAH equivalent to 0.1% of GDP.[39] If so, we wondered if channelling this envelope of DAH – about $50 billion per year – via a Global Fund for Health brings about more desired qualities of DAH than the present channels. It would therefore be a logical flaw to consider one of the underlying assumptions as an outcome. Furthermore, it is difficult to predict the impact of the creation of a fund on the overall volume of DAH. However, it can be argued that the GFATM and GAVI have been quite successful in mobilizing additional DAH, perhaps because of the transparency they offer – which allows activists to see exactly how much their government is contributing and to compare the effort of their countries with those of other countries in similar situations.

38 The spreadsheet presented in the Appendix allows for setting thresholds for contributing countries: a fixed (and low) percentage of GDP below the lower threshold, a progressive scale of percentage of GDP between the lower and the higher threshold, a fixed percentage of GDP above the higher threshold. The example given in the Appendix is set to assume only high-income countries will contribute.

39 Ottersen et al., *Development Assistance for Health*.

5. DISCUSSION

As Table 2 illustrates, a Global Fund for Health appears to be an overall desirable option from the perspective of partner countries. From the perspective of donor countries, the picture is more mixed and the desirability of preserving control over the development assistance for health they provide may well override all other considerations. The latter accept 'collective choice arrangements' if and only if they cannot avoid them, for example in the case of global public goods that require financing. Based on this analysis, one could predict that there will be global funds for infectious disease control, but not for health in general, unless global health is perceived as a global public good.

Table 2: Overview of evaluations of desired qualities of DAH, from donor and partner countries' perspectives

	Would a Global Fund for Health bring out the desired quality of DAH?		
Statements about desired qualities of DAH	**Yes**	**No**	**Not sure**
Donor countries want to preserve control over the DAH they provide		•	
Donor countries want DAH to increase their standing and reputation			•
Donor countries want DAH to be focused on infectious disease control		•	
Donor countries want DAH to be additional to the GHE-D	•		
Donor countries want to share the burden of DAH for global public goods	•		
Donor countries want to discourage corruption	•		
Partner countries want DAH to be aligned with their priorities	•		
Partner countries want DAH to be reliable in the long run	•		
Partner countries want the administrative burden of managing DAH to be as low as possible	•		
Partner countries want unconditional DAH			•
Partner countries want to move away from 'recipient' stigmatization	•		
Partner countries want more DAH			•

In 1986, Vincent wrote a book in which he recommended that 'as a project for international society, the provision for subsistence rights 'has a strong claim to priority over other human rights',[40] in line with Henry Shue's earlier recommendations.[41] But Vincent expected objections, including the following: 'Thus it might be argued that a basic needs programme of this kind would require, from the western world, the equivalent of a Marshall Plan with no political interest to prompt it.'[42]

The political interest for a Global Fund for Health may come from a different corner: global warming. The necessity of reducing greenhouse gas emissions worldwide may well oblige donor countries to support, at a minimum, the provision of subsistence rights in partner countries.

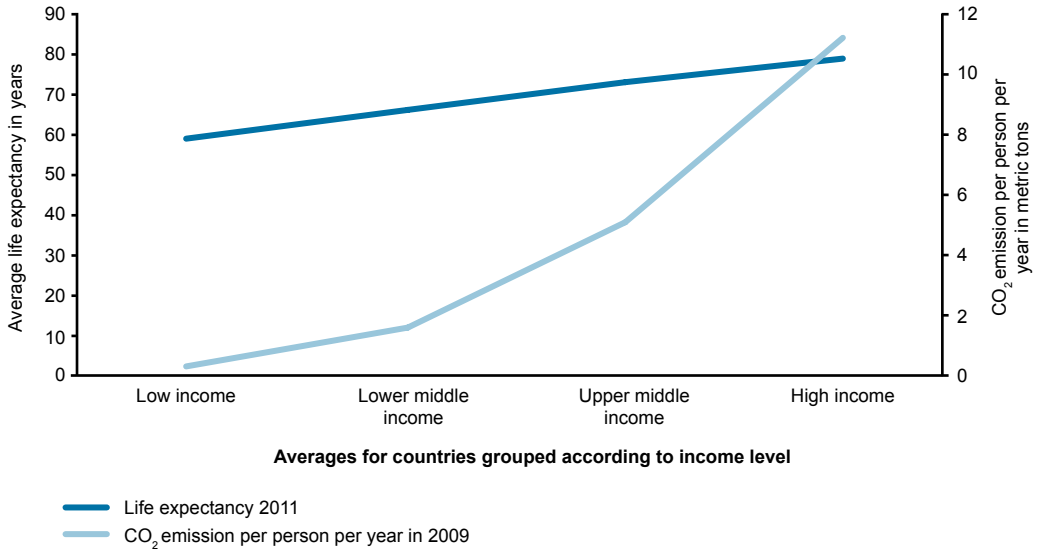
Figure 3 illustrates the relationship between average life expectancy and carbon dioxide emissions in low-, lower-middle-, upper-middle- and high-income countries.

40 Vincent, R.J. (1986), *Human Rights and International Relations* (Cambridge University Press/Royal Institute of International Affairs), p. 2.

41 Shue, R. (1980), *Basic Rights: Subsistence, Affluence and U.S. Foreign Policy* (Princeton University Press).

42 Vincent, *Human Rights and International Relations*, p.148.

Figure 3: Average life expectancy and CO_2 emissions



It certainly looks as if carbon dioxide emissions are good for health! Obviously, there is no direct causality; but higher carbon dioxide emissions are the result of industrialization and economic growth and so is the higher average life expectancy.

High-income countries support the concept of 'common but differentiated responsibility' for global warming – and their focus is shifting from 'differentiated responsibility' to 'common responsibility'. Until now, only high-income countries were expected to make binding commitments about carbon dioxide emission ceilings, but an agreement in principle was reached about a future international legally binding arrangement for all countries. Middle- and low-income countries are expected to accept ceilings at a much lower level than high-income countries' current emission levels, otherwise the arrangement would be ineffective – the present global average of 4.7 metric tons per person per year is unsustainable. Low-income countries, without immediate prospects of substantially increasing industrial activity or consumption, may not be constrained by such ceilings in the short run; but some middle-income countries could be immediately affected – which explains why India tried to avoid the agreement in principle, initially supported by Brazil, China and South Africa.[43]

In these negotiations, some countries – including these four – are promoting 'the idea of common but differentiated responsibilities to be as central a concept in development as it already is in climate'.[44] Evans considers this a 'dangerous game on the post-2015 development agenda', because both the post-MDGs and Sustainable Development Goals (SDGs) negotiations could become 'bogged down amid a mood of mutual recrimination'.[45]

It is difficult to imagine how low- and middle-income countries could be convinced that they should accept shared responsibility for climate change if high-income countries remain unwilling to accept shared responsibility for the provision of subsistence rights. As von der Goltz notes, 'Developing countries uniformly stress the primacy of development and poverty reduction over [climate change] mitigation action.'[46] At the same time, they demand financial

43 Jacobs, M. (2013), 'What is the state of international climate talks?', *The Guardian*, 6 February 2013, http://www.theguardian.com/environment/2012/sep/17/internattional-climate-talks-faq.

44 Evans, A. (2013), 'Emerging economies' dangerous game on the post-2015 development agenda', Global Dashboard, 28 August, http://www.globaldashboard.org/2013/08/28/emerging-economies-dangerous-game-on-the-post-2015-development-agenda/.

45 Ibid.

46 Von der Goltz, J. (2009), 'High Stakes in a Complex Game: A Snapshot of the Climate Change Negotiating Positions of Major Developing Country Emitter', Working Paper Number 177 (Washington, DC: Center for Global Development), p. 8, http://www.cgdev.org/files/1422602_file_High_Stakes_FINAL081009.pdf.

assistance: China envisages high-income countries contributing 0.5% to 1% of their GDP in addition to present aid levels; India expects 1% of GDP; South Africa, with support from other African states, suggested $200 billion per year or 0.5% of GDP.[47] And, according to von der Goltz: 'Many developing countries argue that mitigation support funds are not voluntary relief granted by industrialized countries but dues owed to developing countries in exchange for their likely reaching lower historical per-capita emission levels than developed countries.'[48]

The heart of the matter is that emission caps – like aid commitments – cannot be imposed; they can only be agreed upon. In democratic states, that requires an endorsement by the majority of the people, and even in less-democratic states, authoritarian rulers may find it difficult to adopt caps if that would lead to energy price hikes, for example. Inevitably, the majority of the people will have to agree and individuals will make a rough cost-benefit analysis from their own perspective. If they believe that the benefits of rapid but polluting growth exceed the costs of climate change, they will oppose caps. Conversely, if they view the cost of polluting growth as too high, they will push their government to adopt caps.

This problem is adequately captured by the 'three dimensions of sustainability' – environmental, social and economic sustainability – as expressed in paragraph 3 of the outcome document of the United Nations Conference on Sustainable Development in Rio de Janeiro in June 2012 (known as 'Rio + 20').[49] The idea is that environmental sustainability requires social and economic sustainability: social orders that are accepted by most if not all members and that are based on stable economic activity are required for environmental sustainability.

Thus social sustainability is becoming an international common concern, or an element of one of the most obvious global public goods: a planet that does not warm up too much. As soon as that becomes more widely understood, we can expect to see discussions addressing common-choice arrangements for global social sustainability, including health. One approach that states can take to address health and its determinants as a shared common concern is suggested by Kickbusch, who argues that for the post-2015 and SDG negotiations health should not be presented as a 'sectoral, functional and technical area but as an overarching fundamental goal which is a cornerstone of sustainable development in the 21st century'.[50]

It seems unlikely that the international community will embark on a full-fledged global social sustainability programme in the near future. But we expect that it will move in that direction gradually. For example, a recent European Commission communication on 'Ending poverty and giving the world a sustainable future' states:

> *The EU should promote a comprehensive and integrated approach to the means of implementation including financing issues at the global level. At present, financing discussions related to climate, biodiversity, development and sustainable development are taking place in different fora, even though the potential financing sources are the same. There is a strong need to ensure coherence and coordination and avoid a duplication of efforts with regard to the financing for development process.*[51]

It therefore seems plausible that we will soon witness combined or multi-dimensional negotiations, where aid for health, education and other social issues will fall under the social sustainability heading, and where donors will seek common-choice arrangements out of necessity. At that point, the creation of a Global Fund for Health may become more plausible than it is at present. However, if the arguments of global health advocates like Kickbusch can persuade states and key institutional actors such as the WHO to engage beyond the health sector there may be more cause for optimism.

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47 Ibid., p. 19.

48 Ibid.

49 United Nations General Assembly (2012), *The Future We Want*, http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/476/10/PDF/N1147610.pdf.

50 Kickbusch, I. (2013), 'A Game Change in Global Health: The Best is Yet to Come', *Public Health Reviews*, 35(1), p. 10.

51 European Commission (2013), *Ending Poverty and Giving the World a Sustainable Future*, p. 14, http://ec.europa.eu/europeaid/documents/2013-02-22_communication_a_decent_life_for_all_post_2015_en.pdf.

In a recent survey of the future of global health, Kickbusch argues that for health to gain strength in the global public domain it needs both to link strategically with other transnational agendas and to strengthen its political ability to produce global public goods for health.[52] She stresses the importance of actors such as the WHO supporting states to develop the capacity to practise 'smart sovereignty' and act collectively as a counterweight to largely unaccountable actors such as transnational corporations. Such an approach would both require and allow for a multilateral focus on creating global public good for health underpinned by strong international organizations and governments with the political will and power to engage beyond the health sector and with non-state actors. She identifies the emerging new development paradigm and the post-2015 debates at the United Nations as opportunities for advancing a broader global health agenda. This new development paradigm is characterized by two main streams: 'international solidarity through "global issue networks" to help the poorest and actions to tackle GPG such as climate change, conflict resolution and public health'.[53] This analysis suggests a Global Fund for Health is not so distant.

52 Kickbusch, 'A Game Change in Global Health'.

53 Ibid. p. 7.

APPENDIX: A GLOBAL FUND FOR HEALTH IN FIGURES

To estimate the effect of a Global Fund for Health in line with the parameters that have been developed in other papers of Working Group 2 on Sustainable Financing for Health – namely that all countries should aim for a level of government health expenditure from domestic resources (GHE-D) equivalent to 5% of GDP,[54] and that high-income countries should provide development assistance for health equivalent to 0.1% of GDP[55] – we developed a spreadsheet that is based on the IMF World Economic Outlook dataset of April 2013.[56]

The spreadsheet allows the user to set different targets for GHE-D for low-income countries and for high-income countries, then it automatically applies a sliding scale for GHE-D in middle-income countries. In the example presented here, both were set at 5% of GDP.

The spreadsheet allows the user to set different costs of basic universal health coverage – assuming that because of differences in salaries of health workers, the cost will depend on the average GDP. In the example presented here, the cost was set at $80 per capita per year (pcpa).

Finally, the spreadsheet also allows the user to set different thresholds and targets for country contributions: a fixed (and low) contribution for countries below the lower threshold, a progressive scale of contributions between the lower and the higher threshold and, again, a fixed contribution above the higher threshold. The example presented here sets the lower threshold at a GDP pcpa of $12,499 and the higher threshold at $12,500, meaning that only high-income countries are expected to contribute.

With these parameters, about 50 countries are 'entitled' to receive DAH. Ghana, with a GDP pcpa at $1,532 is on the tipping point; countries with a higher GDP would not or no longer receive DAH.

Table A1: Government health expenditure from domestic sources (GHE-D)

Country name	GDP pcpa, current prices, in US$	Cost pcpa of UHC, in US$	GHE-D, in % of GDP	GHE-D pcpa, in US$	DAH required, pcpa, in US$	Population, in millions	DAH required per year, in US$ millions
Afghanistan	622	80	5.00	31	49	32	1,566
Albania	3,913	80	5.00	196	0	3	0
Algeria	5,694	80	5.00	285	0	36	0
Angola	5,873	80	5.00	294	0	20	0
Antigua and Barbuda	13,429	80	5.00	671	0	0	0
Argentina	11,576	80	5.00	579	0	41	0
Armenia	2,991	80	5.00	150	0	3	0
Australia	67,723	80	5.00	3,386	0	23	0
Austria	47,083	80	5.00	2,354	0	8	0
Azerbaijan	7,450	80	5.00	373	0	9	0
The Bahamas	22,833	80	5.00	1,142	0	0	0
Bahrain	23,477	80	5.00	1,174	0	1	0
Bangladesh	818	80	5.00	41	39	150	5,867

54 McIntyre, D. and Meheus, F. (2014), *Fiscal Space for Domestic Funding of Health and Other Social Services* (Chatham House).

55 Ottersen et al., *Development Assistance for Health.*

56 International Monetary Fund (2013), *World Economic Outlook*, http://www.imf.org/external/pubs/ft/weo/2013/01/.

Country name	GDP pcpa, current prices, in US$	Cost pcpa of UHC, in US$	GHE-D, in % of GDP	GHE-D pcpa, in US$	DAH required, pcpa, in US$	Population, in millions	DAH required per year, in US$ millions
Barbados	16,152	80	5.00	808	0	0	0
Belarus	6,739	80	5.00	337	0	9	0
Belgium	43,686	80	5.00	2,184	0	11	0
Belize	4,536	80	5.00	227	0	0	0
Benin	794	80	5.00	40	40	9	377
Bhutan	2,954	80	5.00	148	0	1	0
Bolivia	2,532	80	5.00	127	0	11	0
Bosnia and Herzegovina	4,461	80	5.00	223	0	4	0
Botswana	9,398	80	5.00	470	0	2	0
Brazil	12,079	80	5.00	604	0	198	0
Brunei Darussalam	41,703	80	5.00	2,085	0	0	0
Bulgaria	7,033	80	5.00	352	0	7	0
Burkina Faso	603	80	5.00	30	50	17	865
Burundi	282	80	5.00	14	66	9	578
Cambodia	934	80	5.00	47	33	15	508
Cameroon	1,165	80	5.00	58	22	21	466
Canada	52,232	80	5.00	2,612	0	35	0
Cape Verde	3,604	80	5.00	180	0	1	0
Central African Republic	447	80	5.00	22	58	5	280
Chad	1,006	80	5.00	50	30	11	319
Chile	15,410	80	5.00	771	0	17	0
China	6,076	80	5.00	304	0	1,354	0
Colombia	7,855	80	5.00	393	0	47	0
Comoros	865	80	5.00	43	37	1	25
Democratic Republic of the Congo	237	80	5.00	12	68	75	5,095
Republic of Congo	3,346	80	5.00	167	0	4	0
Costa Rica	9,673	80	5.00	484	0	5	0
Côte d'Ivoire	1,054	80	5.00	53	27	23	638
Croatia	12,972	80	5.00	649	0	4	0
Cyprus	26,389	80	5.00	1,319	0	1	0
Czech Republic	18,579	80	5.00	929	0	11	0
Denmark	56,202	80	5.00	2,810	0	6	0
Djibouti	1,523	80	5.00	76	4	1	3
Dominica	7,022	80	5.00	351	0	0	0
Dominican Republic	5,763	80	5.00	288	0	10	0
Ecuador	5,311	80	5.00	266	0	15	0
Egypt	3,112	80	5.00	156	0	83	0
El Salvador	3,823	80	5.00	191	0	6	0
Equatorial Guinea	23,133	80	5.00	1,157	0	1	0
Eritrea	546	80	5.00	27	53	6	298
Estonia	16,320	80	5.00	816	0	1	0
Ethiopia	483	80	5.00	24	56	87	4,846
Fiji	4,445	80	5.00	222	0	1	0
Finland	46,098	80	5.00	2,305	0	5	0

Country name	GDP pcpa, current prices, in US$	Cost pcpa of UHC, in US$	GHE-D, in % of GDP	GHE-D pcpa, in US$	DAH required, pcpa, in US$	Population, in millions	DAH required per year, in US$ millions
France	41,141	80	5.00	2,057	0	63	0
Gabon	11,929	80	5.00	596	0	2	0
The Gambia	503	80	5.00	25	55	2	100
Georgia	3,543	80	5.00	177	0	4	0
Germany	41,513	80	5.00	2,076	0	82	0
Ghana	1,562	80	5.00	78	2	25	47
Greece	22,055	80	5.00	1,103	0	11	0
Grenada	7,496	80	5.00	375	0	0	0
Guatemala	3,302	80	5.00	165	0	15	0
Guinea	519	80	5.00	26	54	11	587
Guinea-Bissau	551	80	5.00	28	52	2	83
Guyana	3,596	80	5.00	180	0	1	0
Haiti	759	80	5.00	38	42	10	438
Honduras	2,242	80	5.00	112	0	8	0
Hong Kong SAR	36,667	80	5.00	1,833	0	7	0
Hungary	12,736	80	5.00	637	0	10	0
Iceland	41,739	80	5.00	2,087	0	0	0
India	1,492	80	5.00	75	5	1,223	6,612
Indonesia	3,592	80	5.00	180	0	244	0
Islamic Republic of Iran	7,211	80	5.00	361	0	76	0
Iraq	6,305	80	5.00	315	0	34	0
Ireland	45,888	80	5.00	2,294	0	5	0
Israel	31,296	80	5.00	1,565	0	8	0
Italy	33,115	80	5.00	1,656	0	61	0
Jamaica	5,541	80	5.00	277	0	3	0
Japan	46,736	80	5.00	2,337	0	128	0
Jordan	4,879	80	5.00	244	0	6	0
Kazakhstan	11,773	80	5.00	589	0	17	0
Kenya	977	80	5.00	49	31	42	1,312
Kiribati	1,646	80	5.00	82	0	0	0
Korea	23,113	80	5.00	1,156	0	50	0
Kuwait	45,824	80	5.00	2,291	0	4	0
Kyrgyz Republic	1,158	80	5.00	58	22	6	123
Lao PDR	1,446	80	5.00	72	8	6	49
Latvia	13,900	80	5.00	695	0	2	0
Lebanon	10,311	80	5.00	516	0	4	0
Lesotho	1,283	80	5.00	64	16	2	30
Liberia	436	80	5.00	22	58	4	231
Libya	12,778	80	5.00	639	0	6	0
Lithuania	14,018	80	5.00	701	0	3	0
Luxembourg	107,206	80	5.00	5,360	0	1	0
FYR Macedonia	4,683	80	5.00	234	0	2	0
Madagascar	451	80	5.00	23	57	22	1,287
Malawi	253	80	5.00	13	67	17	1,120
Malaysia	10,304	80	5.00	515	0	29	0

Country name	GDP pcpa, current prices, in US$	Cost pcpa of UHC, in US$	GHE-D, in % of GDP	GHE-D pcpa, in US$	DAH required, pcpa, in US$	Population, in millions	DAH required per year, in US$ millions
Maldives	6,675	80	5.00	334	0	0	0
Mali	631	80	5.00	32	48	16	792
Malta	20,852	80	5.00	1,043	0	0	0
Marshall Islands	3,340	80	5.00	167	0	0	0
Mauritania	1,157	80	5.00	58	22	4	80
Mauritius	8,850	80	5.00	443	0	1	0
Mexico	10,247	80	5.00	512	0	115	0
Micronesia	3,185	80	5.00	159	0	0	0
Moldova	2,037	80	5.00	102	0	4	0
Mongolia	3,627	80	5.00	181	0	3	0
Montenegro	6,882	80	5.00	344	0	1	0
Morocco	2,999	80	5.00	150	0	33	0
Mozambique	650	80	5.00	33	47	22	1,067
Myanmar	835	80	5.00	42	38	64	2,437
Namibia	5,705	80	5.00	285	0	2	0
Nepal	626	80	5.00	31	49	31	1,510
Netherlands	46,142	80	5.00	2,307	0	17	0
New Zealand	38,222	80	5.00	1,911	0	4	0
Nicaragua	1,757	80	5.00	88	0	6	0
Niger	408	80	5.00	20	60	16	959
Nigeria	1,631	80	5.00	82	0	165	0
Norway	99,462	80	5.00	4,973	0	5	0
Oman	24,765	80	5.00	1,238	0	3	0
Pakistan	1,296	80	5.00	65	15	179	2,719
Panama	9,919	80	5.00	496	0	4	0
Papua New Guinea	2,313	80	5.00	116	0	7	0
Paraguay	3,903	80	5.00	195	0	7	0
Peru	6,530	80	5.00	327	0	30	0
Philippines	2,614	80	5.00	131	0	96	0
Poland	12,538	80	5.00	627	0	39	0
Portugal	20,179	80	5.00	1,009	0	11	0
Qatar	99,731	80	5.00	4,987	0	2	0
Romania	7,935	80	5.00	397	0	21	0
Russia	14,247	80	5.00	712	0	142	0
Rwanda	693	80	5.00	35	45	10	473
Samoa	3,727	80	5.00	186	0	0	0
São Tomé and Príncipe	1,535	80	5.00	77	3	0	1
Saudi Arabia	25,085	80	5.00	1,254	0	29	0
Senegal	1,057	80	5.00	53	27	13	356
Serbia	4,943	80	5.00	247	0	8	0
Seychelles	11,226	80	5.00	561	0	0	0
Sierra Leone	613	80	5.00	31	49	6	304
Singapore	51,162	80	5.00	2,558	0	5	0
Slovak Republic	16,899	80	5.00	845	0	5	0
Slovenia	22,193	80	5.00	1,110	0	2	0

Country name	GDP pcpa, current prices, in US$	Cost pcpa of UHC, in US$	GHE-D, in % of GDP	GHE-D pcpa, in US$	DAH required, pcpa, in US$	Population, in millions	DAH required per year, in US$ millions
Solomon Islands	1,786	80	5.00	89	0	1	0
South Africa	7,507	80	5.00	375	0	51	0
South Sudan	1,175	80	5.00	59	21	10	221
Spain	29,289	80	5.00	1,464	0	46	0
Sri Lanka	2,873	80	5.00	144	0	21	0
St Kitts and Nevis	12,804	80	5.00	640	0	0	0
St Lucia	7,276	80	5.00	364	0	0	0
St Vincent and the Grenadines	6,489	80	5.00	324	0	0	0
Sudan	1,789	80	5.00	89	0	34	0
Suriname	8,686	80	5.00	434	0	1	0
Swaziland	3,475	80	5.00	174	0	1	0
Sweden	55,158	80	5.00	2,758	0	10	0
Switzerland	79,033	80	5.00	3,952	0	8	0
Taiwan Province of China	20,328	80	5.00	1,016	0	23	0
Tajikistan	953	80	5.00	48	32	8	258
Tanzania	599	80	5.00	30	50	47	2,359
Thailand	5,678	80	5.00	284	0	64	0
Democratic Republic of Timor-Leste	3,730	80	5.00	187	0	1	0
Togo	585	80	5.00	29	51	6	320
Tonga	4,561	80	5.00	228	0	0	0
Trinidad and Tobago	19,018	80	5.00	951	0	1	0
Tunisia	4,232	80	5.00	212	0	11	0
Turkey	10,609	80	5.00	530	0	75	0
Turkmenistan	5,999	80	5.00	300	0	6	0
Tuvalu	3,260	80	5.00	163	0	0	0
Uganda	589	80	5.00	29	51	36	1,802
Ukraine	3,877	80	5.00	194	0	45	0
United Arab Emirates	64,840	80	5.00	3,242	0	6	0
United Kingdom	38,589	80	5.00	1,929	0	63	0
United States	49,922	80	5.00	2,496	0	314	0
Uruguay	14,614	80	5.00	731	0	3	0
Uzbekistan	1,737	80	5.00	87	0	29	0
Vanuatu	3,125	80	5.00	156	0	0	0
Venezuela	12,956	80	5.00	648	0	30	0
Vietnam	1,528	80	5.00	76	4	90	327
Yemen	1,377	80	5.00	69	11	26	289
Zambia	1,474	80	5.00	74	6	14	88
Zimbabwe	756	80	5.00	38	42	13	548
Total						**6,941**	**50,660**

Table A2: Development Assistance for Health

Country name	GDP pcpa, in US$	Reference contribution, in % of GDP	Population	Reference contribution, in US$ millions	Adjustment to international transfers required for UHC	Contribution pcpa, in US$	Contribution, as % of GDP
Afghanistan	622	0.000	32	0	0	0	0.000
Albania	3,913	0.000	3	0	0	0	0.000
Algeria	5,694	0.000	36	0	0	0	0.000
Angola	5,873	0.000	20	0	0	0	0.000
Antigua and Barbuda	13,429	0.700	0	8	1	14	0.102
Argentina	11,576	0.000	41	0	0	0	0.000
Armenia	2,991	0.000	3	0	0	0	0.000
Australia	67,723	0.700	23	10,792	1,575	69	0.102
Austria	47,083	0.700	8	2,790	407	48	0.102
Azerbaijan	7,450	0.000	9	0	0	0	0.000
The Bahamas	22,833	0.700	0	56	8	23	0.102
Bahrain	23,477	0.700	1	189	28	24	0.102
Bangladesh	818	0.000	150	0	0	0	0.000
Barbados	16,152	0.700	0	31	5	17	0.102
Belarus	6,739	0.000	9	0	0	0	0.000
Belgium	43,686	0.700	11	3,393	495	45	0.102
Belize	4,536	0.000	0	0	0	0	0.000
Benin	794	0.000	9	0	0	0	0.000
Bhutan	2,954	0.000	1	0	0	0	0.000
Bolivia	2,532	0.000	11	0	0	0	0.000
Bosnia and Herzegovina	4,461	0.000	4	0	0	0	0.000
Botswana	9,398	0.000	2	0	0	0	0.000
Brazil	12,079	0.000	198	0	0	0	0.000
Brunei Darussalam	41,703	0.700	0	116	17	43	0.102
Bulgaria	7,033	0.000	7	0	0	0	0.000
Burkina Faso	603	0.000	17	0	0	0	0.000
Burundi	282	0.000	9	0	0	0	0.000
Cambodia	934	0.000	15	0	0	0	0.000
Cameroon	1,165	0.000	21	0	0	0	0.000
Canada	52,232	0.700	35	12,734	1,859	53	0.102
Cape Verde	3,604	0.000	1	0	0	0	0.000
Central African Republic	447	0.000	5	0	0	0	0.000
Chad	1,006	0.000	11	0	0	0	0.000
Chile	15,410	0.700	17	1,877	274	16	0.102
China	6,076	0.000	1,354	0	0	0	0.000
Colombia	7,855	0.000	47	0	0	0	0.000
Comoros	865	0.000	1	0	0	0	0.000

Country name	GDP pcpa, in US$	Reference contribution, in % of GDP	Population	Reference contribution, in US$ millions	Adjustment to international transfers required for UHC	Contribution pcpa, in US$	Contribution, as % of GDP
Democratic Republic of the Congo	237	0.000	75	0	0	0	0.000
Republic of Congo	3,346	0.000	4	0	0	0	0.000
Costa Rica	9,673	0.000	5	0	0	0	0.000
Côte d'Ivoire	1,054	0.000	23	0	0	0	0.000
Croatia	12,972	0.700	4	400	58	13	0.102
Cyprus	26,389	0.700	1	161	24	27	0.102
Czech Republic	18,579	0.700	11	1,372	200	19	0.102
Denmark	56,202	0.700	6	2,196	320	57	0.102
Djibouti	1,523	0.000	1	0	0	0	0.000
Dominica	7,022	0.000	0	0	0	0	0.000
Dominican Republic	5,763	0.000	10	0	0	0	0.000
Ecuador	5,311	0.000	15	0	0	0	0.000
Egypt	3,112	0.000	83	0	0	0	0.000
El Salvador	3,823	0.000	6	0	0	0	0.000
Equatorial Guinea	23,133	0.700	1	120	18	24	0.102
Eritrea	546	0.000	6	0	0	0	0.000
Estonia	16,320	0.700	1	153	22	17	0.102
Ethiopia	483	0.000	87	0	0	0	0.000
Fiji	4,445	0.000	1	0	0	0	0.000
Finland	46,098	0.700	5	1,751	256	47	0.102
France	41,141	0.700	63	18,261	2,665	42	0.102
Gabon	11,929	0.000	2	0	0	0	0.000
The Gambia	503	0.000	2	0	0	0	0.000
Georgia	3,543	0.000	4	0	0	0	0.000
Germany	41,513	0.700	82	23,804	3,475	42	0.102
Ghana	1,562	0.000	25	0	0	0	0.000
Greece	22,055	0.700	11	1,744	255	23	0.102
Grenada	7,496	0.000	0	0	0	0	0.000
Guatemala	3,302	0.000	15	0	0	0	0.000
Guinea	519	0.000	11	0	0	0	0.000
Guinea-Bissau	551	0.000	2	0	0	0	0.000
Guyana	3,596	0.000	1	0	0	0	0.000
Haiti	759	0.000	10	0	0	0	0.000
Honduras	2,242	0.000	8	0	0	0	0.000
Hong Kong SAR	36,667	0.700	7	1,841	269	37	0.102
Hungary	12,736	0.700	10	888	130	13	0.102
Iceland	41,739	0.700	0	96	14	43	0.102
India	1,492	0.000	1,223	0	0	0	0.000
Indonesia	3,592	0.000	244	0	0	0	0.000

Country name	GDP pcpa, in US$	Reference contribution, in % of GDP	Population	Reference contribution, in US$ millions	Adjustment to international transfers required for UHC	Contribution pcpa, in US$	Contribution, as % of GDP
Islamic Republic of Iran	7,211	0.000	76	0	0	0	0.000
Iraq	6,305	0.000	34	0	0	0	0.000
Ireland	45,888	0.700	5	1,473	215	47	0.102
Israel	31,296	0.700	8	1,686	246	32	0.102
Italy	33,115	0.700	61	14,099	2,058	34	0.102
Jamaica	5,541	0.000	3	0	0	0	0.000
Japan	46,736	0.700	128	41,748	6,094	48	0.102
Jordan	4,879	0.000	6	0	0	0	0.000
Kazakhstan	11,773	0.000	17	0	0	0	0.000
Kenya	977	0.000	42	0	0	0	0.000
Kiribati	1,646	0.000	0	0	0	0	0.000
Korea	23,113	0.700	50	8,091	1,181	24	0.102
Kuwait	45,824	0.700	4	1,214	177	47	0.102
Kyrgyz Republic	1,158	0.000	6	0	0	0	0.000
Lao PDR	1,446	0.000	6	0	0	0	0.000
Latvia	13,900	0.700	2	199	29	14	0.102
Lebanon	10,311	0.000	4	0	0	0	0.000
Lesotho	1,283	0.000	2	0	0	0	0.000
Liberia	436	0.000	4	0	0	0	0.000
Libya	12,778	0.700	6	573	84	13	0.102
Lithuania	14,018	0.700	3	295	43	14	0.102
Luxembourg	107,206	0.700	1	397	58	110	0.102
FYR Macedonia	4,683	0.000	2	0	0	0	0.000
Madagascar	451	0.000	22	0	0	0	0.000
Malawi	253	0.000	17	0	0	0	0.000
Malaysia	10,304	0.000	29	0	0	0	0.000
Maldives	6,675	0.000	0	0	0	0	0.000
Mali	631	0.000	16	0	0	0	0.000
Malta	20,852	0.700	0	61	9	21	0.102
Marshall Islands	3,340	0.000	0	0	0	0	0.000
Mauritania	1,157	0.000	4	0	0	0	0.000
Mauritius	8,850	0.000	1	0	0	0	0.000
Mexico	10,247	0.000	115	0	0	0	0.000
Micronesia	3,185	0.000	0	0	0	0	0.000
Moldova	2,037	0.000	4	0	0	0	0.000
Mongolia	3,627	0.000	3	0	0	0	0.000
Montenegro	6,882	0.000	1	0	0	0	0.000
Morocco	2,999	0.000	33	0	0	0	0.000
Mozambique	650	0.000	22	0	0	0	0.000
Myanmar	835	0.000	64	0	0	0	0.000
Namibia	5,705	0.000	2	0	0	0	0.000

Country name	GDP pcpa, in US$	Reference contribution, in % of GDP	Population	Reference contribution, in US$ millions	Adjustment to international transfers required for UHC	Contribution pcpa, in US$	Contribution, as % of GDP
Nepal	626	0.000	31	0	0	0	0.000
Netherlands	46,142	0.700	17	5,412	790	47	0.102
New Zealand	38,222	0.700	4	1,188	173	39	0.102
Nicaragua	1,757	0.000	6	0	0	0	0.000
Niger	408	0.000	16	0	0	0	0.000
Nigeria	1,631	0.000	165	0	0	0	0.000
Norway	99,462	0.700	5	3,508	512	102	0.102
Oman	24,765	0.700	3	535	78	25	0.102
Pakistan	1,296	0.000	179	0	0	0	0.000
Panama	9,919	0.000	4	0	0	0	0.000
Papua New Guinea	2,313	0.000	7	0	0	0	0.000
Paraguay	3,903	0.000	7	0	0	0	0.000
Peru	6,530	0.000	30	0	0	0	0.000
Philippines	2,614	0.000	96	0	0	0	0.000
Poland	12,538	0.700	39	3,414	498	13	0.102
Portugal	20,179	0.700	11	1,489	217	21	0.102
Qatar	99,731	0.700	2	1,284	187	102	0.102
Romania	7,935	0.000	21	0	0	0	0.000
Russia	14,247	0.700	142	14,154	2,066	15	0.102
Rwanda	693	0.000	10	0	0	0	0.000
Samoa	3,727	0.000	0	0	0	0	0.000
São Tomé and Príncipe	1,535	0.000	0	0	0	0	0.000
Saudi Arabia	25,085	0.700	29	5,091	743	26	0.102
Senegal	1,057	0.000	13	0	0	0	0.000
Serbia	4,943	0.000	8	0	0	0	0.000
Seychelles	11,226	0.000	0	0	0	0	0.000
Sierra Leone	613	0.000	6	0	0	0	0.000
Singapore	51,162	0.700	5	1,936	283	52	0.102
Slovak Republic	16,899	0.700	5	643	94	17	0.102
Slovenia	22,193	0.700	2	319	47	23	0.102
Solomon Islands	1,786	0.000	1	0	0	0	0.000
South Africa	7,507	0.000	51	0	0	0	0.000
South Sudan	1,175	0.000	10	0	0	0	0.000
Spain	29,289	0.700	46	9,464	1,381	30	0.102
Sri Lanka	2,873	0.000	21	0	0	0	0.000
St Kitts and Nevis	12,804	0.700	0	5	1	13	0.102
St Lucia	7,276	0.000	0	0	0	0	0.000
St Vincent and the Grenadines	6,489	0.000	0	0	0	0	0.000
Sudan	1,789	0.000	34	0	0	0	0.000
Suriname	8,686	0.000	1	0	0	0	0.000

Country name	GDP pcpa, in US$	Reference contribution, in % of GDP	Population	Reference contribution, in US$ millions	Adjustment to international transfers required for UHC	Contribution pcpa, in US$	Contribution, as % of GDP
Swaziland	3,475	0.000	1	0	0	0	0.000
Sweden	55,158	0.700	10	3,683	538	56	0.102
Switzerland	79,033	0.700	8	4,427	646	81	0.102
Taiwan Province of China	20,328	0.700	23	3,318	484	21	0.102
Tajikistan	953	0.000	8	0	0	0	0.000
Tanzania	599	0.000	47	0	0	0	0.000
Thailand	5,678	0.000	64	0	0	0	0.000
Democratic Republic of Timor-Leste	3,730	0.000	1	0	0	0	0.000
Togo	585	0.000	6	0	0	0	0.000
Tonga	4,561	0.000	0	0	0	0	0.000
Trinidad and Tobago	19,018	0.700	1	177	26	19	0.102
Tunisia	4,232	0.000	11	0	0	0	0.000
Turkey	10,609	0.000	75	0	0	0	0.000
Turkmenistan	5,999	0.000	6	0	0	0	0.000
Tuvalu	3,260	0.000	0	0	0	0	0.000
Uganda	589	0.000	36	0	0	0	0.000
Ukraine	3,877	0.000	45	0	0	0	0.000
United Arab Emirates	64,840	0.700	6	2,513	367	66	0.102
United Kingdom	38,589	0.700	63	17,084	2,494	39	0.102
United States	49,922	0.700	314	109,793	16,026	51	0.102
Uruguay	14,614	0.700	3	346	50	15	0.102
Uzbekistan	1,737	0.000	29	0	0	0	0.000
Vanuatu	3,125	0.000	0	0	0	0	0.000
Venezuela	12,956	0.700	30	2,677	391	13	0.102
Vietnam	1,528	0.000	90	0	0	0	0.000
Yemen	1,377	0.000	26	0	0	0	0.000
Zambia	1,474	0.000	14	0	0	0	0.000
Zimbabwe	756	0.000	13	0	0	0	0.000
Total			**6,941**	**347,070**	**50,660**		

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An earlier version of this paper was written as a background paper for the Chatham House Working Group on Financing. It is part of a Chatham House publication series relating to the the Centre on Global Health Security Working Groups. The first two Working Groups address issues of governance and financing, and the third set addresses antimicrobial resistance.

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