

BMGF Position Paper on Pandemic Preparedness and Response Financing Ecosystem

1. The financing need

The world's experience with COVID-19 has reinforced the criticality of a new, intensified approach to investing in health security at the global, regional, and country levels which has significant benefits not only for health but also for economic stability and broader security. Across the complex Global Health Security (GHS) ecosystem, there are three categories of challenges for pandemic preparedness and response that need to be addressed through more and better financing alongside other global health needs:

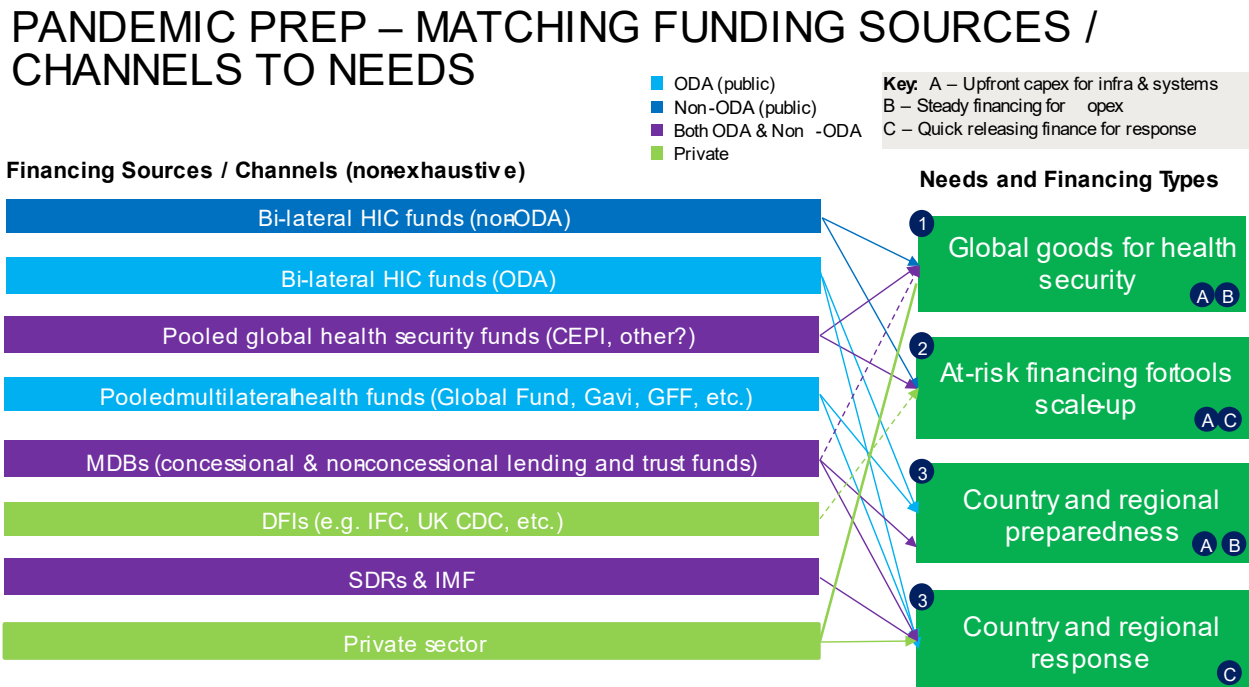
1. **Global goods** with significant health security spillover effects such as R&D for products and platforms, a globally coordinated rapid pandemic response force, and integrated surveillance, zoonotic monitoring, etc.
2. **At-risk" financing for scaling up development and manufacturing and reserving production capacity for medical countermeasures**, not just for high-income countries but for the world. This entails pre-positioned financing that can be deployed during a crisis for producing vaccines and other medical countermeasures even before they are proven effective, at a level of risk that the private sector alone can't absorb. It also includes some "at-risk" financing during non-pandemic times to build up globally networked, distributed capacity that is resilient to nationalistic needs and can be repurposed to target specific viruses during a pandemic.
3. **Regional and country-level preparedness and response needs** with clear benefits at the national level but whose positive externalities for health security are often undervalued. These investments include national public health institutes (NPHIs) and regional coordinating agencies, national health security infrastructure including emergency operations centers, ongoing operational costs, workforce strengthening, delivery infrastructure, surveillance, diagnostic and laboratory capabilities, and rapid emergency response—all of which will require significant external multilateral financing via MDBs and existing global health funds for LICs/LMICs. This category can be further sub-divided into (a) preparedness investments and (b) crisis response.

Among these three categories of financing needs, three different *types* of financing are required to support preparation vs. response gaps. Preparation generally requires two categories of financing flows: a) upfront capital investments for systems and infrastructure (addressing needs 1, 2, 3); and b) long, steady financing for on-going operations (addressing needs 1 and 3). Meanwhile, effective response requires a third category of flow: c) rapidly scalable surge financing, ideally ex ante pooled, that can meet emergency needs (addressing needs 2 and 3). This is shown in Figure 1.

Funding these needs will require not only a step change increase in resources, but also more targeted and effective use of existing resources for health systems, including for "dual use" investments supporting existing health infrastructure and infectious disease responses that offer benefits during pandemics and incentives to invest during non-pandemic times. **Most costs for global goods with non-excludable health security benefits should be borne from high-income country budgets and non-ODA country contributions in tandem with private sector investment in innovation. Aid cannot be the main funding source for global investments as it is defined by spending with primary benefits in LIC and LMIC countries.**

At-risk, non-ODA funding of at least \$20-30 billion for global response should be prepositioned to fund development, manufacturing, and capacity reservations for medical countermeasures prior to completion of clinical trials and product authorization. Meanwhile, ODA spending on country-led preparedness in LICs and LMICs will also need to increase alongside domestic spending, but this should not be at the expense of existing ODA for other critical needs, especially as developing countries face painful recovery from the economic impacts of COVID-19 and tough tradeoffs in how they spend their budgets. Some of this burden can also be relieved by reforming the current multilateral health financing ecosystem to be more effective and efficient, with an emphasis on investments that improve system resilience.

Figure 1 – Categories of Investment Needs and Associated Sources



4. Overall coordination, governance, and oversight

The current global health security ecosystem suffers from a lack of top-level, whole-of-government buy-in along with insufficient independent accountability and oversight of performance. From a financing perspective, there is a need for underlying institutions to operate in a more integrated manner as a synthetic “global balance sheet” for preparedness and response, supported by an effective governance mechanism. **To this end, we support establishing an entity like the Global Health Threats Board (GHTB) proposed by the G-20 High-Level Independent Panel¹, which would play a key policy and commitment-setting, monitoring, coordination, prioritization, investment case development, and accountability role**—though not direct collection or allocation of funds per se (see below). Such a body should include representation at the ministerial level from across sectors (health, finance, etc.) and from LICs, MICs, and HICs, along with an advisory role for representatives from key multilateral implementing and financing

¹This is the High-Level Independent Panel for Financing the Global Commons for Pandemic Preparedness and Response established under the auspices of the G-20 Italian Presidency

institutions to inform effective policy. The specific roles, responsibilities, and membership of the GHSB or equivalent entity could be set out in a charter or similar founding document. (Note that the Independent Panel for Pandemic Preparedness and Response has proposed a similar “Global Health Threats Council” with some variations, which could offer an additional construct to consider.)

Below, we set out some key considerations that should inform the functions and set-up of such a body, including problems to address in the existing ecosystem and potential risks to mitigate.

Figure 2 – Considerations for GHS governance body

Issue or Consideration to Address	Potential Design Implication
Pandemic preparedness and response landscape is complex; no single entity can finance or implement all the needs.	The new GHS body can help to develop comprehensive vision for pandemic preparedness and response and aligned “investment case” that articulates and costs the key needs in the ecosystem and facilitates prioritization.
Existing implementing institutions already have established fundraising and replenishment processes; avoid duplication and unhealthy competition for limited resources if possible.	If the GHS body has a broad mandate for direct fundraising and allocating resources to underlying institutions, the risk is high that it may cannibalize and compete with existing fundraising for other health institutions and challenges. We recommend instead focusing the group on governance functions, while defining specific financing gaps that current institutions don’t address (for example, “at-risk” capital for scale-up of pandemic tools). Any new financing mechanisms should be designed to target those gaps and could still be “housed” in existing institutions wherever feasible.
Need to “expand the pie” of current resources for pandemic prep and response while articulating a compelling vision for those resources	The GHS body can help to galvanize overall resource mobilization by articulating a clear “investment case” and overarching vision for evolution of the pandemic prep and response ecosystem. The GHS body can also track and monitor financing and spending commitments and provide an additional lever to highlight and push on financing gaps.
Resource allocation decisions should be informed by appropriate scientific and health expertise and objective data, not just political considerations.	The GHS body’s priority-setting and performance tracking function could help guide resource allocation needs based on objective criteria; however, giving the body direct, centralized control over resource allocation to underlying institutions may subject the process to a different set of political considerations.
Strong independent monitoring is needed to identify risks and ensure accountability for system performance and spending	The proposed GHS body should still be supplemented by a truly independent, multisectoral, non-political, body (like a reformed GPMB) that can enhance the technical monitoring functions and provide additional accountability.

In addition to global governance, there is also need for stronger coordination across financing and implementing institutions at a country and regional level. For this, a **mechanism like the existing Global Health Financing Accelerator**, which brings together the WB and most relevant multilateral health institutions including the Global Fund, GAVI, GFF, and the WHO for coordination around health financing in priority countries could have an expanded remit for pandemic preparedness and response. The existing accelerator could also be linked more closely to the proposed global governance entity.

5. A proposed financing ecosystem

An effective GHS financing ecosystem should support the three categories of needs described above, channeled through the appropriate mechanisms and institutions. Figure 3 shows one potential view of an enhanced ecosystem, with the specific improvements needed for existing institutions to get there.

For **1) global goods and 2) at-risk financing, the funding should come primarily from high-income country budgets, either directly or via pooled funds** (given global nature of investments and high need for coordination) alongside private sector investment in product innovation. An example of a global pooled fund that could help meet this need is CEPI, which can aggregate and coordinate funding for R&D on vaccines for emerging infectious diseases, with a focus on equity and neglected threats in developing countries that the public and private sectors might not otherwise cover. Examples of high-income country institutions that can directly support this need are BARDA and the new EU HERA, which focus on national health security but should also incorporate a greater focus on equitable global access given the interconnected nature of pandemic threats. Another example of a priority global need without a clear funding source is an enhanced, multidisciplinary cadre of pandemic responders that is coordinated at the global level and can be embedded at the regional or national level and flexibly deployed to respond to pandemics and other health emergencies. Such a program could also be funded with HIC contributions via a coordinating entity like the WHO. Private sector funding should also play a key role in R&D and take on more risk where feasible, with public capital filling gaps where market failures and positive externalities from health security result in underinvestment by the private sector.

For **3) regional and country-level preparedness and response, funding should be highly integrated with existing health systems financing to be sustainable**, and thus external funding (in addition to domestic spending) should flow through existing multilateral health financing institutions and multilateral development banks to the extent possible. Multilateral development banks (MDBs) can play an important role in this regard due to the size of their balance sheets and ability to leverage funding from the market, but they may need a stronger mandate and more technical capacity in pandemic preparedness, along with more fit-for-purpose instruments that can combine loans with grant buy-downs and other incentives and fund regional institutions more effectively. **With additional reforms, MDBs could potentially finance “true” global goods for health security like R&D or global surveillance, but there needs to be a stronger political push for them to do so (potentially from the proposed GHTB) as they are currently focused on country lending.** Multilateral health funds, on the other hand, have more expertise and proven impact in funding pandemic prevention and response (e.g. malaria, polio, vaccine delivery) and broader health system infrastructure. They also provide important mechanisms for grant support to the low income and fragile states with the least ability to pay and lowest incentives to prioritize pandemic preparedness from loan-based support. At the same time, they are “dollar in dollar out” institutions and cannot leverage their balance sheets via the market or financially hedge risks. Looking at the comparative strengths and weaknesses of each category of institution, there are clear opportunities for MDBs and multilateral health funds to work more closely together. A key area for any improved global health security financing strategy should be identifying opportunities for MDBs and multilateral health funds to leverage each other’s

resources. Bilateral funding, including targeted aid for developing country needs, can supplement multilateral system funding.

For 3b) regional and country-level response in particular, MDBs and the IMF are well positioned to provide ex-ante, prepositioned funding that releases automatically or semi-automatically based on specified triggers for pandemic response. These triggers could be staggered, with some funding releasing based on “early warning” signals and additional funding releasing upon full realization of a crisis. It is important not to tie all funding to lagging indicators like declaration of a Public Health Emergency of International Concern, as this could lead to delayed response. This funding should include grant or grant-like funds for targeted uses (e.g. securing medical countermeasures) along with general balance of payments support. Existing constraints for disbursement and use of MDB funds for procurement should be reviewed and addressed (including with an eye to lessons learned during COVID-19) so that funding is more fit-for-purpose.

Given the existing complexities and fragmentation across the global health system, our goal should be to meet the three categories of need above via an ecosystem that maximizes resources and coordination while minimizing additional layers and fragmentation. This means **more effectively leveraging the existing architecture and improving the mandate, funding, and instruments for financing preparedness and response within these institutions.** For MDBs, this requires shareholders to hold institutions accountable to specific policy commitments on pandemic preparedness and response. It may also require injection of concessional funds (for example via trust funds or concessional windows) to improve incentives for countries to incorporate pandemic preparedness into their health sector borrowing or expanding carveouts to fund regional health security goods (e.g. regional surveillance) alongside country-level preparedness. Additionally, MDBs need to develop a holistic strategy and operating model to incorporate health systems resilience as part of their core health systems lending. For response, it requires MDBs and the IMF to expand their envelopes of flexible, quick releasing ex ante financing that respond to a combination of automatic and discretionary “early warning” triggers during a crisis. For existing multilateral health funds like the Global Fund and Gavi, it requires clarifying accountabilities and identifying “dual use” investments (e.g. strengthened community health workers, diagnostic networks, laboratory systems, and digitization of health information systems, and real-time surveillance) that would benefit their existing mandates as well as build pandemic preparedness and response systems.

In addition to improving and increasing funding for current institutions, there may still be a need to pool and earmark funding specifically for health security and pandemic preparedness and response. However, **establishing a broadly scoped, “dollar in / dollar out” fund that simply layers “above” existing institutions and requires regular country contributions risks duplicating and cannibalizing existing funding.** Instead of starting from the premise of needing a new financing mechanism or institution, we would advocate for being as specific as possible regarding the functions that the current ecosystem isn’t positioned to effectively finance. An example of a specific gap is a pooled mechanism for ex ante “at risk” funding that can accelerate pre-approval development, manufacturing, and purchase commitments during a pandemic. Addressing a specific need like this enables us to propose a more targeted financing mechanisms, which could potentially be appended to an existing institution.

Figure 3 - Potential Pandemic Preparedness and Response Financing Ecosystem

Category	Proposed Institutions			What's Missing?
<p>0. Overall governance, coordination</p>	<p>WHO</p> <ul style="list-style-type: none"> • Role: Normative, policy, and technical guidance, with stronger capabilities and political independence. • Ask: Full & flexible financing through increased assessed contributions; 	<p>Global Health Threats Board or similar global governance body</p> <ul style="list-style-type: none"> • Role: Help set vision, policy, define commitments, coordinate holistic health security investment case, assess risks, and monitor progress against financial and performance targets • Ask: G-20 and G-7 countries and/or potentially UNGA provide mandate to establish such a body 	<p>GPMB or similar independent, non-political monitoring entity</p> <ul style="list-style-type: none"> • Role: Even with a new governance entity like a GHTB, there is still a role for an independent, non-political monitoring function to increase accountability in the system • Ask: Examine options for establishing the GPMB as a permanent, independent monitoring body 	<p>Current governance and oversight institutions do not have permanent mandate. Still need non-political, independent accountability alongside a new governance mechanism.</p>
<p>1. Global Public Goods (GPGs)</p>		<p>CEPI</p> <ul style="list-style-type: none"> • Role: Mandate for Vx and targeted mAbs R&D and some manufacturing (complementary to HIC institutions and with a lean toward LMIC needs). • Ask: Fully fund CEPI \$3.5B investment case. 	<p>Bi-lateral / HIC funding</p> <ul style="list-style-type: none"> • Role: Funding for GPGs like upstream R&D; surveillance; and globally coordinated pandemic response force (e.g. via US CDC) • Ask: Increased funding for global health R&D via HIC research institutes. Greater focus on global equitable access from entities like HERA & BARDA. Better coordinated funding for global-level response infrastructure including an enhanced global pandemic response force 	<p>Lack of pooled global financing for true global health security goods like R&D beyond vaccines and global surveillance. Possible solutions: (i) enhanced role of MDBs on global health security goods, or (ii) new, targeted fund (could be part of existing institution) for pooling non-ODA funding?</p>
<p>2. At-Risk Financing</p>	<p>World Bank</p> <ul style="list-style-type: none"> • Role: Potential to use IDA Private Sector Window and blended financed capabilities to de-risk manufacturing. IFC to play a greater role via blended finance capabilities. 		<p>CEPI</p> <ul style="list-style-type: none"> • Role: From a technical capability standpoint, best positioned entity to deploy / allocate “at-risk” financing for Vx manufacturing scale up and dose reservation (both functions which logically sit mid-stream with CEPI and not 	<p>Sufficient pre-positioned at-risk financing for R&D, manufacturing, and purchase commitments that can be flexibly deployed during a crisis, not just beforehand.</p>

	<ul style="list-style-type: none"> • Ask: Reconcile Private Sector Window eligibility criteria and IFC blended finance capabilities with “at-risk” investment needs for pandemic manufacturing 		<p>downstream with procurement), but these needs not included in current \$3.5 billion investment case</p> <ul style="list-style-type: none"> • Ask: Option for countries to mandate and fund CEPI to deploy “at-risk” funding for global (not just HIC) needs 	<p>Unclear how this should be raised and who should hold it – CEPI?</p>	
<p>3a. Country and Regional (Preparedness)</p>	<p>World Bank</p> <ul style="list-style-type: none"> • Role: Stronger mandate, technical capacity, and financial instruments to support lending for preparedness • Ask: Increased incentives or carveout in IDA; integration of health systems resilience into core IDA health funding via a clear strategy; expanded IDA regional window with incentives for regional health security investments 	<p>Regional Dev. Banks</p> <ul style="list-style-type: none"> • Role: Specific mandate for PPR to work more closely with regional / national entities (e.g. Africa CDC, and NPHIs) • Ask: New trust funds or carve outs; new strategies on investing in health systems resilience 	<p>Global Health Funds</p> <p>Global Fund</p> <ul style="list-style-type: none"> • Role: System-level investments w/ dual benefits for PPR & HTM (e.g. surveillance, labs, workforce, delivery infra) • Ask: Additional funding & evolved allocation model <p>Gavi</p> <ul style="list-style-type: none"> • Role: Potential to expand on current, pathogen-targeted efforts on surveillance and stockpiling building on COVAX and core mission • Ask: TBD, funding for stockpiles and some HSS investments? <p>Other</p> <ul style="list-style-type: none"> • Role: Potential role for other global health funds – for example, surveillance and other assets funded by GPEI for polio could have value for broader ecosystem • Ask: Fund GPEI and identify “dual use” applicability of polio assets 	<p>Regional and country preparedness needs additional funding along with comprehensive package of incentives for developing countries to invest towards preparedness in an integrated way</p>	
<p>3b. Country and Regional (Response)</p>	<p>WB/RDBs</p> <ul style="list-style-type: none"> • Role: Can provide flexible, quick release surge financing for targeted use and more general balance of payments support • Ask: 	<p>IMF</p> <ul style="list-style-type: none"> • Role: Can be ‘additional line of defense’ in emergency response. Could add a pandemic response window to supplement 	<p>Global Health Funds</p> <ul style="list-style-type: none"> • Role: Global Fund and Gavi – standing capability for emergency pandemic tools procurement and/or stockpiles (e.g. for Vx, Tx, Dx, 	<p>Regional Procurement and UN Platforms</p> <ul style="list-style-type: none"> • Role: Regional & UN platforms like PAHO, UNICEF, and AMSP will may continue to play a key role in access to countermeasures. Global entities 	<p>Need post-mortem on MDB response in this crisis to understand how emergency lending capabilities can be improved to allow quicker release of funding. Need to identify the strengths and weaknesses of the global health funds response and the associated technical</p>

	<ul style="list-style-type: none"> • Expand IDA Crisis Response Window w/ more dynamic triggers • WB establish standing MPA for emergency response • Add emergency response windows in RDBs • Enhance procurement financing capabilities to enable pre-financing of pandemic tools during a crisis 	<p>current emergency balance of payment relief capabilities</p> <ul style="list-style-type: none"> • Ask: Reserve SDRs to back surge lending 	<p>PPE, oxygen, and basics)</p> <ul style="list-style-type: none"> • Ask: Ring-fenced financing and/or access to pre-positioned surge funding in emergencies 	<p>should develop a clearer vision for how they coordinate and work with each other and alongside regional platforms.</p>	<p>partner support to countries to build stronger capabilities.</p>
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6. Sources of financing

It is important to remember that the primary source of funding for GHS will be country budgets, whether used domestically or transferred as aid, credits, debt relief, or other forms of financing from higher income countries to lower income ones. Even borrowing from MDBs/IFIs, which leverages institutional balance sheets and capital markets to frontload financing, still requires countries to pay back loans. So, effectively funding pandemic preparedness and response requires better ways to raise, pool, allocate, transfer, and leverage public funding. Given the scale and array of needs, ODA alone – while critical – will not be sufficient. Contribution mechanisms that can go beyond strained aid budgets to tap other budget lines, particularly for global goods, may also be needed. Equitable burden-sharing should be based on country means and capacity. High-income and some middle-income countries should be able to fund investments for their own domestic health security from their own budgets, but LIC and LMIC, countries will require support from external resources, especially grants, while investments with truly global benefits will require contributions from countries proportional to their means.

Besides bi-lateral contributions, IFIs/MDBs (which may require replenishment of concessional windows, recapitalization, and balance sheet optimization), additional potential sources of GHS financing include global taxes which hypothecate funding specifically for health security, debt relief and restructuring, and a new SDR allocation. **These same sources are also needed to finance COVID-19 tools, in the near-term and overall economic recovery, so incentivizing countries to “bundle” and include preparedness investments within broader recovery packages will be important.**

Beyond public resources, private sector investment has an important role and should share more risk in areas like accelerating product innovation and scaling up manufacturing, given commercial incentives. Public sector funding should complement private sector investment, rather than crowd it out. Philanthropic financing can fill in the gaps where commercial incentives aren't sufficient, particularly to meet the needs of neglected disease areas and geographies. New

Principles for Financing

For “money in”

- Where possible, move towards **regular, predictable contributions** rather than ad hoc
- Contributions should be **means-based** as all countries benefit from improved global health security, and countries that can afford it should contribute more
- Fundraising for GHS and pandemic prep and response **should minimize competition** with replenishment processes of existing global health institutions
- While it is not realistic that all funding for pandemic preparedness and response be “net new”, **it should not crowd out other health needs** and could also come from more efficient use of existing funds (e.g., via dual-purpose investments)

For “money out”

- Preparedness funding should be predictably and sustainably disbursed, while crisis response funding **should be pooled and positioned in advance**
- Scarce ODA should only be used for investments that primarily benefit LICs and LMICs, while investments that benefit the world as a whole or primarily HICs or UMICs **should be funded from non-ODA budgets** and private sector
- Financing channels and instruments should be **aligned to investment needs and recipient characteristics** in terms of timing, risk tolerance, returnable vs. grant, concessionality, level of aggregation, etc.
- Funding for regional and country-level preparedness and response **should not be excessively “verticalized” and should utilize linkages with other health system needs**; at the same time, resilience and preparedness spending should still be tracked as a distinct category.
- Funding allocation should account for **developed and developing country perspectives** and should be informed by **technical expertise**, not just political processes

public-private partnership models can be explored for accelerating innovation and manufacturing for future epidemics and pandemics. For example, stakeholders are partnering to develop proposals for coordinated, regionally distributed “ever warm” manufacturing capacity built on modular, platform-agnostic manufacturing technologies, which could potentially utilize a mix of public and private investment.

While some innovative proposals for funding global health security at scale (e.g. “recycling” SDRs or taxing sectors with disease-related externalities like livestock) have promise, they are still at an early stage and require dedicated champions in forums like the G20 and G7 to carry forward. Moreover, it is important to note that mechanisms such as SDRs still entail a repayment from countries, which means that donor grants would be still needed to buy down interest for the poorest countries. Moreover, using reallocated SDRs to back IMF support for pandemic preparedness or response in the longer-term will require establishing a mechanism that can utilize reserve SDRs.

Figure 4 – Priority Funding Sources and Channels

Funding Source	Description	Potential Channels	Political / Technical Feasibility	Impact & Fit for Purpose	Estimated \$ Volume
ODA (Official Development Assistance) and non-ODA grants from country budgets	Based on IHME data ² , ~\$374 M of ODA (<1% of development assistance for health) went directly to pandemic preparedness in 2019; another \$7.6 Bn went to investments in infectious diseases and health systems that may have some impact on pandemic / epidemic preparedness. Need to assess how much additional ODA for PPR could be mobilized without cannibalizing other needs. On non-ODA, need to develop viable value propositions and contribution mechanisms to tap non-aid budgets like security and R&D; of the existing global health funds, only CEPI has been successful in tapping non-ODA funding so could be lessons learned there. Opportunities to increase efficiency of existing spend, e.g. integrate preparedness with health systems spend.	Existing global health funds / pooled mechanisms adapted to fund specific PPR needs (e.g. Global Fund, Gavi, CEPI)	High	Medium/High	US \$8-12 Bn per year ³
		IFI concessional windows including MDBs (particularly IDA)	High	Medium/High	
		MDB trust funds, possible role for an adapted GFF-like mechanism?	High	Medium	
		Bi-lateral / Direct (ODA + Non-ODA)	Medium	Medium	
		WHO, UNICEF / Other?	Medium	TBD	
Non-ODA public lending	In addition to concessional windows, MDBs and IFIs can also provide non-concessional lending for pandemic preparedness.	MDBs (e.g. WB and RDBs) non-concessional lending	High	Medium	IBRD - \$12 Bn ⁴ , others TBD
		IMF – long term role for IMF in PPR beyond general BoP support still TBD, but currently being discussed at senior levels; IMF not currently fit to pool \$ for GPGs	Medium	Low/Medium	
Special drawing rights	Supplementary official reserves issued by the IMF that countries can exchange for hard currency. Need to develop appropriate	Most realistic reallocation proposals would flow through IMF; PPR may be a stretch for SDRs in short term given other	Low/Medium	Medium/High	US\$10-\$25 Bn low int. debt ⁵

² <https://www.thinkglobalhealth.org/article/funding-pandemic-preparedness-global-public-good>

³ Range based on stable spending on pandemic prep, health systems, and infectious diseases from 2019 (\$ 8 Bn) up to 50% increase.

⁴ Based on 10% of potential available head room in IBRD lending capacity, as estimated by the Overseas Development Institute: Chris Humphrey, Prizzon A, “Scaling up multilateral bank finance for the Covid-19 recovery,” ODI insights, Nov 2020.

⁵ Based on 5% of potential total amount mobilized, calculated between US\$200 billion and US\$500 billion. See Kharas, Homi, Dooley M. “Sustainable development finance proposals for the global COVID-19 response,” Working paper #141, Global Economy and Development, Brookings Institution 2020.

	reallocation mechanisms for increased share for LMICs.	priorities, but unused SDRs could provide backing for spare capacity / reserve funding for longer term preparedness or response potentially via a specific window in the IMF.			
Taxation (innovative proposals)	These include proposals currently being advanced at the OECD for a cross-border digital tax and global alternative minimum tax that could add some fiscal space in developing countries, as well as designing taxes that could specifically address externalities around PPR. One such idea is a livestock tax which would target the externalities associated with transmission of zoonotic disease via livestock. Another idea is a regional tax on a trading block aligned with a regional spending / governance mechanism (e.g. AFTCA/AU) with a dedicated levy that could fund regional public health entities (e.g. AfCDC).	Channel depends on design of tax. A more general tax like those being proposed at the OECD may just add to overall country fiscal space. However, it is possible to design a specific tax targeting health security with funds hypothecated for public health uses.	Low/Medium	Medium/High	US\$5-US\$10 Bn per year ⁶
Philanthropy	Mechanism to pool philanthropic, corporate, and private sector contributions to health security. Could be modeled after other pooled philanthropic funds like Co-Impact, or based on a donor-matching model like the Gavi Matching Fund.	Pooled or matching fund for private / philanthropic contributions	Medium	Medium	TBD
Private Sector (additional leverage)	Potential to stimulate additional private sector investment in public health R&D via well-targeted incentives, co-financing of distributed manufacturing, and levies / fees for maintaining GPGs they benefit from like surveillance.	Channel depends on design of private sector leverage mechanism	Medium	TBD	TBD

⁶ Based on 10% of US\$100 billion in additional resources that could be potentially generated by reaching a consensus on global digital taxation (2020), Tax Challenges Arising from Digitalization – Economic Impact Assessment: Inclusive Framework on BEPS, OECD/G20 Base Erosion and Profit Shifting Project, OECD Publishing, Paris, <https://doi.org/10.1787/0e3cc2d4-en>

7. Aligning incentives and country buy-in

Financing alone is not sufficient; a critical element for the success of pandemic preparedness and response is for countries to internalize and manage the risk of health threats the way they do economic or security threats, as they are closely linked. **This will require drawing out the investment incentives from a self-interest standpoint while simultaneously capitalizing on the brief political opportunity for collective action.**

In the past, developing countries failed to invest in pandemic preparedness even when concessional funding was available for various reasons, including lack of political or economic incentives, unclear value (“invisible” investments where success is defined by the absence of a crisis), lack of technical capacity, or clarity on “what good looks like.” **A holistic solution doesn’t just provide financing but also addresses these other causes of underinvestment.** Countries may need a broad package of incentives including grant subsidies and matching funds to incentivize borrowing and domestic spending, technical assistance to structure investments, and instruments that tie financing to performance on preparedness indicators.

Additionally, driving efficiencies and incentives to invest requires maximizing synergies with other global health needs. Many of the investments for endemic infectious diseases – including multi-disease surveillance assets, lab networks, febrile illness detection, supply chain and delivery infrastructure for medical countermeasures, personnel deployment systems, and emergency operations centers – are also needed for pandemic preparedness and response. **Such “dual use investments” that increase critical pandemic response capacity but also save lives during non-pandemic times can provide additional incentives for improved preparedness driven by mortality reduction and elimination targets for “visible” health issues.**

Even though it has pressing ramifications for both developed and developing countries, “global health security” risks being seen only as a rich country priority unless developing countries and regional entities are at the table to help define the policy and investment agenda. **Developing countries should be adequately represented within the global governance mechanism, and should receive clear benefits for contributing towards global health security goods** (e.g., support for tech transfers to build out regionalized manufacturing, R&D for products that are designed for low-resource settings, support for stockpiling medical countermeasures via regional platforms like AMSP and PAHO, etc.)