Commentary

Why Do Societies Ever Produce Common Goods for Health?

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The world, and we human beings who live in it, would be better off if we were to invest more resources and attention in producing common goods for health (CGH), such as anti-pollution and safety regulations, epidemiological surveillance that facilitates rapid response to infectious outbreaks, and taxes levied on harmful products like carbon emissions and tobacco. The logical reasons and the highly favorable benefit-cost ratios that should compel countries to allocate more public resources for such things are laid out clearly in the articles in this special issue of *Health Systems & Reform*.

The papers also explain why logic and evidence are not adequate to convince people and their leaders to dedicate sufficient resources and attention to CGH. As the papers show, before societies will fund CGH, they need to solve a range of collective action problems. The papers argue that societies underinvest in CGH for behavioral reasons, such as underestimating risk and short-term thinking; as well as economic reasons, such as externalities and free-riding (which create incentives for people to act without regard to the full social costs and benefits of their decisions).

With all of these factors conspiring against the production of CGH, it is a wonder that they are produced at all. In this commentary, I argue that we need to be clear-eyed about the history and motivations that led societies to invest in the CGH that we take for granted today. Studying the past may help us identify the political strategies that could create, expand and sustain CGH in the future.

So why do societies ever produce CGH? The answer is essentially historical and political, not conceptual and technical. Bump and colleagues address the proximate political factors that explain public investments in CGH. In addition to those insights, I contend that historical analysis demonstrates that broader political factors related to collective identity and power are fundamental, with significant implications for the strategies required to realize investments in CGH. In particular, I argue that investing in CGH requires that:
people come to see themselves as part of a collective identity with reciprocal obligations, typically defined by geographic area. History shows how people have adopted new forms of identity beyond individuals and families to include whole tribes, villages, provinces and even nations. These broader identities make it possible to mobilize action at the scales required by CGH.

the problems that can be resolved by CGH become salient and identifiable as part of individual or collective interests. Attacks by brigands or a neighboring country’s army mobilize investments in collective defense; major flooding may serve as a spur to investing in dikes and levees.

people with social power and resources come to believe that CGH are in their own or their class’s best interests. For example, elites typically believed that educating the masses was costly, wasteful and even threatening until the 19th century when literacy and a common language came to be seen as essential to building powerful nations and economies.

Most cases of collective good provision before the 1950s were explicitly motivated by reasons quite unrelated to the arguments we hear today. Public education was initially promulgated as a way to build nation-states; public health initiatives began as a way to protect and facilitate trade. Elites interested in building strong armies, preempting popular mobilization, repressing colonial populations, and making exploitation and profiteering possible were usually the main source of initiatives and funding to address collective goods when it was in their interest. Private philanthropies and popular movements sometimes played roles only in particular instances.

Consider, for example, the provision of sanitation services in large cities. Today, it seems inconceivable to doubt the legitimacy of public financing and planning for systems to dispose of human waste. Yet only two centuries ago, that was not the case. For millennia, urban households typically disposed of human waste by directing it into a public street or contracting someone to remove it (without concern for where it was dumped).5

While this might resolve a household’s immediate problem, it still suffered from exposure to infectious diseases and odors created by its neighbors. While addressing one’s own sanitation produces some positive externalities, the broader collective disposal of human waste represents a classic “public good” in the sense that once it has been put in place, the benefits of clean air and water are non-rival and non-excludable in consumption. Sanitation has some features of a private good which assist in creating systems to build and finance the required systems (e.g., the ability to enforce sanitation fees or penalize households that do not connect to the system). But based on individual action alone, no major city would have the kind of comprehensive planning, investment, maintenance and financial sustainability that are required.

In European cities of the 19th century, cholera was a common and frightening occurrence. Even before the germ theory of disease was established, people responded to it in sensible ways. The urban rich initially sought to segregate themselves from “pestilent” areas of the city—inhabited by the lower classes. In the earliest wastewater systems, wealthier households paid subscriptions for companies to build pipes that would direct waste away from their homes and into rivers, lakes or oceans.6 Once the upper- and middle-class areas were served by such systems, the marginal cost of connecting the poor was substantially reduced. At that point, elites came to value the universal provision of sanitation and saw to its adoption as a government responsibility financed through taxes and fees for which contributions and participation could be enforced. In some cases, the motivation was altruistic—but only once elites saw themselves as part of a collective urban community. In most cases, the motivation was self-serving and focused on assuring a hygienic environment.7

In this and other cases, collective identity, salience, and elite views of their interests converged, eventually leading countries to the notion that assuring adequate sanitation is a legitimate area for public action. First, a variety of actions by powerful actors and opinion leaders expanded people’s identities beyond household, clan or tribe to city or nation, creating a notion of “collective” which could be referenced and thereby legitimate collective action. Second, the problem (in this case, disease and odors) became salient as urban areas grew densely populated and as the solution of sanitation systems entered public discourse as a feasible and desirable goal. Finally, elites came to see provision of sanitation as part of their interest in financing a safe and respectable city, especially once the costs of making it universal had become manageable.

The logical and empirical arguments for providing collective goods will be convincing to economists and technocrats. They may even be convincing to autocrats. But CGH advocates, schooled in a liberal-utilitarian framework, often come to their task with a mythos about a benevolent state which can be pressed into the service of a common good. Considering past experiences shows instead that the provision of many CGH arose out of conflict, interests, the growing salience of particular health threats, and the emergence of social identities, not just the development of technical solutions and scientific knowledge. This means that the work of the public health policy
community would benefit if it had greater familiarity with these historical perspectives and promoted relevant historical research so as to develop more effective strategies for CGH.

It also shows that the provision of collective goods in most societies—and particularly at the global level—will require efforts that align with the political factors that drive social action as demonstrated by history, some of which are illuminated by the case studies in Bump et al. In the case of advocating for CGH, the papers in this issue provide strong logical and empirical grounding which will be persuasive in some circles. But we will also need political strategies to:

- Construct or exploit notions of collective identity in order to convince societies that those affected by health threats are fully-enfranchised members of their community. This can be difficult when the immediate threats are concentrated among immigrants or in foreign countries. Working to expand the notion that everyone is an entitled citizen of a shared world is important and initiatives promoting this view require greater support from all quarters. Innovative people might look for alternatives, for example, inquiring whether it would be possible to construct new collectivities defined by social media or mobilize funding from mega-corporations.

- Generate evidence that raises the salience of health problems that need to be solved collectively or the costs of inaction. For this purpose, it is not necessary to exaggerate the potential threats from, say, a virulent flu strain or antibiotic resistant bacteria. Though it is necessary to find ways to communicate and persist in communicating what we know about those risks and the future costs to society of inaction today.

- Find ways to convince elites that it is in their interest to be taxed so as to pay for CGH. For example, today’s military leaders are keenly aware that infectious disease, anti-microbial resistance, and climate change all generate major security risks. Financial corporations are increasingly aware that past models of corporate risk are inadequately incorporating unprecedented threats posed by climate change and the inability of public infrastructure to meet the challenges of major population movements and security failures. What would it take to mobilize these powerful groups to lobby their own governments to support domestic and international efforts by providing adequate funding and attention to CGH?

All of these strategies are challenging and by their nature require action by many actors—not just governments, politicians, or international agencies but also civil society groups and private enterprise. In today’s political climate—with influential groups opposing immigration, international cooperation, and diplomatic resolution of conflict—it is all the more difficult to see how a sense of collective purpose can be strengthened enough to mobilize the required action on CGH. The U.S. government’s efforts to suppress national security arguments for taking action on climate change show just how difficult this can be. But the collective investments that we enjoy today were also started in troubled times. In fact, the historical record demonstrates that persuasion and logic have only been part of the solution; rather, social movements, trends among elites, and even political slogans played key roles in mobilizing the necessary resources and action.

This historical perspective on the political dynamics of CGH complements the technical analysis which should, with its logical basis, be sufficient to move governments and elites to action. But studying and learning from the political history of how collective goods have actually come about may provide a surer path to generating the kind of action we desperately need today.

Notes

[a] Exceptions include ancient civilizations, such as those of the Indus River Valley, Crete, and Rome.

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