

# Seeking a global solution

The Copenhagen Consensus neglects the need to tackle climate change.

**Jeffrey D. Sachs**

To address the global challenges of poverty, climate and disease, it is essential to build effective bridges between the scientific community and policy-makers. These issues are much too complex to leave to the normal give-and-take of interest-group politics. The 2004 Copenhagen Consensus failed to build these bridges in an effective manner, I believe — but others could learn from its flawed approach.

The Copenhagen Consensus was set up by the Danish Environmental Assessment Institute, directed by Bjørn Lomborg, to identify priorities for global action regarding poverty, health, hunger and the environment. With an expert panel consisting of eight prominent economists, including three Nobel laureates, and with the backing of *The Economist* magazine, the project received considerable attention. The panel reviewed 32 proposals and ranked half of them as good or bad investments. The “very good” rating for HIV/AIDS and malaria policies, and the “bad” rating for three proposals to control climate change, generated the most publicity when the results were announced in May.

Unfortunately, the project’s headline conclusions do not withstand close scrutiny, especially the conclusion that climate control is a “bad” global investment. More generally, the conclusions offer little sound guidance to policy-makers, much less a new consensus. On the positive side, the project did help to increase public awareness of important global issues, and has produced several useful background papers.

## Wrong question

The panel that drew up the Copenhagen Consensus was asked to allocate an additional US\$50 billion in spending by wealthy countries, distributed over five years, to address the world’s biggest problems. This was a poor basis for decision-making and for informing the public. By choosing such a low sum — a tiny fraction of global income — the project inherently favoured specific low-cost schemes over bolder, larger projects. It is therefore no surprise that the huge and complex challenge of long-term climate change was ranked last, and that scaling up health services in poor countries was ranked lower than interventions against specific diseases, despite warnings in the background papers that such interventions require broader improvements in health services.

It is worth putting the extra \$50 billion — \$10 billion per year — into context. Annual



Waiting for help: floods in Bangladesh last month left people in Dhaka queuing for relief supplies.

income in the world is currently about \$40 trillion, of which some \$30 trillion is in the high-income (donor) countries. So the project looked at investing a measly 0.03% of annual donor-country income to address the planet’s greatest challenges — hunger, disease, environmental degradation and instability — which are life-and-death issues for a billion or more of the world’s poorest people. The United States alone now spends almost \$450 billion per year on the military, a rise of \$150 billion in the past three years.

The Copenhagen Consensus would be more convincing if it acknowledged what the rich world has already promised. At the International Conference on Financing for Development in March 2002, both rich and poor countries adopted the Monterrey Consensus, which declared: “We urge developed countries that have not done so to make concrete efforts towards the target of 0.7% of GNP as official development assistance.” This figure is currently 0.25% of donor GNP, or about \$69 billion per year. The Monterrey goal would mean spending about \$210 billion per year, an increase of some \$140 billion per year. This is 14 times the sum suggested by the Copenhagen Consensus.

Moreover, the world has already committed to fighting disease, hunger and climate change on a bold and broad scale. The Millennium Development Goals, adopted in September 2000, call for dramatic steps to cut child mortality by two-thirds and the number of people suffering from hunger by half

by the year 2015, compared with a 1990 baseline. The United Nations Framework Convention on Climate Change already commits the world to “stabilization of greenhouse gas concentrations in the atmosphere at a level that would prevent dangerous anthropogenic interference with the climate system”.

With the funds already promised, which can easily be delivered by developed nations, the world would not have had to choose between addressing specific diseases or overall health systems, or between small-scale water projects and long-term climate change. We could do both. The Copenhagen Consensus could then have usefully turned its attention towards how to accomplish those tasks, rather than whether to follow through on commitments already made.

## Wrong participants

Mobilizing expert analysis to inform policy-makers is a good idea. A remarkable example is the Intergovernmental Panel on Climate Change (IPCC), which since 1988 has brought together hundreds of leading climate scientists, economists, engineers and other specialists on the issue of anthropogenic climate change. The IPCC has helped the climate-change community to identify areas of consensus and disagreement, and to improve communication across scientific and other disciplines.

Another example is the Commission on Macroeconomics and Health (CMH) of the World Health Organization in 2000–01,

which I had the honour to chair. That effort brought together more than 100 scientists, policy-makers, economists and practitioners for a two-year study on health in low-income countries.

The Copenhagen Consensus fell far short of the IPCC and CMH as a deliberative process. It failed to mobilize an expert group that could credibly identify and communicate a true consensus of expert knowledge on the range of issues under consideration. The panel included distinguished economists but no natural scientists or public-health specialists. Nine of the ten authors of background papers were also economists, as were almost all of the 20 'opponents' (commentators) on the background papers.

With the exception of Robert Fogel, the panel is mostly known for its expertise outside the areas under discussion. A panel of economists brings an important set of tools to the table, but it cannot accurately assess the social costs and benefits of alternative interventions regarding climate, agriculture, disease, water and nutrition without the input of natural scientists, engineers and public-health practitioners.

The evidence made available to the panel was also extraordinarily narrow: the panel received a single background paper and two short opponent papers for each proposal, often with highly idiosyncratic results. The project's timeline itself was far too short for the panel to gain requisite expertise, lasting only a few months in total; the background papers circulated for a few weeks, and in the final discussions, the panel had 5 days to review 32 proposals.

### Wrong conclusions

Many of the panel's conclusions were at odds with the evidence under consideration, and no rationale was offered to the public. Climate change is a salient case. The background paper, by William Cline of the Center for Global Development in Washington, examined the benefits and costs of several strategies to mitigate climate change. Cline's central strategy — an aggressive global carbon tax — showed a long-term benefit-to-cost ratio of 2:1, according to the simulation model that he used. The opponents called for a more gradual approach, but both endorsed a framework of early action to regulate and limit carbon emissions, with increasing constraints in future decades.

Despite this agreement between the author and the opponents, the panel concluded that a global carbon tax is a "bad" investment. The brief description of the panel's judgement notes that "the experts expressed an interest in an alternative, proposed in one of the opponent papers", in which an initially low carbon tax rises gradually in later years. The panel also "urged increased funding for research into more

affordable carbon-abatement technologies". But these proposals were not ranked as they were not examined in detail. Had there been time to examine these proposals further, the headline conclusion might have been that "the Copenhagen Consensus panel supports a carbon tax".

The proposals regarding health services, disease control and nutrition reveal similar problems. The panel rated interventions aimed at HIV/AIDS and malaria as "very good", but rated as only "fair" a broad scaling-up of basic health services in low-income countries. Similarly, the panel rated as "very good" and "good" two targeted interventions regarding malnutrition — micronutrient supplementation and new agricultural technologies — but ranked as only "fair" two broader and more expensive interventions directed at infant and child nutrition and low-birthweight babies. The bias towards smaller, cheaper, targeted projects is clear, but runs contrary to the experts' advice in the background papers.

The basic-health proposal came from Anne Mills of the London School of Hygiene and Tropical Medicine, who wrote the Copenhagen Consensus background paper on communicable diseases. Her paper stresses the interdependence of the proposals: "both malaria and HIV/AIDS control must include a substantial component of strengthening health services if they are to be successful." Both opponents also stressed the need to strengthen health systems generally if investments on specific diseases are to reach their potential, and discussed ways to organize such spending.

As with climate change, then, the background papers and opponents' comments do not really justify the final ranking. In 2000–2001, Mills co-chaired a task force for the CMH that found a very high benefit-to-cost ratio (roughly 6:1) for a broad-based scaling-up of health services in poor coun-

tries. Her study also found that some 8 million deaths each year could be averted within a decade or so. Here, Mills again finds a high benefit-to-cost ratio (now 3.9:1) for a designated package of health interventions for a group of poor countries.

The Copenhagen Consensus panel's low ranking of the broader health interventions seems to reflect the project's two main methodological flaws: the assumption that additional funding is limited to \$50 billion over five years; and the lack of experience in health issues among panel members, which perhaps made the obstacles to a broad-based scaling-up of health and nutrition services look more daunting than they are.

### Lessons for the future

The core concept of the Copenhagen Consensus is a good one: to engage expert opinion to evaluate policy options on major challenges facing the planet. This approach has been used before and should be adopted again. But the project's methodological failures should not be repeated.

First, future projects should avoid a statement of the policy problem that is likely to bias the results. Second, the expert group should have sufficient time to consider the evidence thoroughly, to consult with external experts, and to consider any proposals that seem to have consensus support. Third, the expert group should cover all relevant disciplines, including several members with long-standing professional experience in each area under examination. Fourth, initial assessments by the expert group should be widely circulated for comments, corrections and feedback before a public report is issued. In this way a true 'consensus' may be reached, and the public won't be left wondering which set of experts to trust. ■

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