Background
The knowledge program on “Financing Common Goods for Health” grew from an April 2018 meeting where WHO convened a group of global experts to discuss the prioritization of investments in core health system functions related to pandemic preparedness, health security, and environmental health, using the Ebola outbreak in West Africa as the impetus. This initial meeting scoped out the boundaries, content, and output for these “common goods for health” (CGH) (i.e. common, largely population-based functions or interventions with large social externalities that require collective financing). Inherent market failures necessitate government intervention to finance CGH.

Building from the Technical Expert Group (TEG) recommendations, WHO has been leading work to develop a series of related papers for a special issue of Health Systems & Reform that will be published to coincide with the September 2019 UN General Assembly on Universal Health Coverage (see Annex 1 for the table of contents of this paper series). The objectives of this paper series are to articulate, provide the technical and economic rationale for, estimate the cost of, and identify sources and modalities of financing for core CGH.

March 2019 Meetings
The second round of meetings of the TEG took place in March 2019 to:

- Agree on clear definition and boundaries of the term “common goods for health”;
- Critically discuss the paper drafts and key messages emerging from overall Health Systems & Reform paper series;
- Set the agenda on how to further operationalize this agenda beyond paper publication and dissemination, including linkages to other work.

Given the cross-cutting nature of this work, the first meeting was held at WHO Headquarters in Geneva, Switzerland on March 19th to bring together WHO departments around a core platform. Representatives from WASH, NCDs, immunizations, AMR, hepatitis, health financing, and emergencies program were present for the half-day discussion (see Annex 2 for the list of participants).

The second meeting was held at Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland on March 26th and 27th with global experts from a range of technical areas that fit within the overall agenda (see Annex 3 for the list of participants).
Key Messages

Definition
It was crucial to agree on a definition for common goods for health (CGH) that is understood and approved by both economists and public health individuals.

**TEG comments:**
- Cost-effectiveness and feasibility can be used as a way to prioritize investments in CGH in specific contexts, but should not be part of the definition.
- CGH are held in common and are a common backbone to the health system, and society more broadly. In this way, they are cross-cutting platforms that do not sit within a specific disease or intervention area. There is a need to remain somewhat open in terms of what is or is not classified as a CGH as the boundary might be more on a scale and less binary.

*Revised Definition:*
CGH are **largely population-based functions or interventions** that require **collective financing**, either from the government or donors based on the following conditions:

1. Have a large **impact on human life** and economic progress;
2. There is a clear economic rationale for interventions based on **market failures**, with focus on (i) **Public Goods** (Non-Rival, Non-Exclusionary) and (ii) **large social externalities**.
3. Are **common to all health programs**

Not all public or common goods are CGH, but all CGH must generate large societal health benefits that cannot be financed through market forces. See table 1 below.

**Table 1. Notable common goods for health by category**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Notable Common Goods for Health</th>
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<tbody>
<tr>
<td>Taxes and Subsidies</td>
<td>- Market signals through health taxes</td>
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<td></td>
<td>- Subsidies to address large market failures (e.g. TB, HIV, vaccinations)</td>
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<tr>
<td>Regulations</td>
<td>- Regulation of the safety of medicines and medical devices</td>
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<td>- Environmental regulations and guidelines (e.g. for water &amp; air quality)</td>
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<td></td>
<td>- Accreditation</td>
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<tr>
<td>Information</td>
<td>- Human and animal disease, environmental, and risk (e.g. AMR, chemicals &amp; radiation) surveillance</td>
</tr>
<tr>
<td></td>
<td>- Communication and Dissemination</td>
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<tr>
<td></td>
<td>- Community Engagement</td>
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<tr>
<td></td>
<td>- Research and evaluation</td>
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<tr>
<td>Policy and Coordination</td>
<td>- Planning and management of emergency response</td>
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<td></td>
<td>- Health security national policies and strategies</td>
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<td></td>
<td>- Disease control policies and strategies</td>
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<tr>
<td></td>
<td>- Urban design</td>
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<tr>
<td>Population Services</td>
<td>- Sewage</td>
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<td></td>
<td>- Vector control</td>
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<td>- Medical waste management</td>
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Below are a summary of key message and areas of feedback from the two March 2019 meetings. Specific points related to each of the seven papers in series can be found as an annex to this report.

Key messages and feedback

- **Who is the audience** for this work? Non-specialists, economists, public health specialists, or analysts trying to support government policy?
- This paper series needs to be **evidence-based and take a neutral stance** (given that it is coming from WHO).
- **CGH needs to be consistently used** throughout the seven papers (both in terminology wording as well as definition).
- There should be **consistency across the seven papers with the tables provided on what constitutes a CGH** (environmental, global, regional, and national).
- The papers tend to focus on negative examples of countries (and failures). They would benefit from **bringing more positive country examples** into the papers.
- **Language should be made accessible** to non-economists (including public health specialists).
- At the moment, there is a general bias towards outbreaks. There is a tendency to focus on extreme events and not on the multitude of things that happen at a lower scale more often everywhere. **Be careful to not always fall back on Ebola or other epidemics.**
- How do you quantify the following: adequate supply of health workers, water and access, clinic access, etc.? **How do you know whether a country adequately financed (or provides) CGH?**
- We need to stress that even though a good or function is not mentioned in the series or in a paper that it does not mean that it is not important or does not need to be financed.
- Very few (if any) papers in the series go into the **political economy of this agenda**. Should this be a focus in any of the papers or added in as a commentary? Political failures are not necessarily irrational because political actors are acting for their next election and not necessarily thinking about the CGH and their future benefits.
- The CGH agenda needs to **sit within the lens of UHC and the SDGs**, especially equity, in that this is step 0. Countries need to start with financing CGH, which will serve as the basis for coverage expansion. They need to ask what they are already spending on and which of those areas they need to focus more attention on.
- It is critical that this paper series **receives input from the Public Health, Environment and Social Determinants of Health (PHE) Department and WASH** to ensure consistency and accuracy of efforts across WHO.
- *See Annex for the detailed key messages and action items for each paper."

Additional Commentary Ideas

- Country case studies on challenges and successes to providing CGH. Possibilities include: Ajay Shah on India, Tolbert Nyenswah on Liberia, Palitha Abeykoon on Sri Lanka, Nigeria
- Environmental health and WASH
• Social determinants of health
• Political economy of CGH

Next Steps
Ideas on how to move the financing CGH agenda forward after the publication of this special issue include:

• **One-page policy briefs** on each of the papers to disseminate after the papers are completed. This will help draw attention to the necessary stakeholders in countries to make action and change related to the CGH.
• Identify **national government champions**.
• **Info-graphics** and **media** contacts within countries for notification.
• Integrated into **public health trainings and curriculum**.
• Situate this within the **SDG3 global action plan**.

Timeline moving forward

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
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<tbody>
<tr>
<td>April 20th, 2019</td>
<td>Drafts of papers go out for peer review</td>
</tr>
<tr>
<td>July 14th, 2019</td>
<td>Half-day pre-congress session at iHEA</td>
</tr>
<tr>
<td>July 28th, 2019</td>
<td>Final submissions of papers to HS&amp;R</td>
</tr>
<tr>
<td>September 24th, 2019</td>
<td>Special issue UNGA launch event – Scandinavia House, New York City</td>
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The most immediate next step is finalizing the drafts for the paper series (full notes on each paper can be found in Annex 4) for peer review in time for the July 28th, 2019 submission deadline to *Health Systems & Reform*. Additionally, the editorial team will work concurrently to approach specific individuals for commentaries to add to this special issue with an emphasis towards gathering more country examples to financing CGH (both successes and challenges).
Annex 1. Table of Contents for *Health Systems & Reform* Special Issue:

Overview: Health in a globalized world: The challenge of the Commons  
*Agnes Soucat and Abdo Yazbeck*

1. When both markets and governments fail  
*Agnes Soucat and Abdo Yazbeck*

2. When markets fail: Common goods for health  
*Peter Smith, Abdo Yazbeck and Sylvestre Gaudin*

3. When governments fail: The challenge of collective action  
*Jesse B. Bump, Sumithra Krishnamurthy Reddiar, and Agnes Soucat*

4. What governments can do  
*David H. Peters, Odd Hanssen, Jose Gutierrez, Chih-Yang Mao, and Tolbert Nyenswah*

5. Financing common goods for health: A country agenda  
*Susan Sparkes, Joseph Kutzin, and Alexandra Earle*

6. Financing global common goods for health: When the world is a country  
*Gavin Yamey, Dean Jamison, Odd Hanssen, and Agnes Soucat*

7. The case for public financing of environmental protection as a common good for health  
*Sylvestre Gaudin, Selina Lo, and Agnes Soucat*

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<thead>
<tr>
<th></th>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>1</td>
<td>Jonathan Abrahams</td>
<td>WHO/CPI</td>
</tr>
<tr>
<td>2</td>
<td>Elina Dale</td>
<td>WHO/HGF</td>
</tr>
<tr>
<td>3</td>
<td>Alexandra Earle</td>
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</tr>
<tr>
<td>4</td>
<td>Mark Goodchild</td>
<td>WHO/PND</td>
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<td>5</td>
<td>Bruce Gordon</td>
<td>WHO/PHE</td>
</tr>
<tr>
<td>6</td>
<td>Yvan Hutin</td>
<td>WHO/HIV</td>
</tr>
<tr>
<td>7</td>
<td>Matthew Jowett</td>
<td>WHO/HGF</td>
</tr>
<tr>
<td>8</td>
<td>Jeremy Lauer</td>
<td>WHO/HGF</td>
</tr>
<tr>
<td>9</td>
<td>Catherine de Martel</td>
<td>Infections and Cancer Epidemiology (ICE) Group</td>
</tr>
<tr>
<td>10</td>
<td>Minal Patel</td>
<td>WHO/EPI</td>
</tr>
<tr>
<td>11</td>
<td>Alex Ross</td>
<td>WHO/HEO</td>
</tr>
<tr>
<td>12</td>
<td>Susan Sparkes</td>
<td>WHO/HGF</td>
</tr>
<tr>
<td>13</td>
<td>Agnes Soucat</td>
<td>WHO/HGF</td>
</tr>
<tr>
<td>14</td>
<td>Elizabeth Tayler</td>
<td>WHO/AMR</td>
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### Annex 3. Baltimore, Maryland Technical Expert Group List of Participants
**26 and 27 March, 2019**

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
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<tbody>
<tr>
<td>1</td>
<td>Jonathan Abrahams</td>
<td>WHO/CPI</td>
</tr>
<tr>
<td>2</td>
<td>Mark Blecher <em>(By video)</em></td>
<td>National Treasury</td>
</tr>
<tr>
<td>3</td>
<td>Michael Borowitz</td>
<td>The Global Fund</td>
</tr>
<tr>
<td>4</td>
<td>Jesse Bump <em>(By video)</em></td>
<td>Harvard T.H. Chan School of Public Health</td>
</tr>
<tr>
<td>5</td>
<td>Carlos Corvalan <em>(By video)</em></td>
<td>University of Sydney</td>
</tr>
<tr>
<td>6</td>
<td>Rachael Crockett <em>(By video)</em></td>
<td>The Wellcome Trust</td>
</tr>
<tr>
<td>7</td>
<td>Antonio Duran</td>
<td>Independent Consultant</td>
</tr>
<tr>
<td>8</td>
<td>Alexandra Earle</td>
<td>WHO/HGF</td>
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<tr>
<td>9</td>
<td>Sylvestre Gaudin <em>(By video)</em></td>
<td>Independent Consultant</td>
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<td>10</td>
<td>Odd Hanssen</td>
<td>Oxford Policy Management Ltd.</td>
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<tr>
<td>11</td>
<td>Outi Kuivasniemi</td>
<td>Ministry of Social Affairs and Health, Finland</td>
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<tr>
<td>12</td>
<td>Sumithra Krishnamurthy Reddiar</td>
<td>Harvard T.H. Chan School of Public Health</td>
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<td>13</td>
<td>Joseph Kutzin</td>
<td>WHO/HGF</td>
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<td>14</td>
<td>Jeremias Paul Jr</td>
<td>WHO/PND</td>
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<tr>
<td>15</td>
<td>David Peters</td>
<td>Johns Hopkins Bloomberg School of Public Health</td>
</tr>
<tr>
<td>16</td>
<td>Michael Reich <em>(By video)</em></td>
<td>Harvard T.H. Chan School of Public Health</td>
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<tr>
<td>17</td>
<td>Ritva Reinikka</td>
<td>The World Bank</td>
</tr>
<tr>
<td>18</td>
<td>William Savedoff</td>
<td>The Center for Global Development</td>
</tr>
<tr>
<td>19</td>
<td>Ajay Shah</td>
<td>National Institute of Public Finance and Policy</td>
</tr>
<tr>
<td>20</td>
<td>Peter Smith</td>
<td>Imperial College</td>
</tr>
<tr>
<td>21</td>
<td>Agnes Soucat</td>
<td>WHO/HGF</td>
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<tr>
<td>22</td>
<td>Susan Sparkes</td>
<td>WHO/HGF</td>
</tr>
<tr>
<td>23</td>
<td>Gavin Yamey</td>
<td>Duke University</td>
</tr>
</tbody>
</table>
Annex 4. Key Discussion Points by Paper (from both TEG meetings)

**PAPER ONE: When both markets and governments fail**

**Steps needed to complete draft of paper:**
- Drop cost effectiveness from criteria/main definition points but incorporate into description as a possible prioritization criterion.
- Make sure language is accessible to non-economists (more specifically public health individuals).
- Bring more of the SDG/UHC agenda in the motivation. This is very Ebola-centric.
- Bring in the cost of inaction section from paper 4 and paper 6.
- Draw more into collective action rather than government failures/soften this language on government failure. How do we get citizens, local governments and other stakeholders to care in CGH?
- Bring in the issue around the timing consistencies on the political side. Political failures are irrational because political actors are acting for their next election and not necessarily thinking about the CGH and their future benefits.

**Discussant key points (Bill Savedoff):**
- Stating CGH need to be re-prioritized implies that there was a golden age of CGH (when there wasn’t).
- Frame this in a way where if the health surveillance system is not financed, XYZ will happen. Talk about the impact. For MoF, say what the catastrophic risk is and why CGH is such a small amount compared to this risk. For MoH, the argument is how can you carve out your budget to start with CGH even with all of the service delivery pressures.
- Government failure might be the wrong framework because it sounds like self-interested bureaucrats not doing what the people want. The fundamental thing is collective action and why, as humans, do we not do this. A better way to think about this is the exercise of power. What governments do and what they are not going to do.
- Why don’t we invest in these CGH and what creates a collective?
- A disease outbreak is not salient in who the interested stakeholders are (compared to something like war). What will it take to make elites believe it is in their interest, and what other interest we can mobilize?

**Key Group Discussion Points:**
- We should drop cost-effectiveness as a key criterion because this will only work in specific settings but not everywhere. Instead, either drop it or put “potentially cost-effective”.
  - Cost-effectiveness can also be thought of as an outcome and less of a criterion since the vast majority are likely to be affordable.
  - Another idea is to separate the definition of CGH and then have a table about what the criteria is to finance these CGH, where cost-effectiveness will come into play.
• Making the case for underinvestment in R&D for epidemic response is not surprising, but what is interesting is how to create collective action.
• What is the difference between the lack of governance and the lack of financing? There was not a lack of funding for Ebola, but it was a lack of public financing that prioritized core functions that could deal with this.
• This is not about inventive financing, it is about governments and global stewardship.
• It is important that this language be made accessible to individuals in the public health field and not just economists. Right now, this language is too high level. Additionally, we need to do a better job educating public health individuals on the difference between common goods and public goods. It isn’t entirely clear yet.
• We need to be talking not just about central governments, but about citizens, local governments, etc. – the important of collective action is vital.
• There is too much criticism on governments, they are doing the best they can. It is not about finding new solutions, but about sustaining what already exists.
• It is not enough to talk about the impact on human life, but touch upon the social and economic impacts as well.

PAPER TWO: When markets fail: Common goods for health

Steps needed to complete draft of paper:
• Purpose of the paper is to use and apply the language of economist related to market failure as a way to bring this language and concept to the field of public health to show that the two disciplines are actually coherent in terms of how they would identifying/prioritize these goods.
• Frame that this paper uses cost-effectiveness as a way to establish a list of CGH, which can lead to prioritization, but is not part of the definition.
• State up front that this is an unabashedly technocratic paper. But, in turn, more attention needs to be paid to translate economic terminology for public health and non-specialist community.
• Make more explicit that the use of cost effectiveness criteria on DCP is a demonstration of CGH framework but is not fundamental to the definition.
• Environmental CGH should be integrated or mentioned in these functions.
• Explain why some public health functions in table 1 are not considered CGH.
• Table 1: This is an economist interpretation of public health functions. It is necessary to go back to public health text to revise this.
• The public goods and externality market failures on page 1 are most relevant for CGH whereas the information and natural monopoly relate more to personal services and insurance markets. This is an interesting point to bring into the discussion.

Discussant key points (Ritva Reinikka):
• Why did you pick up this list? When I look at this, it is consistent with market failures and instruments to deal with them and the merit goods are there. Is the public health community familiar with this list?
• When you say government, do you mean civil servants dealing with health? They want private goods for constituents and political pressure is providing other types of goods.

**Key Group Discussion Points:**
• Need to define target audience and use language that is accessible to non-economists to reach the public health audience.
• Potential to weave in case studies because the narrative is very dry.
• Need to make sure all papers are using CGH and not just common goods.
• This paper puts paper 1 more into perspective on why this has a health sector budget focus.
• The public goods theory followed by the Musgrove decision tree is a good beginning explanation and then the cost-effectiveness and public health is more of an imperfect application of what would be the ideal process. From this, it seems that cost-effectiveness is primary, however, under the Musgrove tree, public goods is primary. Need to make the distinction of which comes first, public goods or cost effectiveness.
• 67 interventions are a lot of interventions. Maybe pick out three distinct ones to show how they look differently (like Ebola and tobacco). If you are going to use Ebola, you are going to need a short description of what happened and what the common understanding of the failures are.
• Explain why some public health functions are not CGH (table 1).
• We want to make sure that these papers aren’t purely normative and that countries can implement these CGH functions. What are the main things you want countries to focus on? Decision tree is ok, but it was a long list.
• It is hard to do cost-effectiveness on surveillance.
• Are we talking about essential public health functions? Because people understand these, but this is not introduced in the first paper and is worth discussing. Fragmentation in aid for Ebola, which shows limited investment in things like CDC is not going to be captured in the interventions in the DCP.
• DCP may not be the right list for this. They are too much at intervention level and not at the broader function level.
• Public health ministries have a small role in these identified approaches. We need to figure out new ways for us to organize our countries. Most that we are discussing today are not what MoH do. We need to bring in disaster management, climate change and health.
• What are conditions where international agencies do a better job at providing these CGH?
• Environmental threat needs to be integrated into these functions.
• The boundary of CGH may be less binary and more on a sliding scale. Draw the line for the policy maker and public finance discussion, but be more flexible with the economic argument.
This paper is an exemplary case study using cost-effectiveness for how this type of framework can be used to establish a list, which can lead to a prioritization exercise.

PAPER THREE: When governments fail: The challenge of collective action

Steps needed to complete draft of paper:
- Need to bring in CGH in this paper.
- Paper is too theoretical and needs more practical grounding, particularly in CGH.
- Possible outline: Dramatically shorten current review of government failures (possible to add a summary table). Then bring in examples from CGH, both failures and successes. Then discuss ways to overcome lack of action in government to finance these.
- Bring in and apply the accountability triangle from WDR 2004.
- Soften or define discussion on government failures. Government failure does not have to be a direct reflection of market failures. See if the terminology needs to be changed. Allow for the spectrum of action.
- Bring in some of the discussion and analysis for CGH from your previous draft in February.

Key Group Discussion Points:
- Title suggestion: What is needed for governments to succeed in the financing of common goods for health?
- Regulatory capture and rent seeking are distinct from other theories on why you create a government and why they aren’t doing what they are supposed to. Rather than trying to group these, maybe just use ones that are applicable to CGH. How does this framework explain why there wasn’t a better response to Ebola etc.?
- Is this paper developing a general theory of government failure? Or is it trying to explain why governments don’t invest in CGH?
- Need to show explicit linkage to problems of CGH and then provide explicit linkage to potential solutions/positive examples.
- Might want to compare it to earlier development of social organizations like religion.
- Government failure labeling
  1. It is not a market failure and the government is intervening in society (government should not have been there)
  2. You failed because you chose the wrong intervention/instrument so you have failure
  3. You mad a market failure and the right tool but failed to implement
  4. The market failure is gone but the cost imposed on society is higher than it should have been.
  5. We have the lowest cost intervention and it delivered the goods
- Health might not be the role of the central government (issues around decentralization).
- There is nothing on corruption and there is not enough on the practical implications.
• Political economy of this is confusing. For years we haven’t had collective action on climate, but now we have it (strikes, young people, etc.). Citizens need to put the pressure on the government to fund these things.

• Some governments are just weak, there is a capacity failure.

• When governments fail, it can either happen quickly or consistently over a long period of time. There are certain corrective things that can be produced to minimize disasters (calling on international agencies).

• Collective action is linked to market failures. You have collective action problems because of externality problems.

• We have indicators like IHR and a lot of countries have done JEEs. Do we need to try to look at what drives performance of IHR and JEE in countries?

• If you have indicators for the various dimensions of preparedness, look at which countries are doing better than other countries that are similar to them.

• We need to bring things down to the community level, like emergency. We are often making the case that we need to develop capacity to implement IHR, but actually, we are building capacity to implement at the local level. We tend to prioritize the global scale over that is happening on the local scale.

• The diagram is good because it describes why things did not happen. Use the variant of the ven-diagram to show why it happened. Frame the what, but then what are the ways that governments went wrong and why.

• If you have a common objective, you will get more action with smaller groups than with large groups. Talk in terms of politics.

• The dynamic will be different depending on the CGH but the group of strategies to build coalitions, to undermine groups and to identify champions should be consistent.

• Bill Savedoff’s tables of: threats, CGH costs, contrary interests, salience, coalitions

• There are other strategies outside of coalition building to change the power position. We need to change perception on this issue and target different vested interests.

• Coalitions can be mobilized for all sorts of things so it is important to keep focus on CGH.

• Proposed structure for the paper: (1) explain why governments aren’t intervening and one might be the collective action problem inherent in these public goods and an explanation on inadequate action, (2) what can be done on this lack of inaction and how do we get at the strategies to address constraints to government action.

• Vaccinations: maybe we have played up the public good argument too much and need to go back to the private good/individual benefits.

**PAPER FOUR: What governments can do**

**Steps needed to complete draft of paper:**

• Move cost of inaction discussion to paper 1 motivation.

• Align CGH for EDRM with overall table and definition and framework for CGH.

• The costing is one step, but this does not reflect the actual provision of delivery. Is the spending reflecting quality?
• Mention back to why this is a government responsibility.
• Bring in the political economy dimension into the discussion of investment in EDRM. How do we make sure the political responsibility is there even though this is an upfront investment with future benefits?
• Need to bring in examples other than Ebola, especially positive ones.
• Shorten the paper and bring in links to UHC.

**Key Discussant points (Jonathan Abrahams):**
• We need to address this fragmentation and have a risk-based approach instead of an event-based approach.
• There are large political, social and economic implications in disasters and pandemics. It is part of the government’s responsibility to protect its population from threats.
• Need to improve what the long-term impacts of different types of emergencies are because the paper underestimates this.
• Need to bring in other examples other than Ebola, especially positive ones.
• Is this something that effects all of society? There are also many types of emergencies like food for example.

**Key Group Discussion Points:**
• The cost is very small compared to annualized risk of future large pandemics. This paper is only on one CGH and it would benefit from drawing lessons for others more broadly.
  o Annualized risk needs to have much better risk modelling and we don’t have time for this.
• Will the cost of response systems reduce all of the other costs of events?
• It would be good to separate the costs of implementing preparedness or cost of CGH from cost of inaction. Using health metric is useful to compare and evaluate without having to put a value on lift lost.
• Have you costed coordination with other sectors?
• With epidemics, the costs rise and then go down and with disasters, it hits hard and high and then goes down.
• This paper needs to overlap with the environmental threats like prevention of climate change.
• Relate this back to why this is a government responsibility.
• A lot of times, the money is already there for countries, but what you don’t talk about is the spending reflecting quality.
• Does the dollar in MIC deliver the same thing as in a LIC?
• How do we know if the reason something isn’t being delivered is because of bad organization or low financing?
• There is an example of micro insurance in Indonesia where the premiums are cheap. Is there a way for countries to share costs?
• Why are CGH important to provide from the economic standpoint? What are the political costs and benefits to providing CGH. The political rational is not favorable. How can you change the political calculous to provide CGH to make it more desirable for
governments of all sorts. What are the right strategies of changing the political CBA so that governments become more enthusiastic to provide these, where the political costs are current and the benefits are in the future.

- We want to make sure we are not only focused on the risk side. There are two sets of CGH: the ability of society to manage risk with routine systems and the other is on those events that exceed capacity of those risks.
- This is the first step in UHC. The financing of activities is not an either or, but a first step.
- Ebola distorts the risk and burden of disease. There is a bias towards outbreaks, but there are other types of emergencies that should be considered like housing standards and land use planning.
- This is not just a central government thing, there needs to be investment from the public and local governments as well.
- One of the reasons that national governments may not spend much on pandemic preparedness is that they are not really spending much on anything. Even at the height of the Ebola crisis, other things were having a greater health impact, and if the focus is on burden of disease, then diarrhea and pneumonia are probably still more important, and less invested in. If you get a really big emergency, then additional external resource is likely to come anyway, so why spend money that you don't have preparing for it.

PAPER FIVE: Financing common goods for health: A country agenda

Steps needed to complete draft of paper:

- We want to make sure we stress that this paper is talking about institutional and not just financial arrangements.
- Might be worth bringing purchasing agency back into the paper.
- Need to make sure to talk about decentralization in a neutral way in that it is more about the organization/decision structural issues that need to be accounted for in this type of governance.
- Bring in health taxes.
- Makes sure we are coherent with the definition.
- Issues around multi-sectoral nature of the goods:
  - What happens to CGH in SHI?
  - Budgeting is a political issue. Need to align objectives across sectors and have coordination/champions to make sure objectives are met and pooled resources are available.

Key Discussant points (Ajay Shah): -- 8 points

- (1) We need to design a work program and trace out organization and expenditures (organization diagrams, resource flows, etc.) of each country so we can measure this. An idea on why excessive fragmentation occurs is because of low capacity, which leads to broken agencies. When an agency does something well, it is overloaded with more work and becomes less effective and efficient and the marginal impact is lowered.
• (2) I don’t agree on this point of decentralization. It needs to be located in grand discourse. The function should be performed at the lowest level because at state capacity, this might not work but you need to build capacity at the lower level. We need to confront decentralization, not bring this back up to the central government power and learn how to engage with the decentralized republic.

• (3) There is direct conflict between health and CGH vs. other agencies. A large number of agencies are charged with one task (and one outcome indicator) such as road quality, but not charged with a related function like road safety.

• (4) This is very focused on budget and government expenditure. Some other important levers are regulation (road safety standards, laws, agency structures of laws and regulations for ex.). Procurement, resources, PFM and audit → failure of these four at the state capacity can hamper health and state capacity. You can’t solve health of CGH without fixing these four. How do we organize ourselves for this?

• (5) We need to mainstream disaster resilience. Can we bring this into what you measure and what you do? We need to get health in all sectors of the government.

• (6) Improve budget capacity in not just the health sector. How do we equalize margin of product, move towards performance-based budgeting? Treasury needs to be filled with the concepts so that they can negotiate better.

• (7) We need to develop measurement in order to have cross-country comparability.

• (8) CGH is small money. We don’t want this paper to talk about resource constraint. CGH is cheap and health care is expensive.

**Key Group Discussion Points:**

• The goal of this paper is not to paint a complete paper, but act as an illustrative example. We need to first unpack and think about these issues instead of jumping to solutions. If the issues are about efficient use of resources, financing does not come first, it is more how to organize and deliver these things. From this, what are the implications for the architecture of pooling, financial flows and incentives?

• Focus in on the domestic financing. External financing/ DAH cannot be the only ones to do this. It does not matter where the money comes from, but it is about the domestic architecture. Which areas need to come from domestic resources, and which require regional or external resources?

• Some core functions should be funded by specific disease functions. More pooling – the Global Fund has the opt in opt out model.

**Budgeting/multi-sectoral issue:**

• The multisectoral issue is the core issue. It is good to focus on performance budgeting. Public service agreement sets objectives for individual ministries and then can hold them accountable in a strict way. One instance, when ministries tried to align objectives for things like childhood obesity, it was a disaster because no one was willing to take the lead.

• Institutional and financial arrangements: In Spain, the TB program has been running since 1990 in terms of financing but service provision is done with regular structures because the state didn’t allow programs to be in charge of service provision. Authority
at the highest level needs to make this a priority. Here you have different financing like direct government subsidy, but the delivery of the services will be different.

- The political economy considerations, make sure they are explicit
- What happens to your budget in a social insurance scheme? All MoH would then capture are public goods. Multi sectoral budgeting needs to have joint targets.
- The budgeting problem is a political problem. In order to get funding for CGH you need to have champions at the highest level possible.
- Cross sectoral budgets are not the problem. If each ministry has objectives set, it can look at a project and see if the contribution to its own objective is worth the money to put into the common pool to pursue the larger objective. There is a need to set objectives appropriately and ministries need to work together and have joint accountability.
- It would be helpful to specify which aspects of CGH are under the control of MoH and which ones require other parts of the government to collaborate. This will have implications for getting funds.
- In Finland, after the JEE in 2017, there was a point for health to take a step back and make it a multi-sectoral issue owned by the whole government. Health security was given a large chunk of the budget. Similar things were done in Tanzania – got parliament to do the actions.
- If you have a problem that requires cooperation, what part of the government structure is able to pool across these? Maybe the fragmentation issue in #1 should be MoH and #3 are more across sectors.
- In order to get this working, higher authorities need to be on board.

Decentralization issue:
- For decentralization, the intention of this paper is not to argue one way or the other, but if you have a situation like Kenya’s devolution (to maintain peace), health spending went up as well as cholera and immunization went down. Given this context, how can we influence what governments spend on?
- Decentralization is context specific. Where is the decision space and social organization? It can lead to greater diversity and inequalities. Making local systems work is better than creating parallel ones. Have in between units that are implementation support units.

Misc. issues:
- Nigeria may not be the best case for Ebola for the multipurpose design with Polio. How do we take big investments in Polio and move them towards broader functions? Smallpox can be a good historical example. Also there is the bias of attention with Nigeria. There have been mismanagement of other outbreaks in Nigeria, which have gained less attention.
- SDGs should be mentioned in this paper – where can you package the CGH in the SDG budget.
- Tie more to the global action plan.
- With health taxes, you need different messages for different actors. MoF will be interested in revenue, etc. You need a coalition of reform. We can bring this into the revenue discussion.
• CGH argument is based on the tax itself and not on the revenue generating property.
• How do CGH relate to the question of social determinants of health? This relates to which things fall under MoH and which fall under other aspects of the government.
• Might be worth bringing purchasing agency back into the paper.
• What does coherence mean? Does it mean if every sector doesn’t cohere to CGH, then we won’t achieve adequate provision?
• In education, the framework is delegation of a task, then financing, then information/measurement of performance, then motivation (like a champion) in the system. These elements keep accountability in politics and you might benefit from this simple framework.

PAPER SIX: Financing global common goods for health: When the world is a country

Steps needed to complete draft of paper:
• Need to look at what is already there in terms of global governance and normative guidance, like UN/WHO and how it can work more effectively. Look into how UN and WHO are resourced.
• Look into other GCGH outside of R&D and health, such as National Health Accounts.
• Opportunity to move the cost of inaction to paper 1 (including authorship consideration).
• Give a sense of the scope of investment in terms of prioritization.

Key Discussant Points (Michael Borowitz):
• Can countries pay for all of these drugs we are developing?
• Fostering leadership and stewardship is not covered and WHO only comes in at the end. There should be more on this and the normative guidance international organizations play.
• This is heavily focused on R&D but leaves out things like National Health Accounts.

Key Group Discussion Points:
• What attributes of governance is needed?
• When we look at the experience with clinical research and Ebola, research suggests that WHO should not take this on. How do you look at governance and how do you set up global governance research? We need to arrange a full range of stakeholders.
• How do you address interest ideology and power? WHO mainly works with their member states and the regional offices, but it is not designed for R&D. We don’t want to draw the wrong conclusions.
• How is the UN or WHO resourced? How do we fund the global government. For pooling, it is the question on whether we need one agency for GCGH or more. What drives pooling?
• One role that WHO can play through the strategic partnership through health security is better mapping of resources and assisting member states to engage with these
resources and better alignment. We need to ensure better coordination in the international sources so that it is being directed towards other priority areas.

- The work on global functions have been limited to the health sector. We need to extend this notion and make this new work that has not been done before.
- We don’t want to construct a new government – we want to use what is already there.
- Look at this more of a social innovation organization problem and less of a governance design problem. The trick is, you need a selection mechanism to get more money into the right places. Pay attention to the mechanisms that lead to the organizations mimicking each other.
- Seems like the how is more interesting than the what for this paper. Maybe it should focus more on that.
- If you talk about taxes, there will be a lot of flights with the issues on sovereignty.
- The pre-qualification program is a good example of a public good that can be used.
- Proliferation of agencies example in the UK. There was two audit bodies and they each egged each other on. Sometimes there is an argument for pluralities of agencies.
- There is an argument for reallocation and also a discussion on new revenues. It is not just one or the other.
- Think more substantially given the environmental output.
- There is a serious need to rethink leadership with GCGH, but maybe this paper is just to say here are the issues and what is needed and not to provide clear recommendations. Use this an analytic framework.

PAPER SEVEN: The case for public financing of environmental protection as a CGH

Steps needed to complete draft of paper:
- In the beginning, be bigger and bolder in the messaging in the existential nature of the threat. Start off stronger for how important these are!
- Use common definition for CGH.
- Bring in what countries have done to address this (bring in successful examples).
- All empirical data should be presented very modestly and with no language around causality.
- Make sure the paper focuses on what is feasible and realistic. It can frame the bigger issues but it comes down to the smaller actionable items. These should be on concrete interventions and not interventions or functions that require society to exist in a different format.
- Need to consider which are cross-cutting functions that are not just environment related.
- Ensure consistency in table 4 with CGH framework.
- The costs can be very big, so it is important to have a prioritized list that takes cost implications into considerations.
- Introduce time dimension – which interventions will have an impact and when?
• The “how” needs to come out clearer – interventions to address financing for environmental CGH.
• Concluding remarks should bring up prioritization.

**Key Discussant Points (Odd Hanssen):**

• In terms of the paper structure, what you go into later should be brought up earlier. First, what are the main current environmental threats and which are CGH, then look at why the markets have not been providing them. Financing, include how to provide them and include the link between health financing and environmental protection.
• Where does the health sector play a key role in all of this if any?
• Cost effectiveness might not be the best argument here and continuation of human life on earth should be beyond these issues.

**Key Group Discussion Points:**

• This is potentially a groundbreaking paper.
• Be careful of proving causality in regressions.
• A lot of health outcomes are related to GDP, but in some countries this won’t be an accurate representation. Growth does not always lead to better health. Also, growth of the wrong kind is greater than disease growth.
• What is the role for cross-border litigation?
• You need to be careful with panel data and measurement issues.
• Bill Savedoff’s chart: Cost of inaction, cost of CGH, salience, and interest.
• We don’t want to just monitor biological threats, but also environmental risks. The big agendas like water resource areas are too big to tackle for this paper. We need to set up the framework for all of this to be possible and pick 2-3 examples. Regulation and taxation should play a major role.
• If table 4 could be built up like with some common framework that has the functions as well and another table with the instruments would be helpful.
• Might be worth identifying the gaps that we have in information, research, benefits and modeling issues.
• Possibility for a visual to pull together climate change and health.
• We need media to amplify the message so people believe there is a threat.
• Even though this is panel level data, they are not independent for estimate of governance. It is fine to put this in the paper, but present it very carefully and modestly.
• It would be good to get some data on the cost of inaction.
• Where do these sit in country budgets?
• A lot of countries have already made this argument (US, Canada and other European countries). What were their arguments to parliament?