Research Article

When Both Markets and Governments Fail Health

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Abstract—This paper presents the rationale and motivation for countries and the global development community to tackle a critical set of functions in the health sector that appear to be under-prioritized and underfunded. The recent eruptions of Ebola outbreaks in Africa and other communicable diseases like Zika and SARS elsewhere led scientific and medical commissions to call for global action. The calls for action motivated the World Health Organization (WHO) to respond by defining a new construct within the health sector: Common Good for Health (CGH). While the starting point for developing the CGH construct was the re-emergence of communicable diseases, it extends to additional outcomes resulting from failures to act and finance within and outside the health sector. This paper summarizes global evidence on failures to address CGHs effectively, identifies potential reasons for the public and private sectors’ failures to respond, and lays out the first phase of the WHO program as represented by the papers in this special issue of Health Systems & Reform.

OBJECTIVE AND MOTIVATION FOR THIS SPECIAL ISSUE

The last 20 years have seen amazing improvements in health indicators globally. Global attention directed to health has been impressive and resources have been expanding at unprecedented rates. External spending on health grew five-fold since 2000, reaching about $20 billion USD in 20151 and health sector resources go beyond external funds. We have known for years that OECD countries, especially the wealthiest, have spending rates that grow faster than economic growth.2 A recent publication from the World Health Organization (WHO) using global data on health expenditures shows that this expansion is not unique to high-income countries. Between 2000 and 2016, global spending on health has increased at 4% per annum, while the global economy grew at 2.8%. Health spending growth has in fact been even more rapid in low- and middle-income countries—at 6% per year, it amounted to $1.6 trillion USD in 2016.1
The emerging global empirical picture is that of a sector that will most likely continue expanding, thanks in part to economic growth. The expansion is also associated with increases in public revenue, technology changes, and increasing demand for quality health services. Global health financing is shifting away from the need for resource mobilization to focus on the more challenging question of the “quality of spending.” An important concern for every country, and for the global health community, is the extent to which the increased resources for the health sector are being spent well.

The debate on what defines high quality spending in health is not new, nor is it a settled issue. Further, it includes a number of policy dimensions and advocacy patterns. The main objective of this and the other papers in this special issue is to tackle a specific element of quality of spending in health, rather than to focus on the debate about definitions. This special issue addresses a particular category of expenditures and government actions that relate to health and where collective action is needed for delivery. Namely, these papers focus on financing for Common Goods for Health (CGH), a new construct that will be defined in this paper and expanded on throughout the special issue.

In the next section, we use the 2014–2016 Ebola virus outbreak in West Africa to help articulate what we mean by CGH. We should note up front, however, that the CGH agenda is not just about Ebola or communicable diseases; it also captures other health threats, including some of the fastest growing non-communicable diseases (NCDs) and those related to environmental changes. The focus of the construct is on a number of core functions and actions with sizable impact on human health and which markets either do not finance or underfinance and thus warrant government action. Consequently, when governments also fail to finance these core functions, the lives and livelihoods of many people are negatively impacted.

Another important caveat should be noted up front and will be repeated throughout: the drive for financing CGHs should not be read as encouraging selective financing of certain functions in the health sector while dropping others. Rather, certain core functions that only governments can fund appear to be systematically de-prioritized and underfunded even as resources flowing into the health sector grow. These de-prioritized functions and services, as we discuss in the next section on Ebola and other communicable disease responses, suffer then from a double failure: market failure and government failure. Market failures, described in more detail in the next paper in this issue,3 motivate the need for public action including, in many cases, public financing. Public action and financing, however, are lamentably not automatic,4 especially when no pressure is exerted by citizens on government policy makers.

**THE EBOLA WARNING**

The 2014–2016 West Africa Ebola virus outbreak brought home to the global health and development community the scary realization that the world is not ready to deal effectively with epidemics and pandemics, nor are we prepared to address other existing and emerging planetary health challenges. A number of high level panels and commissions convened in the wake of the 2014–2016 Ebola outbreak to review the national and international responses to the Ebola crisis—the commissions found the responses wanting.5 A recurring theme across the different post-Ebola commissions was a major failure by many countries and the donor community to prioritize investments in core health system functions, primarily public health infrastructure and capabilities. These investments had been systematically crowded out by focusing on activities more visible in the short run.

Perhaps the clearest statement of the problem came in the report of the National Academy of Medicine’s Commission on a Global Health Risk Framework for the Future.6 The Commission’s report summarizes the main issues:

> Framed as a health problem, building better defenses against the threat of potential pandemics often gets crowded out by more visible and immediate priorities. As a result, many countries have underinvested in their public health infrastructure and capabilities.

> Yet, framed as an issue of human security, the current level of investment in countering this threat to human lives looks even more inadequate. There are very few threats that can compare with infectious diseases in terms of their potential to result in catastrophic loss of life. Yet nations devote only a fraction of the resources spent on national security to prevent and to prepare for pandemics.

> Framed as a threat to economic growth and stability, the contrast is equally stark. Both the dynamics of infectious disease and the actions taken to counteract it can cause immense damage to societies and economies.

While the post-Ebola commissions focused on the failure to address risks from global pandemic outbreaks, recent regional outbreaks, increasingly covered by the media, also reflect these failures in health systems. Reports of measles outbreaks in Europe in the last few years reflect a decline in basic immunizations coverage.7,8 Yellow fever continues to be a challenge for large parts of Africa and Latin America. The vexing and somewhat still mysterious evolution of the Zika virus epidemic is likewise testing the strengths of public health systems in the Americas and beyond.9

Many outbreaks, and the human and economic damage they can produce, are relatively easy and low cost to guard against.
Most of the technologies needed to get ahead of outbreaks, such as surveillance and immunizations, already exist and cost a small fraction of what the global health community spends in this sector. Moreover, the basic investments needed to safeguard against outbreaks are typically not controversial in policy circles. Public health specialists and health economists all agree that these should be priorities for the health sector investments. These functions are prominently listed as priorities and advocated for by WHO and the US Centers for Disease Control and Prevention (CDC). And economists argue for them as public goods with large social externalities that require public action.

The direct human cost of Ebola and other communicable disease outbreaks is the appropriate focus for much research and media coverage, but we should not ignore other costs associated with, and directly related to, failed health system investments. The estimates of the economic costs of the West Africa Ebola outbreak have ranged from $3 billion USD to over $30 billion USD. The estimates include the direct costs, of treatment and containment of the outbreak, and other economic costs, from lost trade, investment, travel, tourism, and other economic activities.

Such large economic losses are not unique to Ebola. Between 2002 and 2004, the estimated economic loss due to Severe Acute Respiratory Syndrome (SARS), which infected about 8,000 people and killed 800, amounted to more than $40 billion by some estimates, and higher in others. The World Bank has warned that “a severe flu pandemic” could cost over $3 trillion, nearly 5% of global GDP. Global losses from an avian influenza pandemic could lead to a 2% to 4.8% drop in global GDP and would cause between 14 and 71 million deaths. Most economic losses come from the indirect effects of an epidemic: 60% from disruptions in economic activity from individual and social measures to avoid infection and 28% from illness and absenteeism. A recent estimate calculated that the expected annual losses from pandemic risk are about $500 billion USD, or 0.6% of global income.

**BEYOND EBOLA AND COMMUNICABLE DISEASES**

Communicable disease outbreaks such as Ebola are concerning in and of themselves—they also point to a policy and public spending blind spot worth exploring. These outbreaks reflect risks to human health that require collective action, typically in the form of public financing, in the health system and beyond. An important national and global public policy concern is the extent to which such health system responses requiring collective action exist beyond communicable diseases. In other words, what other threats loom that should be categorized and identified for national and global responses?

This was the main question addressed by a WHO technical expert group that began by studying Ebola and then identified other threats to health of similar magnitude within and even outside the health sector (the group is described in more detail later in this paper and the membership is listed in Appendix 1). For example, antimicrobial resistance (AMR) was noted to be a growing threat; recent analyses estimate AMR already causes 700,000 deaths per year worldwide. A review of 214 studies estimating the burden of AMR projects that it leads to excess health care system costs of as much as an additional $1 billion per year. The OECD estimates that across the 33 OECD countries included in its analysis, AMR is likely to kill 2.4 million people between 2015 and 2030, and will cost $3.5 billion annually in that period.

Another profoundly challenging health concern that includes elements of CGH is the rapidly growing health and economic burdens of NCDs like type 2 diabetes (T2D). The United States CDC reported in 2018 that in the US, between 1980 and 2015, the number of Americans with T2D more than quadrupled, from 6 million to over 30 million people. Global numbers published by WHO in 2016 are similarly concerning, showing a quadrupling of the number of adults with diabetes between 1980 and 2014, from 108 million to 422 million people. The burden of T2D extends beyond health outcomes to economic costs. A recent study that projected the global economic burden from T2D in adults between 2015 and 2030 found that the 2015 costs ($1.3 trillion USD) will grow to between $2.1 and $2.5 trillion USD in 2030. Thus the first condition for a CGH—that it has substantial impact on human health and the economy—is clearly met by the T2D global epidemic.

The next question is: are there market failures that require public collective action in order to address the T2D epidemic? Various recent studies on the pathophysiology of T2D explain the drivers that have already led to the 40 years of expansion of the epidemic; they also point to a number of actions to address the epidemic, involving multiple sectors and that can only be achieved by collective action. T2D is predominantly a nutritional disease in which over-consumption of sugar and other carbohydrates damage the liver and pancreas until they are unable to carry out their regular functions. Reversing the epidemic requires various measures, including increasing the cost of sugar and sugary drinks (agricultural and tax policies) and dramatically changing guidelines on nutrition and identification of insulin resistance by primary care providers (information and training for medical providers), and others that also require collective action and are therefore CGHs.

The human and economic costs of inaction, as in the examples described above, are not unique to issues within
the health sector. Environmental change also contributes to health threats. Between 2000 and 2016, for example, an estimated 125 million vulnerable people were exposed to heatwaves. As in other crises, elderly people, poor people, and children are most affected by extreme weather and the long-term effects of climate change. Pollution of air, water and soil has been estimated to be the largest environmental cause of mortality and morbidity. An estimated nine million premature deaths, making up 16% of all global deaths, are attributable to pollution—that is three times more than deaths from HIV, malaria, and tuberculosis combined. WHO estimates that 3.8 million people die every year from causes attributable to household air pollution (HAP).

Environmental action can be highly cost effective for health. Unleaded petrol, for example, has an aggregate benefit of $6 trillion USD through the improved cognitive function and economic productivity of generations that have low lead exposure from birth. WHO has estimated that the investing in HAP prevention would present a direct economic return of $32.4 billion USD. While focusing on clean cookstoves will not prevent all deaths due to HAP, it and similar measures would help avoid 23 million deaths over five years. An investment of $65 billion USD in air pollution prevention control is estimated to yield a return of $1.5 trillion USD of aggregate benefit.

DEFINING COMMON GOODS FOR HEALTH

Ebola, diabetes, and other headline-grabbing disease outbreaks have provided us with opportunities to assess why and how the health sector fails to address certain priorities. This special issue of Health Systems & Reform summarizes the results of WHO’s work program on financing Common Goods for Health (CGH). Together, these articles point the failures of markets and governments alike to follow through on technocratic agreements on what should be done, and consider why these failures are in fact worthy of political attention and financial support. In the remainder of this paper, we first explore the reasons for the market and government failures and then name and define the types of failures. These points are then further expanded on in the following papers of this special issue, which are briefly described below.

In April 2018, as part of the response to the calls for action by the post-Ebola commissions, WHO brought together global health leaders and technical experts in a technical expert group to guide a program of work to build knowledge on financing CGH (see Appendix 1 for the list of participants). The technical expert group agreed on a program of work, the first phase of which would culminate in this special issue, comprising articles defining CGH, explaining the relevant government and market failures, projecting costing and financing for these CGH, and making a case for addressing environmental CGH. The technical expert group immediately recognized that the global health community lacked clarity about the concept of public goods, and so included a mandate to develop a clear definition of the health functions, services, and goods which its work would address. Specifically, the technical expert group recommended combining concepts and terminology drawn from the fields of public health and public economics to define a category of common good actions and interventions. The technical expert group subsequently met in March 2019 to discuss progress on the proposed agenda and the concrete outputs, including the articles in this special issue, of the first phase. Additional work was carried out between meetings by group members, WHO staff and consultants, and other topic-area experts. What is presented here, and further developed through examples and analysis in the other papers in this special issue, is the product of the first phase of work by the technical expert group, beginning with the definition of what we are calling “Common Goods for Health” (CGH).

CGH, are population-based functions or interventions that require collective financing, either from the government or donors, and fulfill the following conditions:

1. They contribute to human life and economic progress (with a focus on human-life impact, including the potential impact/risk for health in the future, which indirectly includes impaired 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) or (ii) large social externalities.

Not all public or common goods are CGH and vice versa; however, all CGH generate large societal health benefits that cannot be financed through market forces. Like public goods, CGH are held in common; they serve as the backbone of the health system, and society more broadly. In this way, they are cross-cutting functions that do not sit exclusively within a single specific disease or intervention area. There are five categories of CGH (displayed, along with examples, in Table 1): policy and coordination; taxes and subsidies; regulations and legislation; information collection, analysis, and communication; and population-wide services. CGH, then, are health system functions or sets of goods and services that have a clear impact on human life, exhibit specific
forms of market failures requiring public or collective action, and are feasible and potentially cost effective.

The history of global health warns us that definitions tend to expand over time, eventually devaluing the priority-setting nature of the exercise. To safeguard against that, it is therefore important to also list what CGHs are not, and consider how we can maintain and protect the concept.

As is described in more detail in the next article in this issue by Gaudin and colleagues, the field of public finance economics describes a number of reasons markets fail,\textsuperscript{3,28,29} CGH, on the other hand, only tackle two specific market failures: public goods and large social externalities. This does not mean that other types of market failures are not important to core health system functions, but they are outside this specific construct. A good example of a traditional market failure that is not covered under CGH is limited demand due to poverty. Safeguarding the health and welfare of poor and socially vulnerable people is a central priority for health systems; however, it is not a CGH. Further, it is very well captured under the Universal Health Coverage (UHC) agenda through its focus on lack of coverage and financial barriers to care for basic services. The market failures in health insurance markets (namely, moral hazard and risk selection) are also examples of market failure specific to the health sector not covered by CGHs. Like the market failure related to low demand from poor people, health insurance market failures cover most health services and are not limited to public goods or goods with large social externalities. Consequently, we deliberately kept it outside the parameters of CGH. Here again, the UHC agenda addresses these important health market failures.

The technical expert group and the authors of the papers in this special issue all recognize that creating and defining new terms such as CGH, as well as carving out a subset of market failures, may be challenging for broader public health and policy audiences to grasp. However, as the results demonstrate, the effort is important, instructive, and well worth doing. The health system failures exposed by Ebola and other communicable disease outbreaks, growing NCD epidemics such as diabetes, and neglect of other functions in the health sector demand responses. The construct of CGH allows attention to be focused specifically on key actions and policies that address instances when both markets and government fail. The price of these failures, in human life, should be unacceptable to all of us.

**HOW WE GOT HERE**

Understanding why a failure occurs is an important step in identifying what needs to be done to correct it. This
collection of articles, dives into understanding why the global health community and many countries have underinvested in basic priorities that typically form the foundations of health systems. The considerable depths and breadths of underinvestment, by both national governments and development assistance agencies, have led to some of the outcomes quantified and cited in the previous section. Their magnitude suggests that multiple causes are involved and that they represent systemic challenges faced over considerable periods of time. At least four interrelated factors contribute to this situation of severe underinvestment.

First, the failure to invest in basic systems for health reflects misinterpretation of the risks of emerging epidemiological, demographic, and environmental transitions. The world is experiencing drastic shifts away from diseases that affect the young; as population pyramids shift, the leading causes of mortality and morbidity become more dominated by NCDs. Furthermore, health risks are increasingly related to both modern food systems and environmental threats. These threats are combined—as the natural systems upon which all health and life depend change, they threaten to undermine the health gains of the past decades, particularly among vulnerable populations who are at most risk from the harms of environmental degradation and the effects of climate change. These transitions occurring outside health systems nevertheless require health systems to adapt in terms of what services are prioritized, how services are delivered, and how systems are financed. Even the most basic elements of a health system, such as surveillance, must adapt to account for the NCDs and environmental risks that are becoming more important to population health. A major challenge here is miscalculating national and global risk factors. While it is easy to justify adapting services and systems to account for clear changes in individual risks, risks to populations, and the global community more broadly, require different motivations and analytical approaches. For example, while NCDs are widely seen as a priority in terms of the burden of diseases, consequences of environmental degradation might actually have a greater impact on health. Lack of understanding of public versus private risks has contributed greatly to under-investment in basic health systems that address CGH.

Second, and related, increased demand for private goods has far greater political potency than population-based functions requiring public action. As noted earlier, there is now overwhelming evidence that public and private spending on health increases with national income. Indeed, it increases faster than national income as countries move to high-income status. A large and growing body of literature explores the drivers of this growth in health spending and highlights a number of factors, including aging, technology, third party payer, and asymmetric information. The primary driver for these increases, however, relates to the fact that individuals increase their demand for health care services, and specifically services that are private in nature. In other words, a wealthier population demands more public health spending and mainly for private goods. Meanwhile, the evolution of demand for public goods is less understood. It is not surprising that, under population pressure, public spending on health skews away from public goods to private ones.

Third, donors and external partners exhibit the same preference for individual health services over core public functions protecting population health. The post-Ebola commissions noted that donors fail to prioritize investments in the most basic of public health services. While more analysis is needed, one possible reason for this trend is the fragmented and politicized global health community, which can be more easily captured and influenced by special interests that argue for direct support for private services. There does not appear to be a strong community of advocates arguing for basic health system investments that serve population-based functions. The emerging “planetary health” community could potentially undertake this critical advocacy role.

Fourth, short-term thinking (due to time-preference bias) results in preferences for investments that can offer immediate results, including reducing evident pain and suffering. (Time preference bias, sometimes referred to as myopia, is not unique to health; indeed it is the motivation for industrialized countries to force savings for retirement on populations that otherwise would prioritize short term consumption.) Investments in basic elements of health systems that could protect against possible future epidemics or impacts of environmental changes are less attractive to populations and governments facing existing problems. Pain and suffering experienced at any point in time trumps the potential for alleviating more pain and suffering in the future, especially if future outcomes are subject to some element of uncertainty. The impetus to act, especially when there are so many tangible needs now, is diminished.

Ultimately, as the health sector grows it becomes more subject to attention from populations and donors. When this occurs, basic decisions about prioritization will become less technical and more diluted by “democratic pressures.” Current epidemiological and demographic transitions are putting political pressure on health systems to focus more on private services related to NCDs; however, the same
pressures do not necessarily exist for a focus on public goods that would protect populations from environmental, food systems, or epidemic threats. As populations and countries get wealthier, the commercial pressures to focus on private goods instead of public goods (which result from market failures) expand. Similarly, as the number of players and voices in the donor community increases, competition emerges within the development community to meet the need for private services and shifts the focus away from public goods and fundamental elements of health systems. A common theme driving these factors is the time-related bias for addressing today’s needs rather than building robust systems that could detect and deal with future, and potentially terribly damaging, risks and challenges.

**FINDING OUR WAY BACK TO BASICS**

Human and economic disasters, whether created by a virus like Ebola or major flooding, focus attention after the fact. The findings of the post-Ebola commissions speak to our collective failure to invest in relatively low-cost functions and systems, like surveillance and preparedness, that are essentially invisible to most of us when they work correctly. The operational question moving forward is: will we learn from the past? Can we identify in advance the key health systems functions and capacities that are currently falling through cracks in the pressure-filled and multi-stakeholder prioritization processes that comprise health sector spending?

The articles in this special issue of *Health Systems & Reform* are presented as a first step in responding to these questions. As a group, they build on the recommendations of post-Ebola commissions and other global health declarations and agreements. These articles are interconnected; while each can stand on its own, as a whole they represent a continuum with a larger purpose. This article has presented the overall motivation for the creation of the technical expert group, the work program the group generated, and this special issue. In doing so, it identified some of the root causes of widespread failures in health systems and touched on the human and economic costs of these failures. Building on the experiences of Ebola and other communicable disease, which have exposed these health systems failures, the article then offered a new construct, CGH, that is built on core public finance concepts and overall public health objectives. CGH is conceptualized in a way that limits it to a subset of actions typically de-emphasized in national health sector programs and global health investments.

The next article, “Common Goods for Health: Economic Rationale and Tools for Prioritization” by Gaudin, Smith, Soucat, and Yazbeck, provides the theoretical constructs that underpin the definition of CGH in two ways. First, the article tackles the traditional approach to public finance economics through market failures in the health sector, building on the principles and definition presented above. It furthers proposes a functional approach to CGH by reviewing and identifying CGH functions among the larger list of essential public health functions. The article also shows that there is, in fact, considerable consistency between what public health specialists and health economists consider priority functions, most of which are CGH.

The article that follows, “When Do Government Financing Common Goods for Health? Four Cases on Surveillance, Traffic Congestion, Road Safety, and Air Pollution” by Bump, Krishnamurthy Reddiar, and Soucat, uses case studies to explore the political economy challenges faced by national governments in securing funding for CGHs. Due to inherent market failures, the provision of CGH requires engaging citizens as well as the government in political processes to ensure the use of regulatory authority over the private sector. This paper examines the conditions under which governments decide to intervene to finance CGH. A framework for analysis is developed to generate hypotheses about this process.

In the article titled “Core Government Functions in Health Emergency and Disaster Risk Management” by Peters, Hanssen, Gutierrez, and Nyenswah, core functional areas for investment and action in health emergency and disaster risk management (EDRM) are described. The authors calculate the costs to establish and operate basic health EDRM capability in low- and middle-income country groups, with a focus on prevention, preparedness, detection, and response capability. The costs of inaction, both direct and indirect, as well as health and other social costs of health and disaster emergencies, are also explored. To complement the normative nature of the costing analysis, institutional arrangements needed to design and implement health EDRM are presented.

The following article, “Financing Common Goods for Health: A Country Agenda” by Sparkes, Kutzin, and Earle, provides an evidence-based argument about how government and donor financing can be reorganized to enable the more efficient delivery of CGH. Specific countries’ experiences are cited, and issues related to fragmentation of financing—within the health sector, across sectors, and across levels of government—clearly emerge as key constraints. In order to effectively address fragmentation issues, the article considers policy responses, including realigning budgets and adapting organizational structures.
In the article titled “Financing Global Common Goods for Health: When the World is a Country,” authors Yamey, Jamison, Hanssen, and Soucat address failures in the global health community in identifying and tackling CGHs. Many CGH, especially those related to communicable diseases or environmental drivers, have large global cost externalities related to failure, justifying the argument that external financial support is an important investment. The article both makes the case for re-prioritizing investment in global functions, and then examines current financing flows to global functions and the large estimated financing gap. Finally, it proposes options for directing additional finance to global CGH and discusses overall governance requirements.

Building off the paper by Yamey and colleagues, Schäferhoff, Chodavadia, Martinez, Kennedy McDade, Fewer, Silva, Jamison, and Yamey present “International Funding for Global Common Goods for Health: An Analysis Using the Creditor Reporting System and G-FINDER Databases.” This article estimates expenditure trends in international financing for global CGH between 2013 and 2017 to gauge their prioritization in the global health funding agenda. The time period covers before, during, and after the 2014–2016 Ebola epidemic. Their findings provide empirical evidence of the reactive nature of donor financing for health: while international funders increased financing for global functions in response to the Ebola outbreak, they have failed to sustain it.

The final article, “The Case for Public Financing of Environmental Common Goods for Health” by Lo, Gaudin, Corvalan, Earle, Hanssen, Prüss-Ustün, Neira, and Soucat, applies the methodologies and concepts of CGHs to threats to human health emanating from environmental drivers. While environmentally-driven CGHs are consistent with those in the health sector in terms of impact on human health and the characteristics of market and public failures, instruments and accountability for responses may be outside the direct control of the health sector, and therefore require multi-sectoral and in many cases global action.

Common goods for health is a relatively new category of health goods and services. By defining CGH clearly, exploring the importance of this set of health system outputs and functions, explaining why markets alone do not address them, and identifying why governments sometimes fail to fund them, WHO has taken an important first step for health system strengthening and improved global prioritization. While the topic raises many challenges, there is excellent news: most of the policy actions and functions described in this and the following papers are comparatively low cost and can easily be incorporated in national and development assistance budgets. WHO and other stakeholders’ next steps will be to work with countries, donors, and global health agencies to implement the important CGH agenda.

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APPENDIX 1: WHO’S TECHNICAL EXPERT GROUP ON FINANCING COMMON GOODS FOR HEALTH

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(Continued on next page)
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| Alex Ross        | Director, Office of the Executive Director                           |
| Susan Sparkes    | Technical Officer, Department of Health Systems Governance and Financing |
| Agnès Soucat     | Director, Department of Health Systems Governance and Financing        |
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