Drawing light from the pandemic

A NEW STRATEGY FOR HEALTH AND SUSTAINABLE DEVELOPMENT

September 2021

Pan-European Commission on
Health and Sustainable Development

Pan-European Commission on *Health and Sustainable Development*

An independent commission

convened by

Hans Henri P. Kluge
WHO Regional Director for Europe

and chaired by

Mario Monti
President of Bocconi University,
former Prime Minister of Italy

to **"Rethink policy priorities in the light of pandemics"**

This is the final report of the Pan-European Commission on Health and Sustainable Development. It follows the Call to Action issued in March 2021.

The recommendations stemming from the Commission's work are based on a review of evidence that is being published in conjunction with the main report.

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"Countries can now use these recommendations to build back better. I sincerely hope that national governments will carefully consider how they can adopt and implement them."

When I decided to convene the Pan-European Commission on Health and Sustainable Development in September 2020, I wished to elevate health and social care to the top of the political agenda. The aim was to take stock of the lessons learned from the COVID-19 pandemic and to elicit actions by high-level decision-makers that would protect us from future health threats and make progress in health and sustainable development across the pan-European region.

The novelty of this independent commission is its multidisciplinary membership, with outstanding leaders bringing a wealth of political, governmental and managerial experience from within and outside the health sector.

I am most grateful to Professor Mario Monti, former Prime Minister and Minister of Finance of Italy, and former European Commissioner, for his leadership in taking on such an ambitious and challenging task, and to all commissioners for offering their dedication, time and experience to this important cause. A special word of appreciation is addressed to the Scientific Coordinator, Professor Elias Mossialos, London School of Economics and Political Science, and the Chair of the Scientific Advisory Board, Professor Martin McKee, London School of Hygiene and Tropical Medicine, and its co-chairs Dr Natasha Azzopardi Muscat and Dr Josep Figueras, as well as to the Advisor to the Chair of the Commission, Professor Aleksandra Torbica.

This report, which will be presented to Member States at the 71st session of the WHO Regional Committee for Europe, provides us with actionable policy recommendations that are backed by robust scientific evidence, reminding us of the central role that science and scientific evidence play in identifying the root-cause of societal issues and sustainable and adaptable policy solutions.

Countries can now use these recommendations to build back better. I sincerely hope that national governments, and in particular heads of governments, ministers of health and social affairs and ministers of finance, as well as international and multilateral organizations, including WHO and the G20, will carefully consider how they can adopt and implement the recommendations in this report.

The WHO Regional Office for Europe stands ready to work with and support Member States in this journey to strengthen health and social care in the European Region, in order to achieve the health-related sustainable development goals through the European Programme of Work 2020–2025 – "United Action for Better Health".

Dr Hans Henri P. Kluge
WHO Regional Director for Europe

"What the world needs is a bold new strategy for health and sustainable development in the light of pandemics."

When I received Dr Kluge's email proposing this daunting challenge – what lessons could be drawn from COVID-19 for health and social care policies, not exactly my cup of tea – I was appalled, but just for a second. Quite clearly, it could not be me. After a sigh of relief, I called Dr Kluge – we had never had contacts before – and informed him politely of the mistake of person made by his office.

As it turned out, the mistake was mine. The idea of the WHO Regional Director for Europe was indeed to ask a former head of government to help him set up, and then chair, an independent commission comprising not only life scientists and heads of health and social care institutions but also economists, leaders of the business community and financial institutions, as well as a few other former heads of state and government.

Two personalities with a strong academic and policy reputation in public health, Professor Martin McKee and Professor Elias Mossialos, insisted that I should at least consider the request to lead this "out of the box" exercise. When they added that they would be ready to help steer the work, respectively as Chair of the Scientific Advisory Board and as Scientific Coordinator, I felt assured that "the box" would be in credible hands. Furthermore, my access to that rather mysterious box would be facilitated by a Special Adviser to the Chair, Professor Aleksandra Torbica, well versed in the dialogue between health experts and economists.

But would we be able to attract as commissioners personalities of high standing, with the appropriate geographical, professional, political and gender balance? This, I must say, proved easier than expected. So I was left with no excuse and did accept Dr Kluge's proposal. In retrospect, I wish to acknowledge his vision and thank him for the rather unique opportunity provided to the Commission, in full respect of our independence. WHO's Director-General, Dr Tedros Adhanom Ghebreyesus, fully endorsed the initiative.

My deep gratitude goes to my 18 fellow Commissioners for their willingness to engage in a journey across uncharted territory and requiring an uncommon degree of interdisciplinary dialogue. It has been a privilege to work closely with them for one year, even without the pleasure of a single meeting in person. The outstanding commitment of all my colleagues – facilitated by the cultural mediation skills of the co-chairs of the Scientific Advisory Board, Dr Natasha Azzopardi-Muscat and Dr Josep Figueras, and the tireless support provided by Gabriele Pastorino – enabled us to engage in intensive exchanges. From widely different initial perspectives, due also to the disparities among the 53 Member States of WHO's pan-European region, we were able to achieve a gradual convergence of thinking. Ultimately, the report and its recommendations were adopted with unanimous consent.

What the world needs, in our view, is a bold new strategy for health and sustainable development in the light of pandemics, a strategy that requires a combination of two novel approaches. First, we must fully recognize the interconnections between the health of humans, animals, plants and the planet – environment, biodiversity and climate above all. But, secondly, the resulting One Health policy in turn needs not only to be operationally implemented but also to be intimately integrated in a wider and coherent policy framework, comprising in particular economic and financial, technological, social and international policies. We then articulate the proposed new strategy into a number of recommended actions involving the national, pan-European and global levels.

The pandemic has submitted the globe to a real, not simulated, stress test. The test has exposed, with unprecedented clarity, a serious chronic disease of policy-making: short-sightedness. This has two dimensions: short-sightedness over time, when policy-makers try to get consensus today by shifting burdens onto next generations; and short-sightedness over space, when they try to solve nationally problems that are inherently transnational.

Neither health nor sustainable development will be achieved unless these twin diseases, endemic to current politics, are eradicated. The pandemic brought us tragedy and light. Confronted with what now we see, we may decide to close our eyes. But then we will have only ourselves to blame for future tragedies. Perhaps not for long.

Mario Monti
Chair of the Pan-European Commission on Health and Sustainable Development

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We simply cannot accept the consequences of our failings during this pandemic without trying to identify and tackle their causes.

Currently, we are far from reaching the 17 goals identified by the United Nations (UN) for more sustainable development by 2030. We continue to exploit the seas and the earth, to destroy forests and the natural environment, to tolerate inequalities and discrimination, and to produce CO_2 as if all these actions have no impact on the health of humans and other living things. If we are to reduce the many risks to human health, we must begin by tackling these self-inflicted scourges.

This is the first message of this report: health requires sustainable development, as set out in the UN Sustainable Development Goals (SDGs). If we are to respect the commitments that we have made through our governments, we must change our way of life. Our policy-makers need to raise their gaze above the silos they so often inhabit, forging links across disciplines, ministries, communities and nations. And we must draw inspiration from and explore connections with those working to tackle environmental issues such as climate change and biodiversity loss, as emphasized by the Rome Declaration adopted at the Global Health Summit 2021.

The reason why we must do all these things is that, despite decades of warnings of a pandemic on the scale of COVID-19 and calls to pay attention to developments at the interface of human, animal and environmental health, the global community was underprepared when the SARS-CoV-2 virus first emerged in late 2019. Divergent and, too often, mistaken policy responses were made. As a consequence, the impacts of COVID-19 have been and continue to be catastrophic – not only for health and well-being but also for economies, social cohesion, education and more. These effects fall disproportionately on those who were already disadvantaged. We now have an opportunity to create the conditions that encourage investment in a healthy population and planet, with adequately resourced, responsive and innovative health care, social care, environmental protection and related systems. We must not squander this opportunity.

Over the past year, members of the Commission have reflected on what worked and, more often, what did not work in the COVID-19 response and in previous crises. In the Call to Action that we issued in March 2021 and in this final report, we have made a series of recommendations with the aim of achieving seven key objectives to prevent a catastrophe on the same scale from happening again. In formulating our recommendations, we have drawn on the extensive work of other commissions and panels set up to deal with COVID-19 and its aftermath, while taking into account important distinctive features of our Pan-European Commission on Health and Sustainable Development – Rethinking Policy Priorities in the Light of Pandemics, convened by the WHO Regional Office for Europe.

Our distinguishing characteristics are highlighted in the full title and mandate of our Commission: (a) to address health in its entirety, not just pandemics; (b) to uncover interactions between health and sustainable development; and (c) to reconsider the position of health policy in relation to other priorities and policies. Our geographical focus is on the 53 Member States of the WHO European Region and the wider global context in which WHO operates.

Our recommendations fully reflect these distinctive features and provide guidance on how countries should prioritize health and sustainable development now, in order to set systems and societies on the right track for generations to come.

Key objectives and recommendations

OBJECTIVE 1

Operationalize the concept of One Health at all levels

The One Health approach, which recognises the interconnection between people, plants, animals and their shared environment, is not a new concept, but its adoption has been hampered by fragmented policy-making and financing, and siloed organisational structures. COVID-19 has demonstrated how when one part of One Health is at risk, the other pieces are also in danger. Now, more than ever, we urgently need to implement a One Health approach to respond to threats to human health and progress towards sustainable development.

We recommend that:

- **Governments establish structures, incentives and a supportive environment to develop coherent cross-government One Health strategies,** building on the concept of Health in All Policies and the SDGs.
- **Mechanisms for coordination and collaboration between relevant international agencies, such as WHO, the Food and Agriculture Organization of the United Nations (FAO), the World Organisation for Animal Health (OIE) and the United Nations Environment Programme (UNEP) are strengthened,** in order to support efforts towards a shared understanding, common terminologies and an appropriate international architecture for establishing priorities, agreeing areas of responsibility and identifying the scope for joint work to promote the health of humans, animals and the natural environment.
- **Coordinated action is taken at all levels to reduce environmental risks to health,** including biodiversity- and climate-related risks, and to enhance One Health reporting systems.

OBJECTIVE 2

Take action at all levels of societies to heal the divisions exacerbated by the pandemic

COVID-19 has not only laid bare the inequalities and inequities that blight our societies, it has also exploited and exacerbated them. The most disadvantaged and overlooked people in societies have often suffered the greatest consequences from the pandemic and the policy responses to it. These impacts did not arise out of the blue; for years, policies have contributed to high rates of wealth and income inequality, underinvestment in social protection, unequal opportunities for some groups, rising precariousness of jobs, wages, housing and even food supplies, racism and other forms of discrimination, and the prioritisation of the individual over society. We must close these gaps now; not just as a matter of fairness, but also to mend fractures in society, reduce polarisation and restore trust in public bodies. In doing so, we must constantly focus on sustainable change for the benefit of all, as set out in the SDGs.

We recommend that:

- **Information systems capture the many inequalities in health and access to care** within populations, in order to inform policies and interventions that address the deep-seated causes of these inequalities.
- **Those in society who lead impoverished or precarious lives are identified,** and policies are developed and implemented to give them the security that underpins good health.
- **Explicit quotas are adopted for the representation of women on public bodies** that are involved in the formulation and implementation of health policy.

OBJECTIVE 3

Support innovation for better One Health

The pandemic has clearly demonstrated that the existing model of innovation – where most of the risk is borne by the public sector and most of the returns flow to private companies – is widely flawed, with misaligned incentives. The scale of the pandemic and the achievements made in the areas of vaccines have also highlighted the importance of research undertaken with purpose and our capabilities to confront innovation challenges and succeed when we work together as partners – across geopolitical lines, industries and institutions.

We recommend that:

- **A strategic review is made of areas of unmet need for the innovations required to improve One Health** in Europe.
- **Mechanisms are established to align research, development and implementation of policies and interventions to improve One Health,** based on a true partnership between the public and private sectors in which both risks and returns are shared.
- With the support of the WHO Regional Office for Europe, **efforts continue to be made to develop a mechanism for constant generation of knowledge, learning and improvement, based on innovation in the pan-European region.**

OBJECTIVE 4

Invest in strong, resilient and inclusive national health systems

The pressures on the health system that have resulted from COVID-19 throw into sharp relief the failure in many countries to invest in hospitals, primary and social care with flexibility to respond to the crisis that so many had warned about for decades. Policies to increase the resilience of health systems should be centred around the importance of the infrastructure of health systems, including the design of health facilities, the health workforce, and the relationship between health and social care.

We recommend that:

- **All investments in health systems are increased,** particularly in those parts of systems that have traditionally attracted fewer resources, such as primary and **mental health care,** while ensuring that this investment is directed in ways that maximise the ability of health systems to deliver the best possible health for those who use them**.**
- **The health workforce is invested in and strengthened** in the light of experiences during the pandemic, with a focus on ways of attracting, retaining and supporting health and care workers throughout their careers, coupled with reviews of how the roles of health workers can evolve, given the rapidly changing nature of medicine and technology.
- **The links between health and social care are reassessed and strengthened** in the light of experiences during the pandemic, with the goal of increasing integration between them.
- Communicable and noncommunicable disease prevention is prioritized and **investment in public health capacities is scaled up.**

Key objectives and recommendations

OBJECTIVE 5

Create an enabling environment to promote investment in health

Short-termism and negative externalities (such as ignoring the cross-border effects of national health systems), coupled with a failure to recognise the wider benefits that health systems bring to society, are among the factors leading to failure to invest in health. Changes in the information, incentives and norms that govern the allocation of resources, both by national governments and by the private sector, are needed to mitigate these biases. In addition, increased international support is needed to address the cross-border nature of health threats and their impact on global public goods. In the future, finance ministries, central banks, supervisors and public authorities should create incentives that enable investments to promote health and well-being for all. All possible measures should be taken to reduce the impact of activities that damage health, duly considering related risks and making them more costly.

We recommend that:

- The way in which health expenditure data are captured changes, so that there is a **clearer distinction between consumed health expenditure, on the one hand, and so-called frontier-shifting investments in disease prevention and improvements in the efficiency of care delivery, on the other.**
- **Investment in measures to reduce threats, provide early warning systems and improve responses to crises is scaled up.**
- **WHO's health system surveillance powers are strengthened and include periodic assessments of preparedness,** which feed into monitoring by the International Monetary Fund (IMF), development banks and other technical institutions.
- **The share of development finance spent on global public goods,** long-standing cross-border externalities and, more generally, health **is increased.**
- **Health-related considerations are incorporated into economic forecasts,** business strategies and risk management frameworks **at all levels.**

OBJECTIVE 6

Improve health governance at the global level

By becoming States Parties to the International Health Regulations (IHR) (2005), most nations in the world have signed up to the principle of joint action to combat health threats, but COVID-19 has made it clear that this is not enough. We need mechanisms to raise funds for global public goods and to hold countries to account for their contributions to them.

We recommend that:

- **A Global Health Board is established under the auspices of the G20,** in order to promote a better assessment of the social, economic and financial consequences of health-related risks, drawing on insights from experience with the Network for Greening the Financial System, the Financial Stability Board and other climate and biodiversity initiatives, and to scale up private finance for health.
- **A Pandemic Treaty is agreed that is truly global,** enables compliance, has sufficient flexibility and entails inventive mechanisms that encourage governments to pool some sovereign decision-making for policy-making areas.
- **A global pandemic vaccine policy is developed** that sets out the rights and responsibilities of all concerned to ensure the availability and distribution of vaccines.

OBJECTIVE 7

Improve health governance in the pan-European region

Our world, and particularly our WHO European Region, is very interconnected, which yields many benefits but also carries risks for disease transmission. Europe is especially vulnerable to any threat to health, and the world is vulnerable to any threats that emerge in Europe. Equally, reductions in connectedness could have dramatic consequences for Europe and for the world. The pan-European region is also extremely diverse, with wide variations in wealth, population size, culture, political system, demographics and population health that can present a variety of coordination and policy problems. COVID-19 has shone a light on many of the flaws and fragmentations in our global systems of governance and has made it especially clear that more can be done to strengthen health governance and the role of the WHO Regional Office for Europe across the pan-European region.

We recommend that:

- **A Pan-European Network for Disease Control is established,** led by the WHO Regional Office for Europe, to provide rapid, effective responses to emerging threats by strengthening early warning systems, including epidemiological and laboratory capacity, and supporting the development of an interoperable health data network based on common standards developed by WHO, recognising that governments will move at different speeds.
- **A Pan-European Health Threats Council is convened by the WHO Regional Office for Europe** to enhance and maintain political commitment, complementarity and cooperation across the multilateral system, accountability, and promotion of collaboration and coordination between legislatures and executive agencies in the pan-European region.
- **Multilateral development banks and development finance institutions prioritise investments in data-sharing** and data interoperability platforms.
- **The necessary funding is secured for WHO to fulfil its mandate** within the WHO European Region.

Preparing for the future

1. We simply cannot accept the consequences of our failings during this pandemic without trying to identify and tackle their causes. Currently, we are far from reaching the 17 goals identified by the United Nations for more sustainable development by 2030. We continue to exploit the seas and the earth, to destroy forests and the natural environment, to tolerate inequalities and discriminations, and to produce CO_2 as if all these actions have no impact on the health of humans and other living things. If we are to reduce the many risks to human health, we must begin by tackling these self-inflicted scourges.

2. This is the first message of this report: health requires sustainable development, as set out in the UN Sustainable Development Goals (SDGs). If we are to respect the commitments that we have made through our governments, we must change our way of life. Our policy-makers need to raise their gaze above the silos they so often inhabit, forging links across disciplines, ministries, communities and nations. And we must draw inspiration from and explore connections with those working to tackle environmental issues such as climate change and biodiversity loss, as emphasized by the Rome Declaration adopted at the Global Health Summit 2021.

Genesis of the pandemic

3. The pandemic was not only predictable, it was predicted. Over the past three decades, researchers and commentators have highlighted the importance of developments at the interface of human, animal and environmental health. This comprises what we now call "One Health". Yet, despite these many warnings, the international community was largely unprepared for the emergence of a new infectious agent, the SARS-CoV-2 virus, in Wuhan, China, in late 2019. By the time the initial cases were recognised, the virus had spread beyond China's borders and within weeks it was in Europe. Soon it would reach almost all parts of the world.

4. Politicians and the scientists who advise them struggled to decide what to do at first. Some things worked in their favour. The virus's genetic structure was rapidly decoded and diagnostic tests followed quickly, allowing its spread to be tracked. But there were also problems. There was confusion about how the virus spread and it would be many weeks before the importance of airborne transmission was recognised, and even more before the evidence was widely accepted. This gap in our knowledge, coupled with the inevitable political reluctance to take unprecedented measures rapidly to close large sections of the economy, meant that the measures we now know to be effective – reducing mixing in settings where the virus can spread and implementing effective contact tracing – were delayed. And there were other things we were learning. This was not just another viral cause of pneumonia, it was a disease affecting many different body systems and some of our initial treatments, like placing patients on ventilators too soon, could make things worse. Everyone was on a steep learning curve.

5. Given this uncertainty, there were different ideas about how to respond. Some countries, especially those in the Asia–Pacific region that had recent experience of severe acute respiratory syndrome (SARS), moved rapidly to suppress transmission, closing borders and imposing strict restrictions on movement. We can now see that this was the best way of protecting health and the economy, but this view was highly contested at the time. Others, often drawing on plans for pandemic influenza, viewed global spread as inevitable and sought to mitigate the impact of the disease by focusing efforts on preventing health systems from becoming overwhelmed. A few even believed that the best approach would be to allow the virus to spread through the population to achieve natural immunity, while protecting those at most risk. But even when there was agreement about what needed to be done, opinions differed on the timing. It is a normal human reaction to wait and see before imposing restrictions on the scale that was needed, but time is not on the side of those who delay in an epidemic in which cases are doubling every few days.

Impact of the pandemic

6. The consequences of the pandemic have been enormous, with individuals, families, communities and economies in the worst affected countries facing devastation on a scale that would have been difficult for many to imagine when news of the virus was emerging. COVID-19 has now caused the premature death of several million people worldwide and has left many individuals with the sequelae of COVID-19, including what has been termed "long COVID", a combination of conditions affecting several different body systems that is often disabling.

7. But it is not just the direct effects of infection that are cause for concern. Many people have been unable to access health care during the pandemic as health facilities have redirected their efforts to meet the immediate needs of those with COVID-19. Treatment of time-sensitive conditions, such as early cancers, has been delayed and screening programmes have been paused, leaving many people undiagnosed and thus unable to get early treatment. Looking ahead, many health systems will struggle with a massive backlog of cases that could take several years to deal with.

8. There have been further indirect consequences, as people have lost jobs, income and social support. Women have been severely affected, especially where traditional gender roles mean that they have had to take over responsibility for childcare and education when schools and nurseries have closed. Children, too, have been impacted. Many have been orphaned, missed out on education and social relationships at a vital period in their development, and faced economic hardship because of the loss of family businesses. For many, the consequences, including lost education and reduced earning potential, will be lifelong.

9. One of the defining characteristics of the pandemic is how it has shone a light on existing inequalities. Those who were already disadvantaged are more likely to have been exposed to infection. Employed in public-facing roles such as transport or in settings that favoured spread, such as food processing, they are often more likely to spread infection to family members with whom they share overcrowded homes. They are at greater risk of severe disease because of underlying health conditions and, consequently, of premature death. They have also been impacted most by policy responses, since they are dependent on jobs in the informal, self-employed economy that often fall outside government support measures. Societal changes in recent decades have left these communities vulnerable, with growing numbers of individuals living precarious existences where traditional social safety nets have been eroded and uncertain as to whether they will have income, employment, housing, or even food from one week to the next.

10. In many countries, the scale of these inequalities, and thus the nature of the communities at greatest risk, are invisible. There is no systematic collection of data on socioeconomic status, ethnicity and other characteristics linked to health. Where data are collected in a way that can show these inequalities, they often reveal communities struggling in the face of multiple disadvantages. Many of these disadvantages are a product of government policies (or sometimes the lack of policies) that fail to provide services in health, education, employment and other sectors. Others reflect existing divisions in society, including racism.

11. Beyond the health and social impacts, the pandemic has also had catastrophic economic consequences. Estimates suggest that global output fell by 3.3% in 2020, a figure that dwarfs the 1% decline seen during the 2008 global financial crisis. Meanwhile, some equity market valuations soared, especially those dominated by technology companies – widening inequalities. Some of the worst hit countries were those dependent on tourism or commodity exports or with limited capacity to implement appropriate policy responses.

12. Yet the situation could have been much worse. Fortunately, most central banks were well prepared, following reforms that had been introduced after the global financial crisis, and intervened on a massive scale (€1.85 trillion in the Euro area alone). These interventions supported measures that blunted the impact on employment, including widespread use of job retention measures and wage subsidies. However, many young people, those with low skills, migrants, women, and those employed in small businesses were still very hard hit.

13. Looking ahead, there are grounds for believing that many economies will recover rapidly. In its 2021 World Economic Outlook, the IMF projects 6% growth in the global economy in 2021, reducing only to 4.4% in 2022. However, these figures conceal marked variations between and within countries, and IMF cautions that there is still considerable global economic uncertainty. This reflects the potential for new variants of the virus to emerge, the extent to which policy responses during the pandemic enable businesses to bounce back, and the willingness of individuals with savings to spend them. Other uncertainties include investor sentiment, particularly in relation to bond markets, and the risk of inflation. There are also many other severe and, in many cases, interlinked threats on the horizon, such as the continued spread of antimicrobial resistance (AMR), global warming, mass migration, conflict, and threats to democracy, that all pose significant risks to health, well-being, and societal and economic performance.

Lessons from the pandemic

14. We now know that many mistakes were made in responding to the pandemic. As noted above, governments were faced with a rapidly developing crisis but there was little consensus about how and when to respond. Different countries moved at different speeds. They adopted different responses. And they competed in a frantic global pursuit to obtain necessary supplies, in some cases falling victim to unscrupulous or criminal operators, a situation exacerbated in some case by corruption.

15. The devastating consequences of COVID-19 have revealed just how unprepared many countries in the WHO European Region[1] were, even if the details will only become apparent when the inquiries, which will be essential if lessons are to be learned, have concluded. However, we already know quite a lot. Planning was an obvious weakness. Even when countries had prepared plans, they may not have updated or rehearsed them or put in place the necessary arrangements. Technical capacity was often weak, with surveillance and response systems unable to see the warning signs, to design appropriate responses or to implement them. And political leadership, even allowing for the challenging circumstances, was often lacking or weak, and in some cases made things worse.

16. There was no excuse for these failures. We had many warnings, most recently in outbreaks of Ebola and Zika virus diseases, SARS and swine flu. All these experiences highlighted the importance of preparedness in terms of surveillance, capacity to respond and addressing the vulnerabilities in society that left so many people at risk, both of the infection and the responses to it. And we can see from other parts of the world, especially the Asia–Pacific region, that it was possible to reduce the health and economic burden with early and resolute action in countries that were prepared, had invested in public health systems and had decisive leadership.

1 The WHO European Region comprises 53 countries which cover a vast geographical region from the Atlantic to the Pacific oceans. We refer to this as the pan-European region.

17. We cannot afford to repeat the same mistakes next time, and one thing we can be sure of is that there will be a next time. The Commission's detailed recommendations seek to reduce the risk of new infections emerging through measures in the area of One Health, to strengthen our ability to respond rapidly and effectively through greater preparedness, and to rebuild our societies stronger. In drafting them the Commission has, of course, drawn on the extensive work of other groups that have been asking the same questions although, in our case, paying particular attention to the specific issues that affect the WHO European Region, both within its 53 Member States and in the wider global context in which it exists.[2,3,4,5] Underpinning all the Commission's recommendations is a firm belief that we can no longer accept a situation in which we fail to place sufficient value on health, for at least five important reasons:

- The ethical imperative: health is a fundamental human right;
- Honouring commitments: governments have committed, over many decades, to the goal of improving health, most recently in the Sustainable Development Goals, which include a target for achieving universal health coverage by 2030;
- Economics: health, like education, knowledge and infrastructure, contributes to economic growth through several pathways, including greater participation in the labour force and higher productivity;
- Security: as the pandemic has made all too clear, poor health and the inability to respond to severe health threats undermine national and global security;
- Trust in democracy and the rule of law: when governments fail to invest in the health of their people, those left behind can lose trust in political institutions, potentially undermining democracy and the rule of law.

The work of the Commission

18. The Pan-European Commission on Health and Sustainable Development: Rethinking Policy Priorities in the Light of Pandemics, an independent and interdisciplinary group of leaders, was convened by the WHO Regional Director for Europe, with the endorsement of the Director-General of WHO, in late 2020. Among many different commissions and panels set up to deal with COVID-19 and its aftermath, our Commission stands out as unique in several ways, as highlighted in the full title and mandate of our Commission: (a) to address health in its entirety, not just pandemics; (b) to uncover interactions between health and sustainable development; and (c) to reconsider the position of health policy in relation to other priorities and policies. Furthermore, our specific geographical focus is on the 53 Member States of the WHO European Region and the wider global context in which WHO operates.

19. Over the past year, we have examined what has worked and, more often, what has not in the response to COVID-19 and in previous crises. We have asked ourselves how we can better respond to the current challenges and prepare for the inevitable future threats to health. And we have made a series of recommendations that, if implemented, will, we believe, reduce the chances of a catastrophe on the same scale from happening again. We must be more proactive. Prevention and preparation cannot mean doing more of the same. As we move from a world before COVID-19 to one after COVID-19, we must recognise the need for new ways of thinking.

20. Our recommendations are addressed to the governments of countries in the WHO European Region. We ask them to act at two levels: within their own borders, to ensure that they are better prepared because, as has been all too clear, we are only as strong as the weakest link; and at the international level, working in concert to make Europe and the world a safer place.

2 COVID-19: Make it the Last Pandemic. Independent Panel for Pandemic Preparedness and Response; 2021 (https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf).

3 Report of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 response. Geneva: World Health Organization; 2021 (A74/9; https://www.who.int/publications/m/item/a74-9-who-s-work-in-health-emergencies).

4 Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme. Geneva: World Health Organization; 2021 (A74/16; https://www.who.int/publications/m/item/a74-16-independent-oversight-and-advisory-committee-for-the-who-health-emergencies-programme).

5 A Global Deal for Our Pandemic Age. Report of the G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response; 2021 (https://pandemic-financing.org/report/foreword/).

21. In formulating our recommendations, we have spent much time discussing the diversity of this region. The Pan-European Commission on Health and Sustainable Development covers the 53 Member States in the WHO European Region, bringing strengths as well as challenges. Twenty-seven countries are members of the European Union (EU), another five are members of the Eurasian Economic Union, while three more (Iceland, Liechtenstein and Norway) join the EU member countries in the European Economic Area. The remainder comprise a diverse group with varying links to the EU and other regional associations. The 53 Member States are also economically diverse and cover the whole spectrum of income levels, with one low-income country, four lower-middle-income countries, 14 upper-middle-income countries and 34 high-income countries. There are also several ways in which countries work together that are consequential for health and the ability to respond to health threats, including through the G20 and G7. So, as we look at how the 53 countries can work together, we need to recognise the role that can be played by these different forums. This is especially challenging for the WHO Regional Office for Europe, as it needs to think how it can work best within the countries that are members of the EU , within those that are not, and at the global level. This unavoidable reality is reflected as much as possible in our analysis and recommendations.

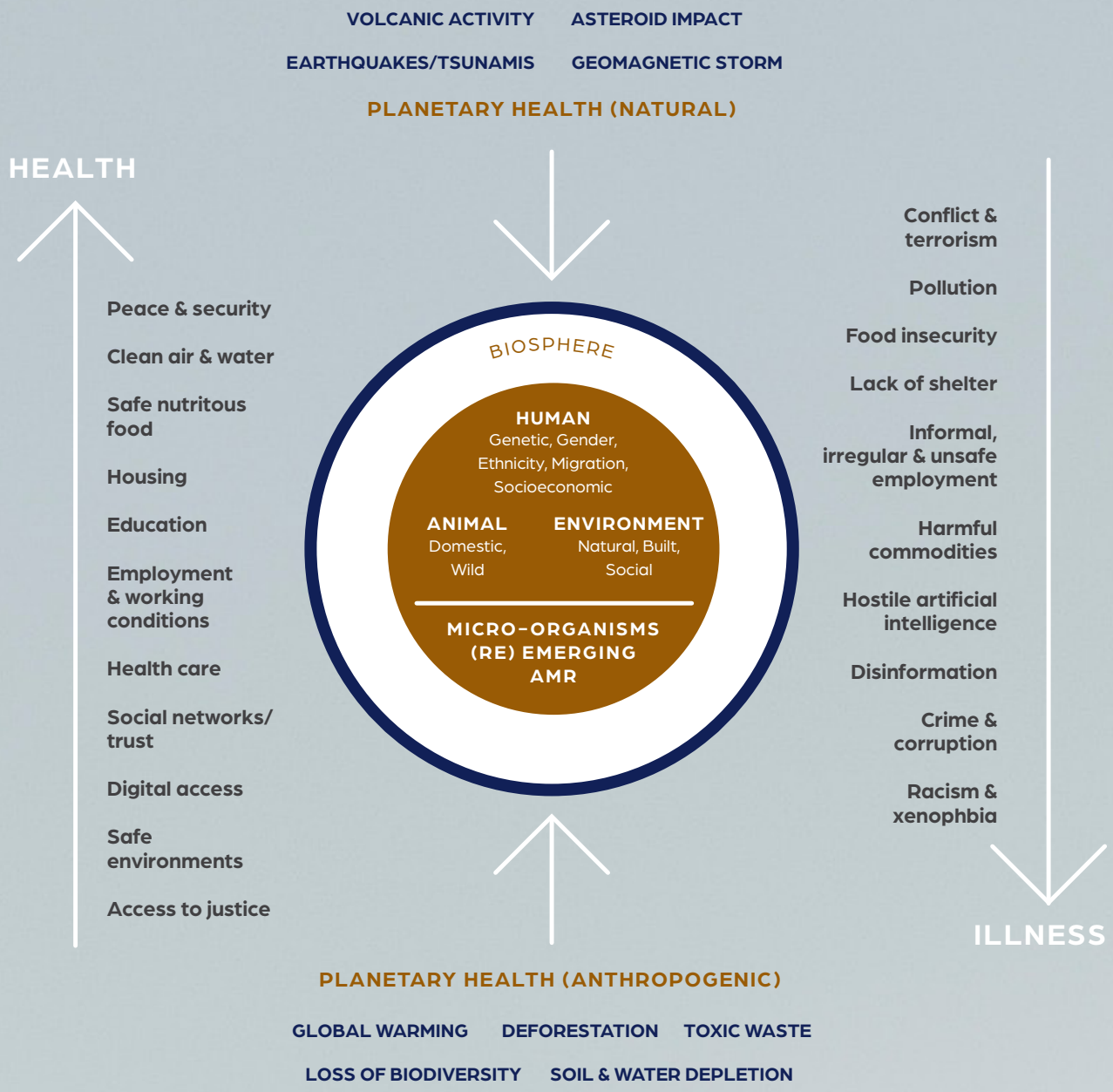
22. We have also reflected on the many and diverse factors that influence health in its widest sense: One Health. This is something that has engaged scholars for decades, drawing insights from different disciplines. We do not pretend that it is easy to summarise the complex relationships involved and, inevitably, our framework simplifies reality. However, we have found it useful to use this concept of One Health as a basis of our approach to health, the things that threaten it and those that promote it, as we seek to understand both the mechanisms and the health consequences of the pandemic, directly and indirectly.

23. At the core of One Health lies a set of individual and collective relationships between humans, animals and the natural environment, all interacting with the microorganisms that coexist with each of them in what we term the biosphere, the setting for life on earth (Fig. 1). Many of the greatest threats to our survival arise at this interface. They include infectious agents that jump species or evolve to occupy new ecological niches, including those that we create for them, for example by inappropriate use of antibiotics or changes in our behaviour, and those things that we need to survive, such as food, water and protection from extreme weather events. These relationships take place on a planet whose conditions are affected by many things. Some we have no control over but many lie in our own hands. For a few centuries and especially over recent decades, we humans have had an unprecedented impact on the natural resources of the planet, we have polluted the land, the air and the water, and we have displaced the many species with which we share this planet. But we have also done many things that have promoted health, discovering medicines, building health systems, and much else.

24. Our model includes many of the things that we do, individually and collectively, to influence One Health, both positively and negatively. The positive influences include the traditional prerequisites for health, such as food and shelter, as well as newer ones, such as health systems, digital access, and mechanisms to monitor ecosystems and veterinary and human health. The negative ones include conflict, insecurity and trade in harmful commodities. All of these have played a role, for better or worse, during the pandemic, while destruction of ecosystems, increased pressure on land and increased human mobility all contribute to the spread of disease-causing agents.

25. For almost two decades, governments from across the WHO European Region have committed to the principle of Health in All Policies. Many of the most important decisions for health and well-being are taken outside health ministries, by those responsible for economic, agricultural, employment, education, environmental and industrial policies. If we are to ensure that our progress in improving the health of our populations is sustainable, we must encourage those policies that promote One Health as an integrated approach across ministries and discourage those that threaten it.

FIGURE 1 – THE DETERMINANTS OF HEALTH IN THE 21ST CENTURY



Source: McKee M, ed (2021). Drawing light from the pandemic: a new strategy for health and sustainable development—a review of the evidence. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

RECOMMENDATIONS

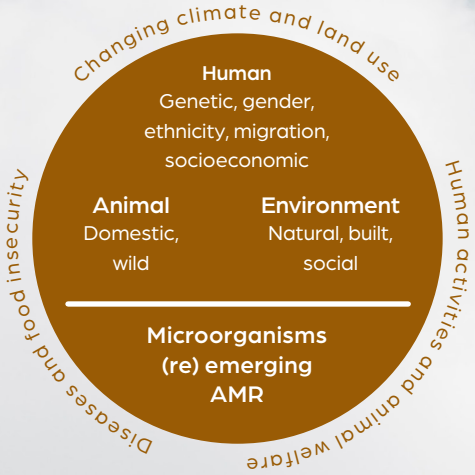
1.1 Obligations at national level: Governments should establish structures, incentives and a supportive environment to develop coherent cross-government One Health strategies, building on the concept of Health in All Policies and the SDGs.

1.2 Enhanced cooperation at international level: Mechanisms for coordination and collaboration between relevant international agencies – WHO, FAO, OIE, UNEP – should be strengthened, in order to support efforts towards a shared understanding, common terminologies and an appropriate international architecture for establishing priorities, agreeing areas of responsibility and identifying the scope for joint work to promote the health of humans, animals and the natural environment.

1.3 Coordinated action at all levels to reduce environmental risks to health, including biodiversity- and climate-related risks, and to enhance One Health reporting systems.

26. The COVID-19 pandemic has exposed the fragility of human health and highlighted its interconnectedness with the health of animals and the wider natural environment, which collectively form the biosphere (Fig. 2). COVID-19 is a zoonotic infection, caused by a virus that jumped the species barrier. However, it is human activities, such as deforestation, trade in and consumption of wildlife, and international travel, that are believed to have led to the insurgence of the SARS-CoV-2 virus and facilitated its global spread. This has profound consequences for us all. We, and our descendants, now face a precarious future unless urgent remedial action is taken.

FIGURE 2 – THE BIOSPHERE AT THE HEART OF ONE HEALTH



Source: McKee M, ed (2021). Drawing light from the pandemic: a new strategy for health and sustainable development—a review of the evidence. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

27. One Health is "a collaborative, multisectoral and transdisciplinary approach — working at the local, regional, national and global levels — with the goal of achieving optimal health outcomes, recognizing the interconnection between people, animals, plants and their shared environment".[6] One Health is both an approach and an outcome – optimal health for people, animals, plants and their shared environment – that is a public good.

A public good has some particular characteristics. It benefits everyone, one person using it does not reduce what is available for others, and people cannot be excluded from its benefits. Street lighting is a classic example. In the context of a pandemic, other examples include surveillance systems and the knowledge that they generate. Their characteristics mean that, if they are left to the market, public goods will be underproduced.

28. **One Health is not a new concept, but its adoption has been hampered by fragmented policy-making and financing, and by siloed organisational structures.** From the individual to the global level, it has never been more urgent to implement a One Health approach to respond to threats to human health and to progress towards sustainable development. As the COVID-19 pandemic has made patently clear, when one part of One Health is at risk, the other elements are also in danger. One Health issues – such as AMR, food security and global warming – transcend national, ministerial, organisational and professional boundaries, and so too must our approach to tackling them. A One Health approach necessitates breaking down the traditional environmental, plant, animal and human health silos, in order to bring relevant expertise and authorities together. Successful operationalisation of the One Health approach is dependent on decisions and processes at every level. This will require synergies between strategies, structures and systems, linking policy, legislation and finance. **The Commission urges all those involved in sustainable development to develop a common understanding of the interdependence of human, animal and environmental health.**

Protect biodiversity and climate– an insurance policy at all levels

29. **Biodiversity is a crucial aspect of One Health, acting as an insurance policy against threats to human survival.** For example, the diversity of vegetation in tropical rainforests means that when climatic conditions disadvantage one type of plant, another can grow into the gap that has been created. In this way, the process of absorbing atmospheric carbon dioxide can continue. This is much more difficult when the original forests have been replaced with a monoculture of food-producing plants or when the remaining islands of jungle become fragmented and isolated from one another. In the same way, the selective breeding that underpins intensive meat production has created flocks and herds that are genetically homogeneous, which leaves them vulnerable to the emergence of a new pathogen. This loss of genetic diversity undermines the resilience of agroecosystems in the face of future hazards, such as pests, pathogens and climate change, and so represents a significant threat to global food security. Much work has been done to develop measures of biodiversity[7,8] but more must be done to include relevant indicators in One Health reporting systems, along with other indicators pertaining to environmental health, such as the health impacts of climate change.[9]

6 Centers for Disease Prevention and Control. One Health Basics [website] (https://www.cdc.gov/onehealth/basics/index.html, accessed 29 July 2021).

7 NatureServe. Biodiversity Indicators Dashboard [website] (https://www.natureserve.org/conservation-tools/biodiversity-indicators-dashboard, accessed 29 July 2021).

8 Dasgupta P. The Economics of Biodiversity: The Dasgupta Review. London, HM Treasury, 2021 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/962785/The_Economics_of_Biodiversity_The_Dasgupta_Review_Full_Report.pdf, accessed 29 July 2021).

9 The 2020 report of the Lancet Countdown on health and climate change: responding to converging crises. Lancet. 2021;397:129–70 (https://doi.org/10.1016/S0140-6736(20)32290-X).

30. Everyone has a role to play in promoting One Health, as citizens at the ballot box, as consumers in the shopping aisles and, for some, as decision-makers at different levels of government or the private sector. The position they occupy will influence their ability to make choices that matter. A senior politician can change the law on issues such as food production. A middle-class family may be able to choose food produced in ways that do least harm to the environment. But others will have few choices available, especially when the cheapest food on the shelves is produced in the least healthy conditions, or where the only jobs available locally are with employers who undermine One Health. But even when choices are limited, it can only help for everyone to understand the issues better, in order to foster an informed public debate. This demands measures **to create a broad understanding of the principles and practices of One Health from an early age that can help to foster sustained support by generations to come linked, at local level, to a broad range of measures to promote awareness-raising, education and behavioural change as part of municipal One Health action plans.**

Obligations at national level

31. Those who are working to improve health, of humans, animals and the environment, have much to learn from each other. Veterinarians, health workers, environmental scientists and behavioural architects can develop communities of practice and knowledge exchange networks, which would allow for signals of concern, such as increased mortality of birds or outbreaks of influenza-like illness, to be swiftly shared and investigated, engaging with existing networks such as the Program for Monitoring Emerging Diseases and the Global Outbreak Alert and Response Network. However, those who contribute to these efforts need a supportive structure, something that is often lacking. Thus, **the Commission calls on governments to establish structures, incentives and the environment to develop coherent national One Health strategies, building on the concept of Health in All Policies.** Each government must decide how it does this, acting within its borders while taking advantage of the benefits of international collaboration. What matters is that those in authority, and in particular ministers of finance, health, agriculture and the environment, come out of their silos to find shared solutions to common problems.

Enhanced cooperation at international level

32. The changes we need to see will be driven by policies and initiatives within individual countries, but they should be supported by the global architecture. Yet, like at the national level, the global and regional landscapes are fragmented. **The Commission calls for the adoption of measures to address gaps and overlaps in existing international governance structures, and especially among the various United Nations specialized agencies.**

33. For many reasons, not least the need to avoid massive organisational disruption at a time when the world is recovering from a crisis, changes will most likely be incremental. But that does not mean that there is no urgency. **We need imaginative thinking about how we can develop synergies among WHO, FAO, OIE, UNEP and other related bodies.** Logically, this will be under the umbrella of the United Nations. An organisation or network (existing or purpose-built) could be tasked with developing norms based on a common understanding of future challenges to One Health, supporting governments as they implement national One Health strategies, and providing a forum for convening relevant groups for mutual learning, dissemination of good practice, and development of appropriate metrics to assess performance. In the WHO European Region, we recommend that the WHO Regional Office for Europe should be the lead convening agency.

34. Reaching policy goals and targets requires common tools and regulatory frameworks. **The Commission calls for the development of common terminologies and an appropriate international architecture to establish priorities, agree areas of responsibility and identify scope for collaboration to promote the health of humans, animals and the natural environment.** Measurable outcomes would facilitate the integration of One Health into existing tools, such as the increasingly widely used environmental, social and governance (ESG) indicators, and other regulatory frameworks, which in turn would encourage the private sector to consider issues associated with One Health, incorporating them within reporting and risk assessments.

OBJECTIVE 2
TAKE ACTION AT ALL LEVELS OF SOCIETIES TO HEAL THE DIVISIONS EXACERBATED BY THE PANDEMIC

RECOMMENDATIONS

2.1 Ensure that internationally comparable information systems capture the many inequalities in health and access to care within populations, in order to inform policies and interventions that address the deep-seated causes of these inequalities.

2.2 Identify those in society who lead impoverished or precarious lives, and develop and implement policies to give them the security that underpins good health.

2.3 Adopt explicit quotas for the representation of women on public bodies that are involved in formulation and implementation of health policy.

Make the invisible visible

35. **One of the most concerning impacts of the COVID-19 pandemic is not just that it has laid bare the inequalities and inequities which blight our societies, but that it has exploited them.** It has shone the most tragic of lights on the fractures between individuals, groups and communities, revealing our continuing failure to look after those who are most vulnerable.

36. While everyone has been affected, to some degree, by the pandemic and responses to it, some groups have suffered much more than others. In almost all cases, they are those who are already disadvantaged or overlooked. They include children living in homes that lack space to study or the Internet access needed for online learning; people in precarious employment, who have to choose between going to workplaces where they are exposed to infection and putting food on the family table; people with chronic diseases, such as cancer, HIV, cardiovascular diseases, and diabetes; and people living in long-term care facilities, many of whom have died without the support of their families, often in terrible circumstances.

37. This situation is a consequence of policies over many years that have given rise to high rates of wealth and income inequality, underinvestment in social protection and, especially in health and social care, unequal opportunities for some groups. These policies have also led to growing precariousness of jobs, wages, housing and even food supplies, racism and other forms of discrimination, and prioritisation of the preferences of the individual over the needs of society. In their own ways, they have all contributed to the difficulties governments across the world have faced in responding to COVID-19.

38. From the beginning of the pandemic, most governments recognised, even if belatedly, that something had to be done to protect those at greatest risk. Governments adopted a wide range of measures, including rent freezes and bans on evictions, business and job support schemes, direct cash transfers, and a range of economic stimulus measures. But, as post-COVID-19 recovery plans emerge, **it is time to make the mantra of "building back better" a reality. There is a pressing need to address the long-standing and deep-seated causes of these inequalities.**

39. This can only happen if governments have an accurate picture of the scale and nature of these inequalities. Yet many do not. Often, those who are most disadvantaged are effectively invisible in official statistics. Unless the characteristics associated with disadvantage are recorded, with appropriate protections, it will be impossible to know if people are systematically being disadvantaged.

40. This will build on the existing work of WHO and other international bodies that have long been engaging with governments to help them improve their health information systems. To be useful, routine data must go beyond the usual disaggregation by age and sex to include, as far as possible, socioeconomic data related to education, ethnicity and migration status, although with strong safeguards to avoid abuses by, for example, police and immigration services. **Regular surveys should be undertaken to track living conditions, health needs and health care utilisation** in ways that enable international comparisons, with adequate sample sizes and harmonised questions. There are already surveys that do this, such as the EU Survey of Income and Living Conditions and the Survey of Health, Ageing and Retirement in Europe, but they do not cover the entire pan-European region.

41. These data are important at all times but are especially so in a pandemic, when effective and appropriate national and international public health responses are contingent on the sharing of sound epidemiological information between countries in order to understand transmission and spread. These systems are sorely lacking within, far less between, countries in the pan-European region (and indeed globally). Worryingly, COVID-19 has exposed wider failings in terms of countries' abilities to work together to develop solutions to the fragmented and incomplete data environment across the WHO European Region. Consequently, **the Commission calls on governments, with the support of the WHO Regional Office for Europe, to develop measures spanning the entire pan-European region to ensure the interoperability of health data and that can provide timely information on the distribution of health within populations by gender, ethnicity (where legally possible), economic status and other relevant characteristics.**

Reduce inequalities

42. Comprehensive strategies to reduce inequalities are not just a matter of fairness. There is a strong argument for action on the basis of self-interest. Many of the conditions that disadvantage individuals and families have provided opportunities for the virus to persist and spread. But there is another reason. In some countries the pandemic has led to increasing polarisation, dividing communities into "them" and "us" and undermining trust in public bodies. Evidence from the recent and distant past reminds us that a situation in which some groups are systematically left behind can weaken trust in the political system, with consequences for all of society.

43. For these reasons, **the Commission calls on governments to identify those in their societies who lead impoverished or precarious lives, recognising the threat that this poses not only to health but also to trust in institutions and to democracy,** and to support policies to address and reduce these inequalities. **Calls to "build back better" and "leave no one behind" must not be empty slogans.**

Strengthen trust

44. Much public (and private) discourse is now characterised by acute social and political partisanship, leading to a dilution of facts and worries about an emergent post-truth era. When conjecture and opinion are given equal weight to scientific evidence, we see an undermining of experts and, worryingly, policies being designed and implemented on the basis of what is hoped for, rather than what is known.

45. The increasing lack of trust in facts and expertise is mirrored by growing scepticism towards political leaders and systems of governance. This has often hindered the pandemic response, especially in those countries where members of the political class are portrayed as a self-serving elite. This is inevitably detrimental to engendering the necessary public support for COVID-19 response measures. The lack of trust creates a societal fracture, and one that demands a new form of leadership and improved approaches to decision-making.

46. The demand from patients that there should be "no decision about me, without me" and the move to patient-centred care are just as relevant for population-based measures as they are for individual ones. Policies enacted in response to the pandemic have, in too many cases, paid insufficient attention to the practical issues that ordinary people face when implementing them. There is growing experience with what is termed the "co-creation of solutions", working with communities to develop policies that can achieve the widespread acceptance needed if they are to work. It is especially important to do this in partnership with communities whose voices often go unheard. Hence, **the Commission calls for new approaches to decision-making that, while based on the best available scientific evidence, are inclusive, embody shared values of fairness and justice, and attract widespread public support.**

Ensure women's participation in leadership roles and beyond

47. Crises, whether as a result of natural phenomena or human actions, almost always have a gendered impact, affecting women and men differently. In the current pandemic, women have been much more likely to lose their jobs, and many of the disproportionate numbers of women in the informal economy have suffered large falls in income. They have experienced higher rates of burnout than men, and some have gone without food to protect their children. Many girls have left education and, as schools reopen, they seem less likely than boys to return.

48. In part, this reflects the gendered nature of employment. Although some progress has been made in narrowing the gender gap in employment since the 1995 Beijing Declaration and Platform for Action, even now many women have traditional care-providing responsibilities while they miss out on educational, labour market and income opportunities. This leads to occupational segregation, with women under-represented in higher-paid positions and higher-profile sectors. Women more often work in precarious employment with less stability, lower pay and benefits; in 2019, the gender pay gap in Europe was estimated at over 14%. With women over-represented in sectors like hospitality, tourism and education, often in lower-level positions with less flexibility for homeworking (particularly in higher-income countries), they have been especially vulnerable to the restrictions imposed to control COVID-19. These pressures have contributed to worsening physical and mental health, while many have experienced gender-based violence. We commend many of the measures that governments have taken to provide support, some specifically aimed at women, but we now need a renewed commitment to gender equality in policy design and decision-making. Demands for an explicit gender dimension in post-COVID-19 recovery plans abound, with the G7 promising investment in girls' education and women's employment, but this will only bring about the necessary structural changes if women participate actively in setting agendas.

49. Thus, **the Commission calls for governments to increase participation by women in decision-making bodies and ensure that their rights and needs are reflected in all government policies.** This should include the adoption of explicit quotas for representation of women on public bodies engaged in the development and implementation of health policy, particularly in preparedness, crisis management and response. We know that gender equality in decision-making has positive economic consequences and brings myriad benefits, **with women in leadership positions shown to prioritise issues of social importance (health, education, welfare, rights, social cohesion)** ahead of their male counterparts. And it is precisely on these areas that any post-COVID-19 planning must focus.

RECOMMENDATIONS

3.1 Conduct a strategic review of areas of unmet need for the innovations required to improve One Health in Europe.

3.2 Establish mechanisms to align research, development and implementation of policies and interventions to improve One Health, based on a true partnership between the public and private sectors in which both risks and returns are shared.

3.3 With the support of the WHO Regional Office for Europe, continue efforts to develop a mechanism for constant generation of knowledge, learning and improvement based on innovation in the pan-European region.

Conduct a strategic review of areas of unmet need

50. The pandemic has confirmed the importance of innovation for better health. At its best, this has included new treatments (and, in some cases, new uses for old treatments) such as vaccines and medicines, some based on new technology, and new models of care, such as online consultations and innovative approaches to surveillance of both the spread of disease and the responses to and consequences of countermeasures. Yet the enormous investments in biomedical innovation do not always flow to where they are needed most. The existing model of innovation is widely recognised as being flawed. First, much of the risk is borne by the public sector, which funds a large share of the basic research that underpins new medicines and technologies, yet the returns mostly flow to the companies that take this knowledge and turn it into products that they bring to market. Second, the priorities of these companies are strongly influenced by the existing pattern of incentives. Products for which there is only a small market, such as those for rare diseases – and thus where the price required to achieve a return on investment is high – are only produced where there are other incentives present, such as extensions of patent protection or public subsidies for research and development. The situation with antimicrobials is even more difficult, as there is a strong incentive for health care providers to use them as rarely as possible, in order to reduce the emergence of resistance. This misalignment of incentives can also be seen in other areas of innovation. For instance, some medical technology shares a business model with printers and razors, for which the initial cost may be kept low while profits are realised on necessary consumables, so there is a strong incentive to minimise the scope for interoperability. Organisational interventions, such as new models of care, give rise to similar problems, because it is difficult to create an economic model that will achieve a return on investment. Many examples of market failure have been recognised, to differing extents, in the pandemic. Thus, the development of COVID-19 vaccines benefited from large sums of public funding for research and development and advance purchase agreements, with strategic investment by the Coalition for Epidemic Preparedness Innovations (CEPI) playing a key role. Much of the evidence on new treatments for COVID-19 came from publicly funded trials, such as the United Kingdom's RECOVERY Trial, or from imaginative use of large databases, such as the insights that have come from the OpenSAFELY initiative.

51. In these and other ways, the scale of the pandemic has highlighted the importance of research undertaken with purpose. A question was identified and researchers and developers, in the public and private sectors, were asked to answer it. Yet there are many other questions that also need answers. Some have been alluded to above. They include: what new antimicrobials might be possible, allowing us to remain ahead in the race against resistance; whether there are rapid diagnostic tools, like the lateral flow tests that have contributed to control of COVID-19, that might be used to reduce the use of antimicrobial agents; and whether there are there drugs that can prevent the progression of dementia. There are also a vast range of questions about how to ensure that innovations are adopted into practice and models of care are optimised. And how can we ensure that patients and frontline health workers are involved in co-production of these answers? Yet as we struggle to answer these questions, we must work within a system that, too often, is developing products with little therapeutic benefit, especially the so-called "me too" products that offer at best marginal advantages over what already exists.

52. Although our existing system can generate essential innovations, too often it fails to do so. There are many examples of alternatives, such as CEPI or the Drugs for Neglected Diseases initiative. These show what is possible. **The Commission calls for a continuous process of assessing unmet health needs in Europe, looking at neglected diseases, population groups and interventions, undertaken to shape a strategic response that spans all stages of the innovation process,** from basic research through to late-stage clinical trials and post-marketing surveillance.

Build partnerships for innovation

53. The assessment of unmet health needs should inform improved systems of innovation governance in Europe, some of which are already emerging, such as the EU's Health Emergency Preparedness and Response Authority (HERA) initiative. **The way forward will, inevitably, require public/private partnerships but, unlike some in the past, these must be based on transparency, with sharing of the risks and benefits of innovation**. There is also scope for making greater use of models of procurement that facilitate dialogue between those procuring the goods and services needed to deliver innovative health care, on the one hand, and those producing them, on the other. And governments, health care providers, professional bodies and others must create mechanisms to ensure that the needs of those delivering health care are heard in shaping the agenda and developing the solutions.

Support learning health systems

54. Health systems are both users and creators of research. Yet, too often, the second of these roles is undervalued. At the onset of the pandemic, when there was still much uncertainty about what treatments would work, many patients in European hospitals were denied the opportunity to participate in clinical trials and instead were given treatments that were unevaluated for use with COVID-19. Eventually, thanks to initiatives like the RECOVERY Trial, several treatments, including low-cost generic dexamethasone, were found to be effective, but by then many people had died needlessly. In some countries, organising such trials would have been prohibitively complex because of a failure to implement streamlined ethical and other approval systems and funding streams before the pandemic. Similarly, it took too long for the complex multisystem nature of COVID-19 to be understood, not least because of the weakness of structures for dialogue among different specialties, whose members read different journals, go to different conferences and often fail to interact with each other. This situation must not happen again. **The Commission calls on governments, research funders, health care providers and professional bodies to review the ways in which they support health systems that are learning, routinely generating new evidence, synthesising and disseminating it, and implementing change in medicines, technology and models of care.**

RECOMMENDATIONS

4.1 Increase all investments in health systems, particularly in those parts of systems that have traditionally attracted fewer resources, such as primary and mental health care, while ensuring that this investment is directed in ways that maximise the ability of health systems to deliver the best possible health for those who use them.

4.2 Invest in and strengthen the health workforce in the light of experiences during the pandemic, with a focus on ways of attracting, retaining and supporting health and care workers throughout their careers, coupled with reviews of how the roles of health workers can evolve, given the rapidly changing nature of medicine and technology.

4.3 Reassess and strengthen the links between health and social care in the light of experiences during the pandemic, with the goal of increasing integration between them.

4.4 Prioritise prevention of communicable and noncommunicable diseases and scaling up of investment in public health capacities.

55. The pandemic delivered an unprecedented shock to health systems. In the worst affected regions, the numbers of patients needing intensive care soared, far exceeding the available capacity. Television coverage from Italy, whose northern regions were the first to be affected, portrayed severely ill patients being treated in corridors by health workers who were struggling against almost impossible odds. There were shortages of almost everything. There were too few beds into which the patients could be admitted, too few health workers, too little equipment, especially ventilators, and, in some cases, problems in ensuring consistent supplies of oxygen. In these circumstances, the priority became saving the lives of those with this new and, for too many of those affected, lethal virus.

56. These pressures threw into sharp relief the failures, in many countries, to invest in hospitals that had sufficient flexibility to respond to the crisis that so many had been warning about for decades. This was quite different from the situation in some Asian countries, where hospitals had been redesigned with the threat of a pandemic in mind, including the capacity to separate those suffering from the pandemic disease from those needing routine care.

57. At the same time, another tragedy was unfolding in facilities providing long-term care, predominantly for frail and elderly people. In some countries, the imperative to empty hospital beds by discharging those who were already in hospital introduced infections into these facilities. A combination of factors, including the low priority that they were given for supplies of personal protective equipment (PPE), the informal employment of many staff, so that individuals might work in several facilities, and a lack of testing allowed infections to spread rapidly, causing the avoidable deaths of large numbers of vulnerable residents and, in some cases, those caring for them.

58. Such a situation cannot be allowed to happen again. The inquiries that are being undertaken in some countries are providing many lessons that must be learned. It is beyond the scope of the Commission to provide a detailed template for how health systems should be organised in future. However, we can point to a number of principles that should be included in policies to increase the resilience of health systems going forward. These relate, in particular, to the infrastructure of health systems, including the design of health facilities, the health workforce, who have played such an important role in responding to the crisis, and the relationship between health and social care.

Strengthen health systems infrastructure

59. It has long been recognised that there is great variation in the level of investment in health systems across the pan-European region. A recent study that gathered data from selected countries in western Europe found that the intensive care bed capacity varied by a factor of five. Unsurprisingly, those countries that had the lowest levels of provision struggled, and the attention of policy-makers was diverted to the need to protect the health system. In the end, many health care providers did cope, but only through the heroic efforts of their staff and by imaginative approaches to reconfiguring services and redeploying health workers. General wards were converted into intensive care units, with staff undertaking rapid training that allowed them to monitor, under supervision, the most severely ill patients.

60. There was a cost, however. Staff who were redeployed could not care for the patients they would normally look after. In many countries, much routine activity, especially in areas such as primary care and mental health services, effectively ceased. Even now, the consequences are not fully understood. However, suspension of some activities, such as cancer screening, is likely to have profound consequences going forward.

61. The most important lesson to learn from this experience is that the practice, in some countries, of running health facilities at over 95 % occupancy, with no mechanism to respond to surges, is short-sighted. While this may seem to be efficient in the short term, it brings a substantial cost in the long term. This is not just a problem of physical capacity. Several countries demonstrated that they could rapidly expand the number of hospital beds, for example by taking over venues such as unused conference facilities. However, in most cases, these were of little use because it was not possible to obtain the staff needed to look after patients.

62. Addressing this challenge will not be easy. Clearly, governments, especially those facing financial pressures, will be reluctant to invest in the additional capacity necessary to respond in a crisis. Yet it has become apparent that there is a need for greater investment in health systems in many countries in the pan-European region. While it is inappropriate and unnecessarily divisive to separate out different parts of the health system (all are necessary to deliver care), taking resources away from one set of activities to support others is unhelpful. However, some areas have historically been under-resourced: primary care, in particular, has often suffered from a set of financial incentives that have made it less attractive than specialist care in hospitals. Mental health services have also come under additional pressure in many countries because of the effects of austerity and employment policies that increase insecurity. As a consequence, in many countries some people with mental health problems are being managed, inappropriately, in the criminal justice system.

63. For these reasons, **the Commission calls on governments to increase investments in health systems overall, but in particular in those parts of the system that have traditionally attracted fewer resources, while ensuring that this investment is directed in ways that maximise the ability of health systems to deliver the best possible health for those who use them.**

Attract, train and retain the health workforce

64. Health workers have been the heroes of the pandemic. They have gone above and beyond the call of duty, working for long hours in often horrendous conditions. They have faced physical discomfort, wrapped in PPE, and mental strain, including high levels of burnout and what is termed moral injury, a feeling of guilt when one is unable to provide the quality of care that one would wish to because of the prevailing circumstances. In too many cases, health workers have given their lives in the service of others.

65. Their struggles have been recognised, with politicians offering public thanks and other gestures of appreciation. However, this is not enough. In many countries, health workers are poorly rewarded. Their salaries are lower than those with similar levels of education and, in some countries, there is a tacit understanding that they will supplement their incomes with informal payments. Their prospects for career progression are limited, with rigid hierarchies. As a consequence, many of them leave the health systems in their countries for better prospects abroad, for opportunities in other sectors, or simply to exit the workforce altogether. This is not just a problem of wasting scarce skills and expertise. There is also compelling evidence that health facilities that attract and retain staff, such as hospitals with Magnet accreditation, provide better quality care, including, crucially, fewer hospital-acquired infections. For these reasons, **the Commission calls on governments to undertake reviews of their strategies to strengthen the health workforce in the light of the experience during the pandemic, with a focus on ways to support these essential workers throughout their careers.**

66. At the same time, i**t is necessary to recognise that the roles of health workers are changing.** This is yet another process that has accelerated during the pandemic. There is a growing body of evidence about what is termed "task shifting" in the health sector. This seeks to ensure that those who are best placed to undertake a role do it. The fact that something has been done by one group of workers for decades is not a sufficient justification for continuing in this way. Many health workers have accordingly taken on additional responsibilities, in particular to support the needs of patients who are much more severely ill than those they normally care for. Task shifting involves relationships among three elements: health and care workers, patients and carers, and technology. Historic medical paternalism is, in many countries, giving way to a recognition that patients, in some cases assisted by their carer, should work in partnership with their health worker, setting shared goals and deciding how best to achieve them. Advances in scientific knowledge and in technology, such as changing ways of accessing the body's internal organs, have created many new roles for different groups of health workers. It is important that deeply entrenched historic boundaries do not obstruct progress. However, it is also important to stress that change should be about improving health outcomes and not simply saving costs. Consequently, **the Commission calls on governments, working with professional organisations, to explore how the roles of health workers can evolve, given the rapidly changing nature of medicine.**

Integrate health and social care

67. The avoidable deaths of so many people living in residential facilities will, for many families, be remembered as a defining characteristic of the pandemic. For too long, social care has been the poor relation of the health system. Few governments have put in place systems to fund it adequately, despite clear warnings from demographers about ageing populations. The necessary decisions can no longer be postponed, especially given evidence from several countries of further declines in birth rates during the pandemic.

68. This will require a comprehensive approach to ageing populations. There is already much evidence about what can be done to promote healthy ageing, in particular through policies which ensure that those in middle age are as healthy as possible and that older people are given opportunities to remain socially engaged, for example through community facilities, free public transport schemes and other mechanisms. Looking ahead, the pandemic has introduced many older people to online platforms, which could provide further opportunities for engagement, although this should not be taken for granted.

69. Some of these policies have already borne fruit. The prevalence of dementia at different ages is falling in several countries; this is thought to be, in part, a consequence of improved management of traditional risk factors such as high blood pressure. Yet, despite these improvements, there will still be many people who need long-term care. Beyond them, there are others living in the community, with support from social services, many of whom have suffered greatly as a result of the necessary restrictions during the pandemic. Both of these groups include many people who require increased support from health services. All too often, however, the fragmentation of health and social care means that they fall through the gaps in the system. Both the residents of care homes exposed to COVID-19 and people living in the community whose complex needs made it difficult for them to adhere to the measures implemented to reduce the spread of infection were failed by the system. For these reasons, **the Commission recommends that governments and agencies involved in the funding and delivery of health and social care should undertake a reassessment of the links between these different elements of care in the light of experiences during the pandemic, with a view to overcoming the systemic failures that were magnified during the pandemic.**

RECOMMENDATIONS

5.1 Change the way in which health expenditure data are captured so that there is a clearer distinction between consumed health expenditure and frontier-shifting investments.

5.2 Scale up investment in measures to reduce threats, provide early warning systems and improve the response to crises.

5.3 Strengthen health systems surveillance powers for WHO, including periodic assessments of preparedness, with these assessments feeding into monitoring by the IMF, development banks, and other technical and financial institutions.

5.4 Increase the share of development finance spent on global public goods, long-standing cross-border externalities, and health more generally.

5.5 Incorporate health-related considerations into economic forecasts, business strategies and risk management frameworks at all levels.

70. Factors such as short-termism in decision-making, not taking into account the large external benefits of action against global health threats, and the fact that the global health system is only as strong as its weakest link led to the failure to invest in the preparedness and resilience of health systems that contributed to the adverse impact of the COVID-19 pandemic. To remedy this, there must be changes in the information, incentives and norms that govern the allocation of resources, both by national governments and by the private sector. In addition, the cross-border spillovers and global interdependencies from health threats such as pandemics and AMR justify greater global financing to combat them.

Differentiate consumed health expenditure and frontier-shifting investments

71. National accounting frameworks have important implications for policy and planning. Over the past century, numerous efforts have been made to institutionalise the systematic measurement of economic activity at national level. The main purposes of these efforts have been monitoring and evaluation, support for evidence-based decision-making, and facilitation of international comparisons. Since 2000, the health sector has had its own specific framework for tracking health expenditure– the System of Health Accounts (SHA) – which serves as the global basis for reporting aggregate health care spending across a wide range of dimensions. There have been revisions to the SHA to take on learned experiences in health accounting and to make health accounts more useful and relevant for policy. The way in which expenditures are captured by these frameworks, including the variables collected and the level of disaggregation, makes it necessary to consider whether there is scope for improving how health expenditure data are recorded.

72. **Current systems can be improved by distinguishing between routine and frontier-shifting health spending.** The current SHA already classifies health expenditure by function, so as to differentiate between various objectives of health spending (such as curative, rehabilitative and preventive). However, it is not fit for purpose because it fails to distinguish between routine health spending (which has a contemporaneous and direct impact on health) and frontier-shifting health spending, that is, expenditure which either delays or prevents the onset of disease (prevention) or which improves the efficiency of care delivery (technological progress). Thus, **the Commission calls for changes to be made in the way in which health expenditure data are captured so that there is a clearer distinction between consumed health expenditure and investments. This will incentivize countries to invest more in preventive services and is likely to support much-needed innovation that improves the efficiency of care.**

Increase public investment in prevention, preparedness and response

73. Future pandemics are preventable if we invest in prevention, preparedness and response. Indeed, as highlighted by the report of the Independent Panel for Pandemic Preparedness and Response (IPPPR), the COVID-19 crisis was preventable. To stop future health crises, **we must act now to urgently address the manifold weaknesses that have been identified in our international preparedness and response systems.** We now know that the costs of activities to prevent pandemics amount to only a small fraction of the costs that can already be attributed to the COVID-19 pandemic. We cannot afford any further delays to investing in a One Health approach to prevention.

74. Pandemic prevention and management cannot be left to private markets or individual countries, as both constitute global public goods. Actions to enhance pandemic prevention, preparedness and response, or to tackle AMR and environmental challenges to health, benefit everyone equally, even if they do not pay for them. The provision and financing of any public good suffers from the free rider problem; private markets will not finance sufficient amounts of a public good because the benefits accrue to everyone. The same is true with a global public good; individual countries will underinvest since at least part of the benefits of successful prevention and management will accrue to others. Finally, pandemic preparedness as well as pandemic management suffer from the weakest link problem. The weakest link in a chain determines the strength of the entire system. The weakest link in fighting a pandemic is the country that is unable to contain the virus and becomes a source of new infection and variants. Together, these spillovers and interdependencies mean that the financing and governance of pandemic prevention and management need to be a common concern for the global community.

75. **The Commission calls on governments, public authorities, development banks and others to scale up investment in measures to reduce threats, provide early warning systems and improve the response to crises.** We must be able to anticipate where, when and how infectious disease threats are most likely to (re-)emerge over the coming decades and to take advantage of innovative methods, such as the genetic epidemiology of microorganisms, to transform the development of future biomedical countermeasures and to enable the rapid identification of and response to future outbreaks.

76. **Fiscal policy should be aligned with One Health strategies and take into account the co-benefits of investment in health and the environment.** As set out above, governments should develop coherent cross-government One Health strategies, aligning fiscal policy with these strategies. It is essential to take a broad perspective. Global warming will increase the risk of extreme heat events that threaten human health and will lead to seawater rise and inundation of low-lying areas, making some places uninhabitable. Policies that reduce incentives for deforestation or intensive farming may benefit environmental and biodiversity goals but will also reduce the risk of zoonotic spillovers and AMR. Tools such as ecological fiscal transfers, which transfer public revenue between governments within a country based on ecological indicators, or the REDD+ mechanism, which offers low-income countries results-based financial incentives for preventing deforestation and forest degradation, have been used with conservation goals in mind, but they could also be adapted to attain health goals. The mechanisms could provide financial rewards for reducing risk factors for the emergence of new infectious diseases. Programmes of this kind would have co-benefits across the various domains of One Health, benefiting human, animal and plant health as well as the health of the environment. Fiscal policy should aim to maximise these co-benefits.

Enhance the surveillance of health systems

77. Multilateral surveillance of health systems and fiscal policies is an established feature of the international order. Multilateral organisations – including WHO, the European Commission, IMF and the Organisation for Economic Co-operation and Development (OECD)– play an important normative role in shaping national policy through routine country surveillance exercises. For example, the European Commission, through the European Semester, engages in an annual cycle of budgetary and macroeconomic surveillance of its Member States; IMF, through Article IV consultations, regularly assesses the economic and financial policies of its 190 Member States and holds discussions with governments, central bank officials and other key stakeholders about its findings and lessons from international experiences; and OECD also conducts country reviews when requested to do so.

78. The pandemic has revealed the costs of underinvestment in health, and the links between surveillance of health systems and fiscal policy should be strengthened. Although some health systems are assessed through the European Semester and by OECD, health does not generally feature in IMF Article IV consultations, beyond considerations of fiscal pressures attributed to health spending and calls to increase health system efficiency. This is a missed opportunity for the international financial institution, as the pandemic has revealed that inadequate health investment, especially in public health systems, can itself constitute a source of macro-critical risk, not just to the country in question but to the world.

79. **The Commission calls for WHO to be given the power to undertake periodic assessments of national health systems, focused on public health functions and the ability to prepare and react to pandemics, and for its assessments to feed into IMF surveillance and the programming of development banks and other technical institutions.** These assessments could draw on the experience of the Universal Periodic Review used by the UN Human Rights Council to assess emergency preparedness and response capacity and compliance with legal obligations under the IHR (2005). Alternatively, a model similar to IMF Article IV consultations could be used, whereby the institution's staff visit governments and analyse and discuss risks to fiscal and financial stability, with the results fed into a final report. Such reviews could in turn feed into IMF surveillance, enabling it to make a judgement on whether levels of health spending on public health functions are so low as to make the overall level or efficiency of health spending macro-critical.

80. **Improved surveillance of health systems and spending should also guide domestic and donor priority-setting.** This will be useful not only for high- and upper-middle-income countries, which are likely to finance health primarily from domestic revenues and could benefit from external evaluation, but also to monitor whether low- and lower-middle-income countries are receiving sufficient support from multilateral development banks (MDBs) and other external financing sources for public health. The reviews could feed into the capacity-building work of WHO and the programming of the World Bank, decisions by regional development banks, and support by other agencies engaged in One Health such as FAO and OIE. Many European Member States of WHO are major shareholders in MDBs and funders of concessional windows, and they could push for policy changes to increase the prioritisation of health within their portfolios.

81. **Alongside increased public investment in health, development finance institutions should increase their support to private sector investment in health.** Development finance institutions that invest in the private sector, including MDBs such as the International Finance Corporation (IFC) and the European Bank for Reconstruction and Development (EBRD), currently undertake little investment in the health sector. Between 2013 and 2018, less than 3% of investment by development finance institutions went to the health sector and less than 1% of this 3% went to low-income countries. There is a clear need to for these institutions to prioritise and increase investments in supporting health research and innovation and strengthening supply chains, rather than just in the direct provision of health services. This is needed not only worldwide but also in the low- and lower-middle-income countries in the WHO European Region, where EBRD and IFC will have a particularly important role to play.

82. **The Commission calls for increases in the share of development finance focused on providing global public goods and managing long-standing cross-border externalities, and for governments which are major shareholders in multilateral bodies to ensure both that the volume of lending from MDBs is expanded and that health issues are given higher priority, including in low- and lower-middle-income countries.**

Incorporate health-related considerations into economic forecasts

83. There is a well established precedent in financial risk assessment to consider ESG factors, in addition to the prospect of obtaining good financial returns, prior to making investments. These factors are increasingly being used to inform investment decisions at all levels, from businesses to sovereign and supranational bonds. The main aim of ESG indicators is to incentivise and reward achievements in socially responsible domains by assessing a borrower's performance in the aforementioned areas. While critics are sceptical as to whether these measures are taken seriously by both creditors and borrowers, there are a growing number of examples where they have been successful in steering capital away from harmful activities.

84. **The One Health framework can be used to identify ESG indicators that encourage ethical and sustainable investment. The ESG concept should be refined to include One Health–related considerations, with a view to minimising risks and maximising opportunities, and to move more effectively towards the SDGs.** Indeed, the impact of investment on health may already be seen as part of the social dimension, and analysis of impact on the environmental dimension can be adapted to capture the impact on One Health as a whole. This could help to increase transparency and awareness of each stakeholder's impact on health and exposure to health risks, as well as shifting the priorities and activities of prospective borrowers.

85. **National, European and global regulators should define disclosure and reporting standards that can raise awareness and ensure transparency of the impact of investments on health and exposure to health risks.** Currently, there is very limited information on the positive or negative impact that some activities have on health, and on the risks that may be faced because of ill health. Public authorities and private initiatives have made increasing efforts to ensure transparency with regard to environmental factors, through labels (such as the European green bond standard and EU Ecolabel), classifications of economic activities (the EU taxonomy) and reporting standards (the EU's reporting directives; recommendations of the Financial Stability Board's Task Force on Climate–related Financial Disclosure). Extending disclosure by companies and financial institutions to health–related information would help to increase transparency and awareness. As with climate, such actions would benefit from efforts conducted at regional level (in particular by the EU) and beyond (by global standard–setting bodies and the International Platform on Sustainable Finance) to harmonise standards, on the basis of a common understanding at global level.

86. **To ensure that the financial system takes account of health risks, these should be incorporated into risk management strategies and frameworks. The Network for Greening the Financial System has shown how climate change may translate into financial risks and has been developing scenarios to assess such risks.** This contributes to better risk pricing and to aligning financial flows with climate targets, as required by the Paris Agreement. Just as financial decisions should take into account climate change risks and the negative externalities from investing in activities that lead to carbon emissions, they should also take into account health risks and negative health externalities. Activities that are detrimental or beneficial to health (negative or positive externalities, respectively) are not properly priced and tend to be over– or underproduced. These include activities that increase risks of greater AMR, such as intensive agriculture and deforestation, and land use changes that increase the risks of zoonotic spill–over. The first step will be to develop a common understanding of, and standard information on, health risks, which will allow companies and financial institutions to assess the risks and opportunities associated with health. The example of environmental risks shows that awareness and ownership by the financial sector takes time and requires evidence. Financial institutions, supervisors and regulators are only starting to investigate this area, for example in the insurance sector, where the question of insuring pandemic–related business interruption arises, or to factor health aspects into climate–related financial scenarios.

87. **The Commission calls for health–related considerations to be incorporated into economic forecasts, business strategies and risk management frameworks at all levels. Measurable outcomes will facilitate the integration of One Health into existing tools and regulatory frameworks, which, in turn, will encourage companies and the financial sector to take up approaches that consider the impacts on and risks associated with One Health. Furthermore, the Commission calls on governments and central banks to consider such aspects in their macroeconomic forecasts and in their financial regulation,** drawing on the significant progress that has been made with modelling the interaction between infectious diseases and the economy over the past year.

RECOMMENDATIONS

6.1 Establish a Global Health Board under the auspices of the G20.[10]

6.2 Develop a Pandemic Treaty that is truly global, enables compliance, has sufficient flexibility and entails inventive mechanisms that encourage governments to pool some sovereign decision-making for policy-making areas.

6.3 Develop a global pandemic vaccine policy that sets out the rights and responsibilities of all concerned to ensure the availability and distribution of vaccines.

88. Traditionally, public goods for health include knowledge generated by research and development and communicable disease control. The Lancet Commission on Investing in Health,[11] however, has broadened the definition of global public goods for health to include the management of negative cross-border externalities (such as controlling epidemics and pandemics, tracking AMR and curbing the spread of risk factors for noncommunicable diseases) and fostering global leadership or stewardship (cross-sectoral advocacy, global convening to develop consensus and global policies).

89. WHO is a major provider of global public goods for health, for example by publishing standards, guidelines and assessments of therapeutic products, developing plans of action, convening coordinating structures, and establishing international law such as the Framework Convention on Tobacco Control. But WHO cannot bear sole responsibility for creating global public goods for health.

90. Given the characteristics of a public good, the question arises: who will pay, and what happens if they fail to? Even though the benefits of international collaboration to create global public goods are well established, individual countries are often reluctant to bear the costs, for fear that other countries will free ride and reap the benefits without contributing any funding. Consequently, unless deliberate actions are taken to produce them, there will be underinvestment in global public goods. There is thus a need for a mechanism which ensures that the funding required to produce global public goods is made available and maintained, either from domestic or from international resources.

91. **Although most nations in the world have signed up to the principle of joint action to combat threats to health by becoming States Parties to the IHR (2005), the COVID-19 pandemic has made it clear that this is not enough.** There is no global taxation system, nor is there any system for sanctioning countries that do not contribute to global public goods. **It is therefore necessary to establish mechanisms to raise funds for global public goods and to hold countries to account for their contributions to them.** These mechanisms can take different forms, with different levels of legal underpinning, different limitations of state sovereignty, and different mechanisms of enforcement.

10 See also Annex, Engagement of the Pan-European Commission with the G20 on the establishment of a Global Health Board.
11 Jamison D, Summers L, Alleyne G, Arrow K, Berkley S, Binagwaho A et al. (2013). Global health 2035: A world converging within a generation. Lancet. 2013;382:1898-955. doi: 10.1016/S0140-6736(13)62105-4.

Establish a Global Health Board under the auspices of the G20

92. **The Commission calls for the establishment of a Global Health Board (GHB) under the auspices of the G20 to ensure effective coordination of health, economic and financial policies within governments and in the international area.** This recommendation has been inspired by the success of the Financial Stability Board established after the global financial crisis, also by the G20.[10] The GHB must have a clear mission with political backing and it must operate on the basis of consensus, so we have not set out a detailed blueprint for its composition or operation, as these must be agreed by the governments involved. However, in broad terms we see it comprising representatives of finance and health ministries. We also envisage it being charged with identifying failures in the provision of global public goods for health and marshalling support from the international community to remedy those failures, assessing risk and ensuring preparedness and responsiveness to health crises, including through the release of necessary resources. However, beyond these views, we can identify a series of questions that will have to be answered by governments. For instance, should it deal only with pandemics or with global health threats more broadly? Given the growing importance of interactions between health and sustainable development, it may be inefficient to create a functioning forum for joined-up health and economic policies but to make use of it only for pandemics. How should its activities link to existing activities in the international arena related to developing responses to global warming? Given the successes of central banks and others engaged in greening the financial system (such as the Network for Greening the Financial System), and the likely tendency to broaden those actions to take biodiversity and health into consideration, should there be some role for such institutions, something that might also inject private finance into the financing of health at national and international level?

93. The G20 should, in establishing the GHB, make a special effort to achieve inclusiveness, much more so than is the case currently. We envisage that, like the Financial Stability Board, **the GHB would include countries outside the G20 and would develop strong institutional links with those agencies concerned with One Health,** such as FAO, UNEP, WHO and OIE.

94. It will be important to differentiate the roles of the GHB from those of these other organisations. **A reformed and strengthened WHO must remain the key pillar of global health governance. Indeed, it would gain in influence and effectiveness if the GHB was set up in the context of the G20**, with the WHO Director-General (and possibly some Regional Directors, perhaps on a rotational basis) playing a strong role. **WHO must also retain the ability to declare a public health emergency of international concern, but the GHB could then support the development of risk assessment tools and the mobilisation of financial resources.** It is important to stress that the United Nations would by no means be undermined by the establishment of a GHB at the G20, which would of course be compatible with the Global Health Threats Council to be set up by the United Nations General Assembly, as recommended by the IPPPR. On the contrary, **the United Nations would likely benefit from the increased effectiveness of global health governance deriving from the GHB.** Finally, the GHB should work with the international financial institutions, and especially the IMF, where it could facilitate release of Member countries' Special Drawing Rights.

Agree a Pandemic Treaty

95. **We add our voice to those calling for a new pandemic treaty, which is in accordance with World Health Assembly decision WHA74(16).** This proposal has already attracted widespread, although not universal, support. Both the IPPPR report and a March 2021 statement by world leaders call for a **pandemic treaty that clarifies the responsibilities of States and international organisations and establishes legal obligations and norms under pandemic circumstances.** They also envisage that the treaty would create and support arrangements which could generate global public goods. Beyond this, the Commission believes that several other issues should be considered in taking forward this process and that the treaty should be truly global, enable compliance, have sufficient flexibility and include inventive mechanisms that encourage governments to pool sovereign decision-making in some policy-making areas. Such a treaty would:

- be truly global – for the treaty to be successful, it must include as many countries as possible. Neither China nor the United States signed up to the March 2021 statement by world leaders and, as two of the largest economic players in the world, their participation in a future agreement of this sort is vital;
- involve non-State actors – researchers and other nongovernmental organisations should be involved in development of the treaty in order to help it gain widespread acceptance;
- learn from previous experience – the treaty should not reinvent the wheel. Instead, it should be informed by a detailed analysis of the issues that limit the effectiveness of existing arrangements, such as those of COVAX and IHR (2005);
- promote compliance – since the treaty will need to be agreed by all governments involved, it is unlikely that sanctions will be used as compliance tools; instead, strong incentives for compliance should be created;
- have the right scope – governments will need to think strategically as to what must be in this treaty and what might be better placed in other measures (such as those discussed elsewhere in this report). It is crucial to strike a balance between what is desirable and what is feasible. While the treaty should have sufficient flexibility to respond to a wide range of scenarios at different jurisdictional levels, it must avoid including so much that compliance becomes an issue;
- pool sovereignty – for the treaty to be successful, governments must pool some degree of sovereign decision-making for policy-making areas to the global body responsible and allow global norms to prevail over domestic prioritisation. Proper incentive mechanisms should be in place to encourage this.

Develop a Global Pandemic Vaccine Policy

96. Policies on the vaccines needed in pandemic circumstances should consider the public goods involved. These are twofold: (1) the knowledge generated from vaccine research and development (R&D); and (2) the potential for population immunity or disease eradication via vaccines. R&D knowledge can include technological platforms for producing vaccines, and if this knowledge can be adopted by others – subject to knowledge transfer and relaxation of intellectual property (IP) rights – then further technological advances may be made, thereby creating positive externalities. If vaccines lead to population immunity or disease eradication, they also produce positive externalities. On the other hand, there is also a double or negative externality issue: producers may prevent knowledge spill-over from their R&D efforts and investments, and individuals may not capture wider benefits such as population immunity from their choice not to be vaccinated.

97. The first COVID-19 vaccines were developed, distributed and administered to a portion of the world's population in less than a year – an incredible and unprecedented scientific feat. Some countries are well on the way to achieving vaccination coverage of their entire adult populations (and even beginning to vaccinate children), but meanwhile vaccination rates in other countries are alarmingly low and new variants of COVID-19 are spreading quickly. This experience has demonstrated just what science can achieve with global collaboration, but it has also illustrated the huge global inequities that exist.

98. There is an urgent need to scale up the availability of COVID-19 vaccines, not just now but for some years to come. This would ensure that most of the global population is vaccinated, which in turn could enable economies to reopen and prevent the emergence of new, more dangerous strains of the virus. As such, several key issues emerge. These include whether to waive IP rights so that manufacturers all over the world could produce vaccines themselves, how to support mechanisms to scale up manufacturing and ensure global access to vaccines, and what vaccine-sharing policies are appropriate in emergencies.

99. **The Commission calls for a Global Pandemic Vaccine Policy – in accordance with the WHO Global Vaccine Action Plan 2030 – setting out the rights and responsibilities of all concerned,** including those funding and undertaking the research needed to develop and evaluate vaccines, those who approve the products, those concerned with IP, and those who must ensure that vaccines are distributed to those in need and administered by frontline health workers. This new policy must find a way to achieve the immediate public health goal of a high level of protection against the disease in question while not dissuading manufacturers from investing in R&D.

RECOMMENDATIONS

7.1 Establish a Pan-European Network for Disease Control convened by the WHO Regional Office for Europe to provide rapid, effective responses to emerging threats, by strengthening early warning systems, including epidemiological and laboratory capacity, and supporting the development of an interoperable health data network based on common standards developed by WHO, recognising that governments will move at different speeds.

7.2 Establish a Pan-European Health Threats Council convened by the WHO Regional Office for Europe to enhance and maintain political commitment, ensure maximum complementarity and cooperation across the multilateral system, accountability, and promotion of cooperation between legislatures and executive agencies in the pan-European region.

7.3 Prioritise the development of data-sharing and data interoperability platforms.

7.4 Secure the necessary funding for WHO to fulfil its mandate within the WHO European Region.

100. Interconnectedness, the basis for the exchange of goods, services, people and ideas, has many benefits but has always carried the risk of disease transmission. The WHO European Region contains many highly interconnected countries. According to the 2020 DHL Global Connectedness Index, 19 of the 25 most connected countries in the world are in Europe (the other six are in Asia). Five of its airports (Amsterdam, London, Paris, Frankfurt and Istanbul) were among the world's 20 busiest in 2017 and at each a much higher proportion of travellers were moving internationally than is the case at equally busy airports in the United States or China. On the one hand, this means that Europe is especially exposed to any threat to health, and the world to any threats that emerge in Europe; on the other, the consequences for Europe and the world of a reduction in connectedness could be dramatic.

101. The pan-European region is also extremely diverse, with variations in wealth, population size, political regime, interconnectedness, demographics and population health. This produces a variety of coordination and policy problems.

102. The effort it has taken to coordinate responses across the region during the pandemic and to produce any comparable and useful data within the EU or WHO shows the nature of the problem. These problems arise in the context of a fragmented and conflictual global governance arena, in which multiple forums and agencies with different agendas influence health policy. They exist in the context of the well rehearsed concerns about the adequacy of WHO financing and complex rivalries with other international organisations that affect health. Global health governance is ever more fragmented and shifting, often dependent on changeable domestic politics and diplomatic strategies. This is not a formula for resilience. There is also more that can be done to strengthen health governance and the role of the WHO Regional Office for Europe across the pan-European region.

Establish a Pan-European Network for Disease Control

103. We call for combined action across the pan-European region to avoid duplication of efforts. The EU has an apparatus for communicable disease control, based on the European Centre for Disease Control and Prevention (ECDC), and it will be developing a specific Health Emergency Preparedness and Response Authority (HERA). The EU is also investing large amounts of new money in pharmaceutical development, civil protection (through the rescEU programme), and health systems (through the EU4Health programme) and in other EU strategies such as the From Farm to Fork strategy. These are very valuable assets that benefit all of the pan-European region and indeed the world, to varying extents. However, there are well established precedents for countries to work together across the borders of the EU, for example in rabies elimination. We call for such pan-European activities to be expanded, co-governed by the EU and WHO.

104. **We call on governments, working with subregional bodies such as the EU and Eurasian Economic Union, to create a Pan-European Network for Disease Control convened by the WHO Regional Office for Europe.** This grouping, which would complement existing structures such as ECDC, would offer a means to strengthen early warning systems, epidemiological and laboratory capacity, and interoperable data systems. The WHO Regional Office for Europe (through its health emergencies hubs and the Health Emergencies office in Istanbul) could serve as a secretariat and convene technical counterparts in Member States and supranational specialist health emergency and surveillance agencies of the Region, including ECDC, the European Food Safety Authority's zoonoses network, the South-Eastern Europe Health Network, and institutions in the Commonwealth of Independent States and the Northern Dimension Partnership in Public Health and Social Well-being. Regional cooperation should also extend beyond the pan-European region, to include countries in the Middle East and north Africa as appropriate.

Establish a Pan-European Health Threats Council

105. Health policy should be forward-looking, but at present our systems and structures remain predominantly reactive when it comes to health emergencies and pandemics. Early warning systems are essential to identify and respond to emerging threats. The specific threats to One Health in a given geographical area may be known, unknown or not monitored. It is essential that there is adequate capacity to track and respond to changes in pathogens and disease symptoms, as well as developments that influence the nature of intersectional elements of the One Health system.

106. **The Commission calls for the establishment of a Pan-European Health Threats Council convened by the WHO Regional Office for Europe** to foster cooperation and collaboration, increase regional solidarity, and promote multilateralism and accountability. This Council would ordinarily convene at the level of Ministers of Health, with the possibility of extraordinary participation at the level of Heads of State in times of crisis.

107. This regionally representative body would serve to:

- enhance and maintain political commitment to pandemic and health threat preparedness (operationalising the One Health approach) and responses;
- ensure maximum complementarity, cooperation and collective action across the pan-European Region at all levels, including:
  - assuring interoperability and, where possible, harmonising public health and social measures and policies for preparedness and response;
  - sharing resources for emergency response, including health workforce and financial and material resources (equipment);
  - holding actors accountable through recognition and scrutiny;
  - promoting cooperation between legislatures and executive agencies in the pan-European region.

Prioritise investments in data-sharing and data interoperability platforms

108. More than 18 months into the pandemic, there are still major challenges in obtaining timely and comparable data on the epidemiology of COVID-19 across the pan-European region. These weaknesses involve even basic measures such as weekly mortality counts, while they are very severe in relation to critical information such as viral sequencing.

109. There is often even less data available on the determinants of health. Existing arrangements for the exchange of data related to trade in agri-food could be extended to cover the entire food chain and on to the many aspects of One Health set out earlier, complementing the Codex Alimentarius. Data on movement of animals is a particular priority and, as both legal and illegal trade have been linked to the emergence of infectious diseases, new guidelines should be developed for trade in all wildlife species, in parallel to the guidelines under the Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES).

110. **The Commission calls for pan-European efforts to create an interoperable health data network based on common standards developed by the WHO Regional Office for Europe, recognising that governments will move at different speeds. The Commission also asks MDBs and development finance institutions to prioritise investments in these fields.**

Secure the necessary funding for WHO to fulfil its mandate

111. Given its vital role in managing and coordinating health security and preparedness across the WHO European Region, WHO needs to be funded sustainably at all three levels of the Organization (headquarters, regional offices and country offices). This was also recalled by the IPPPR to the global Working Group on Sustainable Financing. Since sustainable financing represents only a little more than a third of the funding available to the WHO Regional Office for Europe, the increasing reliance on specified voluntary contributions that are earmarked to specific technical priorities or geographical subregions has generated pockets of poverty in key programmatic areas, such as noncommunicable diseases. While some Member States are leading the way by allocating flexible voluntary donations to the European Region, a more adequately resourced Regional Office (based on such flexible voluntary contributions, a detailed funding analysis and a pan-European investment case) is needed to match its expanded mandate and increased expectations.

112. COVID-19 will not be the last pandemic, and we must consider how to fund R&D and support manufacturing and supply mechanisms now, so that we can ensure equity, accessibility and affordability of vaccines for the next crisis. **The Commission calls for enhanced efforts to build up production capacity and R&D funding in the pan-European region, under the coordination of the WHO Regional Office for Europe, with the aim of speeding up the end-to-end vaccine development timeline even further, to 3–5 months under pandemic circumstances.**

113. **This report calls for action – on operationalizing the One Health concept; on fixing fractured societies; on innovation and investment in health systems; on global public goods; and on better pan-European and global health governance.** We imply changes in governance, within and among countries and in international bodies. These, in turn, give rise to considerable political, economic and governance challenges. Calling for action and making it happen are very different things. The Commission is acutely aware of this difference and of the need to consider how its recommendations might be implemented.

114. COVID-19 has been a massive shock to health systems, but many of the failures that characterised responses to the pandemic will be familiar to policy analysts and decision-makers who have observed earlier crises. The pandemic has reminded the pan-European region of deep-seated structural problems in our health systems and in our societies. Decision-makers were already aware of the issues from the global financial crisis or, more recently, the refugee crisis in the European region. They often have a clear understanding of the causes and effects and of the policies needed to tackle them. Yet making the transformations needed has proved to be much more complex.

115. The main challenge has been less in identifying strategies for success, more in a collective inability to implement them effectively. This reflects not only the complexity of transformation but also the limited understanding of how to implement reforms at system level, a situation exacerbated by the limited number of people with the skills required to do so. Too often, governments depend on external consultants with little understanding of domestic context.

116. The extent to which countries have been able to take on board a common set of lessons from past crises helps explain their success (or lack of success) in achieving change. Key elements include the effectiveness of institutional governance; societal solidarity as manifested in health and social systems; and transparency and participation in decision-making. These enable (or block) implementation and underpin the extent to which countries can deliver equitable access to well financed health systems built on strong primary care and a well trained, equipped and motivated workforce. This can make the difference between withstanding shocks or succumbing to them. If the pan-European region is to act on this crisis and build resilient health systems and societies, it must have a clear focus on reform and transformation and, above all, on achieving implementation.

117. Implementation is a national matter, but it would be a mistake to see the challenges in purely national terms. All reforms need to be tailored to the local context, but there is considerable scope for learning what works and does not work in other countries. There is also a strong international dimension to many of the challenges faced by societies and their health systems.

118. Again, COVID-19 illustrates this point. Many countries' first knee-jerk reaction to the pandemic was to close geographical and economic borders, to proffer isolated national responses and to ignore cross-country considerations. However, financial crises, the spread of communicable diseases and the challenges associated with refugees moving out of conflict zones all happened in a globalized context and made it abundantly clear that single-country solutions are not enough. These issues cross national boundaries and can only be tackled effectively through joint international action.

119. A significant obstacle to implementation has been some reluctance on the part of governments to share regulatory and decision-making powers with international organizations or to subscribe to shared governance arrangements. The justification, on the grounds of national sovereignty and subsidiarity, is often understandable but acting alone may be harmful in those policy areas that are characterised by externalities which cross national boundaries and where there is a need for public goods. Governments' legitimate concerns about sovereignty can (and should) be preserved in international governance settings, but they ought not to crowd out the imperative to achieve shared solutions that benefit all.

120. Antimicrobial resistance is another case in point. The lack of progress in implementing strong international governance regulations to address the threat defies the evidence on the looming health and economic impacts of drug-resistant infections and their potentially devastating consequences. Multilateral agencies such as WHO and the EU have put forward detailed AMR action plans with proven mechanisms such as strengthened global surveillance; regulation of unnecessary antibiotic use; and benchmarking of performance across countries. There have been some successes – not least with the adoption of national One Health action plans – but overall, the take-up of international governance strategies has been insufficient. AMR highlights both the imperative for coordinated global action and the reluctance of countries to join a truly common European and global response.

121. The One Health approach explored in this report offers a way forward, but it requires complex collaborative, multisectoral and cross-disciplinary work. It also calls for multinational initiatives across governments and international agencies and the introduction and/or reform of international governance structures. The failures in tackling AMR globally should serve as a cautionary tale and a powerful reminder of the need to focus on the international dimension of implementation challenges.

122. Accepting a degree of international governance and regulation is critical. It demands the exercise of strong political will and the commitment to go beyond the narrow national lens to recognize the importance of international collaboration. Political will can overcome barriers, support investment in global public goods and strengthen international governance arrangements. Without it, finding a way through is extremely difficult and makes dealing effectively – even well – with impending shocks to our systems an impossibility.

123. **This report calls for action – for concrete progress on implementation. Its recommendations set out directions for change but also raise a series of practical questions. Who acts, and specifically what is the right organization and level for implementation? How do entities go about instituting changes and transforming? When does action happen – and how can medium- and long-term commitments be kept on the agenda?**

124. We Commissioners recognize the diversity of countries across the pan-European region and the autonomy of national governments. We fully acknowledge the diversity of social, economic and political contexts, and the differences in health systems, ways of working and historical trajectories, and understand the intricacies of achieving change. This means that we have not offered detailed "one size fits all" blueprints for implementation. We can, nonetheless, propose some principles and some action in this area – albeit with caution – in the table below.

125. It is critical to all implementation efforts that the "who" is clearly agreed. Determining the right level (local, national, pan-European, global) for implementation and then the right organization is crucial. The choice overlaps with the "how" but must take into consideration mandates, capacity (human and financial) and relevant experience. Mapping of stakeholders can help ensure not only that the right "who" is given the relevant accountability but also that the surrounding "force field" of institutions and networks can be mobilized to support implementation. This is also an opportunity to act on the commitments to engagement and inclusion identified under the objectives on societal cohesion and women's participation.

126. A similar checklist for "how" would not seek to mandate what should be done at all levels and in diverse settings but would suggest that all planning for implementation includes well developed specification of organizational needs, including managerial and financial considerations. Not least among these would be detailed consideration of how to introduce change within health organizations, recognizing that they are deeply entrenched within political and professional cultures; how to work across sectors; and how to deal with other stakeholders and with vested interests, not all of which are supportive of health. "How" would therefore need to include an exploration of the political will to carry out the depth and scope of the changes required (as above). In all cases, success will depend on building a realistic coalition to allow progress, employing tools such as: consultation; engaging a full (non-traditional) range of stakeholders; analyzing and presenting complex issues clearly to overcome misunderstandings; and creating acceptance of the interconnected nature of the challenges.

127. The "when" is in many ways more straightforward but equally mission-critical. Even a step as simple as outlining a timetable for putting reforms in place can uncover misconceptions and practical mismatches across elements of the system that may undermine implementation. Agreeing a timetable can also be a step towards building an enabling alliance for progress. There is a risk that while immediate and short-term actions are taken, medium- and long-term actions get forgotten. Planning and transparency, monitoring and reporting can guard against this.

128. What follows in this final section of the report is a table structured around the main objectives and recommendations. It extracts examples of actions and captures key considerations in implementing change. It touches on who might take these actions forward, and how, but it does not seek to go into detail beyond the broadest indication of accountability and timing. Nor does it offer detailed guidelines, because it would be inappropriate to ignore the specificity of each country's experiences. It does, however, highlight how very critical implementation considerations are and, through its illustrative examples, underline the extent to which a cohesive approach to implementation is linked to the values that inform this report.

129. **Our report acknowledges that implementing change within diverse social, economic and political contexts requires sensitive tailoring to national needs, but it resists the tendency to allow national and subnational specificity to mask the pan-European context and global dimensions.**

130. There is real work to be done to ensure that the lessons that the pan-European region has learned about systems and societies during this pandemic are translated into action. Detailed blueprints for implementation may not be possible or desirable, but concerted commitments by governments to change and to change together are essential if the region is to become truly resilient and address the inequalities and failures that underlie and perpetuate the experience of crisis.

131. **The WHO Regional Office for Europe must have a leading supportive role in translating those commitments into actual effort. It is well placed to work with individual governments within their national context to develop implementation plans and to ensure they are mindful of the externalities and value of international working.** WHO is also well placed to convene discussions that address the international dimensions and ensure the collaborative and collective transformation that can break the cycle of shock, crisis and inequality.

TABLE
AN OVERVIEW OF IMPLEMENTATION: WHAT NEEDS TO BE DONE, HOW, BY WHOM AND WHEN

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
1. Operationalise the concept of One Health at all levels	**1.1 Endorse obligations at national level to establish structures, incentives and the environment to develop coherent national One Health strategies, based on the concept of Health in All Policies and the Sustainable Development Goals.**	Develop and implement national One Health strategies. Convene a national consortium on One Health. Set up education programmes on One Health to create a broad understanding of its principles and practices. Mobilise professional organisations to engage health professionals in One Health. Establish interdepartmental task forces that can facilitate horizontal coordination of One Health approaches. Institutionalise national zoonotic emergency prevention and intervention programmes using a One Health approach. Establish dashboards and systematically use indicators to support action at all levels to reduce environmental risks to health, including biodiversity- and climate-related risks, and enhance One Health reporting systems.	National level: ministries of health, research, environment, agriculture, finance and education, as appropriate Health professional organizations National human and veterinary public health authorities	Immediate, with imple-mentation starting by mid-2022 at the latest

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
	1.2 International governance arrangements for One Health	WHO, FAO, OIE and UNEP to substantially reinforce existing collaboration mechanisms, such as the Tripartite Collaboration, into strong and effective coordination and cooperation mechanisms. Build on existing instruments such as the Codex Alimentarius to cover the entire food chain. Expand the Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES) to cover all trade in wildlife.	International agencies, supervised by Member States	Immediate
2. Take action at all levels of societies to heal the divisions exacerbated by the pandemic	**2.1 Identify those in society who lead impoverished or precarious lives, and support policies to address and reduce these inequalities.**	Update national health policies to ensure that human rights are enshrined in legislation and develop intersectoral synergies and implementation plans that extend beyond the confines of the health system to include housing, education, social care, criminal justice and employment policies. Strengthen the data that informs policy decisions by disaggregating information bysocioeconomic status, ethnicity and other characteristics linked to health so as to identify what leads to divisions in society and shape policies to mend them.	National level: ministries of health, social care, welfare, labour and finance, as appropriate	Medium term

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
	2.2 Tackle societal distrust and improve cohesion through effective and whole-of-government leadership.	Establish forums that support consultative and inclusive decision-making processes, with particular consideration to the needs and voice of the people. Build national and global capacity for effective and whole-of-government leadership. Address data protection concerns from the public.	Multi-stakeholder, including civil society representatives and governmental bodies/ministries	Medium term
	2.3 Ensure the availability of health data that provides information on the distribution of health within populations, using diverse indicators, and develop measures for timely monitoring of health inequality and inequalities in access to health and social care.	Create and monitor indicators within health information management systems to systematically classify and categorise health distribution within populations, identifying target groups. Produce and validate a pan-European tool to measure and monitor within-country inequalities in the Region.	National level: National statistics office or relevant national authority on data, in coordination with the Ministry of Health International level: WHO Regional Office for Europe	Short term
	2.4 Adopt explicit quotas for the representation of women on public bodies that are involved in the formulation and implementation of health policy, particularly in preparedness, crisis management and response.	Develop and adopt legislation to make quotas for women compulsory in boards, steering committees, expert committees, etc. of public institutions. Establish a governmental body such as a Ministry for Women to advise the government on policies and issues affecting women.	National level: implementation with supervision of international organizations	Immediate

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
3. Support innovation for better One Health	**3.1 Conduct a strategic review of unmet health needs for the pan-European region, identifying central missions for health innovation that can provide a basis for aligning funding and action.**	Conduct a pan-European health needs assessment/survey to determine unmet health needs. Appoint a national health innovation lead/expert to advise the government on how to align funding and actions that support innovation in health systems.	WHO Regional Office for Europe National level (national statistics office, with support from the ministry of health)	Short term
	3.2 Establish mechanisms to engage in research and development processes with relevant stakeholders, exploring scope for true partnerships, underpinned by full transparency about the costs involved.	Adopt national and regional legislation and mechanisms (including regulatory) that support innovation in health systems, including tax incentives, subsidies and enhanced international collaboration.	National level (ministries of health and finance)	Medium term
	3.3 Continue efforts to develop, with the support of the WHO Regional Office for Europe, a mechanism for constant generation of knowledge, learning and improvement to implement innovation through systems in the pan-European region.	Mobilise resources to enable the WHO Regional Office for Europe to develop the required information infrastructure/action plan to support countries in implementing innovation through systems in the pan-European region. Increase countries' budgets to support organizational innovation in health systems to the same level as those for biomedical innovation.	WHO Regional Office for Europe National governments	Short term

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
4. Invest in strong, resilient and inclusive health systems	**4.1 Step up investment in health systems to address funding gaps in primary health care, social care, mental health and public health while ensuring transparency and accountability for value for money.**	Allocate additional resources to health systems financing (up to an agreed percentages of the national budget) in order to address and fix funding gaps in primary health care, social care, mental health and public health. Build national capacity for priority-setting processes and initiatives such as health technology assessment, evidence-based medicine, and health systems performance assessments, to ensure transparency and accountability for value for money.	National level	Short/ medium term

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
	4.2 Develop comprehensive strategies to develop, invest in and protect health workforces, taking particular account of demographic trends and the ability of existing reward systems to ensure a sustainable workforce into the future.	All national governments to carry out critical assessments of their workforce composition, profiles and policies. All national governments to commit to a self-sufficiency policy for workforce development through five strategies: • improving the working conditions of the health workforce; • fostering the introduction of skill-mix innovations; • supporting the WHO Global Code of Practice on the International Recruitment of Health Personnel; • establishing international systems of collaboration in health workforce training; and, • setting out pan-European forecasting and planning mechanisms. Regional and national governments to commit to, mobilise resources for and support the formation of an international system of collaboration on health workforce training, established and led by the WHO Regional Office for Europe, the EU, the Eurasian Economic Union and the Commonwealth of Independent States, to learn and share experiences from best practices. Set up a supranational consortium of training institutions and stakeholder organizations to design and organize Region-wide reorientation and requalification training to fast-track adaptation of the existing workforce to post-COVID-19 challenges.	National level (ministry of health)	Medium term

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
	4.3 Prioritise financial protection by putting in place strategies to reduce out-of-pocket payments (to below 15% of current spending on health) to avoid catastrophic expenditure.	Allocate resources to strengthen financial protection and reinforce national commitment to the SDG on achieving universal health coverage through legislation.	National level (ministry of finance)	Medium term
	4.4 Invest in and implement mental health policies and services to place mental health and well-being at the heart of the recovery.	Provide mental health services in health and social sectors as part of pandemic recovery efforts. Provide access to (free) quality mental health services for the most vulnerable communities in society. Fund schools to provide mental health workers.	National level	Immediate
	4.5 Prioritize the integration of health and social care services, ensuring patient-centred care and building on strong primary care.	Carry out budget reforms to combine health and social care budgets and payment reforms to foster coordination across all levels of health and social care.	National level (ministry of finance in close collaboration with ministry of health and of social affairs)	Medium term
	4.6 Prioritise the prevention of communicable and noncommunicable diseases.	Scale up investment in measures to reduce threats, provide early warning systems and improve crisis response.	Ministries of finance, environment and agriculture, in close collaboration with ministry of health	Immediate

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
5. Create an enabling environment to promote investment in health	**5.1 Change methods of capturing health expenditure data, to enable clearer distinctions between consumed health expenditure and investments, so that countries are incentivised to invest more in preventive services and emergency preparedness.**	Create indicators that depict clearer distinctions between consumed health expenditure and investments.	OECD/WHO/ Eurostat and national level	Immediate
	5.2 Enhance the surveillance role of multilateral financial institutions to support investing in health.	Adopt actions modelled on the IMF's Article IV consultations, whereby the institution's staff visit governments to analyse and discuss risks to fiscal and financial stability and provide a final report.	International level	Short term
	5.3 Strengthen surveillance powers of WHO to undertake periodic assessments of national health systems, focused on public health functions and the ability to prepare for and react to pandemics.	Empower WHO to conduct periodic assessments, based on the Universal Periodic Review used by the United Nations Human Rights Council, to assess emergency preparedness and response capacity and compliance with legal obligations under IHR (2005).	International level	Short term

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
	5.4 Use assessment of health indicators to identify areas where better performance is required, and where financial support may help reach such performance.		National level (including financial institutions and corporate bodies) and international level (development banks)	Short term
	5.5 Increase the share of development finance focused on providing global public goods and managing long-standing cross-border externalities.		International level (international development banks/ institutions)	Medium term
	5.6 Incorporate health-related considerations into business strategies and risk management frameworks.	Refine the ESG indicators concept to include health- and One Health-related risks and adopt its use to encourage ethical and sustainable investments. Mandatory ex-ante impact assessment of One Health effects of allocation of non-health recovery funds.	National level (including financial institutions, regulators and corporate bodies) International level	Short term
	5.7 Consider health risks in macroeconomic forecasts, drawing on the significant progress made in modelling the interaction between infectious diseases and the economy over the past year.		National level – governments and central banks	Short term

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
6. Improve health governance at the global level	**6.1 Establish a Global Health Board under the auspices of the G20.**	As stated in the recommendation.	G20	Immediate
	6.2 Develop a global Pandemic Treaty.	Develop a Pandemic Treaty that is truly global, enables compliance, has sufficient flexibility, and entails inventive mechanisms that encourage governments to pool some sovereign decision-making for policy-making areas.	National level	Immediate
	6.3 Develop a global pandemic vaccine policy.	Develop a global pandemic vaccine policy which sets out the rights and responsibilities of all concerned, to ensure the availability and distribution of vaccines.	International and national level	Short/ medium term

Objective	Recommendation	HOW (selected examples of possible actions)	WHO should implement/ supervise	WHEN (time horizon for imple-mentation)
7. Improve health governance in the pan-European region	**7.1 Establish a Pan-European Network for Disease Control to provide rapid, effective responses to emerging threats.**	Establish a Pan-European Network for Disease Control by strengthening early warning systems, including epidemiological and laboratory capacity, and supporting the development of an interoperable health data network based on common standards developed by WHO, recognising that governments will move at different speeds.	WHO Regional Office for Europe	Short/ medium term
	7.2 Establish a Pan-European Health Threats Council convened by the WHO Regional Office for Europe.	Establish a Pan-European Health Threats Council to enhance and maintain political commitment, ensure maximum complementarity and cooperation across the multilateral system, accountability, and promotion of cooperation between legislatures and executive agencies in the pan-European region.	WHO Regional Office for Europe	Immediate
	7.3 Prioritise investments in data-sharing and data interoperability platforms by multilateral development banks and development finance institutions.		Multilateral development banks and development finance institutions	Short/ medium term

ANNEX
ENGAGEMENT OF THE PAN-EUROPEAN COMMISSION WITH THE G20 ON THE ESTABLISHMENT OF A GLOBAL HEALTH BOARD[12] (RECOMMENDATION 6.1. IN THE REPORT)

This Annex features key steps of the Pan-European Commission's engagement with the G20 Italian Presidency on the establishment of a Global Health Board.

16 March 2021
Original proposal published

5 April 2021
Letter to the presidency of the G20

21 May 2021
Statement at the global health summit

28 July 2021
Draft concept note to the G20 delegations

A) Original proposal ("A Call to Action", March 2021)

Create at the G20 level a Global Health Board, modelled on the Financial Stability Board established after the global financial crisis, which can evolve into a Global Public Goods Board that will identify failures in the provision of global public goods and marshal support from the international community to remedy them (pages 6-7).

We call on the G20 to consider a new forum bringing together health, economic, financial and other policy authorities and experts in the form of a Global Health Board, identifying vulnerabilities that threaten the health of humans, animal and the environment (One Health). This could evolve into a Global Public Goods Board, identifying failures in the provision of global public goods and marshalling support from the international community to remedy them (page 11).

12 Currently under consideration by the G20 as the Global Health and Finance Board.

B) Letter to the Presidency of the G20 proposing the Global Health Board (5 April 2021)

Prof Mario Draghi
Prime Minister of
Italy, Chair of the G20

cc:
Dr Daniele Franco
Minister of Economy
and Finance

Dr Roberto Speranza
Minister of Health

Potential contributions to the G20 (Finance and Health tracks)

Dear Prime Minister,

I follow up on preliminary exchanges I had with Prof Francesco Giavazzi, I am pleased to confirm to you, in your capacity as Chair of the G20, that the Pan-European Commission on Health and Sustainable Development would be pleased and honoured to contribute to the G20 process with its reflections and policy recommendations.

Convened in September 2020 by WHO/Europe with the support of the WHO Director-General, the Pan-European Commission, on which I serve as chair, has been tasked with "reconsidering policy priorities in the light of pandemics". This broad mandate means that we are expected to submit recommendations not only in the field of health policies, but also on how the whole set of public policies, in particular economic and financial policies, must be rethought if they are to be consistent with a new vision of health, to which the current pandemic is calling us with unprecedented clarity and urgency. This is true also as regards the adequacy of the current architecture for the international governance of health.

As a first output of its work, the Commission published in mid-March a brief "Call to action". Please find it here (it includes also the terms of reference and list of members of the Commission): https://www.euro.who.int/__data/assets/pdf_file/0010/495856/Pan-European-Commission-Call-to-action-eng.pdf.

The document calls for three key improvements in the governance of health. We need:

a) to implement operationally the "One Health" approach to human, animal and environmental health, in order to reduce the risk of new pandemics;

b) to make the global financial system more supportive of environmental and health objectives;

c) to improve radically the international governance of health.

We decided to issue these recommendations now, without waiting for our final report due in September, so that they may be taken into consideration by those processes, first and foremost the G20, which are being set in motion at this time.

Against this background, dear Prime Minister, I remain at your disposal, as well as of Minister Franco and Minister Speranza, for any clarification that may be needed. Should you consider that, in whatever modality you may deem appropriate, our Commission might be asked to provide inputs, I would imagine that these could be provided with a view to the following moments:

1) At your earliest convenience: an exchange of views on our recommendation that the G20 should create a "Global Health Board", similarly to what it did following the 2008 financial crisis with the "Financial Stability Board". Under your own strong leadership, dear Prime Minister, the FSB has been very effective in promoting changes in financial regulation and supervision. Without it, a repetition of a serious financial crisis may well have occurred. The "Global Health Board" should be composed of authorities and experts from the health as well as the economic and financial areas. Such a Board might in due course evolve towards a "Global Public Goods Board" (financial stability is of course a key public good, as is health, but there are many others).

2) Global Health Summit (May), with the Italian presidency of the G20 and the European Commission in the lead. In view of that occasion, we might provide inputs on the architecture for global governance (perhaps developing the idea of a "Global Health Board", should you express an interest in it) and on how to address the rethinking of policy choices in the light of the pandemic. President Ursula von der Leyen and Health Commissioner Stella Kyriakides are aware of our work.

3) Joint meeting of Finance Ministers and Health Ministers (October). By that time, our final report will have been published. Given its distinctive feature of taking a fresh look at health policies not in a relatively isolated perspective but at the core of new policy trade-offs, some elements from the report might provide inputs for the preparation of that joint meeting. We might of course provide them in advance of publication.

I hope, dear Prime Minister, that you and your Ministers might find some useful hints in what I have outlined above. Please do not hesitate to ask for clarifications or to suggest variations to the above that might fit better with your programmes for the G20. With my colleagues on the Pan-European Commission, I remain at your full disposal and look forward to your responses.

With best wishes of success for the G20 under your leadership, so important for the revival of multilateral governance, I thank you very much for your attention.

Kindest regards,

Mario Monti
Chair
Pan-European Commission on Health and Sustainable Development

C) Statement at the Global Health Summit promoted by the Italian Presidency of the G20 and the European Commission (21 May 2021)

Madame President von der Leyen, Mr Prime Minister Draghi

Thank you for inviting me to deliver a message on behalf of the Pan-European Commission on Health and Sustainable Development. This independent Commission, convened by the WHO, will present its final report in September. It may provide useful inputs for consideration by the joint meeting in October of the G20 Health and Finance ministers, because our focus, not confined to pandemics, is more broadly on how should health policies and economic and financial policies could be better integrated in a holistic approach at the national and global levels, also to avoid that the insufficient attention paid to health policies may fire back and make economic and financial policies hostage of a health crisis.

In a call to action that we published in March, we put forward a few recommendations on how to improve the international governance of health. In this G20 context, let me refer to just one of those. We are confident that, under the leadership of Prime Minister Draghi and President Von der Leyen, the Global Health Summit, which is about to begin, will adopt a number of important principles. However, the implementation of such principles will need the very strong commitment of a strengthened WHO at the centre of a wide network of health organizations and stakeholders. Nevertheless, the family of health will need, on this particular occasion and in the future, a very strong and unprecedented political commitment and massive investments. Therefore, at the global level, a forum for the generation of this momentum needs to be identified to facilitate the provision for this political and financial impulsion. The Rome Declaration will probably call for a high-level political leadership structure: well, without creating new institutions, such a forum could be easily activated at the G20. The G20, perhaps in a more inclusive configuration, should consider setting up a Global Health Board, building on the successful experience of the FSB. In this way, I am confident the G20 could give on a permanent base a unique contribution to global health.

Mario Monti
Chair
Pan-European Commission on Health and Sustainable Development

D) The Pan-European Commission's Global Health Board proposal and forthcoming final report: Rethinking policy interactions between health and the economy/finance (28 July 2021)

Note prepared by the Pan-European Commission and sent by the Sherpa of the G20 Presidency to delegations as a Presidency draft concept note

The Global Health Board proposal (GHB) focuses on the broader scope of health and sustainable development and not essentially on pandemics. Given the greater centrality of health policy and increased awareness of its relevance by our leaders and members of government, strengthened by the enhanced working relationship between Health Ministers and Ministers of Economy and Finance, it is essential that health and financial policies be formulated in such a way as to apply coherently at both national and international level. This consideration brought the Pan-European Commission to propose that the venue for such enhanced health/finance convergence should be a Global Health Board to be established by the G20, given the successful experience of the Financial Stability Board and the auspicious environment provided by the G20 for a trustful health/finance interaction.

Inputs for the G20 Finance and Health Ministers meeting in October

The Pan-European Commission's final report, to be published in September, develops a set of recommendations on how to make the best of a new relationship between health and other policies at the national level. The Commission trusts that the report may provide some helpful inputs for the G20 Finance and Health ministers meeting on 30 October, which could facilitate agreement on a decision to launch the Global Health Board, should that decision be put on the agenda for the Leaders' meeting on 31 October.

Political principles

The Pan-European Commission's view is that:

a) a reformed and strengthened WHO should remain the key pillar of global health governance and indeed gain in breadth of influence and in effectiveness if a GHB is set up at the G20, with the WHO Director-General (and possibly some Regional Directors, perhaps on a rotation basis) in a strong role;

b) the G20 should, in establishing the GHB, make a special effort of inclusiveness, much more significant than it is currently doing;

c) the UN would by no means be undermined by the establishment of a GHB at the G20, which would of course be compatible with the Global Health Threats Council to be set up by the UN General Assembly, as recommended by the IPPPR. On the contrary, the UN as a basis for democratic legitimacy would likely benefit from a gain in effectiveness of the overall health governance system deriving from the GHB;

d) should anybody have doubts on the statement under c), just consider the fact that the IMF did not suffer, but rather was a beneficiary, of the successful action of the Financial Stability Board, the predecessor of the GHB which is now proposed.

Scope

- It should include the promotion of a more sustainable development, i.e. address the causes of pandemics instead of just coping with their consequences and with crisis management;
- It should refer explicitly to the One health approach and to UN development goals.

Mandate

- To manage the Global Health Fund (if created);
- To promote a better assessment of economic and financial health-related risks; to cooperate with the IMF and WB in conducting early warning exercises (including on the potential challenges for monetary policies from health crises) and financial stability reviews;
- To assess vulnerabilities affecting global health (in a One health perspective) and identify and review on a timely basis;
- To promote coordination and information exchange among authorities responsible for health and sanitary resilience, on prevention, on organisation of resilient health systems and on crisis situations (contingency planning, early warning, crisis management);
- To explore the connections and analogies with the Network for Greening the Financial System (NGFS) and FSB efforts on climate and, recently, on biodiversity;
- To scale up private finance for health and better assessment of negative externalities; for this reason, antimicrobial resistance (AMR) should not be separated from pandemics analysis ;
- To encourage the development of affordable private or public health insurance schemes; to identify business opportunities and scale effects;
- To promote implementation of agreed commitments and policy recommendations by

Member States' jurisdictions through monitoring of implementation, peer review and disclosure;

- To develop ways in which international organisations dealing with health could have sufficient enforcement powers.

Structure

- A reformed and strengthened WHO should remain the key pillar of global health governance (with the WHO Director-General and Regional Directors actively involved);
- A GHB with the features described here would of course be fully compatible with the Global Health Threats Council to be set up by the UN General Assembly (as proposed by other Panels);
- Light mixed Secretariat: WHO and One health staff + staff with skills in finance (existing or to be put in place; to be located in Geneva, possibly hosted by the Global Fund);
- Flexible reporting to the G20 and to Heads of State and governments (plus specific follow-ups in the joint Finance and Health meetings).

Composition

- G20+ (i.e. G20 countries which can provide financing and political leadership + some countries or groups of countries facing specific health related risks; if needed, on a rotation basis; three years rather than one);
- For each country, the Minister of Finance and the Minister of Health (or respective high-level representatives) ; flexible composition to be agreed according to the same interdisciplinary criterion for other committees and/or meetings that might be envisaged;
- Reformed WHO at the center + its One Health partners in FAO, OIE and UNEP; IMF and World Bank + regional development banks + WTO;
- FSB/ NGFS could be tasked by the GHB to provide specific works (health related financial risk analysis, data gap, vulnerability check etc).

Institutional and legal aspects

Guiding criteria (on many aspects, the FSB precedent can be used):

- like the FSB, not a treaty-based organisation; described as "a flexible, responsive, member-driven, multi-institutional and multidisciplinary institution";
- could be as well an association under Swiss Law (located in Geneva, close to WHO or in Basle, close to FSB/BIS);
- structures to be more precisely defined (plenary, secretariat, standing committees, working groups, regional consultative groups, see FSB art 20) and to be inclusive;
- chair (elected by the plenary for a given number of years, either keeping his or her original position or even better in a dedicated full-time mandate);
- rules of procedure (should reflect the consensus-based nature of this body while having in mind the needed effectiveness and implementation);
- need to have interaction with civil society (NGOs, charities, etc, in particular with medical doctors, stakeholders, with due attention paid to transparency and conflicts of interest); special efforts for women, vulnerable public;
- transparency, accountability, bold communication (including to fight against disinformation and anti-vaccine movements, etc).

Budget

To be defined.

Process

October 2021, Rome Summit, under Italian G20 Presidency: to achieve a broad agreement on the creation of the GHB, on its principles and on appointing a light interim steering committee, composed of one personal representative for each Head of State or government, tasked with proposing the precise arrangements for establishing the GHB on an enduring organisation footing, using inter alia the experience of the FSB as a precedent.

Notes

- The "Pan-European Commission on Health and Sustainable Development: Rethinking Policy Priorities in the light of Pandemics" was convened by the WHO (Regional Director for Europe, with the support of the Director-General).
- Although the Pan-European Commission's membership is European (of course not only from EU Member States but according to the WHO definition of the European Region) its mandate is not geographically bound. As regards, in particular, improvements in global governance, recommendations cover both the pan-European region and global governance.

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