© Photo by Fusion Medical Animation on Unsplash

T7 Task Force Global health

POLICY BRIEF

UNIVERSAL HEALTH COVERAGE AND GLOBAL PUBLIC GOODS FINANCING: HOW CAN THE G7 FULFIL ITS UNIVERSAL HEALTH COMMITMENTS IN THE AFTERMATH OF COVID-19?

28.02.2022

Rob Yates The Centre for Universal Health, Chatham House

Abstract

All world leaders are committed to the goal of Universal Health Coverage (UHC) - whereby everyone should receive the health services they need without suffering financial hardship - yet the COVID-19 pandemic has undermined progress towards UHC in almost all countries. COVID has exposed insufficient investments in public health and key population groups have been left behind in many national responses. While global scientific solidarity and collaboration to tackle the pandemic has been impressive, the task of ensuring sufficient production and equitable allocation of the resulting technologies has clearly failed. At its 2021 summit, the G7 failed to address vaccine inequity, resulting in some experts calling for the summit to be its last. It is vital that in 2022 the G7 put global health at the top of its agenda and act across a number of priorities to ensure it fulfils its universal health commitments.

Challenges

The last time all heads of government gathered at a global level to discuss health was at the United Nations High Level Meeting on Universal Health Coverage (UHC) in New York in September 2019. At this gathering political leaders from all income levels recommitted themselves to the goal of UHC by 2030, whereby everyone should receive the health services they need without suffering financial hardship (United Nations, 2019). With hindsight, it is regrettable that these same leaders did not attend another event, the day before the High Level Meeting, when the Global Preparedness Monitoring Board (GPMB) presented their first report called "A World at Risk". This warned of the dangers of a potential pandemic of a respiratory pathogen and highlighted that the world was unprepared to respond to such a health crisis and needed to invest heavily in vital public health systems at both national and global levels (Global Preparedness Monitoring Board [GPMB], 2019).

In extolling the virtues of UHC, many of the leaders speaking in New York recognised that UHC is build on principles of rights and equity and using the rhetoric of the SDGs proclaimed that "no one should be left behind". In the case of tackling infectious diseases, this should mean that **everyone** on the planet benefits from public health services that detect and control epidemics, as well as benefiting from preventive services such as vaccines and treatments for those who fall sick. Most importantly, achieving UHC requires that such services be allocated according to need, which requires a system of solidarity whereby wealthy people subsidise services for the poor and vulnerable. Such solidarity arrangements need to occur both within and between countries and are facilitated by public financing mechanisms. Little did the leaders meeting at the United Nations in September 2019 know how soon their commitments to equitable UHC would be tested.

The ongoing COVID-19 pandemic, which has ravaged the world since January 2020 has undermined progress towards UHC in practically all countries – including all G7 nations. This has been shown by higher mortality rates relating to COVID-19 infections but also deteriorating health indicators associated with unmet needs for other infectious and non-communicable diseases (Dyer, 2020; World Health Organization [WHO], 2021a). International reviews of pandemic response over the last two years have flagged shortcomings in UHC performance across the world (The Independent Panel for Pandemic Preparedness and Response [IPPPR], 2021). In particular, it is evident that even in some of the world's richest countries, key population groups have been left behind – including vulnerable elderly people, people living in care homes and migrant populations. In addition, countries have underinvested in essential public health services required to detect and control infectious diseases. Clearly, the world was not adequately prepared to tackle a pandemic of a respiratory pathogen as predicted by the first GPMB report. It was therefore appropriate that their subsequent report, written in the midst of the pandemic, in 2020 was entitled "A World in Disorder" (GPMB, 2020).

When looking at solidarity between countries it is evident that performance to date has been decidedly mixed. On the positive side, the immediate response from the global scientific community to share data and knowledge about the nature of the virus, how it was spreading and how to combat it, was extremely impressive. This led to a multitude of collaborative partnerships between public and private sector scientists

in countries all over the world, which resulted in an amazing arsenal of effective vaccines being produced by the end of 2020. By early 2021, Scientific solidarity had given humanity the tools to see off COVID-19.

But the task of ensuring that these commodities are produced in sufficient quantities and allocated efficiently and equitably to those who need them most has fallen to national governments, multilateral agencies and pharmaceutical companies and here solidarity has clearly failed. Almost immediately mass vaccine roll-outs started in late 2020, global bodies like the United Nations began flagging that G7 nations had secured enormous supplies of vaccines (many times their own populations) which was depriving poorer nations of these life-saving commodities. Moreover, multilateral mechanisms such as COVAX, that were established to overcome this problem were undermined, because rich nations had sewn up contracts with suppliers for earlier deliveries (Storeng et al., 2021).

In early 2021, as rich nations like the UK, US, Canada and the European Union raced to vaccinate more and more of their people, it soon became obvious that less needy people in these countries (healthy young people) were being vaccinated before high need groups in poorer countries – notably health workers who were exposing themselves to risk on a daily basis. From a whole of humanity perspective, the world has failed to fulfil its universal health commitments. This led the UN Secretary General to Tweet as early as January 16th 2021 that "science is succeeding- but solidarity is failing" (Guterres, 2021).

These early warnings about vaccine inequities were amplified in May 2021 when the Independent Panel on Pandemic Preparedness and Response (chaired by Helen Clark, the former Prime Minister of New Zealand and Ellen Johnson Sirleaf, the former President of Liberia) published its much-awaited review of the COVID-19 Crisis. As well as making long term policy recommendations to avert future pandemics, the Panel listed a series of urgent actions to tackle the current pandemic prioritising the need to tackle vaccine inequity. These involved clear recommendations concerning reallocating supplies from stockpiles in wealthy countries, increasing funding for multilateral funding mechanisms and accelerating the transfer of vaccine technologies to developing countries to increase and diversify the supply of vaccines (IPPPR, 2021).

The last annual G7 summit in June 2021 should have been the ideal forum for wealthy nation governments to act on these recommendations and even up the distribution of vaccines. But under the chair of the UK Prime Minister, the G7 did virtually nothing – only promising to reallocate 870 million vaccines over an ill-defined period (WHO, 2021b). Even these commitments have not been met. In a recent op-ed in Foreign Affairs, the Nobel Laureates Esther Duflo and Abejeet Banajee (2022) said:

"That meeting may have marked the lowest point in the West's handling of the pandemic. Indeed, it might be seen in the future as a turning point in the relationship between the rich and poor worlds—the moment where the wealthiest countries quite clearly opted to turn their backs on everyone else."

Similarly, with the G7 failing to act on perhaps the greatest global crisis in its history, Professor Jeffrey Sachs penned a scathing attack in Project Syndicate saying that the Cornwall Summit "should be its last" (Sachs, 2021).

Proposals and Implementation

With the G7 being judged so harshly by such eminent global experts, even questioning its very existence, it is surely in the G7s own interests to raise its game in 2022 by putting global health at the top of its agenda. As Germany was the first G7 chair to prioritise health in 2015, hopefully there is a good chance that this will happen. So what should be the immediate priorities for the G7 to help it fulfil its universal health commitments. We recommend the following:

1. Demonstrate genuine political commitment and global leadership to end the COVID-19 pandemic quickly, by launching a fully-funded strategy to implement the priority recommendations of the IPPPR - especially concerning achieving universal coverage of essential commodities including vaccines, medicines, diagnostic tests and oxygen. This should include:

- *Provide $13.8 Bn of grant funding before October 2022 as a fair contribution to ensure that all elements of the ACT-A (and its potential replacement mechanism) are fully funded for 2022.*[1]
- *Accelerate the transfer of vaccine manufacturing technologies to developing countries by increasing direct financing of new mRNA hubs and encouraging G7-based manufacturers to collaborate effectively with these centres to share relevant technologies and know how.*
- *Support the proposal to the WTO by the Governments of India and South Africa for a TRIPS waiver for COVID-19 related commodities (vaccines, diagnostic tests and therapeutics).*

2. Increasing levels of public financing on their own health systems to get back on track to meet their UHC commitments and close coverage gaps exposed during the pandemic. This should include extending coverage to neglected and marginalised population groups (for example migrant populations, homeless people and people living in long-term care institutions) and for relatively underfunded services such as mental health services and palliative care. Additional resources will also be required to meet backlogs of treatments and preventive services for non-communicable diseases that we were disrupted by the pandemic. G7 countries should also invest heavily in public health services to improve preparedness against future outbreaks of infectious diseases and integrate these services more effectively within the broader health system. In particular, there is a need to break down silos and improve coordination between public health services that focus on protecting and improving population health and health services that focus on meeting the health care needs of individuals. Progress towards these objectives should be tracked as part of UHC monitoring processes undertaken by UN bodies to hold governments to account in reaching the sustainable development goals.

4. Provide greater assistance to less-wealthy nations to accelerate progress towards UHC and strengthen their health security by increasing ODA funding for health systems strengthening and enabling countries to leverage increased levels of domestic public spending on health though global financing reforms eg increasing debt relief, improved access to international financing instruments, raising levels of corporate taxation, and closing tax havens.

5. Invest heavily in global public goods for health[2] through increasing funding and strengthening the existing institutions and systems that deliver them rather than building new ones. The Covid-19 pandemic has demonstrated once again the enormous costs (humanitarian, social and economic) that the world can prevent, or at least substantially reduce, by investing in global health public goods. This includes investments to accelerate the discovery and development of new vaccines and treatments against existing infectious diseases, steps to ensure that existing vaccines and treatments remain effective for as long as possible, and public health systems to ensure the world can respond quickly to the emergence of new infectious diseases. In order to reap the enormous potential benefits associated with global health public goods we recommend the following specific investments, which have been extracted from the recommendations of the IPPPR:

- Transform the current ACT-A into a truly global end-to- end platform for vaccines, diagnostics, therapeutics, and essential supplies delivered as global public goods and ensure its long-term sustainability through multi-year grants based on fair contributions from G7 members.
- Create an International Pandemic Financing Facility, linked to existing structures (including WHO) to raise additional reliable financing for pandemic preparedness and ensure rapid surge financing for response in the event of a pandemic.
- Establish WHO's financial independence based on fully unearmarked resources; and an increase in member state fees to 2/3 of the base programme budget with replenishment for the remainder.

Disclaimer:

All authors are responsible for the content and recommendations contained within this policy brief. The policy brief has been written as part of a consultation process for the T7 Taskforce for Global Health, led by Taskforce's Co-Chairs Ilona Kickbusch, Anna-Katharina Hornidge and Githinji Gitahi, but it does not represent the official position of the Taskforce or the authors' employers.

Endnotes

[1] $13.8 Bn represents the cumulative fair shares for grant funding for G7 countries assessed by ACT-A Facilitation Council Financing Working Group. See Fig 9, ACT-accelerator Consolidated Financing Framework (Act-accelerator Access to COVID-19 Tools, 2022).

[2] Health interventions where major direct benefits are achieved by *all* countries regardless of their income level and which require strong international coordination and collective public financing at scale.

Think7

References

ACT-accelerator Access to COVID-19 Tools, (2022). *Consolidated Financing Framework for ACT-A Agency & In-Country Needs. October 2021 to September 2022. A product of the ACT-A Facilitation Council Financial & Resource Mobilization Working Group.* WHO. https://www.who.int/publications/m/item/consolidated-financing-framework-for-act-a-agency-in-country-needs

Banerjee, A., and Duflo, E., (2022, January 21). Rich countries must make smarter investments in poorer ones. *Foreign Affairs.* https://www.foreignaffairs.com/articles/world/2022-01-21/how-prevent-covids-next-comeback

Dyer, O. (2020). Covid-19: Pandemic is having 'severe' impact on non-communicable disease care, WHO survey finds. *BMJ. 369.* M2210. https://doi.org/10.1136/bmj.m2210

Global Preparedness Monitoring Board (2019). *A world at risk. Annual report on global preparedness for health emergencies*. WHO. https://www.gpmb.org/docs/librariesprovider17/default-document-library/annual-reports/gpmb-2019-annualreport-en.pdf?sfvrsn=d1c9143c_30

Global Preparedness Monitoring Board (2020). *A world in disorder. Global Preparedness Monitoring Board annual report 2020.* WHO. https://www.gpmb.org/docs/librariesprovider17/default-document-library/annual-reports/gpmb-2020-annualreport-en.pdf?sfvrsn=bd1b8933_36

Guterres, A. [@antonioguterres]. (2021, January 16). *#COVID19 vaccines are reaching high income countries quickly, while the world's poorest have none at all.* Twitter. https://twitter.com/antonioguterres/status/1350545107725012993

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

Sachs, J. D., (2021, June 16). We don't need the G7. *Project Syndicate.* https://www.project-syndicate.org/commentary/g7-has-become-obsolete-and-ineffective-by-jeffrey-d-sachs-2021-06

Storeng, K. T., de Bengy Puyvallée, A., and Stein F. (2021). COVAX and the rise of the 'super public private partnership' for global health. *Global Public Health.* https://doi.org/10.1080/17441692.2021.1987502

World Health Organization (2021a, May 20). *COVID-19 responsible for at least 3 million excess deaths in 2020*. https://www.who.int/news-room/spotlight/the-impact-of-covid-19-on-global-health-goals

World Health Organization (2021b, June 13). *G7 announces pledges of 870 million COVID-19 vaccine doses, of which at least half to be delivered by the end of 2021.* https://www.who.int/news/item/13-06-2021-g7-announces-pledges-of-870-million-covid-19-vaccine-doses-of-which-at-least-half-to-be-delivered-by-the-end-of-

2021#:~:text=end%20of%202021-,G7%20announces%20pledges%20of%20870%20million%20COVID%2D19%20vaccine%20doses,by%20the%20end%20of%202021&text=COVAX%20welcomes%20dose%20sharing%20commitments,by%20the%20end%20of%202021.

United Nations (2019). *Political Declaration of the High-Level Meeting on Universal Health Coverage. 'Universal health coverage: moving together to build a healthier world'*. UN. https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/09/UHC-HLM-silence-procedure.pdf

About the Authors

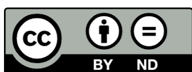
Robert Yates – The Centre for Universal Health, Chatham House

Robert Yates is a political health economist specializing in universal health coverage (UHC) and progressive health financing. He is Executive Director of the Centre For Universal Health at Chatham House. He is also an Honorary Associate Professor at the London School of Hygiene and Tropical Medicine and a long-term consultant to The Elders on their health programme. His principal area of expertise is in the political economy of UHC, with a focus on advising political leaders and governments on how to plan, finance and implement national UHC reforms. He has previously worked as a Senior Health Economist with the UK's Department for International Development (DFID) and the World Health Organisation, advising numerous governments in Asia, Africa and Europe on health financing policy and health systems reforms. He holds a BA degree in Natural Sciences and Economics from the University of Cambridge and a MBA, from the University of Leeds.

The Think7 engagement group under the German G7 presidency 2022 is jointly chaired by the Global Solutions Initiative and the German Development Institute / Deutsches Institut für Entwicklungspolitik (DIE) as mandated by the German Federal Chancellery.

Deutsches Institut für Entwicklungspolitik

German Development Institute



This publication has been being published under the Creative Commons License CC BY-ND 4.0. You are free to copy and redistribute the material in any medium or format for any purpose, even commercially. The licensor cannot revoke these freedoms as long as you follow the license terms:

Attribution — You must give appropriate credit, provide a link to the license, and indicate if changes were made. You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.

No Derivatives — If you remix, transform, or build upon the material, you may not distribute the modified material.

No additional restrictions — You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits.

Publisher:

Deutsches Institut für Entwicklungspolitik

German Development Institute

Deutsches Institut für Entwicklungspolitik gGmbH
Tulpenfeld 6
D-53113 Bonn

www.die-gdi.de