



G20 HEALTH

Position Paper

on

“Healthy and Sustainable Recovery”



Note: This Position Paper on Healthy and Sustainable Recovery has been drafted by the Italian G20 Presidency, in collaboration with WHO and OECD, without prejudice to members' views and does not purport to suggest agreement among G20 members on these issues.



In September 2015, Heads of State and Government and High Representatives came together to adopt the Sustainable Development Goals (SDGs), also known as the Global Goals - a universal call to action to end poverty, protect the planet, and ensure that all people enjoy peace and prosperity by 2030. The 17 Sustainable Development Goals¹ and 169 targets build on the Millennium Development Goals and complete what they did not achieve. They seek to realise the human rights of all and to achieve gender equality and the empowerment of all women and girls. They are integrated and indivisible and balance the three dimensions of sustainable development: economic, social and environmental. Furthermore, in 2019 a UN High Level Meeting adopted a Political Declaration on Universal Health Coverage² (UHC), This Declaration reaffirmed UN Member States' strong commitments to build sustainable health systems and accelerate progress towards universal health coverage and the health-related SDGs, and to revitalise and promote existing global partnerships and networks with all relevant stakeholders.

In this paper public health systems have been considered as 'the ensemble of bodies and institutions in charge of delivering the 10 essential public health operations as defined by WHO', and health care delivery systems as 'all organizations, people and actions whose primary intent is to promote, restore or maintain health and wellbeing'.

COVID-19 has shown the critical importance of work to achieve the SDGs, including achieving full implementation of the Political Declaration on Universal Health Coverage (UHC) and by reaching the most vulnerable with equitable access to integrated, cost-effective primary health care (PHC) services. Without UHC, people with health care needs, have not been treated and tested, damaging their health, but also putting whole communities, societies and economies at risk. Yet, at the same time, COVID-19 has had a significant negative impact on progress towards achieving the SDGs - in many areas progress has gone backwards, in other areas progress has stalled, disproportionately affecting those most left behind.

As G20 members we are determined to end the current phase of the COVID-19 pandemic and to accelerate progress on the health-related SDGs and ensure that the world is better prepared to face the future health emergencies, and that people around the world never again have to endure the suffering and hardship that COVID-19 has brought to all countries. At the same time, we recognise the crucial role of a healthy planet for healthy populations and the need to place greater

¹ https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

² <https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>



emphasis on the intersection of human health, animal health (both domestic and wildlife) and the environment, which is addressed in the G20 “Call to Action on Building One Health Resilience”. We are committed to adopting a One Health approach as we work to strengthen our health systems, recover from the impact of COVID-19, and build forward better prepared to prevent, detect and respond to future health security threats and emergencies.

In this regard, we are committed to support the One Health High-Level Expert Panel, established by WHO, FAO, OIE and UNEP.

We are keen to build on existing initiatives, including the principles adopted in the Rome declaration³ during the Global Health Summit, co-hosted by the European Commission and the Italian G20 Presidency, where possible, and will seek to align future policy developments with other relevant international initiatives, as appropriate. Finally, as we work to strengthen our health systems and make them more resilient, we are committed to sharing our experience as widely as possible to ensure all countries are able to learn from our work, and so we can learn from others.

ACHIEVING UHC AND STRENGTHENING HEALTH SYSTEMS

Full implementation of the Political Declaration on UHC is a vital element of achieving health-related SDGs. COVID-19 has shown dramatically that gaps in high-quality health service coverage affect all countries, regardless of income level. G20 members should show leadership in highlighting and responding to such gaps, and finding solutions, including strengthening PHC as a cornerstone of a sustainable health system for UHC and the health-related SDGs. The shortage of 18 million health workers, particularly in low- and middle-income countries (LMICs), affects the ability of countries to cope with a large surge in demand and deliver continuity of health care to both those directly affected by COVID-19 and those living with other conditions, as well as those accessing routine services such as immunisations. Globally there is a need to invest in prevention and public health, which still only accounts for around 3% of total health expenditure across countries. Out of pocket expenditure continues to rise – in 2015, about 930 million people globally spent more than 10% of their household income on health care, and about 210 million people spent more than 25%. Even in high-income countries, out of pocket expenditure still represents

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https://www.governo.it/sites/governo.it/files/documenti/documenti/Approfondimenti/GlobalHealthSummit/GlobalHealthSummit_RomeDeclaration.pdf



21% of total health spending. COVID-19 has exacerbated gaps in access to health services, including cancer screening, mental health, sexual and reproductive health, medicines, supplies, treatments and diagnostics. It has also resulted in delays to elective surgery as hospitals have reprioritised expanded and/or shifted capacity and resources to manage patients with COVID-19. Investing in health also requires investing in a healthy planet that supports healthy people, and ecosystems, by tackling the environment factors that contribute to the global burden of disease and addressing the three intertwined planetary crises of climate change, biodiversity loss and pollution.

Within UHC, a focus on primary health care is vital – it is the front line to access health services and a crucial link to the wider community. Countries with strong PHC have found it easier to ensure continuity of care, including treatment of non-COVID-19 conditions. In all countries, PHC ensures more equitable access to care and helps prevent ill health; and yet, less than one in every seven dollars spent on health is directed to PHC.

COVID-19 has highlighted three critical pillars to build and strengthen UHC and PHC for the future.

Better leveraging the power of digital health and related technologies, including improving the collection, flows, use, and protection and safeguarding of personal health data. COVID-19 has shown how digital technology has the potential to transform health care delivery and public health surveillance of diseases, as well as enhance access to health services, but only if the collection, protection, and use of health information is improved. The G20 welcome the establishment of the WHO Global Hub for Pandemic and Epidemic Intelligence in Berlin for shared access to vital, multi-sectoral data and drive innovation in data analysis to rapidly analyse public health emergencies.

Strengthening and protecting the health workforce. Globally, the health workforce is under-resourced in all countries, with a projected shortfall of 18m health workers by 2030⁴. In May, the World Health Assembly decided to develop a new action plan for International Labour Organization (ILO), the Organisation for Economic Co-operation and Development (OECD), and the World Health Organization (WHO) Working for Health Programme⁵, and, to accelerate investments in health and care worker education, skills, including through the Working for Health Multi-Partner Trust Fund⁶, jobs, safeguarding and protection. The WHO Academy will also develop innovative methods of

⁴ <http://apps.who.int/iris/bitstream/10665/250047/1/9789241511308-eng.pdf?ua=1>

⁵ https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R14-en.pdf

⁶ <http://mptf.undp.org/factsheet/fund/WHL00>



conveying knowledge and skills to health professionals, including collaboration with initiatives such as the Public Health Workforce Laboratorium for improving training in prevention, preparedness, and response to health - proposed by the G20 Italian Presidency. Protecting existing health care workers is essential to maintaining a functioning health care system.

Improving health care quality, including prevention, patient safety, and progress towards value-based health care quality and outcomes.

G20 members should continue to promote work started under the Saudi Arabian G20 Presidency to strengthen these pillars and also recognise the need to engage with our citizens to rebuild trust in science and evidence based information provided and community-level engagement to build vaccine confidence, trust and acceptance. COVID-19 has shown the need to invest more in improving health literacy in order to increase the ability of people to make informed decisions, including on healthy lifestyle, physical activity and other health-promoting habits, reduce health risks, increase disease prevention, and improve their quality of life.

THE IMPACT OF COVID-19 ON THE HEALTH-RELATED SDGS

COVID-19 has also confirmed that countries cannot deliver improved health outcomes for all by just focusing on health systems; it requires progress on other, inextricably linked SDGs as well. However, there is a real concern that progress has stalled, and, in some areas, advances are being reversed. In this context, it is important to consider social, economic and environmental determinants of health. We note the following, in particular:

- **Food Security, Food Safety and Nutrition.** The 2020 joint Food and Agriculture Organization of the United Nations (FAO), International Fund for Agricultural Development (IFAD), United Nations Children’s Fund (UNICEF), World Food Programme (WFP), and WHO ‘Report on the state of food security and nutrition in the world’⁷ reported that in the context of SDG 2, progress against food insecurity and “malnutrition, in all its forms”, was already off-track. COVID-19 has made the situation worse as it has disrupted health and nutrition services, disrupted food systems/markets and increased the

⁷ https://docs.wfp.org/api/documents/WFP-0000117811/download/?_ga=2.201032171.436587675.1623314919-1686450875.1623314919



challenges in accessing nutritious food, and has led to missed micronutrients.⁸ An estimated minimum of another 83 million people, and possibly as many as 132 million⁹, may have gone hungry in 2020 as a result of the economic recession and food chain disruptions triggered by COVID-19. Additionally, by 2022 COVID-19 could result in an additional 9.3 million wasted and 2.6 million stunted children, 168,000 additional child-deaths 2.1 million maternal anaemia cases, 2.1 million children born to low BMI women and US\$29.7 billion future productivity losses due to excess stunting and child mortality.¹⁰ There could be a 14.3% increase in the prevalence of moderate or severe wasting among children younger than 5 years due to COVID-19-related predicted country-specific losses in GNI per capita. We estimate this would translate to an additional estimated 6.7 million children with wasting in 2020.¹¹ Recent research from the FAO and WFP found that 34 million people are now on the brink of famine in 20 countries around the world, and that 39 billion school meals were missed in 2020 as a result of school closures. The huge rise in unemployment triggered by COVID-19-related containment measures resulted in unprecedented numbers of people relying on food handouts. In addition, childhood stunting trends have also gone the wrong direction, increasing the economic and development impacts on the next generation if not addressed urgently. Taken together, this information shows the importance of addressing urgently, as a supplement to action on the humanitarian aspect of famine prevention and crises preparedness and the overarching goals of the Tokyo Nutrition for Growth Summit aiming at tackling global malnutrition and the and the United Nations Food Systems Summit aiming at transforming food systems with respect to all SDGs, the nexus between public health, food security, and nutrition, mitigation of climate change and sustainable economic recovery, as elaborated in the G20 Matera Declaration¹². Furthermore, non-communicable chronic diseases associated with eating habits and obesity, such as hypertension and diabetes, are also factors that increase the risk of worsening COVID-

⁸ <http://www.fao.org/3/cb1000en/cb1000en.pdf>

⁹ <https://www.who.int/news/item/13-07-2020-as-more-go-hungry-and-malnutrition-persists-achieving-zero-hunger-by-2030-in-doubt-un-report-warns>

¹⁰ <https://www.researchsquare.com/article/rs-123716/v1>

¹¹ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31647-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31647-0/fulltext)

¹² <https://www.g20.org/wp-content/uploads/2021/06/Matera-Declaration.pdf>



19 emphasising the need to give the prevention and control agendas for NCDs greater priority, in line with the UN Decade of Action on Nutrition.

- **Poverty and life outcomes.** Recent World Bank estimates¹³ suggest that COVID-19 could push as many as 150 million people into extreme poverty in 2021, in addition to the nearly 700 million who were living on less than USD1.90 per day before the pandemic. Nine of the ten countries likely to see long-term impacts of COVID-19 on extreme poverty through to 2030 are in Africa. Moreover, COVID-19 may result in more extreme poverty in urban areas. Progress addressing the alarming inequalities in life expectancy within countries and between countries has stalled. There is a growing body of evidence suggesting that COVID-19 will increase the already widening gap between affluent and poor in terms of life expectancy. The pressure placed on health systems as a result of COVID-19 also has consequences for access to PHC, vaccines to protect against common childhood diseases, and other prevention services and life-saving treatments such as for HIV/AIDS, TB and malaria.
- **Gender equality.** Given the disproportionate gendered impacts of the pandemic on women and girls, an equitable recovery from the pandemic will require gender-responsive policies, targeted measures and women's leadership. Women make up 70% of the professional health sector workforce putting them at greater risk of infection than other groups, and have been under-represented in leadership and decision making processes before, during and in recovery from the pandemic. Women also provide the majority of unpaid care and domestic work, face higher risk of income and livelihood loss putting them at greater risk of economic vulnerability, which, in turn, also puts their families at risk. Women also face higher risk of income loss and increased risk of domestic violence, with estimates of an additional 15 million cases of domestic violence for every 3 months of movement restrictions.¹⁴ COVID-19 has led to disruptions of sexual and reproductive health services, including access to contraception and antenatal care, associated with increases in unplanned pregnancies as well as adverse maternal and neonatal outcomes.

¹³ <https://www.worldbank.org/en/news/press-release/2020/10/07/covid-19-to-add-as-many-as-150-million-extreme-poor-by-2021>

¹⁴ <https://www.weforum.org/agenda/2020/04/coronavirus-women-domestic-abuse/>



- **Employment.** People with lower skill levels have been affected most by COVID-19. The true impact has been masked so far by short-term economic support measures many governments introduced, but when these measures are removed, a surge in unemployment amongst some low-skilled sectors is anticipated, which will adversely impact the health of those affected. Working hours declined by around 14% in the second quarter of 2020, equivalent to the loss of 400 million full-time jobs¹⁵ According to the ILO Monitor, losses in post-support labour income were relatively larger for young workers, women, the self-employed, and low- and medium-skilled workers. Women are employed in some of the most affected sectors, like accommodation, food services, and domestic work. They have been particularly vulnerable to layoffs and loss of livelihoods. While women and men are both taking on more labour within the home, the majority of the work, including household chores, care for children and family members, still falls on the shoulders of women and girls – increasing their unpaid labour.¹⁶ Women also make up the majority of workers in the paid care sector, including child care and elder care, which is often characterised by its low pay relative to the value of the work.
- **Education.** Education has also been disrupted. In 2020, some 91% of enrolled learners and their parents worldwide were affected by pandemic-related school closures resulting in disrupted education, loss of education, and even reduced nutrition as meals provided at school were missed. Despite mitigation measures, including massive expansion of online learning, it is once more the most disadvantaged that are at greatest risk of being left behind, burdening them with worse health outcomes through their life course. For example, UNESCO estimates that 11 million girls may not return to school following the COVID-19 pandemic, an unprecedented disruption to education.¹⁷ The WFP estimates that 24 million children are at risk of never returning to school, particularly girls in developing countries. Beyond missed time in school, this education disruption has led to a loss of skills for many students, especially those with more limited access to education support at home or in their communities. The World Bank estimates that without policy

¹⁵ https://www.ilo.org/wcmsp5/groups/public/--dgreports/--dcomm/documents/briefingnote/wcms_755910.pdf

¹⁶ https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/briefingnote/wcms_767028.pdf

¹⁷ <https://en.unesco.org/news/girls-education-and-covid-19-new-factsheet-shows-increased-inequalities-education-adolescent>



response, the combined effect of these disruptions will be a loss of USD10 trillion in lifecycle earnings for this cohort of students.¹⁸ The co-benefits of good education include improved health and earnings. Children with a healthy weight are more likely to perform well at school and have better job prospects in adulthood. OECD work has shown that poor health reduces lifetime earnings by 33% for men with limited education, compared with 17% for highly educated men (18% and 13% for women). In some settings, women's higher burden of care responsibilities, including the schooling of children from home, may force them to reduce paid working time or to leave the labour market altogether. Low and lower-middle income countries saw an average of 4 months of school time lost in 2020 as a result of the pandemic compared to 6 weeks in high-income countries.

- **Hygiene, water and sanitation** remains off track in communities, health care facilities and schools. One in four health facilities have no basic water services, one in ten have no sanitation services and one in three do not have adequate facilities to clean hands at point of care. Yet functioning water, sanitation and practicing adequate hand hygiene is central fundamental to quality of care, patient and health worker safety. Approximately 20% of global deaths are due to sepsis and more than half are preventable through safe water, sanitation and hygiene services as part of infection prevention and control (IPC). Hand hygiene is critical to and helps reduce health care associated infections and the spread of antimicrobial resistance.
- **Environment.** WHO has estimated that about a quarter of the global burden disease is caused by modifiable environmental factors such as air, water and soil pollution, exposure to harmful chemicals and climate change. The health sector has many critical roles to play in addressing the environmental causes of disease, including identification, prevention, treatment, surveillance, research and monitoring, among others. It is therefore essential that efforts to recover from this pandemic and to build sustainability and resilience in health systems, including through achieving UHC, incorporate these risk factors in a meaningful way and strengthen the health sector's capacity to fulfil these roles.

¹⁸ <https://pubdocs.worldbank.org/en/798061592482682799/covid-and-education-June17-r6.pdf>



THE IMPACT OF COVID-19 ON GROUPS EXPERIENCING VULNERABILITY

COVID-19 has had a disproportionate impact on vulnerable groups. Decades of slow but measurable progress on social and health inequities have been reversed and existing inequities have been exacerbated as a result of COVID-19, significantly increasing disparities across the world. COVID-19 inequities are manifest along lines of gender, urban and rural geography, age, disability status, class, religion, minority status, economic status and legal status – to name a few. Women and girls are often disproportionately affected by the social and economic implications of response measures, including the loss of access to sexual and reproductive health services and life-saving nutrition interventions; increased expectations they will deliver unpaid care at home and in the community; and a steep rise in the incidence of gender-based violence, including violence against women, children and health workers. Periods of peak demand for social protection and refuge services coincide with periods that these services have been significantly curtailed due to COVID-19.

In countries that report data disaggregated by social determinants of health, such as ethnicity, occupation, education, living conditions and income, there are notable disparities in terms of exposure, vulnerability, access to health services and health outcomes in the context of COVID-19. Across the world, some of the starkest inequities have emerged along racial and ethnic lines. Rates of COVID-19 morbidity and mortality are significantly higher among ethnic groups experiencing discrimination, indigenous peoples, migrants, stateless persons, forcibly displaced persons, refugees and non-citizens^{19,20,21}. Beyond health outcomes, the disproportionate impact of COVID-19 on populations experiencing racial and ethnicity-based discrimination and intersecting forms of social exclusion is seen in terms of food insecurity, housing insecurity, income and job loss, and heightened risk of leaving children vulnerable to loss of education.

Persons with Disabilities. Persons with disabilities are disproportionately impacted by COVID-19.^{22,23} They are a diverse group, and the risks, barriers and impacts faced by them vary in different contexts according to various factors.

¹⁹ [https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370\(20\)30374-6/fulltext](https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30374-6/fulltext)

²⁰ <https://www.apmresearchlab.org/covid/deaths-by-race>

²¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7484806/>

²² United Nations. (2020). Policy brief: a disability-inclusive response to COVID-19.

²³ Shakespeare, T., Ndagire, F., & Seketi, Q. E. (2021). Triple jeopardy: disabled people and the COVID-19 pandemic. Lancet (London, England).



Firstly, persons with disabilities are at greater risk of contracting COVID-19 because of physical, social, and communications barriers when implementing public health measures. One such barrier is the lack of accommodation necessary to facilitate basic public health actions, such as frequent handwashing and maintaining physical distance. Another example is the lack of timely and accessible public health information. Few countries distribute guidance in formats accessible to persons with disabilities such as closed captioning, sign language or easy-to-read.

Secondly, some persons with disabilities may be at greater risk of developing severe symptoms or dying from COVID-19, due to underlying health conditions or barriers to accessing timely health care. People with conditions such as diabetes mellitus, cerebrovascular disease, chronic obstructive pulmonary disease, and coronary artery disease have a poorer prognosis with COVID-19. In addition, disruptions in essential health services have had a devastating impact on many persons with disabilities, who often require frequent access to health-care services due to their underlying health conditions.

Thirdly, persons with disabilities may be at risk of new or worsening health conditions associated with different environmental barriers. For example, country lockdowns have led to restricted access to public spaces, making it harder for persons with disabilities to undertake healthy behaviors such as physical activity. Social distancing during the pandemic has been harder for people with vision impairment, and the common use of face masks have affected the ability of people with hearing loss to lip read and communicate.

Forcibly Displaced Persons, Stateless Persons, and Migrants. Data collected by the WHO shows that refugee and migrant populations contribute to the health and well-being of society by providing essential services. Yet they are often among populations at increased risk of COVID-19 due to uncertain legal status, trauma, poor living conditions, inconsistent access to adequate health care, and other basic services such as education and lack of access to livelihood opportunities. COVID-19 has challenged the overall response capacities of health care delivery and public health systems and further highlighted existing inequities in access and utilisation.

People living in fragile contexts. The OECD characterises fragility as the combination of exposure to risk and insufficient coping capacity of the state, systems and/or communities to manage, absorb or mitigate those risks. Fragility is measured on a spectrum of intensity and expressed in different ways across the economic, environmental, political, security, human and societal



dimensions. Fragility can lead to negative outcomes including violence, poverty, inequality, displacement, and environmental and political degradation. Notably through its social and economic impact, the pandemic and its associated shocks have exacerbated pre-existing fragilities. Even before the COVID-19 pandemic, poverty was concentrated in fragile contexts. The 57 fragile contexts identified by the OECD's States of Fragility framework were home to almost a quarter of the world population, but three-quarters of the people living in extreme poverty globally. The reduction in daily incomes, coupled with a decline in remittances that are the largest source of external finance to fragile contexts, has caused financial stress for families who have no alternative means of livelihood. Violence has not reduced during the pandemic either: violent conflict displaced 660,000 people between April and May 2020 alone, adding further burdens to fragile states already hosting half of the world's refugees.

Countries have adopted different strategies to respond to the COVID-19 pandemic concerning disproportionately affected groups, including refugee and migrant populations. In several cases, the adopted measures still lack a UHC approach. To ensure appropriate public health outcomes, health system preparedness and response measures must be equitable, based on vulnerability and risk, and inclusive for all. Responding to global migration, including forced migration, from a public health perspective requires specific and comprehensive responses involving actors from across the whole of government and society. Only an inclusive public health approach will ensure that no one is left behind in the global response and recovery efforts.

VULNERABILITY DUE TO UNDERLYING HEALTH CONDITIONS

Cardiovascular diseases (CVDs). The COVID-19 pandemic has exacerbated the need for a coordinated approach to tackle the burden of cardiovascular diseases. Whilst we are still in the midst of overcoming the challenges posed by the pandemic, one uncomfortable truth is becoming clearer: the burden of cardiovascular diseases often falls disproportionately on certain groups and this has been identified as an area of health inequalities – whether it was by discontinuity of care or because cardiovascular disease is amongst the leading co-morbidity in COVID-19 deaths (65%). In addition, mounting evidence shows that COVID-19 sufferers can develop heart complications.

Despite the challenges posed by CVDs, exacerbated further by the COVID-19 pandemic and the increasingly ageing population, there is still a lack of awareness about the risk factors associated with CVDs, leading to premature mortality across the globe.



Mental health. Everywhere that population mental health had been measured in 2020, it declined, bucking a decades-long trend of fairly stable prevalence rates for mental health conditions²⁴. In some countries, prevalence of depression and anxiety doubled among young people with the worst affected people being those experiencing unemployment and financial difficulties. This fact has been especially true for displaced populations, who already had pre-existing trauma and have been disproportionately affected by the socio-economic impacts of the pandemic. These alarming trends of rising mental illness are showing every sign of continuing into 2021. Even before the crisis, the cost of mental ill-health was more than 4% of GDP, and unmet need for mental health care was high even before this recent rise in prevalence.

Dementia. Quarantine and other containment measures introduced to limit the spread of COVID-19, have damaged cognitive and psychological health and functional abilities of people with dementia. Such effects have been observed previously, in affected populations after SARS and Ebola outbreaks. This suggests the need for, new health policies for this vulnerable group.

Accordingly, the Okayama Declaration's section on "Response to Population Ageing" focuses on the importance of improving care pathways, creating dementia-friendly environments, strengthening R&D, and sharing best practices, with special attention to the burden of women as caregivers. There is a need to focus on forward thinking, planning and investment into health infrastructure (diagnostic, digital, therapeutic standards, and human capital) towards better and increased dementia prevention including Alzheimer's disease (AD). There is also a need for improved measures to help people living with dementia to enable the delivery of effective care, and to reduce the burden, mainly characterised by anxiety, on their care givers in a post COVID-19 era.

STRENGTHENING GLOBAL HEALTH SECURITY

COVID-19 is just the latest health security threat, as the past 40 years have seen a series of infectious disease epidemics caused by viruses of zoonotic origin. Large-scale examples include HIV, SARS in 2003, the H1N1 pandemic influenza in 2009, and Ebola virus disease on an unprecedented scale in West Africa in 2013-15. While it is impossible to completely prevent

²⁴ <https://www.oecd.org/coronavirus/policy-responses/tackling-the-mental-health-impact-of-the-covid-19-crisis-an-integrated-whole-of-society-response-Occafa0b/>



unknown pathogens from emerging and causing human disease, improvements in leveraging a One Health approach that recognises links between human, animal (both domestic and wildlife), and environmental health can help combat zoonoses reduce the risk of zoonotic spillover and contribute to epidemic and pandemic prevention. Further, effective preparedness, with strong cross-sectoral and international collaboration, can help countries anticipate and promptly prevent, detect, and contain outbreaks, and mitigate their impacts. Outbreaks and epidemics over past decades have exposed weaknesses in critical areas of national, regional, and global preparedness systems and response capacities. We must take urgent action to address:

- weaknesses in coordination and communication across the multiple sectors needed for coherence in managing infectious diseases;
- integrated public health systems unable to effectively prevent, detect, diagnose, isolate and treat cases, as well as trace and quarantine contacts;
- limited ability to stop infectious disease spread in clinical - long-term and elderly care settings;
- providing adequate hand hygiene facilities at the point of care;
- a lack of timely and transparent information, data, and sample sharing; information systems and capacity of other sectors' systems that cannot support effective One Health surveillance, assessments, forecasting, and risk communication;
- health care delivery systems incapable of surging to meet the demands of epidemics and pandemics in a manner that reduces disruption to essential services;
- the lack of an adequately trained and flexibly deployable workforce, equipped to meet surges in epidemic and pandemic demand;
- vulnerable supply chains, logistics, and contingency plans unable to rapidly respond, scaling manufacturing of essential medical goods, and moving critical supplies to areas of greatest need;
- risk communication and community engagement processes that lack transparency and trust and are ineffective, including at promoting vaccine confidence and addressing misinformation and disinformation; and
- the lack of sustainably agile, innovation programmes to rapidly research, develop, authorise, scale manufacturing and facilitate equitable distribution of safe and effective diagnostics, treatments, and vaccines (such as the ACT-Accelerator).



A lack of sustainable financing for health security and health system strengthening is one of the reasons for these weaknesses. These financing gaps persist due to a lack of political will informed by financial impact analysis to fund resource needs, sustainable investments in preparedness, and previously identified priority gaps. Functional health security systems are needed at the national, regional, and global levels, which are regularly tested, as well as dynamic metrics for preparedness, including at subnational levels. Special attention to vulnerable settings, such as urban, remote rural, mobile, and conflict settings, is critical. As identified by various evaluation reports (such as the IPPPR), failures in international preparedness include incomplete implementation of the International Health Regulations (2005) and supporting the tools and the financial means to put these preparedness measures in place. Too often, the world has fallen back on a cycle of ‘panic-and-neglect,’ resulting in preventable vulnerabilities to health security threats. Representing two thirds of the world’s population and 80% of the global economy, adequate investment in pandemic preparedness in G20 countries will be key to advancing global preparedness. Investment should be directed towards stronger, more sustainable, inclusive, resilient national systems to strengthen national public health functions for prevention, detection, and response to disease outbreaks and other health emergencies, including antimicrobial resistance.

Gaps in national preparedness and financing of national actions plans for health security need to be filled in many countries, especially those with fragile health systems, lack of access to basic water, sanitation and hygiene services, inequitable access to primary health services and/or inadequate social protection systems. This need includes investing in developing the national capacities required to effectively implement and comply with the International Health Regulations (2005) identified through external assessments like the mechanism of the State party's annual reporting on the IHR and prioritised through fully costed and financed, through national sources or international cooperation, National Action Plans for Health Security (NAPHS). These IHR gaps in preparedness in any individual country constitute a weakness in preparedness for all countries. Recognising that investing in preparedness is more cost effective than investing in response, G20 countries should consider providing a source of sustainable, flexible, and predictable funding for country preparedness and response, and aid countries in addressing these and other preparedness gaps, including capacities to rapidly deploy resources to enable the global community to scale responses more quickly to future health security threats.



BUILDING THE INVESTMENT CASE

There is no doubt that strengthening overall health system preparedness, which includes public health surveillance, detection, and resilience, is critical. However, as countries are also contending with a major economic crisis, understanding where investments should be targeted is key to strengthening resilience to COVID-19 and other potential emerging shocks, maintaining delivery of essential services and stimulating the economic recovery, and to promote better prevention in future. Well-chosen investments are needed to build resilient health systems and healthy environments, to ensure that populations, and in particular vulnerable population groups, are better protected from health emergencies. They reinforce the foundations of countries' health systems, their ability to contain the evolving pandemic and other emerging health issues, and their capacity to maintain high quality health services, as well as health information and data systems, for all health care needs. More resilient health systems are also needed to build stronger, more resilient economies – enabling substantial economic and societal benefits from healthier and productive populations, and minimising stringent and costly containment measures in future crises.

The 2020 Report on Assessment of Gaps in Pandemic Preparedness, prepared by the WHO in collaboration with OECD for G20 Finance and Health Ministers, estimated the cost of pandemic preparedness at USD183 billion over five years and emphasised how the cost of the pandemic to global GDP (USD8.8 trillion in 2020) far outweighed the cost of investing in pandemic preparedness. The global economic crisis triggered by the pandemic increased financing needs while reducing available resources, possibly magnifying the SDG financing gap by about USD 1.7 trillion.²⁵

As identified in a recent World Bank publication²⁶, countries need a double recovery to bounce back from the health and economic impacts of COVID-19. However, getting over the economic crisis depends on solving the health crisis. The World Bank calls for the strengthening of delivery platforms and rolling out COVID-19 vaccines as immediate actions to control the pandemic, and,

²⁵ <https://www.oecd.org/development/global-outlook-on-financing-for-sustainable-development-2021-e3c30a9a-en.htm>

²⁶ <http://documents1.worldbank.org/curated/en/670721616095085493/pdf/From-Double-Shock-to-Double-Recovery-Implications-and-Options-for-Health-Financing-in-The-Time-of-COVID-19.pdf>



in the longer term, to invest in the goal of achieving UHC and sound population health as vital steps towards sustainable and inclusive longer-term economic recovery.

Investments to strengthen health system resilience and improve people's health can be grouped under three overarching investment pillars²⁷, which aim to:

- **Fortify** the foundations of health systems and people's underlying health and wellbeing
- **Prevent, detect, and respond** to the spread of a health emergency (COVID-19 or other)
- **Manage** and uphold care for individuals affected by emerging pathogens and those with other health care needs

Within these pillars, seven areas for investment are identified as follows:

- **Pillar 1:** Fortify the foundations of health systems and people's underlying health
 - Investment 1: Enhancing well-being and preventive care, including strengthened primary health care and chronic care to reduce the prevalence of chronic diseases in the population.
 - Investment 2: Core tools, technologies and equipment, including that for care and diagnostics (such as hospital beds, scanners, and laboratory equipment) innovations such as vaccines and digital health and IT infrastructure for robust data collection sharing and reporting.
 - Investment 3: Proactive monitoring, rapid information and data sharing and harnessing of health information – Strengthening the collection, use and reporting of health related data to guide decision making, while respecting personal data protection, to inform evidence-based interventions, and further improve health planning and delivery
- **Pillar 2:** Prevent, detect, prepare for and respond to health threats
 - Investment 4: Health security capacities, including laboratory systems, workforce development, surveillance, infection prevention and control, including measures to combat anti-microbial resistance, and other critical capacities such as genome sequencing as identified in the International Health Regulations (IHR).

²⁷ OECD Health Working Paper, forthcoming publication



- Investment 5: A resilient and scalable innovation, testing, supply chain, manufacturing and distribution ecosystem capable of rapidly researching, developing, manufacturing, authorising, and deploying safe and effective diagnostics, treatments, and vaccines at scale, including increasing geographically distributed production capacities.
- Pillar 3: Manage and uphold care for affected individuals and those with other health care needs
 - Investment 6: Strengthening and innovation in service delivery, especially addressing staff shortages and health service delivery models
 - Investment 7: Multi-disciplinary reserve (surge capacity) and adequate training of medical and public health staff

The cost, averaged across all OECD countries, to build health system resilience is estimated to be in the order of magnitude of about 1.5% of GDP. The main cost driver is the need to invest more (around 1% of GDP) in the health workforce. Offsetting this, the 2016 UN Commission on Health Employment and Economic Growth²⁸ noted the multiplier effect of creating new health worker jobs – estimating that each trained health worker creates up to two additional service sector jobs.

Within the health sector, such investments stop health systems from being overwhelmed in the short-term. In the medium-term, they can also increase efficiency by reducing ineffective and wasteful spending. For example, investing in better health information systems to better collect, share, and use routine health data (one of the seven areas for investments included) is estimated to equate to a return of approximately 3 to 1. Beyond the health sector, such investments will boost the economy. A stronger, more resilient health system helps reduce the stringency of containment and mitigation measures in the future. It also strengthens human capital both now, through a healthier and more productive workforce, and in the future, through less disrupted education.

In the context of a challenging fiscal environment post-COVID-19, policies should ensure ongoing investment into health systems, with considerations on how to coordinate, incentivise, and maintain accountability for sustainable financing and achieve outcomes within tight fiscal

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<http://apps.who.int/iris/bitstream/handle/10665/250047/9789241511308-eng.pdf;jsessionid=E9D6C4C5F54FA2155A94E939169A3FF5?sequence=1>



constraints. This goal should include assessments of both operational and capital expenditures to ensure appropriate surge capacity to respond to future emergencies. The work on Value Based Health Care, started under the Saudi Arabian G20 Presidency, will provide guidance to G20 members, and other countries, on ways to optimise future investment and spending in health, to support the transition to higher value health systems. However, countries that are at increased/higher risk for COVID-19 will still be reliant on technical assistance, as well as development assistance for one-time costs and capital improvements, for the foreseeable future. Nevertheless, as they transition away from aid, many low-income countries will need to develop plans to sustainably finance national health systems and develop appropriate management structures, including structures for procurement and public financial management.

Financing for development has never been under such strain. The SDG financing gap in developing countries – the difference between needs and available finance from all sources – increased by at least 50 percent in 2020. Official Development Assistance (ODA) from DAC members reached record levels in 2020 – USD161 billion – but remained a fraction of the total need. Initial estimates are that USD12 billion of this was spent on COVID-19-related activities. Meanwhile all other resources to developing countries declined, including tax, trade and remittances²⁹.

This, combined with increasing debt levels, put pressure on already tight budgets, significantly affecting the countries' abilities to invest in national health systems. Aggravating debt levels in developing countries put pressures on already tight public budgets, significantly affecting some countries' abilities to invest in national health systems. As of June 30, 2021, and based on the IMF's most recently published data³⁰, 7 countries are in debt distress, 29 countries are at high risk, 23 countries are at moderate risk, and 10 countries are at low risk of debt distress. Faster roll-out of safe, effective and quality-assured vaccines (i.e. by the end of 2022) to all developing countries, accompanied by a stronger global economic recovery, might help to reduce this gap. Detailed figures on 2020 data will only be available in December 2021, but concessional finance for the health sector from all donors (bilateral, multilateral and private foundations) averaged USD 27 billion per year (in real prices) between 2017 and 2019.

²⁹ (1) OECD (2020), Global Outlook on Financing for Sustainable Development 2021: A New Way to Invest for People and Planet, OECD Publishing, Paris, <https://doi.org/10.1787/e3c30a9a-en>
³⁰ <https://www.imf.org/external/pubs/ft/dsa/dsalist.pdf>



Basic health programmes accounted for 50% of total ODA for the health sector, population policies (including family planning) accounted for 34%, and other health programmes (health policy and management, medical education, medical research and medical services) accounted for 16%. Total ODA for infectious diseases (including malaria and TB) amounted to USD 7 billion in 2019. While 2020 data have yet to be confirmed, a very significant rise on health-related ODA on the previous year is expected, given that around 95% of ACT-A will be ODA eligible, and the eligibility of other new sources of vaccine and health financing is also under assessment.

Achieving progress requires financing, especially in LMICs, which are prone to experience significant challenges in their health financing as they see a sudden decline in external assistance³¹. As the world's largest economies, G20 countries play a critical role in crisis response and reconstruction. G20 members should revisit the level of development financing available to support the SDGs. We welcome efforts by the G20 Development Working Group with the support of the OECD and UNDP to promote financing for sustainable development and better mobilise, leverage and align public and private resources in support of developing countries.

Overall, the G20 has a key role to play in crisis response and prevention, to help respond to the current crisis and prevent new shocks, as well as support progress towards the SDGs more broadly.

Another critical contribution to the case for investment and associated governance needed to strengthen health systems is the report from the High-Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response established by G20 on January 26, 2021. The Panel has presented its final report to G20 Finance Ministers and Central Bank Governors in July 2021, who charged experts from Ministries of Finance and Health to follow up with concrete proposals to be presented at the G20 Joint Finance and Health Ministers' Meeting in October.

At the Global Health Summit, the Chair of the "Pan-European Commission on Health and Sustainable Development"³², established by the WHO Regional Office for Europe in August 2020, presented its proposals, including the establishment of a Global Health Board, as set out in its Call to Action "Rethinking Policy Priorities in the light of Pandemics" of 16 March 2021, with the

³¹ https://www.oecd-ilibrary.org/development/financing-transition-in-the-health-sector_0d16fad8-en

³² <https://www.euro.who.int/en/health-topics/health-policy/european-programme-of-work/pan-european-commission-on-health-and-sustainable-development>



aim to promote a better assessment of economic and financial health-related risks, coordination and information exchange among authorities responsible for health and sanitary resilience, on prevention, on organisation of resilient health systems, in a One Health perspective, and on crisis situations (contingency planning, early warning, crisis management).

The COVID-19 pandemic has demonstrated that the state of our environment and the health of our populations, particularly the most vulnerable, are matters of concern for us all. It has also highlighted that investments in health emergency preparedness and response, and in supporting health systems, must expand to take into account environmental impacts on human health as they have detrimental effects on any efforts to recover from pandemics and build future resilience in health systems. The WHO Manifesto for a Healthy Recovery from COVID-19 highlights the critical importance of addressing environmental health risks to protect human health and improve resilience to health shocks and emergencies.



CONCLUSIONS AND RECOMMENDATIONS

The health, social and economic costs of epidemics and pandemics can be huge compared to the costs of preparedness. COVID-19 has underlined that expenditure on health should be regarded as an investment rather than a cost, yet it has also shown the consequences of many years of under-investment in terms of gaps in pandemic response, with countries struggling to meet demand. This Position Paper proposes several actions as part of work to recover better from the pandemic and increase investment, while ensuring health system resilience and responsiveness by adopting a value-based approach to health care investment.

The paper demonstrates how investment in health can accelerate progress on many of the health-related SDGs. Yet the paper also shows how hard-won gains in progress towards the SDGs are being reversed by the impacts of the COVID-19.

As the Sendai Framework for Disaster Risk Response makes clear, the time to build forward better begins even as a disaster is still unfolding. Work to overcome the gaps in health system effectiveness and multi-sectoral coordination exposed by COVID-19 should begin without delay, and positive impacts, for example in accelerating drug discovery or implementing telehealth, should be sustained and expanded.

WE RECOMMEND THAT, IN ACCORDANCE WITH NATIONAL CIRCUMSTANCES:

- 1. EQUITY AND EQUALITY SHOULD BE AT THE CENTRE OF A HEALTHY AND SUSTAINABLE RECOVERY** from this pandemic, including towards achieving the SDGs, as well as addressing the determinants of health.
- 2. INVESTMENT IN HEALTH AND WELL-BEING IS RECOGNISED AS AN INVESTMENT IN OUR ECONOMIES.**

G20 members should therefore support all developing countries and regions by fostering an enabling policy environment, strengthening international and multilateral cooperation and the mobilisation of all possible resources, to invest in health systems and health care services to drive progress on SDG3, on health and wellbeing in order to achieve universal and equitable access to health services– as well as the other health-related SDGs, such as:



- SDG2: actions to improve sustainable food systems and nutrition starting with the promotion of sustainable and healthy diets, including traditional diets that contribute to these objectives through engagement of actors in public and private across multiple sectors, recognising the economic benefits to society of a healthy population, as a long term investment for the benefits of citizens and stakeholders;
- SDG4: education (the education achievements of healthy pupils will be enhanced);
- SDG5: gender equality and the empowerment of all women and girls, (ending all forms of discrimination against women and girls everywhere; eliminating all forms of violence; recognising, valuing and sharing responsibility for unpaid care and domestic work; ensuring women’s participation and equal opportunities for leadership at all levels of decision-making; undertaking reforms to give women equal rights to economic resources). Through UHC, ensure universal access to comprehensive sexual and reproductive health and reproductive rights as an essential part of gender equality and women and girls’ empowerment – with better access to comprehensive, rights based health services and control over their sexual and reproductive choices, women and girls have greater opportunities in education, the economy, and society;
- SDG6: ensure access to water, sanitation and hygiene (WASH) for all. Investments in WASH capacities, particularly in strategic settings like health care facilities and schools, have cross-cutting benefits for public health and economic resilience;
- SDG8: Decent work and economic growth (healthy adults are more likely to find and retain employment, and therefore better able to afford healthy diets SDG 2); and
- SDG11: investing in health literacy will give citizens a powerful voice to drive investment in healthy environments (health literate citizens being more likely to advocate for policies that improve the urban environment).

3. THE RESILIENCE OF HEALTH SYSTEMS NEEDS TO BE STRENGTHENED IN ALL COUNTRIES, WITH EMPHASIS ON:

- a. achieving and sustaining UHC including financial protection for those who are most vulnerable;



- b. sustaining a motivated health workforce, that is adequately resourced, protected, trained, supervised, deployed and retained, keeping in mind that 70% are women;
- c. strengthening a strong inclusive primary health care system that is accessible for all and with good referral linkages;
- d. clinical settings and facility staff that enable care to be delivered without crowding;
- e. providing basic access to water, sanitation and hygiene in all health care facilities;
- f. taking into account environmental impacts on human animal and ecosystem health and strengthening the health systems ability to identify and respond to these impacts;
- g. ensuring people who are at increased/higher risk for certain conditions including women and girls, have equitable access to health services, including sexual and reproductive health services, that respect their human rights and ensuring that the voices of groups, including women and girls, and people with disabilities are integrated in health decision-making at all levels, from community to global, to ensure UHC meets the needs and priorities of all people;
- h. essential public health functions for the prevention, detection, and response to concurrent and future health threats and emergencies, including through the One Health approach;
- i. encouraging new public health guidance in consultation with relevant health organisations on international travel by air or sea, including cruise ship;
- j. developing a more sustainable and equitable model to pay for essential health services including the immediate need for safe and effective COVID-19 diagnostics, therapeutics, and vaccines, learning from the experiences of the ACT-A including COVAX Facility and its AMC Summit successfully mobilized financial and dose-sharing commitments exceeding its financial target;
- k. patient safety and quality of care;
- l. ‘building forward better’, in the context of One Health, should have a ‘health in all policies’ approach that remains grounded in equity and addresses the social, environmental and economic determinants of health; and
- m. during major public health emergencies, temporary financial support policies could be adopted to ensure the stable economic operation of medical institutions.



- 4. A DEDICATED EFFORT IS NEEDED TO INCREASE THE CAPACITY OF AND IMPROVE ACCESS TO MENTAL HEALTH SERVICES**, in particular in times of health emergencies and crises and raise the quality of care, considering the key recommendations for the G20 countries to strengthen community mental health as a crucial element of recovery, as outlined in the Policy Paper released at the Mental Health Side Event organised by the Italian Presidency. In line with the WHO Comprehensive Mental Health Action Plan 2013-2030, recently endorsed at the 74th World Health Assembly, there is a need to integrate mental health into our broader health systems and promoting equitable access to mental health services and psychosocial supports as part of pandemic and economic recovery efforts - a topic that will be discussed at the 3rd World Summit on mental health to be held in Paris, with the support of the WHO.
- 5. INVESTMENT IS NEEDED NOW TO ENABLE MORE EFFECTIVE DELIVERY OF NATIONAL SYSTEMS THAT SUPPORT HEALTH CARE DELIVERY.** To improve the functioning of health systems in many developing countries, greater emphasis on strengthening national systems beyond health care delivery is needed, to include procurement and public financial management, to ensure appropriate surge capacity to respond to future emergencies.
- 6. INVESTMENTS IN COUNTRIES' IHR CORE CAPACITIES ARE URGENTLY NEEDED, ACROSS MULTIPLE SECTORS, FOR GLOBAL HEALTH AND EMERGENCY PREPAREDNESS AND RESPONSE.** Collaboration between finance and health authorities is essential to ensure countries have access to sustainable, flexible and predictable funding for preparedness and response to future health emergencies and to fully implement the IHR.
- 7. GOVERNMENTS NEED TO ENSURE ADEQUATE INVESTMENTS, BOTH TO ADDRESS THE BACKLOG OF CASES POSTPONED DURING THE PANDEMIC DELAYS IN SEEKING HEALTH CARE, UNINTENDED CONSEQUENCES ON NON-COVID HEALTH CONDITIONS AND MENTAL HEALTH AND TO MAKE HEALTH SYSTEMS MORE RESILIENT AS PART OF FUTURE PREPAREDNESS PLANS.** For many countries, this may require a discussion between Finance and Health Ministers, including a consideration of ways to expand their domestic fiscal space for health. It could also involve further funding of pandemic preparedness by the private sector.



8. THERE IS A NEED TO DEMONSTRATE THAT INVESTMENT IN PUBLIC HEALTH AND HEALTH CARE DELIVERY SYSTEMS ARE IMPROVING OUTCOMES AND RESILIENCE. Health systems need to be resilient, safe, responsive, person-centric and value-based to withstand future shocks. All G20 members are encouraged to strengthen their engagement with the Global Innovation Hub for Improving Value in Health (the Hub), created under the Saudi Arabian G20 Presidency. In transforming health systems to make them more resilient, it will be important to make full use of advances in digital technologies also in a way that protects patient privacy. The Hub will present a paper on value based health care and digital health to support the joint G20 Finance and Health Ministers meeting in October this year and similarly support the upcoming Presidency's work.

9. WE NEED DATA IN ORDER TO MEASURE PROGRESS AGAINST HEALTH INVESTMENT OBJECTIVES. We recommend that efforts to provide transparency on the global financing for health be pursued:

- a. external flows for health financing in developing countries, both from traditional and emerging providers, and
- b. the financing of global public goods for health.

Note of the Presidency:

We would like to share the experience of the Italian Alliance for Sustainable Development (ASviS)³³ through its annual report, ASviS³⁴³⁵³⁶³⁷ publishes the results of its monitoring of the progress in the pursuit of the SDGs in Italy and in the European Union, including a detailed analysis of the Italian State Budget, divided into its relevant sections, in light of 2030 Agenda commitments. Through this experience, ASviS is able to support G20 members in the definition of a monitoring system capable of assessing current state budget standing and the progress needed to achieve the Agenda 2030 Goals.

³³ The Italian Alliance for Sustainable Development (ASviS), that brings together almost 300 member organizations among the civil society, aims to raise the awareness of the Italian society, economic stakeholders and institutions about the importance of the 2030 Agenda for Sustainable Development, and to mobilize them in order to pursue the Sustainable Development Goals (SDGs)

³⁴ <https://asvis.it/activities-and-partnerships/>

³⁵ <https://asvis.it/the-working-groups/>

³⁶ https://www.salute.gov.it/imgs/C_17_pagineAree_5459_4_file.pdf

³⁷ https://www.salute.gov.it/imgs/C_17_pagineAree_5459_5_file.pdf