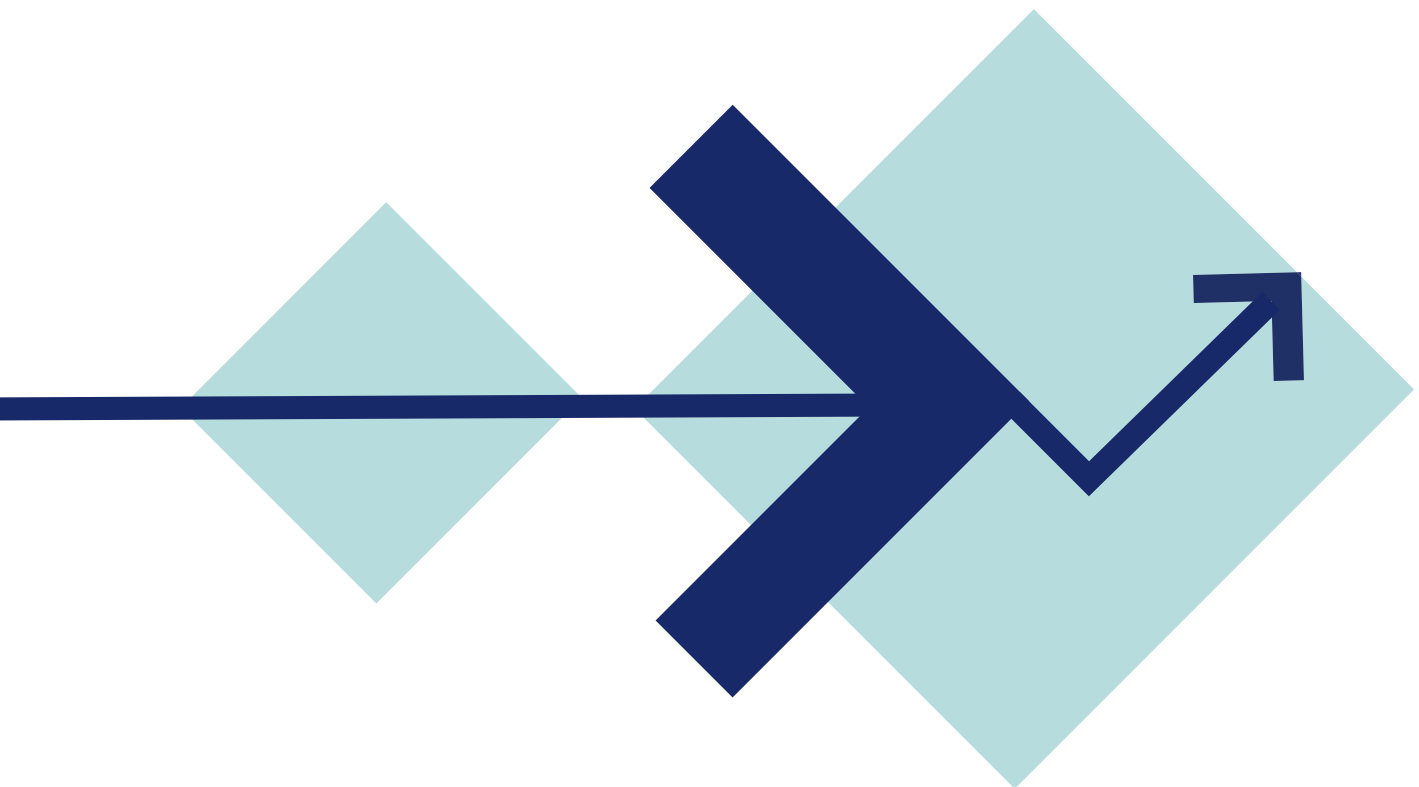




The WHO Council
on the Economics of
Health for All

Financing Health for All: Increase, transform and redirect

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The WHO Council on the Economics of Health for All

The world has been turned on its head by the coronavirus disease 2019 (COVID-19) pandemic. This has provided a stark wake-up call on the severe under-financing of health systems around the world. It has laid bare the inequalities and limitations in the capacities of countries at all levels of development to prevent major health crises or respond to them. But it doesn't have to be this way.

The new WHO Council on the Economics of Health for All recognizes that health and economies are deeply intertwined. Indeed, economic development could improve health and well-being. Leveraging its platform, the Council demands now, more than ever, the need for clear, ambitious goals to catalyze and focus investments and action, and to put priority on financing health as a long-term investment and not a short-term cost.

The Council has written this brief to focus on how to finance Health for All. There are two key dimensions: more finance and better finance. By moving to a new paradigm where health is an investment, governments can overcome internal fiscal limits and transform the relationship between public and private sectors, towards common goals. In other words, increasing financing is not enough: the quality of finance is crucial to delivering Health for All. This mission can be achieved by designing policies to reach Health for All now by realigning finance from all sectors and sources through conditionalities that fuel symbiotic gains in the public interest.

The Council stresses three pathways for action

- 1) Creation of fiscal space
- 2) Direction of investment
- 3) Governance of public and private finance.

For each, this brief proposes specific actions for governments and multilateral organizations. These actions should strengthen health systems to ensure access to life-saving and life-improving products and services; and to improve robust socioeconomic conditions across sectors that recognize the co-benefits of Health for All from a whole-of-government approach.

The COVID-19 crisis has opened a window for a radical redirection. The Council believes that it is vital to pursue a new paradigm that eliminates macroeconomic policies and assumptions that move us away from Health for All, and instead, find finance that achieves the mission of Health for All. To realize such aims, we must reverse – and expand – our perspective on health and economic development: from pursuing health for the economy, to redesigning the economy for health.

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SUMMARY OF KEY PRINCIPLES

MORE FINANCE

We need to increase the quantity of total finance to fund Health for All. Health is an investment not a cost, and therefore needs to be protected from budget cuts. The cost of inaction far outweighs that of action.

Creating fiscal space for Health for All

National governments should:

- reverse the harmful effects of an austerity approach to public administration and public finance reforms;
- harness the power of monetary policy to channel a larger volume of bank credit towards investment in Health for All;
- leverage procurement to expand budgets available for health.

Multilateral organizations should:

- negotiate debt relief for low- and middle-income countries;
- redirect the IMF's new special drawing rights towards investments that enable low- and lower-middle income countries to invest in health system transformation and purchase COVID-19 vaccines;
- push for and help to coordinate minimum corporate tax rates building on the newly negotiated rate of 15% or higher;
- advance the G20 reform of sovereign credit ratings by credit rating agencies at the global level.

BETTER FINANCE

The quality of finance matters: we need to improve the governance, design and delivery of public, private and donor finance to align with the goal of Health for All. Long-termism, mission setting and conditionalities are key to engendering symbiotic partnerships rather than wasteful fragmentation.

Directing investment towards Health for All

National governments should:

- forge symbiotic public-private partnerships through a combination of investment conditionalities, regulations and incentives;
- align public budgets and procurement contracts to channel funds towards public health goals and integrate departmental silos into a whole-of-government approach;
- create a newly unified taxonomy for financial market investments in the health sector with preferential tax and regulatory treatment linked to clear outcome measurements that focus on contributions to Health for All.

Multilateral organizations should:

- shift focus on loan conditionalities and grant co-financing requirements away from narrow disease-oriented spending obligations towards strategic cross-cutting system investments in borrower countries.

Governing public and private finance

- regulate the functioning and financing of private health markets;
- steer private health investment through explicit and implicit subsidies, particularly in health innovation and the extension of health services to underserved populations, and away from investments based on market segmentation that create inequity and inefficiency;
- strengthen and invest in existing mechanisms for global vaccine distribution (through COVAX) and technology transfer (through the COVID-19 Technology Access Pool).

1. Finance is not neutral: the need for more *and* better finance

Health is a fundamental human right, so the goal must be Health for All. In 1981, the then WHO Director-General, Dr Halfdan Mahler, defined Health for All as health and wellbeing within the reach of every citizen of every country globally. Health for All, he suggested, “implies the removal of the obstacles to health – that is to say, the elimination of malnutrition, ignorance, contaminated drinking water and unhygienic housing – quite as much as it does the solution of purely medical problems such as a lack of doctors, hospital beds, drugs and vaccines.”¹ Crucially, Mahler argued that Health for All should be a primary objective of economic development and not merely one of the secondary means for economic development.

Forty years later, the experience of COVID-19 has demonstrated what happens when we ignore such wisdom. When we focus on the minimum health spending required for economic functioning rather than on the strategic investments needed to improve health outcomes over the long-term, we fail to foster healthy populations and resilient economies – as the Economic Resilience Panel of the Group of Seven (G7) has recently pointed out.² The consequences for lives, and for individual, community and economic well-being, are immense.

» The comparison with climate change is acute: the cost of inaction is greater than the cost of action now. «

The COVID-19 pandemic has proven to be a stark wake-up call to the limitations of current approaches. The cumulative financial costs of the COVID-19 pandemic in terms of lost output alone – not accounting for the value of lives lost – over the decade following 2020 are estimated to be around 54.7% of total global gross domestic product (GDP) in 2019, or \$47.7 trillion.³ An

International Monetary Fund (IMF) report calling for a set of urgent actions to tackle the pandemic states that the “benefits of such measures at about \$9 trillion far outweigh the costs which are estimated to be around \$50 billion”.⁴ The comparison with climate change is acute: the cost of inaction is greater than the cost of action now. This requires a view of health as an investment not a cost, and one that requires long-term thinking not self-defeating short-term cost cutting.

» More money is not enough. «

In response to COVID-19, a number of leading international organizations and panels – including the IMF, the High-Level Independent Panel of the Group of 20 (G20), and the WHO Independent Panel for Pandemic Preparedness and Response – have made major calls for substantial additional investments in global health infrastructure, in tens of billions of dollars per annum.

This is clearly a necessary first step. However, more money is not enough. This is because finance is not neutral; the type of finance available can affect the directionality, and eventually the outcomes of the investments.⁵ The structural problems above require not only adding finance into the system, but also addressing the shortcomings in existing structures and transforming them. Therefore, just as important as the amount of investment is the way in which the investment is designed and delivered to align with the goal of Health for All. Indeed, many of the dysfunctions in the current system stem from the ways in which finance has been structured and how priorities have been set. Thus, increasing funding must come with reforming funding mechanisms.





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In the run-up to the G20 Rome Summit, we must recognize the critical challenge is both to increase the proportion of the finance available for health, and to govern it in a more directed and effective manner. Health for All can only be achieved through a realignment of public, private and donor finance (whether multilateral, bilateral or philanthropic). What is needed, therefore, is to:

- a. increase the quantity of total finance to fund Health for All;
- b. improve the governance, design and delivery – the quality – of public, private and donor finance to align with the goal of Health for All.

Thus, rather than invest in healthcare industries and regulate the market to realize important but marginal and often unequal gains for health, we must first set ourselves ambitious goals to achieve Health for All and then work towards the goals by designing financial architecture and an economic system that can deliver on this mission.⁶ Without this radical redirection, we will never achieve Health for All.

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Achieving the goal of Health for All requires a public sector that is empowered to expand the fiscal space for health, direct financing from across sectors, and govern the financing in line with the goal. This Council brief explains why Health for All requires both more finance and a very different form of financing, with strong conditionalities between stakeholders; and renewed urgency and innovation in the policy tools used to govern it. Specifically, it focuses on the critical role of public finance, and its relationship with other sources of finance.

2. Beyond the usual myths

Standing in the way are two basic economic assumptions. The first relates to the quantity of finance. It concerns the notion of government expenditure as being constrained in the same way as household spending, and therefore beholden to the same rules of financial management and prudence. The second assumption relates to the quality of finance, that increased private investment in health would necessarily lead to better health outcomes.

Below, we argue that such assumptions are wrong, and dispelling these myths is indispensable to enhancing the quantity and quality of finance and creating the fiscal space to realize Health for All.

Myth 1

Government budgets are like household budgets

The assumption that no significant increase in government financing is possible without substantially raising taxes or risking bankruptcy or adverse macroeconomic consequences has conventionally constrained public spending on health. However, unlike households, governments can create money and they cannot go bankrupt. We see this during military build-ups and wars, when there seems to be no limit to the supply of finance. We also see this in the COVID-19 pandemic when sizable fiscal stimulus is generated and injected into the economy, but only after the pandemic has become too widespread to control.

Governments, especially those with monetary sovereignty, do not face any real fiscal limits on investments in health – or any other domain – owing to the unique way in which government debt effectively finances money creation.⁷ In such contexts, the rules of the game for delivering Health for All already exist. However, political conditions often prevent governments from playing ball.

Many countries around the world do not enjoy monetary sovereignty in any substantive sense. Most governments, especially in the Global South, are constrained from increasing deficit spending on health for four main reasons:

- a. There are internally imposed legal limits on the levels of budget deficits, national debt, or government expenditure, which is a constraint to long-term expenditure and policy goals.
- b. There are externally imposed fiscal rules, in the form of austerity recommended or required by supranational groups, such as the European Union, or by international

financial institutions such as the IMF, which have historically required governments to limit the size of their budgets or meet debt reduction targets in exchange for financial assistance in the event of an economic, financial or social crisis.

- c. There is concern about the impact on credit rating and ability to access capital. Capital market players tend to have exaggerated concerns with sovereign debt viability, to the extent that even modest increases in fiscal deficits or national debt can lead to sell-offs of government bonds and national currencies.
- d. It is difficult to raise tax revenues consistently in proportion to economic activity, owing to low corporate tax rates and corporate tax incentives⁸, reliance on regressive value added taxes, tax avoidance by multinational corporations and high net-worth individuals⁹, and trade and investment treaties that compromise public capacities to raise tax revenue¹⁰.

None of these obstacles are insurmountable. They are the product of nationally and internationally designed rules rather than inherent economic laws. Changing the rules of the game is a fundamental priority of any strategy to deliver Health for All, and policymakers with the will have the ability to do this now. But even within existing rules, there is still room for manoeuvre. Governments in countries with less than absolute monetary sovereignty, for example Costa Rica and Cuba, have nonetheless created the fiscal space for consistent investments in health despite hard fiscal and balance of payments constraints.^{11 12} Such innovation could become more widespread were fiscal and policy environments made more hospitable.

» Changing the rules of the game is a fundamental priority of any strategy to deliver Health for All. «

Substantially increased and redirected public investment is fiscally and economically possible. It is an urgent political imperative if we are to ensure that basic conditions are met for humans to flourish, prepare for future risks and provide a firm financial footing for long-term leaps in medical innovation.

The challenge is to change mindsets within countries that impose internal constraints on spending. It is also to transform externally imposed conditionalities that hinder spending into positive conditionalities that support and promote Health for All.

Myth 2

Increased private investment in health would necessarily lead to better health outcomes

The private sector (both for-profit and not-for-profit) plays an important role in most of the world's health systems, and nearly all countries have "mixed health systems" – relying on a mix of public and private revenue sources and providers to fund and deliver health-related goods and services. Yet the short-term profit maximization that tends to characterize private finance runs counter to the long-term investments needed to foster Health for All.

» The current rules governing private finance are not delivering Health for All. Therefore we need new forms of governance. «

Capital investment for health is a deeply long-term and holistic endeavour that runs against the short-term profit maximization imperative. Investments in health are characterized by strong positive externalities. In other words, the gains to society extend beyond the direct return to investors because there are more than just monetizable benefits, which are reaped over a longer time horizon than financial markets have the patience for. Long-term financing is thus fundamental to securing Health for All that covers services and essential functions, including pandemic preparedness and response. Health for All and equitable access to products and services can put in practice the core principles of the WHO Constitution, a foundational legal document for global health governance. The Constitution calls for government action as well as broad-based social and economic measures to achieve the highest possible attainment of health for people. Ratified by countries around the world, it has stood the test of time more than 70 years since it came into force.^{13 14}

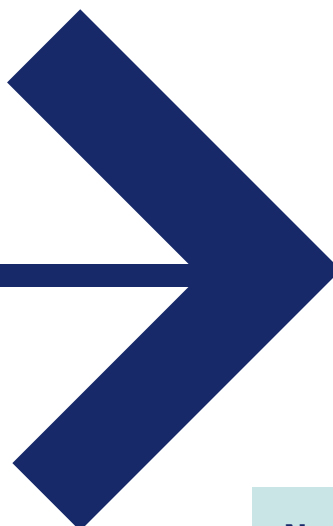
However, the misalignment between the goals of private finance and those of public health has only widened as the global economy has become increasingly financialized and highly focused on maximizing shareholder value. Between 2007 and 2016, 19 of the largest pharmaceutical companies included in the Standard & Poor's 500 Index spent US\$297 billion repurchasing their own shares, equivalent to 61% of their combined research and development (R&D) expenditures over this period.¹⁵ This high level of share buyback has increased share prices and executive pay. The stupendous amount of finance spent on this represents a sizable opportunity cost for investing in innovative and productive activities instead.

Another problem is that large biopharmaceutical firms have increasingly disinvested from riskier early upstream research, focusing instead on acquiring products already in later clinical trial stages from biotech companies.¹⁶ Biotech start-ups seek to project high profitability and boost market valuation, which exacerbates high drug pricing, further hampering access to innovative drugs.^{17 18 19}

Owing to these global economic trends, private finance has not adequately provided funding that serves our collective health needs. Our failure to translate impressive technological progress into an effective global health response to the pandemic and protect the most vulnerable everywhere²⁰ is not only a moral failure²¹, as WHO Director-General Dr Tedros Adhanom Ghebreyesus points out, but also a colossal failure of how we direct finance around health goals.

Private finance has a key role to play in advancing innovative products and services that will improve health outcomes, but the current rules governing private finance are not delivering Health for All. Therefore, we need new forms of governance. Public and private finance must be directed both in terms of what is being financed and how, by improving the design of symbiotic public-private partnerships for the public interest.

From status quo to the new paradigm



	Status quo		New paradigm
QUANTITY of finance	Assumption	Government expenditure is beholden to the same rules of financial management and prudence. While medium-term revenue and expenditure frameworks exist, they are not always operationalized into annual budget processes.	Government budgets function within an operationalized medium- or long-term framework that enables counter-cyclical spending to cushion societies where external shocks create needs for greater social spending. Health as an investment and not just an expenditure leads to long-term thinking.
	Implication	It is not possible to significantly increase government financing for health without substantially raising taxes or risking bankruptcy or adverse macroeconomic consequences.	Governments can overcome internal fiscal limits on investments for health; multilateral organizations and supranational groups can also help transform externally imposed limits.
QUALITY of finance	Assumption	Governments need to get out of the way to enable private investment to drive better health outcomes.	Existing finance – public, private and donor– needs reorienting around the mission of achieving Health for All.
	Implication	The financial sector has not adequately provided financing that serves our collective health needs.	Governments need to transform the relationship between the public and private sectors by regulating private health markets, providing incentives to private health investment through metrics that reflect health values, and redirecting long-term investment towards common goals.



3. Financing Health for All

In a post-pandemic world, we cannot risk returning to pre-pandemic approaches to the financing of health. On the one hand, public finance is urgently needed. On the other hand, there is a need to reorient all forms of existing finance around the goal of achieving Health for All.⁶ This requires a new social contract that promotes value creation over profit extraction, and socializes rewards as well as risks. Additionally it should seek to invest not simply in specific services, companies or sectors, but in public-private partnerships tasked with securing the global common good. The way forward is to follow three pathways to action.

Pathway 1

Creating fiscal space for Health for All

There is a need to ease existing constraints on fiscal space so that governments can increase public investments, which are the foundation for all other sources of financing for Health for All. Creating fiscal space at the governmental level is of utmost importance since the public sector plays the most central role in financing investments in public goods, not least health.²² Such spending needs to be seen as a first charge on ministries of finance and not an item that can be cut during economic downswings or periods of fiscal stress. It is important to focus it back on long-term impacts rather than immediate results or costs.

GOVERNMENTS SHOULD ACT NOW.

1.1 Reverse the harmful effects of public administration and public finance reforms that led to big health cuts²³ and reallocate spending towards health investments, including in health services, preparedness, health innovation, health workforce development and tackling the social determinants of health. Ministries of finance can ensure that preparedness is a recurrent item on national budget plans and integrated in overall plans of governments.

1.2 Harness the power of monetary policy by setting up public long-term lending institutions such as national development banks and use directed credit policies in order to channel a larger volume of bank credit towards investment in Health for All. Steer government regulation and funding towards creating an ecosystem for financing R&D and innovative enterprises aligned with the goal of Health for All, supported by State investment or development banks.²⁴

1.3 Leverage procurement mechanisms to expand budgets available for health, for example, through models such as Brazil's Productive Development Partnerships (PDPs) (see **BOX 1**).²⁵ Governments need to develop domestic and regional sourcing capabilities and systems for drugs and medical devices to ensure timely evaluation of collective needs and facilitate procurement in larger volumes to bring down prices.

BOX 1: PRODUCT DEVELOPMENT PARTNERSHIPS IN BRAZIL LOWER PRICES

The PDPs are innovative practices of the Brazilian State that involve the use of its purchasing power in relation to products, usually of high cost and greater technological complexity, as a tool to stimulate innovation and local production. The implementation of PDPs required adjustments in Brazil's regulatory framework. By using public procurement as a tool to build technological capacity, ensure technology transfer into the health system and interconnected sectors, and differentiate processes for the registration of PDP products, the government was able to orient the health system towards public purpose and make it more resilient. During their implementation (2009–2015), it is estimated that PDPs reduced prices paid by the Brazilian Ministry of Health.

Multilateral organizations such as the IMF, the World Bank and other international development banks can support this goal by increasing direct financing to countries according to need, through the following actions:

1.4 Negotiate debt relief for low and middle-income countries,²⁶ through the G20, especially from consortiums of private lenders.²⁷

1.5 Redirect the IMF's new special drawing rights (SDR) – effective from August 2021 and equivalent to around US\$650 billion²⁸ – towards investments that enable low- and lower-middle income countries to invest in health system transformation and purchase COVID-19 vaccines. This would require that higher-income countries – which would otherwise receive a disproportionate \$400 billion of the total – convert their allocation towards financing timely and equitable access to the tools needed to address COVID-19 in lower-income countries hardest hit by vaccine inequity and enable them to address longer term health-related challenges. In this regard, the establishment of a vaccines facility similar to the Poverty Reduction and Growth Trust²⁹ using SDRs is critical. The African Vaccines Acquisition Trust³⁰ is a good example of how such a facility could function. This should also promote lower-income countries' access to the know-how required to develop and manufacture products for responding to future pandemics.

1.6 Push for and help to coordinate minimum corporate tax rates, applicable to firms' global profits, including for digital businesses. This can be achieved through intergovernmental coordination on a global level (not just through the Organisation for Economic Co-operation and Development), as proposed by the Independent Commission for the Reform of International Corporate Taxation.^{31 32} The recent agreement by the G7 on 15% is a step forward but not enough³³.

1.7 Advance G20 reform of sovereign credit ratings by credit rating agencies at the global level. Credit ratings need to either exclude debt increases due to investment in health or count investment in health as an improvement to credit risks in order to stabilize the flow of capital from institutional investors. A public international rating agency providing an alternative to private rating agencies would be an important step towards greater accountability.³⁴



Pathway 2

Directing investment towards Health for All

Financing for health must be redirected towards delivering Health for All.³⁵ This means enhancing public leadership and dynamic State capabilities to coordinate private and civic stakeholders and economic activities around the common goal of Health for All. Such redirection across geographic regions and sectors should drive sustainable and predictable funding for global health, including a legally binding mechanism to ensure pandemic preparedness and response.

2.1 Transform the relationship between the public and private sectors by redesigning the terms and conditionalities that structure contracts, grants, transfers, loans and partnerships. Lessons can be drawn from European and French COVID-19 recovery funds to airlines and the automobile industry being made conditional on firms committing to lowering carbon emissions.³⁶ In health innovation, early research funding provided by government agencies should ensure conditionalities on pricing, access and intellectual property rights that reflect the public interest,³⁷ including the possibility of consistent and long-term financial return and ownership of research that shares rewards across public and private institutions (see **BOX 2**)³⁸.

2.2 Align public budgets and procurement contracts to channel funds towards public health goals and integrate departmental silos into a whole-of-government approach. Efforts by multilateral organizations financing health should support such goals by ensuring their mandates and policies strengthen health systems and global common goods including pandemic preparedness and response. This can be achieved through integration with existing global health normative frameworks, such as the International Health Regulations³⁹, building on existing WHO tools and mechanisms on national preparedness rather than creating parallel or new systems.

2.3 Create a newly unified taxonomy for investments in health with preferential tax and regulatory treatment, akin to the environmental, social, and corporate governance (ESG) taxonomy for financial assets, and link it to clear outcome measurements that focus on actual contributions to Health for All. Health naturally falls under the social aspect of ESG investment and should be able to tap institutional investors' increased awareness of ESG investment. There is high demand for investible healthcare assets coupled with a lot of pent-up demand

for ESG assets. Indeed, healthcare is a natural choice for the ESG capital pool. For this purpose, the creation of a dedicated financial instrument or a "health" bond could also be considered.

Multilateral organizations such as the IMF, the World Bank and other international development banks should redesign financing tools around Health for All:

2.4 Shift focus on loan conditionalities away from loan repayments for lenders towards strategic investments in borrower countries. For example, focus on conditionalities based on measurable process indicators that contribute to the goal of Health for All or on strengthening dynamic capabilities of governments.

BOX 2: STRUCTURING AND INCENTIVIZING PUBLIC RETURN ON INVESTMENTS

Early stage biomedical research usually takes place in academic settings like university labs. Once publishable discoveries occur, institutions seek to patent the innovations and license technologies to third parties such as other researchers or private sector companies with the goal of commercialization. Although legal mandates focus on improving public health through technology transfers, success is usually measured in commercial activities rather than dollar royalties received annually.^{40 41} For managers in universities or charitable organizations, measuring success without near-term metrics for the common good is difficult. This becomes a problem given the early-stage nature of most State-funded research work, and the fact that the commercialization of a drug or product that generates royalties takes several years. This encourages managers to extract more on the near-term milestones such as budgets and staff costs, rather than long-term royalties based on product sales when negotiating an agreement. But it doesn't have to be this way. LifeArc, a medical research charity based in the United Kingdom of Great Britain and Northern Ireland illustrates a successful royalty-interest case study. In 2007, LifeArc collaborated with Merck Sharp & Dohme (MSD) to humanize the antibody-based therapy, Keytruda (MSD's anti-PD-1 therapy), in return for royalties⁴².

Pathway 3

Governing public and private finance

Private investment remains a significant and important source of financing for health products and services in most countries, at all stages of health provision – from drug development to medical education and patient care. However, owing to the challenges of long-term returns and asymmetric information, markets function imperfectly on their own, exclude many and encourage conflicts of interest. Therefore, as this Council argued in its first brief, *Governing health innovation for the common good*⁴³, it is vital to govern the markets through strengthened public-private partnerships.

3.1. Regulate the functioning and financing of private health markets through measures that crowd in and direct private finance. This will ensure universal access to good quality provision, prevent excessive charges and rent extraction through monopolies, set intellectual property rules that do not inhibit critical access and innovation, reduce information asymmetries and prevent conflicts of interest. Such regulations must extend to all public and private financial players in the health system, from those providing funds for health service delivery (banks, mutual funds and hedge funds, equity markets) to those enabling private voluntary health insurance or care services (see **BOX 3**).

BOX 3: REGULATING PRIVATE FINANCE FOR BETTER HEALTH OUTCOMES

A recent study examined the impact of private equity ownership on patient welfare in nursing homes in the United States of America (USA) and found that private equity investment in long-term care shifted focus away from patient care. Instead it favoured measures to save costs, such as reducing nursing staff, and to increase revenues, such as raising the amount billed to patients. The study also found that such changes led to 10% higher mortality among patients. This meant that 21 150 lives were lost over 12 years as a direct result of the nature of the increased private investment. The increased investment from private finance in this instance did not result in cost savings for the government: in fact, private equity ownership raised taxpayer spending per patient episode by 11%.⁴⁴

3.2 Offer incentives to private health investment through explicit and implicit subsidies, particularly in health innovation and the extension of health services to underserved populations. In such contexts, it is important to put in place conditionalities to ensure that private sector beneficiaries of public incentives invest and act in ways compatible with the common goal of Health for All, including ensuring equity and greater access.

3.3 Strengthen existing mechanisms set up to address the gross vaccine inequity –including the Access to COVID-19 Tools (ACT)-Accelerator global collaboration, and its pillars for the purchase and equitable distribution of vaccines (COVAX), therapeutics and diagnostics, and the strengthening of health systems to ensure that such tools reach people who need them. This necessitates close collaboration with existing regional partners, such as the Africa Vaccine Acquisition Trust (AVAT). Related areas include WHO's COVID-19 Technology Access Pool (C-TAP) to facilitate transfers of technologies and boost supplies. As noted in the Council's brief on governing innovation⁴³, this should be seen not as an approach to fix market failures, but as turning points for creating market-shaping approaches designed for the common good.

» In a post-pandemic world, we cannot risk returning to pre-pandemic approaches to the financing of health. «

4. Towards universal health coverage and the social and economic determinants of health

Health for All requires both strong health systems and robust socioeconomic conditions globally. Countries can support equitable health gains and protection against health threats through (1) access to life-saving and life-improving products and services, and (2) improvements in the social determinants of health.⁴⁵ The first entails individual and population-based health services and functions, provided through the health system, as well as investments in health-related innovation, such as drugs and diagnostics. The second involves addressing other determinants of health such as housing, education, working conditions, residential environments, poverty, insecurity and nutrition.⁴⁶

Access to life-saving and life-improving products and services

Universal health coverage (UHC) embodies the combination of goals that seek equitable access to quality health services for every person, without fear of financial hardship. The health services included here go beyond individual treatment to incorporate the full spectrum of individual and population-based services, from health promotion to prevention, rehabilitation and palliative care across the life course. Progress with UHC is measured by United Nations Sustainable Development Goal target 3.8 – a target that the world is currently falling far short of attaining.⁴⁷ In 2018, for the first time in two decades, global health expenditure growth was slower than world economic growth. In that year, global spending for health was US\$ 8.3 trillion, or 10% of global GDP.⁴⁸ The global figures mask wide disparities across country income groups (see **BOX 4**).

BOX 4: INEQUITY IN HEALTH SPENDING

The average health expenditure in low-income countries is US\$ 40 per person, while in high-income countries it is US\$ 3 313 – more than 80 times higher. In most low-income countries, health expenditure was around 4%–8% of total government expenditure. Meanwhile high-income countries devoted around 14% of total government spending to health. Low- and middle-income countries rely more on private out-of-pocket spending – the most inequitable source of finance – than do higher income countries. The Americas and Europe account for 75% of global health spending. Africa accounts for just 1%. With a mere 9% of the world's population, five countries, France, Germany, Japan, the United Kingdom of Great Britain and Northern Ireland and the USA account for more than 60% of global health spending. The USA alone, with its 4% of the population, accounts for 42% of global health spending.

While donor assistance constituted about 30% of health expenditure in low-income countries and doubled in real per capita terms between 2000 and 2018, there is strong evidence that domestic government spending was drawn away from health as these external sources increased. Across lower income countries, governments devoted the same share of spending to health, on average, as they did to debt service (5.5%), while military spending represented 7.2%.⁴⁸ As a result, the World Bank estimates that low- and lower-middle income countries will face an estimated UHC financing gap of \$176 billion by 2030.⁴⁹

» The average health expenditure in low-income countries is US\$ 40 per person, while in high-income countries it is US\$ 3 313 – more than 80 times higher. «

As the foregoing sections suggest, improving the quantity and quality of finance for UHC requires wise use of resources with clear and ambitious goals in mind. Our collective response to COVID-19 is a poignant example. The massive injection of investment for the rapid development of effective vaccines and diagnostics shows what is possible if increased public finance is made available to speed up, scale up and derisk technological development and manufacturing by private companies, building on years of publicly supported research. And yet deep inequities in vaccine availability and access have left millions at risk of preventable death, while likely prolonging the pandemic, increasing its severity and delaying economic recovery. This illustrates an endemic failure to govern the relationship between health and economics and between public and private actors, or, indeed, to maintain the capacity in health systems to deal with sudden shocks.⁵⁰

COVID-19 has thus exposed the gaps, underlying weaknesses and structural inequalities in our collective capacities to respond to health crises and finance the “last mile” to deliver services to those in need. Yet at the same time it has revealed the latent powers that could be harnessed to deliver Health for All.

Social determinants of health

Guaranteeing social determinants of health is even more important and indispensable to the achievement of Health for All. This also recognizes that the way health systems are designed is essential to shaping a socioeconomic environment that favours the equitable attainment of health.⁵¹ As with UHC, substantial underfunding of social determinants of health and inequalities between countries create huge barriers to realizing Health for All. Lower income countries especially have a massive gap in the financing of Sustainable Development Goals (many of which reflect these broader determinants) to the tune of \$2.5 trillion annually.⁵² To adequately resource a whole-of-government approach, financing across departments – from education to housing – must be integrated into holistic strategies oriented around goals that recognize the co-benefits of Health for All within each sector.

For example, better employment conditions improve nutritional outcomes and mental health, even though employment policies are typically not considered as investments in health. The synergies between investments across sectors – demonstrated by the global response to the HIV epidemic – make cross-sectoral co-financing a vital aspect of realizing Health for All.⁵³ Financing, therefore, must take a holistic approach incorporating health services that address prevention and treatment and guarantee the broader socioeconomic conditions for a healthy population over the life cycle.

Key to developing an economy for health is a shift in focus from health spending, towards more targeted strategic investment aimed at achieving Health for All. Government tools – from transfers, grants, loans and procurement contracts to legislation and regulation – should be geared towards coordinated policy design and delivery. The experience of COVID-19 has underlined the need for investment in a global commons for health, which includes international infrastructure for pandemic preparedness and risk reduction.

Such an approach must build on progress made in response to COVID-19. For example, the Pandemic Preparedness Partnership commissioned by the Government of the United Kingdom of Great Britain and Northern Ireland proposed to the G7 a “100 Days Mission” to accelerate the development of diagnostics, therapeutics and vaccines in response to future pandemics, using existing coordination mechanisms such as the Access to COVID-19 Tools (ACT) Accelerator, and calls for adequate financing through the G20 to that purpose. Likewise, a global finance mechanism for pandemic preparedness and response should integrate formal expert advisory inputs to ensure evidence-based scientific and policy integration within decision-making, including on principles and allocation criteria that shape investments for health.

» The COVID-19 pandemic has demonstrated that the financing of health systems needs to change radically to protect and promote the health of all people. «

– Dr Tedros Adhanom Ghebreyesus, WHO Director-General

5. It's now or never

In the same way that the Intergovernmental Panel on Climate Change report warned us in August 2021 that climate change was irreversible unless action is taken now⁵⁴, our health systems will crumble unless we learn and urgently apply the lessons from the COVID-19 pandemic.

We can continue as usual, and experience another wave of pandemics and other health crises that kill millions, or we can build a new, resilient and inclusive system for Health for All. The latter means focusing our collective energies on the following design principles from the Manifesto of the Council⁵⁵:

➤ Measurement and value: Health spending needs to be measured and budgeted as an investment, not as a cost. There is a need to ease constraints on public finance and rebuild its governance around the new standards of measurement and public value.

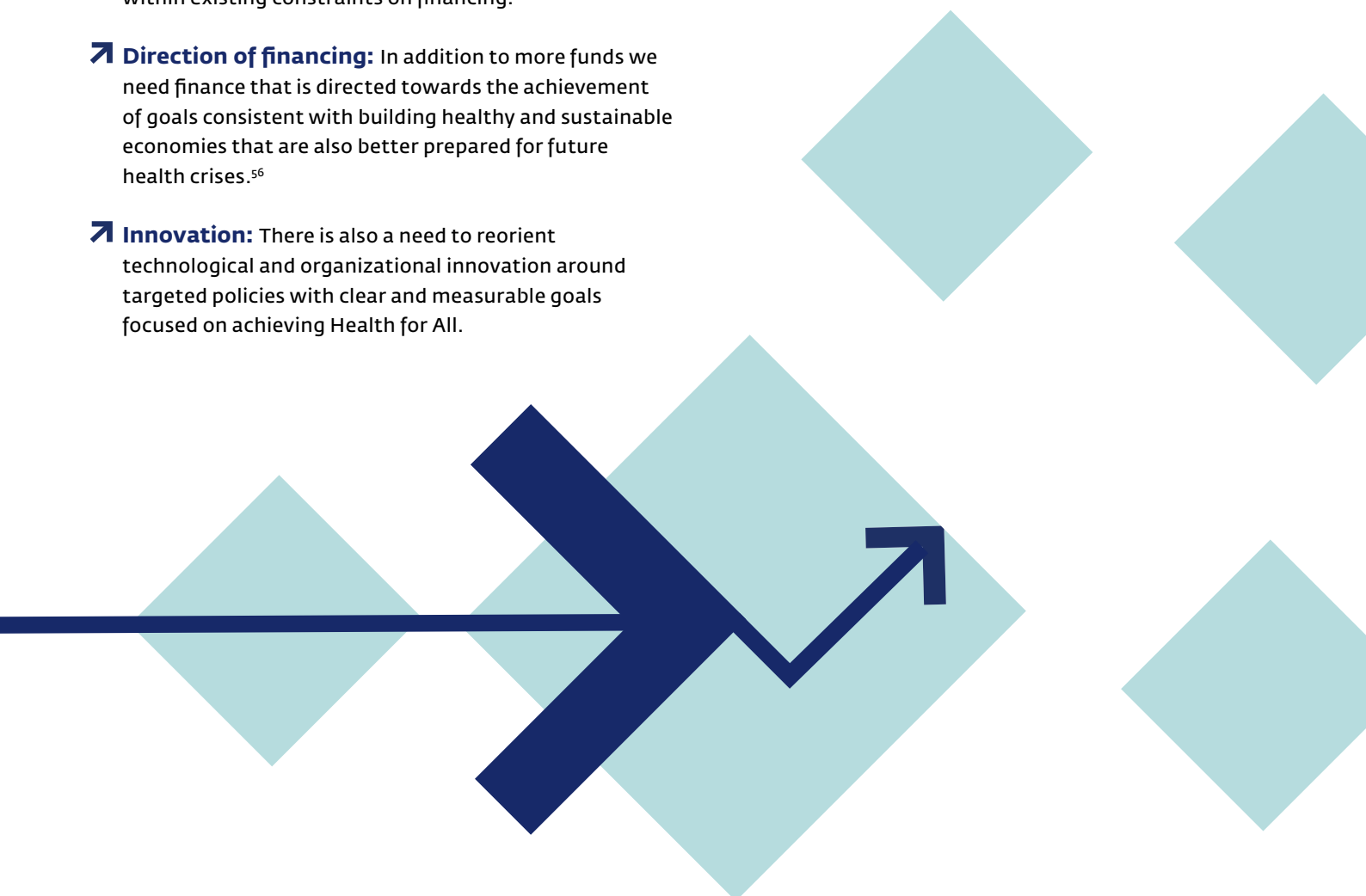
➤ Capacity: Operating capacities of governments and multilateral organizations need strengthening, even within existing constraints on financing.

➤ Direction of financing: In addition to more funds we need finance that is directed towards the achievement of goals consistent with building healthy and sustainable economies that are also better prepared for future health crises.⁵⁶

➤ Innovation: There is also a need to reorient technological and organizational innovation around targeted policies with clear and measurable goals focused on achieving Health for All.

This ambitious agenda requires attention to both the quantity and quality of finance. It also requires renewed public intervention in financing for health and State coordination and the regulation of private finance. Financing Health for All necessarily requires a renewed major role for public investment and regulation. Only significant increases in the quantity and quality of public spending for health, in running expenditures and investments, will enable us to:

1. ensure that basic conditions are met for humans to flourish, from nutrition, water and environmental quality to education and housing;
2. provide the financial foundation for long-term advances in medical knowledge and innovation, as well as provision of good quality services available to all;
3. create the global capacity to prepare for and respond to future shocks, from pandemics to the health impacts of climate breakdown.²

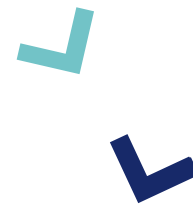


Redesigning financing for health is a key component of a broader project to transform the business models and financing structures that drive the economy as a whole. In our first policy brief we argued that intellectual property rights require urgent reform to inhibit rent-seeking and foster collective intelligence.⁴³ We argued for stronger conditionalities for public investments to build symbiotic public-private partnerships, and for the transformation of corporate governance to foreground stakeholder value over the maximization of shareholder value. This second policy brief builds on those recommendations to make the case for a more strategic, targeted, holistic and long-term approach to public financing and governance in order to achieve Health for All. The ultimate aim is to radically restructure the economy towards delivery of broadly shared goals for the global common good.

For all the pain and suffering caused, the COVID-19 crisis has opened a window of opportunity to radically reframe the economy around long-term health and wellbeing rather than short-term profit. But we need to act now. The window is closing, and new threats will be thrown at us. We

need to prepare now for the tumultuous future ahead, as climate breakdown, economic polarization and ecological destruction combine to produce evermore health crises and epidemiological shocks.

As leading figures in the IMF, WHO, the World Bank and the World Trade Organization have forewarned: “Investing \$50 billion to end the pandemic would pay a huge dividend in development and would boost growth and well-being globally. But the longer we wait to act, the costlier action becomes — in human suffering and in economic losses.”⁵⁷ More money is only the beginning. Determining how that money is spent – on what terms and through which mechanisms and with what conditionalities to encourage which behaviours and outcomes – is the key to achieving Health for All.



#EconomicsHealthForAll

For further information:

<https://www.who.int/groups/who-council-on-the-economics-of-health-for-all>

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The WHO Council on the Economics of Health for All was established on 13 November 2020 to provide guidance on the economics and health agenda of WHO. It is an independent council convened by **Dr Tedros Adhanom Ghebreyesus**, WHO Director-General

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Professor Senait Fisseha

Globally recognized leader in reproductive health & rights, Director of Global Programs at the Susan T. Buffett Foundation & adjunct faculty at the University of Michigan, USA

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Under-Secretary-General of the United Nations and Executive Secretary of the Economic Commission for Africa (ECA), headquartered in Ethiopia

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Former parliamentarian, an expert in gender and economics and is now Professor of Public Policy at AUT University, New Zealand

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