JOURNAL OF HEALTH POLICY AND ECONOMICS

Nuha Bazeer. Only as Healthy as the Unhealthiest: how the COVID-19 pandemic has renewed the call for Global Health System Strengthening. Journal of Health Policy and Health Economics. 2021; 1(1)

Only as Healthy as the Unhealthiest: how the COVID-19 pandemic has renewed the call for Global Health System Strengthening

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Executive Summary

- The geographic spread of the COVID-19 pandemic has had severe health, economic and political consequences, exposing the state of health systems across the globe.
- Progress in Health System Strengthening can lead to better health when health systems are responsive and resilient, such that they can absorb the shock of the current pandemic, and adapt to changing health needs.
- Global Governance for Health is urgently required given the disproportionate impact COVID-19 may have had on countries with poorer health systems with lower resilience and capacity.
- Sizeable vaccine purchases by wealthier OECD countries have exposed the divide between OECD countries and LMICs through inequitable vaccine distribution, prompting greater concern for global recovery.

Keywords: COVID-19; Health System Strengthening; Global Governance; Health Policy; Global Health; Vaccine Equity

Introduction

The shifting epicentre and subsequent geographic spread of the COVID-19 pandemic throughout 2020 raised international concern over a mainstay of national debate: the state of health systems. Comparisons between the rapid response and surveillance witnessed in the Far East, to the varied approaches of Europe (Italy, Spain, and Germany); and the somewhat tentative response of the UK and USA, have revealed more than just quantitative differences in national health systems (1).

Health System Strengthening (HSS) has predominantly been viewed as an agenda item for Low- and Middle- Income Countries (LMICs), defined by WHO as the identification and implementation of policies and initiatives to improve health system responsiveness, coverage, quality, access, and efficiency (2). Yet the unprecedented scale of the pandemic within High Income Countries (HICs) has exposed the true extent of health interdependence in our globalised society, from trade and migration, to education and investment. Just as the 2014-2016 Ebola epidemic demonstrated the consequences of health systems at their breaking

point, the COVID-19 pandemic has renewed calls for global HSS on the basis of three items: responsiveness and resilience; global governance for health; and equitable vaccine distribution.

Responsiveness and Resilience

Alongside health and financial fairness, WHO identifies responsiveness as a key objective of health systems; achieving better health by addressing the legitimate expectations of a population with appropriate responses (3). In 2014, the shock of the Ebola outbreak to existing inadequate health systems within West Africa (4) revealed the need for health systems resilience (5): the anticipation of, and adaptation to changing needs via effective interventions (6), and the ability to absorb such shocks. Following the COVID-19 outbreak, analysis of the International Health Regulations (IHR) State Party Annual Reporting (SPAR) tool found that as of 2018, 57% of 182 countries were operationally ready with the highest level of national health security capacity to prevent, detect, and control an infectious disease outbreak (7). Though this suggests possible effective responses to the current outbreak, the analysis also found that 76% of countries within the South East Asian and African WHO regions had low levels of operational readiness. Within OECD countries, concerns also exist over access and coverage: over a fifth of all OECD health care expenditure is in the form of out-of-pocket payments (OOPs), with over 28 million uninsured Americans (8) potentially foregoing timely health system interactions due to poor financial protection.

In the early months of 2020, many national health systems raced to prevent and mitigate the effects of large-scale community transmission as witnessed in China, Iran, Italy and Spain (9), mobilising high levels of health resources to detect and treat COVID-19 cases. The reallocation of resources has not been without an opportunity cost however, as health systems have struggled to balance the maintenance of essential services, exposing the finite nature of health system capacity. Globally, health systems have struggled with excess demand (diagnostics, hospitalisations, and critical care treatment) and limited supply (diagnostics, personal protective equipment, ventilators, fewer health workers due to infections, lower ward capacity). Long-term management of this surge in activity will require more than just swift public health measures of social distancing and handwashing, with varied policy responses for HSS across 4 fronts (Table 1).

Table 1 OECD Strategies for Health System Strengthening

Priority	Policy	Examples(8)
Access	► Waive user-charges for care and treatment related to COVID-19 to improve coverage and equity ► Emergency funds for health care systems to manage excess demands ► Legislation to reduce risk of infection and ensure long-term care	► US: Legislation passed on 18 March 2020 to provide COVID-19 diagnostic testing with no OOPs ► UK: £5bn emergency fund for NHS, social care and public services has been provided (albeit with few specifics) ► Germany: COVID-19 Hospital Relieve Act passed on 25 March 2020 for funding and liquidity of hospitals including subsidisation and compensatory payments
Supplies **(8)**	► Management and review of both national and international supply chains for diagnostics, ventilators and essential medicines	► European Commission: pre-existing Joint Procurement Agreement with Member states to enable joint purchasing

Staff **(8)**	► Provision of sufficient personal protection equipment (PPE), mental health support & child/social support ► Task-shifting of community workers and mobilisation of inactive/retired health workers & students nearing ends of studies ► Reallocation of health workers to more adversely affected areas	► France, Italy, Spain, UK: ensure health workers have sufficient/priority childcare options ► France: deploying the "sanitary reserve" ("réserve sanitaire") for temporary increase in staffing ► UK: mobilising retirees/inactive health workers for temporary increase in staffing
Space **(8)**	► Optimising healthcare facilities to increase critical care capacity ► Utilisation of telehealth or online triage as a first point-of-contact strategy and for better patient management ► Postponement of non-essential services.	► France, UK: repurposing of army camps and creation of temporary hospitals such as the NHS Nightingale Hospital ► Germany: daily online updates on available intensive care capacity to support doctors in identifying treatment availability. Use of a web-based application for patient assessment "CovApp" ► Italy, UK: delaying non-urgent (elective) care

Global Governance for Health

On 30th January 2020, WHO determined a Public Health Emergency of International Concern (PHEIC), bringing expectations of intensified preparedness with hopes for 'coordination, cooperation, and global solidarity' (10). What transpired since is perhaps less pleasant: from the distal erasure of almost all financial gain since the 2008 Financial Crisis, to the deserted cities and rising death tolls of neighbouring countries, and the proximate panic buying and empty supermarkets. At the height of these social distancing measures, the COVID-19 pandemic has offered a rather rude awakening to the extent of globalisation in our society and its fundamental reliance on strong and responsive health systems. Frenk *et a*l conceptualises Globalisation and Health as the international transfer of health risks; cross-border 'movements of people, products, resources, and lifestyles' (11). This presents 3 main governance challenges: sovereignty, accountability, and cross-sector interdependence. While in recent years, strong economic growth has emboldened inward-looking politics with enigmatic leaders arguing for protectionism, the political signal (10) of the PHEIC has transcended national health systems, echoing firmly that countries are only as healthy as the unhealthiest. Effective tackling of the pandemic will thus require global health system responses to demonstrate collective action via legitimate and monitored intergovernmental organisations, as well as consideration of the effects on interrelated policy areas, such as the environment, trade, migration and security.

The disproportionate effects of the COVID-19 pandemic have greatly emphasised the unequal distribution of wealth and health risks globally. Countries with less developed health systems, such as Mexico and Peru (12), have suffered higher levels of excess mortality as a result of weaker health infrastructure, lower health system capacity, and higher levels of respiratory infections (13). Countries with vulnerable populations and conflict zones – such as those the UN sought $2bn for – have also suffered rapid transmission due to overcrowding, scaled back humanitarian presence, and limited access to basic sanitation (14). However, health systems with limited capacity and ineffective policy responses are not only limited to those less developed, and in the face of rising infections and death tolls, the UK has joined South Africa and Brazil in recording a new, more transmissible variant (15). While the rapid launch of the COVID-19 Health System Response Monitor (HSRM) across the WHO European Region (9), in April 2020 is highly commendable, there must be intensified surveillance of health systems

evidence globally, so as to detect new variants, strengthen capacity and improve responsiveness accordingly.

Equitable Vaccine Distribution

As preliminary efficacy data trickled in by the end of November 2020 (16), the long-awaited news of COVID-19 vaccines and the promise of a return to normality soon arrived, manifesting in global stock market booms (17). Not soon after the release of this news from Pfizer/Biontech, Moderna, and Oxford/Astra Zeneca (18) however came the pertinent question: which populations would get vaccinated first? In much the same way that OECD countries demonstrated substantial financial responsiveness to the pandemic early on, their efforts in purchasing vaccine doses - sometimes pre-ordering over 3 doses per member of their population – has exposed stark differences amongst global health systems (16). Where wealthier countries have had the advantage of negotiating advance purchase agreements, low vaccine supplies are greater felt by LMICs, increasingly reliant on contributions from COVAX, a partnership between Gavi, the Coalition for Epidemic Preparedness Innovations (CEPI) and WHO, tasked with equitable and fair vaccine distribution (18). In turn, COVAX relies on global collaboration to 'support the research, development and manufacturing of a wide range of COVID-19 vaccine candidates and negotiate their pricing' allowing LMICs to benefit from the collective purchasing power of two-thirds of the world (19).

Despite these aspirations, as of 8th January 2021, of the 42 countries who had rolled out national vaccine programs, HICs accounted for 36 while Low Income Countries (LICs) accounted for none (20). Such divergences could not come at a deadlier time, warned the WHO Director General, where the arrival of new variants demonstrate desperate survival attempts by the virus, coupled with the risk of vaccine nationalism threatening equitable vaccine distribution and jeopardising the safety of all countries (20). Though COVAX has estimated the cost of its vaccination target of 2 billion doses by the end of 2021 at US $5 billion, it has also estimated that the current pandemic has cost the global economy at least US $375 billion every month (19). Ultimately, the race to vaccinate populations will require a committed and equitable multilateral effort with clear recognition of the indirect protection afforded to national populations through international vaccination (18).

Limitations and Conclusions

The challenges and consequences of COVID-19 are unprecedented; with many wealthy nations implementing large-scale emergency domestic stimulus packages to cope with social and economic disruptions. The initial responsiveness of OECD health systems demonstrated through adaptative policies (Table 1) shed light on the disparities between countries with poorer infrastructure more exposed to the world trade cycle due to manufacturing and commodity-exporting economies than services. Though fears of insurmountable economic costs caused by the pandemic have often wrestled with appropriate health policy responses, countries who have been successful with the zero-COVID approach, such as New Zealand, have not had to endure high death tolls and periods of economic uncertainty. Improvements in responsiveness will require large financial support from intergovernmental organisations, such as the WHO COVID-19 Solidarity Fund or the releasing of approved grant funding to fight COVID-19 by the Global Fund (21). The efforts of the WHO, GAVI, and CEPI through COVAX in securing sufficient vaccine doses for equitable distribution are recognised as supporting Global HSS but is also reliant on pharmaceutical companies to make their vaccines available at affordable prices for greater vaccination impact in LMICs, as AstraZeneca has done (16).

While Global Governance for Health and robust health information management systems (HMIS) will play an increasing role in the detection of new variants, there also needs to be strong political will, advocacy, and stronger regulations to uphold responsibility and accountability within the field of public health. Differences in health stewardship (such as initial denial of the severity of the virus in the US in early 2020 and perpetuation of a false dichotomy between health and the economy) have shown deep disparities in approaches to health. Unequal distribution of wealth and health risks across the globe, alongside the unprecedented nature of this pandemic, suggest now more than ever, that Global HSS is fundamental in improving health systems within countries with weaker health infrastructure and thus ensuring stronger resilience against future outbreaks globally. Though mass vaccination programmes will also attest to the responsiveness and resilience of individual health systems, without equitable vaccine distribution and sustained efforts in Global HSS, none will be safe until all are.

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