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COVID-19 Health System Governance

World Health Organization
REGIONAL OFFICE FOR Europe

European Observatory on Health Systems and Policies
a partnership hosted by WHO

Special Guest Editors:

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› COVID-19 and the opportunity to strengthen health system governance

- Public health leadership
- Health system resilience
- Drawing lessons on governing emergencies
- Strengthening the governance of preparedness and response
- Hard questions about sovereignty
- How credit and blame shape governance
- Health workforce surge capacity
- The private sector in pandemic times
- Engaging with communities and civil society

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Eurohealth Monitor

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EDITORIAL

Governance strategies for building health system resilience

Governance is about making and implementing collective decisions. It is therefore vitally important to health policy and implementation and is a pivotal, yet often underestimated, enabler for leading a health system in times of emergencies, preventing them from becoming a crisis.

EDITORIAL

The importance of effective governance for determining health system performance and resilience has been emphatically highlighted by the COVID-19 pandemic. Across Europe, governance mechanisms have provided a foundation for countries to rapidly mobilise and deploy financial and human resources to where they were most needed, to reconfigure service delivery, to implement mass test-trace-isolate-quarantine operations and to implement evidence-informed policies. Yet, in the face of unprecedented challenges, key gaps in governance for emergencies have been revealed and have undermined the effectiveness of national and international responses. A central challenge now is to learn from all of these experiences, as this evidence will be critical for building stronger health systems to support the post-pandemic recovery and for renewing and strengthening health emergency governance mechanisms to be better prepared for future emergencies.

In support of this analysis, this special issue of *Eurohealth* brings together a collection of articles that examine different elements of governing the COVID-19 pandemic in the countries of the WHO European Region. These articles shed light on the achievements and progress made despite many unknowns during the early stages of the pandemic, and the challenges faced over a long-term emergency. In doing so, the issue draws out clear lessons for how to advance positive changes in support of developing stronger national and global governance structures that can better respond to health emergencies.

A first important lesson that emerges is that more resilient responses have been launched by countries that had good governance structures, underpinned by strong state capacity, in place prior to the pandemic [see Sagan et al., in this issue]. Nevertheless, while pre-existing governance strategies and mechanisms have supported timely and effective responses, more adaptive approaches to governance during the crisis have also been required. These have encompassed setting out clear and timely COVID-19 response strategies, developing novel public-private partnerships, seeking engagement with communities, and harnessing improved coordination across sectors and across levels – from the local to the global.

Many of the governance elements identified by Sagan et al., as being critical for building a resilient response are further highlighted throughout the issue. Rajan and co-authors, for example, demonstrate the importance of bringing civil society's perspectives, insights, and experiences into COVID-19 decision-making, but suggest this has not been achieved in a systematic way in many countries. The authors therefore propose investing in developing participatory mechanisms to improve social participation in the future, which will help

drive forward more equitable health system reforms. Tille et al., meanwhile show how rapidly developed, new public-private partnerships have enabled some countries to gain faster access to and more stable supplies of products and services, ranging from personal protective equipment to the development and deployment of COVID-19 vaccines. Learning from these pandemic experiences provides a unique opportunity to re-shape governance frameworks for public-private partnerships in the future, to help improve equity, fairness and transparency.

Governance, inevitably, cannot be discussed without reflecting on the role of leadership. Capable and effective leaders that engaged with scientists and took evidence-informed decisions have been fundamental enablers of resilient pandemic responses [see Sagan et al., in this issue]. However, in some countries, orientations other than health short-sightedly and repeatedly became the foundation of decision making at the expense of effective COVID-19 strategies. It is therefore argued by Nathan and co-authors that public health leadership in the future should be strengthened – by investing in public health institutions, breaking down internal silos in health sectors and building leadership capacity across the public health workforce – to empower a broader range of health actors to inform health policy to see us through some potentially bigger challenges ahead.

Leadership at many levels has also played a critical role in strengthening the health workforce with regards to creating surge capacity, protecting the health and well-being of health workers, and the roll-out of vaccination programmes [see Buchan et al., in this issue]. Here, national and local policymakers, professional associations and employers of health workers, have worked together effectively, often breaking up sclerotic governance structures which have hampered past health workforce development and reform. While the pandemic has proved immensely challenging for health and care workers, building on progress and momentum seen during the pandemic may hold the potential to help develop a more resilient workforce in the future.

As well as strengthening national governance structures, the pandemic has highlighted the need to revitalise the global health governance architecture, as discussions on the International Health Regulations (IHR) (2005) and a pandemic treaty demonstrates. Countries cannot tackle global threats in isolation; they need to intensify their collaboration. This includes the timely sharing of data and financial and technical support. McKee and Greer in this issue go further in their analysis, arguing that more effective global collaboration on public health requires that countries pool some of their health-related sovereignty and strengthen WHO as the custodian of such a treaty.

This special issue also documents how WHO is supporting Member States in strengthening their pandemic governance. One example is the WHO's Health Emergencies Programme (WHE) created in 2016 [see Smallwood et al., in this issue]. It demonstrates the important role of multinational governance in responding to the pandemic. Learning from pandemics and building stronger global governance structures is possible as advances following the swine flu in 2009 have demonstrated, with the resulting Pandemic Influenza Preparedness Framework strengthening capacity to identify the virus though the activation of a network of laboratories and experts in a timely manner [see Nitzan et al., in this issue]. From the lessons learned through the WHO's work in the Region, it also becomes clear that universal health coverage is a precondition for the overall whole-of-society and whole-of-government preparedness. The pandemic has also amplified the need to take action to address the social and economic determinants of health and to develop pandemic preparedness and post-COVID recovery plans that link policy actions across sectors [see the article by Permanand and Azzopardi Muscat].

It is clear that effective governance strategies are fundamental for building health system resilience. The next emergency, whether it is the economic fall out of the pandemic, an environmental, cyber or refugee and migration crisis, or another virus, is just around the corner. We must not wait to prepare for it, but should rather draw on the lessons learned from this pandemic to help strengthen the governance of our health systems now to ensure better resilience and performance.

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PUBLIC HEALTH LEADERSHIP AND THE COVID-19 PANDEMIC IN EUROPE

By: Naomi Limaro Nathan, Natasha Azzopardi Muscat, John Middleton, Walter Ricciardi and Govin Permanand

Summary: The COVID-19 pandemic has emphasised that calls for clearer mandates and leadership from health authorities has gone unheard for decades. Preventable occurrences in response to the pandemic depict that countries in the WHO European Region suffer from various issues that undermine public health leadership – a necessary capacity to navigate extraordinary times, such as these. What remains clear is that there is a dire need for public health to be reinforced and enabled to ensure effective public health responses. Furthermore, internal siloes within the field must be broken down and collaboration within and across sectors nurtured, to help build up resilience to handle future emergencies.

Keywords: *Governance, Leadership, Public Health, COVID-19, Resilience*

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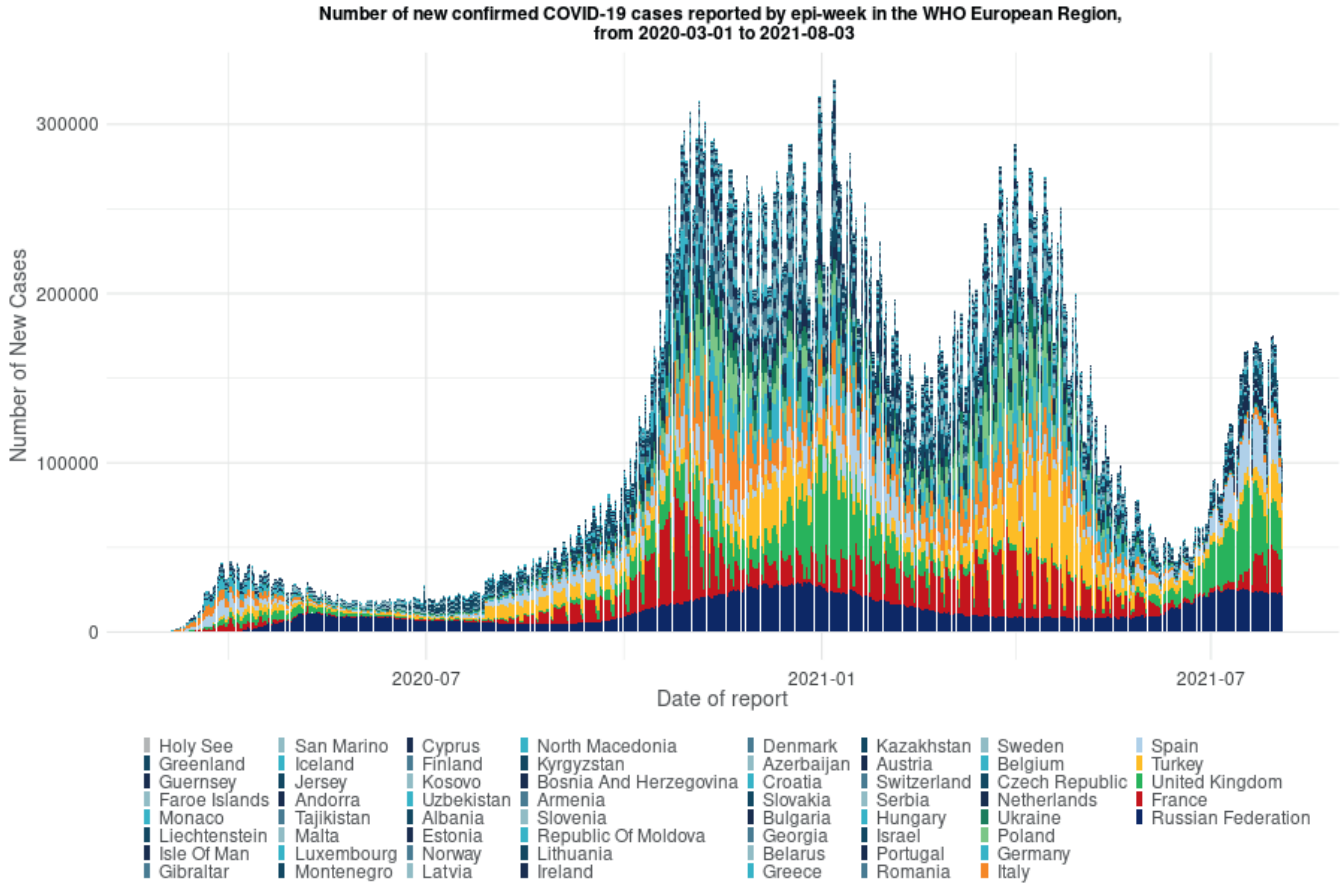
Introduction – Leadership trends in public health over the past decades

In 1998, the influential United States' (US) Institute of Medicine (IOM) released a seminal report entitled 'The Future of Public Health'.[1] Based on the findings of an expert commission tasked with looking at the state of public health organisation and delivery in the United States at the time, the report set out a conceptual framework for the 'core functions of public health', defining public health as "what we, as a society, do collectively to assure the conditions for people to be healthy". The IOM report stressed the need for public health bodies at all levels to be strengthened and, crucially, to work closely together. While referring to municipal, state and federal bodies in the US, this broader appeal for a collective approach to improving health – a clear vision of what public health is and the importance of a coherent approach to counter "continuing and emerging threats to the health of the public" – has been used to orient the public health community globally.

The IOM report's vision demanded a rethinking of not just what and how services were delivered, but more importantly, the need for clearer mandates and leadership from health authorities. Published 20 years after the IOM report, a 2018 review by the World Health Organization (WHO) of how public health is organised, financed and delivered in Europe suggests this call was not heeded.[2] The authors conclude that public health in the region remains fragmented and uncoordinated, delivery structures are not in line with population health goals,

Figure 1: COVID-19 cumulative cases in countries of the WHO European Region across time – July 2021



Source: WHO Regional Office for Europe, Health Emergencies Programme (WHE)

Note: *Turkmenistan is the only country in the Region that has not yet officially reported any cases of COVID-19; comparability is greatly hindered by the huge variance in testing capacity and eligibility between countries.

services are underfinanced, and that there has been a failure of leadership in many countries. This was the analysis of the state of public health in Europe a year before SARS-CoV-2 emerged and unleashed a global pandemic.

This article explores health leadership around the COVID-19 pandemic in the WHO European Region, and elicits reasons as to why leadership has not been as effective as expected. It necessarily deals in generalisations given different health systems, political structures, and relationships between society and decision-makers; both in health and beyond. We note the politicisation of COVID-19, complications related to politicians not being up to the task and putting their interests first, however, our focus is on where the public health community might have done better. As the pandemic is very much on-going at the time of writing, offering any definitive lessons learned is somewhat premature. But we can see that certain things were eminently preventable, and these in turn point at potential solutions going forwards.

Public health leadership – a pre-requisite for successful pandemic response

In their 21 May 2021 joint statement on the COVID-19 pandemic, the European Public Health Association (EUPHA) and Association of Schools of Public Health in the European Region (ASPHER), noted: "The COVID-19 pandemic has shown the importance of public health leadership. Countries that had strong public health leadership were better able to design and implement rapid and effective responses that reduced the spread of infection, minimised the impact on lives and the economy, and engaged with the public".[3] Case numbers in much of the WHO European Region were dropping at the time and vaccination rates were rising. A number of countries had therefore begun relaxing public health and social measures (PHSM) and there was a push to allow the hospitality and tourism industries in particular to resume their activities, supported by the use of COVID-19 'passports' to enable international travel. The focus of many was on the 2021 summer holidays. Since then, however, the emergence and exponential spread of the B.1.617.2 mutation of the SARS-CoV-2 virus (known as the Delta variant), has contributed to rising numbers of cases (**see Figure 1**), increasing hospitalisations and growing numbers of persons suffering from 'Long Covid', including children* in most countries in the Region, despite increasing numbers of vaccinated

* WHO uses the term 'post-Covid-condition' given the range, severity and length of symptoms.

individuals. In some countries, where PHSM were relaxed, we are seeing a re-imposition of these mandates,[4] and even high-level governmental apologies for releasing measures too soon.[5] What does this say about Europe's ongoing response to the crisis, and about public health leadership specifically?

Resounding legacy issues and the politicisation of COVID-19 responses

As COVID-19 grew from a public health issue to a wider societal and economic disaster, the question of 'Who is in charge?' became a contested one. It was clear from the outset that, despite scientists and experts in many countries expressing grave concerns about this pathogen and its likely spread, policymakers often did not listen nor take evidence-based decisions. This ought not be surprising. Expertise and science can inform policy, and indeed should, but it is one of many inputs political decision-makers must weigh. The question, rather, is why this expertise appears not to have been given sufficient weight in the face of a clear public health emergency.

> "a failure of leadership in many countries"

One answer relates to the diminishing roles of 'science' and fact-based approaches versus opinion in much of public discourse today. As we see in the context of COVID-19, this has knock-on effects in terms of politicians having influence over scientific recommendations as a means of serving their electorates.[6] Those countries which – at least initially – responded well to the emerging pandemic were ones in which political leaders engaged with the science and prioritised the threat to health over other issues. In others, the scientific and public health side was given less priority than, for instance, the economy – a false dichotomy as many have pointed out. A more important answer, therefore, concerns legacy. Recalling the chronic underfunding and fragmentation of public health raised earlier, this has resulted in a loss of authority and voice of the public health community. Worse yet, it has resulted in weakened ability and capacity of the workforce, especially in the face of a health emergency.

Table 1: Issues undermining public health leadership

Legacy Issues	Issues that eluded public health leaders during the pandemic
• The inexorable erosion of public health in Europe • The loss of authority and voice due to chronic underfunding and fragmentation • Health workforce siloes • Inability to engage with other sectors and enact Health in All Policies (HiAPs) • The politicisation of public health issues	• The lack of a clear goal • Mixed and inconsistent messaging

Across many countries in the European Region, we have witnessed failures in surveillance, testing and contact tracing. These are bedrock public health functions which in some instances were entrusted to agencies other than public health. Moreover, perceived public health failures can have knock-on effects. A recent study in the United Kingdom (UK) has pointed to higher rates of vaccine hesitancy in areas where the National Health Service was struggling to manage cases early in the pandemic.[7] The UK went so far as to re-structure its public health agency entirely, ostensibly on the basis of poor performance.[8] Although clearly a high-level political decision – opposed both within and outside the health arena – the fact the government could dismantle the national public health authority in the midst of the pandemic demonstrates the influence that non-health sector policymakers have over the health sector. While it is easy to point to political decision-makers as being to 'blame' for not ensuring appropriate and up-to-date pandemic plans were in place, and for politicising the pandemic often for their own political gain (see the later article by Greer et al. in this issue for more on the politics of credit and blame), it is also the case that in a number of areas we – in the public health community – have not delivered as expected. Some of these shortcomings too can be attributed to legacy issues (**see Table 1**), but others require a bit more introspection if we are to ensure that we can move forward in a solid, more effective and trusted manner.

Lack of a clear goal

Looking at strategies for tackling the virus across the European Region, as well as the protracted discussions on what strategy to adopt even within individual countries, one could conclude that the public health community (nationally and internationally) failed to agree upon and espouse a clear goal. Various narratives were given. Initially, the risk from the virus was deemed low, then the aim became to limit transmission between individuals. With the pandemic underway, the goal was then to 'flatten the curve' – this referred to slowing the transmission of the virus, ostensibly to spread out hospitalisations rather than reduce overall cases. Thereafter, interest was in protecting the vulnerable, and the goal varied between containment and suppression (with degrees up to 'maximum'), while the concept of 'zero-Covid' was even considered. The actions in many countries now belies an implicit assumption that the goal today is simply learning to live with the virus.

But these narratives are not representative of a clear and consistent public health goal at any stage. Unlike other public health crises, e.g. HIV where clear targets have been adopted, the concept of sustained control of COVID-19 has not yet been sufficiently pursued nor effectively communicated by the public health community through a series of evidence-informed agreed targets. Yet, public health professionals understand that risk is not just about the immediate future, but the longer-term. Moreover,

early in the outbreak, epidemiologists were already aware of just how transmissible the virus was and warned of many deaths. Minimising the number of deaths from COVID-19 was, however, not articulated as an overarching public health goal in most countries. Instead, it was couched in messages of reassurance, both towards the public and society at large. Further, those who sought to point at predictions and forecasts – the backbone of epidemiology and public health – were often wilfully ignored.

> a clear need for a series of common goals to be swiftly agreed

Evidently, the result of this lack of clarity was seen when hospital care led the early health response in most countries. This reflects a reactionary rather than proactive view of public health, and one that is clearly not sustainable. Hospital reform has been on the agenda across Europe for decades – bigger hospitals, specialist hospitals, regional hospitals, hospitals which offer integrated health services etc. – and most health sector investment has gone to hospitals rather than primary care. It can, therefore, be legitimately argued that, to some extent, this too is a legacy issue. In the absence of public health leadership and the lack of a clear goal across Europe, a hospital-led response was a necessary consequence rather than an informed choice.

Obviously, goals and their enabling strategies need to be flexible and adapt as evidence emerges, as the issue of droplet versus airborne transmission of the SARS-CoV-2 virus and the use of facemasks has shown. It should also be acknowledged that at any stage of the pandemic, the direction of travel was not fully understood, even by those involved in the response – whether front line health workers, hospital support staff, educators, employers and even the public at large, given their own personal responsibilities towards protecting themselves and others. Without a clear statement of intent around a unifying goal, the response will most likely be trepidatious, also allowing for a political rather than evidence-driven response. There is a clear need for a series of common goals to be swiftly agreed, even if such goals need to be couched in the contextual reality that different countries are at very different stages with health system capacity, testing capacity, and even being able to protect their population through vaccination. This may necessitate a scenario driven, staged approach that countries can strive and work towards, rooted in both epidemiology and behavioural science.

Mixed and inconsistent messaging

An important corollary is that messaging – communication, especially towards the public – is a core function of public health. This too has been patchy within and across European countries.[9] Obviously in the context of a fast-moving pandemic, the science can be uncertain, and the evidence base not definitive. But transparency and clarity in messaging, and specifically about the uncertainties and risks, is crucial to engender public trust. Balancing good news with the bad helps to promote hope rather than fear, and it is important to include context that connects the news to people's concerns and prior experiences; "the 'so what' of the message has to feel relevant".[10] In addition to causing confusion and undermining public trust domestically, mixed messaging around key issues – such as European countries' changing positions on the Astra-Zeneca vaccine – can have global consequences as well.[11] Whilst it is difficult to ensure clear messaging when the overall goal itself has not been clearly set out or has been politicised, attention to clear and consistent messaging is tremendously important when the goals have been set as otherwise the whole objective risks being undermined.

Health workforce siloes

The need for a clear goal has wider relevance for the health workforce. This is the time for health workers to become united around a singular vision of public health – one in which they can identify their contribution and understand their roles, and especially so in the context of a health emergency. Nonetheless, one feature of the COVID-19 response across many countries has been the division between clinical care including emergency response, and public health care. For the former, identifying cases, undertaking testing and providing life-saving treatments (hospital care) have been crucial to the response. For the latter, mitigating spread of the disease through surveillance, education and community outreach, as well as undertaking contact-tracing and setting out behavioural guidance have been equally crucial. Some countries have been better at merging these perspectives and approaches, while others remained inflexible and have struggled. The role of the public health community in protecting the clinical front liners by advocating for appropriate measures based on data science is critically important in bringing a common purpose round which the entire health workforce can rally.

In recognition of the tremendous effort made by health workers, WHO declared 2021 'The Year of the Health and Care Workers'.[12] During the initial 'waves' in Europe when hospitals were becoming overwhelmed and routine services were being delayed or cancelled, health professionals sought to overcome professional boundaries. Hospitals developed differential care pathways, intensive care and nursing teams re-organised themselves, personal protection equipment was rationed, and shared, primary health care professionals provided remote services and specialists were repurposed as part of the surge response (see the later article by Buchan et al., for more on governing the health workforce during the pandemic). The public health workforce has been far less visible in this campaign even though individual public health practitioners have borne as much of the brunt as clinical front liners.

This is, at least in part, also a legacy issue. Across Europe, public health, as a profession, continues to be under-valued and under-resourced in the context of growing demand. Medicine, particularly specialisation, and the private sector, continue to offer better remuneration, opportunities for advancement and higher levels of reported job satisfaction. In many

Table 2: Tackling issues undermining public health leadership

Challenge	Good practice example
Lack of a clear goal	Initiatives such as the Public Health Leadership Coalition, launched by the World Federation of Public Health Associations (WFPHA) to bring together prominent public health experts to help ensure that the global response to the COVID-19 pandemic and other planetary health concerns is evidence-informed, equitable and effective, is a step towards achieving clear goals.[14]
Health workforce siloes	Some countries in Europe like Germany, whose strong enabling environment, with a good public health care system, health authorities and expert scientific institution, made it possible to merge both clinical care including emergency response, and public health care perspectives and approaches during the COVID-19 response, going beyond the traditional siloed methods that other countries struggled with.[15]
Mixed and inconsistent messaging	Ongoing monitoring and evaluation of the impact of public health messages across different channels is necessary to enable adjustment, as was practiced in Montenegro.[16]
Health in all policies/the need to engage with other sectors	Addressing the issues of school-related and travel measures, amongst others brought the public health community out of their comfort zones, as they had to interact with and understand the perspective of other sectors. Avenues for joint initiatives, e.g. with United Nations International Children's Emergency Fund (UNICEF), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and World Health Organization (WHO) on school-related public health measures in the context of COVID-19, have been established. This wave of opportunity should be ridden and maintained going forward.[17]

countries there are so-called 'medical deserts' where even basic public health services are absent. Rather than sharing an identity around a singular public health vision, most health professionals see themselves as contributing to a broader understanding of public health through their particular area of focus; that is, as a part of the whole rather than being a "microcosm" of that whole. Notwithstanding the rise of chronic diseases, which show the public health – medicine divide to be an outdated if not somewhat artificial one, the pandemic has pressed home just how fundamental a more integrated understanding of public health is.

Health in All Policies and the need to engage with other sectors

One of the impediments to a coherent health response and good governance in the face of the pandemic has been the lack of joined-up thinking. We know that public health is about the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society. We understand that this requires a holistic view of health. So too are we aware of the need to ensure heath in all policies, which in turn demand whole-of-government and all-of-society approaches. But our failure to implement this as a matter of course has contributed to the number of infections and deaths given that COVID-19 is especially severe for those with underlying health conditions and those who are disadvantaged societally. With a more coherent and inclusive practice of public health, would the impact of the disease have been so severe?

Interconnectedness of the social, commercial, environmental, and economic determinants of health

As a public health community, we have traditionally not done well in reaching out to other sectors; ensuring Health in All Policies, despite progress and a growing evidence-base, remains under-developed. COVID-19 has revealed the interconnectedness of the social, commercial, environmental, and economic determinants of health. It thus implores us to expand the scope of public health and to work more closely with sectors such as food, housing, transport, employment and the environment, and to engage with individual actors and entities we would not traditionally see as directly involved in the practice of public health, e.g. trade-unions, supermarkets, employers groups and business etc. Good health leadership will ensure other sectors are involved as partners in the public health system, rather than the relationship being unidirectional – us reaching out to them, or vice versa. It is obvious that a healthier population is going to be more resilient, especially towards any disease that targets those in poorer health or who are at most risk of contracting it.

Table 2 provides some examples of international and country efforts to enable public health leadership by addressing specific challenges.

Going forwards

We know from previous health emergencies that it is key to be 'ahead of the game'; to be able to predict and plan for likely outcomes, to develop scenarios and be prepared to act swiftly, and to ensure that medical and public health systems are fit-for-purpose. Already on 13 March 2020, Dr Mike Ryan, Director of the WHO's Global Health Emergencies Programme, said "… you need to be coordinated, you need to be coherent, you need to look at the other sectoral impacts".[18] It has been over 18 months since his words made global headlines. He was warning both the public health community and politicians against inaction in the face of a deadly pathogen, noting further that "If you need to be right before you move, you will

Box 1: Towards a reinforced public health in Europe – Key messages

- Public health Institutions should be strengthened with adequate financing.
- Build leadership capacity for public health across the health workforce.
- Acknowledge the necessary contributions of different stakeholders and engage them in the public health community.
- Break down internal siloes and embrace collaboration within and across sectors.

never win".[18] We now have considerable evidence around strategies and specific measures that work to limit transmission of the virus, and how this can help avoid restrictive PHSM in countries. Crucially, we now also have highly effective vaccines. And yet cases continue to rise in many countries, messaging remains unclear and some countries are engaged in stop-start PHSM strategies.

Written almost 25 years ago, the IOM report expressed grave concern over the fact that: "… public health in the United States has been taken for granted, many public health issues have become inappropriately politicised, and public health responsibilities have become so fragmented that deliberate action is often difficult if not impossible".[1] In looking at contemporary European responses to the COVID-19 pandemic, substitute 'Europe' in place of 'United States', or indeed any single European country, and it seems the reasons behind Europe's poor response and the solutions to them are encapsulated in that sentence. The public health community has been advocating for the need to strengthen public health institutions and break down silos for decades. This is crucial for protecting and promoting the health of our populations (**see Box 1**). It has been suggested that: "COVID-19 is our teacher, giving a heads-up to bigger storms ahead: new epidemics, health backlogs, economic strain, and the health consequences of the climate crisis. These will dwarf our present problems".[19] Perhaps COVID-19 will, finally, be the catalyst for the necessary public health leadership to see this through.

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HEALTH SYSTEM RESILIENCE DURING THE PANDEMIC: **IT'S MOSTLY ABOUT GOVERNANCE**

By: Anna Sagan, Erin Webb, Dheepa Rajan, Marina Karanikolos and Scott L Greer

Summary: Governance is the most important enabler of health system functioning. It provides a foundation and lever for resource generation, financing, and service delivery and ensures they operate well and in coordination with the rest of the system. It also extends beyond the health system through interactions between levels and actors. While there is no unanimously accepted framework for assessing governance, country examples can be used to illustrate how governance has contributed to health systems resilience during the crisis. Good governance prior to the pandemic, underpinned by strong state capacity, political leadership and community engagement, is key to responding resiliently during a novel infectious disease outbreak, such as COVID-19.

Keywords: *Resilience, COVID-19, Governance, Health Systems Performance, Health Systems Strengthening*

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Resilience can be understood as the ability to maintain the performance of key health system functions

Health systems are complex, and shocks create diverse and sometimes unexpected consequences for health systems. A whole system approach, encompassing all functions and the interactions between them, is therefore needed to understand the implications of shocks on the functioning of health systems and which responses to adopt.[1] In case of a major shock, such as the COVID-19 pandemic, an even wider analysis, extending to other sectors and broader contextual factors, can help to understand the best course of action.

A resilient health systems response to a shock means pursuing strategies that ensure sustained performance of health systems functions, thereby protecting overall system performance (**see Box 1**).

Governance plays a critical role in health systems performance, thereby also providing the principal lever for resilience

Constructive deployment of funding and resources relies heavily on governance. Governance – the way decisions are made and implemented [2] – enables the financing, resource generation, and service delivery functions to operate as intended and in coordination with the rest of the system to achieve maximum overall system performance, and by extension, resilience. For example, public financial

management (governance of financing) influences how nimbly and transparently financing can be made available for emergency response purposes while re-organising funding for health system operations. Health workforce planning and management of procurement systems (governance of resource generation) have been pivotal in redeploying and repurposing the workforce and directing emergency medicines and diagnostics in the current pandemic. Health facility management and local community engagement mechanisms (governance of service delivery) determine whether COVID-19 response measures are adhered to and whether services are delivered in accordance to need (see the later article by Rajan et al. in this issue for more on engaging with communities and civil society).

At the macro-level, governance enables the other functions to work in unison, for example, by ensuring there is a clearly articulated strategic vision for the health sector, to which governments can be held accountable, or by ensuring that evidence generation and use drives decision- and policy-making. The governance function, however, goes beyond the health system through interactions with other sectors, since population health is largely determined by actions outside of the health sector. Governance is also increasingly conducted across levels, from local to global, with multilevel governance becoming increasingly important.[3] New adaptive approaches to governance surfaced during the pandemic, with more actors such as private sector companies (see article by Tille et al.), NGOs, civil society groups, religious organisations, and others providing support to the government in response to the pandemic. These many whole-of-society responses, often improvised, did not disempower or threaten governments and may well have enhanced overall quality of governance for the population. Indeed, as seen with joint efforts to fight the COVID-19 pandemic, the inputs of non-state actors can improve broader governance, delivering solutions that the state alone could not provide.[4] The coordination problems of involving more actors in response can be worthwhile if we gain their contributions, resources, and skills, while ensuring their transparency, legitimacy, and accountability.

Box 1: Health systems resilience and the performance of health system functions

Application of the concept of resilience in the context of health systems has typically focused on understanding health system preparedness and the ability to absorb, adapt, and transform to cope with acute shocks. In terms of performance, a resilient health systems response to a shock can be understood as doing things that ensure sustained performance of health systems functions – governance, financing, resource generation, and service delivery – so that the ultimate health systems goals, especially that of improving health of the population, can be achieved. Thus financing, human and physical resources had to be mobilised and optimally deployed during the COVID-19 pandemic to prevent the spread of the virus and treat COVID-19 patients, while maintaining the provision of essential services for other patients. But health systems resilience can also be viewed as something that goes beyond what it was before, which may be neither feasible nor desirable, and includes a health system's ability to evolve, learn, and transform, ideally improving its future performance. Making the link from recovery and learning from a shock to preparedness for upcoming shocks is crucial although often neglected in practice – once the shock has passed, decision-makers tend to revert to dealing with day-to-day system strains and stresses.

> "governance enables the other functions to work in unison

Governance remains difficult to assess

The past decade has seen a proliferation of frameworks for understanding governance for health systems. These have differing perspectives (e.g., policymaker or donor), focus (e.g., health sector or broader), uses (checklist or normative program versus diagnostic tool), and components.[5] As a result, there is no single concept of health system governance with a unanimously accepted framework. Thus, assessing governance, even in normal times, remains elusive, making it even more difficult to evaluate health systems steering in times of crisis. Furthermore, many governance frameworks were not developed with emergency response or broader resilience as a goal. In many cases they are focused on constraining political power rather than enabling and directing its use, which is not always helpful in emergency situations. They also emphasise efficiency and transparency rather than creativity and inclusiveness. For that reason, we should look at governance, like so much else, with different eyes after the pandemic.

What have we learned about governing the COVID-19 response?

Analysing national responses during the first 18 months of the pandemic shows the broad range of measures that countries undertook to maintain performance of the key health system functions. It also provides an opportunity to distil the governance factors that supported (or undermined) a resilient health system response. We summarise these factors below, drawing on resilient response strategies identified in the forthcoming Observatory study on health systems resilience during COVID-19 (**see Box 2**) and the underlying country evidence collected through the Health Systems Response Monitor (HSRM) platform.[6]

Box 2: Key governance strategies for a resilient response to the pandemic

1. Setting out a clear and timely COVID-19 response strategy backed by appropriate laws and regulations
2. Having well-functioning monitoring, surveillance, and early warning systems
3. Drawing on the best available evidence supported by effective knowledge-transfer between research and policy
4. Coordinating effectively within the government and across sectors and jurisdictions (horizontally) and across levels of government (vertically)
5. Ensuring transparency, legitimacy and accountability in policy decision-making and implementation
6. Communicating clearly and transparently with the population and relevant stakeholders
7. Involving non-governmental stakeholders including health workforce, communities, and civil society
8. Coordinating the COVID-19 response beyond national borders.

Source: [7]

1. Existing response plans and emergency legislation supported a clear and timely COVID-19 response strategy

Having a clear and timely response strategy has been key to steering the overall response. While some countries sought to eliminate the novel virus, most countries assumed that – as with pandemic flu – widespread community transmission was inevitable. Irrespective of the chosen approach, deciding on a clear strategic direction allowed stakeholders to make concrete plans for action, although this was not always a pre-ordained path and required adaptations and sometimes more radical policy U-turns. This was supported by drawing on or quickly developing or amending response plans and emergency legislation to give the government special powers to impose restrictions or release emergency funds. Even if the existing emergency plans had limited applicability, the process of planning that preceded their development was nevertheless useful as it forced its participants to interact and, through this, better understand other perspectives which they would otherwise only encounter in a crisis.

2. Monitoring, surveillance, and early warning systems were crucial for early detection and ongoing management

These systems allow countries to develop effective and timely public health containment measures, strategies for health care delivery, and policy actions that may be needed outside health, such as social support measures. They cover not only epidemiological indicators but also other areas such as the availability and distribution of financial, human, and physical resources, and indicators measuring barriers to accessing services, among others. In many countries, existing disease surveillance and monitoring systems have been enhanced to inform the pandemic response and were often supported by extensive coordination across a range of actors and the use of digital health tools. Despite these improvements, critical knowledge gaps and other weaknesses, such as a lack of 'one health' approach, remain in most countries. The pandemic has also exposed weaknesses in the national, EU-level, and multilateral early warning systems and key gaps in information about the health workforce.

3. Effective knowledge-transfer between research and policy helped bring the best available evidence to light

Given how little was initially known about the virus, the ability to generate and/or access evidence across multiple disciplines has been pivotal in developing effective evidence-informed response strategies. Evidence on COVID-19 was generated at an astounding speed; all countries could benefit from open-source information provided by international agencies, journals and other data sources. Yet, information on the new virus, and later on its variants, was never complete and critical political decisions had to be made under conditions of uncertainty.[8] In many cases, the accumulation and use of epidemiological, clinical, and virological knowledge outpaced that of social science on issues such as public adherence to mandates, the challenges of vaccination, or the operation of labour markets.

Deficiencies in the use of social science knowledge contributed to problems in the adoption, implementation, and operation of public health and vaccination measures. With a virus that exhibits exponential growth, delaying decisions can have a big cost. Given the pace with which this information has been developed and the vast amount of evidence, those in charge of crafting policy responses have in most cases taken steps to develop formal mechanisms to enable scientists and experts to guide them, although the composition of these advisory groups has raised concerns in some countries. Close links between scientific experts and policymakers have raised some questions over the transparency, rigour, objectivity, and independence of scientific advice, highlighting the important role of independent knowledge-brokers such as the World Health Organization (WHO), the European Commission (EC) or the European Observatory on Health Systems and Policies. One of the surprises of the current pandemic is how frequently public health agencies were not granted much of a role in advising governments.

4. Horizontal and vertical coordination was necessary for aligning policymaking and implementation

The scale of the pandemic has required coordination of efforts across many different parts of government, as well as NGOs. For the health sector, this meant horizontal (with other ministries, with relevant non-governmental actors and across jurisdictions and borders) and vertical (spanning central, regional, and municipal levels) coordination of decision-making. Centralisation of executive power has often been used to enhance

coordination of the response across sectors, at least initially (see article by Greer et al.), with special committees and other mechanisms often created to support coordination. Over time, as national lockdowns for regional outbreaks were increasingly seen as unnecessarily restrictive, there has been a shift to a more localised approach but with an important role for central governments to ensure coordination. Coordination among stakeholders was often supported by leveraging pre-existing structures and tools, such as medical associations, or by establishing new accountability mechanisms, such as those dictated by the crisis preparedness plans and emergency legislation. In practice, after a short period of centralisation in spring and summer 2020, most governments decentralised authority again, with irregular efforts to recentralise during new waves (e.g. in winter 2020–21).

> can provide a buffer against ineffective political leadership

5. Political decision-making and implementation did not always safeguard transparency, legitimacy, and accountability

Transparency, legitimacy, and public accountability have not always been easy to maintain during the pandemic response, as governments had to act quickly and flexibly. This is a problem because emergency interventions (e.g. PPE acquisition) are always a time of extreme vulnerability to corruption. For example, many governments have loosened their procurement checks and balances. Leading transparency and anti-corruption organisations have supported ensuring transparency, preventing corruption, and strengthening whistle-blower protection during the state of emergency; yet corruption and fraud were rife in many countries. Having dedicated committees to ensure parliamentary scrutiny has helped strengthen oversight and ensure that peoples' needs were represented, particularly when participation and engagement of the public and key stakeholders were restricted. Detailed presentation of response measures and performance indicators have been used to support accountability of decision-making, but proactive communication of such measures was often lacking.

6. Ongoing communication with the population and relevant stakeholders was often neglected

Despite the crucial need for effective communication coordinated across channels and actors, it has been often neglected during the COVID-19 response. For example, while various traditional communication channels (i.e. TV, radio) and newer ones (i.e. social media platforms) have been used to communicate with the public, national communication strategies were lacking in many countries. Moreover, targeted communication to address specific groups, e.g., those not speaking the country's official language, was generally underutilised. Communicating transparently about uncertainty and tackling misinformation and disinformation has remained a major challenge throughout the response and has undermined public health measures, including vaccination efforts. The WHO and the EC have played a key role in combatting misinformation, but in most cases reinforcing national efforts has also been necessary.

7. Non-governmental stakeholder involvement could be improved

Participation of non-state actors including citizens and communities, health workers, civil society, and the private sector, can provide insights into how the crisis is affecting various communities. This enables the formulation of informed, real-time policy responses and adjustments, which can enhance the chance of effective implementation. In particular, engagement with civil society can allow governments to understand risks in vulnerable populations and win more adherence to public health measures and vaccines by working with trusted groups. Yet, many countries had limited inclusion of civil society and community groups (see article by Rajan et al.).

8. International coordination of the COVID-19 response has been fragmented

Despite longstanding cooperation in communicable diseases control, the global response to COVID-19 has been highly fragmented, with effective enforcement mechanisms largely lacking. Nevertheless, the WHO played an important role in drawing attention to, and coordinating global efforts against, COVID-19. Within a relatively short period of time the EU managed to organise a range of support measures, such as coordinating repatriation of stranded citizens; sharing and building up epidemiological knowledge; stockpiling key supplies; reopening borders for medical and critical goods; initiating joint procurement processes (for example for PPE); deploying health personnel; releasing funds for urgent health care spending, vaccine development strategy and acceleration of pharmaceutical strategy, among other things. In South-east Asia, regional cooperation through the Association of Southeast Asian Nations (ASEAN) has supported countries in containing the pandemic early on.[9] The region's prior experience with pandemics such as SARS and MERS has allowed ASEAN Member States to develop their own lessons and priorities which proved highly applicable to the emerging coronavirus (see article by Nitzan et al.).

Discussion

Analysing factors that enhance health systems resilience is vital for strengthening health systems to better prepare for future shocks. As seen during the pandemic, public health capacity – the specific, designated public functions relevant to public health such as surveillance, epidemic intelligence and local service delivery – can be a critical enabler of a resilient response. For example, countries such as Vietnam that invested in developing their public health capacities in the aftermath of SARS and MERS epidemics were able to quickly implement effective contact tracing

strategies – something that many countries have struggled with well into 2020 (and some continue to grapple with until today). But as demonstrated by the experiences of countries that topped the Global Health Security Index (GHSI) during the COVID-19 pandemic, public health capacity is not a sufficient condition for a resilient response.

State capacity and political leadership are critical enablers of a resilient response

State capacity refers to a state's *ability* to make and effectively implement policy decisions in health and other sectors. This requires competent multifunctional local and/or regional governments and administrative and bureaucratic institutions, professional civil service (e.g., to implement the necessary legislative and regulatory changes), and other specialised services such as the police. During the pandemic, state capacity could often substitute for weak public health capacity, which could enable a response even in countries with limited public health capacity.[10] However, the reverse was not true, and COVID-19 has been particularly challenging for countries that have underinvested in state and in public sector capacity more broadly. Shrinking of the state under the dogma of new public management (NPM), which gained popularity in the 1980s, has led – in many countries – to an erosion of public-sector capacity and capabilities to handle emergencies (see article by Greer et al.).[11] The pandemic may result in calls to rebuild state capacity to enable governments to respond to health and other future crises and pressures, particularly the 'wicked problems' such as climate change. But these are not necessarily calling for 'more state' but instead for a different type of state – one with the right capacities and capabilities.[2]

While the capacities described above might be the necessary conditions for a resilient response because they are required to implement policy, political leadership capacity is needed to activate them. Having good political leaders is, however, not something that can be taken as a given and the advice "have better leaders" falls flat during a crisis. The challenge is how those seeking to protect health can be most effective in doing so with the leaders they have. One approach is to try to steer attention of leaders towards issues where they may be motivated to support. This may be helped by intelligent use of data: numbers of COVID-19 cases and deaths can be tracked in almost real time, making it possible for politicians to be held to account for their (in)ability to protect the health of their populations. But as we have seen during COVID-19 this may not always work. Another approach is to diminish the importance of any one person by distributing leadership, i.e., by reducing centralisation and sharing the responsibility and decision-making across bureaucratic hierarchies. In particular, countries with highly centralised leadership or leaders that do not seek cross-party consensus may be more likely to be paralysed in a crisis, for example, if the leader becomes sick, and their policies might suffer if the leader resists taking necessary actions.

> ultimately depends on strong political support

The judicial system can also play an important role, ensuring that public health officials act within the existing laws and help hold governments to account. Further, building 'flat, fast and flexible' structures that are open and adaptive to finding solutions to new problems and working across hierarchical boundaries can be helpful in crises that, like the COVID-19 pandemic, require a 'whole-of-society' response.[12] This may benefit from commitment over time and investment in development of leadership capacities, which ultimately depends on strong political support. But it can also be developed during a crisis, with Liberia's Incident Management System set up in 2014 to manage the Ebola crisis being one example where this approach has been implemented successfully.[13] However, such an approach may not be appropriate in all contexts and there is no consensus on whether a centralised or decentralised approach is the best.[13] Thus, while it may not always be possible to have the right leaders in a crisis, effective governance could potentially provide some defence against those that are especially bad. Strong governance that enables good health policy "works in the absence of especially good leaders, and is a defence against especially bad leaders" because it determines the extent to what is possible for the politicians.[2] Governance can therefore enhance resilience against pandemics as well as political crises.

Community engagement is important during times of crisis, but is often neglected

How far the voice and needs of the population have been brought into the emergency response has also been shown to be an important element of a resilient response.[14] The more community-oriented governments are, the more responsive emergency measures can be, with higher policy adherence and buy-in. For example, countries with institutionalised mechanisms for government-community dialogue were able to easily adapt COVID-19 communication to the needs of hard-to-reach population groups.[15] When public health authorities have the tradition and ability to work side by side with communities, they are able to better address the inequities exposed by the pandemic through their insight and understanding of people's context. The more people-focused and bottom-up political leadership is or is perceived to be the less likely it will face opposition for far-reaching restrictions of basic liberties which can support sustained compliance with these measures. In some cases, communities can step up to compensate for the deficiencies in the government's response.

Community engagement is seen as critical to many health initiatives.[14] Previous experiences show that it has been central in prevention and control of past epidemics, such as Ebola, Zika, and H1N1 outbreaks, where it has been mostly used for social and behavioural change

communication and risk communication, surveillance and contact tracing, although rarely as part of organised response programmes.[14] Effectively responding to a pathogen that spreads through community transmission requires devising contextually appropriate strategies that consider the ways people interact and live with each other and how this and people's needs are affected by the outbreak. Some of the newest health systems resilience frameworks that draw on the COVID-19 experience have recognised that community engagement is core to building resilience and that resilience must be developed with and according to the needs of the communities it is meant to serve.[16] However, meaningful community engagement work is often 'poorly understood, left until too late and clumsily executed'.[17] While community engagement can be improved during a crisis, high-quality coproduction is hard to establish rapidly.[18] Community co-production under the COVID-19 pandemic has also been challenging and national responses, at least initially, have largely been top-down, with community involvement being seen more as an additional burden, rather than a fundamental element of a successful, sustainable response.[18] But the importance of community-sensitive approaches has grown over time, reflecting the key role of communities in reaching marginalised populations, increasing adherence to nonpharmaceutical interventions and improving vaccination take-up, among others.

Conclusion

Governance has been a key determinant of an effective response to the COVID-19 pandemic. The effectiveness of governance at multiple levels – the health system functions, the health system overall and beyond the health system – enables a resilient response and can provide a buffer against ineffective political leadership. While changes to crisis governance can be made during the pandemic, these cannot be created from nothing and must recognise existing opportunities and barriers, including where power lies both formally and informally. New adaptive approaches to governance surfaced during the pandemic, with more actors, including actors at the community level, providing support to the government in response to the pandemic. Mechanisms to ensure community engagement have been essential for effective disaster response and can improve preparedness for and response to future emergencies, especially infectious disease outbreaks that spread through community transmission and require community-sensitive responses. These community voices should be incorporated to co-create both better pandemic response and better health services.[18] Looking forward, as health governance continues to evolve, community engagement should be firmly built into crisis responses as well as governance and resilience frameworks.

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DRAWING LESSONS ON BETTER GOVERNING FOR EMERGENCIES FOR IMPROVED RESILIENCE AGAINST HEALTH EMERGENCIES

By: Dorit Nitzan, Ihor Perehinets, J. Sam Meyer and Catherine A. H. Smallwood

Summary: The COVID-19 pandemic has taught us that preparedness for and resilience against health emergencies is critical. To improve preparedness for health emergencies, the emergency preparedness and response governance architecture at all levels should be strengthened. It should be based on cross-cutting, whole-of-government, and whole-of-society approaches, moving away from siloed perspectives. Moreover, resilience against health emergencies should be based on universal health coverage and anchored in the International Health Regulations (IHR) 2005 core capacities implementation. Capacities and capabilities that are required to improve health services for national and global health security should also be strengthened.

Keywords: *Emergency Response, International Health Regulations (IHR), Preparedness, Resilience, COVID-19*

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Introduction: COVID-19 has revealed shortcomings in governance mechanisms for health emergencies

The COVID-19 pandemic has revealed serious shortcomings in preparedness and response to health emergencies both at the national and global level. Traditional health governance mechanisms have faced an unprecedented need to interconnect the various complex aspects of society and systems to manage the response.

The WHO estimates that the excess deaths directly and indirectly associated with COVID-19 was at least three million in 2020 alone, which is almost double the reported cumulative deaths from COVID-19 infections.[1] A recent report by the Global Preparedness and Monitoring Board estimated that the cumulative global cost of the COVID-19 pandemic is already in the order of USD 11 trillion; in comparison, investments in preparedness capacities which could have significantly mitigated these costs would have amounted to less than USD 40 billion, or USD 5 per person per year.[2] Baseline analyses conducted by the World Bank Group estimate that COVID-19 pushed an additional 88 million people into extreme poverty in 2020, yet this number could be as large as 115 million people with the largest share disproportionately living in South Asia and Sub-Saharan Africa.[3]

The global community has seen that health is a critical determinant of development and should be placed at the centre of the UN's Sustainable Development Goals (SDGs).

The Independent Panel on Pandemic Preparedness and Response (IPPR) has found weak links at almost every point in the chain of preparedness and response. Preparation was inconsistent and underfunded; the alert system was too slow and too meek; the WHO was underpowered; the response has exacerbated inequalities; and global political leadership was absent.[4] The IHR Review Committee concluded that the IHR helped make the world better prepared to cope with public health emergencies; however, the core national and local capacities called for in the IHR (2005) are not yet fully operational and are not on a path to timely implementation worldwide.[5]

In this article, we consider lessons that countries and the global health community can learn from the COVID-19 pandemic and how preparedness and response for the next health emergency can be strengthened.

Box 1: The Pandemic Influenza Preparedness (PIP) Framework advanced global capacity to prepare and respond to the pandemic

- **More than 150 laboratories across 126 countries, areas, and territories** contribute to the Global Influenza Surveillance and Response System (GISRS) and can share viruses
- **50 000 sentinel specimens** are tested for COVID-19 each week through GISRS, with data reported through WHO platforms including FluNet
- **233 laboratories (including 130 National Influenza Centres) in 164 countries, areas and territories**, participated in the WHO COVID-19 EQAP; 94% of them scored 100%
- **40 countries** provided PIP support that were then able to develop a COVID-19 response plan early on
- **More than 50 countries** share their COVID-19 data using an established influenza platform
- **Many PIP-supported countries** were able to authorise COVID-19 vaccines within 15 days of WHO issuing an emergency use listing
- **More than five million people** have enrolled in the OpenWHO platform, including for the 28 COVID-19 courses that are available in 50 languages
- **11 new National Influenza Centres** have been officially recognised by WHO
- **10% of future, real-time pandemic influenza vaccine production** has been secured by WHO in the event of a pandemic, through legally binding PIP SMTA2 advance supply contracts with 14 manufacturers
- **10 million antiviral treatments, 250 000 diagnostics kits, and 25 million syringes** have also been secured through PIP SMTA2 agreements

Source: [8]

Driving forward using the wisdom of hindsight

Previous emergencies have motivated countries to better prepare for future emergencies. For example, just after the 2009 A(H1N1) pandemic, the global health community, led by WHO, mobilised the Pandemic Influenza Preparedness (PIP) Framework.[6] Together with industry and other partners, the PIP enabled capacity strengthening with the main aims: [7]

- to improve and strengthen the sharing of influenza viruses with human pandemic potential through the WHO Global Influenza Surveillance and Response System (GISRS), and
- to increase the access of developing countries to vaccines and other pandemic response supplies.

Some of these suggested capacities were already evident and used at the start of the COVID-19 pandemic response (**see Box 1**). Yet, while PIP helped advance capacities to respond to a health emergency in some aspects, other areas of emergency preparedness and response remained lacking. A global mechanism to ensure equitable distribution and access to vaccines within the context of a pandemic was not in place. This gap has contributed to millions of people having no access to COVID-19 vaccines, despite them being developed in record time. Vaccines, the most effective weapon to fight the pandemic, are notably not yet accessible to many low- and middle-income countries in an amount that would prevent the SARS-COV-2 virus from spreading and mutating.

To address this gap in global health governance, the WHO's strategy was to establish COVAX to close the immunity gap globally, starting with protecting at-risk groups and frontline health care workers, then proceeding with vaccinating other groups.[9] It is important to note that since the COVAX partnership was created when the pandemic had already wreaked havoc around the world its mission, strategy and tools were new to all. Had structures like COVAX been implemented before the pandemic, it is likely that morbidity and mortality could have been reduced. It is estimated, for instance, that the unequal distribution of vaccines has contributed to the over three million lives lost and millions more who are still facing Long-COVID and these numbers continue to grow.[10] If the principles and structures of COVAX were developed further (perhaps also in areas other than vaccines) then humanity could move forward more equitably in terms of recovering from COVID-19, but also in building resilience for future health emergencies.

An opportunity for global shared learning

Throughout the pandemic, countries have experienced various morbidity and mortality rates at different times,

Box 2: The Over-C's of pandemic governance: capacities and capabilities (IHR and beyond)

1. **C**ommitted, coherent and accountable leadership employing a whole-of-government and whole-of-society approach, which is accountable and trusted, has dynamic capacities and capabilities to adapt to new challenges;
2. **C**ommand-control-coordination architecture that is anchored at the community level with clear top-down, bottom-up, and cross-cutting approaches towards responsiveness, planning, actions;
3. **C**apitalise on emergency response funds to aid traditional sustainable health finance;
4. **C**ommunication, including risk communication and infodemic management;
5. **C**ommunity engagement and volunteering;
6. **C**ase investigation; Contact tracing, surveillance, intelligence, early warnings, isolation, quarantine;
7. **C**hains of procurement and supply that are intricately planned, and carefully managed with adequate stockpiles, enhanced local production, and allowing for rapid import and export;
8. **C**ontemporary tools, cyber innovation, digital health information and blockchain management and integration;
9. **C**ountermeasures including essential packages of health services and goods, research and development, One Health; Antimicrobial resistance; infection prevention and control; social and defence services;
10. **C**ore services, emergency workforce and institutional capacities, Chemical, Biological, Radiological, Nuclear, and high yield Explosives (CBRNE) defence, and mass events;
11. **C**ommon public goods promoting global health governance and common standards for critical public health information, with global participation, including enhanced investment on research and development;
12. **C**ohesiveness of people, countries, regions and globally, based on solidarity, stability, flexibility, and sharing best practices.

reflecting the different data collected, policy decisions, and adherence to local measures. WHO has encouraged countries to learn from each other's experiences, especially with respect to harmonising health information systems.

The WHO Intra Action Review (IAR) tool has been proposed to countries to assess their response and enable them to pursue corrective measures in real-time.[11] The key purpose of a country IAR is to provide an opportunity for continuous collective learning by bringing together relevant stakeholders to critically and systematically analyse and document best practices and challenges identified in the response so far. IAR tools also allow countries to evaluate whether the governance and coordination structures implemented prior to the pandemic have helped them launch and continue to respond to the COVID-19 pandemic. At the time of writing, six countries have held IARs with WHO and partners in the European Region.

When taking a step back and reflecting on the pandemic through a governance lens, certain capacities and capabilities, coined here as the "**Over C's**", require specific corrective actions (**see Box 2**).

Building resilience against health emergencies

Throughout the pandemic we have gained new knowledge, technologies, and tools which have led to milestone achievements and critical insight. However, the world remains in the grip of COVID-19 as cases continue to surge, and new challenges continue to surface. The notion of resilience recognises that extreme interruptions can and will happen and therefore core systems must have the capacities for adaptation and recovery (see Sagan et al. in this issue). It proposes to see emergencies as opportunities to improve the system through broader systemic changes and constant change management. The COVID-19 pandemic therefore provides an opportunity to switch from "bouncing back" to "bouncing forward".[12]

Necessary ingredients for building resilience to respond to health emergencies include the maturity of health systems and emergency preparedness.

1. Maturity of health systems

Governance structures based on societal norms and values can help cultivate effective leadership and timely decision-making as they breed trusted, fair, and participatory policies. Universal Health Coverage (UHC) is an example of such policies as it guarantees access for all people and communities to good quality health services, without financial hardship. Countries with UHC are those with matured health systems. In many cases, they have adjusted better to the high demand for health care services throughout the pandemic exhibiting lower case fatality rates.[13] These systems have been able to continue the provision of essential health services, including mental health, throughout the pandemic. Countries with mature health systems also have a capable, agile, and diversified public health workforce and tools. In many cases, they have been able to provide timely and accurate data, share information, activate laboratories, repurpose their services, and deliver a diversified portfolio of activities, including surveillance, contact tracing, and risk communication.

> resilience against health emergencies specifically is the first line of defence

2. Emergency preparedness

In order to combat COVID-19 and be ready for future health emergencies, it is necessary pursue a multidisciplinary approach accounting for local norms, values, and politics. This multidisciplinary approach must be supported and reflected in policy, laws, and procedures that enable a rapid response to emergencies. They should be strengthened in conjunction with the evolving evidence base, technology, capabilities, and necessary competencies in the public health workforce.

The COVID-19 pandemic revealed that resilience against health emergencies specifically is the first line of defence against emergencies of any kind. Yet to date, many countries, rich and poor alike, have not adequately invested in comprehensive preparedness. In the context of governance, the pandemic revealed weaknesses in both steadfast evidence-based policymaking and subsequently translating policy into practical guidance and implementation. The ability of policymakers to take good quality, timely, evidence-based, and relevant decisions requires an effective architecture of command-control-coordination that is anchored in human rights, ethics, and integrity. Such systems must be transparent, accountable, participatory, and continuously monitored to ensure their effectiveness.

The sum of these components can lead to resilience in the face of health emergencies

Mature health systems and emergency preparedness are both necessary to achieve resilience against health emergencies. They must be jointly secured through good governance, and anchored in societal norms and values, setting them in global and country-wide leadership. Globalisation has unprecedently interconnected humanity though the travel of people and the transport of animals and goods, as well as by communication and technology. While this interconnectedness has enabled the rampant spread of the virus, it can also be turned into a strength by having robust multinational collaboration.

To become resilient against health emergencies, the core capacities of both health systems (through the essential public health functions) and health emergency preparedness must be strengthened and included at the centre of national agendas and supported by societal actions and community empowerment (see Rajan et al. in this issue).

Strengthening global resilience against health emergencies

A strengthened global, regional, national and subnational resilience against health emergencies requires the global sharing of data, information, medicines, vaccines, diagnostics, consumables, genetic material, knowledge, research, and technology. The IHR (2005) lays the foundation for global health security requiring State Parties to accelerate implementation, continue reporting annually to the World Health Assembly on their gaps and achievements, and to use the IHR monitoring and evaluation tools to further assess and improve their systems and capacities.

Effective global health governance that puts people at the centre, at all levels of society, could be the platform to enhance resilience. It should be based on interconnected, all-hazards, and 'One Health' approaches, aiming to include all people. Only through coordinated, holistic, and equitable governance structures, can the world be resilient and ready for these future hurdles, and ultimately leave no one behind.

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WHO'S EMERGENCY RESPONSE FRAMEWORK: A CASE STUDY FOR HEALTH EMERGENCY GOVERNANCE ARCHITECTURE

By: Catherine A. H. Smallwood, Ihor Perehinets, J. Sam Meyer and Dorit Nitzan

Summary: During COVID-19, attention was drawn to a lack of functional governance frameworks for health emergencies. Routine governance structures were neither agile, nor flexible enough to operate with the speed required for urgent and coordinated action within complex and far-reaching responses. WHO's Emergency Response Framework has significantly contributed to a stronger WHO response capacity in the European Region by providing accountabilities, responsibilities, delegation of authority, and rapid access to resources for response, while also allowing for participating members to be held accountable for their actions. We argue that now is the time to move health emergency management forwards by supporting States in strengthening their emergency governance architectures.

Keywords: *Health Governance, Emergencies, Emergency Response Framework, WHO, COVID-19*

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Background

The importance of ensuring clarity in roles, relationships and coordination mechanisms within the health sector and across government before, during, and after health emergencies is highlighted within the International Health Regulations (IHR 2005) and models to address this need have evolved over time.[1] During the course of the COVID-19 pandemic response, broader governance and accountability frameworks for emergencies have been deemed insufficient at both international and national levels. The three independent reviews that recently submitted their reports on the preparedness for and response to COVID-19 to the 74th World Health Assembly,[2,3,4] point to the inadequacy of 'just-in-time' planning during emergencies and to the need for strong governance architectures for emergencies established from global to national and community levels. Such

architectures need clear direction, coordination, planning, target setting, policy, norms, technical guidance and technical support, as well as procedures that promote agile, timely, and adequate response with solidarity.

Up to now, emergency management has seldomly been mentioned in the health governance literature. Rather, the field of health governance has focused on strengthening governance as a health systems function, and even this has shifted over the past decade. This shift, as described by Meesen (2020),[5] has been towards an understanding of governance as the organisation of collective action. Collective action is precisely what is required during the response phase of health emergencies, where timing and coordinated interventions are critical to save the lives and livelihoods of affected populations. Meesen proposes thinking of health governance around four key variables: (i) the set of collective action problems to solve; (ii) the group of individuals facing the problems; (iii) the set of possible actions that members can take in time; and (iv) the conditions determining the problems.

> now is the time to move health emergency management forward

The field of health emergency management is dynamic and often described using the four phases of the emergency cycle. This article starts by explaining how all stakeholders need to be involved in health governance and must be mobilised during the response phase to health emergencies. We then make the case for countries to use the Emergency Response Framework as a tool during the response phase. Finally, we discuss the gaps in the governance of health

Figure 1: The emergency cycle

Source: [6]

emergencies and suggest taking a more holistic approach that could be applied to all phases of the emergency cycle.

COVID-19 has revealed critical gaps in the governance architecture

The emergency cycle is dynamic. We are always in a state of either prevention, preparedness, response and recovery, and these phases may overlap (**see Figure 1**). COVID-19 has revealed that if emergency management systems, processes and capacities are not in place upstream to an emergency, they have the potential to ultimately cripple the efficiency of the response over time. Over the past decade, the response mechanisms and infrastructure through the Incident Management Systems (IMS) and the establishment of a Public Health Emergency Operations Centre (PHEOC) that creates strong coordination and command systems for acute responses has been the main governing function for health emergencies and was also able to contribute to all other aspects of the emergency cycle.

Though a critical function of emergency management, we find that the IMS and associated Incident Management Support Team (IMST) must be supported by a robust governance system, that includes command-control and coordination systems, and embedded within national legal frameworks which feed into community action with clear accountability and capacities. Whilst emergencies are unpredictable, and often the specific actions and resources associated with them are difficult to plan for as part of routine health planning cycles there must be advance planning. In order to be prepared and functional at the very start of an emergency, the architecture that governs the health emergency cycle needs to be established in advance, and well understood and accepted by those who will eventually come to rely on it.

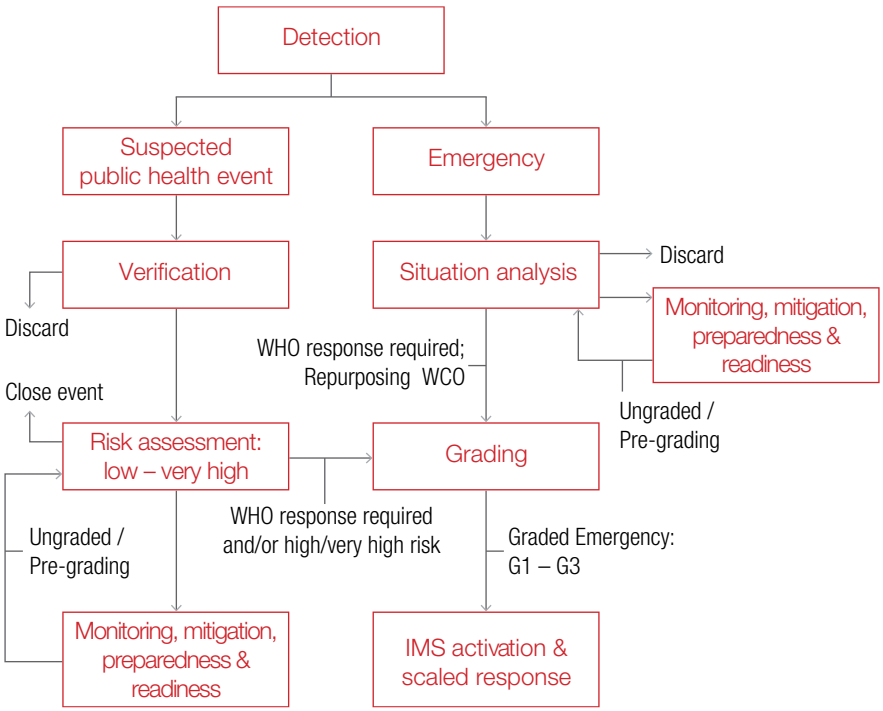
The governance of all actors during a large-scale health emergency extends beyond the health sector need

WHO identifies key stakeholders in health governance as the State (government organisations and agencies at central and sub-national level); health service providers (public and private, non-clinical health service providers, professional

Box 1: WHO's 10 core commitments during health emergencies

1. Undertake a timely, independent, and rigorous risk assessment and situation analysis.
2. Deploy sufficient expert staff and material resources early in the event/ emergency to ensure an effective assessment and operational response.
3. Establish a clear management structure for the response in-country, based on the Incident Management System.
4. Establish coordination with partners to facilitate collective response and effective in-country operations.
5. Develop an evidence-based health sector response strategy, plan, and appeal.
6. Ensure that adapted disease surveillance, early warning, and response systems are in place.
7. Provide up-to-date information on the health situation and health sector performance.
8. Coordinate the health sector response to ensure appropriate coverage and quality of essential health services.
9. Promote and monitor the application of technical standards and best practices.
10. Provide relevant technical expertise to affected Member States and all relevant stakeholders.

Figure 2: The choice of actions algorithm for emergencies at WHO



For acute events and emergencies, grading occurs within 24 hours of risk assessment/situation analysis

Source: [9]

Notes: WCO=WHO Offices in countries, territories, and areas, IMS=Incident Management Systems

associations, expert networks etc.); and people (population representatives, patient associations, civil society organisations, etc.) who become service users when they interact with health service providers.[7]

During emergencies, particularly during large-scale emergencies that have far-reaching and non-health consequences, these stakeholders expand to include humanitarian actors, and those in non-health sectors. Within the global humanitarian landscape, these include water, sanitation and hygiene (WASH), protection, shelter, education, social protection and logistics. The broader governance of these actors is facilitated by the 'cluster approach' established to enhance predictability, accountability, and partnership. In the wake of several humanitarian failures, the cluster system was established to bring together the humanitarian actors (UN agencies, international NGOs and others) involved across sectors and designated by the Interagency Standing Committee (IASC) and coordinate their collective interventions.[8]

WHO's Emergency Response Framework helps clarify roles, responsibilities and actions

With the creation of the WHO's Health Emergencies Programme (WHE) in 2016, the WHO's Emergency Response Framework (ERF)[9] was updated and revised with the adoption of new protocols for both acute and protracted emergencies. The ERF clarifies WHO's roles and responsibilities during emergency responses and brings WHO's response to all types of hazards into a single approach. Ultimately, the ERF requires WHO to act with urgency and predictability, and serve and be accountable to populations affected by emergencies. It provides shared accountability, roles and responsibilities, delegation of authorities, standard operating procedures, and reporting lines. The first variable of governance is the set of **collective action problems** and the ERF lays out WHO's commitments during health emergencies (**see Box 1**).

The **individuals charged with these actions** are the relevant WHO personnel at the country, regional and global levels. As

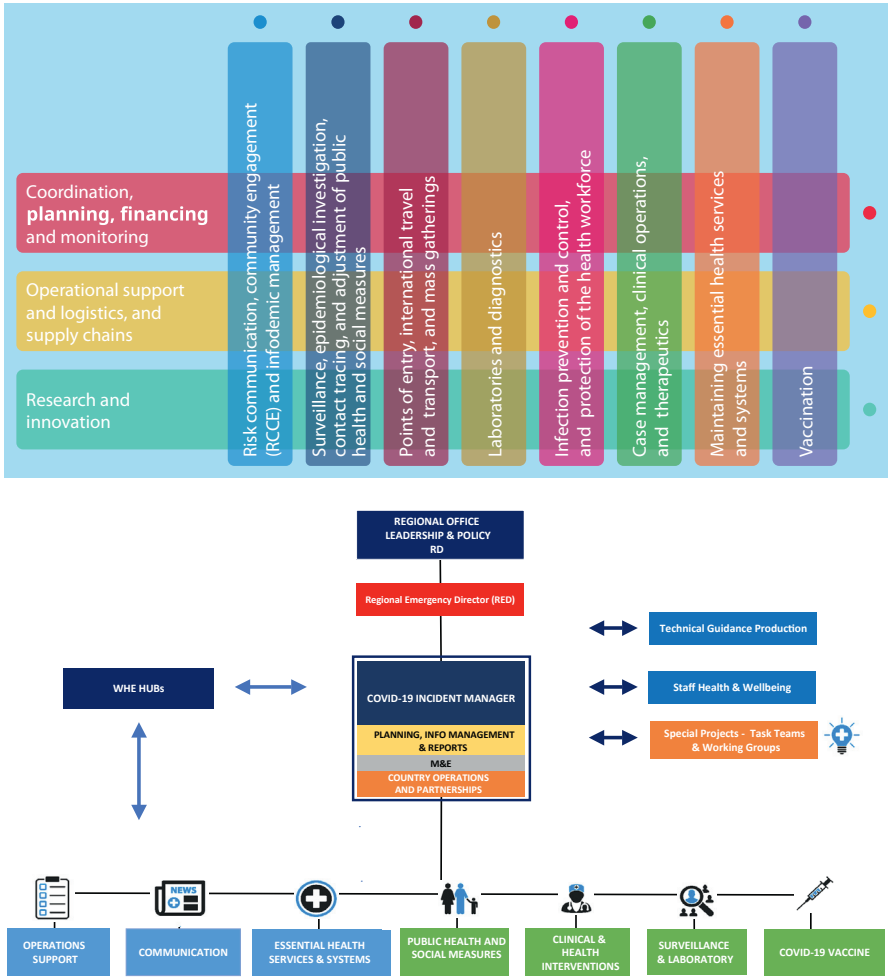
an outward facing framework, the ERF is also consistent with and reflects the WHO Secretariat's engagement with a range of stakeholders engaged in emergencies. This includes Member States, the global humanitarian system and Inter-Agency Standing Committee (IASC), partners (UN agencies, the International Red Cross and Red Crescent Movement, the Global Outbreak Alert and Response Network (GOARN), Emergency Medical Teams (EMTs)), donors, and the public.

The set of possible actions that members take in time is set out by a framework based on procedures for decision making and systematic actions which extend from before an event is detected, to assessing and grading events so that the response, as well as the resources provided to it, can be scaled up and down as necessary (**see Figure 2**). All actions are based on a key planning assumption in emergencies, the 'no regrets' policy.

The **conditions determining the choice of action** are defined during the activation of an emergency response (pre-grading), during the internal grading process, and during the management of the emergency (including its scale down and recovery). During the course of the emergency, it is assessed against the five international humanitarian criteria of: scale, urgency, complexity, capacity, and reputational risk. Based on these five criteria, and the extent of the needed WHO response to an emergency, the resources, the responsibilities, and the accountabilities associated with WHO's response are defined within the grade assigned to it.

Following the grading process, the incident management system and emergency Standard Operating Procedures (SOPs) are immediately activated. These SOPs allow for faster administrative approvals, delegation of authority, and rapid access to financial resources for Incident Managers and the WHO Representatives through the Contingency Fund for Emergencies (CFE)*.

Figure 3: WHO's country, regional and global critical functions (top) and WHO/Europe's Incident Management Support Team structure (bottom) for COVID-19 during 2021



Source: [10]

During the lifetime of the IMST, there are several conditions assessed to determine the actions required:

- Changes to the international humanitarian criteria and to the Grade assigned: this determines the operational **responsibilities and accountabilities** within WHO, allowing a response to be scaled up or down and accountabilities to be adjusted.
- Critical response functions needed for the specific emergency: this determines the **form and function** of the IMST based on the actual needs of the event. The functions need to be adapted to the specific hazard (e.g. respiratory virus, chemical hazard, natural disaster, conflict) and applied to all levels of the response (global, regional and country level).

Fundamental to this system is its key features of scalability and predictability, with each level of the organisation adopting the same shadow structure enabling rapid horizontal communication and coordination, as well as a single line of authority for command and control to ensure responsibility, transparency and accountability.

This structure is illustrated for COVID-19 based on the critical response functions identified for COVID-19 as part of WHO's 2021 *Strategic Preparedness and Response Plan*, and with the translation of these critical response functions into a

* The CFE is included in WHO's constitution which states in Article 29 that: "A special fund to be used at the discretion of the Board shall be established to meet emergencies and unforeseen contingencies".

functional organigram, WHO/Europe's Regional IMST, with the same structure replicated in each of the region's 31 WHO Country Offices (**see Figure 3**).

During the course of any graded emergency, the ERF sets out key performance standards for which members of the response can be assessed against based on their individual responsibilities and accountabilities, and these are outlined for all critical functions. Across the organisational structure of WHO, the ERF provides roles and specific responsibilities of each major office and builds on institutional compliance measures by providing a single line of authority in case of disagreement.

While there remains much room for improvement in WHO's own governance structure to manage emergencies, the ERF has already set up new ways of organising human, technical, and procedural, mechanisms, responsibilities, authorities, accountabilities, and financial resources during responses and highlighted what preparedness capacities and governing mechanism are needed. During COVID-19, the ERF and its procedures has brought consistency to the actions taken by the WHO-wide efforts across all levels of the organisation. Despite the unprecedented global emergency, the ERF proved its value during the pandemic response. Nevertheless, observations based on the lessons learned from the pandemic and other large-scale emergencies will now be integrated into its next edition.

Moving towards a model of governance for the State

As the global community struggles to reconcile the immediate human loss of the COVID-19 pandemic with the deficits to our emergency response architectures, now is the moment to look for the opportunities attainable before they drift from our collective priorities.

WHO is an international organisation governed by its governing bodies, and executes its policy documents, following its constitution, through its Secretariat. As such, it reflects a distinct institutional structure that can neither be equated nor compared to those of Member States. Yet, the challenges that Member States and WHO face are interdependent. Moreover, the authorities of Member States operate across different levels with complex institutional relationships that change with the events that they face, creating similar dynamics that require complex systems to address them. The WHO tools related to the management of the emergency cycle in general, and the ERF in particular, could be considered and tailored to meet the specific needs at national and subnational level, strengthening the predictability, effectiveness and governance of responses to health emergencies.

Box 2: Governing the health emergency cycle: Towards a holistic and adaptable governance framework and practice

Dealing with serious health emergency requires additional conceptual governance frameworks that facilitate better governance practices. The health emergency cycle as described in Figure 1, is composed of four stages including prevention, preparedness, response and recovery. Each of the stages are very different. They include different actions, stakeholders and organisations. Adequate governance will therefore vary from stage to stage. This makes the health emergency cycle very dynamic and a 'moving target' for governance.

There are existing governance principles and capacity measurement tools to build on. Most importantly the international health regulations (IHR) and related tools like, e.g. the Intra Action Review (IAR), the annual reports of the State Parties to the IHR (SPARs) or the Joint External Evaluations. These principles and tools, though they establish a solid understanding of the governance mechanisms and capacities of the health emergency cycle, are neither 'holistic' enough to cover sufficiently all stages nor sufficiently adaptable to address the variations in actions, stakeholders and organisations.

This governance shortcoming, however, can be remedied. One way to do so is by adapting the more 'holistic' existing health system governance framework. Key dimensions of this framework include accountability and transparency, capacity, organisational adequacy and intelligence. All of those are embedded in the human rights framework.

Conclusions

At the level of the State, beyond the rights and obligations set out in the IHR, there is no agreement or common understanding on what models are applicable to the governance of health emergencies, and to how such models fit within broader health governance structures. Moreover, there remains a gap in the global governance of health emergencies (**see Box 2**) across the entire emergency cycle . Indeed, the institutional capacities and structures required for such governance to function have not yet been described. As we emerge from the worst pandemic in a century, the conditions are right to move this critical area forward.

This article argues that now is the time to move health emergency management forward by supporting States in strengthening their emergency governance architectures, recognising the complex nature of the systems that underpin them.

A first step is to *define the core elements of national emergency governance* applicable within broader national health governance systems. This requires for States, in the same way as the ERF has done for WHO, to lay out the roles, responsibilities, systems, and accountabilities not just for the emergency response phase, but throughout the emergency management cycle. The governance architecture needs to be able to support emergency actions at all levels of the State, within communities, and beyond health actors alone.

A second step will be to *lay out and promote the conditions favourable* to such an architecture being successful,

namely, by engaging all those that need to be involved and generating the support that will be required at all levels (from the field level, to the highest levels of the State), and to agree on clear accountability frameworks.

A third step will be for WHO to *develop the tools, guidelines, and support necessary for countries* to put such architectures in place.

An opportunity exists now, amidst the COVID-19 pandemic, to demonstrate and build momentum around what is needed, from the very local levels to the highest levels of the State. Only when these architectures feed into a functioning global governance system for health emergencies will we have made true progress in mitigating the risks of future pandemics.

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RESPONDING TO THE COVID-19 PANDEMIC IN EUROPE: TOWARDS STRONGER POLICY THAT INCORPORATES THE IMPACT OF SOCIAL DISPARITIES

By: Govin Permanand and Natasha Azzopardi Muscat

Summary: The impact of the COVID-19 pandemic on countries in the European Region has been devastating with substantial morbidity and mortality and broader societal and economic effects. This in part reflects poor public health leadership and politicised responses but more importantly, a failure to account for social disparities. The stop-start pattern of Public Health and Social Measures further exacerbates the disproportionate impact on those most vulnerable. A Health in All Policies lens offers an indication of the type of coherent multisectoral thinking needed to address these social disparities in the COVID-19 context as well as in pandemic planning measures going forwards.

Keywords: *Pandemic Preparedness, Governance, Health Inequalities, COVID-19*

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Introduction

Hindsight suggests that no country in the world was adequately prepared for a pandemic on the scale of COVID-19. Yet, at a press conference in late February 2020, the then President of the United States (US) touted America's readiness, brandishing a 300-page report which he said proved it. The 2019 'Global Health Security Index' (GHSI) [1] was the first comprehensive assessment and benchmarking of health security and related capabilities across the 195 countries that are States Parties to the International Health Regulations (IHR [2005]).[2] It ranked the US first. What the President did not mention, however, were the US flaws identified in the report – such as low hospital beds per capita and poor access to health care, which have proven especially damaging in the current pandemic – nor its overall finding that "No country is fully prepared for epidemics or pandemics. Collectively, international preparedness is weak".[2]

Turning to Europe, while the GHSI covered more than pandemic preparedness, it suggested that the United Kingdom (UK) (ranked second) was better prepared than Germany (ranked fourteenth); while Sweden placed seventh and Spain fifteenth. The GHSI report is based on data that a country has published itself or which it had reported to an international entity, such as the World

Health Organization (WHO) – and the UK (not to mention the US) had a well-formulated pandemic preparedness plan before COVID-19. But what we know now about the pandemic in these countries suggests that the GHSI ranking was not an accurate predictor of response success. The UK has the third most deaths per million population in the WHO European Region and, at the time of writing, the highest number of new weekly cases per million.[3] Spain suffered heavily during the first wave in particular, and has seen some of the most stringent application of Public Health and Social Measures (PHSM) globally. Germany has, by many accounts, handled things fairly well, while Sweden has been an outlier in allowing the virus to circulate without the widespread application of restrictions, and has suffered higher death rates than its Scandinavian neighbours.

> an understanding of social disparities into future pandemic preparedness plans

In view of the above, it can be asked why there has been so little correlation between the assessment of countries' readiness plans and actual outcomes? And given the harsh and inequitable impact of COVID-19 on those most vulnerable, have decision-makers pursued appropriate response strategies? The second question is the focus of this article. Without reviewing each country's pandemic plan and response, we provide a high-level discussion of the types of strategy adopted across the European Region and the leadership priorities behind them. We then apply a Health in All Policies (HiAP) lens, arguing that a failure to recognise and act on social disparities pre-COVID-19, as well as during the course of the pandemic itself, has worsened both the health and social impacts. By way of conclusion, we suggest that building an understanding of social disparities into future pandemic preparedness plans – and ongoing COVID-19 responses towards 'building back fairer' – is a must.

Strategies to prevent pathogen spread

Across Europe, countries have pursued different strategies for tackling the pandemic. As the pandemic unfolded and more clarity emerged around the epidemiological characteristics of SARS-CoV-2, the virus that causes COVID-19 disease, strategies were necessarily adjusted. But they were adjusted not only to stop the spread of the virus. The wider impacts of the pandemic on society, and particularly the economy, were necessarily also taken into account. Despite differences in approach and the communication and messaging about this not having always been clear, most countries in Europe have sought to achieve a balance between the two.

In respect of COVID-19, response strategies have translated into discussions about eradication, elimination, suppression and mitigation. Eradication involves eliminating occurrence of the disease (which may or may not mean extinction of the pathogen even in a laboratory setting). Elimination focuses on eliminating occurrence of the disease in a given geographical area. Suppression, by contrast, is a 'control' approach. It is aimed at reducing mortality and morbidity through interventions that are acceptable to the public, but without looking to stop community transmission completely. Finally, mitigation, also a control mechanism, is primarily concerned with protecting the health system rather than preventing transmission. The latter two often go together as "the response is typically to increase stringency as the pandemic progresses and for more disruptive interventions, such as school closures, to be held in reserve to flatten the peak".[4]

Given that COVID-19 is also caused by a coronavirus, much comparison has been made with countries' responses to the 2002–04 Severe Acute Respiratory Syndrome (SARS) outbreak which ultimately resulted in the eradication of the disease. But SARS was eradicated because countries focused on breaking the chains of human-to-human transmission from the outset, which involved following a clear set of measures: a stated commitment to eradication; robust syndromic surveillance; enforced isolation (of patients) and quarantine (of contacts) policies, including at community-level in some cases; and all supported by clear communication and messaging to the public. COVID-19 did not see the same level of initial commitment to tackle the virus, at least not in Europe, and many would argue still not. Despite warnings from the scientific and public health community, many policymakers seemed unwilling to countenance an epidemic in Europe; many felt they were in any event prepared – recall the earlier-mentioned GHSI report – and, after all, SARS itself had been eradicated. Additionally, there was still much we were not aware of regarding both the SARS-CoV-2 virus itself and COVID-19 disease, with some continuing to compare it with the flu.

The result was that as early as March 2020, less than two months after WHO declared a Public Health Emergency of International Concern (its highest warning-level), scientists were suggesting that COVID-19 was already past the possibility of eradication.[5] This on account of the high transmissibility of the virus, the fact that mild infection meant that cases would be missed (we have subsequently understood that asymptomatic transmission occurs as well), and an overall slow global response.

Europe's focus on mitigation and suppression ahead of elimination

Responses in the European Region focused initially on mitigation i.e., 'flattening the curve' to prevent hospitals from being overwhelmed, rather than breaking the chains of transmission. On the one hand this is understandable as hospitals were quickly filling up with COVID-19 patients. On the other, there were early projections suggesting that "even optimal mitigative strategies would lead to substantial excess mortality and exceedance of health care capacity".[6] Yet, tackling clusters and treating COVID-19

patients remained the initial priorities. But this was often undertaken at the local level, sometimes resulting in the diversion of key health resources away from one part of the country in favour of another, thereby raising the risk of continued transmission and undermining the overall response.[7] By contrast, in other regions of the world where countries adopted both mitigation and suppression measures simultaneously from the start, while case numbers have risen overall, they have been more gradual and controlled.[8]

With the development of highly-effective vaccines, most European countries have since moved towards suppression, with Sweden an outlier (**see Box 1**). This involves all the control measures that public health experts have been advocating throughout the pandemic, and which have now become part of the common lexicon i.e., (rapid) identification and isolation of infected persons; effective contact-tracing, testing and quarantine of individuals following contact with a potential case; and the application of PHSM such as: physical distancing requirements, the banning of mass gatherings involving a defined number of individuals, and imposition of wider societal lockdowns as appropriate. The use of non-pharmaceutical interventions at the personal level e.g., hand-hygiene, minimising personal contacts, and use of facemasks are also fundamental. The application of travel restrictions to prevent the importation of cases is associated primarily with elimination but can be central to suppression as well. And the degree of strictness around the application of these measures, in particular their scope and duration (including border controls), is what differentiates suppression from eradication.

A pattern of stop-start measures and a disproportionate impact on those most vulnerable

In focusing on mitigation and suppression because of concerns about the wider societal and economic impacts of an elimination approach, the result in much of the European Region has been the 'stop-start' application of PHSM mandates. While comparing across countries and regions is fraught, evidence suggests that this stop-start pattern has resulted in higher levels of morbidity and mortality in Europe versus those countries in other regions, such as Australia, Japan, Republic of Korea and New Zealand, which implemented an elimination strategy from the get-go.[11]

> "has amplified the need to take action on the social and economic determinants of health

This morbidity and mortality impact has not been equal across segments of the population. As alluded to earlier, older persons, those who are immunocompromised and with certain pre-existing health conditions (especially asthma, cardiovascular disease, hypertension, chronic kidney disease and obesity) are more susceptible to infection and severe disease. Many of these pre-existing conditions are correlated with social inequalities and socioeconomic status, and factors such as income, education, housing, type of employment are all correlated with inequities in morbidity and mortality. But it is not just in terms of health outcomes that the most vulnerable and disadvantaged have been worse affected by the pandemic.

We see that stop-start measures have had further deleterious impacts, and again with an inequitable impact. Evidence suggests that they are harmful for economic growth in the longer-term. According to one study of OECD countries, "GDP growth returned to pre-pandemic levels in early 2021 in the five countries that opted for elimination, whereas growth is still negative for the other 32".[12] From Europe, only Iceland features in the top five. The same is true at the micro-level as companies seek to develop a buffer in anticipation of the next lockdown rather than investing for the future; this is also in respect of turning to short-term staff rather than investing in longer-term skills and training.[11] As many who are already socially-disadvantaged are dependent on lower-wage jobs, often in the informal sector, or are self-employed without social safety net support, government policy responses to the pandemic have exacerbated their vulnerability and widened inequalities; pushing them

Box 1: The Swedish 'outlier' case

Sweden has been something of an outlier in its response. By shunning restrictive measures and issuing voluntary recommendations to its population, the policy of allowing the virus to circulate was viewed as an attempt to achieve 'herd immunity' by infection.

While Sweden has not altered course towards suppression as is the case in other countries,[9] the authorities have at times been forced to impose certain restrictions, especially in cities when case numbers were putting a strain on the health system.

There have been a high number of deaths, in particular of older persons, and while some of these excess deaths were amongst individuals who were at risk of death anyway (the so-called 'dry tinder effect'), this appears marginal.[10] At the same time, Sweden's economy has not suffered to the same degree as its neighbours.

It is noteworthy that, in comparison to many other countries, the national public health agency *(Folkhälsomyndigheten)* has been very much central in the response.

further into precarity and worsening the pandemic's impact overall. This underscores the false dichotomy between health and the economy. For we have known for decades that investing in health, which in turn demands action on health inequalities and inequities, is investing in economic development both at an individual and societal level; yet this appears not to have been part of the COVID-19 response thinking in most countries.

In view of suppression and mitigation having so far not allowed us to get a real grasp on the virus – in turn potentially undermining the effectiveness of existing vaccines vis-à-vis the emergence of variants such as B.1.1.7 (Alpha) and B.1.617.2 (Delta) which are more transmissible than the original strain and affect younger age-groups – nor escaping the stop-start pattern, calls have grown for a so-called 'Zero-Covid' strategy across Europe.[13] Proponents contend that countries have to abandon suppression and push for elimination, at least until populations have been fully vaccinated. And while a 'Zero-Covid' strategy is not feasible for all countries in the European Region, not least on account of shared borders, it is argued that pursuit of the goal is more important than actually achieving it – the gains to be made in controlling the virus and breaking transmission are more substantial than continuing with current stop-start PHSM and suppression efforts. Additional evidence from OECD countries suggests that those which pursued swift lockdown measures as part of a clear elimination approach in fact saw lockdowns that were less strict and of shorter duration.[12] Going in the opposite direction now, the UK appears to be eschewing suppression in a similar vein to the Swedish approach despite very different case numbers,[3] leading to some accusations of the government "embarking on a dangerous and unethical experiment".[14] **Box 2** also notes 'exclusion' as falling under a 'Zero-Covid' / elimination strategy.

With SARS-CoV-2 so transmissible and so much unknown at the outset of the pandemic, it remains unclear from a public health perspective as to why suppression rather than elimination was initially seen as the way forward in Europe, and especially in view of the more decisive action taken in countries in South East Asia. Moreover, with each 'wave' revealing the need to focus first on breaking the chains of transmission to the extent possible before resuming social and economic activities, it seems baffling that decision-makers did not learn. Despite continued warnings from the public health community on the need to stop transmission and develop an integrated health promotion approach, this reflects a reactionary health protection approach to the pandemic, and an overarching concern with the economic and societal impacts. As the stop-start suppression pattern has been especially harmful to those most vulnerable, this raises questions about a lack of foresight, learning and health leadership (see Nathan et al. in this issue).

Box 2: An 'exclusion' strategy

Some Pacific Island and Caribbean countries and territories, which are especially vulnerable to COVID-19 on account of population health characteristics and fragile single-sector economies,[15] have been able to pursue a so-called 'exclusion' strategy. That is ensuring, by way of suspending all incoming travel, that the virus would not (re-)enter the country.

In the European Region, a number of smaller Greek islands have been able to do this. But on account of economies that are almost wholly dependent on tourism, they are now touting their COVID-free status and in some cases fully vaccinated local populations in order to attract visitors.[16]

The Faroe Islands first declared COVID-19-free status on 26 February 2021 (following detection of the first cases in July 2020). This lapsed on 13 April 2021 and, since then, they have declared COVID-19-free status on three further occasions only for this to not hold. Each time new cases were detected they were traced to arrivals either by air or sea. The same can be observed for example in New Zealand where the initial elimination strategy was followed by exclusion, but with cases flaring up once border controls were eased.

Adapting responses to account for social disparities in the context of COVID-19

We understood early on that severity of COVID-19 disease was correlated with age and a number of underlying health conditions resulting in higher death-rates. We saw outbreaks and widespread deaths in long-term care facilities across the European Region; which remains a major stain on our collective conscience. Also, we have subsequently seen the significant role played by social and economic determinants in exacerbating the effects of the pandemic on those already disadvantaged and vulnerable.

But did we really need to wait for such tragic real-world results from COVID-19 to understand the importance of social disparities? Whether it was the Spanish Flu of 1918–20 when the poor, the unemployed, and those living in cramped accommodation in poorer parts of cities were most affected,[17] or the West African Ebola outbreak of 2014–16 when socio-economic factors were shown to be a driver of the disease,[18] we know that susceptibility to disease outbreaks can be significantly reduced by addressing the social determinants of health. Already in 1996 Paul Farmer showed the link between social inequalities and infectious diseases specifically.[19] And we also see this in practice every year with seasonal influenza; yet public health experts continue to lament the lack of explicit recognition of social disparities in influenza preparedness plans. In this regard, the COVID-19 pandemic has amplified the need to take action on the social and economic determinants of health. The response across Europe has in the main been reactionary – hence stop-start – when it needed to reflect a concerted and multisector health protection and promotion approach.

In asking to what extent governments have adjusted their responses accordingly, one lens we can turn to is HiAP.* HiAP is an approach which focuses on health equity and demands concerted multisectoral actions to ensure that all public policies are geared towards protecting and promoting health (**see Box 3**). It applies not just in terms of routine policy, but clearly has relevance to pandemic planning and response as well.

> a coherent response demands every part of government work together

We are not proposing HiAP as the answer, but the application of a HiAP lens to Europe's overall COVID-19 response reveals that this dual health promotion and protection role does not appear a discernible feature of most countries' responses, neither initially nor later. This is reflected in how European countries prioritised hospital-based care over the continuity of essential services as part of initial response measures. Noncommunicable diseases (NCDs) provide a case-in-point. A rapid review of the impact of COVID-19 on the provision of NCD services showed many national health departments and agencies having postponed their NCD health improvement services, focusing instead on health protection.[21] As the pandemic has evolved and NCD patients continue to struggle, this has led some to refer to a syndemic,[22] and even to suggestions that COVID-19 is not the real pandemic.[23] Focusing on protection is perhaps understandable early in the pandemic, but as it has to go hand-in-hand with promotion, responses ought to have been adjusted accordingly.

Box 3: WHO Helsinki Statement on Health in All Policies

Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.

We recognize that governments have a range of priorities in which health and equity do not automatically gain precedence over other policy objectives. We call on them to ensure that health considerations are transparently taken into account in policy-making, and to open up opportunities for co-benefits across sectors and society at large.

Policies designed to enable people to lead healthy lives face opposition from many sides. Often they are challenged by the interests of powerful economic forces that resist regulation. Business interests and market power can affect the ability of governments and health systems to promote and protect health and respond to health needs. Health in All Policies is a practical response to these challenges. It can provide a framework for regulation and practical tools that combine health, social and equity goals with economic development, and manage conflicts of interest transparently. These can support relationships with all sectors, including the private sector, to contribute positively to public health outcomes.

Source: Taken from[20]

Moreover, stop-start by its nature reflects a lack of the joined-up multisectoral thinking central to HiAP.

Examples of health promotion and multisectoral actions in response to COVID-19 can be found at local level. Towns and cities across Europe are developing (post-) COVID-19 recovery strategies that seek to link policy action in areas such as housing, 'green' policies, healthy environments and transport.[24] In many cases these have been achieved despite a lack of support from national governments.[25]

Overall, therefore, the focus on suppression (and mitigation) across Europe, and the resulting stop-start pattern of PHSM application we have highlighted, suggest that decision-makers have not sufficiently adapted their COVID-19 responses to reflect the inherent social disparity issues which are driving the worst impacts of the pandemic. If a pandemic preparedness plan is to ensure protection of those must vulnerable, in both health and non-health terms, then addressing the root causes from the outset must be a given. Moreover, a coherent response demands every part of government work together. While we have seen examples at the local level, HiAP-type thinking has not necessarily been part of the overall planning nor the practice at national level. The question going forwards therefore is whether COVID-19 can precipitate the necessary change in thinking.

Final remarks

Just over a month after the US President cited the GHSI report as showing the US to be prepared for COVID-19, another ranking, this time covering 150 countries and entitled the 'COVID-19 Safety, Risk and Treatment Efficiency framework and indices' (CSRTE), was released.[26] Drawn up by a consortium of for- and not-for-profit organisations called the Deep Knowledge Group, their indices did not correlate with the GHSI ranking – neither the US nor the UK made the top-40. Germany ranked second and Israel – fifty-fourth according to the GHSI – was top. The CSRTE was undertaken with the pandemic already underway and is

* For a summary of Health in All Policies as a framework and approach in practice, see: https://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf

regularly updated (now covering countries and regions), so the two are not directly comparable. But as the CSRTE includes parameters such as: 'literacy rate', 'percentage of population with tertiary education', 'poverty rate', 'incidence of diabetes, cancer and obesity', 'size of elderly population', 'economic support for quarantined citizens', and 'unemployment rate due to COVID-19', it reveals a more sensitive and nuanced view of pandemic preparedness – one that touches on the social determinant issues which have driven the worst impacts of COVID-19.

Recalling the first of our opening questions – namely, why have most European countries' pandemic preparedness plans not stood up to COVID-19 – two related responses are therefore clear. First, it appears that initial plans have failed to sufficiently account for social disparities. Moreover, foresight and forecasts visible on paper were not acted upon in a timely nor determined manner (it is not clear, for example, that either the UK or US kept to their pandemic 'playbook'). Second, despite some countries introducing specific policies to protect those most vulnerable, a more forward-looking health promotion approach involving a coherent multisectoral understanding appears in the main absent. Current recovery strategies and future preparedness plans need to account for social inequalities from the outset, and here health leadership will need to come to the fore much more than it has done to-date. And while this article has not been about HiAP per se, the lens it provides offers a potential perspective on the type of decision-making and leadership required in both a pandemic and non-emergency context.

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EFFECTIVE PANDEMIC PREPAREDNESS DEMANDS THAT GOVERNMENTS CONFRONT HARD QUESTIONS ABOUT SOVEREIGNTY

By: Martin McKee and Scott L. Greer

Summary: No-one is safe until everyone is safe. But what can be done when a country fails to take measures to control a pandemic virus? It poses a threat to its own people but also to its neighbours and beyond. Countries do pool sovereignty, working through supra-national structures, such as international agencies, or using processes set out in treaties, recognising the mutual benefits of the international rules-based system. Here we review the ways in which governments have, or have not worked together on other issues that pose a threat to global health and discuss the implications for pandemic responses.

Keywords: *Pandemic Preparedness, Sovereignty, Global Health*

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The limits of sovereignty in a pandemic

It is a cliché that microorganisms do not respect national frontiers. Unseen, they hitch lifts on the people, animals, and goods that cross them. Yet when we look at the maps that have been prepared to monitor the spread of the COVID-19 pandemic, those frontiers are often clearly visible. Infection rates can be many times higher on one side than on the other. This seems inexplicable. All governments have access to the knowledge needed to respond to the pandemic, even if they need to monitor it constantly as it accumulates. The difference is what they do with that knowledge.

Had they prepared for the pandemic that so many had predicted? Had they invested in the infrastructure, whether in the form of essential supplies, laboratories, high quality housing, well ventilated schools, or high speed internet that was required to mount an effective response? And above all, were they prepared to work together with other countries in the face of a common threat? The last of these is especially important. We now know that successive waves of infection, driven by new variants of SARS-CoV-2, have spread from certain countries. A country that fails to suppress a virus with pandemic potential is a threat to the entire world

so the international community has a legitimate interest in the decisions that its political leaders make.

But what does this mean in practice? Countries are sovereign. They make their own laws and create the structures and institutions to implement and uphold them. Indeed, some have elevated the pursuit of sovereignty above almost all other goals regardless of the cost.

> most countries have recognised that there are reasons for pooling their sovereignty

Yet, for over a century, and in some cases far longer, most countries have recognised that there are reasons for pooling their sovereignty for the greater good. Often, they have acted because the consequences of failure to do so earlier became apparent. Examples include the League of Nations after the First World War and the United Nations (along with a large number of specialised agencies), and the European Economic Community after the Second World War. More recently, the G20 nations came together after the global financial crisis to create new structures, centred on a Financial Stability Board, that can strengthen the global financial system.[1] At their heart are reporting, risk management, and the prospect of greater returns on investment (the 3 Rs).

There are clear precedents for working together

Now, as the governments of the world look at how they can "build back better" in a post pandemic world, it is timely to reflect on whether, and how, they might share sovereignty in the interests of protecting and sustaining health.

In some ways they have already taken the first steps, with a commitment to report on what they are doing to improve health. In 2015, world leaders committed to an ambitious agenda of sustainable development, building on the earlier Millenium Development Goals. In a series of 17 goals, operationalised in 169 targets, they signed up to take actions to achieve a better and more sustainable future for all. One of these goals, Sustainable Development Goal (SDG) 3, focuses explicitly on health, calling on governments to ensure healthy lives and promote well-being for all, at all ages. Many others include targets that will contribute, in different ways, to better health. These include alleviation of poverty and hunger, improvement of education, promotion of gender equality, and action on climate change, all underpinned by peace, justice, and strong institutions.

The SDGs are, however, aspirational. They form a political declaration that imposes no legally binding obligation on governments to make their best efforts to achieve them. There are no sanctions for failing to make progress and, indeed, even if there were, it is not obvious what mechanism might judge them or otherwise hold them to account. The 2030 Agenda, from which they have arisen, speaks of "accountability to our citizens" and of review processes at all levels that will be "open, inclusive, participatory and transparent for all people" as well as being "people centred, gender sensitive, respect human rights and have a particular focus on the poorest, most vulnerable, and those furthest behind".[2] The question of how these aspirations can be realised remains unanswered.

Beyond the SDGs, there are many other international agreements in which they have agreed to report progress on measures that have implications for health. Examples include the Paris Agreement on Climate Change, the UN Convention on the Rights of the Child, the Ottawa Treaty banning landmines, the Framework Convention on Tobacco Control, the International Health Regulations, and many others. They differ in the extent to which they include goals and obligations, the number of countries that have signed up to them, mechanisms for monitoring implementation, and the extent to which they can be enforced. Their operation also depends, to varying degrees, on the features of the state that has ratified them. Thus, the extent to which citizens of a country can seek remedies based on treaties will depend, for example, on whether that country has acceded to the Vienna Convention on the Laws of Treaties, and on whether the state adopts a monist approach, whereby international law has direct effect, in some cases, overriding domestic legislation, or a dualist approach, whereby treaties must be translated into domestic legislation. There are also a number of regional structures, such as the European Union, MERCOSUR*, ASEAN†, the African Union, and others, as well as bodies with historical connections, such as the Commonwealth, some of which have a significant role in health policy. Finally, there are numerous intergovernmental agreements.

Not all threats are treated equally

At the risk of generalisation, these instruments have had greater impact in some areas than others. Those with the strongest systems for enforcement typically focus on security (e.g. the Nuclear Non-Proliferation Treaty and the Chemical Weapons Convention, with their inspectorates) and trade/the economy (the World Trade Organisation, with Disputes Settlement procedures) rather than health per se. For example, international law contains stronger provisions against counterfeit banknotes than counterfeit medicines.[3] This situation is, however,

* The Southern Common Market with Spanish initials for its members, initially established by Argentina, Brazil, Paraguay and Uruguay, and subsequently joined by Venezuela and Bolivia.

† The Association of Southeast Asian Nations including Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand, and Vietnam.

changing. Thus, in the pre-2005 International Health Regulations, reporting of outbreaks was the prerogative of the national government. It was difficult for the World Health Organization (WHO) to act in places where that government denied the presence of an outbreak, with several well-known examples of where this happened. The new Regulations enable WHO to draw on other sources of evidence and, where necessary, to challenge governments in denial.[4–6]

> there is a growing consensus that we need a new pandemic treaty

The important point is, however, that there is an extensive range of international instruments that have implications for health and there are many areas where governments have, to greater or lesser extent, surrendered a degree of sovereignty. In most cases, governments consent to provisions in international agreements. However, where they do not, there is the potential of sanctions. Conventionally, these can be imposed for several purposes:

- those designed to force cooperation with international law, such as the sanctions on Iraq in Resolution 661 after the invasion of Kuwait, an act that violated the sovereignty of Kuwait;
- those designed to contain a threat to peace within a geographical boundary, such as the Iran nuclear proliferation pact;
- those that condemn a specific action or policy of a government, as with those following the Rhodesian Unilateral Declaration of Independence in 1965.

These examples illustrate how the international community is willing to act, but primarily where there is a threat to security in military terms. Thus, the case for concerted action in the face of nuclear proliferation is easy to make (leaving aside the many anomalies including the rights of the original nuclear states). The same arguments apply, although arguably even more so, to the Biological Weapons Convention. However, in a post-pandemic world, there is at least an argument that there should be some mechanism for collective action in the situation where a government pursues policies that encourage the spread of a pandemic disease, placing not just residents of that country but also its neighbours at risk. A further, arguably more controversial, question is whether the international community should act in situations where a government adopts policies that pose a grave risk to its own population. Here too, there are analogous arguments. The Genocide Convention includes a Responsibility to Protect (although one consequence is that the international community has striven hard to avoid ever labelling an atrocity as genocide, instead favouring euphemisms such as "ethnic cleansing"). Although not enshrined in instruments of international law, some might point to the doctrine of international community, which was used to justify interventions in settings such as Sierra Leone, and in later, in Iraq.

The reality of a divided Europe

As with all debates in the WHO European Region, identification of common solutions is complicated by the differences between member states in the European Union/ European Economic Area (including the accession countries) and those that are not. Obviously, those in the former group have already accepted the importance of pooling sovereignty in many ways and the opportunities for joint or coordinated action are substantial, even if in practice, they are not always realised. The remaining countries in the Region do not have the same opportunities available to them.

The contested roles of international organisations

Making the case for international organisations always involves confronting the problem that they frequently have poor reputations, with critics accusing them of everything from excessive politicisation to hidden agendas to low-grade corruption. Part of the problem, which must be squarely confronted, is that some of the key functions of international organisations are not ones that are good for morale or effectiveness. Notably, they are arenas for diplomatic activity of all sorts. One result is that staffing them is difficult, since some member states are at times more interested in promoting their citizens into key positions than in filling jobs effectively. They are also, and this is very important, easy to blame for policy failures. Blaming the WHO for inadequate or late pandemic response, for example, is an obvious and easy strategy for all sorts of actors. *Absorbing blame is a key function of international organisations,* whether or not they match the blame with the autonomy and power to make blameworthy decisions.[7] In many cases, the reason the UN is involved in intractable conflict is precisely because the problem is intractable. The implication is that designing any new international organisation, or trying to reform an existing one, involves a full appreciation of the less palatable functions these organisations serve. In particular, decisions about their roles and functions should be taken with full understanding that one role is to be blamed for member state mistakes, and decisions about their organisation and staffing should reflect a realistic understanding of what staff and member states are actually trying to do when they create and fill jobs.

Where next?

So, what needs to happen now? We clearly need far better, internationally comparable health data if we are to have early warning of health threats. This is not just a technical issue, although agreeing definitions, standards, and interoperability of systems will be complicated enough. It will also require substantial donor assistance, financial and technical, to put systems in place, while navigating concerns about issues such as privacy and cybercrime.

But information is not enough. There is a growing consensus that we need a new pandemic treaty. The members of the International Panel on Pandemic Preparedness and Response are only the latest to conclude that the International

Health Regulations, most recently revised in 2005, are inadequate.[8] But this will require an acceptance that a strengthened WHO, as the custodian of such a treaty, must have the power to ensure accurate reporting, transparent risk assessment, and measures to fix any weaknesses that are revealed, just as has happened in the global financial system, making it able to respond to threats arising from the pandemic. A new treaty must not become merely a substitute for actual commitment to the level of transparency and realism that we need.

This will raise important questions about the sovereignty that many countries guard jealously, especially when it comes to human health. We can see in successive European Union treaties how member states have been willing to cede much greater powers to the European institutions in areas such as animal health and the environment.

As we have seen repeatedly, legal compliance with the International Health Regulation has, it seems, often outpaced state capacity or the incentives of politicians to comply. Is there a case for a mechanism to take concerted international action where a government is failing to take effective measures to control the spread of infectious disease beyond its borders? Does the international community have a responsibility or duty to protect those living within the borders of a country that is failing to protect its population? The "Responsibility to Protect" doctrine has been abused by governments that use its language to justify actions taken for other reasons, but some would argue that if the international community has a right, or even duty to intervene to prevent crimes against humanity the same principle, even if not involving force, could apply to prevent pandemics when other measures fail.

Many critics tax international organisations, laws, and regimes with hypocrisy, pointing out selective application of any and all international norms. But it is worth remembering that the norm of state sovereignty itself has always been breached as much as any other.[9] Countries truly adhere to a doctrine of non-interference with the same lack of regard for consistency as they adhere to other doctrines; creditor states, for example, rarely interpret respect for others' sovereignty as including respect for their debtors' autonomy. This pattern has held as long as there has been anything resembling international debt, and has shaped the behaviour of creditor state governments regardless of their politics or espoused ideals.[10] In short, respect for sovereignty is just as often breached as respect for any other norm. If governments are willing to concede their sovereignty to protect against other threats, we need to ask them why they are unwilling to do so in health.

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CENTRALISATION AND DECENTRALISATION IN A CRISIS: HOW CREDIT AND BLAME SHAPE GOVERNANCE

By: Scott L. Greer, Michelle Falkenbach, Holly Jarman, Olga Löblová, Sarah Rozenblum, Noah Williams and Matthias Wismar

Summary: The COVID-19 pandemic led to unprecedented challenges and political creativity worldwide. In governance, this often led to unexpected centralisation and decentralisation in response to case surges. Changes in the distribution of power and responsibility throughout governments changed quickly as the pandemic progressed. Centralisation and decentralisation occurred *within* governments and *between* governments, as power shifted. The main explanation for the patterns of centralisation and decentralisation is the politics of credit and blame. Politicians at all levels seek to centralise when there is credit to be had from forceful action and decentralise when there are unpopular policies or bad news coming.

Keywords: *Governance, Centralisation, Decentralisation, COVID-19, Politics*

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Centralisation and decentralisation occurred between and within governments

The COVID-19 pandemic was far from business as usual, and governments responded with dramatic measures in governance as well as in policy. Governance is how societies make and implement decisions. In an analysis of the key components of governance,[1] participation in decision-making, transparency of decisions, policy capacity, integrity and accountability were key dimensions, and changes in centralisation in a pandemic affect them all. In the tumult of 2020, governments and citizens alike learned a great deal about what is possible, helpful, and sustainable in governance.

There has long been a public health argument for "command and control" in emergencies,[2] which critics would argue could overestimate the expertise and good intentions of central commanders. COVID-19 thus did not just give us an opportunity to evaluate that argument; it allowed us to understand the *political logic* of command and control and decentralisation. If public health scholars, practitioners, and researchers recommend approaches that are not politically

sustainable and do not respond to the changing politics of a health issue, they will be giving bad advice that might discredit them, undermine the people who listen to them, and limit the effectiveness of public health policies.[3]

> voluntary horizontal coordination among regional governments was challenging to sustain

Here, we focus on the often rapid and dramatic changes in how governance worked during the crisis. First, we highlight the distinction between centralisation *within* and *between* governments. There are two kinds of relationships in politics – transactional and hierarchical.[4] In hierarchical relations, centralisation is straightforward: the central authority issues orders. In transactional relations, such as between different branches of government or in federations, there has to be negotiation. Both *within* and *between* governments, there was a marked shift towards hierarchy and centralisation in most European countries in early 2020. By the summer of 2020, we saw a shift back to decentralisation and transaction. We close by discussing the political reasons for those shifts.

We draw on our research for the COVID-19 Health Systems Response Monitor as well as other research.[5]

Centralisation within governments occurred during the first wave

On a day-to-day basis, much of the activity within any government is decentralised. Ministries, independent agencies, and other organisations carry on their work in relative independence of each other. This fact has long frustrated advocates of coordination, including intersectoral coordination such as Health in All Policies.

The first wave of the pandemic saw a wave of centralisation within governments almost everywhere. (**see Table 1**). Heads of government in different countries took control of both the agenda and the public administration, taking prominent roles in communications and often setting up their own advisory groups.

Centralisation between governments

Centralisation and decentralisation between governments is perhaps more recognised. It demonstrably shapes health systems and is a constant theme in the politics of some countries such as Spain and Belgium.[7] Local and regional governments are often important actors in health and health care policy, specifically in pandemic-related policy. In a crisis it is not surprising that central governments choose to commandeer their resources or at least give them more direction than in normal times. This can mean a substantial shift from transactional to hierarchical relationships, as when the initial "state of alert" decrees in Spain gave the central government extensive powers, temporarily changing the normally transactional nature of Spanish politics and health policies. It can also mean political challenges to hierarchy, as posed by the Madrid regional government, and substantial shifts back to transaction later. Even in countries with relatively unitary public administration, such as Czechia, the role of regional public health agencies and governors varied over the pandemic.

A third way? Coordination among regional governments can be challenging

Making health policy through hierarchy and transaction is not appealing to many. So, is it possible for regional governments to coordinate amongst themselves effectively, without a key role for the central government? To a limited extent, yes. In countries with a long tradition of such coordination, established mechanisms for doing so, and party politics conducive to it, notably Germany, this seems to work. However, as the pandemic wore on, it turned out that voluntary horizontal coordination among regional governments was challenging to sustain over time, even in Germany. Voluntary horizontal coordination among governments depends on their leaders' shared sense that they are on a team together and that there is an agreed-upon set of policy goals, neither of which is the normal state of politics.

Explaining centralisation and decentralisation: The politics of credit and blame

What explains these patterns? One of the key concepts of political science: the politics of credit and blame.[8] Politicians who wish to be effective and elected seek credit and avoid blame. That is also how they get re-elected. Politicians' focus on getting and staying in high office might not seem as statesmanlike as we could ask for, but a politician in office can almost always do more than a politician out of office. Therefore, it is quite effective to understand politics in terms of credit and blame as understood by particular politicians.

> short-term malleability and long-term durability of governance structures

In the context of the first wave, in spring 2020, this meant that heads of government had enormous incentive to centralise power, creating hierarchies and emphasising their position at the top. Heads of government had all the reason to do so: they would be blamed if they declined the opportunity to be heroes, and they stood to reap credit for decisive action. It was time to be a hero. Other politicians such as regional health ministers were often initially happy to cede leadership since they would escape blame if things went badly. Thus, federal and regional governments in countries

Table 1: Centralisation and decentralisation by country and domain of intervention

Domain of intervention		Centralisation within government (spring/summer)	Centralisation between governments (spring/summer)	Centralisation within government (autumn/winter)	Centralisation between governments (autumn/winter)	Decentralisation (any kind) (autumn/winter)
Governance	Interministerial committee, Coordination agency, National security council					
	Expert/Vaccine committee			–	–	
	State of emergency/ Emergency Laws				–	–
	Centralised governance of the health care system	–		–		–
Preventing transmission	Health communication		–	–	–	–
	Physical distancing	–		–	–	
	Contact tracing	–		–	–	–
	Isolation and quarantine	–		–	–	
	Monitoring and surveillance, Contact tracing, Reporting cases and hospital capacity					
	Testing			–		

as different as Austria and Spain largely agreed to implement central direction and not raise questions about the unusual degree of centralisation.

In summer 2020, in Europe, centralisation continued, with heads of government taking credit for low case counts and the end of public health restrictions. But over the summer, in more and more countries the head of government began to quietly decentralise again, whether by letting emergency measures lapse or just holding fewer press conferences. Some leaders announced reopenings timed to facilitate public holidays, declaring (premature) victory. Decentralisation put other parts of government and other governments, such as regional governments, to the fore when the inevitable second wave hit.

Box 1: "COVID-19: The end of new public management?"

Not everybody saw decentralisation within government as a bad thing. New Public Management (NPM) had often advocated for decentralisation within government in the decades prior to COVID-19. Independent agencies, purchaser–provider splits, strategic purchasing, and the addition of corporate structures such as boards to government departments were all efforts to create decentralisation within government. The idea was to tap expertise while creating agencies that could pursue set goals without interference. Thus, for example, the UK government deliberately attempted to divest much of its power over the National Health Service (NHS) to various agencies over previous decades,[6] while an autonomous public health agency became something of an international model for communicable disease control. Unsurprisingly, governments took back a great deal of control at the expense of such agencies in the context of the 2020 crisis and gave orders where they might previously have tried to steer systems through contracts, competition, or regulations. In some cases, such as England, that recentralisation may last.

The efficiency that NPM was supposed to promote is also less clearly attractive now that COVID-19 has shown the extent to which there is a trade-off between efficiency (e.g. limited bed numbers) and resilience (ability to adapt to unexpected challenges such as COVID-19 posed). One major open question is whether governments will conclude that resilient and effective response to emergencies such as COVID-19 requires more hierarchy and resources and less of the elaborate and putatively efficiency-enhancing policies associated with NPM.

It is no accident that autumn 2020 in Europe was such a confusing time. Heads of government had mostly withdrawn from their highly exposed centralising positions, leaving the blame for rising cases and deaths, and renewed public health measures, to ministers, agency heads, and regional or local governments. This was a rational strategy for them, since by autumn 2020, the initial enthusiasm for leaders and health policy – symbolised by clapping for health care workers and surges in the popularity of almost all leaders – was long gone. Even if public opinion often remained positive about public health measures, political conversations shifted, with energised opponents of lockdown increasingly visible, the media looking for new stories of political conflict, and opposition parties seeking a basis on which to critique governments. In the countries where social policy measures were insufficient to support public health restrictions on the economy, the politics of public health were even more complicated since there was more blame and less credit to be had.[9]

In short, in spring of 2020, when there was credit to be had in forceful action, heads of government centralised, accentuating hierarchy at the expense of their fellow ministers, agencies, and regional or local governments. In summer, when there was credit to be had in relaxing public health measures, heads of government did that- and decentralised so that the expected next waves and lockdowns would be shared with others. Regional politicians often went along with this strategy, only using their positions to challenge the government and articulate different stances on issues such as restarting nightlife after the initial centralising, solidaristic dynamics of spring and summer 2020 had worn off. In autumn 2020 and onwards, when the next waves hit, there was less credit and more blame to be had, and a wide variety of voices with views on who merited blame and credit. Unfortunately for many heads of government in Europe, their inherited political institutions and cultures meant voters still attributed credit and blame to heads of government. This implied that the heads of government still often ended up imposing new public health measures and being the face of those measures.

Likewise, it was heads of government who received credit and blame during the varied experiences of vaccine acquisition and rolling out vaccination programmes in Europe.

Centralisation and decentralisation, credit and blame

COVID-19 made two things clear about governance. The first is the short-term malleability and long-term durability of governance structures. In the short term, such as spring-summer 2020, a crisis enables dramatic changes in governance and politics. But over time, the logic that led to federalism, independent agencies, or powerful ministers, reasserts itself. The lasting institutional effects of COVID-19 might be less than the politics of 2020, or even the voluminous emergency legislation of that year, might suggest. If there is a change, it might be in the loss of enthusiasm for new public management (NPM) reforms that deliberately fragment decision-making in efforts to replace hierarchical public sector organisations with various forms of internal markets. Centralisation within government of health care and health care services might be a lasting legacy after policymakers saw the needless complexity and limited resilience of many NPM ideas in a crisis (**see Box 1**).

> "politics of credit and blame are fundamental to pandemic governance

The second is the extent that the politics of credit and blame are fundamental to pandemic governance. In country after country, from Czechia to the UK and from the US to Austria, the head of government proved able to briefly change governance, centralising and decentralising in order to make creditworthy decisions and then

gently decentralise more blame-attracting ones to agency heads, scientists, less powerful ministers or other governments.

Conclusion

It is a truism that good public health means "knowing your pandemic," but that cannot be understood to mean that good public health allows us to ignore history and politics.[10] Politics explains governance in many cases, and governance explains the effectiveness and the nature of governments' response to COVID-19. Governance responses were a mixture of centralisation and decentralisation, and they reflected the particular ways that politicians understood credit and blame to work at different stages of the pandemic and in different political systems.

There is extensive debate about when and whether centralisation might be a good or bad idea.[7] There is extensive debate about whether technical experts or heads of government should lead and communicate responses.[5] But in addition to those excellent questions, there is a third question: what is the political viability and sustainability of the advice they produce? Recommending politically nonviable ideas can discredit public health experts, while recommending politically unsustainable ideas can discredit their allies in government as well.

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What are the key priority areas where European health systems can learn from each other?

By: J Hansen, A Haarmann, P Groenewegen, N Azzopardi Muscat, G Tomaselli, M Poldrugovac

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Health systems in Europe face numerous challenges which will only intensify following the shock of the COVID-19 pandemic. There is therefore an urgent need for innovative solutions to ensure that health systems provide accessible, high quality, responsive, affordable and financially sustainable health services. Cross-country comparisons are a valuable tool for capturing the range of innovative approaches countries have harnessed to address common challenges. However, in order to learn from each other, countries need to better understand what their common topics of interest are.

In this new policy brief, the authors draw on key documents and inputs from stakeholders within European health systems in order to propose a set of priorities for cross-country learning. These priorities focus on innovation areas that are likely to dominate the policy agendas of today and the years to come. This is the second of two briefs that set out key findings from the TO-REACH project, funded by the European Union's Horizon 2020 programme.

The authors show that priorities for cross-country learning and innovation can be clustered in four domains: person- and population-centredness; integration of services across all health sectors and traditional health system boundaries; four key sectors of care requiring reform including, long-term care, hospital care, primary care and mental health care; and preconditions for improved functionality of the priority areas above. Certain supporting mechanisms are also needed across all sectors to improve the functionality of the identified priorities. In concluding, it is argued that the scale and nature of challenges faced by European health systems mean they cannot be met by Member States acting alone and a partnership is needed that brings together stakeholders from across European health systems.

GOVERNING HEALTH WORKFORCE RESPONSES DURING COVID-19

By: James Buchan, Gemma A. Williams and Tomas Zapata

Summary: Countries in Europe have rapidly scaled-up, redeployed, repurposed, retrained and retained their workforce during COVID-19 to create surge capacity, protect the health and well-being of the workforce, and ensure effective implementation of vaccination programmes. Doing so has had enormous governance implications, including the need for intra-governmental and cross-organisational governance actions, increased transparency for planning, and delegated leadership to health employers and health workers. It is important that stakeholders continue to learn and share their experiences on the effectiveness of different workforce governance responses to allow the health workforce to recover, rebuild and repurpose.

Keywords: *Human Resources, Health Workforce, Surge Capacity, Governance, COVID-19*

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Introduction

The health workforce has been a critical determinant of the effectiveness of policy responses to COVID-19. Health care is always labour intensive, but in the specific conditions of the pandemic, the ability of a health system to rapidly scale up, redeploy, repurpose, retrain and retain its workforce has been crucial to success. It is important to note that "insufficient staff availability" was the most common reason for service disruption reported by Member States in the European Region in the second WHO "pulse" survey on health services during the pandemic (January – March 2021).[1]

A review of the sparse literature on health workforce governance shows no agreement on conceptualisation or definition. The wider governance literature nevertheless emphasises that governance is largely about how decisions are made and implemented, including the ability to take and effectively implement evidence-based decisions and create alignment between different stakeholders.[2] There is also broad agreement on key elements of good governance, such as the need for transparency, accountability, and participation in decision making.[2] Applying these dimensions to governing the health workforce during a pandemic, with the pressure for rapid responses, raises several critical questions. *Do countries have the necessary data and systems to plan for health workforce up-scaling, redeployment, etc? How are those responsible for decision-making*

held to account? Is there bottom-up functional participation in decision making processes or is it all top-down? Are processes in place to promote cross-sectoral and cross-organisational collaboration? The existing literature also reveals a clear message about inter-dependence of health workforce governance with broader health system governance.[3,4,5] In turn, this means that governance aspects health workforce during COVID-19 will be shaped by how the overall "crisis response" itself was determined by broader political, cultural and institutional contexts.[6]

> Countries in Europe entered the pandemic with a marked variation in health workforce profile

In this article, we consider some of the effective governance tools that have been utilised to mobilise, redeploy and repurpose the health workforce during the COVID-19 pandemic. We also consider key messages that are emerging on health workforce governance, which can be drawn on to help support the development of a more resilient health workforce in the future.

For the purposes of this paper, within the context of responses to COVID-19, we focus on four dimensions of health workforce governance:

- national/regional government policies (e.g. policies on health care, education, employment);
- legislation (e.g. legislation covering working hours, prescribing);
- regulation (e.g. professional councils defining roles and standards); and
- the role and remit of employers and management (e.g. determining pay levels, working patterns).

These are all important factors in determining how the workforce is employed, deployed and contributes. Different stakeholders may be involved in different countries, but will usually include government departments/ministries, professional councils and employee associations, universities, politicians/legislators. The interplay and balance of effect across the four dimensions will vary in different contexts and countries, but we keep all four in mind as we examine the workforce implications of the response to the pandemic.

We explore the workforce governance implications of responding directly to the pandemic challenges in three key areas:

- creating "surge" capacity to meet new and rapidly growing demand, notably in hospital care;
- protecting workforce health and well-being; and
- rolling out the vaccination programme.

These key elements are presented linearly but the variable timing, phasing and number of pandemic waves in different countries and regions has created different circumstances, timelines, and policy challenges. They have also had to be aligned with the need to maintain essential (non-COVID-19) services. Our focus is to highlight the key aspects of health workforce governance from early 2020 to May 2021 by reporting on specific case studies from across Europe.

Governance implications for creating workforce surge capacity

In Europe, the need for a surge response first became apparent in early 2020, but it has also been a factor in previous pandemics.[7] Whilst "surge" is often characterised as a short-term phase about rapidly increasing numbers, the reality is that redeployment, reskilling and new ways of working are also required, and will be needed in the longer term, to support recovery and re-mobilisation of other essential services. Countries in Europe entered the pandemic with a marked variation in health workforce profile and availability, with many health systems experiencing staff shortages and/or a sub-optimal workforce skill profile and deployment.[8,9] The initial impact of the pandemic increased demand for services but also increased infections of unprotected health workers, and has exposed these workforce gaps and weaknesses, adding to the governance challenge.[10]

Analysis of the immediate health workforce surge responses by the European Observatory highlighted that there were a core group of interventions to "scale up" the workforce, all of which had governance challenges.[11] These interventions included: increasing the capacity of the existing workforce, bringing student health professionals into the workforce, bringing retired and inactive health professionals into the workforce, "fast tracking" the deployment of foreign health workers, encouraging volunteers, and included other measures such as deploying the military.

Implementing these changes often required adoption of emergency legislation to facilitate exceptional hiring procedures, or suspension of existing legislation such as on working time limits or minimum staffing requirements (e.g. Germany), and changing (re-)registration requirements (**see Table 1**).[11] Surge was, however, not just about "more" staff; it was also about redeployment, additional training and development of new competencies, and the accelerated use of technology, such as for remote consultations or use of electronic health records. This had significant workforce governance implications in terms of training, development of new skills, and learning new ways of working.[1]

One essential component of an informed approach to workforce governance is the ability to plan and project in order to understand staffing requirements during a surge. This enables policy-makers to identify the necessary governance levers – be it a legislative change, new regulations, or incentives – to understand how many and where more or different types of health workers may be needed or to attract

Table 1: Examples of governance mechanisms utilised to create surge capacity, support the health and well-being of health workers, and enhance vaccination programmes

Governance areas	Examples for surge capacity	Examples for health and well-being	Examples for vaccination programmes
National/regional government polices	Authorisation for new staff to be hired National or regional recruitment campaigns to attract new or returning workers Agreements to temporarily employ private sector workers in the public sector Allocation of additional/new funding to provide support and remuneration and hiring of new workers Coordination between health facilities and regional or national government to assess rapidly and report workforce demand and supply Supporting implementation/adaption of IT systems to monitor supply and demand/project "surge" requirement for staff Authorisation for certain professions to take on new tasks	Ensuring sufficient supply and distribution of PPE Developing clinical guidelines, protocols and training programmes for using PPE Supporting implementation/adaption of IT systems to monitor supply of PPE through funding and policies Establishing strategies for mental health support and occupational health and safety Ensuring health and care workers have access to free mental health treatment and care Provide alternative accommodation for health workers to prevent infections of people living in the same household	Defining and authorising health and non-health workers permitted to vaccinate Developing clinical guidelines, protocols and training programmes and minimum standards for training for administering vaccines
Legislation	Emergency legislation to restrict or cancel leaves of absences Suspend legislation on working hours, change shift working or relax minimum staffing requirements Emergency legislation for public sector organisations to take over private sector hospitals and staff Emergency legislation to launch exceptional recruitment procedures Legislation to clarify or extend medical indemnification to health workers taking on new tasks	Suspending legislation restricting access to mental health services Updating legislation to direct effective use of PPE Calls for all countries to classify COVID-19 as an occupational disease, which can then trigger health worker compensation for, e.g. illness or death	Temporary legislation allowing additional/different types of workers to administer vaccines Legislative amendments to enable retired and foreign-trained staff to administer vaccines Legislation to clarify or extend medical indemnification to health workers newly vaccinating
Regulation	Building competencies through training and education Changing registration requirements to fast track new or "returner" workers Establishing registers of inactive workers Medical and nursing schools approve early graduation Reduce language requirements and waive fees for conversion exams for foreign-trained workers Suspending requirements for re-registration Relevant professional associations or health authorities to develop and offer temporary recruitment contracts Agreement from professional associations that certain professions could take on new tasks	Defining PPE requirements for different roles Establishing helplines/online services for mental health support	Defining professional competencies to administer vaccines

Governance areas	Examples for surge capacity	Examples for health and well-being	Examples for vaccination programmes
Employers and management	Modify contractual arrangements on work schedules, increase working hours, change night shift working or relax minimum staffing requirements Re-deploy health workers at higher risk of COVID-19 infection Put in place procedures and infrastructure to support remote working where possible Training for new workers or those being re-deployed to other roles Training on remote consultations Individual health facilities appealing to past employees to return	Training on use of PPE Meeting occupational health and safety requirements Monitoring and reporting PPE use and availability Monitoring and reporting on staff absenteeism Putting in place procedures for employees to report lack of PPE, other infection risks or mental health issues Providing mental health and psychosocial support and encouraging people to seek help Providing a supportive work environment and managing workloads Training managers in general psychosocial skills	Training for those administering vaccines Supervision (usually by a physician or nurse) in place for certain health workers to administer vaccines

Source: Authors' compilation based on [11] [12] [13]

volunteers. **Box 1** below highlights the application of surge planning tools at the national level in Kyrgyzstan.

Governance for protecting workforce health and well-being

Another critical aspect of workforce governance during the pandemic has been the need to protect the health and well-being of the workforce. This first became evident as a policy priority early in the pandemic with the large shortage of sufficient Personal Protective Equipment (PPE) and the need to put in place other preventative measures such as hand and respiratory hygiene/cough etiquette to prevent infection. This has had a range of governance implications at all levels, including defining infection control policies and minimum standards of PPE use, monitoring PPE supply and distribution, and the development of regular testing procedures among others (**see Table 1**). Managers and employers also had an important role in protecting the health of their workforce by providing training to staff, monitoring PPE supply and demand, and ensuring a safe working environment.

There was also a need to protect the mental health of health workers due to stress, intensive workload, and increased

Box 1: Applying and adapting health workforce tools to support COVID-19 "Surge" Response in Kyrgyzstan

The Ministry of Health in Kyrgyzstan used health workforce planning tools to rapidly assess workforce requirements to respond effectively to the "surge" of infections during the COVID-19 pandemic. These projections helped inform operational planning and management of the deployment of the workforce, and optimise the aggregation and analysis of relevant data.

The WHO Adaptt and Health Workforce Estimator planning tools were used, which had been developed rapidly by the WHO Regional Office for Europe in response to the pandemic*. The Ministry of Health and e-Health team in Kyrgyzstan used the tools, with support from WHO experts, using data on the available health workforce, collected both nationally and in the Bishkek (capital) region, and the number of patients hospitalised over time. Treatment times per patient per day, by type of health worker and level of disease severity were determined.

The outputs from the tools were checked to confirm that the estimated workforce times for treating patients was realistic. This enabled an assessment of the potential impact on the workforce if there were to be subsequent surges. The application of the planning tool highlighted which workforce groups would have shortages, and how soon this would occur, and therefore played a major role in supporting effective planning and management of the workforce. Recommendations were made for data collection to highlight any regions and workforce groups in deficit or surplus and indicate which staff may need to be moved or shared to balance resources in order to best respond to the workforce deployment challenges of the pandemic.

By: Aigul Boobekova, Pam McQuide, Saltanat Salieva, Graham Willis.

* The WHO Adaptt and Health Workforce Estimator is available at: https://www.euro.who.int/en/health-topics/Health-systems/pages/strengthening-the-health-system-response-to-covid-19/surge-planning-tools

risks of "burnout" for "frontline" workers.[12] [14] [15] **Box 2** reports on the coordinated and adapted system response to the challenge of providing relevant health and well-being support to the health workforce in Ireland. Putting in place mental health support has important governance implications, ranging from the need to ensure that health workers have the right to access free mental health support to ensuring mangers and employers train staff on self-help, create a supportive environment where people feel able to seek help if needed and to manage the work environment such as through the implementation of breaks (**see Table 1**).[16]

> "skill mix changes to expand the workforce staff profile of authorised vaccinators

These long-term solutions to address health and well-being support for the workforce are needed not only to secure a sustainable supply of workers by mitigating against people leaving the workforce, but also to reduce the long-term impacts of decreased quality of life after the pandemic.[16]

A critical aspect of effective workforce governance during the pandemic should be the ability to rapidly assess the changing rates of absenteeism amongst the workforce. This can help highlight concerns about health and well-being and support making more informed decisions about where to focus attention on staffing concerns, but this has not been feasible in all countries because of lack of data and monitoring. Ideally this should take account of trends and patterns of variation by area and by occupation. It can also signal where issues of workforce health and well-being are most prominent. An example of good practice in this area can be seen in the National Health Service (NHS) in Scotland, which used nationwide, rapidly updated data to monitor workforce absence (**see Box 3**).

Box 2: Ireland has implemented an adaptive response to protect the health and well-being of health workers

In Ireland, it has been recognised that the mental health and well-being of health care workers have been severely affected by COVID-19. An analysis by the Health Service Executive (HSE) Workplace Health and Wellbeing Unit showed absence rates in 2020 (6.1%) were 1.4 percentage points higher than in 2019 (4.7%).

Since the pandemic began, the HSE Workplace Health and Wellbeing Unit has mobilised and adapted pre-existing structures to safeguard the mental health and well-being of health care workers during the COVID-19 pandemic and worked on strengthening and improving its infrastructure for providing mental health and well-being services to HSE workers. Key aspects of the adaptive response have included:

- HSE Employee Assistance Programme – a free-of-charge, needs based, individualised, confidential and independent counselling service for all HSE workers. The issues identified may be personal or work-related, affecting job performance or home life.
- National Health and Security Function and the HSE Work Positive Framework – provides resources that enable managers and staff to discharge their legal and moral duties with regard to occupational safety and health management.
- Organisational Health Service and WHO healthy workplace framework – supports the implementation of evidence-based best practice to support sustainable health and well-being. It provides direct support to managers and their teams in preventing and managing complex psychosocial risks in the workplace and working environment.
- Occupational health services – provide support to proactively reduce health care worker exposure to work-related stressors; and also in building working environments in which health care workers feel mentally safe. Work and organisational psychology interventions will continue in support of and in response to complex psychosocial workplace risks.

The Workplace Health and Wellbeing Unit is planning for a future of mixed delivery of online and face-to-face services to improve the accessibility of the provided services.

By: Esther Gonzalez-Hernando, et al.

Source: [17]

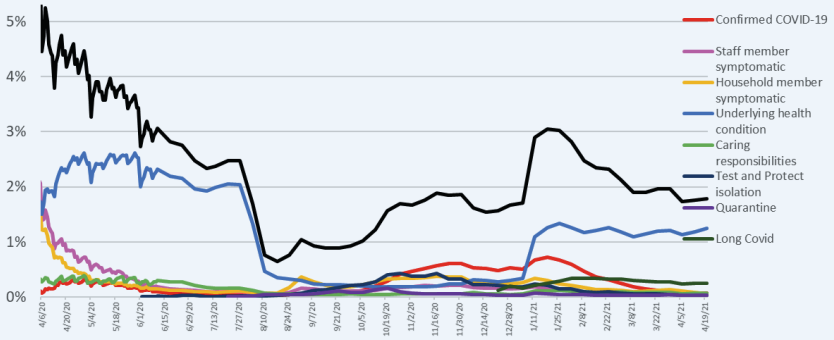
Governance implications for expanding the workforce to support vaccination campaigns

A population wide delivery system for vaccinations must have workforce at its core. While health workers that normally perform vaccinations, in particular physicians and nurses, have been tasked with administering COVID-19 vaccinations in most countries, some countries have also implemented skill mix changes to expand the workforce staff profile of authorised vaccinators.[18] For example, authority to perform vaccinations has been granted to dentists (Ireland), doctors' assistants (Germany, Netherlands), medical students (Austria, Belgium, UK), paramedics (Austria, Israel, Ukraine, UK), pharmacists (Portugal, Switzerland), physiotherapists (UK) and speech therapists (UK). Some countries have also involved military personnel,

Box 3: NHS Scotland closely, monitors and manages staff absence

The NHS in Scotland used an absence monitoring and reporting system which provided almost 'real time' reporting, updated every week. Absence rates were reported in standard format, by regional health authority (Health Board), by main occupation (nurse, doctor, etc.), and by type of absence (non-COVID related absence was identified separately; and eight types of COVID-related absence were reported) (see Figure below). This rapid, standardised, unified whole system reporting of absence rates and types of absence supported more effective governance of the system, in terms of responsive policies and informed management.

Figure 1: NHS Scotland: COVID-19 related types of staff absence over time, March 2020 to April 2021



Source: Scottish Government, NHS Scotland.

This unified system covered about 170,000 staff in total, working in the NHS in Scotland. The ability to tap into existing data reporting systems using standard definitions and data templates helped the rapid response, national analysis and reporting. The ability to connect directly with 170,000 employees was also used to conduct research, led by Public Health Scotland, on other aspects of COVID impacts on the population*.

* See for example Shah ASV, Wood R, Gribben C, et al. Risk of hospital admission with coronavirus disease 2019 in healthcare workers and their households: nationwide linkage cohort study. *BMJ* 2020;371. doi: https://doi.org/10.1136/bmj.m3582

or utilised members of the public and trained volunteers ("peer" and "non health care") to administer vaccines (Belgium, Ireland, UK).[18]

There are obvious governance implications to using "new" types of workers to vaccinate, most notably where there is legislation and/or regulation that in normal times limits which professions can be involved (**see Table 1**). Introducing skill mix changes has necessitated the implementation or suspension of such existing legislation, while in some cases (e.g. Italy) legislation has needed to clarify or extend medical indemnification to health workers newly tasked with administering vaccines. Rules in most countries also still require those vaccinating to be supervised by a registered nurse or physician.[13]

In order to administer vaccines, health workers in most countries have been required to undertake online or in-person training, which was often adapted for different vaccines (e.g. Estonia) or skills of the person undertaking it (e.g. Belgium).[13] Training of volunteers (both with and without medical experience) to assist in all other operations of the vaccination process, including check-ins, taking vitals, helping vaccinators complete paperwork, and staying with people in the recovery area following their jab has also been required. While training in these support aspects of vaccination delivery usually do no necessitate legislative changes, it does have implications for management governance.

> "provide opportunities for building a more resilient workforce in the future

Training has been accompanied by the publication of clinical guidance and protocols in some countries (e.g. Ireland, UK), that have been updated as evidence evolves and new vaccines are authorised.[13] Adjustments to payment mechanisms have also been required to support health workers to carry out vaccination, which has often required legislative changes to be made (e.g. Romania), negotiations with professional bodies (e.g. UK) and/or government approval for additional funding (e.g. Ireland).

Workforce governance is at the core of the recovery

Rapidly scaling-up and repurposing the health workforce during COVID-19 has had enormous implications for health workforce governance structures at the national, sub-national and local levels and for coordination and cooperation across all stakeholders. At the time of writing, there has been little comprehensive evaluation of the impact of these governance measures for health workforce planning, recruitment, deployment, management and training; there are thus more lessons to learn and share about how effective the different workforce governance responses have been, in order to be better prepared for the future.[9,19]

While the pandemic has proved challenging for the health workforce and those involved in its governance, it may provide opportunities for building a more resilient workforce in the future. In many countries, some of the pandemic responses have broken up sclerotic governance structures which have hampered past health workforce development and reform. For example, changes to scope-of-practice that have previously been resisted (e.g. allowing pharmacists to vaccinate) have been implemented with unprecedented speed, while new competencies and training programmes have been rapidly developed, often making use of online delivery. Meanwhile, leadership roles have been delegated to health professionals that did not have them in the past. Monitoring systems that provide more rapid data on staffing levels have been put into place, facilitating greater coordination between health facilities and between health organisations and policy-makers at different levels. Learning from these governance changes will be important to help inform future pandemic responses, and can also provide insights into how governance of the health workforce can be strengthened.

The WHO European Programme of Work 2020–25 has recognised that Member States will face post-COVID-19 recovery related health workforce challenges.[20] The 2021 World Health Assembly further reinforced that Member States should prioritise investments in a sustainable health and care workforce that is responsive to population needs, universal health coverage and future preparedness and response capacities, aligning with the Year of the Health and Care Worker theme: *Protect. Invest. Together.*

Health system recovery and future preparedness will be dependent on the workforce and the continuing ability to flexibly mobilise, train and deploy sufficient health and care workers with the necessary skills, whilst also making effective use of technology. In turn, the workforce itself must be "protected": supported and enabled to recover, rebuild and repurpose. Notably, the pandemic has left its mark on workforce health and well-being, with increasing concern about workforce absence, burnout and the potential of higher levels of turnover and early retirement. If the workforce is to be both effective, and effectively protected, then system responses will have to be channelled through the four strands of workforce governance which have been identified in this paper, with appropriate coordination by the different responsible authorities.

Box 4: The Israeli vaccination workforce has been led and managed by the nursing profession

Managing the COVID-19 vaccination campaign in Israel was a complex and significant challenge that involved aspects of policy, legislative, and management governance.

To meet the campaign objectives defined by the Israeli government, the Ministry of Health (MOH) published a professional outline defining the groups within the health workforce which were authorised to vaccinate, the training and professional competences required, and the legal authorisations enabling them to do so. According to the outline, the workforce authorised to vaccinate included doctors, nurses, and certain advanced medical students and paramedics.

The Nursing Division at the MOH formulated a national training programme for all vaccination teams, and conducted webinars with thousands of physicians and nurses. Videos, information sheets, and posters were also produced and distributed to all clinics, forming the professional basis of clinical knowledge required to deliver the vaccination programme.

The chief nurses at the health plans and hospitals have led and managed the vaccination campaign workforce. They deployed personnel to vaccination clinics, trained them according to the required programme, supervised and monitored their quality and safety of practice with structured tools and procedures.

One significant resource, which reinforced the nurses, were civilian paramedics who had been certified in the past as military paramedics, and had since maintained ongoing professional qualification. This was the first collaboration of its kind between the MOH and the Israeli Defense Forces (IDF). More than 700 paramedics were recruited and trained by the health plans for four months, and worked under the direct supervision of the nurses. Within this framework, paramedics received access to patients' digital files for assessing and documenting and were required to meet the standards of safety and quality.

By: Shoshy Goldberg, Elza Lavon.

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Use of digital health tools in Europe: before, during and after COVID-19

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Digital health tools hold the potential to improve the efficiency, accessibility and quality of care, but widespread adoption in Europe had been slow prior to the COVID-19 crisis. Many digital health tools nevertheless moved from being viewed as a potential opportunity to becoming an immediate necessity during the pandemic, and their use increased substantially. This forthcoming policy brief takes stock of how digital health tools have been used in Europe during the COVID-19 pandemic, in order to review what has happened, assess how uptake and use of these tools has been facilitated, identify issues that are emerging, and learn lessons for the longer term to support the sustained use of digital health tools in the future.

The authors show that digital health tools have been used to support four main areas during the pandemic: communication and information, including tackling misinformation; surveillance and monitoring; the continuing provision of health care such as through remote consultations; and the rollout and monitoring of vaccination programmes. Policy changes to regulation and reimbursement, investment in technical infrastructure, and training for health professionals has been needed to facilitate utilization. The authors conclude by arguing that greater strategic investment is needed longer term to support developments in digital health, targeting both the development of infrastructure within the health setting and outside (e.g. internet provision), and research and development to ensure that technologies continue to evolve.

GOVERNING THE PUBLIC-PRIVATE-PARTNERSHIPS OF THE FUTURE: LEARNINGS FROM THE EXPERIENCES IN PANDEMIC TIMES

By: Florian Tille, Dimitra Panteli, Nick Fahy, Ruth Waitzberg, Nadav Davidovitch and Alexander Degelsegger-Márquez

Summary: When observing countries' responses to COVID-19, conclusions can be drawn on the modalities, successes, failures and governance challenges of partnerships between the public and private sectors during the pandemic. In the United Kingdom, Israel and Austria, these partnerships have contributed substantially to the overall emergency response, albeit with gaps and weaknesses in their structures and processes. These have differed from those of typical public-private partnerships. To be sustainable, partnerships need to be based on key principles of good governance, notably transparency and fairness as well as equity and social justice, all of which may be strengthened both during and post-pandemic.

Keywords: *Public-private partnerships, Governance, Transparency, COVID-19*

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Introduction

Since the onset of the COVID-19 crisis, it has become clear in many countries across the European region that government departments and public sector bodies were not sufficiently equipped to effectively respond to this public health emergency. Private sector capacity has made major contributions and rapid, innovative solutions where private actors working in partnership with the public sector were critical to strengthen some existing services and develop new ones. At the same time, the lack of transparency and inefficiencies also became apparent. In the long term, it is crucial to assess whether the introduction of such partnerships, creates or exacerbates social and health inequalities.[1]

The scope for these public-private partnerships (PPPs) has ranged broadly across health system elements. Examples include collaboration at national and international levels on the research, development and deployment of COVID-19 vaccines; providing personal protective equipment (PPE), medical equipment and ICU surge capacity in

hospitals; developing and implementing applications for surveillance and monitoring; increasing testing and laboratory capacities.

> transparency remains a key safeguard to enable subsequent scrutiny

Many of these partnerships between public and private actors worked efficiently to speed up research by using public funding, to enhance production facilities, to streamline approval and administrative processes and to make planning for future supplies more efficient, but there have also been significant challenges. Relying on such partnerships in the long term could potentially weaken existing public structures, which are commonly the main foundation for public health responses.[2,3]

Governance issues played a critical role in their successes and failures. This paper examines selected examples of PPPs, aiming to enhance the understanding of these arrangements in the context of a public health emergency as well as of the governance aspects that have proven indispensable to these in the response to COVID-19.

Conceptual aspects and principles of good governance of PPPs

PPPs are typically thought of in terms of large infrastructure projects. They are understood as long-term (i.e. running for years or several decades) working arrangements based on a complex contractual commitment "between a public sector organisation with any other organisation outside the public sector".[4] Essentially, they involve the sharing or reallocating of risks, costs, benefits, and responsibilities between public and private partners to provide services.[5] PPPs are argued to have advantages over traditional public sector projects by improving the design of a public service and enhancing its quality, while delivering value for money and increasing the efficiency of public investment,[4] provided that the right institutional capacities and processes are in place. The *governance of PPPs* comprises rules and procedures that define the incentives and requirements guiding the strategies of the various stakeholders that engage in a PPP, including a range of complexities and difficulties in making PPPs work effectively on different levels. Criticism of PPPs puts them in the context of other neo-liberal reforms and the retreat of the state from its social obligations, leading to the commodification of health, inequities and even inefficient systems.[2,6]

There are various models of good governance for PPPs. Drawbacks of PPPs in the absence of effective governance might include unbalanced risk sharing thus high risk for wasting public money, while still being profitable for the private sector. Other concerns might be over creating hidden debts, corruption, and distorting public policy priorities. The United Nations Economic Commission for Europe's guidebook identifies the following core principles for good governance of PPPs: [7]

- *Participation* (involving stakeholders);
- *Decency* (undertaking the partnership without harming third parties);
- *Transparency* (taking and communicating decisions clearly);
- *Accountability* (being responsible for actions and outcomes of partnership);
- *Fairness* (applying rules equally to everyone); and
- *Efficiency* (using human and financial resources without waste, delay or corruption).

Similarly, the Organisation for Economic Co-operation and Development (OECD) highlights three overall processes as critical for successful PPPs: [8]

- establish a clear and legitimate institutional framework;
- ground the selection of PPPs in value for money; and
- manage the budgetary process transparently to minimise fiscal risks and ensure the overall integrity.

In practice many of these directives are hard to fulfil; market failures such as cream-skimming, duplication of services and access problems can be the consequences.

PPPs are context-specific, and a product of policy and political cycles. Indeed, while forms of the private-public mix in health care are emerging in countries, their specific form depends on both the local context and the global changes in the political economy of health. The COVID-19 pandemic has created a unique set of needs and pressures for partnerships between the public and private sectors. Building on examples from three countries, the following sections look at 1) the types of PPP created during the pandemic, and what insights they provide for the role and shape of PPPs during a time when many countries declared national emergencies, and 2) to what extent core governance principles and processes also apply in this extraordinary context. It concludes with an outlook on lessons learned for post-pandemic opportunities.

Examples of partnerships to counter the challenges of the COVID-19 pandemic

There have been PPPs in all areas of the emergency response during COVID-19, focusing on surveillance, public health prevention and mitigation measures, diagnostics, therapeutics and vaccination in countries. The following examples illustrate some of these, to provide an understanding of the scope, aims and outcomes of PPPs newly established during the pandemic.

A) United Kingdom – expanding the supply of PPE

A key area where the UK government sought active cooperation with the private sector was on supply of PPE, for which the COVID-19 pandemic produced an urgent need.[9] In late March 2020, the national government established a new supply structure aiming to rapidly source and distribute PPE from a combination

of existing and new suppliers, whether recommended by government contacts or those who offered help through a government online portal. This supply structure used streamlined procurement procedures, with the competitive dimension of tendering reduced or eliminated, and simplified oversight within government. Arguably, this enabled public payers to act in a more expedient and agile way. At the same time, it is important to consider the extent to which this element of fast-tracked contracts to government-recommended suppliers is commensurate with the notions of transparency and accountability for the disbursement of public funds.

> consideration of good governance principles and mechanisms is pivotal

The process was largely successful, although there have been widespread reports of local difficulties and shortages of PPE. Moreover, although there have been some instances of PPE being purchased which has proved unsuitable for its intended use, the government estimates that this affected less than 1% of the items of PPE purchased.[10] There has, however, been a lack of transparency about the contracts that have been awarded, with many awarded without competitive tendering or not being published within the normal timelines. Concerns about transparency and due process was exacerbated by the creation of a "high-priority lane" for potential suppliers suggested by ministers, Members of Parliament and other officials, which resulted in contracts for a much higher proportion (around ten times) of potential suppliers than those identified through the normal lane.[10] The cost of the PPE purchased has also been significantly higher than before the pandemic, although it remains unclear how much of this is due to the much greater competition for limited supplies, and how much due to the purchasing approach taken.[9]

B) Israel – monitoring waterwaste and post-vaccine surveillance

One example from Israel has been the partnership between the Ministry of Health's (MoH) Central Virology Laboratory with the private company Kando in the area of surveillance and early warning for SARS-CoV-2 circulation through the monitoring of urban wastewater systems. In May 2020, Kando approached the MoH to initiate a sewage surveillance project. The project was piloted, and when the model proved to be effective, expanded to 14 cities in October 2020. In collaboration with two public state universities, Kandu is responsible for taking sewage samples, while the universities perform the virologic testing, analysis, and provide the diagnoses to the MoH. The MoH and universities validate the results and combine them with epidemiological data.[11] [12]

This collaboration was promoted by the "Control Centre of the COVID-19 task force" of the MoH as an attempt to enhance the surveillance of COVID-19 during the outbreak and maintain it for the long term. During the pilot, Kando provided the equipment, charging only for the sampling services. At the time of writing, there are ongoing negotiations to expand the system to the national level.[13] While this collaboration was shaped with the participation of different stakeholders from its initiative, it is important to remember that the context of the pandemic necessitated a less standardised decision making process, and further deliberation is needed to turn this project into a more organised and long-term endeavour.

Another partnership in Israel is the epidemiological evidence collaboration agreement between the Israeli Government and Pfizer, signed in January 2021. The partnership aims to measure and analyse epidemiological data arising from the rollout of Pfizer's COVID-19 vaccine, primarily to determine whether herd immunity is achieved after reaching a certain percentage of vaccination coverage in Israel and to conduct high level post-marketing phase IV surveillance for efficacy and side effects.[14]

The agreement followed relevant regulatory requirements of the health system, including patient's rights and privacy protection laws. Following privacy concerns in the population once the agreement was made public, details were partially published on the MoH website. It resembles Israeli standard clinical trial agreements between public research entities and private drug manufacturers. According to the agreement, in early January 2021 Israel purchased from Pfizer sufficient doses to offer inoculation to its entire population in a short period of time, with Pfizer guaranteeing adequate supply. The MoH provided Pfizer with aggregated and anonymised epidemiological data to study population immunity reached through the vaccine. Data analysis and the publication of results were conducted jointly and published in academic peer review journals.[15]

The two parties had been working on the agreement since early in the pandemic, and the government took the initial risks of this vaccine not being approved or effective. The agreement enabled Israel to vaccinate in record time, contributing to reducing COVID-19 mortality and morbidity.[20] Pfizer gained data that facilitated the completion of phase IV of the COVID-19 vaccine trial. Several NGOs and think tanks in Israel have raised other concerns such as who owns the data and who will gain from this, and similar contracts between non-profit public health funds and pharma companies.[16]

C) Austria – contact tracing

When the contact tracing app *'Stopp Corona'* was released in late March 2020, Austria became one of the first countries in Europe to offer a contact tracing app for COVID-19 cases. The app was developed independently by the Austrian Red Cross, in a partnership with the private consulting company Accenture as the project management lead. Funding for developing and operating the app was initially provided by the private

UNIQA foundation. The app was presented to the Austrian government for endorsement. The Austrian MoH included it in the government's wider COVID-19 containment strategy and, following a government decision in July 2020, decided to take over the funding until the end of 2020.

The app has been downloaded 1.4 million times (as of mid-April 2021), representing around 15% of the country's population.[17] In comparison, a similar app in Germany has been downloaded by around one third of its population (ibid.). The ongoing technical development of the app is decided by the *'Stopp-Corona-Plattform'*, which includes representatives from different civil society stakeholders (e.g. government, health and social care, data protection, faith groups). The Red Cross remains in a decision-making position, and Accenture as the project manager. This set-up aims to improve the transparency, degree of inclusiveness, and public's approval of the project, hence increasing the use of the app, after issues regarding the public trust in the data protection and storage as well as on the voluntary nature of the app were identified as some of the major barriers to uptake.[18]

Learnings, shortcomings and challenges of PPPs during the COVID-19 pandemic

As these and other examples show, different partnerships between the public and private sectors have contributed to containing, mitigating and suppressing COVID-19. While evidence on their effectiveness is not yet available, many have demonstrated the potential for outcome-focused, creative ways of mobilising skills, funds and capacities to help achieve public health goals.

These partnerships have mostly not followed the typical model of PPPs as described in the introduction. Tension between the necessity to partner and act swiftly, while attempting to fulfil good governance requirements such as equity, competition and transparency, has shaped different practices during the pandemic. First and foremost, the time horizon for these arrangements has been very different to conventional PPPs: they were established and performed rapidly during the weeks and months of the emergency response, instead of over years and decades. Consequently, these partnerships have not typically been formalised through the complex contractual arrangements that often characterise PPPs (even in the field of research and innovation funding). Rather, they have been put in place through accelerated exceptional procurement procedures, often reducing or eliminating standard processes (e.g. tenders) without following other validated governance conventions.

Secondly, the private sector's innovation supply push played a more important role in the demand formulation than usual. This overburdened government actors, who are used to procurement when public demand is already clear. Many MoHs were overstretched with filtering innovative ideas while figuring out what the public sector demand in the crisis situation may actually be.

Thirdly, rather than seeking calculated risk sharing with the private sector, governments have frequently acted during the pandemic to take on additional risk themselves, in particular through investing large amounts of funds with a much higher uncertainty regarding the returns and outcomes as well as the value for money involved than has been the case pre-pandemic. COVID-19 has created a high-risk environment, where the private sector has borne entrepreneurial risk in search for returns from public contracts, while the government has accepted risky procurement and partnerships. Neither parties have had the necessary time and resources to deliberate and formalise risk-sharing in long-term PPP contracts.

On the one hand, the speed and flexibility with which many PPPs have been established and functioned during the pandemic have made a valuable contribution to overall response efforts. On the other hand, the reduced procedures and increased acceptance of risk by the public sector raise questions of equity, privacy, and value for money, and hence whether such models are appropriate and sustainable in non-pandemic times. While simplification of procedures is understandable and necessary during an emergency period, transparency remains a key safeguard to enable subsequent scrutiny, and this transparency has been widely lacking during the pandemic. This deficit of public information in many countries on the exact features of these PPPs hinders any assessment of how well they have performed, how fair the processes were that put them in place, and the value they represent. Beyond evaluating their immediate effects, follow-up should also assess their long-term sustainability, impact on capacity in the public sector, and their influence on health inequities and social justice.

Prospects for sustainable, well-governed PPPs post-pandemic

The pandemic created a unique set of circumstances, and we should be cautious in drawing lessons for PPPs more generally. Nevertheless, this period has shown the ability of both sectors to collaborate towards meeting shared goals under heavy time pressure and uncertain legal conditions. The full degree of success is yet to be assessed, requiring continuous monitoring and evaluation. However, early insights are already available regarding both successes and concerns, as highlighted by the country examples and below.

One key area concerns how outcomes were achieved during the pandemic through innovative solutions and flexible forms of collaboration between public and private partners. This contrasts with the notoriously complex and time-consuming character of traditional PPP contracts, and aligns better with perspectives on how hybrid spaces of collaboration between public and private sectors can help to facilitate innovation.[19]

PPPs will remain an important component of the arsenal underpinning governments' strategies throughout the recovery phase of the pandemic as well as for future threats. For instance, the G7's new partnership on pandemic preparedness includes governments, international organisations and industry.[20] The PPPs of the future may combine the best of both worlds: a long-term perspective and shared risk, as well as fast reaction times in case of crises. Further evaluation is needed to

assess the potential of such fluid forms of partnerships – what these are, what they can achieve for the public good and under what conditions. Equally important is to see that the public health sector is funded in sustainable ways that enable strong public health systems to emerge and react to emergencies.

In order to maintain public trust in such partnerships, consideration of good governance principles and mechanisms is pivotal. While streamlined processes are appropriate during an emergency phase, and there may be value in more flexible forms of cooperation, transparency remains of immense value in enabling the subsequent scrutiny that can help to maintain trust and support learning. The decisions made by public and private actors during emergency periods can have a direct and long-term impact on equity in a country, and these innovative partnerships may become a model for the future. Considering influences on social and health equity is crucial as well as understanding who is carrying the risks and who is gaining from such arrangements. Transparency is thus not only a value in itself shaping organisational performance, but is linked to other key principles of good governance, such as participation, accountability, efficiency and fairness. Its shortfall can lead to the failure of a PPP and result in a loss of trust by the public, undermining overall efforts of a government's emergency response.

As European countries are emerging from the height of the pandemic, there is an opportunity to learn from the novel PPPs that have emerged during this emergency period, both to improve performance, and safeguard against inequities, and to ensure the public's trust in governments working with the private sector. These lessons can also help to reshape governance frameworks for PPPs for the future, both for peacetime and for pandemic preparedness.

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‘BUILD FORWARD BETTER’ MUST INCLUDE HEAVY INVESTMENT IN GOVERNMENT CAPACITIES TO ENGAGE WITH COMMUNITIES AND CIVIL SOCIETY

By: Dheepa Rajan, Kira Koch, Sascha Marschang, Caroline Costongs, Katja Rohrer-Herold, Naomi Limaro Nathan and Gabriele Pastorino

Summary: Civil society and community groups are active players in the COVID-19 response, providing support, advice and information where government reach is poor. Yet most governments have not managed to bring civil society’s perspectives, insights, and experiences into the COVID-19 response in a systematic way. If the world is to ‘build forward better’, more regular and systematised government-civil society engagement will need to underpin a shift towards more inclusive health governance. Doing so successfully will require heavy investments in capacity-building for government actors to value and feel comfortable managing and sustaining participatory spaces and in skills to bring forward the kind of governance needed to build resilience against the next pandemic.

Keywords: *Civil Society, Community Engagement, Decision-making Processes, Governance, COVID-19*

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2020: Insufficient government engagement with civil society for the pandemic response

The Coronavirus pandemic has exacerbated entrenched inequities in society, affecting the most vulnerable and marginalised more harshly than others.[1] Yet many governments woke up to that reality fairly late into 2020, partly because the governance mechanisms put in place for the COVID-19 response did not systematically engage with those very communities affected most by both the virus itself as well as the restrictions put in place to suppress viral spread.[2,3]

Where there have been gaps in government reach, civil society and community groups have stepped in and played a vital, often intermediary role, providing support, advice and information to lay people and hard-to-reach population groups,[4,5] (**see Box 1**). By doing so, civil society in many settings also took on

a monitoring or watchdog role, either inherently or explicitly, due to their insight and access to how government measures were playing out in communities.

> neither fully transparent nor inclusive nor particularly diverse

Yet without a more inclusive, institutionalised health governance approach, these very insights from civil society and community groups were not always capitalised on for the emergency response. Instead, individual civil servants' willingness to value, hear, and act upon the lived experiences and challenges encountered by different parts of society often determined whether it was considered at all.

The acute nature of the crisis was often cited as justification for a closed-door, default mode of governance that was neither fully transparent nor inclusive nor particularly diverse.[2,9] To the contrary, many governments responded to the pandemic seeking advice predominantly from a rather narrow medical-technical expert circle, leaving out the diverse group of voices needed to remind policy-makers that the COVID-19 pandemic is much more than a health crisis but rather a syndemic* precipitated by socially patterned inequities and the social determinants of health.[10]

Numerous calls were thus made in the early months of the COVID-19 crisis to engage more broadly,[2,3,5,9,11] with governments increasingly acknowledging the importance of collaborating with communities and civil society.[12] Yet, more than one year into the pandemic, how has that translated into practice?

* A syndemic is a situation in which two or more interrelated biological and/or social factors work together to make a disease or health crisis worse.

Box 1: An example of civil society's COVID-19 response actions: Ireland

An Irish civil society organisation working with indigenous Traveller communities highlighted the value of a trust-based collaboration with government authorities, commenting in a recent survey (see next section for survey details): "We have seen real goodwill, support and collaboration [from government]".

The fruitful government-civil society partnership led to a series of tailored government COVID-19 response measures including: prioritisation for COVID-19 testing and vaccination, provision of targeted emergency facilities, Traveller accommodation to self-isolate where necessary, and Traveller representation in the local COVID-19 response committees.

The win-win of this collaboration is further demonstrated by Irish Traveller communities largely rating health systems interactions during the pandemic as positive,[6] while being spared both the huge disparities in Covid outbreak numbers seen across itinerant minority groups in other European countries,[7] as well as their increased marginalisation.[8]

2021: A rapid survey in the European region to understand developments in government-civil society engagement

A rapid survey was conducted from 20 May to 4 June 2021 by the World Health Organization (WHO), the European Public Health Alliance (EPHA) and EuroHealthNet to gain a better understanding of developments in government-civil society engagement over the course of this protracted pandemic. The survey's aim was also to get a sense of both key challenges and solutions for meaningful engagement in the WHO European Region.

The survey link was shared via EPHA and EuroHealthNet networks as well as disseminated by the WHO European regional and country offices to civil society partners. Respondents therefore reacted on their own volition to an open call (self-selection). A total of 34 respondents from 18 countries, including three who work at pan-European level, answered a mix of multiple choice and open-ended questions. Responses were analysed using a coding framework in a qualitative data software programme (Dedoose®).

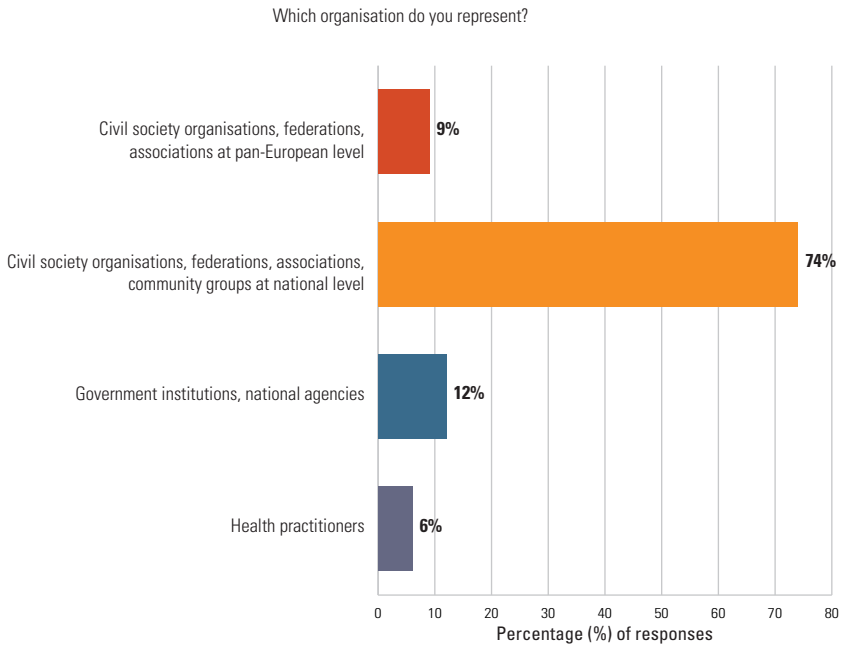
We explicitly emphasise that the simple and rapid nature of the survey does not allow for any representative conclusions. Nevertheless, we take the pulse on trends in COVID-19 governance in the European Region almost 1.5 years since the start of the pandemic, with a focus on any potential changes or improvements over time. By doing so, our survey paints a picture of government-civil society engagement which is often irregular, unsystematised, and ad-hoc. In order to render it more institutionalised and integral to sectoral modus operandi, we argue that specific policy-maker capacities need targeted prioritisation and investment, especially if the world is to truly 'build forward better'.[13]

Main findings from the rapid survey

By far, the majority of respondents came from civil society and community groups working at national level (**see Figure 1**). The remaining respondents were government authorities, civil society active at pan-European level and health practitioners. There was a fairly even 50–50 split of respondents from the Western, higher-income part of the WHO European Region versus the upper and lower middle-income Eastern part of the region.

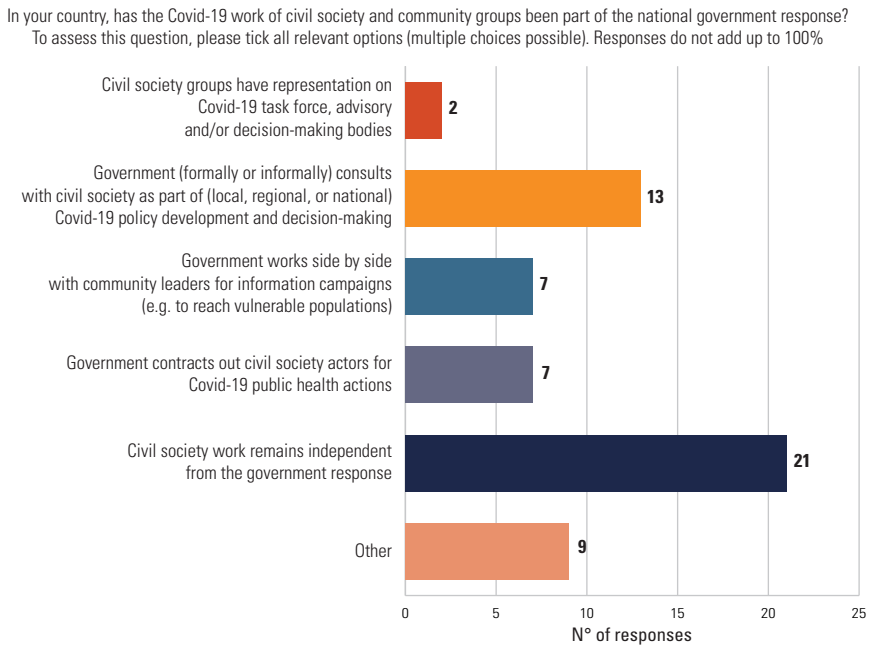
More than half of the respondents stated that civil society work remained largely independent from the government-led COVID-19 response (**see Figure 2**), with a small sub-set of those respondents specifying further that parallel engagement channels were sometimes used with individual government actors.

Figure 1: Survey responses predominately reflect civil society's views and standpoints *



* The source for all figures relates to the survey 'Engagement between government and civil society during the COVID-19 response'. WHO, EPHA, EuroHealthNet, 2021.

Figure 2: Despite some good pockets of cooperation, civil society's COVID-19 work remains largely independent from the government response



Some 32 out of the 34 respondents (representing 16 out of 18 countries) reported that civil society representation was absent from their country's COVID-19 task force.

Roughly two-thirds (68%) of all respondents described government's engagement with civil society actors as sporadic and unsystematic (**see Figure 3**), with one civil society respondent regretting that since *"no formal mechanisms (are) in place, … [the interaction is] often ad-hoc and contingent on individual civil servants"*. The respondent continues by describing the government approach to civil society collaboration as *"often reactive rather than proactive [for] policy planning and/or responses"*. Out of the 68%, roughly three-quarters assessed government follow-up subsequent to the ad-hoc engagement to be 'little, if any', and only one-quarter as 'good'.

Almost one-fifth (18%) of all respondents reported no government-civil society engagement at all, while only 9% indicated regular engagement through established channels for participation and communication. To be noted are variations in government engagement with communities within the same country, with the picture at sub-national levels sometimes more positive than at national level. For example, one civil society at pan-European level respondent pointed out: *"Cooperation at local and municipal level is relatively good, while the cooperation and dialogue at national level is limited"*.

Half of the respondents did not think that government-civil society collaboration and engagement has improved (50%) over time (**see Figure 4**), and a further 29% assessed improvements as minor, compared to those who assessed them as moderate (18%) or even substantial (3%).

Overall, the 2021 European region survey results reinforce findings from a global 2020 survey [4] among more than 200 civil society actors from 58 countries. The 2020 survey results also highlighted the disconnection between civil society's actions and the

government's COVID-19 response. Interestingly, the 2020 civil society respondents pointed out that where active collaboration did prevail, risk communication was felt to be more effective and communities more willing and able to adhere to preventive measures.

2021: Government engagement with civil society for the pandemic response remains ad-hoc

The government COVID-19 response thus continues to be largely disconnected from the actions and efforts of civil society to address the crisis. The insights gained from civil society's engagement with communities are also not systematically brought into decisions made for the COVID-19 response, with governments losing out on adapted policies and more adherence to pandemic restrictions.

Survey results drive home the message that the ad-hoc, one-way nature of government engagement with civil society and communities does not provide the necessary platform to enable fruitful and meaningful collaboration with longer-term impact. As expressed by one respondent: *"We clearly state the needs/wishes/demands and there is hardly any feedback".*

Ensuring more regular and systematised government-civil society engagement (**see Box 2**) requires political will and prioritisation. It also calls for a shift in mindset which recognises that meaningful interaction is fostered when policy-makers make visible efforts to listen and accept that one may not have all the answers to solving health system challenges. In essence, an enabling environment must be created where not only the more influential but also the less powerful stakeholders have a real opportunity and feel safe to relate their views and experiences.

The skill set needed to foster such an environment, i.e. knowing how to design and maintain a locally adapted participatory space, is one which many government cadres have not (yet) been adequately trained in. Investing in such training is a crucial step towards cultivating a culture of participation, which can then be a powerful driver for institutionalisation of participatory spaces. A participatory health system culture supported by systematised government-civil society engagement contributes to the resilience needed when a crisis of COVID-19 proportions hits. This is because those very participatory spaces embedded into health system operations can be leveraged in service of an emergency response – rendering the default crisis mode of governance an inclusive rather than an exclusive one.

Figure 3: Ad-hoc engagement with little or no follow up by government authorities is most common

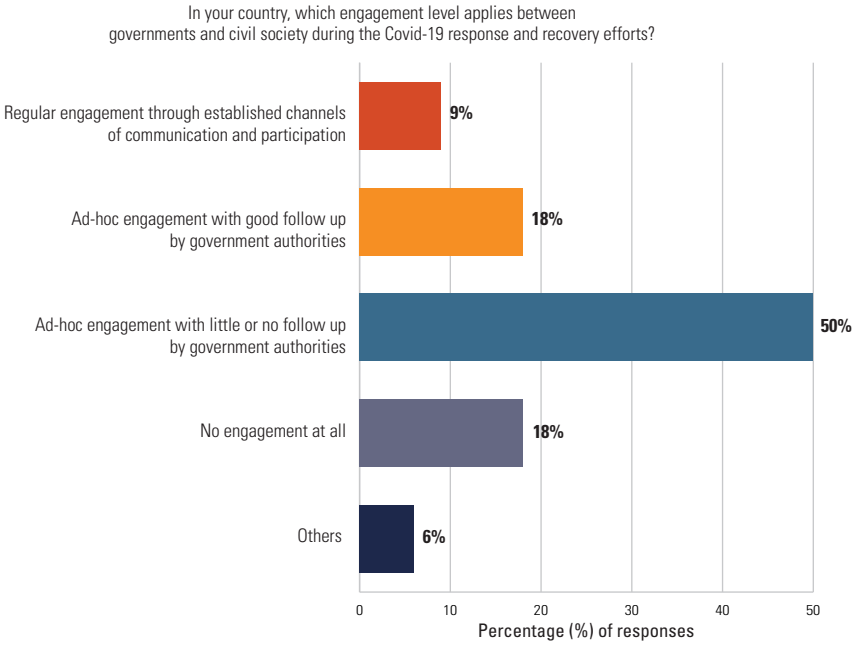
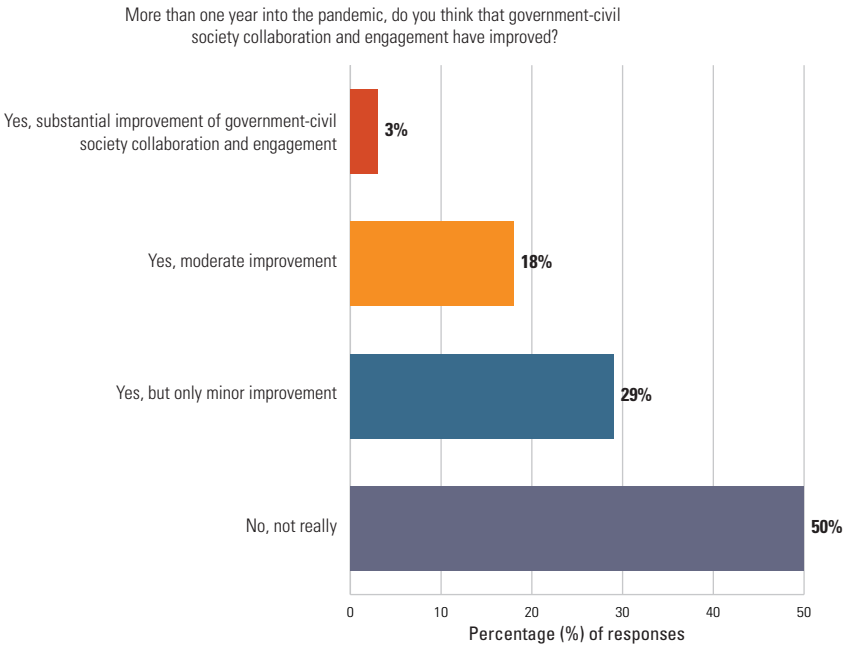


Figure 4: Government-civil society collaboration has not substantially improved during the course of the pandemic



Box 2: Regular and systematised government engagement with the population, communities, and civil society: an explanation[13]

Systematic government engagement with its people, either directly or through the intermediary of civil society, takes place through participatory spaces where people come together physically or virtually to interact with one another.

Various mechanisms can be used by organisers of such spaces to foster communication and debate.[14] A key characteristic is that the interaction should allow for a back-and-forth between participants and/or between organisers and participants, and not only be one-way. Methods used for purely communicating information to, or solely receiving feedback from, a population group (such as surveys, polls, interviews, radio and TV programmes etc.), are also important but should be seen as a complement to two-way dialogue.

A brief overview of participatory spaces are provided in **Table 1**, keeping in mind that there is no single-best participatory mechanism available. Depending on the context, policy objective, and participant profiles, a mix of mechanisms usually serves to balance out the cons of each single one, allowing for more triangulation and validation of information and findings. Most institutionalised social participation mechanisms (for example: National Health Assembly in Thailand, the Societal Dialogue for Health in Tunisia, the Etats généraux de la Bioéthique in France, National Health Council in Portugal) draw on a variety of the below-mentioned participatory spaces for meaningful engagement with their people.

Government capacities to foster meaningful engagement with civil society: a closer look

Recent research on social participation re-affirms that most government cadres working in health struggle with the 'how' of participation.[13] The policy-maker capacity gap with regards to creating, managing, and sustaining long-term, institutionalised participatory processes contributes to the ad-hoc nature of engagement highlighted by survey respondents, with heavy *"[reliance] on individual champions/civil servants"*. Relying on individuals rather than the system leaves engagement mechanisms negatively exposed to high public sector turnover, especially since participatory engagement and building trust rely on fostering relationships over time.

WHO's recently released *Handbook on Social Participation for Universal Health Coverage* offers three capacity dimensions which are most relevant for policy-makers when it comes to both steering a participatory process, and sustaining it over time: recognition, technical, and communication skills.[13] Drawing from our survey, we offer insights into the specific policy-maker capacity needs linked to these 3 dimensions.

Recognition skills essentially encompass acknowledging and understanding the added value of participation for policy-making, i.e. having a strategic vision of how participatory input can enhance one own's work and objectives. Good recognition skills should translate into a willingness to create equitable spaces for participation grounded in government accountability to the population because it is seen as a win-win for all sides. Survey respondents underlined how the lack of recognition skills translated into practice: *"The main challenge was and is the so called "scientific approach" which ignores the experience of the civil society"* deplored one. Another criticised the way government *"misregarded … civil society expertise"*. A view to short-term gain without the longer-term perspective of the common interest in responsive policies is evinced by this sentiment: *"Political interests made decision makers … fear that they will lose the chance to show how effective they were if civil society was involved"*.

Some government cadres may well have recognised the added value of social participation but then struggle with the ***technical skills*** and experience needed to conduct a participatory process. One respondent stated it plainly as government's *"lack of expertise on how to involve civil society actors"* while another saw it as a root cause of *"one road engagement"* with *"hardly any feedback"*.

Governments need to be able to choose the appropriate methods and tools for participation[15] as well as design processes[16] tailored to the context, subject of discussion, and the actors involved. A clear capacity deficit governments evince is the ability to take people's experiential testimonies and relate it technically to the subject at hand.[13] This shortcoming leads to vital information from communities remaining lost or unused in terms of feeding into potential solutions,[17] leading not only to poor policy uptake of social participation results but also bringing down motivation levels of communities to engage on the next policy question.

Motivation levels are also influenced by government's ***communication skills***, that is, the ability to leverage different communication channels to hear and understand attempts by the population, communities, and civil society to express needs.[5] Government cadres also need skills in translating sometimes abstract health systems concepts into relatable and concrete real-life issues in simple, non-technical language which is adapted to different audiences.[13] This links in with feedback communication following public consultation processes which survey respondents generally felt are decidedly rare.

Social participation needs to be at the heart of 'build forward better'

While our rapid survey amongst mainly civil society actors was small and potentially tendentious, it nevertheless sheds light on shortcomings in European countries' Covid response strategies which have manifestly not improved in some areas over the course of the pandemic. Newspaper articles, blog posts, conference seminars as well as peer-reviewed literature over the past 1.5 years generally

Table 1: Overview of participatory spaces[13]

Participatory space	Explanation of the space	Examples
In-person, open for all forums.	Open to everyone; Large sample size, aiming to capture the diverse and divergent views from many different segments of the population.	Citizen forums, public hearings, open-mic events, townhall meetings.
Consultative methods with attendance by invitation.	Open forum for exchange albeit with a smaller and closed, usually invited, numbers of representatives of population groups and technical experts (and others).	Consultative meetings, policy dialogue, stakeholder consultations, focus groups.
Deliberative engagement methods.	Small group of selected participants; Emphasis is on deliberative nature to elicit informed opinions from lay people and others about a specific health topic. Key characteristics include: preparing participants with data & information, allowing sufficient time to reflect and deliberate, ensuring a non-intimidating environment.	Citizen panels, citizens' juries, consensus conferences, planning cells, scenario workshops.
Formalised mechanisms with fixed seats for the population, communities and/or civil society.	A fixed (at least for a certain period of time) group of people coming together to make recommendations and/or decisions. Certain seats are reserved for the lay population, community groups, and/or civil society representatives. The mechanism may be anchored in a legal framework.	Health council, health committee, district committees, citizen advisory boards, representation on steering groups and review boards.

confirm weak government collaboration with civil society, with pockets of good partnerships happening primarily in an ad-hoc manner.[2–5,9]

While ad-hoc interaction may be appropriate for certain policy questions, it should only be a complement to *regular* government interaction with the people they serve. Especially in terms of moving forward in a post-Covid world, countries must prioritise investment in capacities and skills within their public health sectors to ensure that long-term, functional, social participation mechanisms are embedded in sectoral modus operandi. In order to ensure true institutionalisation, such mechanisms should ideally be anchored in a legal framework, and an adequate, and predictable budget. The latter, in particular, is crucial for ensuring regularity as well as relationship- and trust-building which in turn fosters a culture of participation and dialogue.

Systematic and regular mechanisms for social participation also provide the platform for building the skill sets needed for both government and civil society actors to engage effectively in participatory spaces. Investing in such mechanisms can ensure that post-Covid health system reform does indeed build forward better as it contributes to strengthening the very fabric of society, building the resilience needed to not only tackle future pandemics head-on but also to surmount the inevitable 21st century challenges world leaders face with the transition to a more digital, greener economy.

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NEW PUBLICATIONS

Ageing and Health: The Politics of Better Policies

By: SL Greer, J Lynch, A Reeves, M Falkenbach, J Gingrich, J Cylus, C Bambra

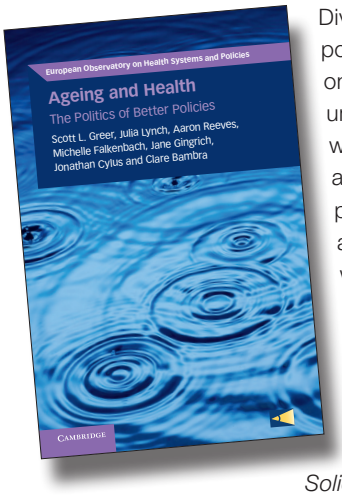
Published by: Cambridge University Press, 2021

Number of pages: xvii + 167; **ISBN:** 978 1 108 97287 1

Download forthcoming: https://eurohealthobservatory.who.int/

Must ageing populations create conflict between generations and crisis for health systems? Our answer is no. The problem is not so much demographic change as the political and policy challenge of creating fair, sustainable and effective policies for people of all ages.

This book, based on a large European Observatory study, uses new evidence to challenge some of the myths surrounding ageing and its effects on economies and health systems.



Divisive and alarmist views of population ageing are often based on stereotypes and anecdotes unsupported by evidence. How we address ageing societies is a choice. Societies can choose policies that benefit people of all ages, promoting equity both within and between generations, and political coalitions can be built to support such policies.

Contents: *Introduction, Older People in Europe, Ageing Equally: Politics, Health and Solidarity, The Coalitional Politics of Win-Wins, Unequal Ageing: the Politics of Ageing As the Politics of Health Inequalities, The Implications of Win-Win and Win-Lose Policies for the 'Ageing Crisis', Conclusion, Bibliography, Index.*

How does Latvia's health sector contribute to the economy?

Edited by: D Behmane, G Scarpetti, K Polin, J Cylus, T Habicht, S Thomson, T Evetovits

Published by: WHO Regional Office for Europe & the European Observatory on Health Systems and Policies, 2021

Number of pages: xviii + 574 pages; **ISBN:** 978 0 521 12582 6

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Health matters. The health sector is an important and innovative industry, as well as a source of stable employment for many people. Health systems support active and productive populations, reduce inequities and poverty and promote social cohesion. A strong health system makes good economic sense and underpins the overall sustainable development agenda.

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This Latvia snapshot is part of the Health and the Economy series which provides country snapshots developed by the European Observatory in collaboration with the WHO Barcelona Office for Health Systems Financing. It draws on cross-country comparable data and country-specific analysis and expertise to explore how well the health sector in Latvia contributes to the economy – and how it can do more, especially in the context of COVID-19.

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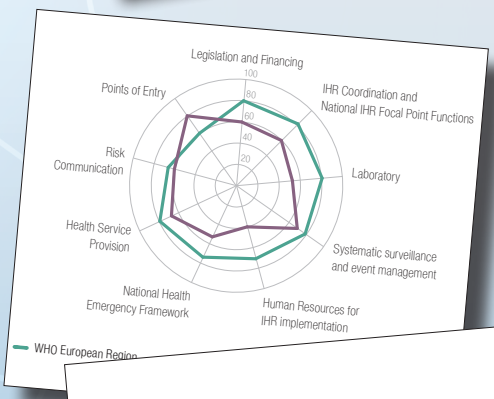
- flag key concerns, progress and challenges health system by health system
- build a baseline for comparisons, so that member states can see how their health systems develop over time and in relation to other countries.

The pilot series is co-produced by the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies. It draws on the knowledge and understanding of the WHO Country Offices and of the Division of Country Health Policies and Systems (CPS), the Barcelona Office for Health System Strengthening and other WHO/Europe technical programmes; as well as the Health in Transition series and the work of the European Observatory on Health Systems and Policies.



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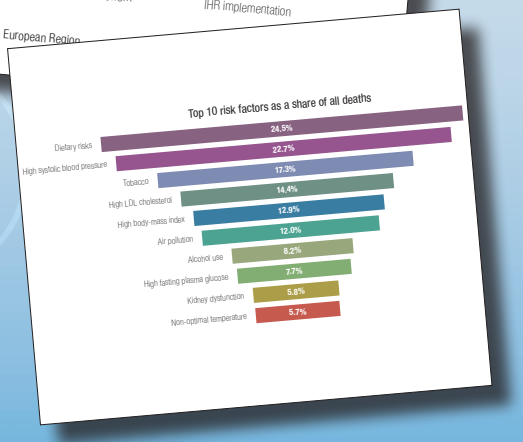

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