



The WHO Council
on the Economics of
Health for All

Health for All – transforming economies to deliver what matters

Final report of the WHO Council
on the Economics of Health for All



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» Physical and mental wellbeing for all people must be a central goal of economies, not just a stepping stone to other objectives. «



Foreword by Dr Tedros Adhanom Ghebreyesus

In 2020, I established the independent Council on the Economics of Health for All, a group of experts in economics, finance, development, health policy and public health, chaired by Professor Mariana Mazzucato. I asked these distinguished thinkers, advisers and activists to do nothing less than completely reimagine the relationship between economics and health.

This final report is the result of their extensive consultation, thinking and leadership over the past 2 years. It provides bold, profound recommendations informed by evidence and experience.

The work arises from a radical and welcome premise: that physical and mental wellbeing for all people must be a central goal of economies, not just a stepping stone to other objectives. To make this happen, "Health for All" must be a key priority across all government departments, not just ministries of health.

The Council has focused on four key drivers of change: reimagining the measures of economic development and growth; improving both the quality and quantity of financing for health; equity-focused governance for new vaccines and treatments; and developing the capacities we need in government and society to deliver Health for All.

My deepest gratitude goes to every member of the Council. These recommendations could change the way countries view and finance health. I hope that policy-makers, civil society and members of the health and economics communities will give full consideration to the recommendations in this report and use them as a starting point to develop new economic policies and structures that can move us along the road to making Health for All a reality.

A handwritten signature in blue ink, appearing to read "Tedros Adhanom Ghebreyesus".

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

Preface by Professor Mariana Mazzucato (Council Chair)

A healthy population is not just human and social capital, or a by-product of economic growth. Health is a fundamental human right. Alongside a healthy and sustainable environment, human

» **A healthy population is not just human and social capital, or a by-product of economic growth. Health is a fundamental human right. «**

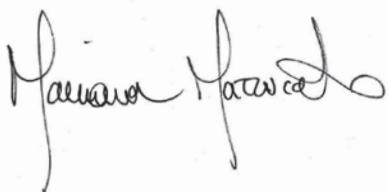
health and wellbeing must be the ultimate goal of economic activity. This goal requires investment and innovation by all actors in the economy, which can also help steer the rate and direction of economic growth. Growth not for growth's sake but for people and planet.

We need a new economic narrative that transforms financing for health from an expenditure to an investment, grounded in fundamental truths: that wellbeing and the economy are interdependent; that health is not only a key economic sector but also a cross-cutting lens through which to view many different sectors; that health is critical to the resilience and stability of economies worldwide; and that states can move from reactively fixing market failures to proactively and collaboratively shaping markets that prioritize human and planetary health.

It has been an honour for me to serve as Chair of the World Health Organization (WHO) Council on the Economics of Health for All. The Council was established in late 2020 by Dr Tedros Adhanom Ghebreyesus (Director-General, WHO) to provide new economic thinking – reassessing how health and wellbeing are valued, produced and distributed across the economy. An all-female group of 10 distinguished economists and area experts, the Council has focused on reimagining how to put Health for All at the heart of government decision-making and private sector collaboration at regional, national and international levels.

» **States can move from reactively fixing market failures to proactively and collaboratively shaping markets that prioritize human and planetary health. «**

The Council – in this report and in its previous work – has recommended policy approaches underpinned by this new economic narrative. The choices made about how to channel and shape public and private investments will determine whether the world continues to struggle with the consequences of major health challenges, or succeeds in creating a new political economy based on *Health for All*.

A handwritten signature in black ink, appearing to read "Mariana Mazzucato".

Professor Mariana Mazzucato

Chair, WHO Council on the Economics of Health for All



Summary of recommendations

The WHO Council on the Economics of Health for All has called for shifts in economic thinking – in each country, region and globally – to prioritize Health for All. Drawing on the Council's previous work, this final report provides 13 bold recommendations across four interrelated pillars:

01

VALUING HEALTH FOR ALL

VALUING THE ESSENTIAL

Treat health and wellbeing, health workers and health systems as a long-term investment, not a short-term cost.

02

HUMAN RIGHTS

Use legal and financial commitments to enforce health as a human right.

03

PLANETARY HEALTH

Restore and protect the environment by upholding international commitments to a regenerative economy which links planet and people.

04

DASHBOARD FOR A HEALTHY ECONOMY

Use a range of metrics that track progress across core societal values, above and beyond the narrow, static measure of GDP.

FINANCING HEALTH FOR ALL

05

LONG-TERM FINANCE

Adopt a comprehensive, stable approach to funding Health for All.

06

QUALITY OF FINANCE

Redraw the international architecture of finance to fund health equitably and proactively, including an effective and inclusive crisis response.

07

FUNDING AND GOVERNANCE OF WHO

Ensure WHO is properly funded and governed to play its key global coordinating role in Health for All.

INNOVATING FOR HEALTH FOR ALL

08

COLLECTIVE INTELLIGENCE

Build symbiotic public–private alliances to maximize public value, sharing both risk and rewards.

09

COMMON GOOD

Design knowledge governance, including intellectual property regimes, for the common good to ensure global equitable access to vital health innovations.

10

OUTCOMES ORIENTATION

Align innovation and industrial strategies with bold cross-sectoral missions to deliver Health for All

STRENGTHENING PUBLIC CAPACITY FOR HEALTH FOR ALL

11

WHOLE-OF-GOVERNMENT

Recognize that Health for All is not just for health ministries but for all government agencies.

12

STATE CAPACITY

Invest in the dynamic capabilities of the public sector, institutionalizing experimentation and learning, to lead effectively in delivering Health for All.

13

BUILD TRUST

Demonstrate transparency and meaningful public engagement to hold governments accountable for the common good.

Health for All at the centre of the economy

The COVID-19 pandemic was an avoidable catastrophe; a direct consequence of a collective failure to govern our world for the common good. For years, warnings about the need for pre-emptive action to protect against the risk of pandemics were ignored. Essential investments in health systems and health workers and in tackling broader sources of vulnerability to disease and ill-health, from poor housing and bad working conditions to entrenched inequities, were not made – though the need for them was clear.

As a result, **millions of people died unnecessarily.** In 2020 alone almost 100 million were pushed into poverty (1). Even the scientifically remarkable achievement of rapidly developing an effective vaccine against COVID-19 failed to prioritize the common good. Within a year, 870 million excess doses had been hoarded by high-income countries (2). Knowledge was not shared, with intellectual property rights remaining in the hands of a few pharmaceutical companies. This dysfunctional dynamic created a “vaccine apartheid”.

However, the problems run much deeper than the latest pandemic. As of May 2023, COVID-19 may no longer be classified as an international emergency, but it has revealed troubling structural issues of inequity. It is now time to act to reshape the economy to deliver on the goal of Health for All.

As part of this call to action, in 2020, WHO Director-General Dr Tedros Adhanom Ghebreyesus announced an expert Council on the Economics of Health for All to **rethink the economy from a Health for All perspective.** We call for shifts in economic thinking and health systems – in each country and globally. Over the last 2 years, our independent council, led by the Chair, Professor Mariana Mazzucato, has argued that Health for All must be placed at the heart of how we design our social and economic systems. It is not enough to say that investing in health is good for our economy. Our economy must be designed to prioritize Health for All.

Providing that inspiration, launched at the 2023 World Health Assembly in Geneva, is the goal of this report.

» **Health for All must be placed at the heart of how we design our social and economic systems.** «



The report provides recommendations based on the four pillars of the Council's work on:

- 1 Valuing Health for All**
- 2 Financing Health for All**
- 3 Innovating for Health for All**
- 4 Strengthening public sector capacity.**

It represents a culmination of the Council's work to date. The Council's webpage (3) provides briefs, with detailed recommendations; statements produced for high-level meetings of the G7, G20, COP26 and COP27; and case studies on promising examples, which if scaled could contribute to transformative change.



The ultimate wake-up call

COVID-19 AND BEYOND

Fighting COVID-19 has cost every government money, but those in low- and middle-income countries (LMICs) have been penalized most by the current terms of international finance. While the richest nations created fiscal stimuli to respond to

extraordinary circumstances, poorer countries were forced to restrain spending and even cut budgets to appease international creditors.

The right to health of hundreds of millions of people has been subordinated to the pressures of short-term debt payments. Indeed, there is a parallel with climate change, which is why at COP27 in 2022, as part of the Bridgetown Initiative, Prime Minister Mia Mottley of Barbados called for greater emergency funding for pandemic preparedness and climate justice in the form of reparations, or “loss and damage” funding. This funding would go from industrialized nations to lower income peers to increase fiscal space for climate change adaptation and mitigation investments.

Health workers, 70% of whom are women, unduly suffered on the frontline in the treatment of COVID-19 for lack of decent protective equipment and support. There remains a huge shortage of health workers globally and especially in low-income countries. While Africa and the Eastern



Mediterranean are the regions most in need: many countries struggle with constraints on their ability to invest in staff. **The world needs to rethink how to value both paid and unpaid health work as well as care giving** more effectively in pursuit of Health for All, including by addressing underlying gender inequality (4,5).

Experts, including WHO (6), have long warned about the dangers of failing to prioritize investment in strong, effective health systems (7), and in addressing commercial (8,9) and social determinants of health (10) that directly influence health outcomes. These determinants also influence people's opportunities and choices for health, and can reinforce inequities based on income, gender, age, region, race and ethnicity. As WHO Director-General Dr Tedros Adhanom Ghebreyesus put it, "realizing the highest attainable standard for health starts not in the clinic or the hospital, but in homes, schools, streets and workplaces." (11)

The ultimate outcome must be that every person should be able to flourish physically, mentally and emotionally, endowed with the capabilities to lead a life of dignity, opportunity and community, as part of a healthy living planet. This is Health for All.

Delivering this transformative vision will demand turbocharging the collective imagination that so far has been sadly absent – for all the talk about the pandemic presenting an unprecedented opportunity for creating an economy that is fit for purpose.

Given how much is at stake, we **must build forward better** to deliver Health for All through collective intelligence and bold action, guided by a new economic wisdom and a sense of urgency.



Health, inequality and climate

OUR INTERLINKED CRISES

Placing health and wellbeing at the centre of conceptions of purpose, value and economic growth is fundamental for societies that are just, inclusive, equitable and sustainable. Given the disastrous consequences climate change is already having on health, **Health for All should be seen as a guiding principle in making a just transition to a post-carbon economy.**

The Intergovernmental Panel on Climate Change (IPCC), the world's leading scientific body on climate change (12), continues to warn us that the clock is ticking, and we are almost too late. Dr Tedros has described the Paris Agreement on fighting climate change as "potentially the most important public health agreement of the century" (13). And yet the goal of the Paris Agreement to keep the average rise in temperatures to 1.5 °C by 2050 could be broken in this decade.

» **Health for All should be seen as a guiding principle in making a just transition to a post-carbon economy. «**

Climate and health are deeply interlinked: transitioning to clean energy, more sustainable food systems and cleaner transportation systems has the potential to generate massive public health benefits in the coming years. It also creates the basis for a sustainable economy that operates within planetary boundaries and creates new job opportunities and innovation.

Worldwide, air pollution from burning fossil fuels is responsible for a global total of 10.2 million (14) premature deaths, roughly the population of Bangkok or Hyderabad. Climate change is on a course to cause 83 million (15) excess deaths by the end of the century due to rising temperatures caused by greenhouse gas emissions.

Human health relies on a healthy planet. Human and planetary health, in turn, are critical to the resilience and stability of economies worldwide. But the science is clear – current economic thinking does not respect our capacity to live fulfilled lives within planetary boundaries.

It is evident that the three great crises of our time – health, inequality and the climate emergency – are profoundly interconnected, and none respects national borders.

The populations of LMICs suffer most in times of hardship. Within these populations, persistent differences based on race, class, gender and age shape people's vulnerabilities. COVID-19 is only the latest crisis to demonstrate this. For example, in sub-Saharan Africa, among 15- to 19-year-olds, six out of seven new HIV infections are in females (16). Regarding age, a survey of 133 countries found that when catastrophes strike, it is the poorest households with older dependent adults that experience the greatest financial hardship (17).

In thinking about interlinked crises, we must redress intersecting structures of oppression and systemic exclusion. **Achieving the Council's vision of an economy designed to deliver Health for All requires that health, inequality and climate challenges be tackled together, not as separate challenges.**





The cost of inaction

Taking pre-emptive action to address the social and economic determinants of health should always be seen as an investment and not a cost. At the same time, it is worth noting that it is more cost effective to prevent than to cure.

For example, the costs of the COVID-19 pandemic would have been far lower had the world spent the money necessary to put in place systems of disease detection and wellbeing promotion *before* the pandemic. World Bank and WHO estimates (18) suggest that **it would cost a mere US\$ 1.30 per person on the planet to build an effective global system of pandemic prevention and response** that could avoid repeating (or worse) the experience of COVID-19. The actual financial, economic and human costs of that pandemic are already many times higher (19).

The struggle, however, to get even a fraction of the money required for a global Pandemic Fund is symptomatic of how averse governments remain to investing up front in prevention. This aversion exists across many persistent challenges. The positive trends in maternal health observed between 2000 and 2015 have been replaced with stagnation and even an increase in mortality rates during 2016–2020 in many regions across the world (20). If this trend continues, this decade we will have failed Sustainable Development Goal (SDG) 3.1 by 1 million maternal deaths. Another example is **antimicrobial resistance (AMR)**, often referred to as the silent pandemic, which is expected to lead to 10 million deaths annually by 2050, unless action is taken immediately (21).

Moreover, the five leading causes of noncommunicable diseases (NCDs) – cardiovascular disease, chronic respiratory disease, cancer, diabetes and mental health conditions – are estimated to cost US\$ 47 trillion between 2010 and 2030, an average of more than US\$ 2 trillion per year (22). One estimate suggests that the cost of US\$ 140 billion required to reduce by one third global deaths from NCDs would generate economic benefits almost 20 times greater – of US\$ 2.7 trillion (23).

Prevention is not limited to the health sector, but engages multiple sectors to address the social, economic and commercial determinants of health (**Box 1**). Incentivizing oil and gas industries by means of subsidies, for example, ends up burdening health care in the form of respiratory conditions from air pollution. We need cleaner energy

for better health yet governments continue to subsidize fossil fuels – and according to some estimates, these explicit and implicit subsidies exceed public sector expenditure on health care (24,25).

As with climate and inequality, policy-makers might prefer to kick the can further down the road when it comes to investing in health. However, in doing so, they increase the economic and social burden of future generations. The case for urgent action is strong (26). Health for All is more than reactively saving lives in times of crisis. While doing so is necessary, it costs less to proactively invest in areas that make our lives better than to pick up the pieces later. The ripple effect of such investments – the “multiplier” – is thus good both for people and for the economy.

» **It is more
cost effective
to prevent
than to cure. «**

New economic thinking and policy

Conventional economic theory has convinced policy-makers that at best they can fix “market failures” – investing public money only when there is not enough private money. Instead, policy-makers must actively create and shape an economy that delivers on goals that are critical to human and planetary wellbeing. This approach cannot rely only on “filling the gap” – even when that gap is large – and it must make sure that financing is just and equitable.

The goal of Health for All runs through the SDGs – there is not one SDG that does not have a health or wellbeing component. Achieving these goals requires mission-driven governments that work with purpose-oriented businesses and civil society to deliver on people-oriented outcomes. **Purpose-oriented businesses are the ones that maximize stakeholder rather than shareholder value**, recognizing that business success is the result of collective efforts, including those of workers, the state and the community (27).



A **new understanding** on health and the economy, structured across a **new framework** for reorienting our economies to deliver Health for All, is built on four interrelated pillars (28).

» **Policy-makers must actively create and shape an economy that delivers on goals that are critical to human and planetary wellbeing. «**

↗ VALUING HEALTH FOR ALL

We need to value and measure the things that truly matter – human and planetary flourishing – rather than pursuing economic growth and gross domestic product (GDP) maximization regardless of the consequences. To achieve Health for All, governments must rethink value and reshape and redirect the economy based on social and planetary wellbeing, guided by new metrics (29).

↗ FINANCING HEALTH FOR ALL

A fundamental overhaul of national and international systems for financing health is needed, so that spending on health is treated as a long-term investment. This is another reason to reinforce the importance of a pandemic accord across governments (30). Delivering Health for All will require both more money and higher quality financing (31).

↗ INNOVATING FOR HEALTH FOR ALL

Innovation requires collective intelligence – it is never the fruit of just one company or government agency. But unless innovation is governed for the common good, many people remain excluded from its benefits. A new end-to-end health innovation ecosystem that prioritizes the common good is needed (32).

↗ STRENGTHENING PUBLIC SECTOR CAPACITY FOR HEALTH FOR ALL

As COVID-19 made clear, the quality and capacity of government matters. Effective governments are not the smallest, but those that are well designed and properly resourced, both financially and in terms of their people and infrastructure. Re-investing in government capacity is crucial to delivering Health for All (33).

Applying this new economic understanding to Health for All requires recognizing that health and the economy are interdependent. Health is a key economic sector in itself and a cross-cutting lens through which to view all sectors. Moreover, global and national economies and financial systems are crucial determinants of health (34). Vitally, public and private investments and collaboration can be shaped and channelled to build an economy that is conducive to health and wellbeing (35), and to achieve cooperation around local, national and supranational goals.

The intention is that this report's recommendations will serve as a compass, guiding policy-makers and others in a bold new direction. Realizing this ambitious, yet urgent and essential, mission of Health for All will require all of us to think and act creatively, collaboratively and courageously.



BOX 1

Broader determinants of health

Achieving a Health-for-All economy requires addressing the social, economic and commercial determinants of health. This includes guaranteeing good education, decent working conditions and safe environments. It requires organizing and financing health systems in a way that ensures access to effective services for all. And it requires regulating commercial activities to limit harm and promote positive health outcomes.

» Achieving a Health-for-All economy requires addressing the social, economic and commercial determinants of health. «

Incorporating a broad understanding of the determinants of health into policy-making foregrounds the social and economic disadvantages or privileges that shape people's lives. To understand and mitigate current shortcomings in providing Health for All,

capturing data on the lived experiences of individuals and households is essential. Such insights can enable policies to better address these determinants and increase people's access to resources and opportunities (36).

It also requires coordination across different sectors and actors. A key message from the Marmot Commission on Social Determinants of Health is that a whole-of-society approach is needed to lift up the entire "social gradient" (10). Universal programmes that benefit all people are key, complemented by programmes tailored to the needs of individuals, households and communities.

WHO has also accelerated work addressing the commercial determinants of health. Four industry sectors (tobacco, ultra-processed foods, fossil fuel and alcohol) are estimated to account for at least one third of global deaths (37). Commercial determinants of health are not limited to produced goods and services, but also include marketing strategies, working conditions, production externalities and political activities, such as misinformation, lobbying and donations, which are undertaken by private companies for their financial gain (38).

Valuing Health for All

Economics has, until now, measured the price of everything and the value of nothing. That needs to change. Currently, health spending is treated as a cost rather than a long-term investment (39,40,41). GDP as the dominant measure informing economic policy does not help here.



GDP provides a narrow, distorted view. It treats many economic activities that are bad for human and planetary wellbeing as contributions to growth (42,43), and excludes many vital activities, including women's unpaid caregiving work (5,44) and the preservation of the natural environment by local and indigenous communities (45).

Governments must rethink value and reshape and redirect the economy, guided by new metrics (46,47,48,49,50). This means valuing and investing in health workers and health systems,

based on the recognition that health is a human right, and that a healthy planet and healthy people are interlinked (51). It means getting beyond maximizing GDP and, instead, using a range of dynamic metrics to track progress across core societal values (52). These recommendations are described in this section.

Additional detail and evidence supporting these recommendations can be found in the Council's brief on *Valuing Health for All: rethinking and building a whole-of-society approach* (29).

O1

VALUING THE ESSENTIAL

Treat health and wellbeing, health workers and health systems as a long-term investment, not a short-term cost

Currently, health expenditure can be threatened by governments under pressure to balance their books. This jeopardizes the long-term benefits of stable health provision for the sake of myopic, counterproductive austerity measures. Failing to invest in health for the long term leaves lower income countries more reliant on donor aid and individuals forced to pay more for health out of their own pockets – for those who can afford it. Inconsistency undermines efforts at building Universal Health Coverage (53,54). Short-termism has to be replaced by making Health for All a central societal goal, recognized in whole-of-government policy-making and regulation. Structural, long-term investment protects provision, including the training and development of health workers, values unpaid carers and improves social cohesion by ensuring equity of access to health care without financial burden to households, young and old alike.





O2

HUMAN RIGHTS

Use legal and financial commitments to enforce health as a human right

At least 140 countries recognize health as a human right somewhere in their constitution but only four countries, to date, mention how to finance it (55). Of these promises, some mean little in practice. Laws on paper need to be translated into laws in action. Governments must be supported in realizing the right to health. In the world of international finance, however, health expenditure can still be subordinated to debt repayments (56,57). This hierarchy must be overturned by excluding health investments from sovereigns' fiscal deficits. In the health care sector itself, the activities of private sector actors must be governed to ensure they cause no barriers to access or affordability of health services. Increasing the fiscal space for health can enable countries to meet their immediate obligations to enforce the right to health.

03

PLANETARY HEALTH

Restore and protect the environment by upholding international commitments to a regenerative economy which links planet and people

It is likely that no country is currently meeting the needs of all its people and operating within ecological boundaries (58). Many high-income nations have strong social foundations but their carbon and material footprints are unsustainable. Many low-income countries are not putting undue pressure on the planet but experience severe shortfalls in providing for people. In this sense, every nation must take an unprecedented journey of transformation to bring about human and planetary health.

These actions cannot be unilateral. Governments and multilateral mechanisms must prioritize addressing social and economic inequalities within and between nations to counter the stark disparities between those most responsible for climate and ecological degradation and those most severely affected by it.

Safeguarding the right to health for the growing number of climate-displaced populations in host countries is now imperative. Addressing the interconnected nature of climate and health challenges necessitates increased funding for initiatives at their intersection, such as the Alliance for Transformative Action for Climate Change and Health established at COP26.





O4

DASHBOARD FOR A HEALTHY ECONOMY

Use a range of metrics that track progress across core societal values, above and beyond the narrow, static measure of GDP

What is measured tends to get prioritized. It is essential to set broader targets for human and planetary thriving. Measuring and reporting progress in a timely manner enables such metrics to replace GDP at the core of decision-making. Importantly, no single universal metric can encompass the different components of Health for All. Nor is there any need to reinvent the wheel given that all countries who are members of the United Nations have agreed to the SDGs, a starting point for these improved metrics and indicators (55). A dashboard for measuring progress that aligns with the goal of health turns the economy's focus to priorities such as **equal pay, childcare, mental health, Universal Health Coverage for all ages and access to green spaces**. These things that ought to be valued can be captured by a range of indicators that inform policy-making and its ongoing adherence to those values. The Doughnut model and Genuine Progress Indicator are two examples (59,60).



Box 2 gives another perspective on how countries are collaborating in assembling indicators and steering policy by them.

BOX 2

For an economy in service of life

THE WELLBEING ALLIANCE

The Wellbeing Economy Alliance (WEAll) is a network of six governments – Canada, Finland, Iceland, Scotland, Wales and New Zealand (Wellbeing Economy Governments, WEGo) – and over 600 organizations, ambassadors, researchers and an increasing number of local hubs worldwide. The alliance works together to transform economic systems and has co-created an economic policy design guide (61) that uses a five-step process to shift societal success beyond GDP growth and instead deliver shared wellbeing.

THE FIVE-STEP PROCESS

- 1 Developing a wellbeing vision** by understanding what matters across different communities, communicating that vision and measuring it. Using a dashboard of indicators can be particularly helpful to measure overall progress on outcomes in separate but interconnected areas of wellbeing.
- 2 Designing a wellbeing economy strategy** that identifies the areas of economic life most important for collective wellbeing and outlines a plan to foster them.
- 3 Assessing and selecting wellbeing economy policies** based on their alignment with wellbeing values and goals. This change in paradigm requires governments and communities to develop policies to transform the economy to achieve wellbeing goals.
- 4 Implementing wellbeing economy policies by empowering communities** to take the lead in this transformation. In stark contrast to traditional economic policy, wellbeing economy policy is bottom-up, decentralized, requires coordinated implementation, and leverages the interconnectedness of government agencies, the private sector, civil society and community activities.
- 5 Evaluating policy impacts on wellbeing for learning and adaptation.** This requires moving beyond economies evaluated based on productivity and GDP growth as well as recognizing that transforming the economy can take time and wellbeing impacts may not be immediately evident.



The network's activities document (62) that **a wellbeing economy approach minimizes harm to people and planet and is also financially desirable.** Actions reduce avoidable challenges that would otherwise require greater public spending – **demonstrating that the cost of action is less than the cost of inaction, and escaping the cycle of "paying to fix what we continue to break."** WEAll's research focuses on three key interlinked sectors (paid work, housing and the environment) and examines the impact on both direct and indirect national financial resources.

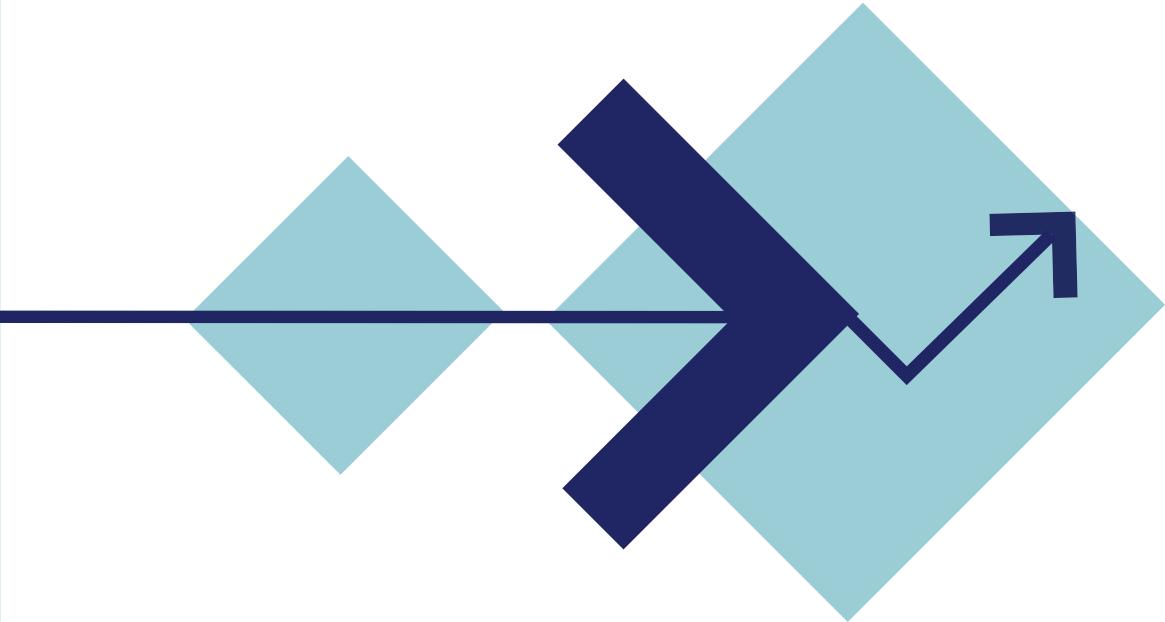




financing

for Health for All

The world today is tragically underinvesting in Health for All. The United Nations High-Level Advisory Board on Effective Multilateralism, for example, estimates that the SDG financing gap has grown from US\$ 2.5 trillion before the COVID-19 pandemic to between US\$ 3.9 and US\$ 7 trillion today (63).



Health spending should not be seen as an easy cut to meet short-term budget targets; it must be seen as a long-term investment. States must be empowered to manage this, through policies that prioritize health systems and investments in the social and economic determinants of health and through coordination at a global level, rather than being lauded for austerity or left to divert limited resources across multiple challenges (64).

Delivering Health for All will require both more money and a higher quality of financing. Key to this shift are: long-term financing to create more fiscal space for lower income countries to make critical investments in health; a redesign of the international architecture of finance to fund health equitably and proactively; and a properly resourced and governed WHO to play its key global coordinating role. These recommendations are described in this section.

Additional detail and evidence supporting these recommendations can be found in the Council's brief, *Financing Health for All: increase, transform and redirect* (31).

» **Health spending should not be seen as an easy cut to meet short-term budget targets; it must be seen as a long-term investment.** «



05

LONG-TERM FINANCE

Adopt a comprehensive, stable approach to funding Health for All

If health is a human right, then it has to be funded accordingly, on an enduring basis, rather than only a means to economic targets (as measured crudely by GDP) (65). **Countries thus deserve more flexibility in raising finance for this fundamental social goal.** This requires new economic thinking to replace counterproductive austerity (66). Budgets across government for the likes of housing, transport and employment should be viewed and managed through the lens of determinants of health. Fiscal space for long-term investments in Health for All can be opened through leveraging all government budgets including procurement budgets as well as regulatory changes within states, and directing investment to align with long-term goals (33).

On the world stage, changes to the rules governing global finance are needed. For example, liquidity should be available via an international fund to stabilize low-income countries in times of emergency. This should be supplemented by a longer term borrowing facility, such as the Bridgetown Initiative call for US\$1 trillion from multilateral agencies, including the International Monetary Fund, for lower income governments (67). It also requires suspension of debt repayments by lower income countries experiencing health pandemics and natural disasters and other structural reforms (68). In addition, the quantity of finance available can be augmented through tax reforms, including through taxes on wealth (69) and tax rates for multinationals (70) that reflect their activities and sales in each country – recognizing that currently they arbitrage between nations to pay less and shift profits (71).

06

QUALITY OF FINANCE

Redraw the international architecture of finance to fund health equitably and proactively, including an effective and inclusive crisis response

Lower income countries remain hobbled by the terms of international credit markets and multilateral lenders (72). Higher income countries can borrow far more at lower rates (73). This does not secure Health for All but instead leaves the former struggling to make debt repayments rather than provide care or invest in their populations. This is not just about the quantity of finance available, but about its quality: **finance must be proactive, enabling preventative investments** *ex-ante* as well as spending on crisis response *ex-post*, and it must be equitable, enabling investments in health not just for some countries and people but for all.

The Pandemic Fund, for example, has the potential to be an important mechanism for strengthening global cooperation and action when it comes to pandemic prevention, preparedness and response (74) However, as the Council has argued, the Pandemic Fund's success is dependent not only on how much capital it can mobilize, but also on how this finance is structured and governed (75). Decision-making cannot ultimately revert to the biggest funders. Global finance must depart from problematic conditions that have limited the ability of lower income nations to make long-term investments or shape markets. Instead, conditions on global finance should maximize public value and align economic activities with the goal of Health for All (31). Broader social indicators should be incorporated into financing to better align all actors with Health for All, per the recommendation for a dashboard approach to directing investments and tracking progress described under Recommendation 4.





07

FUNDING AND GOVERNANCE OF WHO

Ensure WHO is properly funded and governed to play its key global coordinating role in Health for All

The current multilateral system for financing Health for All is underfunded, too reliant on short-term fundraising rounds, and too disjointed, with much unnecessary duplication of activity by different institutions within the system. **There is an urgent need for a coherent approach to delivering Health for All**, which will only be possible if WHO is equipped with the capacity to play its critical role in governing this system (76). This includes dramatically increasing contributions from its Member States to represent 50% of its core budget (77). WHO can support countries arguing for expanding public spending on health – even in times of crisis – and efforts to improve the quality of health investments. It also has a **key advocacy role** to play on the global stage making the case for economies to be designed around the goal of Health for All, in line with this report's recommendations (78).



The United Nations SDG Stimulus Plan would see US\$ 500 billion raised for multilateral development banks to support lower income countries in attaining the SDGs. Box 3 summarizes the recent work of three of these development banks.

BOX 3

Regional development banks as enablers of change in the Global South

In the face of debt overhang and rising rates, **the United Nations has warned that multilateral policy action is necessary to avoid hardship in lower income countries. It has called for an SDG stimulus of US\$ 500 billion per year to massively scale up affordable and long-term financing for development and mobilize significant additional international and national finance.** There is a unique opportunity to coordinate multilateral development banks, regional development banks (RDBs), and national public banks around ambitious SDG-aligned missions. Investigating the role of RDBs in funding health outcomes offers insights on how to do this.

In Latin America, the Inter-American Development Bank (IDB) is the primary source of multilateral lending. The IDB's outstanding health loan portfolio amounts to US\$ 5.7 billion, just over 5% of its total loans. IDB supports health care system strengthening, disease prevention, treatment,

malnutrition and innovative digital health across 16 countries (79). A positive step transitioning away from charity-based priorities is the Salud Mesoamérica (80), an alliance between the IDB, governments and public donors such as the Carlos Slim Foundation and the Bill & Melinda Gates Foundation (77).

The Asian Development Bank (ADB) operates across developing Asia. During the COVID-19 pandemic, ADB significantly increased health sector financing, reaching 26% of total commitments in 2021. A key response included the Asia Pacific Vaccine Access Facility, aiming to support vaccine coverage in the region, by committing US\$ 4.1 billion in loans and grants for 15 developing member countries, delivering 227 million initial doses. ADB developed vaccine prioritization and deployment plans, incorporating a gender perspective in rollouts, including a database tracking immunization side-effects by sex (81).

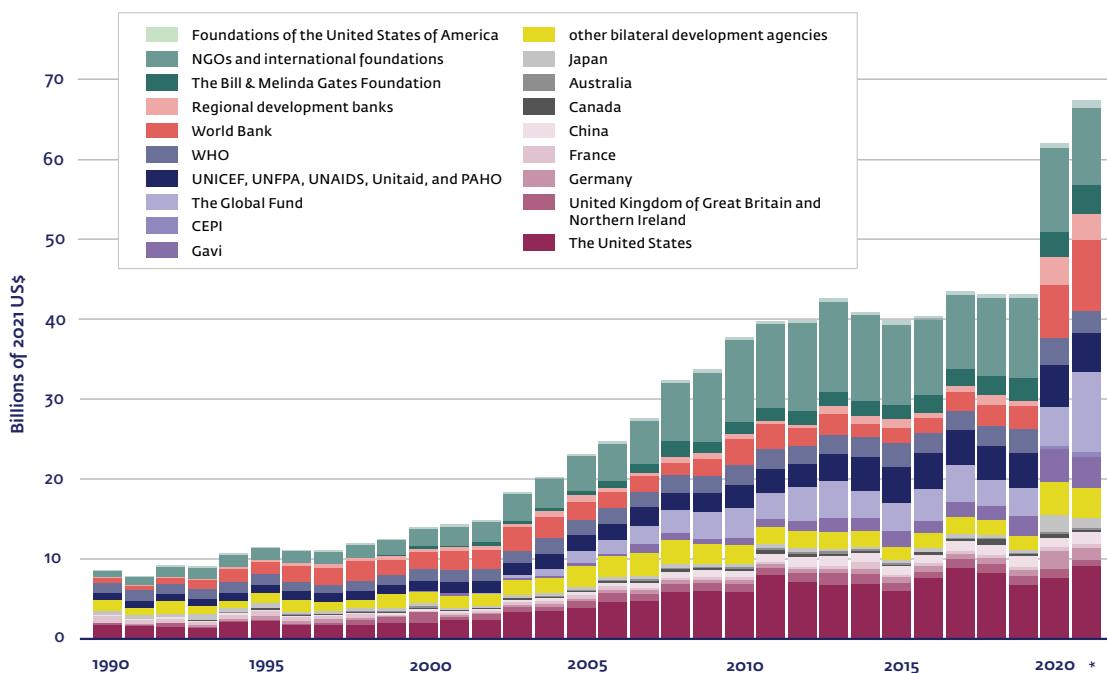
The African Development Bank (AfDB) plans a US\$ 3 billion investment by 2030 to develop regional pharmaceutical manufacturing capacities in Africa (82). Implementing this strategy requires participation from all relevant public and private stakeholders, including regional economic communities, governments, pharmaceutical companies, private equity funds and financial actors – with the aim to get products to those who need them, not only produce at the lowest unit cost. The AfDB already participates in the Good Manufacturing Practice Scheme for improving pharmaceutical industries' capacities in the region based on WHO standards (83).

During the pandemic, RDBs in aggregate became the third largest provider of development assistance (some US\$ 2.4 billion) after the World Bank and the Global Fund (FIG. 1) (84). There is an opportunity to increase RDB financing for health by better leveraging their balance sheet in capital markets, for example, by guarantees that enhance commercial and national development banks' loans.

While RDBs have been crucial in providing needed health financing during the pandemic, an important open question remains whether they will continue their pandemic level commitments with the aim of achieving Health for All beyond this crisis (85,86).

FIG. 1

Development assistance for health (84) by channel of assistance, 1990–2021



*2021 estimates are preliminary.

CEPI = Coalition for Epidemic Preparedness Innovations

Gavi = Gavi, the Vaccine Alliance

NGOS = Non-governmental organizations

PAHO = Pan American Health Organization

UNAIDS = Joint United Nations Programme on HIV/AIDS

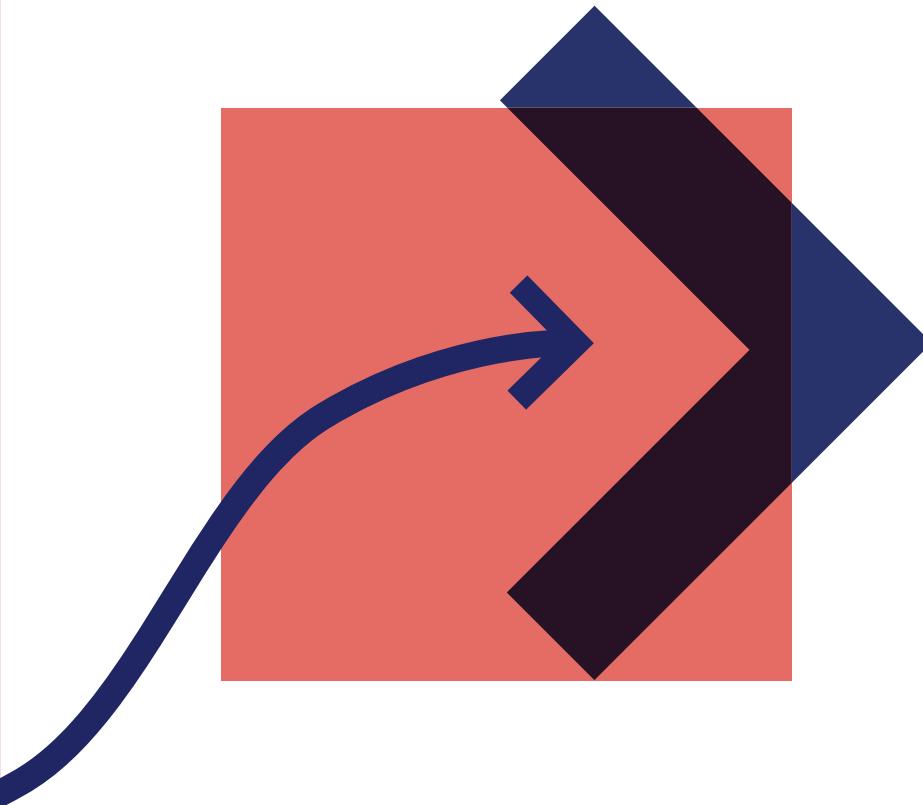
UNFPA= United Nations Population Fund

UNICEF = United Nations Children's Fund

"Other bilateral development agencies" includes Austria, Belgium, Denmark, Finland, Greece, Ireland, Italy, Republic of Korea, Luxembourg, the Netherlands, New Zealand, Norway, Spain, Sweden, Switzerland, the United Arab Emirates, the European Commission, and the European Economic Area (EEA). "Regional development banks" includes the African Development Bank, the Asian Development Bank, and the Inter-American Development Bank.

Innovation for Health for All

The first step in rethinking innovation for Health for All is the recognition that health innovation involves collective intelligence. Multiple actors from public institutions to private companies, university laboratories and civil society organizations are involved in creating the medical technologies we rely on for health.



The development of multiple COVID-19 vaccines in less than 1 year shows how much can be accomplished when human ingenuity and solid medical research and development (R&D) capabilities are given extensive public support (87). However, inequitable access to these vaccines revealed that unless innovation is governed for the common good, many people remain excluded from its benefits (88). **A new end-to-end health innovation ecosystem is needed** for the common good – one that prioritizes health needs from all regions of the world, including LMICs. This requires a major shift from a model where innovation is (falsely) seen as led by market forces to one that: harnesses and rewards

collective intelligence by shaping public and private alliances to meet public health goals; ensures global knowledge sharing and reforms intellectual property rules; and applies mission-oriented industrial strategies to galvanize cross-sectoral innovation to achieve Health for All-related missions.

These recommendations are described in this section. The mRNA Vaccine Technology Transfer Programme case study included on page 56 of this report points to what this end-to-end health innovation system could look like in practice.

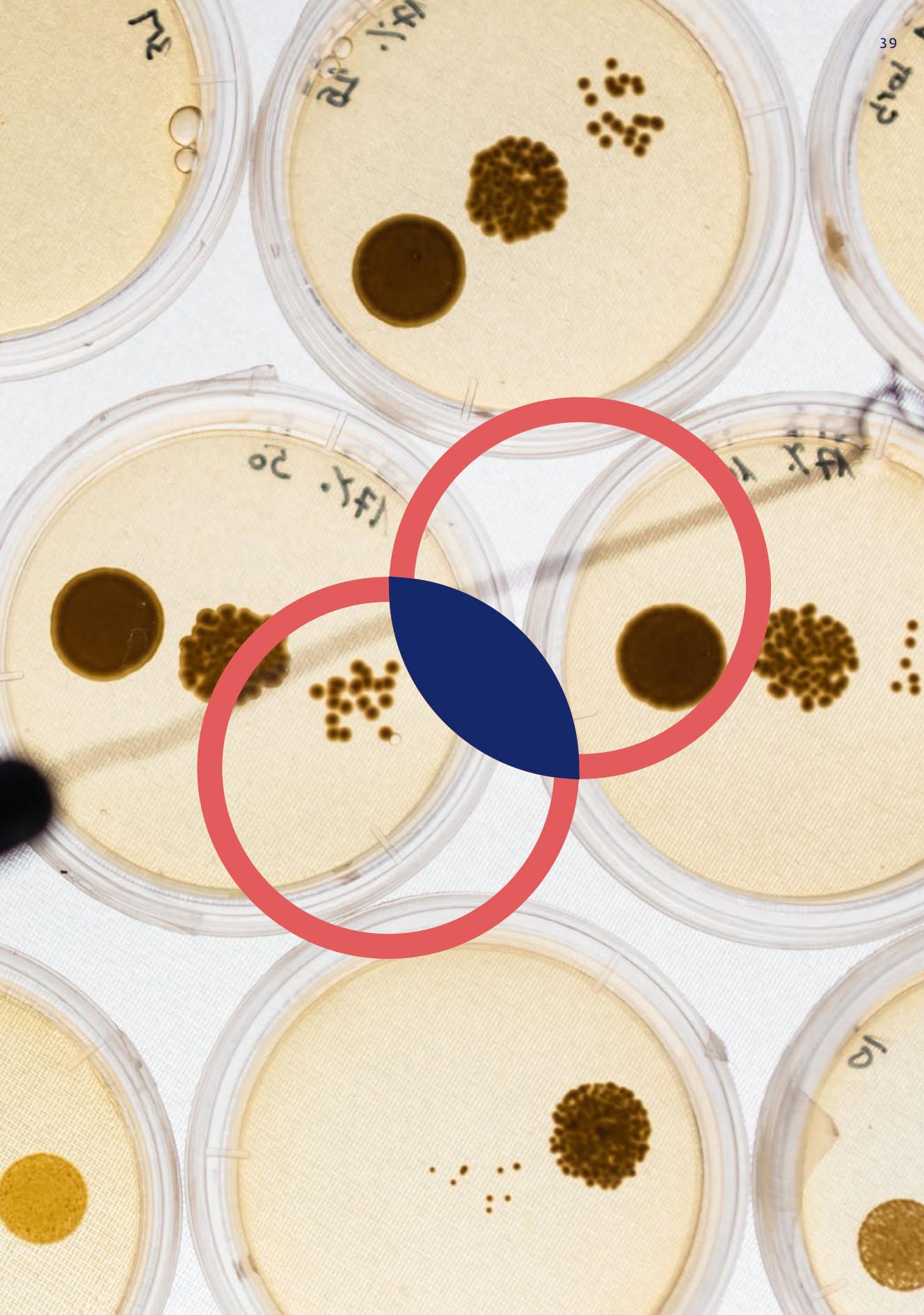
Additional detail and evidence supporting these recommendations can be found in the Council's brief on Governing health innovation for the common good (32).

08

COLLECTIVE INTELLIGENCE

Build symbiotic public–private alliances to maximize public value, sharing both risk and rewards

Redesigning the health innovation ecosystem for the common good requires public–private alliances that are symbiotic and share a truly common purpose that goes beyond a win-win discourse. Too often, these relationships tend to be parasitic, with large amounts of public funding flowing to private sector actors without conditions attached to align this funding with the public interest (89). Conditions on public funding for health-related R&D could, for example, ensure affordability, equitable access, and re-investment of profits into health innovation (90). Health technologies that come from a collective effort should not be under the control of relatively few private companies but be considered as part of a global health commons, available and accessible to all those needing them. Setting the right regulations and incentives in public–private alliances will make this happen, with the state as a co-creator and co-shaper of health innovation (91).





09

COMMON GOOD

Design knowledge governance, including intellectual property regimes, for the common good to ensure global equitable access to vital health innovations

RECOMMENDATION

Notably, a health innovation ecosystem governed for the common good must recognize that knowledge sharing and diffusing know-how among researchers is essential (92). Health innovations that result from collective efforts, including global and domestic public sector funding and intellectual contributions, must involve common good conditionalities, such as knowledge sharing within and between countries (93). This would advance greater public return and equitable access and help to **decentralize innovation and manufacturing capacity** to enhance global resilience. Patents should be viewed from a knowledge governance perspective, not just as a means of generating revenue or an innovation incentive for pharmaceutical companies. The granted monopoly should effectively stimulate productive entrepreneurship and further innovation, rather than being a wealth transfer to shareholders. The criteria for granting patents and secondary patents should be more stringent, including the disclosure of information that can help governments evaluate the market power they grant. Patents should only cover fundamentally new and inventive areas, focusing on downstream inventions to prevent the privatization of research tools, processes and technology platforms (94).

TO

OUTCOMES ORIENTATION

Align innovation and industrial strategies with bold cross-sectoral missions to deliver Health for All

Getting to the moon and back required governments to lead a strategy that galvanized innovation not only in aerospace but in sectors such as health, nutrition, materials and electronics. This mission required many challenges to be solved between these sectors – related to how the astronauts would eat, medicate, breathe and process data. Such problems resulted in innovations on Earth including software, camera phones and foil blankets. **Health for All goals, similarly, can catalyse cross-sector innovation and economic spillovers if governments orient industrial strategy around them** (95). We have seen this in the case of net zero goals, which have required change not only in the energy sector but also in sectors like steel to lower their material content and create greener supply chains. For health, this means less focus on “life sciences” strategies and more on strategies that are about getting life sciences to work with other sectors to achieve bold aims – for example, related to healthy ageing, which would require collaboration between sectors as different as the digital, health and mobility sectors (96). This mission-oriented approach to industrial strategy would require **transforming health goals into concrete, ambitious and inspiring missions**, with measurable indicators and timelines for completion, aligning innovation funding with these missions and enhancing coordination between public and private sectors to solve major problems (97).



Brazil has planned its health sector to develop many medicines, diagnostics and therapeutics in state-owned enterprises (SOEs) and to govern for the common good joint ventures between the public sector and private companies. Box 4 explains further.



BOX 4

Brazil's Health Economic-Industrial Complex

Brazil's success in becoming a regional producer of vaccines in Latin America is the result of a long-term, broad investment in the common good. Brazil made a bold bet for the public sector and offers a deviation from the profit-centred model that created inequitable outcomes during the COVID-19 pandemic regarding access to vaccines, diagnostics and therapeutics. The creation of a local health-pharmaceutical industry known as the Health Economic-Industrial Complex (HEIC) (98,99) has developed the health sector's technological base – crucial for realizing the fundamental right to health. Materializing this vision used many different policy tools, three of which are described below:

STATE-OWNED ENTERPRISES IN THE PHARMACEUTICAL SECTOR

SOEs in Brazil were responsible for more than 30% of COVID-19 shots for Brazilians and are currently spearheading the innovation process through the development of their own patentable, second-generation, self-amplifying mRNA COVID-19 vaccine (100).

PRODUCTIVE DEVELOPMENT PARTNERSHIPS

The country used innovative public-private partnerships, known as PDPs, to negotiate technology transfer agreements in exchange for access to the domestic market. In 2021, there were 81 ongoing PDPs involving technology transfer and national production of 75 drugs, vaccines and blood products, and another six PDPs for health products (101). Centralized procurement, market size and a strong commitment to building the technological base in the health sector, including investment in public options, created the conditions for PDPs to emerge.

EXECUTIVE GROUP OF THE HEALTH ECONOMIC-INDUSTRIAL COMPLEX

From 2008 to 2019, and recently reinstated, Brazil's Executive Group of the Health Economic-Industrial Complex (GECIS) brings together the ministries of health, finance, science, innovation and technology, and foreign relations, with the private sector, academia and development banks, to discuss the present and future of industrial policy in the health sector (102). GECIS is part of a **whole-of-government strategy** to increase coordination and communication among all stakeholders. The existence of GECIS contributes to building the required legitimacy to support the PDP programme.

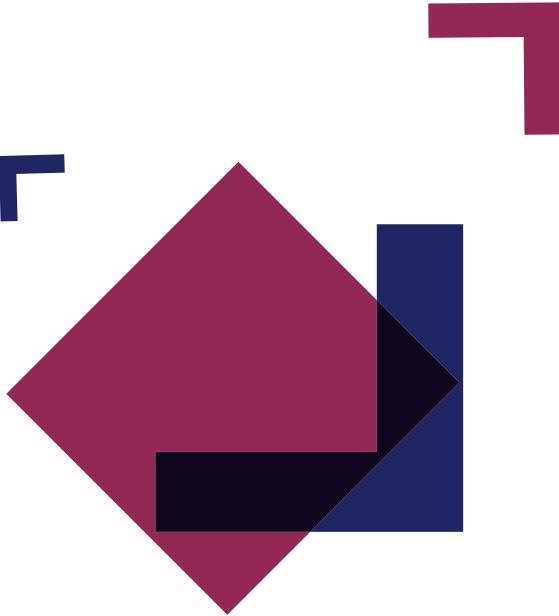


Strengthening public sector capacity for Health for All

Effective governments are not the smallest, but those that are well designed and properly resourced, both financially and in terms of their people and infrastructure (103). Decades of anti-“big government” policy have hollowed out public sector capacity (104).

Capacities and capabilities needed by governments to respond to and prepare for crises include:

- Adapting and learning in the face of incomplete, at times conflicting, information and radical uncertainty.
- Aligning public service and peoples' needs.
- Governing resilient production systems and capabilities to foster symbiotic public–private collaborations and tapping into innovation driven by people.
- Capacity to govern data and digital infrastructure, including handling the “infodemic” while balancing human rights protection.
- Inter- and intra-governmental learning and coordination (including at different levels of government, e.g. federal and local, inter-ministerial and international).



To realize this report's vision of healthy people living on a healthy planet, **it is crucial to re-invest in the ability of governments to drive transformative change** – including their ability to set a direction for economic policy that results in equitable health gains, act on the social determinants of health, address evolving health and social care needs, respond to crises, and collaborate effectively with the private sector and civil society.

Delivering Health for All requires governments to recognize that health does not only concern health ministries, but rather demands collaboration between all government ministries and a whole-of-society approach. It requires investments in the dynamic capabilities needed within the public sector to work in a collaborative, coordinated way and to experiment, adapt and learn (105). It necessitates meaningful public engagement and accountability to build trust. These recommendations are described in this section.

Additional detail and evidence supporting these recommendations can be found in the Council's brief on *Strengthening public sector capacity, budgets and dynamic capabilities towards Health for All* (33).



11

WHOLE-OFGOVERNMENT

Recognize that Health for All is not just for health ministries but for all government agencies

When the pandemic hit the world, state leaders had to take a whole-of-government approach to rapidly implement test and trace systems, deliver personal protective equipment to frontline workers, make sure vaccines went into people's arms, and manage the infodemic aspect of the crisis (106).

Such holistic efforts should not be limited to crises. States must put in place and maintain a whole-of-government (107) ethos to secure domestic resources for health, promote cross-sectoral whole-of-society approaches (108), and thereby reorient economies towards Health for All. A key goal in national development plans must be to break departmental silos, and include transparent and accountable mechanisms to track commitments and progress.

In particular, **ministers responsible for finance and the economy should see themselves not only as guarantors of macroeconomic stability, but also as active supporters of healthy and equitable societies.** Budgets for community centres, green walkways, nutritious food production and affordable housing should harmonize with progressive taxes and regulation targeting negative commercial determinants of health, such as the sale and marketing of ultra-processed foods.

 *Health for All requires greater collaboration and concord between government agencies. In the fight against AMR and other health hazards, Thailand has used joint budgeting to unite various departments in a common cause. See Box 5.*

12

STATE CAPACITY

Invest in the dynamic capabilities of the public sector, institutionalizing experimentation and learning, to lead effectively in delivering Health for All

Government departments and public sector agencies must be enabled to develop, implement and oversee policies that achieve Health for All. For governments to step up in their leadership role as co-creator and co-shaper of health finance and health innovation for the common good, **investments are needed to boost the capacity of the public sector** (109,110) – rather than relying on external consultancies. Reform is not just about spending more but about building the dynamic capabilities (111) required to design public policies, partnerships, institutions and tools that are capable of delivering on bold goals, and to align investment, innovation and growth with these goals.

To achieve Health for All, governments need, for example, to negotiate with businesses to ensure that access to public funds is contingent on robust conditions aimed at maximizing public – not just private – value (112). Another example is the redesign of procurement policy to leverage this significant source of public funds to shape markets that align with the goal of Health for All (113). Particular attention is needed to build the capacity of LMIC governments for health innovation and manufacturing, and to foster local and regional innovation networks, to support a shift away from the current concentration of these activities in a small number of high-income countries (114). The mRNA Vaccine Technology Transfer Programme – described in more detail on page 56 – is one example of how this can work and the efforts required for it to succeed (115).





13

BUILD TRUST

Demonstrate transparency and meaningful public engagement to hold governments accountable for the common good

Meaningful public engagement, accountability and trust are critical to ensure that governments can anticipate new needs and set goals that resonate with people, and to build support for the changes required to reshape economies that support these goals (116). In addition to building their capacity to work in the public interest, governments need to build public trust that they are doing so (117,118). Participatory mechanisms must be adopted more widely that both capture the public's opinions and reflect them in central decision-making. **Amplifying people's voices increases legitimacy of the policy-making process, rendering governments more responsive to the needs of the population** (119). The public sector also needs to work harder and be smarter to communicate effectively with the public, especially on digital platforms, in order to tackle fake news and disinformation, which erode trust in public institutions (120). Digital infrastructure must be subject to standards that protect the public interest and personal information.

BOX 5

A whole-of-government approach to finance AMR national action plans (121)

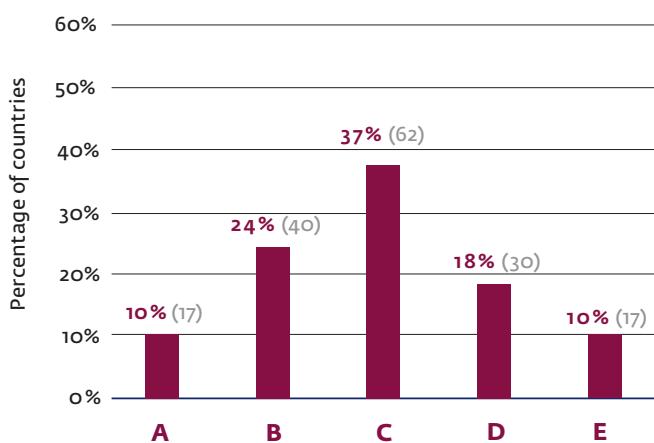
AMR, if not addressed, is estimated to lead to **10 million global deaths a year** by 2050 (21).

AMR represents not only a threat to human livelihoods but also to livestock, wild animals and the environment. This makes AMR a “One Health” challenge, or, in other words, a cross-sector mission.

An effective multisectoral effort against AMR requires that countries prepare, implement and finance a well-designed AMR national action plan (NAP). Of 166 countries surveyed in 2022, 90% have developed such a plan. Only 10%, however, report that their NAPs are financed from national budgets (**FIG. 2, column E**) (122). Funding of other NAPs, especially in LMICs, is largely donor driven (123).

There are alternatives. Joint budgeting, where resources from different departments and agencies are pooled into a common budget and bank account, is one such tool (124,125,126), as used by Thailand in its 2017–2021 WHO Country Cooperation Strategy. Lead and implementing agencies are assigned for each programme, responsible for the overall implementation. A midterm evaluation of the strategy noted that stakeholders found **joint budgeting mechanisms reduced transaction costs** for the lead and contracting agencies, brought funders into closer alignment to achieve the objectives of the strategy, and facilitated the strategy’s principles of country ownership (127).

FIG. 2
AMR NAP status,
(166 reviewed), 2022



Countries at level A

no NAP

Countries in levels B,C,D and E
have an AMR NAP

Countries in levels C,D and E
implementing their AMR NAP

Countries in level E
financed NAP from national budgets



AN EXEMPLARY CASE

The mRNA Vaccine Technology Transfer Programme

**A values-driven system
that tries to get the
innovation, financing and
capacity right ex-ante**

In response to the highly inequitable access to life-saving vaccines during the COVID-19 pandemic, WHO launched the mRNA Vaccine Technology Transfer Programme to increase LMICs' capacity to produce their own vaccines (128). The project was set up in 2021 under the leadership of WHO and the Geneva-based Medicines Patent Pool and aims to establish the capacity to produce mRNA vaccines at a hub in South Africa, organized around the biopharma company Afrigen. The technology will subsequently be shared with a network of around 15 mRNA (vaccine) production sites in a range of LMICs to decentralize and diversify mRNA vaccine manufacturing capacity, as well as the capability to drive local innovation efforts with this new and versatile mRNA technology platform. There is great enthusiasm among the participants of the programme to receive and adapt the technology for mRNA vaccines. Dr Abdul Muktadir, CEO of Incepta Vaccines, describes the mRNA technology as a platform for the future: "It has given us the confidence that we will soon be able to produce vaccines and biologics using cutting edge mRNA technology at an affordable price. We now know that it is not so difficult to develop mRNA vaccines."

The mRNA vaccine technology transfer programme is a promising example of an initiative set up in the interests of Health for All. Unless the programme's further design and development embody a common good approach rooted in health equity and resilience, however, it will struggle to have sustainable impact. The four pillars described in this report provide a valuable lens through which to understand the potential of this initiative to contribute to the goal of Health for All and to prepare for future health crises *ex-ante*.

Value – for Health for All

The mRNA vaccine technology transfer project values health equity and is built on the premise that **creating local capacity in LMICs to make effective epidemic countermeasures** where and when needed is critical to achieving equitable access. This premise is materially different from the present orientation of vaccine R&D and production, which only takes place if, when and where it is profitable for commercial producers. This leads to capability and knowledge concentration in just a few countries. The African continent, for example, uses a quarter of vaccines globally, but produces only 1% of them (129). This project, if successful, would reduce such dependency in all continents.

Building an ecosystem conducive to the programme's success challenges laissez-faire economic thinking, which endorses an excessive

To realize its full potential, the mRNA vaccine technology transfer programme could rally participants and donors behind a common good vision for this shared mRNA technology platform to collectively develop an R&D pipeline addressing local health needs and ensuring equitable access. This requires a collective definition of success and sustainability centred around these objectives, as opposed to focusing on the individual fortune of each producer in the global market.

Finance – for Health for All

The currently available funding for the South African consortium is around US\$ 117 million, mostly from western government donors, with efforts underway to increase it. This is a very modest budget for the ambitions of building sustainable local manufacturing capacity in LMICs, and focuses only on direct expenditures for the establishment of the technology and infrastructure. This approach stands in stark contrast to what high-income countries spent on securing a conducive health R&D and manufacturing ecosystem. For instance, governments in the United States and the European Union (EU) committed, respectively, US\$ 19.3 billion and US\$ 22.3 billion in 1 year to advanced purchase agreements of the COVID-19 vaccine. In the United States alone, the R&D of the mRNA technology was supported by US\$ 13 billion in public investment in basic research (130).

For the mRNA programme to be sustainable requires much higher levels of financing into an end-to-end R&D, manufacturing and access ecosystem. This includes not only support from local governments through procurement and subsidies, but also from international financial institutions whose mandate includes epidemic

» The African continent... uses a quarter of vaccines globally, but produces only 1% of them. «

focus on efficiency, maximizing revenue and economic growth. Instead, a common good approach to health must be pursued that values local resilience for epidemic preparedness and response and creates metrics for success accordingly. One example is prioritizing the ability of new multiple small- to medium-scale units to locally produce epidemic countermeasures when needed instead of competing on price against global producers that have established economies of scale.

preparedness, technological development and health resilience. This is especially true in an environment of limited fiscal space in many developing countries in the aftermath of the COVID-19 pandemic. Recognizing health as a long-term investment, not a short-term cost, is essential in creating the fiscal space needed to build an ecosystem of health innovation for the common good. The programme could also explore innovative financing mechanisms to harness additional, appropriate public and private financing, for instance a collective bond issue guaranteed by current mRNA donors.

Governing innovation – for Health for All

The COVID-19 pandemic evidenced that **global innovation is not designed to facilitate access to all in need**. The intellectual property system in the health sector currently protects secretive competition, monopolies and extractive financial behaviour. It thus entrenches structural patterns of dependency between high- and low-income countries. For instance, even though Moderna used public investments and public research to develop the COVID-19 vaccine, it refused to share intellectual property and know-how with the programme during the pandemic, forcing it to establish the technology from scratch, duplicate work and lose precious time.

In order to realize its ambitions, the programme could collectively explore governing the shared mRNA technology platform and future R&D pipeline for the common good, with the goal of making available safe, effective and appropriate epidemic countermeasures equitably where and when needed in participating countries or regions. This would include the co-creation of **regenerative business plans based on collectively owned knowledge and technology** with clear access and use rights, alongside collective investments and sharing obligations that reflect a common good approach.

The programme has the potential to become part of an ecosystem with coordinated and sustained investment in networked regional research, development and manufacturing programmes, operated and staffed by a local, skilled workforce. To that end, participating governments must work together to create a conducive end-to-end

» **International institutions need to break out of their own silos to best support technology transfer programmes. «**

health-industrial ecosystem and play a market-shaper role through mission-oriented policy. That may mean issuing compulsory licences or other approaches to ensure freedom to operate in order to ensure health equity.

Strengthening state capacity – for Health for All

The mRNA technology transfer programme is an opportunity to ramp up capacity across LMICs for epidemic preparedness and response, and health equity and resilience more broadly. This entails a whole-of-government approach with public agencies coordinating R&D, vaccine production and health policy. It requires **increasing regulatory capacity to facilitate clinical trials and rapidly approve new health interventions based on solid evidence**; and having a conducive financing environment and intellectual property regime that support the mRNA technology transfer programme.

Finally, international institutions need to break out of their own silos to best support technology transfer programmes and similar cross-border innovation in LMICs. The work of WHO has not yet sufficiently connected with the International

Monetary Fund or World Bank. Just as in commercial sectors and government, **cooperation at the international level should occur at an earlier stage** to systematize Health for All.

The Council recommends that the mRNA Vaccine Technology Transfer Programme is considered a common good for epidemic preparedness, driven by South–South collaboration and pursuing the shared mission of health security, with equity and local resilience at its heart (115). This requires moving from the current technological capacity-building project spearheaded by WHO/Medicines Patent Pool to a truly collective approach in which participating vaccine manufacturers agree to join in vision, knowledge and resources around the shared technology platform. They must collectively develop an R&D pipeline, leveraging the strengths of the participating organizations. This is not a typical model in the biotech sector but offers a fresh direction for public and private partners to collaborate for the common good.



Conclusion

The economy is yielding poor, unequal health outcomes by design. Until we redesign it, we will continue to fall far short of Health for All. **Health must be seen as a long-term investment, not a short-term cost.** By valuing and investing in Health for All, our economies and societies are stronger. All people can flourish and be productive members of society, reaching their potential of wellbeing and creativity. This is also the key reason why the cost of inaction – not investing in health – is many multiples of the cost of action. By not investing, we end up spending more on all the social costs that result from an unhealthy population.

Importantly, **health is a fundamental human right.** As such, a healthy population cannot only be seen as "human capital" – as an input or by-product of economic growth. The purpose of investing in health is not to increase GDP or economic productivity; economic activity must be in service to human and planetary health. Alongside a diverse and sustainable environment, a healthy population must be the ultimate goal of economic activity.

» If Health for All is the overall goal, then the economy must be repurposed to serve it. «



Countries have come a long way in better prioritizing health but the risk remains that it is counted as a variable in an economic equation, a secondary concern of economic policies or a cost, disassociated from its core value in a thriving and resilient society. This view has led to where we are at present: a major health crisis has wiped out the gains from decades of global development, while exacerbating persistent inequities.

If Health for All is the overall goal, then the economy must be repurposed to serve it. This calls existing economic narratives, underlying assumptions and tools into question. It requires a fundamental rethink of how value in health and wellbeing is measured, produced and distributed across society as well as the adoption of a dashboard of metrics that prioritizes human and planetary health. It requires a fundamental redesign of national and international finance focused not only on the quantity of finance available for health, but also on its quality and governance. It requires innovation to be governed for the common good. And it requires states to be willing and able to shape economies that deliver the goal of Health for All, with the capabilities to do so.

We hope the Council has succeeded in articulating and advancing a new narrative that recognizes health and the economy as interdependent and recasts financing for health from an expenditure to an investment. Efforts to improve health cannot be considered independent from decisions about economic policy. Health is not just one sector – it is a cross-cutting lens through which to view every sector. Importantly, it cannot be considered in isolation from planetary health, and like planetary health, it cannot be pursued by any one state in isolation from others.

This broadened framing of health and investments in health will enable us to move from focusing on maximizing value for money within a given health budget through narrowly understood efficiency gains, towards the ambitious agenda of creating an economy designed to deliver Health for All.

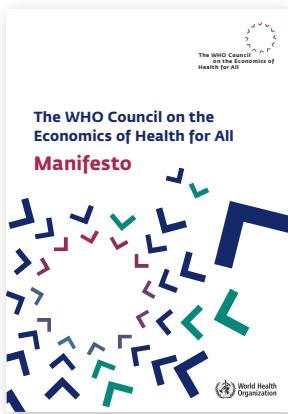


Council outputs

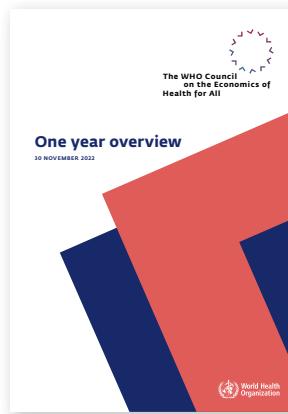
For additional detail on specific recommendations and supporting evidence, please see the Council's previous briefs and statements as well as the insights and case studies used to inform its work.

PUBLICATIONS

Manifesto (28)

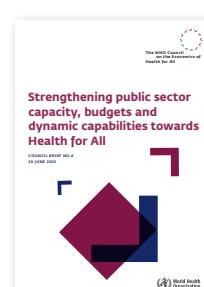


One year overview (131)



COUNCIL BRIEF NO. 1 Governing health innovation for the common good (32)

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COUNCIL BRIEF NO. 3 Valuing Health for All: rethinking and building a whole-of-society approach (29)

COUNCIL BRIEF NO. 4 Strengthening public sector capacity, budgets and dynamic capabilities towards Health for All (33)

COUNCIL INSIGHT NO. 1

Time-use data can clarify crucial inputs to Health for All (5)

COUNCIL INSIGHT NO. 2

Approaches and tools to finance and implement AMR national action plans (121)

COUNCIL INSIGHT NO. 3

Proposal for an international classification of economic activities and investments in Health for All (35)

COUNCIL INSIGHT NO. 4

Proposal: Engaging policy-makers in multiple sectors to build a society with Health for All at the centre – developing an in-service executive course (110)

COUNCIL INSIGHT NO. 5

Advancing the right to health: from exhortation to action (55)

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Exploring innovative financing solutions for pandemic preparedness and response (75)

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The mRNA Vaccine Technology Transfer Programme: a pilot for transformative change for the common good? (115)

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Building an inclusive global fund to address pandemic preparedness and response beyond COVID-19: policy principles and strategic considerations (132)

STATEMENT NO. 2

A proposed Financial Intermediary Fund (FIF) for pandemic prevention, preparedness and response hosted by the World Bank – elevating ambitions beyond business as usual (133)

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Policy priorities for Germany's G7 Presidency in 2022 (134)

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STATEMENT NO. 5

New international instrument on pandemic prevention, preparedness and response: contributing to the second round of public hearings (136)

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Barbados' introduction of a pandemic debt suspension clause (137)

STATEMENT NO. 7

What is at stake at COP27? Our last chance to achieve a healthy future for humanity (138)

STATEMENT NO. 8

The WHO Council on the Economics of Health for All. Green financing for good health: common investments for people and the planet (139)

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- An effective pandemic response must be truly global (141)
- Failing the pandemic preparedness test (142)
- Financing the common good (27)
- For the common good (143)
- Getting drug development right (144)
- Health innovation for all (145)
- How the G7 could help the debt-distressed (146)
- How to design a pandemic preparedness and response fund (147)
- Intellectual property and Covid-19 (148)
- Mariana Mazzucato: leading a new type of economics (149)
- Reboot biomedical R&D in the global public interest (150)
- The gender pay gap is wider than you thought (151)
- The WHO's penny-wise and health-foolish members (152)
- The world is still failing at pandemic preparedness and response (153)
- Three lessons from countries that performed best in tackling Covid-19 challenges (154)
- What if our economy valued what matters? (155)

CALL FOR PAPERS

Building an economy for Health for All:
a call for papers for a theme issue of the Bulletin
of the World Health Organization (156)

Council members

Professor Mariana Mazzucato (Chair)

Professor of the Economics of Innovation and Public Value at University College London and Founding Director of the UCL Institute for Innovation and Public Purpose, United Kingdom of Great Britain and Northern Ireland

Professor Senait Fisseha

Director of Global Programs at the Susan T Buffett Foundation and adjunct faculty at the University of Michigan, United States of America

Professor Jayati Ghosh

Professor of Economics, University of Massachusetts at Amherst, United States of America

Vanessa Huang

General Partner at BVCF Management Ltd., Hong Kong SAR, China

Professor Stephanie Kelton

Professor of Economics and Public Policy at Stony Brook University, New York, United States of America

Professor Ilona Kickbusch

Founding Director and Chair of the Global Health Centre, Graduate Institute of International and Development Studies, Geneva, Switzerland

Zélia Maria Profeta da Luz

Public health researcher, Oswaldo Cruz Foundation, Rio de Janeiro, Brazil

Kate Raworth

Senior Associate at Oxford University's Environmental Change Institute, United Kingdom of Great Britain and Northern Ireland

Dr Vera Songwe

Chair of the Liquidity and Sustainability Facility, London, United Kingdom, Co-Chair of the High-Level Expert Group on Climate Finance and Non-Resident Fellow, The Brookings Institution, Washington D.C., United States of America

Dame Marilyn Waring

Former parliamentarian, feminist economist and Professor Emeritus of Public Policy at Auckland University of Technology, New Zealand

Abbreviations

| | |
|----------------|--|
| ADB | Asian Development Bank |
| AfDB | African Development Bank |
| AMR | antimicrobial resistance |
| EU | European Union |
| GDP | gross domestic product |
| GECIS | Executive Group of the Health Economic-Industrial Complex (Brazil) |
| HEIC | Health Economic-Industrial Complex (Brazil) |
| IDB | Inter-American Development Bank |
| IPCC | Intergovernmental Panel on Climate Change |
| LMIC | low- and middle-income country |
| NAP | national action plan |
| NCD | noncommunicable disease |
| PDP | Productive Development Partnership (Brazil) |
| R&D | research and development |
| RDB | regional development bank |
| SDG | Sustainable Development Goal |
| SOE | state-owned enterprise |
| WEAll | Wellbeing Economy Alliance |
| WHO | World Health Organization |

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Approach to developing the recommendations

This is the final report of the independent Council on the Economics of Health for All convened by the WHO Director-General. The report reflects the Council's work, discussions with external parties and deliberations during some 20 Council meetings held between May 2021 and May 2023. The Council's work and framework (published in its brief Valuing Health for All) reflects a social determinants approach to improving the health and wellbeing of people and the planet. The work also explicitly integrates and addresses processes and determinants that stratify societies and make them more or less equal, including those related to age, gender, income, household structure, ethnicity including indigenous people, migrant status, financial literacy and place of residence.

Council members developed a set of high-level recommendations between 2021 and 2023. The Council's four pillars, outlined in its manifesto, served as the basis for its work and the organization of its final recommendations. Initial recommendations reflected the Council's briefs, statements and other materials produced during 2021–2022. These documents (available on the Council's website), reflecting literature and systematic reviews, are all well referenced. In October 2022, with the support of the WHO Secretariat supporting the Council, 80 suggestions and recommendations from across the Council's outputs were identified. In November 2022, through a structured survey, all 10 Council members selected, ranked and prioritized these into 30 statements. These were deliberated on during subsequent Council meetings and grouped into high-level points and subpoints, which formed the basis of the high-level recommendations and the report's proposed structure. They were disseminated widely to stakeholders through an online public consultation during January 2023; the affiliation of each stakeholder and institution which responded were noted. Council members reflected on the results of the consultation, and the high-level recommendations were restructured in February 2023. An initial annotated outline of the final report was circulated in March 2023 to WHO staff and external peer reviewers and stakeholders. In subsequent Council meetings in April and May 2023, Council members, led by the Chair, discussed the comments, reviewed three expanded drafts, and refined the narrative and level of detail to be included in the final report, resulting in 13 high-level recommendations and the final text. The final report refers to a series of background papers that were developed specifically to inform the report and which provide further details (listed on page 63).

All Council Members and external consultants involved in the development of this report completed a WHO declaration of interest document; none declared any conflict of interest.

Council members

Professor Mariana Mazzucato (Chair)

Professor of the Economics of Innovation and Public Value and Founding Director of the Institute for Innovation and Public Purpose at University College London, United Kingdom

Professor Senait Fisseha

Globally recognized leader in reproductive health and rights, Director of Global Programs at the Susan T Buffett Foundation and adjunct faculty at the University of Michigan, United States of America

Professor Jayati Ghosh

Taught economics at Jawaharlal Nehru University, India, and is now Professor of Economics, University of Massachusetts at Amherst, United States of America

Vanessa Huang

Specialist in health care and investment banking, and is currently a General Partner at BVCF Management Ltd., Hong Kong SAR, China

Professor Stephanie Kelton

Leading expert on Modern Monetary Theory and Professor of Economics and Public Policy at Stony Brook University, United States of America

Professor Ilona Kickbusch

Founding Director and Chair of the Global Health Centre at the Graduate Institute of International and Development Studies, Switzerland

Zélia Maria Profeta da Luz

Public health researcher and former Director of the Instituto René Rachou - Fiocruz Minas, Oswaldo Cruz Foundation from July 2012 to June 2021, Brazil

Kate Raworth

Creator of the Doughnut of social and planetary boundaries and is a Senior Associate at Oxford University's Environmental Change Institute, United Kingdom

Dr Vera Songwe

Chair of the Liquidity and Sustainability Facility, London, United Kingdom, Co-Chair of the High-Level Expert Group on Climate Finance and Non-Resident Fellow, The Brookings Institution, Washington D.C., United States of America

Dame Marilyn Waring

Former parliamentarian, feminist economist and Professor Emeritus of Public Policy at Auckland University of Technology, New Zealand



In memoriam of Council member

Linah Mohohlo, the former Governor of the Bank of Botswana



WHO Secretariat

Dr Ritu Sadana

Head, WHO Secretariat for the Council
on the Economics of Health for All, and
Head, Ageing and Health Unit, Switzerland

Research team: Dr Devika Dutt,
Dr Roberto Duran Fernandez, Alberto Huitron,
Dr Şerife Genç İleri, Dr Maksym Obrizan

Communications team: Gregory Hartl,
Nicole Schiegg († 5 November 2022)

Erica Lefstad, Design

Brendan Maton, Editor

Diana Ntreh, Administrative Assistant

Advisor to the Council's Chair

Azzi Momenghalibaf

Special Adviser to the Chair, University College
London Institute for Innovation and Public Purpose,
United Kingdom

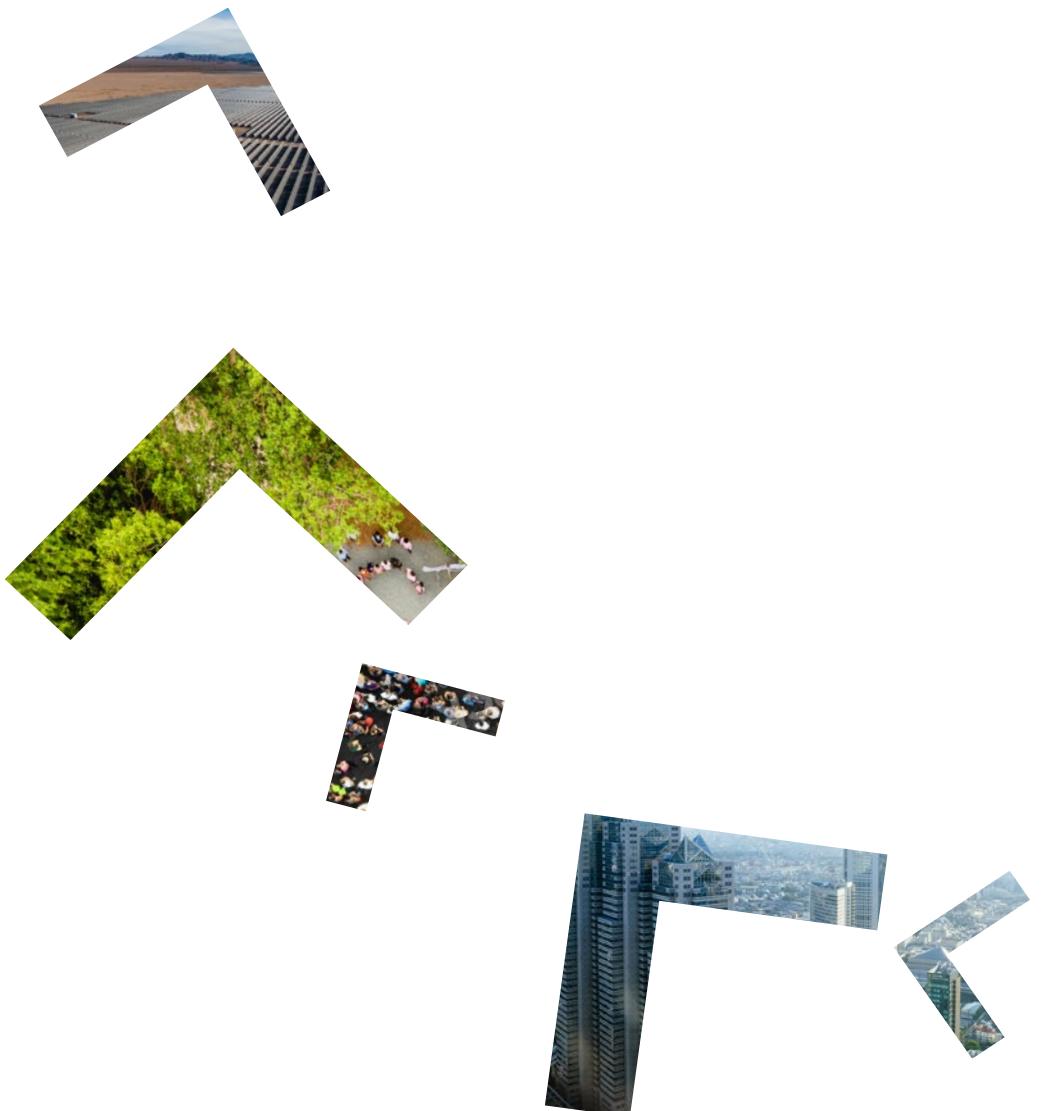
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For further information contact

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For further information:

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