A GLOBAL DEAL FOR OUR PANDEMIC AGE
B. PLUGGING FOUR MAJOR GLOBAL GAPS

- Globally networked surveillance and research: to prevent and detect emerging infectious diseases
- Resilient national systems: to strengthen a critical foundation for global pandemic preparedness and response
- Supply of medical countermeasures and tools: to radically shorten the response time to a pandemic and deliver equitable global access
- Global governance: to ensure the system is tightly coordinated, properly funded and with clear accountability for outcomes

Establish a Global Health Threats Board
B. Plugging Four Major Global Gaps

20. The investments that the G20 HLIP proposes will enable the world to plug the four major gaps in pandemic PPR:

   a. **Globally networked surveillance and research: to prevent and detect emerging infectious diseases**
   
   b. **Resilient national systems: to strengthen a critical foundation for global pandemic preparedness and response**
   
   c. **Supply of medical countermeasures and tools: to radically shorten the response time to a pandemic and deliver equitable global access**
   
   d. **Global governance: to ensure the system is tightly coordinated, properly funded and with clear accountability for outcomes**

(1) Globally networked surveillance and research: to prevent and detect emerging infectious diseases

21. Without significant investments in an early warning system, we will not be able to prevent and address future outbreaks quickly enough.

   a. We must step up our investments in **One Health**.

      i. WHO, OIE, FAO and UNEP must be supported to drive the development of standards for the prevention and control of health risks at the human-animal-ecosystems interface, with the WHO providing active support to the immediate response to emerging outbreaks once identified.

   b. We must prioritize installing a **global genomic and epidemiological surveillance program within the next five years to prevent and detect cross-species spillovers and to rapidly share data:**

      i. Comprising a tightly coordinated network of authorities and experts, with the WHO at the center. There should also be representation especially of countries and regions at higher risk of cross-species spillovers.

      ii. With just-in-time sharing of data on new pathogens.

      iii. Enabling rapid genome sequencing.

      iv. This is a critical capacity for detecting emerging outbreaks, allowing for rapid tailoring of public health interventions based on the attributes of a pathogen and its transmission, and the early development of diagnostic kits, vaccines and therapeutics where viable.

         1. A good but underfunded precedent to build on is the WHO’s Global Influenza Surveillance and Response System.
v. The G7 has recently endorsed a broadly similar proposal for an enhanced international pathogen surveillance network\(^{18}\) which will be docked into the WHO, and supported by partners from national public health agencies, governments and research organizations to ensure the utility of the network all the time.

c. As proposed by CEPI experts, the development of countermeasures would also be sped up through a [global prototype pathogen agenda] — that addresses the problems of vaccinology and develops vaccines against representatives of the roughly 25 viral families known to cause disease in humans. The number of prototype vaccines required to substantially reduce future risk has not been determined but, even if large (~100), is clearly finite.

d. We must build up the requisite in-country and regional capacities for effective surveillance. International financing and technical assistance are needed to help build this up especially for LICs and LMICs.

i. Investment is required in specialized labs and staffing, advanced molecular diagnostic capabilities, and digitalization and data integration.

ii. These capacities for detecting new outbreaks have to be built on systems that are able to provide continuous and cost-effective utility\(^{19}\). This can leverage the work of the Global Fund and other global health bodies which have been developing such systems in many countries.

iii. We must also build up effective capabilities for the broader disease surveillance pyramid that should include timely reporting of the number of deaths and the domestic circumstances in an outbreak in all countries; the strengthening of conventional diagnostics and community health worker reporting; population-based CRVS (Civil Registration and Vital Statistics) or sample registration systems so that the impact of outbreaks can be measured; and data surveillance infrastructures to aggregate data and extract recommendations for swift action.

iv. Technical assistance can also help in regulation of wildlife trade as well as private, informal and unregulated drug-sellers, pharmacies, and providers.

v. National public health institutes, regional centers for disease control, and international agencies like WHO, FAO and OIE require greater funding support to develop and maintain this key capacity.

1. Urgent work is needed to define and coordinate the partnership ‘hubs’ and ‘spokes’, put key infrastructure and training in place, and define the necessary policies, principles, and an underlying ethical framework essential for global cooperation within the network.

2. There is also a need for a globally networked group of pandemic responders who can be embedded in national and regional public health institutes.

e. A deeper understanding of zoonotic infections and disease origins is absolutely critical to successfully prevent future outbreaks.

i. We know that we must urgently enhance our ability to track, report and immediately respond to disease outbreaks at local, national and international levels.

ii. It will require minimizing possible spillovers from animals and humans, through internationally coordinated efforts to reduce the loss of natural habitats, regulate the wildlife trade and take down illegal trade, and address livestock production near to wildlife. **Strengthening One Health approaches is critical to this effort.**

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\(^{19}\) There are already well-functioning surveillance systems for HIV, tuberculosis, malaria and influenza, and can be augmented by including other pneumonia, meningitis, typhoid, cholera, STIs, drug resistant pathogens and clusters of defined clinical syndromes, as well as tracking the interplay between human and animal pathogens.
1. Few policies today seek to minimize human-animal interactions linked to environmental degradation, close live wildlife markets, reduce wildlife consumption, or ban commercial trade of high-risk wildlife — and rarely do these topics come up in mainstream health policy discussions.

2. Interventions to arrest environmental degradation not only help to reduce the risk of spillover, they also help to reduce greenhouse gas emissions, conserve biodiversity and provide natural climate solutions.

iii. Policies governing gain-of-function virological research should be reviewed with accountability for safeguards and responsibility clearly placed on sponsors and funders.

(2) Resilient national systems: to strengthen a critical foundation for global pandemic preparedness and response

22. Every country must play its part, share information, and be accountable for strengthening pandemic PPR. Doing so has benefits both domestically and for the rest of the world.

a. Countries that are in the tropics or have significant interfaces between human and wildlife habitats are more vulnerable to pathogens jumping into human populations, and becoming the source of a future outbreak.

b. But highly urbanized countries and those which are most closely integrated within their regions and globally, run the risk of amplifying the spread if they are unable to keep pandemics under control.

23. It is not possible to neatly separate efforts to counter new diseases with epidemic potential from continuing efforts to contain existing infectious diseases. They require many similar investments in infrastructure, healthcare workforce and technical specialists, and technologies and information systems.

24. It is therefore critical to have robust, whole-of-government health security plans that are regularly and transparently stress-tested, and assessed for compliance with the IHR and adherence to best practices. The IMF should incorporate assessments of health security status into regular monitoring of countries’ broader economic resilience (see below).

25. National authorities have the primary ownership and responsibility.

a. However, the strong element of global public goods in national-level pandemic PPR, the scale of past underinvestment, and today’s gaps in capabilities require significantly enhanced funding and technical support for LICs and LMICs.

i. Stronger funding support should be provided by the MDBs, working together with the WHO, the One Health partners, other global health intermediaries and regional healthcare organizations, as well as with bilateral partners and philanthropies.

ii. A significant share of the additional financing will have to be in the form of grants. Grants are required for investments in global public goods, and to incentivize countries to borrow from the MDBs (by making their non-concessional loans more IDA-like). Grants should also be used to incentivize governments to allocate their own budgetary resources to complement external support from their development partners.

20 The few laboratory biosecurity incidents that have been documented include a 2007 incident at Pirbright laboratories in the United Kingdom that caused a foot-and-mouth outbreak. The laboratory was a Defra category four, similar to those that deal with smallpox and Ebola, and was investigated thoroughly to find that the virus likely leaked from drainage pipework. The incident had wide-reaching international trade repercussions.
b. Development partners must coordinate better with each other, and with national authorities.

   i. The use of country and regional platforms can leverage the strengths of each development partner; and

   ii. Allow countries room to decide on the most effective use of PPR funds, but with tracking and reporting to ensure effectiveness of spending and progress towards preparedness standards.

c. Key global health intermediaries like Global Fund, Gavi and UNICEF should work with countries to improve the value proposition for private sector co-investments in dual-use capacities\(^2\) that can significantly contribute to health outcomes during the inter-pandemic years, including by making a forceful contribution towards the control of endemic diseases.

d. International organizations also play a key role in strengthening domestic delivery systems. Massive effort has to go into developing in-country systems for agile, last-mile delivery of essential supplies, which are critical in a pandemic but also have continuous utility in normal times. This applies not just to vaccines but lifesaving therapeutics and oxygen cylinders and concentrators.

26. We also need credible benchmarks for tracking each country’s progress and identifying gaps in preparedness. The Panel recommends establishing a new Health Security equivalent of the Financial Sector Assessment Program (FSAP), that will provide in-depth assessments of countries’ pandemic prevention and preparedness capabilities and investments, building on lessons learned from the IHR State Party Self-Assessment Annual Reporting (SPAR), Global Health Security Agenda and the associated Joint External Evaluation (JEE) peer review process.

   a. The Health Security Assessment Program (HSAP) should be led and coordinated by the WHO and the World Bank, with its findings put out in the public domain. It should factor in findings from the JEE and other voluntary assessments under the IHR.

   b. This would include the aforementioned stress tests to assess preparedness and resiliency in multiple scenarios, including highly mutable viruses and non-viral health risks.

      i. Administered nationally, stress tests should be supervised by regional and/or global authorities applying the same criteria and methods to all geographies.

      ii. Stress tests should include quantitative and qualitative assessments to enable authorities to take into consideration all factors when allocating resources, aligned with agreed incentives.

   c. The outcomes of this regular assessment of pandemic preparedness should be reflected in IMF Article IV reports, so as to ensure attention by Finance Ministers and national leadership. This is similar to how climate has recently been integrated into the Article IV surveillance.

\(^2\) These could include multi-disease surveillance, lab networks, febrile illness detection, supply chain and delivery infrastructure for medical countermeasures, personnel deployment systems, and emergency operations centers.
(3) Supply of medical countermeasures and tools: to radically shorten the response time to a pandemic and deliver equitable global access

27. **Speed, scale and equitable rollout of medical countermeasures are critical in a pandemic.**

28. Experts point to the prospect of a future major outbreak involving pathogens as transmissible as or even more transmissible than SARS-CoV-2. Given the devastating impact of such a pandemic, a **year is too long to wait** for vaccines. **We must collectively commit to achieving a 100-day goal for the development, production and deployment of effective countermeasures.**

29. Further, each of the medical countermeasures and other essential medical supplies needed in the current pandemic, including diagnostic tests, PPE and ventilators, and the components and raw materials required for their production, have been in **severe shortage, in many cases even one year into the pandemic.** The consequence has been a much wider spread of the virus, and much greater human and economic costs.

30. **With regard to vaccines, governments and international organizations should co-invest with the private sector to strengthen the supply chain during the inter-pandemic years.** Estimates by the Accelerating Health Technologies (AHT) group\(^\text{22}\) find that **having sufficient at-ready capacity for multiple vaccine candidates generates very high economic returns.** This is because the payoffs to having large quantities of vaccine available rapidly are enormous, most early-stage vaccine candidates fail, and it historically has taken many months to repurpose capacity from one vaccine candidate to another. However, utilizing new, low-cost modular manufacturing technologies that can interchangeably manufacture products across multiple platforms could reduce the need for ‘duplicative’ capacity in the future, so procurement systems should be open to such proposals.

   a. During COVID-19, vaccine capacity installation and production was constrained by shortages of production capacity that could be repurposed, trained staff, and inputs. This led to costly delays in vaccination. A shortage of vaccines and inputs also increased incentives for countries to restrict exports and ‘hoard’ vaccine doses.

   b. To mitigate this problem for future pandemics, governments and international organizations should create standby production capacity for both finished vaccines and inputs in the vaccine supply chain. Such capacity includes having adequately trained staff, quality checks and procedures in place to ensure that facilities are ready to produce quickly when needed. Companies could submit proposals for providing this capacity which should be judged on both cost and other dimensions.

   c. As much as possible of this capacity should be kept occupied producing other products during non-pandemic times, which would have the benefit of keeping capacity warm, as it is difficult to rapidly ‘engage’ manufacturing capacity that is left idle. It might also significantly reduce costs.

   d. The aim should be to enable vaccine capacity to be ready for each of several vaccine candidates to be produced at scale so that mass vaccination could begin globally as soon as clinical trials prove successful, and for this to be possible even if only one of the candidates was successful.

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\(^{22}\) A group of economists and statisticians, including G20 HLIP member Michael Kremer, working on the problem of how to accelerate widespread access to vaccines and other health products to address COVID-19.
e. **Companies have limited incentives to make investments that will be needed only during pandemic periods.** Some capacity investment may have valuable dual uses in the inter-pandemic years, but having sufficient at-ready capacity for multiple vaccine candidates is socially valuable even if much of it cannot be used during non-pandemic years. Ethical, social and political considerations may prevent companies from charging very high prices during a pandemic which would allow them to recoup costs. Therefore, governments and international organizations will need to be prepared to cover a large portion of the costs of this capacity. To the extent that capacity can be used for other purposes, this will bring down costs and help ensure pandemic readiness.

f. Contracting can be undertaken through a standard procurement process, in which governments and international organizations solicit bids from companies.

g. These bids should be judged on several dimensions. These include but are not limited to price, quantity, dual-use possibilities, speed to repurpose during a pandemic, geographical location, and reliability.

i. For example, a bid which could use capacity to produce other valuable products in peace-time at low cost would be more attractive, both because the dual-use is valuable and because using capacity might ensure that it could be repurposed quickly and reliably during a pandemic. However, capacity which requires high and constant demand to stay ‘warm’, may be less attractive if that demand does not match social needs.

ii. For certain more standardized inputs, stockpiles can be created. Once stockpiles are sufficient, the supplies can be sold and replenished, where ongoing production enables verification of capabilities for achieving contracted capabilities.

31. **When a pandemic hits,** governments and international organizations should sign contracts to repurpose sufficient manufacturing capacity for each of many vaccine candidates, ahead of final regulatory approvals for the successful candidates.

a. Sufficient capacity is needed to ensure rapid and equitable global access, including by the LICs and LMICs, which is critical to containing a pandemic everywhere. This will require global support. In order to fund these contracts, a pool of flexibly deployable ‘at-risk’ funds will be needed.

b. Both national and multilateral investments should be welcomed.

c. It is efficient to structure contracts to reimburse companies for most of the cost of capacity repurposing, with an option to buy product from that capacity at a pre-agreed price.

32. **Governments and international organizations should also make investments to ensure sufficient supply and delivery of therapeutics, diagnostics, and PPE.**

a. The right financing mechanism differs for each product, and should be designed appropriately.

b. For example, while for vaccines and therapeutics it is important to duplicate capacity for several candidates, this is not necessary for PPE.

c. Some kinds of PPE and medical equipment are useful for a broader set of pathogens than a specific vaccine, meaning it may be possible to maintain stockpiles in advance.
33. We need to make sure there are sufficient raw materials and intermediate inputs to rapidly provide critical medical supplies at a global scale in a pandemic and that there is a large enough margin of error to accommodate multiple negative shocks, such as some supplies proving unusable or only one vaccine candidate with particular specialized adjuvant requirements proving successful in clinical trials.

   a. Doing so will also reduce the short-term trade-offs that nations face between meeting immediate domestic needs and the global good, which all nations eventually benefit from.

   b. Ensuring broader geographical diversification of manufacturing capacity would help develop resilience in supply chains in a crisis, and avoid the huge trust deficit seen in COVID-19 among countries dependent on unpredictable global arrangements.

      i. This could begin with a broader distribution of fill-and-finish facilities, while building up more advanced capabilities for biomanufacturing in the longer term.

      ii. We will however have to ensure that regional supply chains continue to work as part of a global system:

         1. The scale required for manufacturing means that individual regions will find it difficult to comprehensively cover all the possible platforms needed for responding to a future pandemic.

         2. Regional supply chains can still be vulnerable to localized shocks.

      iii. The need for greater diversification and resilience of supply chains also extends to PPE and other critical medical supplies23.

   c. The remarkable progress achieved in research, manufacturing and market launch for vaccines has to be extended to diagnostics and therapeutics.

34. We also need a substantially larger network of sustainably-financed, ever-warm manufacturing capacity that can be repurposed in a pandemic to target specific pathogens.

   a. Multi-modal manufacturing capacity (mRNA, protein, and virus-based vaccines and therapeutics) can rapidly ramp up production of pandemic-specific medical countermeasures when needed.

   b. At-risk financing is needed for manufacturing of multiple prototype pathogen vaccine/diagnostic/therapeutic candidates before outbreaks.

   c. Dual-use purposes should be sought for such capacity, which could contribute to controlling endemic diseases and improving health outcomes during the inter-pandemic years. This can also improve the value proposition for such investments.

   d. Production capacities in different regions would render the system more resilient and contribute to a more equitable global distribution of scarce supplies24.

23 IPPPR Background Paper 7 — “Access to Essential Supplies.”
24 The recent Franco-German initiative to boost BioNTech vaccine production in South Africa is a positive example in this regard, see https://www.dw.com/en/vaccine-makers-want-to-help-south-africa-germanys-health-minister/a-57715373
35. **This requires both public and private participation and risk sharing**. The private sector cannot on its own invest in excess (peak-load) capacity ahead of a pandemic, given the uncertainties over the scale and timing of demand, and over which specific vaccines or other medical countermeasures will meet regulatory approval.

   a. **A combination of push incentives (co-funding of R&D and supply capacity) and pull incentives (assured procurements) will be needed** ahead of a pandemic, as well as to accelerate R&D and manufacturing capacity expansion at the beginning of an outbreak.

   i. It is more cost-efficient for this to be weighted towards push contracts. They provide the greatest opportunity for securing significant access commitments because of the higher risk involved in the early stages of developing vaccines and other medical countermeasures.

   ii. There should also be government funding to support the development of **new manufacturing technologies**, e.g. for mRNA vaccines and therapeutics to be made on biochips. This has the potential of reducing production costs and human capital requirements, and enabling more ready access to supplies.

   b. Contractual clauses must incentivize early deliveries and commit firms to quantity, **adequate allocations to LICs and LMICs**, and affordable pricing.

      i. Government funding in the current pandemic, as well as prior public sector investments in R&D, played an outsized role in the funding of vaccine discoveries for COVID-19. However, these were not structured to fully recognize the public good nature of R&D and such discoveries.

      ii. Future government funding for medical research should attach clearer conditions if successful discoveries are made, e.g. commitments to provide affordable medical countermeasures with cost-plus pricing for LICs and LMICs, treatment of intellectual property and requirements for technology transfers to third-party manufacturers.

      iii. There is a critical need for transparency of contracts and in particular, with regard to pricing. The lack of this transparency has militated against developing countries in the current pandemic, with some of them ending up paying more than high-income countries for their vaccines.

36. **Expanding public-private-philanthropic partnerships**: We should ensure that this end-to-end ecosystem for global supply of medical countermeasures is tightly networked to significantly scale up production of these supplies.

   a. We have to leverage comparative strengths across a network of ready-to-act, adequately-funded entities working across different functional areas (from R&D through to manufacturing and procurement).

   b. ACT-A was an important, ad hoc arrangement during COVID-19, to coordinate efforts to fund and enable equitable access to diagnostics, vaccines, therapeutics and implementation of these in health systems.

      i. Each of the institutions in ACT-A adapted to an evolving situation, and added value through its respective expertise and networks with the private sector and within countries.

      ii. ACT-A’s experience also showed the ability of the international community to assemble a coalition of the willing in short order during a major crisis.

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25 https://science.sciencemag.org/content/371/6534/1107
27 This includes the WHO; CEPI; the international procurement agencies (Gavi, Global Fund, FIND, Unitaid and UNICEF); the WBG; national/regional agencies like BARDA, HERA and the African Vaccine Alliance; national regulators; the private sector and non-state entities.
iii. But it has also shown the drawbacks of waiting for a crisis to occur. The current system — under a loose coordinating mechanism within ACT-A — lacks upfront financing and is not speedy enough. A year on, it remains significantly underfunded, which has hampered progress in purchasing and deploying medical countermeasures to those in need.

iv. Further, as also observed by the IPPPR, ACT-A is seen by countries and civil society as supply-driven and not inclusive enough, with large donor countries and institutions having an asymmetric influence on decision-making, and some parts of the world opting for regional pooling as an alternative.

c. **We should learn from the COVID-19 experience and develop a permanent, scaled-up and tightly networked ecosystem of partners** — public, private and philanthropic — to enable the following:

i. Accelerating innovation processes and facilitating the development of candidates and platforms to the regulatory end-point

ii. Achieving adequate global scale in manufacturing, including by:

1. Having a full view of global manufacturing capabilities to know which ones can be activated rapidly at any point

2. Enabling adequate global diversification of facilities to ensure supply resilience in a pandemic, and supporting technology transfer to countries or regions to build up manufacturing capabilities

3. Implementing a coherent strategy of push and pull contracts to support the business case for the needed ever-warm global manufacturing capacity, including its use in inter-pandemic periods to meet continuing needs

iii. Focusing on last-mile delivery, including investments in critical domestic supply chains in developing countries for delivering vaccines and other medical supplies

d. Significantly enhanced, continuous and pre-arranged funding is required to enable this end-to-end supply chain ecosystem and avoid huge gaps in access to medical countermeasures in a pandemic. **We propose that this be financed through a new Global Health Threats Fund (Proposal 2 in Section C), which will provide enhanced and more predictable funding to complement existing global health intermediaries.**

37. **We also need regulatory reforms to speed up time from development of these medical countermeasures to manufacturing.**

a. Enable trials to be conducted across pharmaceutical companies and for multi-vaccine platform technologies.

b. Allow products that are developed in one country to be able to rapidly undergo regulatory assessment internationally.

c. Formalize process for adaptive regulatory reviews in emergency situations.

i. Governments should also consider setting up commissions to be able to make decisions rapidly on novel study and trial methods — based on both scientific and ethical foundations — in the effort to speed up availability of medical countermeasures.

28 IPPPR Background Paper 5 — “Access to Vaccines, Therapeutics, and Diagnostics.”

29 For instance, CEPI could support development and technology transfer of a yellow fever mRNA vaccine, which would set up a new manufacturing plant with a potential commercial product in the inter-pandemic period but prepared to manufacture mRNA-based vaccines during a pandemic. UNICEF could support the tech transfer for key vaccine platforms from manufacturers to entities based in LICs and MICs by supporting the business case, incentivizing regional supply, supporting prequalification for new manufacturers and awarding them UNICEF offers for pediatric vaccines to ensure a warm manufacturing base and functional production sites.
38. Besides enhancing research upstream, integrated with global surveillance, a whole range of downstream R&D on medical countermeasures will also have social returns significantly higher than commercial value, and would be undertaken more swiftly with the aid of the public sector. Examples include:

   a. **Efficacy studies** (e.g. studies to ascertain the optimal dosing regimen given vaccine shortages, and to evaluate mix-and-match vaccine doses, should take place in parallel with standard clinical trials, so this information is available as soon as possible.)

   b. **Thermo-stable mRNA vaccines**

   c. **Repurposing of generic drugs**
      
      i. A Repurposed Generic Development Program (RGDP)\(^30\) could be part of this global ecosystem.
      
      ii. Employing public-private partnerships with academic labs, clinical development networks and drug manufacturers, to identify promising drug repurposing targets, coordinate clinical trials, and contract for the manufacturing of promising candidates.

   d. Earlier release of data from clinical trials, before final regulatory approvals, can also shorten the response time for investments in production capacity.

39. Governments and international organizations should also fund rigorous, quantitative evaluations of the **causal impact and efficacy of various non-pharmaceutical interventions (NPIs)**.

   a. These include mask-wearing, ventilation, closure of different institutions (schools, restaurants, public transport), and reduction in contact between people, indoors and outdoors.

   b. This will allow governments to design NPIs appropriately to reduce transmission in a way that is more sustainable over time, and minimize the economic and social costs of achieving targeted transmission reductions.

(4) **Global governance: to ensure the system is tightly coordinated, properly funded and with clear accountability for outcomes**

40. The current global health architecture is not fit-for-purpose to prevent a major pandemic, nor to respond with speed and force when a pandemic threat emerges. As the Global Preparedness Monitoring Board highlights, the system is fragmented and complex, and lacks accountability and oversight of financing of preparedness.

41. We must address this by establishing a governance mechanism that integrates all the key players in the global health security ecosystem, with the WHO at the center. **It should integrate health and finance bodies, within a tightly networked system of responsibility and accountability.**

   a. Ensuring adequate and sustained investment in normal times, to break the cycle of panic and neglect in pandemic preparedness

b. Enabling the world to respond with speed and force when a pandemic does strike

c. Putting the system on stronger and more reliable financial footing, anchored in rules-based multilateral funding
   i. Going beyond funding for specific diseases and interventions towards broader investments in core capacities needed to prevent and respond to future pandemics

42. Several global mechanisms have been set up in recent years, including the Global Preparedness Monitoring Board (GPMB)31, Independent Oversight and Advisory Committee (IOAC)32 for the WHO Health Emergencies Programme and the Global Health Security Agenda (GHSA)33. However, none has the mandate to ensure the effective coordination of key health and finance institutions needed to achieve the objectives above.

Establish a Global Health Threats Board

43. We propose establishing a new Global Health Threats Board (Board). This will comprise a G20+ group of countries and major regional organizations, to provide systemic oversight of finance for pandemic PPR, and ensure coordination and accountability of the key international health and finance organizations. The Board should be supported by a permanent, independent Secretariat, drawing on the resources of the WHO and other multilateral organizations.

44. This new Board will complement the recent proposal by the IPPPR for a Global Health Threats Council, to be established by the UN General Assembly and mainly comprising Heads of State/Heads of Government34. The Panel supports the case for top-level political leadership to demonstrate the strong commitments required for global health security.

45. The Board will aim more specifically to match tightly networked global governance with financing, which are both critical enablers to reduce pandemic risks. It is loosely modeled on the successful experience of the Financial Stability Board (FSB), which was established by the G20 following the Global Financial Crisis and has played a key role in strengthening global financial system resilience35. It also has similarities with the Global Health Board proposed by the Pan-European Commission on Health and Sustainable Development.

46. The Board should make available progress reports to G20 leaders as well as to the UN General Assembly through the UN Secretary General. These reports should include the allocation and usage of funds by the Global Health Threats Fund (see below), as well as reliable and transparent reporting of investment outcomes to ensure accountability.

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31 The GPMB, which was set up by the WHO and the World Bank in 2018, is a time-bound scientific advisory body, not a policy-making board. It provides an independent appraisal for policy makers on progress towards preparedness and response capacity.

32 The IOAC was established in 2016 with a specific mandate to provide ongoing oversight by a group of health and humanitarian experts of the effectiveness of WHO’s Health Emergencies Programme.

33 The GHSA, established in 2014 and currently extended till 2024, facilitates target-driven, multi-sectoral coordination and communication among its members. It currently lacks the necessary higher-level political engagement, financing, and wider country membership required for oversight of pandemic PPR.

34 The UN General Assembly will appoint two Co-Chairs for the Council and the G20 shall be invited to nominate a Co-Chair. The three Co-Chairs will put forward suggestions for the remaining Council members, for the UN General Assembly to endorse.

35 The FSB’s role has comprised:
   i. Identifying risks to financial stability and orchestrating appropriate responses amongst financial regulators
   ii. Promoting coordination of policy development and exchange of information and best practices among financial stability authorities and standard-setting bodies
   iii. Overseeing member jurisdictions’ implementation of agreed commitments, standards, and policy recommendations through implementation monitoring, peer review and disclosure
47. **Mandate.** The Panel recommends that the Board be mandated to provide systemic financial oversight to ensure proper and timely funding for pandemic PPR across the international system and the most effective use of funds. This will require a few functions:

   a. Identify the **key priorities to be addressed by the proposed Global Health Threats Fund**, which would be established as a Financial Intermediary Fund (FIF) at the World Bank. The most efficient governance arrangement could be for the Board to constitute a committee (‘Investment Board’) to directly oversee the Global Health Threats Fund. *(Proposal 2 in Section C.)*

   b. Contribute to a **tightly coordinated approach among all the relevant international organizations**, with joint and clearly delineated responsibilities, to ensure the most effective use of funds with each institution doing what it does best in pandemic PPR.

   c. **Ensure complementarity between multilateral and bilateral funding and initiatives to maximize their combined impact.**

   d. **Identify gaps for proactive action and funding:**

      i. Review emerging pandemic threats based on scientific assessments and a global health risk map.

      ii. Oversee the proposed HSAP, to be instituted and coordinated by the WHO and World Bank.

         1. This will provide in-depth assessments of countries’ pandemic prevention and preparedness capabilities and investments.

         2. It would take into account findings from the JEEs and other assessments.

         **The Board should, in these regards, take reference from the initiatives and work of the proposed Global Health Threats Council.**

   e. **Ensure that when a pandemic threat emerges, global resources are swiftly mobilized and flexibly deployed to support the key international institutions**, which should readily constitute a global pandemic response force.

48. **Composition.** The Board should have leadership and membership that ensures credibility, effectiveness and inclusivity.

   a. We believe that the G20 is the most effective platform for this new Board, given the sizeable role of G20 nations collectively in funding pandemic PPR (if relying on established approaches for international contributions), and in containing global pandemic risks given their size and global interconnectedness.

   b. Anchoring the Board in the G20 also ensures the participation and active collaboration of both Health and Finance Ministers. This will build on the efforts at the G20 to deepen collaboration between health and finance authorities, with the inaugural joint meeting of Health and Finance Ministers in 2019.

   c. However, the composition of the Board would have to be expanded to **comprise a broader ‘G20+’ group**, including the major regional organizations and a rotating representation of countries that are more vulnerable to infectious disease outbreaks with pandemic potential. It should also include other significant non-G20 contributors to the proposed Global Health Threats Fund that is discussed in Section C of this report. The geometry of the Board should provide for flexibility so as to respond to the major threats of the day.

49. Provisions should be made to ensure that the leadership of the Board does not rotate every year. We recommend a three-year term to ensure adequate continuity, besides the establishment of the permanent Secretariat.
50. **Advisors.** The leadership of key global and regional agencies with major roles in funding and implementing pandemic preparedness and response programs would serve as Advisors to the Board. Besides the WHO, which plays the leading role, they should include the leading multilateral agencies as permanent Advisors: the IFIs (World Bank, IMF, and the rotating chair of the Heads of Regional Development Bank meeting) and the WTO. They should also involve either on a permanent or rotating basis, the One Health partners (OIE, FAO and UNEP); major global health intermediaries (CEPI, Gavi, Global Fund, FIND, UNICEF, WFP, Unitaid, OCHA); regional Centers for Disease Control and Prevention (e.g. Africa CDC, ECDC); philanthropies with a large role in funding global health and pandemic preparedness; relevant civil society organizations; and leading private sector participants.

51. **Scientific advisory panel.** More effective pandemic PPR requires improved data collection, system-wide analysis of emerging health threats, and advice based on the best available science. GPMB is working on a global monitoring framework and developing a dashboard using a risk scoring and preparedness measurement approach. It will bring together different data sources and synthesize them. **We recommend that the GPMB be transformed to constitute this scientific advisory panel (“Intergovernmental Panel on Epidemic Risks and Infectious Health Threats”),** drawing on the parallel of the Intergovernmental Panel on Climate Change. The Panel should be independent, and tap on a large network of scientists to analyze data on risks and the level of management of those risks across all geographies. This Panel’s reports would serve as valuable input to both the Global Health Threats Council proposed by the IPPPR and the Board.

52. The Board must ensure that the world **leverages fully the strength of regional ownership.**

   a. An example in the last year has been the African Union (AU)’s initiative to establish the **African Vaccine Acquisition Task Team (AVATT)** to overcome the continent’s lack of access to vaccines. (See Annex F.)

   i. The AVATT was launched in August 2020, under the leadership of the AU and Africa CDC, and supported by the WHO, UN Economic Commission for Africa (UNECA), and UNICEF. It aims to achieve a minimum of 60% immunization of the African population to eliminate COVID-19, augmenting the COVAX initiative.

53. The Board must also ensure that there is continuous learning from responses to pandemics and outbreaks. It should promote post-crisis reviews of responses, especially at the national level, to **generate solid, evidence-based national policies and investment plans for pandemic PPR and enable sharing of best practices globally.** This will help ensure that injections of new resources can be most effectively deployed.

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26 See also https://www.nature.com/articles/s41591-021-01374-x