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ARTICLE COMMENTARY



## COVID-19: Can this crisis be transformative for global health?

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### ABSTRACT

The UN has described the health, social and economic consequences of Covid-19 as a global crisis unlike any other encountered in its history. Although a pandemic of this nature was not unforeseeable, its arrival seems to have caught the world off guard, hurling us into a state of partly haphazard disaster mitigation. It has shed sharper light on the failure of global health in its current form to tackle acute and systemic challenges in a rapidly changing world, and the unequal patterns in society that leave us vulnerable. This commentary argues that, despite its devastating effects, the Covid-19 pandemic can be a longer-term positively transformative event for global health. However, this will require going beyond the development of more effective plans for health emergency preparedness, to confront the crisis in global health governance and leadership, and rethink the roles of key actors involved in world health. It ultimately calls us back to the very concept of ‘global health’: the values it should encompass, what we should expect from it and how we might envisage reshaping or ‘co-creating’ it for the future.

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In a press briefing on 1 April 2020 Andrew Cuomo, the governor of New York State, asserted that COVID-19 would be transformative, that it would change us from a personal, social and systems perspective. The challenge would be to make sure this longer-term change is positive and not negative.

Certainly it is difficult to think of positive change during a global crisis. On the same day, April 1st, there were over 80,000 estimated cases of COVID-19 in New York State alone, representing approximately half of the total cases in the US (WHO, 2020g). Globally, the WHO reported over 800,000 infections and 40,000 related deaths, with several African countries confirming their first cases (WHO, 2020g) and many parts of the world at the early exponential growth phase of their epidemics. Three months later, on 1st July, over 10 million people had been infected, and over half a million had died; about half of these cases were recorded in the Americas and a quarter in the US (WHO, 2020c). Cases had risen to over 300,000 in Africa and over 500,000 in India and Russia (WHO, 2020c). Today, while some countries have flattened their epidemic curve (Vally, 2020), globally the number of daily infections continues to rise (WHO, 2020c). The unfolding health, social and economic consequences of this virus are already enormous (Lazzerini & Putoto, 2020; United Nations, 2020b) and we have likely not yet seen the worst. The United Nations has described the pandemic as a global crisis unlike any other in its 75-year history (United Nations, 2020b, p. 1).

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This article has been corrected with minor changes. These changes do not impact the academic content of the article.

Although the world could not have predicted the exact date or genome sequence, a global pandemic of this nature was not unforeseeable, as we are reminded by resurfaced warnings of health experts, previous pandemic simulations and the apparently discarded US National Security Council playbook containing steps to manage a similar event (Amanpour, 2020; Pearce, 2019). Nevertheless, the arrival of COVID-19 seems to have caught the world off guard, hurling us into a state of crisis and partly haphazard disaster mitigation.

Some of the globe's highest-resourced areas, such as Lombardy and New York State, were among the hardest-hit initially outside of China. They faced overwhelmed health systems, insufficient essential medical equipment and a large portion of frontline health workers falling ill (Lazzerini & Putoto, 2020). Northern Italy's public health system, considered one of the best in the Western world, found itself on the brink of collapse, with health workers representing over 10% of COVID-19 cases (Lazzerini & Putoto, 2020; WHO, 2020b). Yet in March and April, while coffins piled up in Bergamo's cemeteries, Italy's pleas to the European Union (EU) for help with life-saving medical equipment remained largely unanswered (Adler, 2020). EU member countries were preoccupied with their own emerging crises, and divided over what to do (if anything) about debt sharing through 'coronabonds' (Adler, 2020). At the same time, in the US, State governors pleaded for federal government intervention to increase production of medical equipment, as global prices of essential items, such as ventilators, spiked because of increasing demand and open-market competition. Individual countries, including South Africa, Spain, Italy and the US, acted in part independently to pursue their own needs, seeking help from other countries, such as China and Russia, through bilateral engagement. Moreover, in some of the world's wealthiest and most developed nations, decisive responses to testing and disease containment arguably came too late to halt widespread transmission. Policies and messaging on lockdowns, border closures, the use of face masks and other containment measures have at times been inconsistent across, and even within, countries (the UK and US being cases in point).

Given what this grim global picture augured for less-resourced countries and displaced communities – where access to basic services and healthcare is already challenged, and social isolation often impossible – it is tragic but not surprising to hear of people 'waiting for death to come' (Burke & Mumin, 2020). The reality has to date been more nuanced, however, with the virus continuing to surge in several upper-middle and high-income countries, such as the US and Brazil (Phillips, 2020; Smith, 2020), while there are examples of initial success stories in less-resourced settings (Hirsch, 2020). It would seem these differences can be attributed to prompt evidence-based action, strong leadership by example, community mobilisation and a good dose of creativity, driven by the realisation that the large-scale testing and hospitalisation observed in wealthier parts of the world would not be an option. Senegal, for example, embarked on the development of a low-cost Covid-19 testing kit, while Ghana implemented 'pool testing' (testing of multiple blood samples together followed up only in the case of a positive result) (Hirsch, 2020). Both put in place good contact tracing systems and involved community health facilities, community health workers and volunteers (Hirsch, 2020). Similarly, the south-western Indian state of Kerala managed to flatten its epidemic curve early in part as a result of good communication strategies and protocols for case isolation and contact-tracing, and strong community surveillance and support systems for families in need (Kurian, 2020).

While we need to laud and learn from what has worked, we should also be cautious in our optimism. These have been pockets of success, based on individual initiative and good leadership, versus the outcome of an efficacious global effort. These are also early times, and new hotspots or spikes in infection can occur once containment measures are loosened. Many countries in Africa, including South Africa and Nigeria, are currently battling to keep contagion under control, and in May the WHO declared South America the 'new epicentre', following surges in countries like Brasil, Peru', Mexico and Chile (Shaban, 2020; Taylor, 2020; WHO, 2020c).

In the end resources do matter. For one, they determine the economic margin to manoeuvre with lockdown restrictions and closures, which jeopardise millions of already precarious livelihoods, and

with fiscal stimulus packages and social protection measures to buffer some of these adverse effects (Coetzee & Kagee, 2020). In Senegal, for example, lockdown restrictions were eased earlier than planned, following protests spurred by their economic impact (Reuters, 2020). Moreover, once community transmission sets in, countries with less equipped public health systems will struggle to address Covid-19 related health care needs and maintain routine health care (United Nations, 2020b). Many of these countries, already facing a high burden of infectious and non-communicable disease, will not be able to affront the health and economic effects of this pandemic alone.

Yet to date the mechanisms and allocated funds for global solidarity have not come close to the predicted need. The UN's Global Humanitarian Response Plan (GHRP) for the COVID-19 Pandemic, launched in March, brought together appeals for US\$2.01 billion from the World Health Organization and other UN humanitarian agencies. These represented the estimated resources needed, at the time, to analyse and respond to the public health and humanitarian consequences of the pandemic, with a particular emphasis on more vulnerable countries and populations (United Nations, 2020a). Only two months later, in mid May, this appeal was raised to over \$6,7 billion, due to a rapid increase in humanitarian needs, the inclusion of additional countries (from 54 to 63) and the increased cost of health supplies and transportation (OCHA, 2020). At the time of update less than 15% of this need had been met and the total funds received for the humanitarian crisis, including outside the GHRP, was around \$1,5 billion (OCHA, 2020). This indicates how far we are from meeting the global health and humanitarian challenges linked to this pandemic, and also how rapidly these can change as the situation evolves.

The WHO draft strategic preparedness and response plan, released in early February and updated in April, outlines comprehensive actions needed to establish international coordination, scale up country preparedness and response operations and accelerate priority research and innovation (WHO, 2020a, 2020d). However, this plan requires sufficient buy-in, funding and implementation capacity, at a time when the WHO's standing in global health is weakened by factors such as inadequate unconditional and emergency funding, increasing fragmentation in global health (Negin & Dhillon, 2016) and divisions between some of its most influential member states. Accusations of pandemic mismanagement and threats to withhold funding directed at the WHO by the president of the US, its largest contributing member (Riley-Smith, 2020), have only served to undermine an effective response at a time when focus, trust and unity are critical.

## **A moment of reckoning for global health**

Unfortunately the picture described above is not an encouraging one for global health and cooperation. Rather, it exposes a stark, sad truth: while health risks and threats are global, our ability to respond to these effectively is not. The global health apparatus has clearly not kept pace with the interconnectedness of the world's populations and economies, or its shifting political landscape. The focus now has to be on saving lives and livelihoods. But once the emergency phase of this pandemic is over, an honest post mortem should leave us with some harsh assessments and crucial questions moving forward.

The most immediate observation with regard to health security, is that we need more effective national and global guidelines or 'playbooks', that will ensure higher levels of preparedness and earlier, stronger international coordination for the next health crisis (because there will most certainly be a next time). These guidelines should be overarching, but also flexible enough to adapt to the specific and evolving needs of a given health emergency. They should be geared to coordinating and fast tracking the multitude of processes that constitute an effective health crisis response, across states, countries and regions. These include: (1) providing clear, accurate and timely information to relevant end-users, including general health information, real-time surveillance data, prediction modelling, new research findings and medical know-how developing on the ground; (2) prevention and mitigation measures to be implemented at different stages of individual epidemics; (3) production and redeployment of vital health equipment and, where possible, training and deployment

of health experts and workers to where they are most needed in the world at any given time; (4) regional and global mechanisms of support and solidarity for the least resourced and hardest hit countries, including financial and technical support for both crisis preparedness and mitigation, and the maintenance of essential healthcare services; (5) priority medical research studies, and related multi-partner initiatives developing key biomedical and technical products, to ensure the best use of research funds and swift, equitable access to vaccines, diagnostic tests and medications across the globe.

But, as importantly, we need to address the question of *who* will lead in coordinating future global emergency responses, and global health more broadly. This speaks to the importance of what has been referred to as health system ‘software’ (Palagyi et al., 2019, p. 1861; Sheikh et al., 2011) such as values, governance and trust, considered the ‘glue’ binding any system (Palagyi et al., 2019). Good leadership and trust in leaders are necessary to ensure effective emergency responses and widespread adherence to public health regulations, and it has been argued that any new set of health system frameworks needs to recognise their importance (Bennett et al., 2018; Palagyi et al., 2019). Beyond the inadequacy of current systems and implementation plans, this pandemic has exposed a crisis of governance, one that should take us back to the core questions of what we expect from global health and who we expect (and trust) to lead it.

### **A crisis of global health governance**

A multiplicity of actors are involved in global health, also described as a ‘multitude of communities’ (Bennett et al., 2018, p. 522). This reflects the dynamism and diversity, but also the complexity of the global health architecture, and its increased fragmentation. It reinforces the need for strong coordination to achieve a common agenda (Bennett et al., 2018), particularly where action is urgent.

Despite its shortcomings, the WHO is arguably still best placed to play this central coordinating role. Currently, there is no other organisation with a similar global mission, cross-sectorial convening power, worldwide presence and networks, strong information systems, and its level of experience and initiatives for health emergency responses (including the WHO Health Emergencies Program to streamline emergency response efforts (WHO, 2020h) and the R&D Blueprint to accelerate research (WHO, 2016)).

However, as the initial dismal responses to both the Ebola (Gostin & Friedman, 2015) and Covid-19 crises have demonstrated, the WHO in its current form is not well equipped to perform this role effectively. There have been many calls for extensive reform of the WHO over the past decade. These have highlighted its expensive organisational structure, inefficient and bureaucratic processes, misalignment between the activities of its headquarters and regional offices, overly broad scope of activities and politically motivated decisions (Nay et al., 2020; Negin & Dhillon, 2016). However, as rightly argued, now more than ever the world needs a central transnational coordinating agency for global health, one that can continue to promote multilateral cooperation and global solidarity (Nay et al., 2020). The longer term question is whether the WHO should be restructured to better perform this role, or whether we should be thinking of a new world health order and coordinating mechanism. This, in turn, raises the questions of who should take the lead in creating this new order, what it would look like and how to prevent it running into the same snags.

But beyond the WHO, we need to consider the roles of other key players in global health. These include other UN agencies, country leaders, multi-country regional bodies, as well as private sector organisations such as companies and philanthropies, and multi-stakeholder initiatives. And, importantly, we should not forget the roles of individuals, communities and civil society organisations, ultimately representing the people that global health should be designed to benefit and protect.

The issues posed above, linked to health security and governance, cannot be adequately understood and tackled without going back to the roots of global health, to consider the principles and constructs from which it developed and the forces that have shaped its current agenda and

architecture. This requires some reflection on what we mean by ‘global (public) health’, how it has lived up to its expectations, and how we might envisage reshaping it for the future (Adams et al., 2019).

### **A return to the roots of global health: purpose and paradigms**

‘Global health’ is a relatively new term that has been increasingly used over the past two decades. It has been described as ‘the necessary continuance of Public Health in the face of diverse and ubiquitous global challenges’ (Holst, 2020, p. 1). As such, it is a complex and cross-cutting concept that should encompass every health challenge or transnational determinant, including global eradication of disease and issues of health governance (Holst, 2020). It should connect the local and the global (Holst, 2020). And importantly, as an extension of the concept of public health in an increasingly interconnected world, it should be premised on the goal of achieving ‘health for all’, which regards health as a rights-based, universal good (Holst, 2020). This cannot be achieved without confronting broader social inequalities and power disparities, that have their roots in historical and structural injustices (Okonkwo et al., 2020; Shamasunder et al., 2020) and sadly persist notwithstanding decades of poverty eradication and development goals.

Despite the promises and prosperity that have come with globalisation, the world is an increasingly unequal place, where rapid technological advances have disproportionately benefitted those most able to take advantage of them (United Nations Department of Economic and Social Affairs, 2020). Health is no exception. Various scholars have argued that the principles at the core of global health have in reality been forsaken, as wealthier countries and specific interest groups pursue their own priorities. It is contended that a disproportionate focus on health security, a vertical approach to disease management and public-private partnerships or privatisation promoting predominantly ‘profitable’ biomedical and technological solutions, have come at the expense of community health and the creation of a more inclusive society (Adams et al., 2019; Aggleton & Parker, 2015; Holst, 2020).

Far from being equalisers, disasters such as Covid-19 only heighten existing health inequalities (Okonkwo et al., 2020). They disproportionately affect the most vulnerable, who are often the least able to avoid infection, access decent health care or weather social and economic impacts (Quinn & Kumar, 2014). As a result, every crisis pushes the world backwards, making the achievement of the Sustainable Development Goals (United Nations, 2015) more distant on our horizon. Social and linked environmental determinants of health – including gender, poverty, poor nutrition, exposure to pollutants, and inadequate housing – can negatively affect the risk of infectious disease transmission, severity of disease and mortality; some of these are also risk factors for underlying chronic conditions, which in turn are associated with worse morbidity and mortality (Abrams & Szeferc, 2020; Ahmed et al., 2020; Garg et al., 2020). These social and health inequities don’t only exist between lower- and higher-income countries, but also within countries and regions. They exist across and within countries in Europe, where they do not seem to have improved over the past decade (WHO Europe, 2019). They exist in the US, where emerging evidence is showing the disproportionate impact of Covid-19 on ethnic minorities and marginalised communities, including individuals without medical insurance or stable housing (Ahmed et al., 2020; Garg et al., 2020; Okonkwo et al., 2020)

It could be argued that a similar dynamic occurs at a country level, as investment is withdrawn from emerging markets, leaving governments of low- and middle- income countries (LMICs) with less resources for health and social spending (Kentikelenis et al., 2020). And this exacerbates a further key dimension of health inequality that should be of central concern to a global health premised on a rights-based approach: disparities in public health systems and access to decent healthcare. As with individual social determinants of health, these health system disparities exist within and across countries and cannot be dissociated from ‘longstanding global power differentials’ (Shamasunder et al., 2020, p. 1) that have shaped responses to disease and health (Shamasunder et al., 2020).

High income countries represent 80% of global spending, with a more than 70 fold difference between average per capita spending in low versus high income countries (WHO, 2019). Public health systems in many LMICs and some high income countries (HICs) are underfunded, with far from adequate infrastructure, health care workers and equipment to serve their populations (Shamasunder et al., 2020; WHO, 2020e). Promises to strengthen national public health systems have unfortunately to a large extent not materialised, despite this being a core component of the International Health Regulations (IHR) (Gostin, 2015; Shamasunder et al., 2020; WHO, 2008) and central to the achievement of ‘health for all’.

Lastly, issues of unequal power and disparities are reflected at the highest level, in the decision-making and priority setting for world health. Various scholars have argued that global health in its current form entrenches and reproduces historic inequalities because health funding and decision-making, research, media and political debates continue to be concentrated in the Global North, while many of the issues of key importance for infectious disease management and broader global health challenges disproportionately affect the global South (Gautier et al., 2018; Holst, 2020). The global health agenda is therefore controlled by organisations without a legitimate political mandate, that are not representative of the world’s populations (Holst, 2020; Shamasunder et al., 2020).

Once again, these patterns are not new. The COVID-19 pandemic has simply further illuminated phenomena that have existed and been known to us for a long time. Yet the dimension and geographical spread of this pandemic make it unique in modern history for the intensity with which it has brought these issues to the fore. The need for equitable access to health care, strong public health systems and effective national and global health leadership has never been more apparent (United Nations, 2020b). Covid-19 has reminded us, as never before, that we are all connected, and as vulnerable as the most vulnerable among us.

## Looking forward: transforming global health for the future

It is clear that we cannot adequately strengthen health emergency preparedness or sustainably improve the health of the world’s populations without aligning health policies, funding mechanisms and systems with the principles of social justice and universal health that underpin ‘global health’. This cannot be effectively tackled during times of crisis, but instead requires longer-term sustained action and involvement at all levels of society. It should include policies and interventions that seek to address key social determinants of health, such as access to housing and basic services. It should also include greater international solidarity and cooperation to transform the rhetoric around health systems strengthening into more substantial change, in countries where these systems are unable to meet the needs of their populations. This will require providing technical support to country governments and health departments, in a way that respects their local priorities and decision-making (Shamasunder et al., 2020). Moreover, international funding for systems strengthening should see systems holistically and as the starting point, versus a by-product of vertical disease-specific programmes (Warren et al., 2013); there should be sustained support beyond emergency situations, as envisaged by the IHR.

It is also clear that an effective reform of health governance cannot be divorced from the question of *who* sets the global health agenda. The power dynamics in health decision-making must be redressed if global health is to return to its core tenet of social justice, and maintain relevance and legitimacy for the populations it should serve. Governance structures of global health organisations need to be more representative of LMICs and marginalised communities most affected by historical and current health inequities. Shamasunder et al. (2020), for example, advocate for LMIC leaders constituting more than 51% of the governance structure of multilateral institutions, and the prioritisation of proposals from communities most affected by poor health and disease. Gostin (2015) rightly argues that civil society and NGOs should be involved in governance structures of the WHO and key global health players (Gostin, 2015).

Going back specifically to the reform of the WHO, proposed solutions have included better priority setting, empowering the WHO's director-general to directly appoint regional directors, a focus on coordination, regulation and technical assistance (as opposed to implementation) and outsourcing functions to other global agencies (Gostin, 2015; Negin & Dhillon, 2016). However, it is clear that no amount of operational or technical restructuring will address the issues at the core of the WHO's shortcomings as leader on the world health stage. These are fundamentally political, and related to its governance and funding structure. The ability of the WHO to be effective is subject to its 194 member states agreeing on its focus and priorities, through the annual World Health Assembly. The challenges of this are evident, especially given diverging country-level priorities and current geopolitical tensions among some of its most powerful member states (Ioannou, 2020). Moreover, the WHO has become increasingly dependent on voluntary contributions: these currently represent around 80% of its total funding, over 90% of which is tightly earmarked to specific programmatic areas and geographical locations (WHO, 2020f). All of this means that setting a clear direction is both highly challenging and likely to be disproportionately influenced by the (various) priorities of the WHO's member countries and donors providing the most funding. If bound by similar constraints, any attempt to set up an alternative world health coordinating agency is doomed to run into the same hurdles and risk further fragmenting the global health apparatus.

This impasse can only be overcome if the world's most powerful countries and organisations involved in global health empower the WHO to pursue what is best for world health. On the one hand this would entail members providing the WHO with a clear mandate and greater autonomy to make decisions, some level of supranational authority to enforce compliance, and more stable funding (Gostin, 2015; Nay et al., 2020). On the other hand, it would require the WHO to become more representative of the world's population, by giving a stronger role to LMICs, and involving civil society, community organisations and other key global health actors in its decision-making (Gostin, 2015; Shamasunder et al., 2020). This is no small ask, since member countries would need to agree to relinquish some level of sovereignty and power for the collective good. It would, however, be the right thing to do and crucial to address before the next crisis hits. If the WHO is to continue to be the main coordinating agency safeguarding the world's health, it has to be put in a position to do this job well, and regain the world's confidence that it can.

Of course, the WHO is not the only organisation of interest for global health. Effective health responses will require collaboration and coordination of activities between the WHO and various other UN agencies focused on health, food security and development, or specific vulnerable populations; these include agencies such as the UN Refugee Agency (UNHCR), the World Food Programme (WFP), the UN Children's Fund (UNICEF), the UN Development Programme (UNDP) and the Joint UN Programme on HIV/AIDS (UNAIDS). Further attention should also be given to the role of other international and supranational bodies. While the G7 and G20 are not specifically health-focused, they are important to consider because of their influence on the world's economic decisions and their ability to mobilise finance mechanisms. The question is whether their focus could be further extended beyond their relatively small groups of wealthier member countries, and whether they could develop mechanisms more suited to investments in sectors such as housing, education and healthcare, that provide more equitable social benefits (Benatar et al., 2011). As the world's leading financial institutions, the World Bank and the IMF also have a key role to play in supporting LMICs with emergency and longer term health funding mechanisms. This is already happening to some extent. For example, the World Bank has pledged \$160 billion in grants and financial support over 15 months, to help developing countries respond to the impact of Covid-19 and economic shutdowns, and reported having reached over 100 countries by early July (Pate, 2020). The IMF has set up rapid emergency financing facilities to meet an expected demand of \$100 billion from over 100 countries, and is currently fundraising to increase its Catastrophe Containment and Relief Trust to provide temporary IMF debt relief grants to its most vulnerable member countries (International Monetary Fund, 2020). While these relatively quick responses from both financial institutions have been welcomed, these funds are likely to be well below the estimated



needs of LMICs (Duggan & Sandefur, 2020). Health scholars have raised concerns around whether they can be scaled up and how fast, how much can effectively be directed to public (versus private) health services in the lowest income countries, and whether some countries will risk once again ending up with an increased debt burden and weakened public health systems in the longer run (Duggan & Sandefur, 2020; Kentikelenis et al., 2020). Kentikelenis et al. (2020), for example, call on these institutions to see the Covid-19 pandemic as an opportunity to do things differently, by focusing investments towards public health systems, real economy activities and social protection, and suspending conditionalities on emergency aid.

The Covid-19 crisis has also prompted some useful introspection and the introduction of measures to ensure greater cohesion within supranational regional bodies such as the EU and AU. Despite its initial floundering, the EU has been forced to revisit its role in supporting individual country members in times of crises, aware that its very survival is at stake amidst growing anti-EU sentiment spurred by populist and nationalist movements (Chadwick, 2020). It has since created a stockpile of medical equipment and allocated funds to Covid-19 related research, testing and vaccine development, and has loosened existing austerity rules for member States (Chadwick, 2020). While not committing to 'coronabonds', €750 billion were allocated in mid March to purchasing sovereign and corporate debt to protect EU economies (European Central Bank, 2020). Similarly, initiatives from the African continent include the African Union's Joint Continental Strategy to guide cooperation between member states, a Covid-19 response fund (City Press, 2020), and a platform to pool African countries' procurement of diagnostic and other medical supplies (Fabricius, 2020). While these measures will certainly not be sufficient, they are important steps forward. Covid-19 could in fact be seen as a catalyst for greater economic integration in Africa (Fabricius, 2020) and stronger solidarity and cooperation on health on both continents. It remains to be seen whether developments can be sustained and potentially lead to longer term cooperation on health and social projects, within and beyond these regions.

It is also important to consider the roles of private companies, private-public partnerships and private philanthropies in global health, among which the largest and most influential is the Bill & Melinda Gates Foundation. Despite the attention and resources brought to specific health issues, such as malaria and polio eradication, various health and development scholars have understandably raised concerns around organisations with no public accountability or representative decision-making exerting so much influence on the global health agenda (Adams et al., 2019; Aggleton & Parker, 2015; GAVI, 2020; Holst, 2020). This influence, it is argued, has contributed to a focus on biomedical solutions ('biomedical reductionism') at the expense of the social dimension of health (Adams et al., 2019; Holst, 2020). What is missing though is a concrete proposal on how to address this dilemma, that is how to ensure greater public involvement and accountability of activities funded by large private entities, given the current dependence of many global health programmes on this funding. Initiatives funding the development and more equitable distribution of vaccines, therapeutic medicines and other technical solutions across the globe, such as the GAVI Vaccine Alliance (GAVI, 2020), Coalition for Epidemic Preparedness Innovations (CEPI) and COVID-19 Therapeutic Accelerator (Suzman, 2020), arguably have their place within a better coordinated global health system with clear common goals. While these organisations should certainly not be determining the global health agenda, they can make a highly useful contribution if integrated within a broader health network that pays adequate attention to the social aspects of access to and acceptability of health interventions.

Similarly, private companies can support health in times of crisis and beyond in various ways, and there have been many examples of positive initiatives since the onset of the Covid-19 crisis. Besides taking measures to improve the safety and wellbeing of their employees (Fadel et al., 2020), companies can redirect their operations to produce personal protective equipment and other innovative health items (Fabricius, 2020; Hirsch, 2020) and they can support health more broadly through constructive public-private partnerships, information technology, innovative finance (Gostin & Friedman, 2015) and participation in local and international committees focused on improving public health.

Lastly, and most importantly, communities and civil society organisations should be at the centre of a global health that connects the local to the global. As articulated by Adams et al. (2019), ‘Human health and illness always take a local form, even while our models of them are enacted across both global and local spaces and epistemologies.’ (Adams et al., 2019, p. 1394). Decisions and initiatives undertaken nationally and transnationally will ultimately affect the lives of individuals and local communities, who should have a central role in shaping these.

The influence of civil society within governance structures of organisations setting national and global health agendas is one crucial aspect, as discussed above. We have also seen the power of community buy-in and direct involvement in successful responses to health crises and effective health promotion; this is illustrated by the examples of Senegal, Ghana and Kerala during the Covid-19 outbreak, described above. There have been many further examples of inspiring initiatives taken by civil society organisations around the world during the Covid-19 crisis, supported by online platforms and social media. International NGOs such as Doctors without Borders and the International Rescue Committee are often the most visible because of the dimension and global reach of their work (Doctors without Borders, 2020; IRC, 2020). However, a myriad of smaller community-based organisations have also been raising money for emergency relief, donating medical equipment, masks and food, disinfecting public spaces and even fighting the barrage of fake news, criminalisation of free speech and other human rights violations (Brechenmacher et al., 2020).

We should also not disregard the power of social movements, led by individuals and civil society organisations, and supported through social media connecting the world in a way not previously conceivable. For example, the recent ‘me too’ (‘me too’ movement, 2020) and ‘Black Lives Matter’ (Bobes, 2020; Noor, 2020) movements are global outcries against systemic discrimination based on gender and race. While not directly related to health, these movements are still highly relevant to the achievement of a more just and inclusive global health system, which cannot be divorced from the longstanding social and economic disparities driving these movements. They are born from a sense of exclusion and detachment from the institutional structures making decisions on behalf of the world’s peoples, often without their voices.

There have been many social movements in the past. Some have not been successful while others have led to real and important change, including the enforcement of civil rights and the toppling of authoritarian regimes (Engler & Engler, 2017). What is perhaps unique about the social movements of today is their increasingly global dimension and digital organisation, a result in large part of rapid developments in communication and information technology. The recent anti-racism protests, for example, have connected millions of people, across very different social, economic and geographical settings, with common experiences of social injustice and a shared desire for change. It is argued that social movements are more likely to lead to systemic change if they combine short-range disruptive action and longer term community organising to build institutions and organisations (Engler & Engler, 2017). Time will tell if the current grassroots-oriented movements will be strong and sustained enough to build adequate reform coalitions and force long-term political change (Brechenmacher et al., 2020), and what this will imply for global health.

### **Concluding thoughts: dare we hope?**

The Covid-19 crisis is a moment of reckoning unlike any before. It has shed a sharper light on the unequal patterns in society that leave us vulnerable, and the failures of global health in its current form to protect us from both acute and systemic challenges in a rapidly changing world. It has been a brutal reminder that the status quo or its ‘minor tweaking’ (Engler & Engler, 2016) are not sustainable options, that the future of global health will depend on our ability to rethink and re-create it – or perhaps more aptly, co-create it – going back to its very purpose and the principles it was founded on.

This will require a vision that is starkly different to the current reality. One that pursues global justice in substance and not just rhetoric, that sees health as ‘the aspiration of every human being’ (Holst, 2020, p. 9) and not primarily a profitable business model. It will also require different governance, one that is more focused and determined, more representative of the needs and voices of individuals and communities it should ultimately have been created to serve, one that harnesses creativity and grassroots innovation. It will require a longer term approach to health promotion, beyond crisis management, to build systems, capacity and dedicated financial resources in an on-going and sustainable way. Only through a real shift in paradigm and actions will we be able to aspire to ‘health for all’ and make progress in disrupting enduring patterns of inequity.

This latest health crisis has in a sense left us at a crossroad, and the direction we choose will shape the future of global health. We can respond with greater individualism, denial, deflection of blame, and a ‘me first’ attitude, as some have. This will embolden nationalist and populist agendas, that tend to look inward and backward, and lead to greater division among the ‘multitude of health communities’ (Bennett et al., 2018). It will further diminish our ability to respond to future emergencies coherently, and to move forward with a more equitable shared health agenda. It will ultimately make us all more vulnerable.

Alternatively we can take a second path. One that acknowledges that our lives, health and destinies are all inextricably linked, and that we will have to work together towards a vision of a healthier and more equal world. A path that puts collective wellbeing before specific interest groups, that will allow us to co-create a global health more aligned to the needs of the people it should serve, and better affront the challenges of today’s increasingly volatile and interconnected world. If we choose this course, the Covid-19 pandemic, that has shaken the world to its core, could indeed be positively transformative.

Is this a utopian vision? One may argue that we have been here many times before, that we have faced many crossroads. But this *is* a unique moment in history representing the confluence of various phenomena: the devastating worldwide effects of this pandemic; the realisation that our future may be scattered with similar or worse biological threats; a growing awareness of the real implications of environmental damage and climate change; the increasingly exposed dangers of self-serving populist leadership; an unprecedented connectivity across the world’s populations through technology and media; and a mounting quest for social justice that has unified people across cultural and geographical divides as never before. We need to dare to hope that things can be different this time, or perhaps more aptly dare to fight against a return to a form of ‘status quo’, or worse. We need to move with the energy and resolve of this moment.

The creation of a new global health order is highly ambitious, but not impossible. It will not happen in a day or a month, but we can start taking important steps towards it. This will ultimately depend on how much we value our collective wellbeing, and what we are prepared to give up for it. It calls for bold moral leadership, and determined citizens willing to exert organised and sustained pressure on leaders and institutions, to demand the change they deserve. This will be neither easy nor convenient, especially at a time when bold moral leadership appears to be in short supply. But there have been many moments in history when change seemingly confined to the universe of the unimaginable was propelled into the realm of reality by ‘outbreaks of defiance and hope’ (Engler & Engler, 2016). As powerfully put by Engler and Engler (2016) ‘Every once in a while, an outburst of resistance seems to break open a world of possibility, creating unforeseen opportunities for transformation... They turn issues and demands considered both unrealistic and politically inconvenient into matters that can no longer be ignored; they succeed, that is, by championing the impractical.’

The Covid-19 pandemic is a global health tragedy but also an important wake up call. We need to heed it.

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