



COVID-19: Make it the Last Pandemic

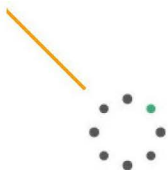
The
Independent
Panel

FOR PANDEMIC
PREPAREDNESS
& RESPONSE

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4. What happened, what we've learned and what needs to change

The Panel has carefully reviewed each phase of the present crisis in order to establish facts and draw lessons for the future.

4.1 Before the pandemic – the failure to take preparation seriously

In under three months from when SARS-CoV-2 was first identified as the cause of clusters of unusual pneumonia cases in Wuhan, China, COVID-19 had become a global pandemic threatening every country in the world⁽¹¹⁾. **Although public health officials, infectious disease experts, and previous international commissions and reviews had warned of potential pandemics and urged robust preparations since the first outbreak of SARS, COVID-19 still took large parts of the world by surprise.** It should not have done. The number of infectious disease outbreaks has been accelerating, many of which have pandemic potential.

It is clear to the Panel that the world was not prepared and had ignored warnings which resulted in a massive failure: an outbreak of SARS-COV-2 became a devastating pandemic.

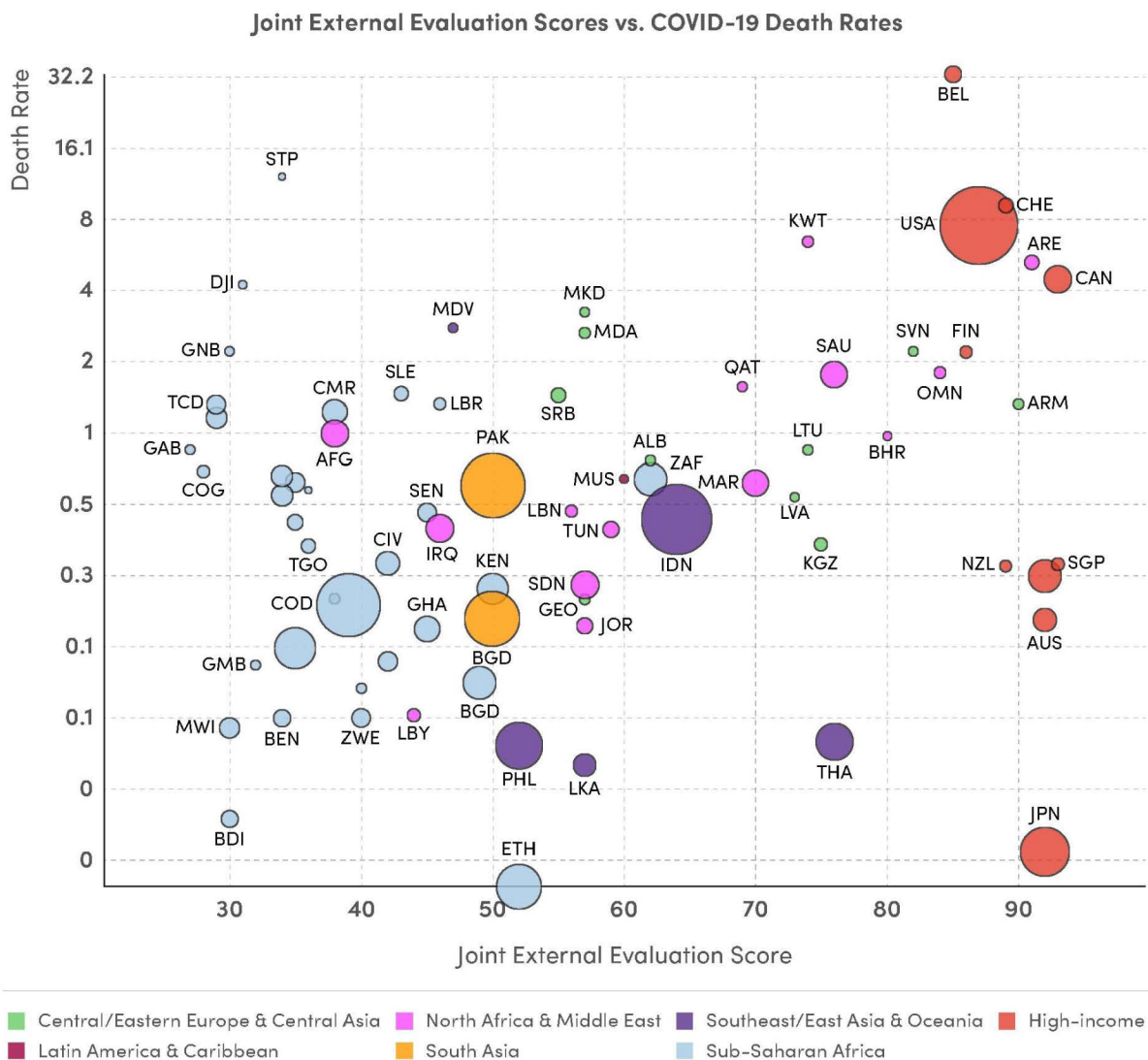
The fast-moving **SARS epidemic had shaken the world in 2003**. While the epidemic only lasted some six months and was responsible for 8096 cases and 774 deaths⁽¹²⁾, it was judged by the WHO Regional Director for the Western Pacific to have “caused more fear and social disruption than any other outbreak of our time”⁽¹³⁾. SARS was a novel coronavirus causing respiratory disease. It travelled rapidly to 29 countries, territories and areas, and debilitated health systems, with many health workers being infected. Even so, expert observers knew that, with SARS, the world had dodged a bullet – screening and isolation could readily contain its spread, because people with SARS did not transmit the virus until several days after showing symptoms and were most infectious when symptoms were most severe. It was understood that **if a new fast-moving pathogen were transmissible in the absence of symptoms, it would pose a much deadlier challenge.**

The SARS epidemic was followed by the 2009 H1N1 influenza pandemic, the 2014–2016 Ebola outbreak in west Africa, Zika and other disease outbreaks, including another new coronavirus, Middle East respiratory syndrome (MERS). These outbreaks were the impetus for a series of initiatives to strengthen health security, animated by the conviction that disease outbreaks and other health threats constituted a major global risk and required a web of actions across all countries.

While there have been concerted efforts in recent years to boost pandemic preparedness, they have fallen far short of what is required. Too many national governments lacked solid preparedness plans, core public health capacities and organized multisectoral coordination with clear commitment from the highest national leadership⁽¹⁷⁾. The self-reported assessment of core capacities for preparedness that countries are required to submit to the WHO under IHR (2005) gave a global average score of 64 out of 100⁽¹⁸⁾. Only two-thirds of countries reported having full enabling legislation and financing to support needed health emergency prevention, detection, and response capabilities⁽¹⁹⁾. Country preparedness was also assessed under the voluntary Joint External Evaluation process, undertaken to date by 98 countries. An independent academic exercise, the Global Health Security Index, also sought to score country pandemic preparedness.

Figure 1: Death rates in this figure shows the cumulative, reported, age-standardized to COVID-19 deaths per hundred thousand people in the 50 days following the date of the first death in that country

Source and adapted from: Sawyer Crosby et al, IHME, Think Global Health



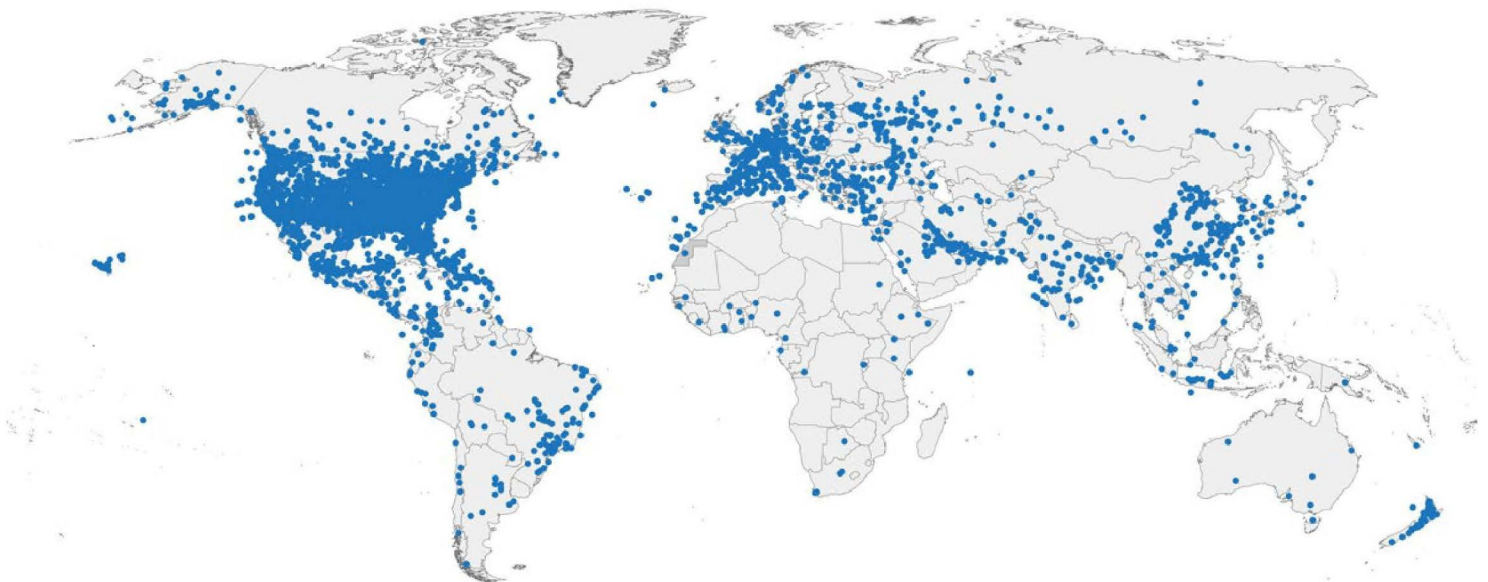
What all these measures have in common was that their ranking of countries did not predict the relative performance of countries in the COVID-19 response^(20, 21, 22). **The measures failed to account sufficiently for the impact on responses of political leadership, trust in government institutions and country ability to mount fast and adaptable responses⁽²³⁾.** For example, while the US ranked highest in its aggregate score on the Global Health Security Index, it scored less well on universal health care access, and in relation to public confidence in government received a score of zero indicating a confidence level of less than 25%⁽²⁴⁾. The failure of these metrics to be predictive demonstrates the need for a fundamental reassessment which better aligns preparedness measurement with operational capacities in real-world stress situations, including the points at which coordination structures and decision-making may fail. The current pandemic will generate a wealth of data to guide that reassessment.

Underscoring the consequences of a failure to invest sufficiently in preparedness capacity is the increasing background level of risk. Population growth and accompanying environmental stresses are driving an increase in emerging novel pathogens. Air travel, which has increased fourfold since 1990, enables a virus to reach any place in the world in a matter of hours⁽²⁵⁾. A new pathogen could emerge and spread at any time.

Most of the new pathogens are zoonotic in origin. Driving their increasing emergence are land use and food production practices and population pressure. Global surveillance systems need to monitor burgeoning infrastructure, environmental loss and the status of animal health. One Health interagency and multisectoral collaboration need to be an integral part of pandemic preparedness planning. Accelerating tropical


Figure 2: Air travel has increased four-fold since 1990. This figure shows concurrent flights in the air as of 02 May 2021, 9pm CET

Source: FlightAware, accessed online 2 May 2021.



went on to characterize COVID-19 as a **global pandemic on 11 March 2020**, when there were a reported 118 000 cases in 114 countries⁽³⁷⁾.

The Panel has considered this sequence of events between December 2019 and the declaration of a PHEIC on 30 January 2020 in detail in order to assess what could potentially have been done differently and whether changes are needed in the international system of alert.



There is a case for applying the precautionary principle in any outbreak caused by a new pathogen resulting in respiratory infections, and thereby for assuming that human-to-human transmission will occur unless the evidence specifically indicates otherwise

The IHR (2005) are designed to ensure that countries have the capacity to detect and notify health events. They require that, when disease or deaths above expected levels are detected, essential information is reported immediately to subnational or national levels. If urgent events, defined as having “serious public health impact and/or unusual or unexpected nature with high potential for spread” are detected, they must be reported immediately to the national level and assessed within 48 hours. Events assessed to warrant a potential PHEIC must be reported to WHO within 24 hours of assessment, via the IHR national focal point. Events with PHEIC potential must meet at least two of four conditions, namely: (1) have serious public health impact; (2) be an unusual or unexpected event; (3) have significant risk of international spread; and (4) carry significant risk of travel or trade restrictions.^(a) The Panel’s view is that the outbreak in Wuhan is likely to have met the criteria to be declared a PHEIC by the time of the first meeting of the Emergency Committee on 22 January 2020.

While WHO was rapid and assiduous in its early dissemination of the outbreak alert to countries around the world, its approach in presenting the nature and level of risk was based on its established principles guided by the International Health Regulations of issuing advice on the balance of existing evidence. While WHO advised of the possibility of human-to-human transmission in the period until it was confirmed, and recommended measures that health workers should take to prevent infection, the Panel’s view is that it could also have told countries that they should take the precaution of assuming that human-to-human transmission was occurring. Given what is known about respiratory infections, there is a case

^a In addition, SARS, poliomyelitis, smallpox and a new subtype of influenza are automatically defined as events that may constitute a PHEIC. See International Health Regulations (2005), 3rd edition. Geneva: World Health Organization; 2016 (<https://www.who.int/publications/i/item/9789241580496>, accessed 26 April 2021).