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BSW is chair of and DLT is a co-chair of the *Lancet* Commission on hearing loss and BSW was a consultant for the generation of WHO's *World Report on Hearing*. We declare no other competing interests.

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Priorities for the COVID-19 pandemic at the start of 2021: statement of the *Lancet* COVID-19 Commission



The *Lancet* COVID-19 Commission calls for three urgent actions in the COVID-19 response (our broader overview is available on our website). First, all regions with high rates of new COVID-19 cases, including the USA and the European Union (EU), should intensify measures to minimise community transmission alongside rapid deployment of COVID-19 vaccines. Second, governments should urgently and fully fund WHO and the Access to COVID-19 Tools (ACT) Accelerator,¹ including COVAX. Third, the G20 countries should empower the International Monetary Fund (IMF) and multilateral development banks to increase the scale of financing and debt relief. Success on all three priorities—containment of transmission, rapid vaccination, and emergency finance—will require improved global cooperation.

The high rates of community transmission (>100 new COVID-19 cases per million per day)² in the USA, Europe, South Africa, and other countries show the emergence of new variants of SARS-CoV-2, such as lineage B.1.1.7 in the UK,^{3–7} 501Y.V2 in South Africa,⁸ and additional variants emerging in California, USA,^{9,10} and in Brazil.^{11,12} New lineages are increasing transmission of infection

and raising risks in regions that have been less affected by COVID-19, including in sub-Saharan Africa.^{13–15} Additionally, acquired immunity from earlier COVID-19 infections might be less protective against reinfection with some of the new SARS-CoV-2 variants.¹⁶ Mutant lineages might also reduce the efficacy of COVID-19 vaccines and require adapted vaccines or boosters.^{17,18}

The numbers of new COVID-19 cases in east Asia and the Pacific (<10 new cases per million per day in most countries) have been consistently below those of Northern America and Europe. The lower numbers of COVID-19 cases in these countries result from the successful implementation of comprehensive containment measures: border restrictions and other limits on movement; behavioural changes including widespread use of face masks and physical distancing; active surveillance by public health systems, including mass testing, backward tracing (to identify the sources of outbreaks), and forward tracing (to identify the contacts of new cases); and the quarantine of all suspected cases and the use of facility-based isolation of confirmed cases of COVID-19. The USA and the EU failed to implement

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such comprehensive measures, and there was generally excessive decentralisation of containment efforts across the 50 US states and 27 EU members in 2020. Lack of centralised coordination undermined control of COVID-19, not least because of interstate travel in the USA and intercountry travel in the EU.¹⁹ Both the USA and EU need to step up more top-down coordination in 2021.

Stronger health systems that incorporate universal health coverage and community-based health workers are vital in the response to COVID-19. At least half of the world's population lacks access to essential health services.²⁰ Strengthening community-based and gender-responsive health systems will be essential to implement inclusive and comprehensive COVID-19 immunisation campaigns.

The global roll-out of COVID-19 vaccines to date is neither inclusive nor adequately planned. COVAX has targeted immunisation coverage of at least 20% of the population in each participating country by the end of 2021,²¹ and has contracted for 2 billion doses of COVID-19 vaccines. Yet the timely supply of vaccines to COVAX is in question, as high-income countries (HICs) step to the front of the queue for limited supplies of COVID-19 vaccines.

As of Feb 9, 2021, 148.08 million COVID-19 vaccine doses had been delivered, of which 115.67 million were delivered in the USA (43.21 million), China (40.52 million), the EU (18.36 million), and the UK (13.58).²² Other countries in Africa, Latin America and the Caribbean, and Asia (not including China) have received very few vaccine doses or none at all.²² This unequal access to COVID-19 vaccines is partly due to the difficulty of

managing the ultracold supply chain needed for the two mRNA vaccines, but it is also due to the vaccine supply deals negotiated by HICs directly with the vaccine producers, rather than through COVAX.

If COVAX is provided with more guaranteed funding, it could incentivise expanded production and delivery of COVID-19 vaccine doses for low-income and middle-income countries (LMICs) and assure COVAX's place in the vaccine queue. To achieve meaningful results in 2021, COVAX should have guaranteed funds in 2021 of US\$20–40 billion, which it would turn into firm agreements on expanded vaccine production. Moreover, members of the Developing Countries Vaccine Manufacturers Network should be engaged with the efforts of COVAX to produce low-cost vaccines at scale. India and South Africa have called for an urgent waiver of the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) on intellectual property related to COVID-19 prevention, containment, or treatment.²³ The *Lancet* COVID-19 Commission supports the emergency waiver of TRIPS in all circumstances that would facilitate the rapid scale-up of production and distribution of life-saving COVID-19 vaccines and therapeutics, noting that it is in the interest not only of LMICs but also of the entire world to suppress the pandemic as rapidly as possible.²⁴

During the COVID-19 pandemic, the revenues of governments have plummeted at a time when higher government spending is urgently needed.²⁵ As a result, the need for emergency deficit financing is unprecedented. HICs are able to finance large deficits by borrowing in the capital markets together with open-market operations by the central banks that partly monetise the new debt. If LMICs run deficits and open-market operations equivalent as a share of gross domestic product to those in the USA and Europe, most LMICs would incur steeply rising interest rates, depreciating currencies, and high inflation. Thus, while HICs are running huge budget deficits,²⁶ the poorest countries are reducing investment spending to make room for urgent social spending.²⁷ Even worse, many of the poorest countries cannot cover the costs of urgent social needs.

The IMF and multilateral development banks (the World Bank and regional development banks) were created for such emergencies. In 2020, the IMF lent about \$105.5 billion of emergency financing to 85 countries.²⁸

We welcome the possibility of a new allocation of Special Drawing Rights (SDRs), the reserve currency of the IMF. As the IMF supplements the international reserves of IMF member states, a new SDR allocation would be particularly important for countries that face balance of payment shortfalls in the context of COVID-19 and could be mobilised in innovative ways to increase the financing capacity for COVAX. If an additional SDR allocation of about \$650 billion were agreed, the amount available to LMICs would be of significant macroeconomic benefit. The multilateral development banks should similarly be supported to substantially increase long-term financing of infrastructure to ensure that COVID-19 does not derail the Sustainable Development Goals and other development objectives, such as mass electrification with renewable energy and universal access to digital technologies.

Now more than ever the multilateral system must be supported to work effectively to deliver know-how and COVID-19 vaccines, therapeutics, and other vital supplies (eg, personal protective equipment and COVID-19 test kits) to all nations. Multilateral cooperation should include technical training and cooperation, active sharing of best practices, and the full deployment of international policy instruments, including emergency multilateral financing, flexibilities under the WTO-TRIPS agreement, and active cooperation in global institutions, including WHO, the ACT Accelerator, and COVAX.

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The changing face of medical professionalism and the impact of COVID-19

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Medical professionalism is changing with the increasing gap between what doctors have traditionally been trained to do and the realities of modern clinical practice.¹ In high-income countries, the changing demographics of patients with an ageing population, the large proportion of patients with long-term conditions and multiple comorbidities, and rising health-care costs have placed huge pressures on health systems globally.² Advances in technology and science have changed the way health professionals interact with patients, and democratisation of knowledge and increased accountability that come with changing patient and societal expectations have added to the

demands placed on physicians.³ In many countries, inadequate staffing levels aggravate this situation.⁴ Morale among doctors is generally declining—eg, a survey in the UK showed 54% of physicians reported morale as low or very low⁴—and burnout is rising (prevalence about 66–80%).^{5,6} There is a crisis in staff retention in some countries with up to 48% doctors considering leaving the profession.⁷

COVID-19 has exacerbated these tensions between medical professionalism and physician wellbeing. The pandemic has placed substantial demands on already overstretched, understaffed, and under-resourced health systems. COVID-19 has tested doctors and health-care