Cette série de contributions s'efforce de mettre en partage les réflexions, observations, témoignages et questionnements que suscitent, chez chacun d'entre nous, les développements de l'épidémie et les multiples conséquences qu'elle aura aussi bien à court qu'à long terme.

NATION STATES, MULTILATERALISM AND COVID-19

April 9th 2020 | **Marisol Touraine**, Former French Minister of Health, Chair of the Executive Board of Unitaid

The coronavirus pandemic requires a strengthening of policies and greater international cooperation. But up until now, we have seen the opposite and this is likely to continue unless rigorous measures are put in place. Drug procurement strategy can be the first test, or testing ground, of a new strategy for international cooperation.

The time for taking stock has not yet come, but analyses of the world after the pandemic are already making the rounds even if it seems presumptuous to guess what our new 'New World' will be like when the fight against the disease is far from over and its economic consequences have yet to be measured. On the other hand, the list of practical proposals is getting longer, including increasing salaries for certain jobs, using new technologies in the field of health and encouraging more ecologically responsible consumption patterns. These two approaches are clearly necessary, and will become vital as soon as the crisis comes to an end: what kind of world do we want from now on? What actions must be taken to bring it about?

Personally, I would like, at this stage to take a step back to look at what the crisis reveals about the link between national and international health policies and at the decisions that are called for in this area.

In Europe, the idea that health policies are, and should be, decided at national level is strongly rooted in people's minds and in practice. Like all countries with advanced policies in this area, France has always refused to advocate greater health and social integration, with left-wing governments, for example, unwilling to take the risk of reducing the level of protection afforded to the French people. This concern has been particularly acute in recent years, with populists espousing a pullback of social policies.

Furthermore, the French are convinced, as am I, that health policy, particularly public hospitals, strongly marks their identity and common history. At the end of the Second World War, the establishment of social security and public hospitals also met the explicit political objective of strengthening a democracy that had been tested by the perturbations of the 1930s. In our collective imagination, public hospitals on the front line against COVID-19, is not just the site of heroic medical battles, it is the most complete expression of the right to health, which embodies equality and guarantees strong social cohesion in the face of populist temptations and difficulties.

Although this model has been shaken in recent years for a variety of reasons, which themselves would merit analysis, it remained firmly anchored within us even before the current crisis brought it back in epic guise.

As such, any prospect of closer European cooperation has tended to be perceived more as a threat than an opportunity. What is true for France is, for other reasons, also true for our neighbours. This was evident at the beginning of the crisis, as the European Union was slow to grasp the threat posed by the pandemic, withdrawing into the silence afforded to it by its lack of jurisdiction in the matter, when it did not allow some of its members to send the Italians, who were the first to be affected, back to their alleged negligence. It is true that this inertia over healthcare took place against the backdrop of a wider European crisis, the signs of which have been striking in their number. In any case, the result is that the health (and economic) crisis resulting from the accelerated spread of COVID-19 has been directly managed by the nation states, without them even exchanging strategies, approaches and perspectives.

Yet, since the turn of the millennium, the AIDS pandemic has highlighted the need for global responses to health problems arising from transmissible infections that know no borders: a global response is needed for global pandemics. Institutions have been set up, firstly the Global Fund, which deploys large-scale aid programmes, and then Unitaid, which pilots innovative projects to promote access to health.

But the focus of these organisations is on countries in the southern hemisphere, primarily African countries, as if cooperation between these countries was undoubtedly required for humanitarian reasons, whilst a national approach continued to prevail in the northern hemisphere, with rich states seen as being capable of and having the knowledge to act independently. It was within a framework of national strategies that the countries of the northern hemisphere controlled the AIDS epidemic; the deployment of hepatitis C treatments when they appeared in 2013, was also negotiated at national level, as French attempts to promote a European approach in this area came to a halt in the race for the cheapest treatments in each Member State. It is as if the evidence that global health issues call for global responses applies to countries in the southern hemisphere, but not to those in the northern hemisphere, who see it as a matter of solidarity and not of public health. In fact, solidarity with countries of the southern hemisphere, even if it also has an obvious humanitarian dimension, is all the more sensible: eradicating communicable diseases in poor countries protects poor populations but, in the age of globalisation, also protects the (more) rich populations. Thus, for the richest countries, this solidarity does not only come from development policy, but is also a public health measure for the benefit of their own populations.

In the same way, access to medicines has been systematically conceived of in two successive stages: the development of innovative drugs (to treat AIDS or hepatitis C, for example) are sold at high prices in countries in the northern hemisphere and are then subject to negotiations by Unitaid, which obtains much lower prices for low-income countries within the framework of voluntary agreements for the production of generic medicines. For example, the annual treatment for an HIV patient in Europe costs about $10,000; for a whole range of other countries it has been negotiated to less than $70. Ninety per cent of antiretroviral patients in Africa are treated with these generic drugs at negotiated prices.

It is this approach that is being torn apart before our very eyes due to the outbreak of a massive epidemic that is affecting the entire planet more or less simultaneously, and which requires robust action to be taken.

While multilateralism was established 20 years ago as THE incontrovertible response to the pandemics of the turn of the century (HIV-AIDS, malaria, tuberculosis, then hepatitis C), multilateralism has been conspicuously absent from the current crisis and the acutely national nature of the response to the pandemic in the northern hemisphere constitutes a threat to international institutions, starting with the European Union.

The almost global choice of adopting a containment strategy, moreover, leads to the paradox that our answer to the global epidemic is not only based on national responses, but that within these, small-scale local strategies are at play.

Although health was certainly not one of the Union's areas of jurisdiction, there is a great risk that the slow start observed in the management of the health crisis could weaken the entire European edifice. At the same time, UN multilateralism will be left as one of the direct victims of the period when it should have emerged strengthened. In the absence of a collective strategic orientation driven by these institutions, which undoubtedly do not have the political means to achieve this ambition, other perspectives must be explored. The development of crisis management strategies at European level, the establishment of and provision of venues for shared scientific and political exchanges, is a first necessity (the European Centre for Disease Prevention and Control (ECDC) is now manifestly missing in action). A second requirement is that the likely imminent arrival of treatments for COVID-19 will allow a new cooperative model of price negotiation to be put in place from the outset. In concrete terms, the disappearance of UN multilateralism may mean the death of approaches of international cooperation, unless it allows for the emergence of better targeted strategic approaches, which, on the one hand, opens the door to increasing European cooperation, and on the other hand to strengthening ad-hoc organisations such as the Global Fund, Unitaid and, on the specific subject of vaccines, Gavi.

With regard to increasing European cooperation, the aim is not to propose an integration of European policies in the face of global health threats, but to act pragmatically in two directions. The first is to adapt the regional governance of global epidemics and to extend what has finally been put in place with the reception of patients in countries other than their own and, above all, to provide for a coordinated reflection on the conduct to be adopted and strategies to be put in place. This is needed for the effectiveness of the fight against the disease: the differences in the approaches of the European countries have been disturbing to say the least. There is no reason to say today that the French strategy will have been less successful than others. Presenting a united front, or at least explaining the differences in approach, would nevertheless have been reassuring for public opinion. The second direction in which resolute European action is needed is in the rebuilding of a strategic industrial supply chain so that we do not have to depend on China or the United States for essential medicines, devices or medical equipment.

The shortage of masks certainly raises questions about stock management (there were 754 million surgical masks in France's strategic stocks in 2017). Above all, it raises the question of France's dependence on foreign production sites. The serious and emerging problem of the risk of a shortage of anaesthesia products, despite them being produced in Europe, furthermore raises the issue of coordinated and proactive action by European industrial and public authorities. Determining what ought to be produced in France as a matter of course, and what can be produced at European level portends intense debate. In any case, the establishment of a strategic European supply chain obviously presupposes that a basis for cooperation has been clearly asserted in advance.

Negotiation of the price and access to COVID-19 treatments will be a highly political testing ground in the coming years. Behind the highly technical devices, lie fundamentally political issues such as patents, remuneration for innovation, the link between public research and private industrial development, and equitable access to treatments. Fortunately, several treatments for COVID-19 appear to be feasible and are currently undergoing clinical trials. Around 700 of them have been included under the banner of the WHO's Solidarity programme. But as soon as one or more effective treatments have been identified, each country will find itself alone in negotiating the price with the laboratories concerned. If nothing is done, as always, rich countries will pay a high price for the treatments, which they will receive immediately, while others will wait for generic production agreements to be negotiated, notably by Unitaid.

Faced with the threat of the pandemic, faced with the risk of the epidemic returning after containment measures are lifted, it is essential, and not only from a moral point of view, that vulnerable countries be able to treat their populations rapidly, i.e. at the same time as others. This is the first time that it has been so apparent that unity of action, place and time is essential in impacting on the curve of this tragedy: we must face the same disease, everywhere, at the same time.

This requirement can become an opportunity, an asset in the long run. We are not starting from scratch. The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS, 1995), namely those provisions that were recognised in the Doha Declaration (2001) already permits countries to make use of compulsory licences in order to allow production of treatments, especially in the event of an epidemic.

Unitaid is proposing taking a new step: at the same time that countries are investing heavily in the development of new drugs and devices, which is a gigantic level of public investment, they must immediately negotiate low-cost mass production with industrial partners, and from the outset, make provision in the contract clauses that allow for patents to be shared (not relinquished) without any geographical limitation.

This is not a utopian ideal. Ten years ago, Unitaid created the Medicine Patent Pool (MPP), which allows pharmaceutical companies to assign their rights on a voluntary basis. This has enabled the manufacture of generic drugs that treat tens of millions of people worldwide. But it took at least 10 years from the treatments becoming available in the northern hemisphere to their availability in the southern hemisphere. Faced with COVID-19, we must act immediately, so that everyone, everywhere, has access to treatment at the same time.

What is new about this step, due to the urgency and in view of the sum of public funds invested, is to register the availability of patents within an organisation that is responsible for managing the entire process from the management of rights to finding reliable producers, and to do so right from the very first contracts with these companies. Until now, there has been a structure like this – the MPP – but firstly, it has only intervened as a second step, in order to enable access to treatments in countries of the southern hemisphere, a long time after they have been available in the northern hemisphere. Secondly, negotiation has always meant setting strict geographical limits to patent transfers, whereas in this case, it would be a question of ensuring that the sharing of patents can be done for the whole world right from the start. Thus, this is about enlarging the scope of intervention for the MPP (or another ad-hoc structure, which would, however, not be the most sensible course of action).

A mass deterrent weapon? Certainly a massive persuasion tool, which has just proved its effectiveness. This option had never been considered by rich countries until now, even when the laboratory producing the cure for hepatitis C had offered it at an exorbitant price. But for the first time, Israel, as well as countries as reluctant to curb the pharmaceutical industry as Germany, Chile, Australia or Canada, have adopted resolutions allowing them to take this route. Mindful of this prospect, Abbott Laboratories have chosen to assign their rights to the MPP without any geographical limit or therapeutic indication for Kaletra, a drug used in the treatment of AIDS and currently being tested to treat COVID-19. Other companies would be prepared to go down this route too.

France has remained silent as yet. But this opens up a perspective that could turn traditional international cooperation on its head. And, at the same time, create a new framework for debate on the cost of therapeutic innovation that is more favourable to states, and moreover, by extension to citizens everywhere who could thus benefit from it more rapidly.