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That is the topic that Els Torreele, a Fellow with the Institute of Innovation and Public Purpose at University College, London, will now address. Els, the floor is yours, and thank you. Hope you feel better.

Els Torreele

Thank you, Michel, for the kind introduction and for the good wishes. I have recovered meanwhile. I have just confirmed myself, testing negative this morning, but unfortunately I could not travel to be with you.

What I will talk about in the next 10 minutes is really looking back to the Covid response. In addition to all the non-pharmaceutical interventions that Antoine eloquently talked about, I think one major success stood out, which is our collective scientific community came together and, in record time, was able to create and produce effective vaccines that have dramatically limited the risk of severe disease and death during Covid.

We were also lucky, we have to admit, that when scientists made this famous spike protein which would indeed be able to elicit an adequate immune response, it paid off. Also, several of the existing vaccine technology platforms from the classic attenuated viruses to these new viral vector platforms, and especially at the meanwhile famous Messenger RNA (mRNA) platform, they could rapidly be adapted to this new virus.

This was not just luck. This was also the result of massive investments, public and taxpayers investments, into research and development over many years, and then, of course, massive investments during the response.

However, as indicated already by Michel, the main failure of our collective Covid response has been that large parts of the world were precluded from the timely and equitable access to these life-saving vaccines that would have been able to avoid many more deaths, and probably would also have been much more effective in controlling the pandemic.

Just to remind you, 15 months after the vaccines became available mainly in high-income countries, and where even persons with very low risks of getting ill, including children, were being vaccinated, most countries in Africa had not been able to vaccinate even their healthcare workers that were at the first line and at high-risk of getting ill, or the most vulnerable populations.

As you know, the risk of dying increases significantly with age and with coinfections or comorbidities, and so those people were most concerned. Because that is what equity means, right? Equity means that those who need it most, those that are at highest risk of getting ill, should be prioritized. And that is not at all what we did, and that was the extreme inequity that Dr Tedros, the Director of the World Health Organization, referred to as vaccine apartheid. That is really what happened.

Therefore, are we ready for the next pandemic, to do better in terms of vaccine equity or countermeasure equity? Because it is not just vaccines, it is also access to diagnostics and treatments.

In order to respond to that, we need to understand why we ended there, and there are many factors that contributed. The initial scarcity led to hoarding and vaccine nationalism with countries buying up all the stocks of these newly produced vaccines to be able to vaccinate their whole population, even multiple times, while other countries were precluded to even buy vaccines for their healthcare workers.

However, a very important reason was that a handful of companies held monopolies on the science and technology and therefore controlled the production and availability of these vaccines, and were able to actually decide how much to produce, when, to whom to sell and at what price.

While wielding a monopoly and power to control markets and maximize revenues may be normal business practice in many economic sectors, here we are talking life-saving vaccines, moreover, developed with massive public investment, and we are in the biggest health crisis of our lifetime.

Therefore, while it was stunning that many normal business practices were interrupted or dramatically changed – think about lockdowns, we have never done such a dramatic intervention in our economy – somehow the powers that be did not think that it was needed to do something about the pharmaceutical business ecosystem, trusting that the market mechanisms could be relied upon to deliver. We know how that ended.

We have to acknowledge that some vaccine producers, AstraZeneca together with the Oxford vaccine and some Chinese producers, did enable some local production in a few countries, but this was largely insufficient. It was too little too late to really supply the world. Many producers that were trying to obtain such licenses were refused.

Very importantly, the producers of the mRNA vaccines, who very quickly became the preferred option in many countries, totally refused to share their technology, instead doubling down on scaling up their own production capabilities.

This was even more dramatic because one of the key advantages of this novel technology is that it is actually relatively easy to produce compared to traditional vaccines. It is also very suitable for decentralized medium-scale production and it can quickly be adapted to new variants. However, both Moderna and Pfizer and BioNTech chose to keep tight control of their technology.

What must we do differently? The first is to really have a change of perspective. Life-saving health technologies, especially in times of pandemics, cannot be viewed as private commercial goods. They should, first of all, be considered as essential public health tools, instruments for public policy. That is not a technical issue. That is a political choice.

It also means that policymakers must be able to use these tools and implement such policies as they see fit to control the pandemic. In wealthy countries, the market-based pharmaceutical ecosystem may be able to deliver, and that is clearly what most Western policymakers think.

However, as we have seen, that does not deliver for the rest of the world. Therefore, governments in other parts of the world were not able to use these tools to implement the best public health response. They could not buy and they could not produce.

What can we do to ensure that countries in the Global South – and we are actually talking about a majority of the world population, let us be clear – can do differently to secure the health of their populations?

What they say is, ‘We no longer want to be recipients and beggars. We actually want to be part of the solutions, to contribute as full participants to the research and development of diagnostics, vaccines and treatments and to be able to respond to epidemic outbreaks when and where they occur, not waiting until it is a pandemic or waiting until Western pharmaceutical business models develop the products that we can use to stop outbreaks when and where they occur’.

For that, what they need is access to the technologies and the know-how for health innovation and the freedom to do research and produce, without any constraints, such as intellectual property rights, which, again, are a policy tool, they are not a natural right. They also need access to the capital to build and sustain the necessary infrastructure, for instance, through regional R&D hubs.

Of course, all of this needs to be considered as common goods for health, not private commodities for business, because we are talking about the biggest health crisis in our lifetime, and maybe future ones.

You all know the saying, ‘Give a person a fish and they will eat today; teach them how to fish, and especially allow them to fish in the collective knowledge pond, and they will actually be able to take care of themselves’. That is actually what we do today, we stop them from using the knowledge and technology to develop their own solutions. Again, this is a political choice that we have made.

In the military, there is this concept of technological arms race and you do not want to share your technology, but it is a mistake, and we actually do it often, to compare health security with military security. It is a mistake to use military language, thinking and narratives for global public health. Health threats are very different. Advantages in health technologies in one country do not translate in health security. No one is safe until everybody is safe against epidemic threats. We all know that viruses and other pathogens cannot be contained by borders.

That is why it is so critical that more countries and regions are allowed to and empowered to be part of that health innovation ecosystem, not as competitors in a global market, but as contributors to global health security that can be viewed as a global common good.

That is, in essence, the type of transformational change we need for true preparedness and that will allow us to put equity at its heart, as demanded today by many Global South countries, for instance, in the discussions about a Pandemic Treaty. That is what they want: to be allowed to establish maybe a parallel ecosystem in other parts of the world. If the Western world says, 'We want to continue how we do it', fine. But can we create a space such that, in other parts of the world, there can be different ways of addressing that?

This is not a utopia. Today, for instance, there is an initiative driven by the World Health Organization in which a hub for mRNA technology has been created in South Africa and where this technology is being shared with researchers, developers and companies in 15 other middle-income countries, such that they can actually develop their own mRNA-based health tools, vaccines and other treatments to protect themselves against the health threats that they are facing.

Maybe just one final thing to say is that, quite often, what we hear today as a olution for vaccine equity, is that there are investments in local manufacturing capacity. Now, that will not, by itself, create the equity we need.

What we need is to share the knowledge and technology, such that developers and researchers in the global south are no longer dependent on the charity response of the global north and that they can develop the solutions for their own health needs.

One final line: health security cannot be gained by technological competition and business as usual. It is not a war against each other for technological dominance. It actually requires collaboration and sharing because we are all in this together against the virus.

Thank you.

Michel Kazatchkine

Thank you very much, Els.