

HEALTHCARE

Pandemic preparedness means working to reduce health inequality

Tim Tucker

A great injustice of the Covid-19 pandemic is that it affected poor and marginalised communities far worse than the wealthy.

As we work to prepare for the next pandemics we must work to reduce inequality in the provision of healthcare.

The Covid-19 pandemic has cost millions of lives and livelihoods worldwide. However, the rate of severe illness and death is far higher among poor and marginalised communities than among those who are middle class and wealthy.

Global inequality was made extremely clear – yet again – by the Covid-19 pandemic.

In preparing for the next pandemic we must invest in meeting the needs of the poor and the marginalised.

This investment need not be specific to individual pandemics, or even healthcare. This requires a wholesale shift in the way we develop and improve the lives of whole communities globally.

Why? Regardless of whether people are marginalised economically or because of social stigma, or marginalised because of access to healthcare,

housing and education, or because of poverty-related illnesses, marginalised communities have worse outcomes.

The narrative that Africa was less affected by Covid than other continents is not correct. Much of the continent had fewer diagnostic capabilities and less data. But the excess deaths recorded in multiple countries tell a tragic story of communities affected.

We have seen about 330,000 excess deaths in SA over the Covid-19 pandemic period, most directly attributable to Covid disease.

VACCINE INEQUALITY

When it comes to vaccine access and distribution, there are also significant inequalities.

How we develop new products globally, be they vaccines or other drugs, is based on the inequities of who invests in science and how we value the lives of those in poorer countries.

Whoever invests can then patent and exploit the products that emerge selectively, and to the earlier benefit of those who can pay.

Pandemic preparedness investment takes decades. For example, during the pandemic, we saw that 30 years of investment in mRNA

technology came to maturation just as Covid-19 appeared. We then were able to quickly produce an effective vaccine.

Parties that had patented those vaccines often sold them on to the large pharmaceutical companies, which are compelled to maximise profits for their shareholders. (We are often the problem, as we instruct our pension funds to maximise return on investments in such companies).

The pharma companies scaled up to deliver, putting billions of dollars into manufacturing capacity to recoup their investment. Those who could pay the most for those vaccine products then received them first.

An interesting philosophical change to this model was the Covax global vaccine alliance, a well-intentioned initiative to distribute vaccines equitably around the world. Sadly, it was hampered by a lack of funds and products, as wealthy countries bought up supplies for themselves first.

Thus, market forces ensured that developed nations, which could pay, kept large vaccine stocks for themselves. This slowed down vaccine access in the developing world.

It's also important to differentiate between the issues

of equitable access and issues of acceptability. By this stage of the pandemic even SA is not distributing vaccine doses because people are not taking them. That is an issue for behavioural scientists, not vaccine safety and efficacy.

LESSONS FROM HIV

We have faced similar, though not identical, challenges during the battle against HIV.

HIV was a global challenge requiring an unprecedented level of health activism. It required global advocacy campaigns to overcome the inequities around getting drugs to poor countries at affordable prices. Today we have been able to make some progress with Covid as a result of that HIV activism.

Everyone now understands that it is important to overcome those systemic issues. Covax, although not as successful as we had hoped, would not have happened without the historical advocacy of HIV.

We need to invest more in people ahead of another pandemic. Many of the people who have emerged as "superstars" of SA's Covid response – Prof Glenda Gray, Prof Salim Abdool Karim, Prof Koleka Mlisana, Prof Penny Moore and more – cut their

teeth on HIV, TB and malaria over the past 20 or 30 years.

The HIV vaccine trials network became the Covid vaccine trials network, thereby allowing for an extremely rapid set of clinical trials. This emphasises that we need to invest in systems and people to be ready for the next wave.

Even before the arrival of vaccines SA's intensive-care physicians, and other clinicians, were able to develop a great understanding of how to manage patients, working from their past experience of HIV and TB as well as cardiac disease, hypertension and diabetes.

There has been learning and innovation around treating populations with diabetes and high blood pressure; how to ventilate more than one patient on the same ventilator; how to manage overburdened staff and so on.

THE LONG VIEW

Pandemic preparedness needs to take place across decades-long time frames. There needs to be an understanding that our health interventions are not about one election cycle or individual political parties.

We need to invest in people, as well as clinical, scientific and manufacturing capacity beyond the next election cycle.

We don't know whether the next virus is going to come next week, next year or in 25 years' time. But we have to be prepared.

Overcoming inequity requires that we invest over an extended period. It also requires universal, quality healthcare. This is a basic human right. It's unacceptable that wealthy people have better access to healthcare than those who are poor.

We need to build a better, more equitable healthcare system. To do that we must invest in people – because it is people who respond to pandemics. We also need to invest equitably in infrastructure such as hospitals and laboratories.

We must invest in research – a direct application of new knowledge for the community's benefit.

If we have enough well-trained people with the right knowledge, and the infrastructure to develop our own products, we will be able to respond better to the next pandemic.

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