Access and Benefit-Sharing Isn't Equity

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It is unsurprising that equity has featured so prominently in the Pandemic Treaty negotiations – the Treaty is a direct response to the COVID-19 pandemic, which was characterised by gross inequality between high-income and LMICs. The pandemic saw wealthy countries deploy discriminatory and sometimes racist travel restrictions, engage in rampant vaccine nationalism, and hoard much of the limited personal protective equipment (PPE) and other medical countermeasures, while simultaneously blocking efforts at the WTO to pass a waiver on intellectual property protections which could have reduced these inequalities, especially in access to medical countermeasures. In contrast, advocates claim that a Pandemic Treaty grounded in "norms of solidarity, fairness, transparency, inclusiveness and equity" will overcome many of the shortcomings of the international COVID-19 response. [1] In a wonderful twist of irony, many of the countries *responsible* for these vast inequities – the UK, Germany, France, along with a number of other high-income European countries – were some of the first to call for equity in future pandemics.

Equity in the negotiations

Equity has been central to the Treaty's development from the very start. In September 2021, the Member States' Working Group on Strengthening WHO Preparedness for and Response to Health Emergencies (WGPR) claimed that "*equity is at the core of the breakdown in the current system" ,* [2] *and* argued that a Pandemic Treaty could push equity from being a "soft law" aspiration, to become an active, legally-binding, operational aspect of pandemic preparedness and response. [3] At the Special Session of the World Health Assembly (WHASS) in December 2021, that began the formal process of negotiating the Treaty text through the WHO Intergovernmental Negotiating Body (INB), Member States emphasised their "commitment…to develop a new instrument for pandemic prevention, preparedness and response with a whole-of-government and whole-of-society approach, *prioritising the need for equity.*" However, despite these broad lofty goals for equity in a future Pandemic Treaty, the language of equity is increasingly being tied to a legal concept called Access and Benefit-Sharing (ABS) as a vehicle to *operationalise the goal of equity.* In November 2022, the WHO INB produced the first major draft of the Treaty text called the "conceptual zero draft". Equity is noted in the preamble, noting that Members remain "[d]eeply concerned by the gross inequities that hindered timely access to medical and other COVID-19 pandemic response products, notably vaccines, oxygen supplies, personal protective equipment, diagnostics and therapeutics", [4] and as a Principle for the Treaty. It also proposed text for an ABS system, to deliver on this goal of equity. While the

Treaty has gone through several iterations since the Conceptual Zero draft – which consistently see's obligations in respect of equity getting watered down – one thing remains constant and consistent, the idea that ABS is a mechanism for ensuring equity in future pandemics.

ABS and pathogen sharing

Access and Benefit-Sharing, like shoulder pads and Miami Vice, is emblematic of everything that was wrong with the 1980's. It came out of the negotiations for the Convention on Biological Diversity, and is predicated on the idea that competition, and market-based solutions can fix global problems, [5] and has such blind-faith in neoliberalism that *Reagan and Thatcher would be proud of it. ABS represents* the enclosure and commodification of genetic resources, believing that the solution to injustice and inequality lies in greater competition. CBD frames ABS as a bilateral contractual agreement between the provider country and the user of a genetic resource, coming together to arrive at mutually agreed terms about accessing and using the provider country's sovereign genetic resources. [6] The expectation was that these bilateral contracts would generate sufficient benefits to incentivise biodiverse provider countries to conserve their genetic resources, safeguarding biodiversity for future generations, while trading samples on an open and competitive market. While originally thought to be limited to flora and fauna the logic of ABS has, bizarrely, been extended to pathogen samples. In 2006, Indonesia refused to provide the WHO their H5N1 influenza samples, citing their sovereign rights over the samples under the CBD, choosing instead to attempt to trade these samples to the highest bidder in the pharmaceutical industry. Indonesia rightly highlighted the gross inequality in pathogen access prior to the ABS mechanism being extended to pathogen samples. LMICs were fhttps://verfassungsblog.de/?p=79397&preview=truereely and openly providing their samples to the international community, who passed these samples on to the pharmaceutical industry. Pharma then used the samples to develop vaccines and medical countermeasures, which LMICs couldn't afford to purchase on the open market. [7] This system was exploitative and grossly unfair. But ABS isn't the answer to it. More enclosures, more competition, and more markets aren't the solution to this problem (is it ever the solution to *any* problem?!). The explicit framing of access to pathogen samples in exchange for medical countermeasures led to the adoption of the WHO's *Pandemic Influenza Preparedness Framework* (PIP Framework) in 2011, which creates an ABS system specifically for "influenza samples with human pandemic potential". There are, however, good reasons to think the PIP Framework will fail to deliver "benefits" – i.e., lifesaving vaccines and medicines – to LMICs during the next influenza pandemic. [8]

ABS in the Pandemic Treaty

Nevertheless, the logic of ABS and the PIP Framework has been transferred over to the Pandemic Treaty. Numerous Treaty drafts have seen the extension of the

ABS construct to *all* "pathogens with pandemic potential", and any associated data, with the intention being to create a "Pathogen ABS System" (PABS System). As my coauthors and I have previously argued, [9)] the PABS System ties what should be two separate public health problems together:

1. High-income countries (HICs) want early warning of any pandemic threats that they believe are most likely to come from LMICs. This requires access to up-to-date pathogen samples (and genomic data) sourced from all countries, which can be passed on to researchers and pharmaceutical companies to develop countermeasures, should the need arise.
2. LMICs have never received fair and equitable access to the pandemic-related products that are generally produced in HICs, even if the development of these products was reliant upon access to samples of pathogens and/or data originating in (or isolated from) LMICs.

It does so by firstly requiring parties to share all physical samples, and associated genetic sequence data, with WHO recognised laboratories. [10)] This obligation relates to LMICs predominantly, as the site of origin for most emerging infectious diseases. When doing so, parties lose their sovereign rights over these samples; they cannot refuse to share them, and they do not have any control over how those samples are to be used, or by whom. The second set of obligations relate to manufacturers of pandemic goods. These manufacturers can elect to contract with WHO, via a Standard Material Transfer Agreement (SMTA), whereby they agree to provide access to at least 20% of real time production of a pandemic related product to WHO for onward distribution to affected countries, based on "public health risk and need". [11)] This is the mechanism by which WHO hopes to secure medical countermeasures to deliver equity during the next pandemic. There are two significant problems with this. Firstly, there is nothing to say that these doses will be reserved for use in impacted LMICs, and could be distributed in high income countries who have a public health need, even if those countries are also purchasing doses on the open market. We saw such 'double dipping' during the COVID-19 pandemic, where high income countries received allocations of vaccines from the multilateral COVAX initiative, even though they were simultaneously dominating procurement of vaccines on the open market. [12)] Secondly, and perhaps most importantly, 20% of real time production, even if it is delivered (see below for why it may not), is nothing close to equity or fairness. Even if this system works, it will represent a minor blip in rebalancing the huge gulf which exists between high income and low-income countries during a pandemic. Put bluntly: it's not enough. The WHO only has competency to make international agreements with Member States. It has no authority to compel private entities (like pharmaceutical manufacturers) to enter into these SMTAs. So what of those manufacturers who do not wish to sign such an agreement? Well, the text of the present draft states that "it shall be understood that the production of pandemic-related products requiring the use of WHO PABS Materials, implies the use of the WHO PABS System. Each Party, with respect to such a manufacturer operating within its jurisdiction, shall take all appropriate steps, in accordance with its relevant laws and circumstances, to require such a manufacturer to provide benefits….". [13)] But what of these relevant laws and

circumstances? The negotiating text of the Pandemic Treaty notes that benefit sharing occurs “with the understanding that each Party which has manufacturing facilities that produce pandemic-related products in its jurisdiction shall take all necessary steps to facilitate the export of such pandemic-related products, in accordance with timetables to be agreed between WHO and manufacturers”. [14)] But given the rampant vaccine nationalism which we have witnessed by high income countries during COVID-19 and 2009-H1N1, are we confident as an international community that high income countries will not breach this obligation during future pandemics when it appears right to do so? The idea that wealthy countries, such as my own, will allow 20% of real time production of life saving vaccines to leave the country while our own populations are dying, is, to my mind, fanciful at best. The entire PABS System rests upon the assumption that high-income countries will gladly let vaccines and medical countermeasures leave the country during the next pandemic and won’t use export restrictions and compulsory requisition powers to ensure their own populations are protected first. That is quite an assumption.

Conclusion

For all the talk at the start of the Treaty negotiation process of equity, of doing things differently in the future, it appears that very little will change. The fact that equitable access to vaccines in the next pandemic is so reliant upon ABS working, is testament to this point. At the end of the day, ABS is still just asking LMICs to *trust* that HICs will do the right thing (and release medical countermeasures) during the next pandemic. ABS doesn’t change the fact that the overwhelming majority of manufacturing capacity for pandemic related products is limited to a small number of high-income countries, it doesn’t change the dependency-based neo-colonial model of global health (in fact it reinforces it [15)]. If it works, and there are very good reasons to believe that it will not work, it will at best make sure that a small proportion of vaccines end up where they need to be, and the rest will continue to go to the highest bidder, regardless of need, equity, or justice.

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