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Agenda 2021: U.S.-India-Europe Cooperation on Health Challenges

Among some of the biggest challenges highlighted by the coronavirus pandemic are how to reform multilateral institutions like the World Health Organization while working toward equitable and rapid vaccine distribution around the world. Tara Varma and Oommen C. Kurian explore the scope for cooperation between the United States, Europe, and India in addressing these challenges.

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Cooperation on Global Health—the View from Europe

Tara Varma

The beginning of the coronavirus crisis unveiled the very limited capacities of the European Union when it comes to health. To be fair, health is not (yet) one of its competencies: The responsibility in this field lies with member states. At the same time, this was the first time that the EU was hit by a pandemic, and European governments and citizens made their expectations clear of the EU being the most appropriate platform to find a solution for the continent and globally.

Though in its initial phase, the pandemic affected member states on different scales and to different extents, almost all were confounded by their heavy reliance on goods and services from third countries. This reliance undermined the EU's capacity to respond autonomously. It also demonstrated that the nexus between the internal and external responsibilities on health is growing and cannot be detangled. This entails for the EU to promote healthcare standards for its citizens, to develop schemes making patient and healthcare-personnel mobility a reality, to prioritize investment in research and innovation in health, and to adopt a significantly more important role on the international stage. The EU has a responsibility to coordinate with global health institutions and to develop a vision for global health governance. It should pursue a values-based strategy and

use its economic might to enshrine higher health standards in multilateral trade and environmental agreements.

The coronavirus crisis has provided an opportunity for European governments and private-sector actors in health to review and adjust their value chains for greater health sovereignty. In fact, increasing the supply security of critical health goods could go hand in hand with a general review of supply chains that aims to increase protection from economic coercion more broadly. The EU needs to assess products according to how critical they may be in a health crisis. In this regard, the European Council on Foreign Relations has suggested to bracket products according to four key actions:

- **Reshoring** for products where the EU finds full (or quasi-full) supply-chain redistribution necessary for health sovereignty.
- **Nearshoring** for products whose supply chains should operate in the EU periphery, such as in the Balkans or North Africa.
- **Diversification** for products whose critical components must have a minimum number of diverse suppliers, or for which certain countries may be excluded or supply from countries is conditional on certain guarantees.
- **Addressing chokepoint vulnerabilities** for products where supply chains either rely on single suppliers (because it is a highly trusted third country) or where they must (because components cannot be found elsewhere).

The European pharmaceutical industry should take this opportunity to expand to new markets. For example, shifting manufacturing to additional countries and diversifying to limit disruptions and shortages. One option already discussed by experts is for health companies to be "obliged through a kind of quota to include suppliers in their tenders who obtain their active ingredients from the EU instead of from abroad."

In asserting its health sovereignty, the EU will have to make difficult choices about whom it wants to partner with. One obvious option is India, which is already a major partner in supplying medicine and developing research. India has also joined the EU in the fight for multilateralism and this could expand European engagement in the Indo-Pacific. In light of increasing China-U.S. tensions, the EU and like-minded Asian countries could find a common path forward.

The coronavirus crisis has seen convergence between the European and Indian agendas on global health cooperation. The latest EU-India Summit communiqué mentions bolstering their cooperation to respond to global health emergencies, improving preparedness, and developing synergies especially in the production of pharmaceuticals and vaccines as well as in research and development.

Given India's extensive capacity to produce non-mRNA coronavirus vaccines, it could be a destination of choice for the EU to mass-produce these. The EU and India could reach an agreement that Johnson & Johnson and Sanofi-GSK, which both have plants in India, increase their manufacturing capacities there. Part of these could be used in the COVAX initiative for ensuring the equitable access to the vaccine to all, especially in the developing world.

As the proposed investigation into the source and propagation of the coronavirus has left the World Health Organization (WHO) in a deadlock and subjected a few countries, including in Europe and in the Indo-Pa-

cific, to economic coercion, the EU will have to initiate important reforms of the global health multilateral system. With Italy presiding over the G20 and the United Kingdom presiding over the G7 this year, European countries are in a position to promote multilateralism through existing institutions and ad hoc coalitions. They can do so on several levels.

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First, the EU can convene ad hoc global initiatives such as the Access to Covid-19 Tools pledge conference and position itself as the convening platform for state and non-state actors, such as the WHO, the G7, the G20, foundations, and the pharmaceutical industry. European Commission President Ursula von der Leyen pledged in her State of the Union speech last September to build a European health union and to strengthen the EU's crisis preparedness and management. Such proposals could be put forward at the Global Health Summit in Italy in May.

The EU could also unblock multilateral institutions by avoiding getting caught in any Sino-U.S. confrontation in these institutions and by determining which partners it wants to work primarily with, such as India. The EU should engage actively in the WHO, with the appropriate financial conditions and coordination support to bolster more traditional international health governance.

Finally, the EU should push to reform the global system to respond to health emergencies. It should insist on the implementation of verification mechanisms and improvements to early-warning and response capabilities—especially, as the world is still managing the impact of the coronavirus pandemic and needs at the same time to prepare for the next crisis. The EU, alongside like-minded partners, should bolster coordination with international financial institutions, multilateral funds, and member states. It should also ensure an equitable access to vaccines to all, possibly by encouraging research partnerships, with India among others, that enable the indigenous production development and manufacture of vaccines.

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Strategic Interdependencies: Challenges and Opportunities from the Global Pandemic

Oommen C. Kurian

The coronavirus pandemic has brought into focus weaknesses within national healthcare-delivery systems and amplified some of them. It has also highlighted the blind spots within multilateral institutions and global

structures, reaffirming the validity of the call for reform of international organizations. The pandemic has also brought to the fore the intricate interdependencies that exist within the international health system.

China, the epicenter of the global outbreak, currently is the world's largest supplier of active pharmaceutical ingredients. India is a leading exporter of generic drugs across the world—for example, it is estimated that it supplies up to 50 percent of the United States' generic drug needs—yet it also depends on China for more than two-thirds of its bulk drug needs. Vulnerabilities caused by the pandemic have caused disruptions across global supply chains. As the global powers use the crisis as an opportunity to reassess their dependencies and plan for the future, one outcome has been that health policy has shifted to the heart of the discourse around national security and of global diplomacy.

India's strong private sector in pharmaceutical manufacturing has been working closely with its counterparts in the United States, the United Kingdom, Belgium, Sweden, and other countries, to develop affordable vaccines and medicines to control the pandemic. The success of the global COVAX facility is heavily dependent on India's vaccine manufacturing capacity—the interim distribution forecast released in February states that 240 million of the 337.2 million doses to be distributed in the first half of the year are to be produced by India's Serum Institute. India also has largely bilateral research and development collaborations with many European and North American countries.

In addition, India is invested in the movement to reform global institutions, triggered in part by the pandemic's challenges. For example, in order to build a new global partnership with reformed and effective multilateralism, it has offered recommendations to reform the World Health Organization (WHO), including with regard to funding, accountability, response capabilities, governance structures, and pandemic management.

Challenges to reform in such institutions stem from the embedded inequities in the global system and from differentiated strategic interests. There are times when clear conflicts in interests come into play, like when India and South Africa jointly called for the World Trade Organization (WTO) to suspend intellectual property rights related to the coronavirus until the world achieved herd immunity, so as to ensure that poorer countries can access and afford the vaccines, medicines, and other medical technologies to fight the pandemic.

These battles are playing out in a context where mass coronavirus vaccination is likely to be slow and limited by intellectual property, narrow national strategic considerations demonstrated by vaccine nationalism, prohibitive costs, and fiscal as well as other constraints. Experts have argued that a focus on financing universal health coverage should be a central theme in the reimagining global-health governance and policies. However, even among major UN agencies, there is consensus that the international architecture is not well equipped to address current health challenges, with no sustained revenue for common health goods.

Given this complex state of affairs, what a global health system should strive toward is a situation of pooled resilience against common threats like pandemics, where all partners gain from cooperation. That many poorer countries subsidize the health systems of richer ones is a fact—whether it is through export of skilled medical workforce or cheaper generic medicines, even as health-workforce shortages and lack of access to medicines remain domestic concerns. Formalizing such flows into cross-border investments that improve the status quo and offer a win-win to all parties should be promoted.

For example, U.S. investments in India to improve its pharmaceutical regulatory system would offer maximum returns given the enormous financial pressures that the pandemic has put on the U.S. healthcare system and the need to depend more on generic medications in the foreseeable future. Similarly, a possible collaboration between the United Kingdom and Nigeria and other major source countries for their health human power with direct investments to improve medical education infrastructure could be considered. Lessons can be learned from the massive expansion of medical education that India has undertaken in a public-private-partnership mode.

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Rather than the current models of externalization of domestic regulation and calls for ethical recruitment—both having had very limited success in ensuring quality of drug production and equity in the supply of health workers—new strategies based on positive externalities will benefit all parties. In addition, serious thought is needed about innovative models of dual, multiple, and global citizenship to create a pool of "global health-keeping forces" along the lines of the UN peacekeeping forces, to be readily accessible to any crisis-hit country. This would be a precious resource when a pandemic hits different countries following different trajectories and peaking at different times.

In the recent past, because of strategic concerns and the need felt by global powers to make supply chains less dependent on China, many new initiatives like the Quad Plus or D-10 indicate a movement away from predominantly Western groupings and a fresh wave of inclusion. It is only natural that a major disruptive event like the coronavirus pandemic will guide their focus toward global health security, either directly or indirectly. The attention to ways of containing China's ascendence in these initiatives may relegate global health concerns to only an instrumental role, with any possible gains being purely incidental.

Any real progress will need sustained momentum and real country-level action, which looks possible more through reform of established multilateral institutions and global structures like the WHO and the WTO than through their replacement with parallel structures with ambitious global health objectives. The emerging multilateral structures and issue-based coalitions can use their collective heft to catalyze the process of change within traditional global institutions around issues of global health, and to push them toward course correction when needed.

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