

New international pandemic treaty: potential implications for clinicians worldwide

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The advent of the SARS-CoV-2 or COVID-19 pandemic has spurred a broad interest in efforts to reform international health institutions. Central to this effort are calls for the creation of a new multilateral pandemic prevention treaty under the auspices of the United Nations or the WHO, with initial treaty talks slated for November.¹ Such a treaty is intended to share information about new infectious diseases among member states, develop global pandemic surveillance and response capacity and more.² If done correctly, such a treaty holds unique potential to help the world effectively detect and contain outbreaks of novel infectious diseases.^{1,2}

Nevertheless, in the debate over a new global health treaty, the benefits and drawbacks of a new agreement to practising clinicians worldwide have been underdiscussed. Indeed, far from what some believe, a new pandemic prevention treaty has significant potential to alleviate burdens faced by clinicians treating infectious diseases in developing nations.³ Alternatively, a poorly constructed pandemic treaty may also reify disparities in global healthcare.² It is therefore vital to discuss ways in which a new pandemic treaty ought to be designed to improve clinical care worldwide.

The COVID-19 pandemic has exposed structural inequities in global health, especially with regard to clinical care for infectious diseases. Two key factors, in particular, are uniquely responsible for these disparities due to their systemic impacts. The first of these is the fragility of many healthcare systems in less developed states in Africa, Latin America and Southeast Asia, making these nations more vulnerable to infectious disease outbreaks.⁴ This fragility is rooted in several factors that pre-date the COVID-19 pandemic, such as chronic underfunding of hospitals and clinics, shortages of trained staff and degrading physical infrastructure.⁴ These issues uniquely hamper clinical

care for infectious diseases in these countries, as hospital systems lack the beds and equipment to handle surging case loads while clinicians are overstretched and overworked.⁴ Additionally, this fragility means that allocating even limited resources to infectious disease care in these nations can cause trade-offs with care for other non-communicable diseases, causing further harm.⁵

Second, the pandemic has also exposed a structural gap in the global supply of medical equipment, as less developed nations have struggled to access the diagnostics, therapeutics and vaccines that are uniquely integral to the successful mitigation of COVID-19.^{4,6} The driving causes of these shortages are diverse, but prominent factors include intellectual property regulations that limit the ability of developing states to produce medical equipment, as well as export bans on medical supplies and raw materials for production.^{6,7} Hence, these supply disparities have had a significant impact on clinical care for infectious diseases like COVID-19. For example, the inability to access high-quality diagnostic and therapeutic equipment can hamper detection and treatment of COVID-19 and other infectious diseases.⁴ Vaccine shortages, meanwhile, can impede efforts to immunise patients, putting clinicians in harm's way and creating a dangerous feedback loop that drives clinical staff shortages and burnout.⁷

An international pandemic treaty, however, could be a unique mechanism to resolve these systemic disparities in global health. For too long, global health preparedness has largely been built on a trickle-down model, with poorer nations often waiting years or longer for treatments accessible in richer countries.⁴ This arrangement is both epidemiologically and ethically problematic. On one hand, it heightens the risk of pathogens mutating into more infectious variants as diseases spread in the population of less developed countries.^{4,6,8} This trickle-down arrangement can also cause significant harm to historically marginalised populations and further widen disparities present in global health today.^{4,6,8}

A new pandemic treaty, however, could potentially tackle these systemic disparities if designed correctly. For example, to tackle the systemic issue of fragile health systems, a new treaty could create an international financing framework to direct grant funding and development assistance from international organisations like the World Bank to developing states.^{2,9} Using this investment, developing states could modernise hospitals and clinics, train and hire clinical staff and more.^{2,9} A treaty could also create mechanisms for international organisations and developed states to provide high-quality technical expertise to developing states, providing them with experience and know-how to assist these nations as they attempt to modernise their healthcare systems.^{9,10}

Similarly, an international pandemic treaty could also be a useful tool against the systemic disparities present in the supply of medical resources. For example, a new treaty could tackle the intellectual property regulations hindering vaccine, therapeutic and diagnostic manufacturing by working with other international institutions to create a streamlined pathway for developing nations to receive emergency waivers and licences to produce key medical products if there is an ongoing global health crisis.¹¹ A treaty could also include provisions to overcome the impact of national export bans on vaccines and other clinical products by diversifying supply chains. For example, the treaty could standardise international regulations and create global data-sharing guidelines for medical supply producers, providing manufacturers in developing states with both a predictable regulatory environment and technical know-how to expand their operations.^{6,12}

At the same time, it is important to note that these benefits are not guaranteed to be part of a new pandemic treaty. If negotiations for a treaty are largely dominated by political actors from powerful countries with only token input from doctors, nurses and other clinical practitioners, the resulting document may not be responsive to the needs of clinicians worldwide, especially those in developing states. In this scenario, a pandemic treaty will have little impact on alleviating global health disparities, rather only reifying an unequal and unjust status quo. As a result, it is vital that treaty negotiators adopt a whole-of-government and whole-of-society approach by giving clinicians a seat at the table during negotiations.¹³ In particular, international and national organisations of clinicians should be invited to play a prominent role in talks over a new

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pandemic treaty to ensure the final document is responsive to the needs of clinicians worldwide.

More specifically, it is especially important that organisations and representatives of clinicians from less developed or underserved global populations be represented as key stakeholders during negotiations. Many such groups have seen the impact of global disparities in clinical care firsthand, dealing with shortages of vaccines, therapeutics and diagnostic equipment during the last year while also treating patients in fragile health systems. Therefore, it is important that they are represented during negotiations so that a treaty is responsive to their experiences and ultimately reinforces fragile health systems and improves the supply of medical products in developing states.¹⁰ Only by embracing this whole-of-society approach will a new pandemic treaty be able to effectively promote global health equity. By creating frameworks to finance international health development, reform intellectual property requirements and diversify medical supply chains, a new pandemic treaty has the potential to greatly assist clinicians and improve infectious disease care globally. Doing so will help build a safer and healthier global community for everyone.

Contributors SN drafted and edited this article.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

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To cite Nagar S. *Postgrad Med J* 2022;**98**:733–734.

Received 28 August 2021

Accepted 5 September 2021

Published Online First 11 September 2021

Postgrad Med J 2022;**98**:733–734.

doi:10.1136/postgradmedj-2021-141090

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