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Health and access to care : why it is necessary and urgent to switch from a global public good approach to a commons based approach

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**Health and access to care : why it is necessary and urgent to
switch from a global public good approach to a commons
based approach**

Issues and Challenges

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Health and access to care : why it is necessary and urgent to switch from a global public good approach to a commons based approach. Issues and Challenges

Abstract

During the Covid 19 Pandemic, there have been countless calls for the creation of “global public goods” or “global commons” issued by a variety of actors with sometimes diametrically opposed views, as if the two notions had the same meaning.

And indeed, even today these notions are still often used as synonyms and interchangeable, leading to an amalgamation of concepts. The meaning and implications of using one notion or other notion (global public good, global commons) is never examined.

We believe that, contrary to the dominant view, it is urgent to put an end to this confusion which is not only of a semantic order and has huge economic and social implications.

In this article, we start by recalling what constitutes the notion of “Global Public Good” and by extension the content of what can be called the GPG approach (section 1). Then, by difference we present the notion of common good and the commons based approach (section 2). Finally, in a concluding section, we present some of the most significant initiatives taken during the covid-19 pandemic, designed and deployed to producing and distributing health products as common goods (section 3). Our overall ambition being to highlight that the deployment of the commons based approach that we are calling for, is not a utopia, as it is already moving on.

Key Words and JEL codes

- F55 International Institutional Arrangements
- H41 Public Goods
- I14 Health and Inequality
- K11 Property Law
- O32 Management of Technological Innovation and R&D

Introduction

With the Covid-19 pandemic, the notion of "global public good" has regained the same aura that had propelled it to the forefront of the HIV /AIDS pandemic. Alongside it has come the notion of "global commons".

During the pandemic, there have been countless calls for the creation of "global public goods" or "global commons" issued by a variety of actors with sometimes diametrically opposed views, including the French President, politicians from the right and the left sides, activists claiming for universal access to Covid-19's vaccines, international organisations and expert panels.... In the discussions and documents of the various parties, these concepts were most often used and presented as synonyms. Used interchangeably, their meanings were amalgamated, without differentiating their specific content. These notions are still often used as synonyms, interchangeable, leading to an amalgamation of concepts. The meaning and implications of using one notion or other notion, was never examined.

We believe, on the contrary, it is urgent to put an end to this confusion which is not only of a semantic order. We believe that the prevailing confusion between the two notions prevents us from grasping the major conceptual and political issues at stake.

In this context, *this paper aims to make explicit the critical difference between the notions of global public goods one side, commons, and common good on the other, therefore the issues involved.* While the former is a stabilised notion that has its origin in the mainstream neoclassical economics, and is based on the intrinsic nature of goods and postulates the supremacy of market rules, the notion of common goods and the commons based approach, aim to completely reverse this logic, to open up another way to address the management of pandemic crisis.

We start by recalling what constitutes the notion of Global Public Good and by extension the content of what can be called the "GPG approach" (section 1). Then by difference we present the notion of common good and the commons based approach (section 2). Finally, in a concluding section, we present some of the most significant initiatives taken during the covid-19 pandemic, designed and deployed to producing and distributing health products as common goods (section 3). Our overall ambition being to highlight that the deployment of the commons based approach that we are calling for, is not a utopia, as it is already moving on.

1. The Global Public Good Approach : content, implications and shortcomings

To clearly understand the conceptual content and status of the notion of GPG and of the GPG approach, we first need to recall how this notion is derived from the previous concept of "public good". In fact, the notion of global public good

was coined by extending the notion of "public good" developed by neoclassical economics theory (Samuelson, 1952). According to this theory, public goods are those that combine by their intrinsic nature the dual property of being "non-rival" and "non-excludable". A typical example is the lighthouse at the entrance to a port. Once installed the signal can be seen by everyone (non-excludable property) and the "consumption" of the signal by a given person or actor doesn't deprive any other from the access to the same signal (non-rival property). The same can be said as regards scientific knowledge, to give here an example of a non-tangible public good. According to neo-classical theory, these situations are considered to be exceptional and are characterised by "market failures," because there is no incentive to produce these goods privately even though their usefulness to society is certain. Indeed, in these situations (of non-rivalry and non-excludability), everyone will wait for his neighbour to 'start' producing the good in order to benefit from it for free. As a result, these kind of goods are subject to opportunistic behaviours, known as "free rider" behaviours. Consequently, these goods will only come into existence if they are produced with public funds and at least, public regulation is required to make production and access to this type of good possible.

It is based on this concept, which entirely belongs to "neo-classical" theoretical background, that the notion of global public good (GPG) was later on developed and proposed. The notion of GPG shares the same pillars than the concept of public good, with only the two additional distinctive features that a GPG must have i) a "global" and ii) a 'trans-generational' dimension. In practice, the notion of GPG appeared in the early 1980s. It is linked to the extension of globalisation that led to the rise of issues that cross national boundaries (such as biodiversity, climate change ...), and thus can be efficiently tackled *only if transnational cooperation is implemented*. Kindleberger (1986) proposed an initial definition, characterising GPG as: "all goods accessible to all states but not necessarily of interest of an individual to produce them". This notion was then further elaborated and developed by Kaul, Grunberg and Stern (1999) who gave to the notion its iconic status. The work published by these authors sparked a wide-ranging debate both in the academic circles and in the major international organisations, revolving around the question of *how to produce public goods at a global scale* given that neither the market, nor existing inter-national organisations were capable of doing so. And in fact the claim for GPGs have never been anything more than "injunctions" or "proclamations" without being accompanied by institutional changes in the dominant modes of production and administration of these goods¹.

1. Some exceptions should be mentioned. For example, it is certainly under the political pressure to create GPGs, that was put to existence the Global Fund to Fight Tuberculosis Aids and Malaria when the AIDS pandemic began to spread all over the world. But it has to be noted that this institution is of "hybrid "nature. On one side it has been conceived and designed to facilitate universal access to drugs and treatments (against Tuberculosis Malaria and HIV/AIDS), but on the other this access : i) remained conditioned to a series of requirements posed to the virtual beneficiaries

The GPGs have mainly served as a basis for the elaboration of a new “grand narrative” of development aid, masking the allegiance to market rules and a failing global governance. As it has been rightly pointed out by some development policy experts, the notion of GPG has offered the opportunity to promote a new “grand narrative”, says S. Leyronas “whose power is triple”. According to this author : "By importing from the language and key concepts of the dominant neoclassical economic theory (indivisibility, non-rivalry and non-exclusion, sources of positive or negative externalities, etc.), it does not appear alternative and remains audible to aid actors. By introducing the idea of market failures of all kinds into a globalised system, which makes the destinies of OECD and developing countries inseparable, it links the issue of North-South dialogue to the resolution of common human problems. By implicitly inserting the issue of equity into the traditional debate of economic theory, it opens the way to questions about the systems of property rights best suited to ensure the most efficient production or management of goods". (Quoted from S. Leyronas in Alix, Bancel, Coriat, Sultan, 2018). Defined as it is with all the ambiguities it brings with it the notion of GPG concludes the author "... allows all interests to seize it, to weigh on it and, ultimately, to weaken its initial strength. Metaphorical meaning and rhetorical discourse then prevail over analytical sense and theoretical analysis." S. (id)

During the 1980s (in the era of HIV/ AIDS pandemic) just like today, one can declare that “health is a GPG” while leaving the world as it is, *i.e.*, ravaged by endemic diseases and epidemics. To proclaim loudly that “this or that good is a GPG !” (as it has been repeated so many times for COVID-19 vaccines), however practically *implies nothing in terms of obligations and constraints posed on national or international agencies and states*. Fundamentally the notion of GPG is designed in such a way that it leaves in the hands of *nation-states* the power to decide what steps should be taken (or not) to bring into existence the GPGs deemed necessary. Moreover, in all cases, it is presumed that the measures taken (if and when it happens), must be entirely submitted to and compliant with market rules (as it has been the case for GFTAM, which procured its medicines and other health products at the market prices newly imposed by the TRIPS agreements).

Thus, *at best*, the claim for GPGs implies for the actors concerned, to introduce, in the respect of the market rules and in its interstices, incentives and devices that would allow to mitigate some of its failures. The way in which the covid-19 pandemic has been managed at the global level (during the years 2020-2022) bears witness more than ever to the great “tragicomedy” of GPGs: the health

countries and patients, ii) this access to drugs and treatments was in no case “universal”, iii) above all the new organism operated in full respect of market mechanisms especially the extension of IPRs to pharmaceuticals products that was implemented by the TRIPS agreement signed in 1994. (see Coriat, Orsi, d’Almeida 2006).

products needed at global level to the fight against the virus throughout the world - masks, screening tests, oxygen, essential medicines and above all vaccines- have been massively supported by public money, whilst access to these goods remained highly selective to poor countries. In fact, HIC's (high income countries) piled three or four times the necessary quantities of vaccine to protect their populations, the LMIC (low and middle income countries), especially in Africa having access to less than 10% of their needs².

Regarding vaccines, whether we consider their manufacture, their accelerated marketing or their purchase ... : everything, for the most part, was guaranteed by public contracts. In many cases, responsibility for the health risks of pharmaceutical products has even been transferred to the national states thus discharging the pharma companies from possible negative health effects in the countries where people were vaccinated. All was done to place these goods under the rules and the omnipotence of the market and the monopoly power exercised by the pharmaceutical companies. This has created a level of profit for pharmaceutical companies that has reached historical records, while the scale of inequality in access to health products between rich and poor countries is reaching new heights.

Indeed, in accordance with the ideology conveyed by the approach in terms of GPG, the main initiative taken was to set up a "charity", Covax, whose shortcomings and inability to face the objectives that had been announced, quickly came to light (more on Covax : Box 1)

The spotlight shines on the "Janus" face of GPGs: a pure and complete commercial logic on the one hand, pure "charity" on the other³.

² Figures that provides a good snapshot of the level of inequalities regarding access to vaccines are available at: <https://www.knowledgeportalia.org/covid19-r-d-funding>

For a critical assessment of the functioning of the R&D system in the production of drugs see Dosi et al (2021). For the role of NIH see Clearly and al (2018), and for the specific role of NIH regarding the Covid vaccine see Rizzi (2020).

³ See below the role of Covax as a « Charity » installed to mitigate the most violent effects produced by the market mechanisms under which the acquisition and distributions of vaccines (and other health products) has been placed.

Box 1

The Covax "Facility": a model of "charity" set up in full compliance with market mechanisms

Abandoning and turning a blind eye to the institutions set up by the WHO around ACT-A (*), but in full compliance with the recommendations stemming from the notion of GPG, the major players in global public health and the States (of the Western world) have confined themselves to promoting the constitution and promotion of a so-called "facility" which under the name of Covax was officially intended to achieve access to vaccines and treatments, especially for low- and middle-income countries. Designed and installed at the initiative of large private foundations (such as the Bill and Melinda Gates or the Wellcome Trust) with, the support of a large number of nations States but in fact, a very weak power of control of the WHO over the devices put in place, Covax is emblematic of what the reference to the notion of GPG is able to generate. Covax is based mainly on "grants" from high-income countries, and on credit mechanisms granted to middle- and low-income countries to access products acquired through the facility. With regard to the "donations" of vaccine doses (to take just one example) at no time, no rules or agreements have come to constrain market logic. In fact, it is a logic of "charity", in the tradition of the 19th century that organizes COVAX, "donations" being made according to non-transparent criteria to countries whose eligibility obeys opaque criteria.

Crucially, in accordance with the ideology conveyed by the notion of GPG, Covax in no way contravenes the laws of the market and in particular the recognition of full and exclusive IPR on health products. Covax is conceived as a set of institutional provisions, aimed within the market and its laws, to install "palliative" mechanisms to try to mitigate the most exclusionary effects. In no way does it contravenes the order of things and the market driven framework installed by the TRIPS agreement for fights against pandemics

(*) The accelerator ACT-A has been implemented by WHO, in the early months of the Covid 19 pandemic, in order help to coordinate and speed up innovation and facilitate access to new health technologies.

The large multinationals and the other majors players look very comfortable with a model based on charity that does not, in any way, interfere with the lucrativeness of the market of goods needed to protect the life of billions. The refusal of the rich/wealthy countries to support the proposal by India and South Africa (known as the *waiver*)⁴ before the WTO to suspend all intellectual property rights on health products that are essential to the fight against covid-19

4. <https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/IP/C/W669.pdf&Open=True>

for the duration of the pandemic, is undoubtedly the best and most visible expression of the duplicity to which the discourse on GPGs leads.

To sum up, the crisis opened by the Covid 19 pandemic, plainly confirms, concerning the concept of GPG, what all previous crises had already highlighted and established, as regards the notion of GPG. The notion is born "orphan" since its promotion in no way implies the establishment of institutions capable/enable of ensuring and binding appropriate mechanisms to effectively ensure a global access to the "GPG" such declared. This concept is "orphan" because it is empty of implications and effects. In the case of the Covid 19 and health crisis, as for all other cases where it is or has been invoked (climate, ocean, arctic...) it does nothing to hinder market forces. At best, as indicated earlier, it contributes to mitigating the most violent effects of the market mechanisms without contributing to install effective alternative mechanisms.

2. Commons and the commons based approach : a new vision and a radical inversion of the foundations of the GPG approach.

We invite readers wishing to understand how and why the commons based approach opens to a very different way regarding the collective management of pandemics, to undertake a radical reversal in the logic and reasoning.

In what follows, our reflections follow the seminal the work of Ostrom on the commons (Ostrom, 1990, 2014; Schläger & Ostrom 1992) and his successors and in particular those conducted by S. Rodotà, on the notion of common goods (*beni comuni*)^{5,6}. Together, these works constitute what we refer to here as the "commons based approach"⁷, creating the conditions for effective access to health goods.

5 For the work of Rodotà Commission see :

https://www.giustizia.it/giustizia/it/mg_1_12_1.wp?facetNode_1=3_1&facetNode_3=0_10_21&facetNode_2=0_10&previousPage=mg_1_12&contentId=SPS47617

From S. Rodota see his (2013) book.

6 For an overview of the different notions and concepts related to the commons based approach, the reader may refer to: Cornu, M, Orsi, F, Rochfeld, J. *Dictionnaire des biens communs*, PUF, 202. On this issue .See also see Coriat (2015 and 2020)

7. To a certain extend, this section extends some previous results acquired in the field of software, which showed how the community of innovators organized within the framework of the F/LOSS (Free/Libre Open Source Software) Movement was able to establish a regime of production of innovations based on commons, opposed to the dominant regime of production of innovations based on exclusive property rights. (see Coriat 2018)

The conceptual foundations posed by these authors make it possible to construct a notion of common good(s) that separates completely and opposes that of GPG. The main features that emerge can be presented as follows. First of all, the notion of common good breaks with that of public good, in that *it is no longer a question of defining a good from its "intrinsic" nature (as for the notion of public good defined from the properties of non-rivalry and non-excludability attached to the very "nature" of the good)*, but to do so from *attributes of a social character attached to it*. Thus, according to the definition proposed by Rodotà, a common good is intended to be considered and characterized as such if its conception is the result of decisions and elaborations of rules shared by one or more communities concerning its production and management. In other words, the commons (or common goods) become such *only if a system of ownership and a set of institutional arrangements built around them, make it possible to ensure both their production and their access to the greatest number*. Therefore, a vaccine or a drug is by "nature" neither public nor private.

Everything here will depend on the *legal regime* attached to its production and distribution. Thus, vaccines against covid 19 (we refer here to the two vaccines from Pfizer and Moderna that have taken centre stage during the pandemic) are indeed **private property**. They are the object of exclusive property covered and guaranteed by sets of intellectual property rights whose exploitation has generated via market transactions, immense rents for the holders of the rights. A vaccine can only become a true "common good" *when and if* it is established as such on the basis of rules formulated by the community for which it is intended, As Rodotà argues, any good - and the vaccine like other health products - to acquire the status of common good must be placed "*out of the market*".

According to this view, a common good cannot be an object based on exclusive private property and it must be distributed according to a governance framework that will ensure access to the greatest number of people and in an equitable manner.

It is therefore no longer in the commons based approach a question of designing devices that only make it possible to "compensate" some market failures. It is not a question of "incentives" introduced inside the market mechanisms to try to influence some of the actors operating inside its rules. *It is a question of creating the conditions for placing effectively the good "off-market"*, on the basis of a set of appropriate and adequate institutional arrangements. Finally, the opposition between GPG and common goods can be formalized from the three features presented in Box 2.

Box 2

Main oppositions between the GPG and the Commons based approaches

We can distinguish the world postulated by the GPG, from the one that intends to institute the promotion and constitution of common goods, on the basis of the three following criteria

- **Property rights:** in the context of GPG, the property regime is based above all on private property in its exclusive form; while exclusivity is banished from the world of common goods that are always based on various forms of *shared* property; the commons based approach is grounded on the concept of property rights conceived as *bundle of rights* (Schläger and Ostrom 1992)

- **Access:** in the world of GPG, access is dictated by market mechanisms and is entirely subject to its requirements; on the contrary, access to goods is held "off- market" when they are established as common goods, the objective here being to ensure their availability for all and especially for the most disadvantaged; -

- **Governance:** in the case of GPG the governance is placed under the domination of nation states (and/or intergovernmental organisations) and ensured by them, whilst it is ensured by communities of producers and users, elaborating their own governance rules when the goods produced have been instituted as common goods.

To make a step further, we can add that a commons based approach needs to start from *praxis*, grasping the facts and initiatives that contain within them the seeds of another worldview. And more specifically for what regards the issues tackled on this paper – the focus should be put on how *access for all is obtained and guaranteed* for the medicines required to fight pandemic diseases.

In these conditions, it is easy to understand how the debates and controversies generated by the proposal of India and South Africa to temporarily lift intellectual property, supported by more than 100 governments from low- and middle-income countries, can be read. This proposal, as expected from the countries that promoted the TRIPS agreement, that received a very unfavorable opinion from the high-income countries (those of the European Union in the lead !...), was finally examined by the WTO, which issued a decision which, while marking under pressure a weak opening, rejected the core of the request⁸.

⁸ The final text of the WTO decision merely reiterates the possibilities existing under the provisions on compulsory licensing, and contrary to the request filed by South Africa and India, relates only to vaccines, excluding all other products necessary to

3. Some achievements towards the building of health goods as common goods

To conclude, we would like to briefly show from the presentation of some ongoing initiatives, that the idea of building health goods as common goods, is not a utopian perspective, which would be regarded and considered as a pure "wishful thinking".

On the occasion of the Covid 19 pandemic (whilst HICs were engaged in their nationalist vaccine race) a set of initiatives - most often emanating from actors of the civil society and/or from institutions and NGOs focussed on health issues - have been deployed to fight the pandemic with the aim of ensuring the widest access possible to health products. Although these initiatives have received limited interest so far⁹, they deserve attention. Beyond their differences and specificities, all share the same objectives of working to make possible the discovering and producing of effective treatments, and making them available without hindrance to as many people as possible.

To begin with, let us mention the ANTICOV Consortium¹⁰, a collaborative clinical research platform promoted by DNDi (Drugs for Neglected Diseases Initiative) and its partners. It brings together thirteen African countries and an international network of associated research institutions from April 2020 to conduct clinical studies in Africa for COVID-19 treatments intended to be offered at affordable prices for populations affected by mild or moderate forms of Covid (see Box 3).

combat the pandemic.

9. In our research report (Coriat (dir) 2021) some of these initiatives are examined and described in some details

10 <https://dndi.org/research-development/portfolio/anticov/>

Box 3

The ANTICOV consortium : a typical illustration of shared governance principles put at the heart of an international collaboration

The consortium coordinated by DNDi is in line with the clinical platforms created for sleeping sickness, leishmaniasis, Chagas disease and filariasis¹¹. It brings together 26 entities with a strong presence of countries conducting the study and having strong experience in conducting clinical trials in Africa. Its governance is ensured by a Joint Strategic Committee (JSC) which meets every 15 days around an agenda coordinated by DNDi. The principles agreed upon by the institutions under the terms of a framework agreement are based on the following principles:

Mode of Governance

- The JSC coordinated by DNDI is the ultimate decision-making body on the project in which each of the institutions is represented by at least one member. The JSC has the authority to make major decisions on the ANTICOV project (duration, suspension, selection of drugs tested on the proposal of INSERM, DNDI and MMV, management of the consortium, etc.). A representative of patient communities is also involved in JSC discussions;
- Decisions are taken by consensus but if necessary they are taken by majority vote with a minimum quorum of 75% of the JSC. Each entity leads a part of the project, knowing that some institutions may be involved in all parts of the clinical trial. Votes were held on the choice of study arms as well as on the choice of members of the DSMB (Data safety Monitoring Board);
- Collaborative and coordinated approach to fundraising;
- Inclusive approach of other members/partners. Implementation of research and access to results

Implementation of research and access to results

- Aligning with COVID-19 principles Clinical Research Coalition: accelerating R&D in low- and middle-income countries;
- Enrich the expertise of consortium members to accelerate research;
- The knowledge and research data generated by ANTICOV will be integrated and shared in an open and transparent way, in order to inform public health policies. Scientific publications resulting from the work of

11 On DNDi envisaged as a commons see Coriat et al (2019)

the consortium will be submitted "on behalf of the consortium" by the authors of the publication;

- Ensure that treatments that are safe and effective are affordable, available and accessible to all.

In the same spirit, the **Covid Moonshot project** initiated by a consortium of scientists launched on Twitter works transparently as an open source initiative to identify an affordable and easy-to-use antiviral treatment against covid 19¹². The public sharing of information in the early stages is at the heart of the project which is based on the principles of open science. Researchers and participants to the project¹³ are building on what was already known about previous coronaviruses.

In collaboration with the University of Oxford and the Weizmann Institute of Science in Rehovot, Israel, the facilities at Diamond Light (opened to the Moonshot project) were used to develop fragment screens utilizing crystallography and mass spectrometry to target proteins.

Researchers examined thousands of possible fragments from diverse screening libraries and identified at least 71 possible protein–ligand crystal structures, chemical fragments. These results were immediately made available online.

Because COVID Moonshot is based on open science principles and shared open data, any molecule generated by the consortium may be manufactured and sold by whoever wishes to produce it, worldwide. For this reason, the open-science drug discovery model promoted by the Moonshot project appears to be a key instrument for combating both current and future pandemics.

These two initiatives (ANTICOV and Moonshot) are complementary insofar as Anticov has currently only worked on molecules available in the public domain (the rights attached to these molecules having expired) while Moonshot has created new molecules already disclosed on the internet and therefore not patentable as such- though patents could be filed on manufacturing processes or formulations. The treatments that may be conceived on the scientific research conducted will be free of any intellectual property rights from the Moonshot consortium and will be designed primarily for patients in the south. They will have to obey simplified storage and administration conditions.

12 For a short but precise presentation of the Mooshot project see: <https://dndi.org/research-development/portfolio/covid-moonshot/>

13 Among the many participants in the COVID Moonshot project are the University of Oxford, University of Cambridge, Diamond Light Source, in Rehovot, Israel, Temple University, Memorial Sloan Kettering Cancer Center, PostEra, University of Johannesburg, and the Drugs for Neglected Diseases initiative (DNDi) in Switzerland.

In line with these initiatives, on December 28, 2021 Texas Children's Hospital and Baylor College of Medicine announced the development of a new vaccine and the obtaining of an emergency use authorization from the Indian health authorities so that its production can be initiated on a large scale by Indian manufacturers, and subsequently in Indonesia, Bangladesh and Botswana¹⁴. The vaccine is patent-free, adapted to the logistical constraints of low- and middle-income countries and the agreement provides for close collaboration with technology and know-how transfer.

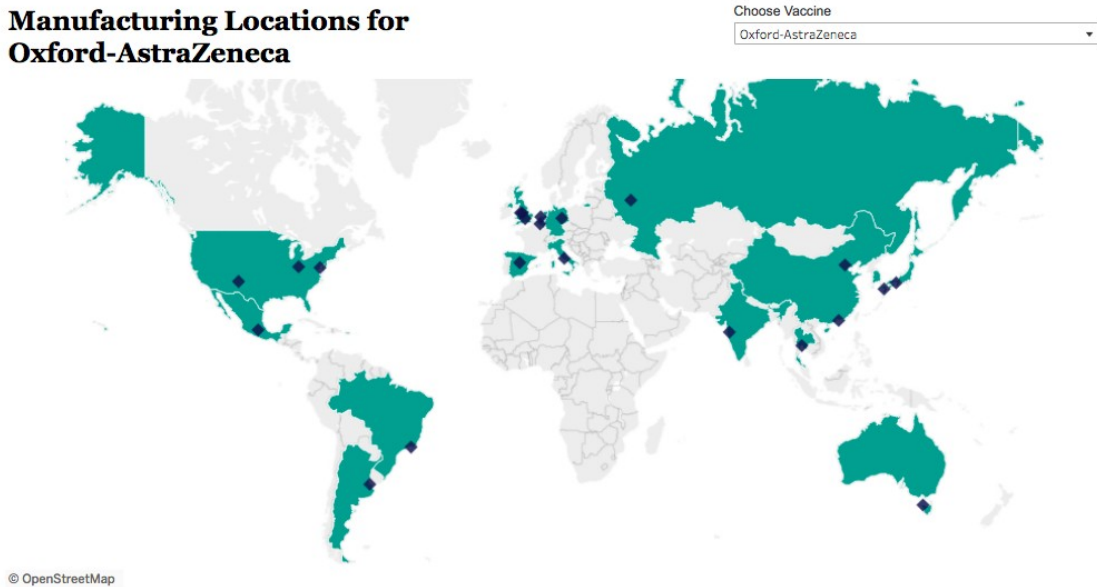
Innovation from the Commons has penetrated up to and including the major models of mass production. It has been very insufficiently noted, but the "economic and organisational model" of the Oxford/AstraZeneca vaccine deserves here a special attention¹⁵. Regarding the model that serves as a support, this vaccine has several particularities. First of all, it was essentially designed by academic research within the University of Oxford. For its final development and commercialization an agreement has been passed with the firm AstraZeneca, which rests on two pillars. The first is that the vaccine is offered at a so-called "cost+" price (cost price + a low profit margin), at least for the duration of the pandemic. Second pillar : the firm agreed to cede exploitation rights and to transfer the technology to producers installed on all continents ensuring an international distribution of vaccines produced locally at low prices : see figure 1 that shows the worldwide spread of facilities in which the Oxford-AstraZeneca vaccine was produced during the pandemic and in the majority of cases continues to be produced today. However, coherent with the concept of bundle of rights, even if large number of producers have been given the rights to produce the vaccine, the intellectual property rights of the initial designers of the vaccine (Oxford and AstraZeneca) are preserved.

14 <https://www.texaschildrens.org/texas-children%E2%80%99s-hospital-and-baylor-college-medicine-covid-19-vaccine-technology-secures-emergency>

see also : <https://www.washingtonpost.com/world/2021/12/30/corbevax-texas-childrens-covid-vaccine/>

15 For a detailed case study of the Oxford/AstraZeneca agreement see G. Garisson (2020)

Figure 1



Thus, the economic model chosen brings it very close to those who are at the base of the commons.

Last but not least, it is worth recalling the importance of setting up the technology transfer program for messenger RNA (mRNA) vaccines, launched in April 2022 by the World Health Organization (WHO)¹⁶. For its promoters, it is a question of establishing collaborative "Hubs" (the first is already in South Africa) with local production capacities. The project is to meet local health needs by sharing the know-how acquired in the hubs. As Cassier (2022) points out, in all cases, the knowledge and know-how acquired are made available, free of rights. The choice was made to focus on mRNA technology, because in addition to its proven vaccine efficacy against Covid-19, it has great potential for many other infectious diseases. South African biotech companies Afrigen Biologics and Vaccines and Biovac have formed the main backbone of the platforms deployed. Finally, it should be noted that the initiative seems to have a bright future since in March 2022, Afrigen, in collaboration with 15 international companies, announced the manufacture of a first vaccine, similar to that of Moderna.

For most of them, these initiatives are still emerging and fragile because they evolve within an economic environment where pharmaceutical innovation is

¹⁶ For a short presentation of this initiative and its main achievements see <https://www.who.int/news/item/18-02-2022-who-announces-first-technology-recipients-of-mrna-vaccine-hub-with-strong-support-from-african-and-european-partners>

driven by market forces and profit seeking and not by public health objectives. However no one could ignore the strengths of ongoing innovative pathways in developing and implementing new health technologies as (potential) common goods. Various models already exist and/or are ramping up from collaborative platforms and research (ANTICOV, MoonShot, the South African Hub), as well as original business models of partnership (AstraZeneca, Texas Children's Hospital with Indonesia, Botswana and Bangladesh) .

They have the immense merit of showing that a path that leads to making health products real common goods is open. Different models of collaborative platforms and research (ANTICOV, MoonShot, the South African Hub), as well as "original business models" of partnership (AstraZeneca, Texas Children's Hospital with Indonesia, Botswana and Bangladesh) are in place and for some of them are already ramping up.

Making health goods commons is no longer a purely theoretical and ideal perspective. The few initiatives described show how it is possible to conceive and get pandemic tools available globally and equitably beyond empty calls for GPG. Moving out of the impotence into which the ideology of the GPG approach has led, to enter into the world of commons based initiatives is now an ongoing and promising process.

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