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Jean-Paul Gaudillière, Claire Beaudevin

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Covid-19 and global health, seen from France: the end of a "great divide"?

By Jean-Paul Gaudillière and Claire Beaudevin
This article is part of the series: Dispatches from the pandemic

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On March 13th, 2020, an aircraft lands at the airport in Rome and stops on the tarmac. Nine people get off the plane and immediately stop next to the jetbridge for a group photo. In the background, airport personnel start unloading boxes labeled in Mandarin. The first medical mission from China to Italy has just arrived. China intends to support the Italian health system by sending expert doctors, respirators and facemasks.

This scene appeared repeatedly on social networks and news channels over the following week. For China, it displayed a new register of health intervention: no longer oriented only towards Africa, where the country is now the leading manufacturer of hospitals, but towards Europe, once the leader in international aid. Beyond questions of China's geopolitical uses of the crisis, for Italy and for Europe in general, this episode casts a harsh light on the disorganization and shortages, which have characterized responses to the epidemic, accompanied by massive disruptions of health care systems.

Unpreparedness is of course not only Italian. The same difficulties and shortages have been increasingly visible every day in France over the past 2 months, giving rise to protests among health workers and pressing questions from citizens about how health and political authorities have acted (or failed to act) since the announcement of the initial contamination cluster in Wuhan in January.

The accumulating information about the shortage of disposable surgical masks is puzzling Chinese, Korean and Vietnamese journalists and scientists. More than one month after the lockdown started on March 17th in France, the dramatic scale of the shortage still makes it impossible to systematically provide protective equipment to the most affected individuals. They include the residents of nursing homes, many home-visiting health care workers, and even, in many hospitals, staff members who do not perform the riskiest procedures. This is not to mention all of the other categories of exposed workers who are not systematically receiving protective masks, i.e. cashiers, shopkeepers, teachers, postal workers, public transport staff, technical personnel in municipalities, and so on. The harshness of this massive discrepancy in exposure is increased by two facts: first, the heavily gendered dimension of risk–the vast majority of these workers are women; second, the application of the newly-crafted 'essential' label to some activities by the government, allowing for companies to remain open during the lockdown without always guaranteeing safe working conditions.

Managing scarcity and shortages

The roots of this problem are not recent. They are not cyclical but structural. Mask scarcity results from the successive reorganization of the entire production and distribution chain for these materials. As a result of the internationalization and relocation of these supply chains,

France has very low production capacities for protective masks. Two thirds of the masks used in the country are produced in Asia—in China in particular for FFP2 masks (the equivalent of N95 masks in the US). Initially, the eruption of the Italian crisis led European producers, Germany in the first place, to ban exports — including to their neighbors. In addition, Chinese masks have become objects of an increasingly ruthless competition between countries and organizations looking for supplies, with the federal and distinct state governments in the United States leading the way.

As a result, in France, *ad hoc* solutions have multiplied: the distribution of expired masks deemed reusable; the recycling of disposable masks after their ironing or decontamination; the urgent launch of local production at the request of some hospitals; the collection of all kinds of masks from research laboratories, companies and local authorities; DIY cloth masks completed by 3D printed protective visors, all produced by local people; and finally, as had already happened for medicines in Greece after the implementation of austerity plans (Papadaniel 2019), donations by private individuals.

The French health care system, considered among the top ones not long ago, is therefore experiencing forms of medicine more often thought to be typical of health systems in the Global South where the management of scarce resources, real-time adaptation, tinkering and DIY are structural features rather than consequences of exceptional disasters. A medicine of patient-oriented triage, deciding who can access which therapy (Lachenal et al 2014, Redfield 2013), is at stake as well, since the number of people in serious respiratory distress has for weeks exceeded the number of intensive care and resuscitation beds in several regions of the country, despite the creation of hundreds of additional emergency beds.

The managerial turn in French public hospitals and severity of the pandemic

Against the backdrop of these shortages and following a year of mobilization and strikes by public hospital staff prompted by the “hospital crisis” (Chrisafis 2019), one must reflect on the ways in which the transformations of our health system over the last two decades participates in aggravating the current pandemic.

Indeed, this social movement in hospitals highlighted the effects of the cost-cutting and “rationalization” policies pursued since the early 2000s: massive bed closures (including in ICUs), significant increases in the number of people admitted (particularly to the ER), a painful intensification of work for all staff-members — producing, for many, the temptation to leave (Juven et al 2019). Mobilized hospital workers opened a public debate about priority needs (in terms of positions and funding), which unfortunately led only to minimal governmental commitments, which most practitioners understood as a denial of the situation.

The temporalities of crisis are therefore manifold. First, there are the long-running processes of the managerial turn, of cost reduction, of the multiplication of indicators and the continuous quest for economic performance. The current shortage of protective masks very directly relates to this context: it partly stems from decisions taken after the H1N1 swine flu epidemic of 2009. This epidemic led to public criticism of the massive state purchase of flu vaccines, most of which were not used. In 2010, the National Court of Auditors issued a report on the matter, which justified decisions (unquestioned since then) to considerably reduce the budget and stocks of the health reserve (Bastamag, March 19, 2020; Mediapart, April 12, 2020).

The second temporality is shorter, that of the three months since the Chinese revelation of the situation in Wuhan, the publication of the genome of SARS-CoV-2, and the discovery of the first imported case in France. This period was dedicated to activating emergency plans prepared for an influenza crisis, taking into account the specificities of the new virus and choosing priority interventions. Therefore, it is also the time of direct responsibilities regarding the framework of the national response. It is too early for a final reading of this process, but we can already be astonished that after decades of discussing risks, expertise and crises, the French government among others sticks to the simplistic mantra of only following the data of "science". This claim of immediate adherence silences the variety of knowledges and experts, the political meaning of choosing between them, and the intrinsic limits of predictive modeling. It also diverts attention from the inherent responsibility of politicians to take precautions prior the moment of crisis, that is, before conditions of emergency and shortage constrain their decision-making.

Shortage of tests: a Euro-centric health strategy?

What strategy was adopted mid-March? It focused on a general lockdown decided in a week's time while testing was limited to confirming the diagnosis of infection in medical personnel or individuals with severe symptoms. This strategy contrasts choices made in Germany, Singapore or South Korea, countries that implemented screening for people with moderate symptoms and/or contacts of proven cases. The South Korean example is particularly important as local policy allowed for containing transmission within three weeks without confining the entire population. The testing policy alone cannot of course explain this result, but it is a crucial factor.

This extended detection of infected persons in fact led to two types of intervention: 1) reinforced social isolation based on the reconstruction of movements of people who tested positive, through the collection of their personal data and the public dissemination of anonymized versions of this information; 2) the acceleration of clinical care for monitored affected people, facilitated by a hospital infrastructure with a number of beds per inhabitant double that of France (Duddu 2020, Kesavan 2020).

The French government justified its strategy with two successive arguments. First, at the end of February, as the number of cases increased very rapidly across a broad geographical range, the authorities claimed that testing and targeted isolation was no longer an efficient strategy. Then, as critiques mounted in the media, the governmental argument shifted towards the impossibility of increased testing due to material scarcity. Carrying out more tests was indeed barely possible because of the insufficient number of dedicated PCR machines in the country and the harsh international competition for reagents, again usually imported from China and the USA.

How then was South Korea able to base its response on testing, if in January it did not have greater SARS-CoV-2 testing capacities than did France? South Korea had implemented a decisive reorganization of its public health infrastructure after the fiasco of MERS control in 2012. Drawing on accounts from the South Korean press, it seems that the implementation of the testing strategy began on January 24th (after the detection of a first case on the 20th) when the government organized a network of research laboratories, approved a first testing technique on February 7 and required that 50 medical institutions be available for sampling. Mass production of testing kits reached 10,000 per week (corresponding to one million potential tests) a couple of weeks later, in late February.

In comparison, given the good standing of the French biotech industry, it would have been technically and logistically possible to create a mass testing infrastructure in France. In fact Germany implemented a strategy comparable to that of South Korea, taking decisive steps to ensure the local supply of materials and the opening of testing sites in February. One can wonder whether the French apathy towards testing originated not only in the weakness of public health institutions in France but also in a widespread lack of interest and concern for the timeline of events taking place in Asia. It is striking that most clinicians and health policy makers commenting on the chronology of the pandemic in the media evoke the shock of the hospital crisis in Lombardy as a moment of revelation that Covid-19 was not only a Chinese problem and that the danger for France was quite serious. By early March, in the absence of the infrastructure necessary for testing all individuals with symptoms, lockdown had become inevitable, as had its massive social, sanitary, psychological and economical consequences.

When the time finally comes for more in-depth assessments of the response, the arrival of Covid-19 in Europe may well be recognized as the collapse of an illusory dichotomy between the Global North and the Global South in the domain of health. According to this vision, expertise and resources are located in the North while the health problems to be solved are those of the South. In other words, the Covid-19 pandemic could mark the moment when a vision of European hegemony bound to outdated 20th century post-colonial experiences was finally shaken to its foundations.

Verticality and global health

Not only is the Covid-19 crisis a product of global circulations, but responses to the pandemic are also largely constrained by imaginaries of globalization. Hence the striking dimension of the profound discrepancy between the principles, targets and tools in Covid crisis management and those fostered by global health for more than thirty years. Global health was of course a relatively new mode of worldwide health governance, which emerged during the 1990s and stemmed from a strong critique of policies and practices carried out by United Nations organizations and governments of the so-called Third World over the previous two decades. A particular object of this critique was the primary health care (PHC) strategy advocated by the World Health Organization (WHO) in the late 1970s following the Alma-Ata conference (Chorev 2012, Packard 2016).

One could consider the PHC approach “horizontal”, insofar as it focused on several transversal issues: claiming a right to health; linking health intervention and development; reducing the reliance on imported advanced technology in favor of local resources; and finally giving priority to rural populations and community health centers. Contrary to what the WHO’s “Health for all by 2000” slogan seemed to assume, the PHC strategy was not meant for “all health, for all”. It rather aimed for a strict prioritization of “basic” needs. For the WHO, those needs were the major infectious diseases, in addition to maternal and child health.

This strategy was deeply entangled with development policies of the new nation-states in Africa and Asia. It thus became increasingly unsustainable in the 1980s and 1990s, because of the conjunction of 3 processes: the debt crises (accompanied by externally imposed structural adjustment programs); the consequences of the HIV/AIDS epidemic; and the political offensive of Reagan’s administration in the United States against the United Nations. In the aftermath of these events, the new actors of global health largely took up the idea of “vertical” programs, each targeting a disease to be controlled through a limited range of technical

interventions (theoretically chosen on the basis of cost-effectiveness calculation) (Gaudillière et al 2020).

Decision-making and evaluation of most of these programs is no longer performed by states but relies on the funding institutions themselves — ranging from the Bill & Melinda Gates Foundation to the World Bank to the Global Fund to Fight AIDS, Tuberculosis and Malaria. These vertical programs aim to limit the burden of infectious diseases (in this respect, historical continuity dominates) by providing free access to drugs or vaccines.

Covid-19: a challenge to global health

The Covid-19 pandemic highlights the obsolescence and inadequacy of the global health framework in several ways. First of all, expertise about the pandemic and the relevant responses is not solely located in Europe and North America and thus cannot be only a matter of transferring knowledge and tools along a North-South gradient. Secondly, containment strategies require large-scale implementation of medico-social interventions, conditioned by the state of administrations and health infrastructures, an issue largely ignored in most vertical programs. Finally, the response to Covid-19 relies almost exclusively on state initiatives and their implementation by national or regional public health administrations.

In fact, since the beginning of the Covid-19 crisis, the only global health institution playing an important role has been the WHO. Though key global health actors remained silent until March, the Gates Foundation and the World Bank are now back on stage with initiatives to support care, testing and research. However, their framework remains the same as it has for decades: biomedical innovation is the main response and Africa is understood as the primary region at risk.

The Covid-19 pandemic is thus indicative of the end of what we might call "the great divide" (following Latour's (1993) discussion of the non-advent of modernity): that is, the end of the exceptional status of health in most advanced capitalist societies in comparison to the rest of the world. The political affirmation of this exceptional status relied on the ideology that health governance in the Global North, despite all its limits and imperfections, was based on a policy of rights, on the socialization of costs, on the universalization of beneficiaries, and on the mobilization of science and technology. Political discourses have long set this policy of abundance in opposition to a policy of essential needs, dominated by scarcity and triage, considered typical of the Global South.

Yet, this great divide between abundance in the North and scarcity in the South is increasingly losing its practical and analytical relevance. The global spread of SARS-CoV-2 reveals the converging trends of sanitary policies from the generalized lockdown to organized and DIY practices for managing scarcity. More fundamentally, after three decades of intense globalization, of mass urbanization and industrialization, many areas or regions of the former Global South are now facing health challenges similar to those once deemed typical of the Global North, such as the mounting burden of chronic disorders or the effects of environmental degradation. In this sense, the Covid-19 pandemic vividly highlights the fact that the differences that matter to the government of health are increasingly issues of scale and inequalities *within* countries rather than divides of global or even regional significance (Ferguson 2006).

Is Covid-19 an illness of globalization? Undoubtedly it is, and the pandemic reveals the inadequacy of global health. But paradoxically, it also demonstrates the very necessity of a reconceived international and planetary approach to health. In the 2000s, the alter-globalization movement claimed “another world is possible”. When SARS-CoV-2 loosens its grip on humanity, this new world (as well as a new global health framework) will be more essential than ever.

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Jean-Paul Gaudillière is senior researcher at the French Institut National de la Santé et de la Recherche Médicale (Inserm) and Professor at École des Hautes Études en Sciences Sociales, Paris. His research explores the history of the life sciences and medicine during the 20th century. His recent work focuses on the history of pharmaceutical innovation and the uses of drugs on the one hand, the dynamics of health globalization after World War II on the other hand. He is coordinator of the European Research Council project "From international to Global: Knowledge, diseases, and the post-war government of health".

Claire Beaudevin is a medical anthropologist, permanent researcher at the National Centre for Scientific Research (CNRS). She conducts her work within the Centre for Research on Medicine, Science, Health and Society (Cermes3) in Paris. Her research deals with the anthropology of genetic medicine and genomics in the Arabian Peninsula (mostly in Oman), and with cancer genomics in France. In the European Research Council project "From international to Global: Knowledge, diseases, and the post-war government of health" (dir. JP Gaudillière), she coordinated the Genetic Medicine segment.