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Some lessons from the COVID-19 pandemic

Now and then, over the past dozen years or so, one might hear a random comment about how precarious it is to be nearly completely dependent on the drug supply from distant countries. Yet, nothing was done because it appeared to nearly all that the global trade system was functioning properly and Americans as well as citizens in the European Union seem to have an adequate supply of the medications they needed at quite attractive prices. Now in 2020, this concern has moved from a theoretical question of concern to an actual problem that might have consequences for millions worldwide. The virus first was observed in China where it became so prevalent that many factories and distribution facilities were paralysed due to employee illness and absence causing closures for anywhere from a few weeks to several months.

Now, we can look back with perfect 20 : 20 hindsight and realize that putting all of our (proverbial) eggs in one basket was not such a good idea. In the USA and in the EU, over 80% of the prescribed medications are from generic sources. The sellers of these generic drugs purchase the active ingredients (API) from firms primarily in China and India, and formulate the final dosage form locally, dependent upon foreign, imported ingredients. Now, we are coming to the conclusion that it makes sense to perhaps pay a little more to reactivate a domestic pharmaceutical synthesis and generic manufacturing capability in the USA and in the EU. Western governments can give tax and other financial incentives for firms building domestic capacity.

For example, during World War II in the 1940s, Norway had virtually no domestic pharmaceutical production capacity and was forced to endure shortages of numerous critical medications. Their lesson was to see that such shortages would never occur again by the creation of a government-owned system of warehouses that would hold approximately a three-month supply given the usual levels of consumption. More recently, the US Food and Drug Administration (FDA) and the European Medicines Agency (EMA) have agreed to a mutual recognition scheme where products not registered in one area can be imported from the other area, since it assumes that the drug marketing approval process is of approximately equal rigour on both sides of the Atlantic Ocean. But, if every country relies on API from the same blocked source in China, that is of no help. Recently, the Indian government has suggested banning the export of hydroxychloroquine which may provide some benefit to COVID-19 patients. Understandably, they desire to have an adequate supply for their own population. Given the unpredictability of crises requiring foreign-sourced drugs, it makes perfect sense to foster a domestic capacity. What country would be satisfied having to purchase all of its military equipment and weapons from other countries that might not always align with US or EU national policies?

So, in summary, it might be that no one was harmed by our foreign drug dependence this time, but kicking the can down the street for some future administration to deal with in the future is not acceptable. We must demand the creation of local pharmaceutical (API) productive capacity in the very near future, and it does not have to entirely exist within one single country. For example, Canada, the USA and Mexico could share such a plan, as could several countries in Europe with long-standing friendships.

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