Private Profits, Technology Denial and Global Vaccine Inequity

By prioritising profits, the vaccine policies of developed countries seriously hinder vaccinations in developing countries.

R Ramakumar writes:

The COVID-19 pandemic has not yet been officially reclassified as an endemic disease by the World Health Organization (WHO). As on 1 March 2022, the seven-day rolling average of the number of confirmed cases was 1,35,435 in Germany, 62,331 in the United States (US), 41,712 in the United Kingdom (UK), and 39,339 in Italy. The seven-day rolling average of the number of daily deaths was 159 in Germany, 1,830 in the US, 117 in the UK, and 212 in Italy. The emergence of the fourth wave of infections over January and February 2022 has signalled the continuing possibility of mutations in the SARS-COV-2 virus even if accompanied by lower case fatality rates.

From the initial months of the pandemic, the WHO and public health experts have placed faith on universal vaccination as an important pathway to reduce severe disease outcomes and mortality rates. It was no surprise—with the advancements in science—that a blueprint for the COVID-19 vaccines was ready within a few weeks of the virus outbreak. Several vaccine options emerged based on multiple technology platforms; they included M-RNA vaccines, adenovirus vaccines, inactivated vaccines, and protein subunit vaccines. The development of most of these vaccines was funded by governments, as under the Operation Warp Speed in the US or by the Vaccine Taskforce in the UK. The Oxford–AstraZeneca vaccine, the Moderna vaccine and the Pfizer-BioNTech vaccine were developed using public funding.

Till February 2022, 33 vaccine candidates based on different platforms were approved for use by the WHO. However, the salutary role of science and scientists was eclipsed by the constraints in the political economy of vaccine production and distribution.

To begin with, vaccine developers lacked mass-production capacities or expertise in supply chains. Hence, they tied up with large-scale vaccine manufacturers. However, manufacturing capacities and skills were concentrated in a few countries. Even in these countries, existing capacities had to be repurposed to manufacture COVID-19 vaccines. To complicate matters further, supplies of vaccine-manufacturing equipment were disrupted due to export restrictions in the major supplier countries.

The lack of adequate production led to hoarding. There were two types of hoarding. The first was technology hoarding. Vaccine production was closely protected by layers of intellectual property rights (IPRs). Despite the promises that they would sacrifice extra-normal profits during the pandemic, vaccine producers refused to transfer the know-how, trade secrets and data to the producers in developing countries. Even though vaccine development was publicly funded, developed country governments refused to invoke emergency legal provisions, which would have forced vaccine producers to share their IPRs.

The second was vaccine hoarding, a phenomenon also termed as vaccine grab or vaccine nationalism. The wealthier developed countries placed advance purchase orders that grossly exceeded their requirements, which meant that only a trickle was left for the developing countries. The wealthier countries refused to share their excess stock of vaccines with others, and instead used them to give booster shots to their citizens.

Global public health experts had anticipated this outcome. That is why the WHO, GAVI and the Coalition for Epidemic Preparedness Innovations (CEPI) formed the COVID-19 Vaccines Global Access (COVAX). The goal was to bring together "governments, global health organisations, manufacturers, scientists, private sector, civil society and philanthropy" to promote vaccine donation and ensure equitable access to vaccines. The initial goal was that a minimum of 20% of the population in each of the 92 low- and low-middle-income countries—comprising the healthcare and front-line workers, elderly and the vulnerable—must be vaccinated by the end of 2021. The goal was later revised to 40% by end 2021 and 70% by mid-2022.

Yet, the noble intentions of COVAX were derailed as vaccine producers and developed country governments discouraged mass production and open-source technologies. They received support from organisations like the Bill and Melinda Gates Foundation. Proposals at the WTO to waive IPRs on vaccines were effectively defeated. COVAX remained severely underfunded. Consequently, if the goal of COVAX was to deliver two billion doses by end 2021, actual deliveries were only about one billion. The goals for the proposed vaccination by end 2021 failed, and those for mid-2022 appear tough to achieve.

The major losers have been the African countries. Of the one billion doses delivered by COVAX, only about 430 million doses were directed to 50 African countries. As a result, only about 13% of the African population is fully vaccinated. The share of the fully vaccinated population is 10% in 18 countries and less than 1% in three countries. The vulnerable sections in the population—including the health workers, those aged above 50 years, and those with comorbidities—are also poorly covered.

It is now a cliché to repeat the obvious—no one is safe until everyone is safe. The virus does not recognise borders. Even if the developed countries fully vaccinate their populations, and add booster doses and fourth doses, the virus may still mutate in the less vaccinated parts of the world and reach them. Until a large section of the population in the developing world is vaccinated, the pandemic will not become endemic. Yet, the urge to profiteer amid the pandemic, ably supported by perverse policies in the developed capitalist world, has promoted a regime of vaccine apartheid. What we need is global solidarity, but what capitalism gave us is a display of a narrow, inward-looking, and ultimately a self-destructive set of policies.

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