

The International Political Economy of Health: The Covid-19 Vaccine Distribution

Written by Mohid Iftikhar

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MOHID IFTIKHAR, SEP 14 2021

The relationship between international politics and global health issues is not coming of age. From the nineteenth century, states have had various interactions at the system structure due to health epidemics and infectious diseases such as Cholera, Small Pox, Typhus, and Yellow Fever, and Scarlet Fever and the Bubonic Plague. It was during the mid-nineteenth century when the International Sanitary Conference of 1851 took place, leading the European States for a multilateral approach towards quarantine regulations. In turn, with regional and international trade and development coupled with globalization, health professionals and governments started recognizing the threat of contagion and chaos from such diseases. The 20th century had also its fair share of similar pandemics and infectious diseases such as the Spanish Flu, Polio, HIV and Legionnaires' disease and Lyme disease. By the mid-twentieth century with the inception of the World Health Organization (WHO), global institutional mechanisms came in place, hence binding a common consensus of international health crisis by both the global north and south.

First appearing in the Chinese city Wuhan in late 2019, by March 2020 Covid-19 was declared as a global pandemic by the WHO. During Covid-19's early onset, little was understood about the virus. Simply, countries due to their capacity, cultural, social, political, and economic factors varied in their responses to Covid-19. Some countries had tighter policies towards Covid-19 such as social distancing, contact tracing, lockdowns, identifying asymptomatic individuals, testing kits/methods and halting international and domestic travel, whereas some countries including the US quashed Covid-19 as nothing more than a myth.

The IMF (2020) noted that,

the Great Lockdown (is) the worst recession since the Great Depression, and far worse than the Global Financial Crisis...cumulative loss to global GDP over 2020 and 2021 from the pandemic crisis could be around 9 trillion dollars.

It became evident in mid-2020 that the Covid-19 pandemic was one of the worst catastrophes of the 21st century. According to WHO estimates, 4 million people had died due to Covid-19 worldwide by June 2021. Subsequently, with the development of Covid-19 vaccines, new debates have emerged in the international political economy (IPE). Borrowing from Susan Strange's (1988) theoretical premise of four primary structures in IPE; security, production, finance, and knowledge, this piece aims at establishing linkages to understand the distribution of the Covid-19 vaccines.

Interaction of Finance, Knowledge, Production, and Security Structures

The global distribution of Covid-19 vaccines can be viewed from complex interactions between finance, knowledge, production, and security structures. A web of processes such as institutions, spending, research, investors, capacity and manpower, and technological innovation determine the diffusion of medical breakthroughs. In essence, the complex dimensions of power both material and normative determine factors of production, output, and distribution.

Firstly, unequal distribution of global health (spending, research, infrastructure, and innovation) is not novel. In 2018 five leading global powers, constituting 9% of global population; France, Germany, Japan, the United Kingdom, and

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the United States accounted for 60% of global health spending. However, in terms of the average health spending per capita in 2018; low-income countries had an average of US \$40 whereas high-income countries had an average of US\$3,313. Furthermore, health spending patterns vary across high-income, upper-middle-income, low-middle income, and low-income states. The primary sources of health spending are public, households, private insurance, external aid, and a relatively small number of workers receive health benefits at private organizations. For example, in 2018, lower-income countries health spending through external aid was 30%, the household was 41% and public sources was 21% whereas, in lower-middle-income countries, the same spending was 42%, 10%, 40%. However, in high-income countries, public health spending (including social insurance) was 70% and in high middle-income countries, public health spending (including social insurance) was 55%. In addition, the general trend for low-income countries has been an increase in external aid from 2000-2018 and declining public and private health spending. Hence, concerning global health spending patterns, for the developing world, easy and affordable access to medical resources remains restricted. Moreover, the weak and fragmented health structures in poor countries are bolstered through political decay, corruption, patronage networks, vested interests, and lack of accountability and this further adds to the intricacies for the masses to access basic health resources.

Second, the development of vaccines has long remained a techno-medical issue. It is the years of research, innovation alongside technological advancement, and testing that determine the success, effectiveness, and market roll-out. Historical lessons provide us that under normal conditions, vaccines take at least a decade or even more to develop. For example, scientists started working on the polio vaccine in the 1930s; however, it was 1953 when polio vaccine became completely effective. In comparison, due to the global pressures, the Covid-19 vaccine took a year to develop. As rightly stated by Brüssow (2021), regarding the Covid-19 vaccine “what normally takes a decade was worked out within a year.” According to one study, during the early trials of vaccine development the estimated cost was said to be approximately US \$31-68 million and with further advancements this number is set to increase. In addition, the challenges for developing vaccines do not pertain to only medical research, but there are institutional-bureaucratic challenges and financial constraints. In the US, only numerous institutes such as the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) along with others had to partner in developing the vaccine.

Third, it remains vital to understand the link between international corporates and global health governance and how they shape intellectual property (IP) regimes. According to the IDEA Pharma twin indexes—“the Innovation Index and the Invention Index”, the top leading R&D pharmaceutical companies have their origins primarily in the US, Western Europe, and Japan. Some of these corporates include Eli Lilly (US), Roche (Swiss), Regeneron Pharmaceuticals (US), Seagen (US), Incyte (US), and GSK (UK) and Sanofi (France), and AstraZeneca (UK & Sweden) and Novartis (Swiss) and Johnson & Johnson (US) and Eisai (Japan). It is vital to note that Multinational Corporations (MNCs) influence does not stem only from their sheer value of global revenues, but also their ability and capacity to innovate and invent drugs and to politically influence domestic and international institutions. Sell and Williams (2019) argue that “capitalism is an all-encompassing global phenomenon that interacts with health at multiple scales and via a range of ‘vectors’ that must be engaged, examined and understood.”

From the late 1970s, developing countries focused upon cultivating their indigenous pharmaceutical industries for harnessing affordable socio-economic and health benefits, but this faced strong resistance from the Western MNCs. For example, American pharmaceutical companies were able to utilize their domestic institutions to protect pharmaceutical products under the patent product with the inception of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in 1994. TRIPS was legally binding by all WTO members. This novel regime placed new arrangements of robust intellectual property checks (patent protection) towards the developing world for accessing affordable medicine. In consequence, IP severely impeded generic producers in the developing world and truncated their capabilities to resist constraints by institutional structures. For example, noted in an article of BMJ

previously, the two companies with a duopoly for the human papillomavirus (HPV) vaccine held patents that prevented competition. According to one estimate, low income countries paid up to 10 times the estimated cost of production for these vaccines. Millions of girls globally are still unable to access this critical protection against cervical cancer.

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Subsequently, the emerging patterns of governance in the 1990s led transnational NGOs to strengthen and extend support to the developing world's generic pharmaceutical producers. In consequence, this also allowed pharmaceutical giants to channelize new strategies for protecting their products. The new IP regime reinforced the protection of clinical trials as well as limiting counterfeit drugs. According to Roemer-Mahler (2012),

The IP issues involved in data exclusivity and the debate on counterfeit drugs, namely undisclosed information and trademark protection, are assuming increasing importance for R&D-based pharmaceutical companies at a time when patents are becoming less effective as tools to mitigate competition.

This was because new drugs under IP had a time frame and once that lapsed, generic companies had an opportunity to significantly gain by starting their production and selling much cheaper drugs in their domestic markets. In addition, R&D-based companies also confronted an economic dilemma, as they were unable to bring new drugs into the market along with facing patent expiration of their products.

Fourth, by end of June 2021, there have been "around 180 potential vaccines...in preclinical development by pharmaceutical companies, academic institutions, and government agencies." However, the vaccine development lead rests in the ambit of a few states such as: the US (Johnson and Johnson, Moderna & Novavax), China (CanSino, SinoPharm, Sinovac), Russia (Gamaleya, Vector Institute), and consortia between the UK and Sweden (Oxford-AstraZeneca) and the UK and Germany (Pfizer-BioNTech) and India (Bharat). Moreover, other than WHO's emergency use listing (EUL) of Covid-19 vaccines, the global acceptance, and distribution remain with Western states and to some degree with Russia and China. Haggart (2017) rightly states that "It is not an exaggeration to state that knowledge and its communication have become a primary vector for the exercise of power in the global political economy."

What is alarming is that by May 2021 only 2% of Covid-19 vaccines had been administered in world's 50 poorest countries. One study of the British Medical Journal notes that countries in the Global South are constrained by the intellectual property law in accessing Covid-19 vaccines and this only aggravates global inequalities. Such IP constraints and financial disparities depict impediments for the developing world to access Covid-19 vaccines in a timely manner.

According to the WHO Director-General "I need to be blunt, the world is on the brink of a catastrophic moral failure and the price of this failure will be paid with lives and livelihoods in the world's poorest countries." Despite COVAX, a global co-led venture between CEPI, Gavi, and WHO, and delivery partner UNICEF; there has been a significant failure for the vaccines to reach the world's poorest. "Covax hasn't failed, but it is failing," according to Dr. Ayoade Alakija, a co-chair of the African Union's vaccine delivery program. Assistant Director-General of the WHO notes "you can't distribute vaccines that you don't have." And by July 2021, "more than 80% of the doses have gone to people in high-income and upper-middle-income countries. Only 1% of people in low-income countries have been given at least one dose, according to the website."

It is also important to note that structural constraints such as export restrictions by the US, EU, and India on vaccines and their ingredients alongside hoarding and little cooperation for knowledge have equally exacerbated addressing Covid-19 vaccine needs of the developing world. The US secured contracts for 1.3 billion Covid-19 vaccines, 5 per citizen. Whereas Canada secured 65 million Covid-19 vaccines and sought another 120 million. Similarly, the UK had deals for securing 500 million Covid-19 vaccines – 8 per person; and Australia, for its 25 million population, secured 170 million Covid-19 doses. Interestingly, at the height of the Cold War and despite being competitors, the Soviet Union and the US cooperated to eradicate smallpox through global vaccination program, and this only points to the deepened fractures in the core structures of IPE today.

Conclusion

There is an urgent need to advance new scholarship that explores how global policies are shaped for the distribution of important vaccines such as Covid-19 and HPV and particularly why the developing world lags at the receiving end. For a robust and in-depth theoretical understanding, the complex interaction of security, production, finance, and

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knowledge structures of IPE allows exploring the linkages between markets, governments, researchers, INGOs, societies, and MNCs and how their varying interests collide. In relation, drawing upon Susan Strange's (1996) argument of examining IPE problems beyond the conventional political and economic domain provides a strong model for causal precision. And primarily because today with the free-market system, global linkages and technological advancement, stakeholders such as MNCs seek to promote and reinforce their interests. This piece in no way seeks to conclude which structure of IPE takes precedence in cause-and-effect relation of Covid-19 vaccine distribution. Rather it points to global health spending patterns, the time frame of vaccine development, interests of global pharmaceuticals, and their strategies embedded in international institutions as well as highlighting constraints in global health diplomacy. While countries such as China have taken a lead in Covid-19 vaccine diplomacy, more effective strategies such as flexible IP regime, interest free financing and checks on hoarding are in need for the developing world to have an equitable access.

History provides us important lessons about the global cooperation on common threats, as during the Cold War when the Soviet Union and the US worked together to eradicate smallpox. However, today we must account for the complex composition of regional-multipolar systems as rising and regional powers compete for resources. Moreover, due to the liberal market system, increasing number of actors such as scientists, investors, manufacturers, governments, NGOs, international institutes are at constant play for security. It is seemingly a black-box problem to explain policy processes. This is where the epistemological and ontological foundations of political science in conjunction with the ongoing theoretical development and innovation of IPE reinforces a path to solid social inquiry.

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