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WIDER Webinar | Jayati Ghosh | University of Massachusetts
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The COVID-19 vaccine apartheid and how to end it

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The Covid-19 vaccine apartheid and how to end it

Jayati Ghosh
University of Massachusetts at Amherst, USA
(formerly Professor, JNU, New Delhi)

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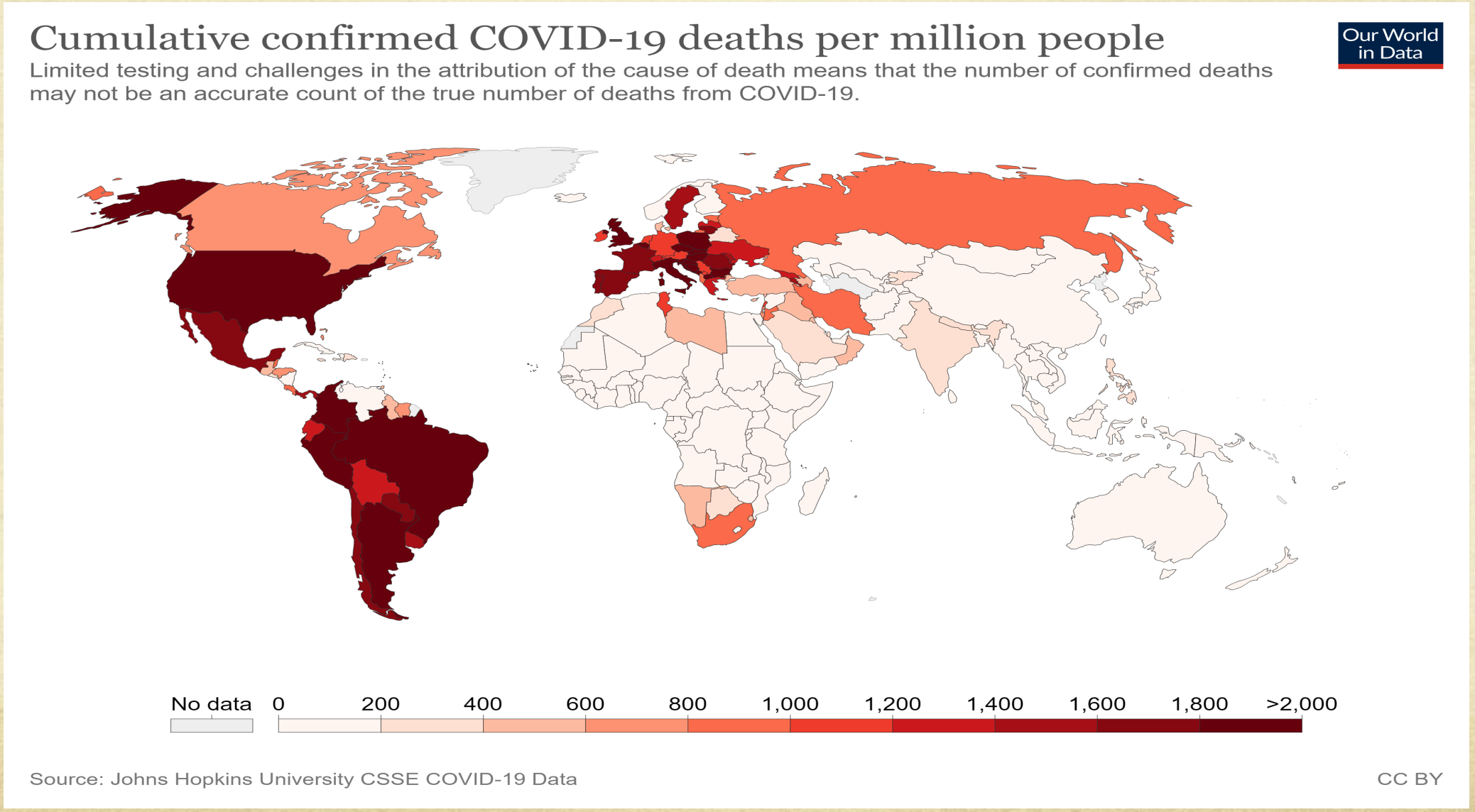
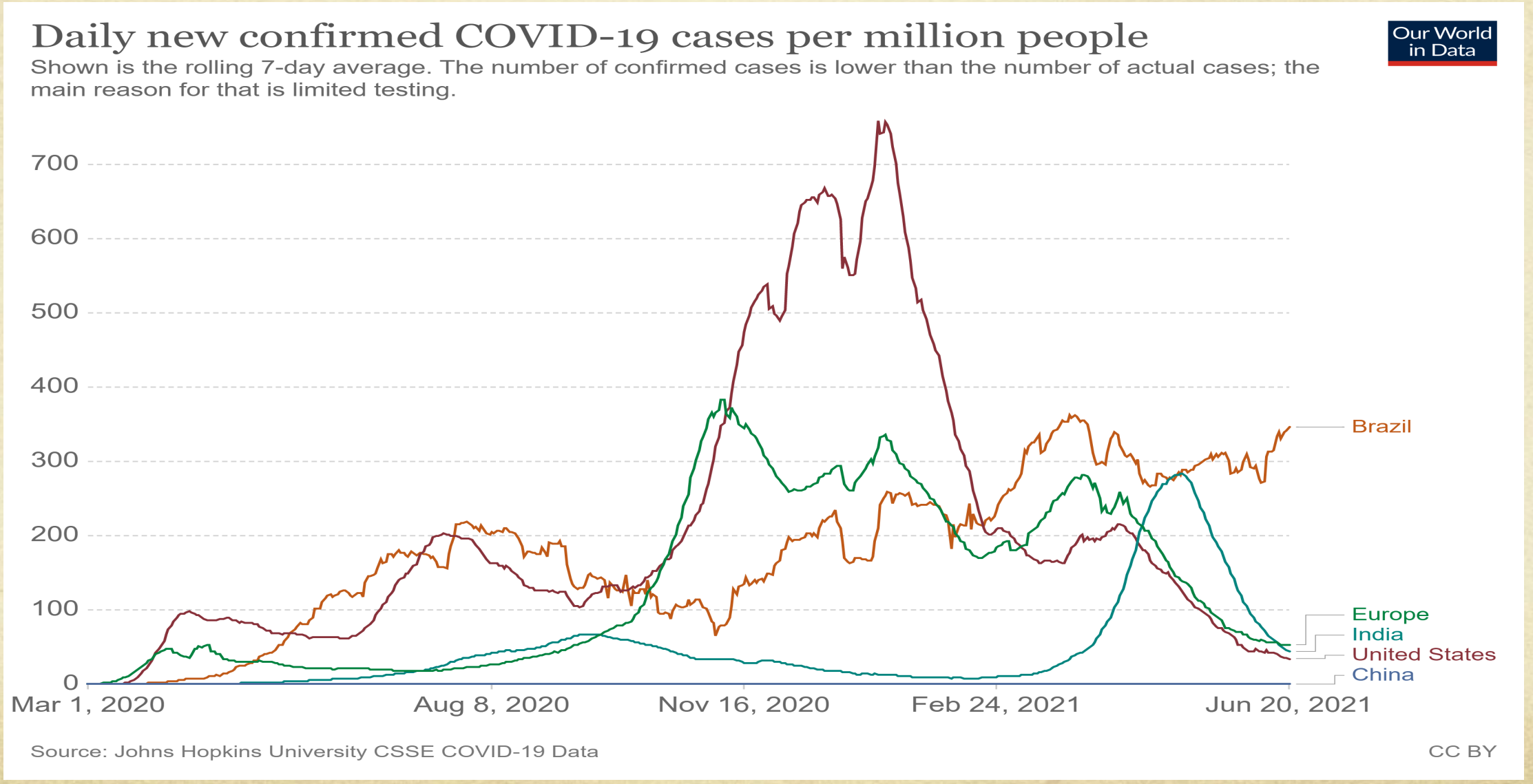
Some background on the Covid-19 pandemic

- Rich countries were most affected in first wave
- Scale and nature of the policy response for containment, designed for more advanced economies
- Speed and urgency of the global response, particularly with regard to vaccine development
- These features are not unrelated – they reflect global inequality and power imbalances, and have added to them.
- “Some viruses are more equal than others”.

“North” and western hemisphere most affected



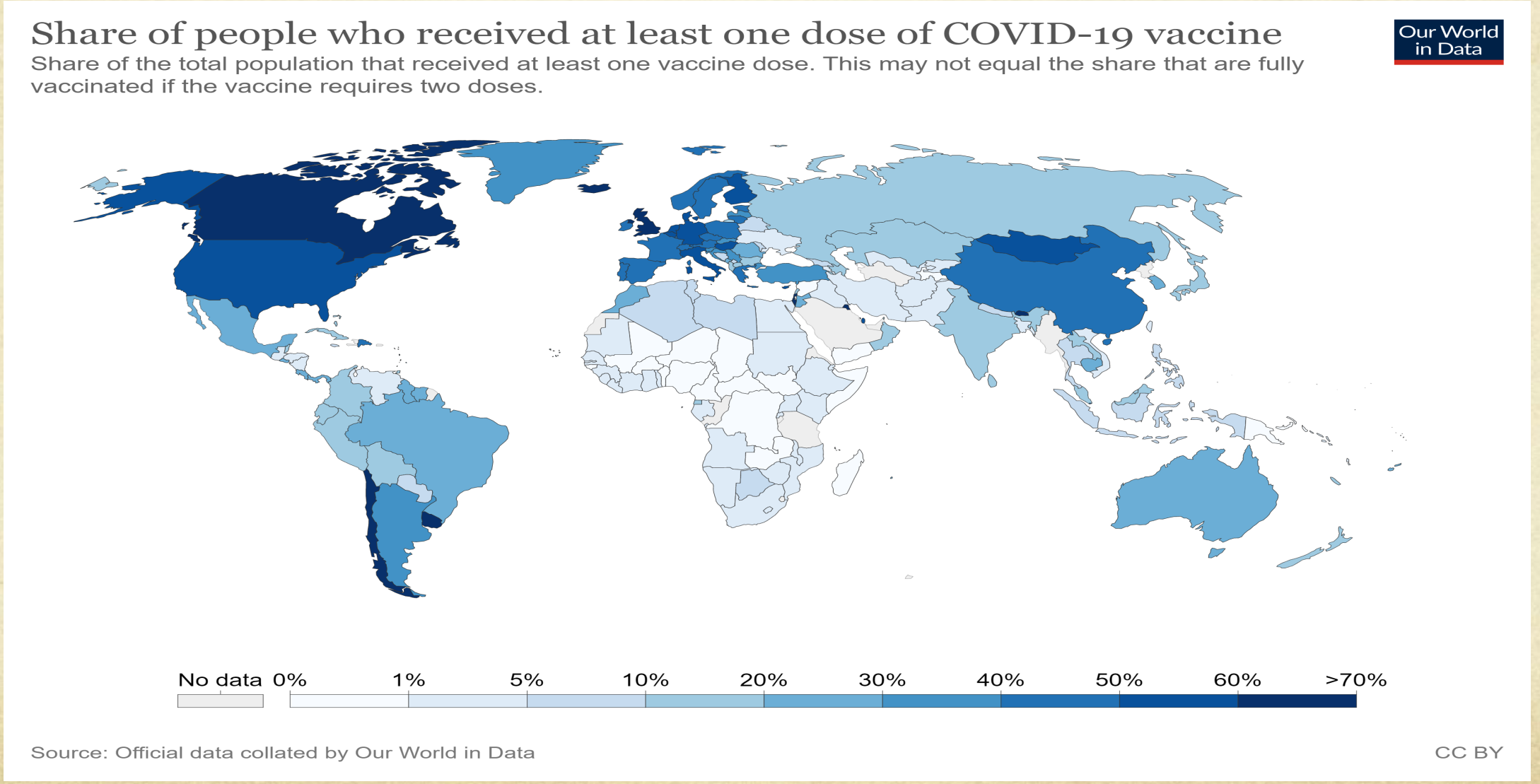
Devastating second waves in some developing countries



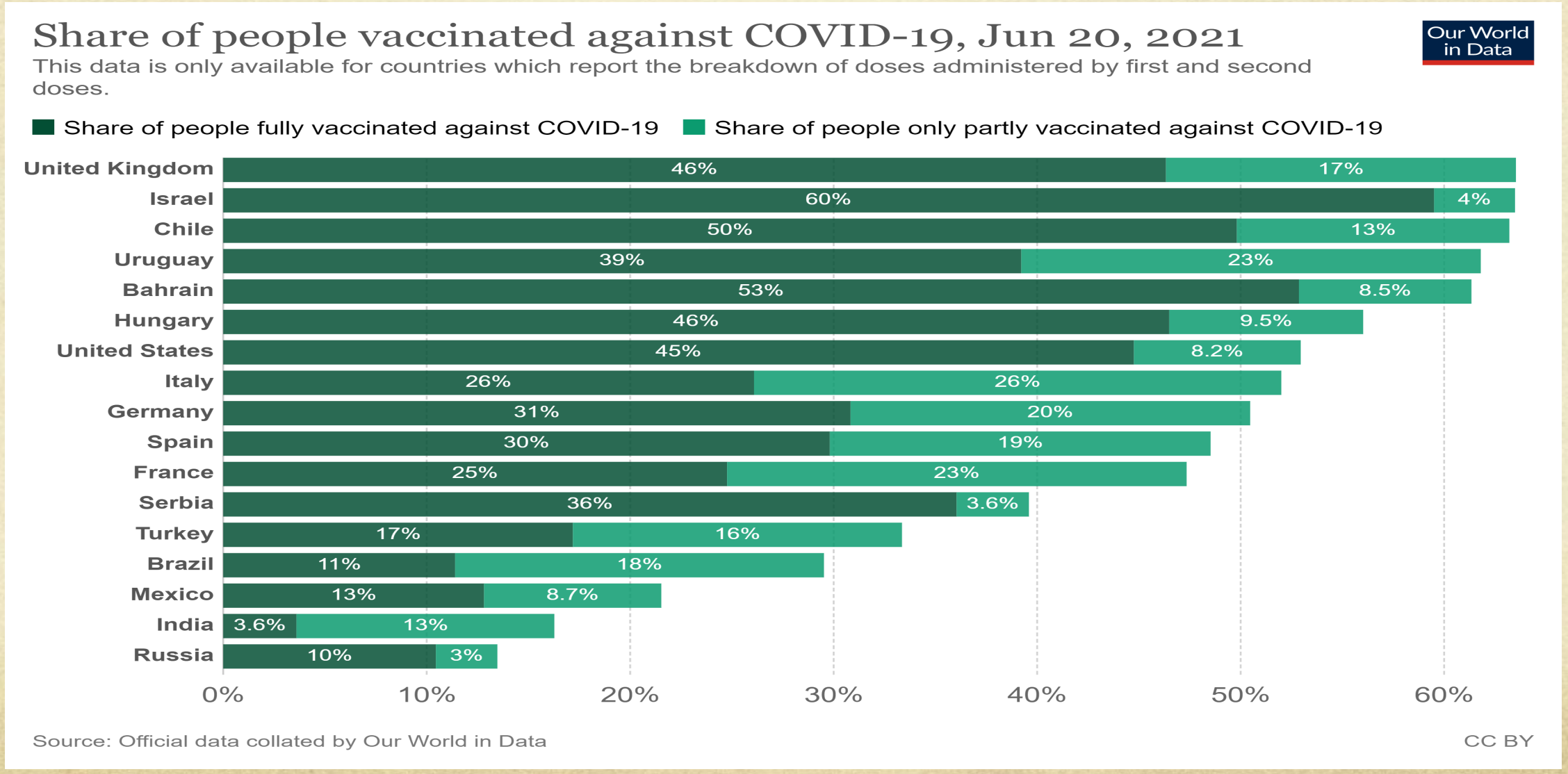
Vaccine production and distribution has become a stark sign of inequality during pandemic

- Vaccine grab by rich countries
- Protection of IPRs of pharma companies by rich country governments
- Use of vaccine distribution to promote both nationalism and diplomatic “soft power”
- But a pandemic can be overcome only when it is overcome everywhere.
- Delayed vaccination of people across the world increases possibilities of virus mutation, and affects economic prospects in the both developing and developed economies.
- Already there are concerns that new double mutant variants like Delta+ are more infectious, more deadly, and less controlled by vaccines.

Vaccine apartheid



Unavailability vs vaccine hesitancy



What are the bottlenecks?

- Overall supply inadequate, because of insufficient production
- Global distribution skewed because of vaccine grabbing by rich nations
- Internal distribution in many countries also messay and incompetent
- Vaccine hesitancy

Global distribution: COVAX was designed to prevent this

- The COVID-19 Vaccines Global Access Facility (COVAX)—led by the WHO, the Coalition for Epidemic Preparedness Innovations, and Gavi (the Vaccine Alliance) was created to prevent hoarding by rich country governments and ensure access of the world's poor. [It is the vaccines pillar of the WHO's Access to COVID-19 Tools (ACT) Accelerator.]
- In mid 2021, 190 member countries, with most of the world's population. US (kept out by Trump) joined in February.
- Higher-income and middle-income countries can access vaccines in the COVAX list, by paying for their doses, and should contribute to fund. 92 lower-income countries will receive their doses free of charge.
- Distribution phases: 3%, 20%, then specially vulnerable areas and people, finally all of a country's population.
- But only around $5 bn of the required $24 bn raised so far, and COVAX has not been able to purchase vaccines as required.

COVAX is underfunded AND allowed bilateral deals

- COVAX pricing is not transparent.
- Within a month of approval for Pfizer-BioNTech, Moderna and Astra Zeneca vaccines, advanced country governments (only 14 % of world's population) booked 85% of 2021 production.
- 44 bilateral deals between governments and pharma companies in 2020, another 20 already signed this year.
- Canada booked vaccines more than 10 times population; US more than 4 times. (But incompetent internal distribution)
- Pricing opaque but higher than COVAX.
- Prices of vaccines vary from $2.19 to $40 per dose.
- Developing countries often paying more than advanced countries (AZ $5.25 in South Africa, $3.50 in EU).

Stockpiles, “charity” and timing

- 75% of vaccines have gone to just ten countries.
- Rich countries that grabbed vaccines are now sitting on large stockpiles of vaccines, some of which may soon be unusable.
- G7 in recent meeting pledged 870 mn doses to COVAX and to other countries, half by end 2021.
- This is nowhere near the global requirement and the pace is too slow.
- Only 25 mn vaccine doses administered in Africa (population 1.36 bn)
- Some doses delivered as “charity” to African countries were found to be close to expiration dates, had to be destroyed.
- At current pace, 75% vaccination of entire world would not happen until late 2024.

Supply issues: The patent problem

- Vaccine supply limited first because of patent rights that give pharma companies monopoly on production, limiting supply to their own capacities and the few production licenses they choose to issue to others.
- Patents are supposed to reward innovation.
- But big pharma has already got massive government subsidies to develop these vaccines – In US, $12 bn to 6 companies that covered costs, and initial sales ensured very big profits.
- mRNA vaccines also used prior public research, companies only did last mile development. Development of AZ vaccine 97% publicly funded.
- Big Pharma doesn't really use profit for R&D: e.g. Pfizer spent $139 billion on buybacks and dividends between 2007 and 2016, compared to $82 billion on R&D.

WTO TRIPS agreement

- In October 2020, India and South Africa requested the WTO to allow all countries to choose to neither grant nor enforce patents and other IPRs on COVID-19 drugs, vaccines, diagnostics, etc during pandemic, until global herd immunity achieved.
- This is very limited request: it only prevents governments from facing cases in WTO for giving other producers compulsory licenses.
- Advanced country governments have repeatedly blocked this in the TRIPS Council.
- This is surprising: this would also benefit their own populations by making available more vaccines quickly, and larger supply would reduce costs of additional vaccines, making them cheaper for governments and taxpayers across the world.
- US Biden administration recently agreed to stop blocking TRIPS waiver.

Countries opposing TRIPS waiver

Limits to compulsory licensing

- A compulsory license is an authorisation granted by a government to a third party to produce a patented product/process without the consent of the patentee.
- TRIPS allows it to prevent monopolistic behaviour and during public health emergencies.
- In addition to TRIPS, some FTAs, EPAs, BITs also could prevent compulsory licensing.
- But TRIPS waiver still important because of number of patents involved in production (mRNA vaccines around 60-64 different approvals required in process).
- Important: transfer of technology by the inventor to other licensed producers is not compulsory, and data provided during patenting process may not be enough to enable other production.

The TRIPS waiver is only the first step

- Transfer of technology to manufacturers to other countries, especially low- and middle-income countries, is urgently necessary. There are existing producers in may countries that have state-of-art facilities, and are willing and some have even applied for licenses but been denied. (WHO list of >200 companies)
- Governments can push those companies that have received significant public funding to share their technology.
- Building up manufacturing capacity across the world is vital for distributing systemic risks and building systematic resilience in the manufacturing and supply of essential pharmaceuticals at local levels.
- These are global health commons, but current experience is forcing many countries to think regionally, nationally and locally.
- This will be critical in future pandemics and health threats: it is not possible to know in advance which vaccines and treatments will prove most effective, so we may need to invest in a range of assets and technologies.

WHO Regulatory approval

- All Covid-19 vaccines are only have “emergency authorisation” for use because of speed of approval.
- Other vaccine candidates in China, Russia, Cuba, India.
- But WHO approval process skewed in favour of companies based in advanced economies.
- WHO list of "stringent regulatory authorities" it trusts for quality control are in Europe, and US, Canada, Australia and Japan.
- Everyone else has to go through “prequalification” - a much more complicated and extended process.
- Pfizer-BioNTech vaccine approved very quickly, with WHO working with European Medical Agency; Chinese Sinopharm and Sinovac just approved even though they applied before, Russian Sputnik V not yet approved.

Key recommendations of WHO Council on Economics of Health For All

- **Vaccine solidarity**: Redistribute available vaccine doses from countries that have vaccinated >20% of their population, allocating a significant proportion of doses to COVAX
- **Knowledge governance**: Waive IPRs to create freedom to operate for anyone wishing to help scaling up availability and access to Covid-19-related medical technologies without fear of legal constraints
- **Technology transfer**: Compel vaccine producing companies to share knowledge and transfer technology (with appropriate compensation) to WHO Technology Hub, C-TAP, or directly to other producers that request it, with special focus on vaccines whose development benefited from public funds or public research
- **Supply chain resilience**: Ensure production and wider distribution of all raw materials and intermediate goods required for production of vaccines and therapies for Covid-19
- **Manufacturing resilience**: Mobilize financing to expand vaccine manufacturing capacity in all regions, to better respond to this pandemic and as part of establishing an end-to-end pandemic preparedness and response infrastructure that includes globally distributed ready-to-use manufacturing capability.

Thanks for your attention!