Who Gets a Covid-19 Vaccine and When? A Summary of the Forum on Equitable Access*

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In March of 2021, the Forum for Global Health Ethics had its second of a series of online events targeting a community of practitioners, researchers, students, and policymakers interested in jointly considering cases that pose ethical challenges in the field of global health. This second discussion centered on the question of equitable access to Covid-19 vaccines, considering their current scarcity. In a situation where receiving the vaccine can be the difference between life and death and where some will have priority while others must wait, the stakes are high and moral questions pressing. Wealthier countries have launched massive vaccination campaigns while low and middle-income countries struggle to even get started vaccinating their citizens, leaving vulnerable populations and healthcare workers unprotected. Some argue that governments have a duty to prioritize their own citizens, others call for equitable allocation at the global level, and still others hold views in between. In this forum, hosted by **Nikola Biller-Andorno** and moderated by **Tania Manríquez Roa** and **Felicitas Holzer**, experts including **Arthur Caplan**, Division of Medical Ethics, New York University; **Heidi Larson**, Vaccine Confidence Project, London School of Hygiene & Tropical Medicine; **Florencia Luna**, Program of Bioethics, FLACSO Argentina; **Keymanthri Moodley**, Centre for Medical Ethics & Law, Stellenbosch University; **Rino Rappuoli**, External Research and Development, GlaxoSmithKline Vaccines; and **Jan Helge Solbakk**, Centre for Medical Ethics, University of Oslo presented various angles from which to consider the question of what it means for distribution to be fair. The event was organized jointly by the Institute of Biomedical Ethics and History of Medicine at the University of Zurich (a World Health Organization Collaborating Center), the Swiss Medical Weekly, and the Latin American Faculty of Social Sciences (FLACSO). EACME, together with the World Health Summit and the Berlin-Brandenburg Academy of Sciences and Humanities, kindly supported this event. The key points from the forum are summarized below.

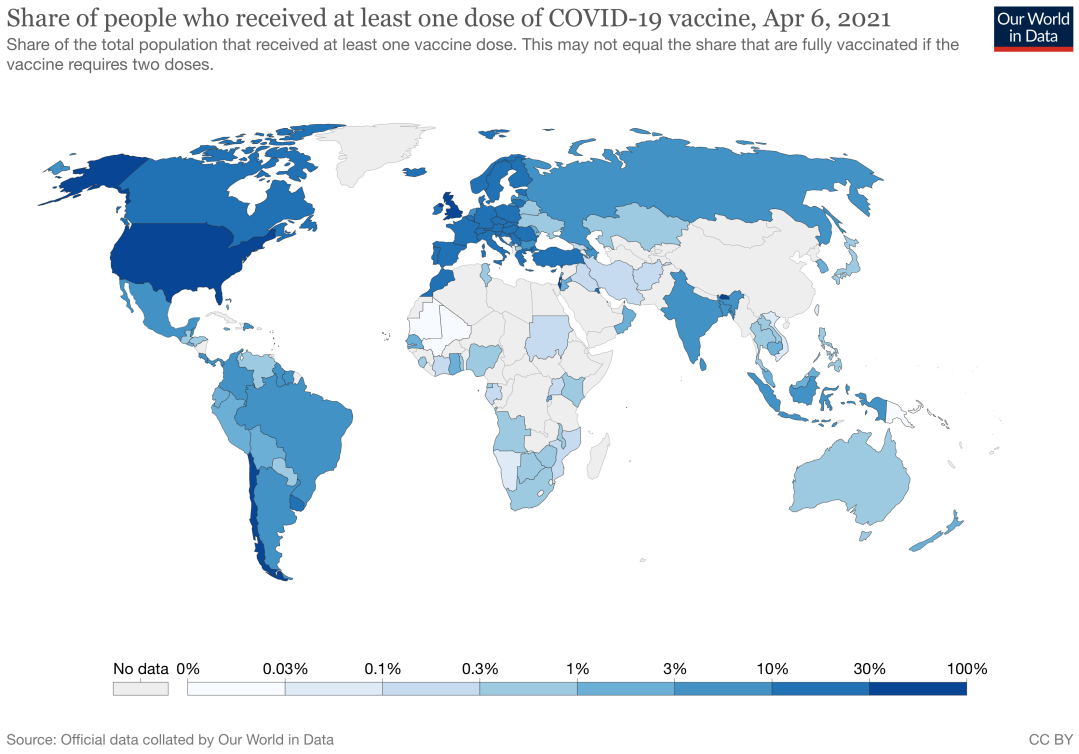
Why might a nation be entitled to prioritize its own citizens? Is this problematic?

Nationalist arguments recognize the weight of associative ties; certain relationships entail specific duties. Although it is acknowledged that the rich have an obligation to the poor and that citizens of the world are in peril, the connections to family, community, friends, and nation have significance. Associative ties create an obligation to fellow citizens that can be framed as stronger than the obligation to people with needs abroad. Following this argument, governments have a moral duty to prioritize vaccines to their own population before helping citizens abroad.

Another argument to defend prioritizing one's own nation is a recognition that if some people are at risk of infection during a pandemic, then everyone is at risk. If it is possible to successfully mitigate that risk within one's nation, one is contributing generally to mitigating the spread and thereby offering a benefit to all. Moreover, it could be argued that wealthier nations are in a position to better aid others from a place of secured stability.

Cosmopolitan arguments stress that in creating equitable vaccine access, considering citizenship or community membership is ethically irrelevant. This position holds that citizens of the world have equal rights and there is particular responsibility due to the most vulnerable. Some see the disregard for global solidarity as egregious. Here, blame is placed both on the pharmaceutical companies that are driven primarily by profit interests and on countries that are comfortable with the idea of vaccine nationalism. Given the number of people who stand to die as a result of for-profit and country-first agendas, some believe that these policies should be framed as crimes against humanity. In this conception, vaccine distribution must reflect respect for all human lives, and a failure to do so cannot be justified.

As of April 6 2021, the countries with higher vaccination rates are mainly high-income economies according to the World Bank Classification. If we consider the top 10 countries with a population of one million or more with higher vaccination rates, we find one country classified as an upper-middle-income economy (Serbia), and nine countries classified as high-income economies (Israel, United Arab Emirates, Chile, United Kingdom, United States, Bahrain, Hungary, Qatar and Singapore)[1]. The map below shows the proportion of the total population by country that received at least one vaccine dose[2].



How should we think about alternatives to nation-level approaches?

Some contend that the virus does not recognize national borders, so policy by nations is irrelevant. When nations are competing, everyone is disadvantaged: vaccine prices rise, and a sense of scarcity encourages hoarding. In response to this, the **Coalition for Epidemic Preparedness Innovations** (CEPI), the Vaccine Alliance (Gavi), the WHO, and the **United Nations International Children's Emergency Fund (**UNICEF) have led a unique effort called COVAX. COVAX aims to provide doses for at least 20% of countries' populations using a diverse portfolio of vaccine options delivered as soon as they are available in order to end the acute phase of the pandemic.

Some cosmopolitans believe that although COVAX is a step in the right direction, it does not go far enough. They argue that the underlying ethical criterion of this initiative, a proportional allocation system, is still problematic because it is not sensitive to where the threat is greatest. Fairness, they believe, is not even distribution but priority based on need.

What are some of the unique disadvantages faced by low and middle-income countries?

A clear example of the unique disadvantage faced by low and middle-income countries is their weaker bargaining power. For example, South Africa, an upper-middle-income economy, has had to pay more than twice what the EU pays per dose[3]. There have also been significant delays because the government must find a way to pay no fault insurance: if there are serious adverse effects, the

pharmaceutical companies want insurance that the government will respond to the liability. For example, Pfizer requested that military property and embassy buildings be held as a kind of security in some Latin American countries as a condition for those countries to be able to purchase doses[4]. Despite the fact that the pharmaceutical industry received public funds to develop the vaccine, those companies still refuse to assume some risks. Some argue equitable distribution is not possible when pharmaceutical companies have so much power.

Another position is that the greatest disadvantage isn't faced by the low-income countries, but rather by middle-income ones. High-income countries have leverage and resources to make their own agreements with pharmaceutical companies, and low-income ones receive some philanthropic attention. The middle-income countries are left truly struggling, neither able to provide for themselves nor receiving support from others. Equitable access, therefore, requires a solution that considers and includes all.

Can we create equitable access by democratizing the means of vaccine innovation and development?

Some contend that democratization of vaccine development is not possible because there is not equitable capacity. A unique feature of the race to find a Covid-19 vaccine is that the information about the sequence of the virus was made public so labs worldwide could use that information to begin parallel vaccine development projects. While this democratizes the process in important ways, nations do not actually have equal ability. In order to develop a vaccine, large investment and technical expertise is necessary. This capacity cannot be easily levelled; wealthy nations necessarily play a bigger and more effective role.

What implication does inequity of development capacity have for equitable distribution?

Typically, companies must take on the risk of investing in development and, therefore, those companies move forward sequentially: success at one stage is necessary before investment is made to prepare for the next stage. In the case of this current pandemic, wealthy nations, specifically the United States, put forward immense capital, removing the financial risks from companies, and allowing preparations to begin for all stages. This led to the unprecedented speed of development. It can be argued that it is reasonable for the countries that put forward such heavy investments to be entitled to first doses, especially considering that other nations will still directly benefit. Even if the countries without the capacity to develop vaccines themselves do not have access to the vaccine when wealthier nations first do, those countries will ultimately receive the vaccine earlier than they otherwise would have without the wealthy nation' investment; their position is still improved.

Are there other, less commonly recognized inequities?

One unique challenge is that inequity in vaccination follows an uneven demand for the vaccine. In wealthier countries, there is a notable disparity in that a smaller percent of minorities have gotten vaccinated[5]. These vaccination rates reflect vaccine hesitancy in those populations. Some argue that equitable distribution doesn't mean simply vaccinating according to demand, but rather building equity in the demand. In this framing, equitable vaccine distribution means also investing in underserved areas and providing a support that allows those populations to become engaged and activate their demand.

Questions for future research:

- What role does, can, and should international law play in ensuring equitable distribution?
- Which parties should be held liable in the event of adverse effects from the vaccine?
- How should greatest need for the vaccine be conceptualized?
- How can increased transparency and communication with society be encouraged, especially when it comes to details about the negotiations that take place with pharmaceutical companies?

- What efforts should be made and by whom to influence vaccine readiness so there is more equitable vaccine demand?

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[1] Our World in Data (2021). Share of people with at least one dose of Covid-19 vaccine [Internet]. 2021 April 6. [cited 2021 April 8]. Available from: https://ourworldindata.org/explorers/coronavirus-data-explorer?tab=map&zoomToSelection=true&time=latest&pickerSort=desc&pickerMetric=total_vaccinations_per_hundred&Metric=People+vaccinated&Interval=7-day+rolling+average&Relative+to+Population=true&Align+outbreaks=false&country=ISR~ARE~CHL~GBR~USA~BHR~SRB~HUN~QAT~SGP

[2] Idem

[3] Dyer, O. (2021). Covid-19: Countries are learning what others paid for vaccines. *BMJ: British Medical Journal (Online)*, 372.

[4] Davies, M., Furneaux, R., Langlois J. and Ruiz, I. (2021). Held to ransom: Pfizer demands governments gamble with state assets to secure vaccine deal [Internet]. The Bureau of Investigative Journalism. 2021 February 23. [cited 2021 April 8]. Available from: https://www.thebureauinvestigates.com/stories/2021-02-23/held-to-ransom-pfizer-demands-governments-gamble-with-state-assets-to-secure-vaccine-deal

[5] Razai, M. S., Osama, T., McKechnie, D. G. J., & Majeed, A. (2021). Covid-19 vaccine hesitancy among ethnic minority groups. BMJ, n513. https://doi.org/10.1136/bmj.n513