The Case for free and universal access to vaccination: A Bare Minimum in a world of intolerable inequalities

By Shobha Raghuram

Abstract
We examine the role of national governments in rising poverty and inequality during the ongoing COVID-19 pandemic. People's access to a people's, not-for- profit vaccine has been thwarted by some rich nations at the WTO TRIPS negotiations. We call for distributive-justice policies during this crippling pandemic during which jobs have been lost, children have had no access to school, and poverty and inequality have increased in many south countries. The failures of public-health systems in coping adequately with the treatment of those who have fallen severely ill with COVID- 19 has become most evident. We make recommendations for restoring public health as a social claim.

The Covid-19 Pandemic

What is the context today?

The Covid-19 pandemic, a severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2), was first identified in December 2019 in Wuhan, China. It was declared a Public Health Emergency of International Concern in January 2020; and it was declared a pandemic in March 2020.

As of January 13, 2022, more than 331.57 million people have been confirmed COVID-19 compromised, and more than 5.56 million deaths have been attributed to COVID-19. Asia has lost about 1 million lives, roughly half of these in South Asia. Citing official data, it is said that South Asia accounts for 17% of global COVID-19 cases and more than 11% of deaths. India has registered 486,761 fatalities, with a cumulative number of 37,618,271 cases. India's effort at vaccination of over a 1.58 billion doses at home and the worldwide coverage of over 9.68 billion doses are commendable.

The context in many Asian countries is reflective of the dire conditions of inequality. The sweep of the pandemic has exposed again the failure of the idea of globalisation itself. The structural adjustment policies, mooted and accepted by south countries in the early nineties at the behest of the Bretton Woods Institutions. i.e., the World Bank and the IMF, hastened privatisation, deregulation, and the private appropriation of public goods. Increasingly, over the years, this resulted in health and education becoming further privatised and a purchasable privilege. The declining investments by national governments in public-health facilities have opened up the shortfalls of privatisation during the pandemic. The WTO negotiations by the south countries, led by India and South Africa and supported by a majority of south countries, the US, and committed academics worldwide, for a temporary waiver on TRIPS for COVID-19 vaccines have been stalled repeatedly during the last one-and-a-half years by many wealthy European countries, especially Germany, and also the European Commission.

It is useful never to forget the history of the polio vaccine, which has been brought back to public memory during the current pandemic: Jonas Salk refused personal ownership of the polio-vaccine discovery. He cut through years of cumbersome paper work and ensured that vaccine production could begin immediately.

Ground realities

Hundreds across Indian cities received oxygen while sitting in cars and autorickshaws, parked near pavements. where private companies supplied the oxygen cylinders. The hospitals overflowed with people, makeshift beds spilling out into the compounds, and crematoria stacked the dead, awaiting a decent cremation. The lockdown announcements resulted in massive outflows of migrants. returning to their villages, their jobs in cities evaporating overnight. Many died while travelling on foot, enduring the heat in late March 2020, when the lockdown was announced. Now many of them have returned to the metropolises, leaving their wives behind, living in extremely poor settlements, and facing the uncertainty dogging their lives.

The financialisation of health services is the terra firma on which we must base discussions regarding equity in health, including the access to and the utilisation and enjoyment of good health care. The industrial profiteering approach, which marketises the impact and results of preventive and institutional care, has monetised medical care. Technological advancements have been spectacular, but the human condition has been marked by growing pauperisation and inequalities.

The lack of access to the COVID-19 vaccines, in many south countries, has only sharpened our conditions of inequality, which has few parallels in history. Extremely wealthy nations are being forced to reckon with having to dump excess unutitlised vaccines. We have heard of this before: excess crops are burnt in the USA to keep pricing steady; and hunger in the countries of the south becomes a permanent condition.

Unequal distributions; rising inequalities

There is extreme shortage of vaccines in low-income countries: in some of them, only 0-0.2% of the population have received both doses of a vaccines. This leads to the forecast that a total of 7 years will be required before all people across the world are vaccinated. In contrast, the United States of America, the European Union, and other high-income economies such as the United Arab Emirates, Canada, and Singapore have vaccinated between 50 %-75% of their populations.

Inequality sets people apart. Inequality builds walls between people along religious lines, on the basis of income, on the basis of an hierarchy of knowledge-based skills, access to knowledge systems, on the basis of access to and the enjoyment of good health.

The pandemic has posed other health challenges. A UN news report stated that disruptions in health services because of COVID-19 “may have contributed to an additional 239,000 child and maternal deaths in South Asia”. Clinics and other health facilities have been closed repeatedly, with each wave of the pandemic; and many vital health and nutrition programmes have been halted as different regions battle to contain COVID-19 cases. School food programmes have been disrupted as well, adding to growing hunger and malnutrition. Maternal mortality has been added to the list of high risks for COVID-19, with women (especially displaced migrant labouring women) delivering babies on the footpaths in India in some cases, turned away by hospitals. It is important to see with clear lenses the multidimensional consequences of COVID-19 being prolonged because of delayed vaccinations and vaccine shortages: These include children leaving school and being driven into child labour, loss of employment, death, and long-term debilitations from long COVID-19. Loss of income, indebtedness, and displacement will continue if the world does not achieve equality of access to vaccines on a free and universal basis.

The conditions of access to hospital beds are dismal, with 0.6 per 1000 people in South Asia. In contrast, there is more than one bed per 100 members of the population in Japan, the Republic of Korea, and Korea DPR. The stock of beds is less than one per 1000 people in Bangladesh, Pakistan, Cambodia, and India. These large disparities reflect substantial differences in the resources invested in hospital care across countries.The situation has left hundreds of millions across South Asia unable to access vaccines for the foreseeable future, including groups such as Bangladesh's one million Rohingya refugees and Afghanistan's 4 million internally displaced. Thousands of families have lost working members. Children have been orphaned, and the adults who have survived have joblessness and lack of income staring at them. The ILO underlined that 255 million jobs were lost worldwide in 2020; the share of the Asia-Pacific region was 80 million.

It is, for many, a futureless world; the present has become intolerable. And how unforgettable the past has been, since the pandemic struck, exacerbating the already rapidly rising inequalities!

Unfortunately there is no vaccination for equality, for the protection of vulnerable people from unregulated globalisation, from markets, from the acceptance of inequality as a way of life. Redistributive justice is a core operative principle in economic and social life. So what are the challenges? Covid-19 has exposed the catastrophic impact of the privatisation of vital services. Several writers have critiqued the financialisation of public services and human welfare. Health is central and access to medicine a right; and this must be the clarion call for the 21st Century.

A groundswell is needed. The Covid-19 crisis is expected to push another 176 million people into poverty (World Bank data). Experts suggest that the first step is making the vaccine available for all, reducing pressure on scanty health services, and ensuring, in the long term, the strengthening of public heath, access to medicines, and a focus on economic growth with full and fair employment.

Social Movements have called for a People's Vaccine - A not-for-profit Vaccine

They call for a People's Vaccine:

- Available to all and inclusive.
- Free of charge, a right, a social claim.
- Temporary Waiver of TRIPS at WTO.
- Distribution criteria; transparent processes.
- A focus on vulnerable populations: age, race, income, poverty, gender, and disability.

A feminist focus

On average, globally, women are paid 24% less than men; in South Asia, the gender pay gap is 35% for women, with children, compared to 14% in terms of the women without children. Across Asia and the Pacific, women perform 80% of the total hours of unpaid care work, on average 4.1 times more than men.

Special focus needs to be placed for women in the informal sector: women workers in factories, domestic workers, for women in the health-sector frontlines, for women in care providing, for rural urban poor women, for women and children in shelter homes.

Conclusion

Growing economic marginalization has major implications for health equity. Vaccine availability or the lack of it demonstrates the regressive distribution of financial flows and locational imbalances in fulfilling basic health care, needs, and services. COVID-19 is a wake-up call: it has highlighted the complete failure of the political economy, which has driven and promoted unequal access, exorbitantly priced medicines, and out-of-reach expensive health care. To address these problems we must embark on the following long-term solutions:

1. Reinforce the necessary role of the State in protecting vulnerable populations.
2. Translate rights into reality.
3. Negotiate a consensus among governments and international agencies to make sure that public health is a central concern of development goals.
4. Reservation of required national budgets for basic social progress.
5. Reversing declining standards in the access of the poor to sanitation, housing, food, water, and health services.
6. Need to link public-health efforts with macro-development strategies at both national and global levels.
7. Address the continuing divide in global governance, varying standards for equity, access, and control.
8. Collaboration between global institutions and local actors in all health concerns to stop the deepening of the erosion of rights to good health care.
9. The gains won in public health in the 20th century must not be rolled back
10. Cooperation operation in public health must be based on the following non-negotiable terms:
    - Broadly egalitarian distribution of public resources.
    - Effective decentralization of public (including State) decisions and implementations.
    - Change the present situation of undersupply of global public goods. The growing civil-society resistance in several countries against the excesses of States in allowing public-health facilities to decline.
    - Counter push-and-pull factors in the pharmaceutical industry and drug-pricing policies of national governments, which leave millions without access to medication.
11. Solutions for this class of problems include:

    - Sensitivity to unequal relations of power, class, and gender.
    - Equity and sustainability in financial terms.
    - The ethics of health as a social claim.

See https://www.nature.com/articles/d41586-022-00104-8?utm_source=Nature+Briefing&utm_campaign=628f2b80d3-briefing-dy-20220118&utm_medium=email&utm_term=0_c9dfd39373-628f2b80d3-45073462 Last accessed, 19/01/2022, **(Nature, The pandemic's true death toll: millions more than official counts,** 18 January 2022.)

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