

Ethical Obligations of Global Justice in the Midst of Global Pandemics – A case for radical redistribution and extensive reforms of global health care order

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This paper considers the ethical obligation high income countries (HIC) have to lower and middle income countries (LMIC) during a global pandemic. The COVID-19 pandemic revealed the shortcomings of distributing scarce medical resources according to economic bargaining power and of responding to the global health crisis with national isolation. This paper will present a pragmatic argument against vaccine nationalism and arguments for a more cosmopolitan approach. We argue that vaccines and medical equipment should have been distributed according to Brock's needs-based minimum floor principles, thus defending positions of vaccine Sufficiency. HIC ought to adopt such a strategy based on, 1. the duty to rectify past injustices from colonisation, and 2. a negative duty not to uphold unjust institutions and to contribute to radical inequalities. Finally, three practical steps to improve the vaccine rollout are advocated for: HIC should redistribute the excess vaccine doses to LMIC rather than letting doses go to waste; necessary infrastructure to mobilise medical supplies and healthcare staff to administer vaccine doses; and patents should be suspended to prioritise saving lives.

Introduction

The COVID-19 pandemic presented the world with an opportunity to rebalance the disparity in global healthcare equity. Over the course of two years the death toll exceeded 6.5 million and hospitals were forced to triage limited medical resources.¹ The priority became vaccinating enough of the world's population in order to reach herd immunity, which is expected to be between 60-70%. With only 23.7% of low income countries vaccinated and over 80% in many high income countries (HIC), the glaring inequality points to poor priority setting from the beginning of the pandemic. In May 2022, the COVAX initiative and its partner organisations—including WHO—called for countries to set ambitious goals in order to close the gap in vaccine

¹ WHO. *Coronavirus (COVID-19) Dashboard*. (October 2022). Online at covid19.who.int/.

distribution.² As of October 27, the US—the largest donor to COVAX—had donated more than 640 million doses to over 120 countries around the world.³ In total, the COVAX initiative delivered over 1.4 billion doses worldwide. While many HIC have contributed to efforts to ensure vaccine equity, those efforts were undertaken only after international organisations such as WHO and World Bank proposed those obligations. But have the HIC fulfilled their moral obligations towards LMIC with these donations?

After the Coronavirus pandemic began in late 2019, the global community was forced to make decisions about distribution of health care supplies and the resulting disparities primarily fell along income lines. Lower and Middle Income Countries (LMIC) suffered the brunt of resource shortages, which resulted in a prolonged recovery. This shortfall is due, in part, to poor pandemic preparedness and missteps in national strategy decisions across various countries. But the proceeding global health crisis also revealed already latently existing issues of distributive justice and brought to light historic, yet persistent unjust global distribution. In the beginning of 2020, as countries faced shortages of COVID-19 testing kits, mechanical ventilators, and personal protective equipment (PPE) like face masks, supplies went to the highest bidders, which tended to be HIC. When India struggled to contain COVID-19 cases during the outbreak in April of 2021, they had to turn away patients as their hospitals became overwhelmed.⁴ Leading many to wonder if better foresight and planning could have reduced the toll the pandemic took on these countries. Or if HIC had an obligation to share some of the scarce resources they had claimed in financial bargaining.

In this paper, we will look at various countries' strategies to address the pandemic, and analyse where they failed. We recognize that the overwhelming strategy in the pandemic response was a nationalist approach and argue that even from a merely practical standpoint this was destined to fail, because of the interconnectedness of our world. Nonetheless, arguments from liberal nationalism are reviewed. But when they are contrasted with basic premises of luck egalitarianism, the arguments for vaccine nationalism quickly lose their force. We further consider a more ethical approach to pandemic response. The proposed ethical approach to pandemic response centres around global obligation, which requires that HIC take the welfare of LMIC into account from the onset. Siding with a cosmopolitan position that endorses a needs-based minimum floor principle, we argue for vaccine Sufficiency.⁵ We will argue that governments of HIC have an obligation to reform global institutions in such a way that wealth disparities will not determine whether a person has access to life-saving medical care in a global pandemic or not. This obligation is rooted, on the one hand, in the duty to rectify the harms colonial powers have inflicted on former colonies. On the other hand, the obligation arises from a negative duty to not uphold a global institutional order that is unnecessarily unjust because it can be reformed by adopting a model of vaccine

² CEPI. *COVAX calls for urgent action to close vaccine equity gap*. (May 2022). Online at [Cepi.net](https://cepi.net).

³ U.S. Embassy & Consulates in Indonesia. *With Over 40 Million Doses Delivered, United States Supports Indonesia's COVID-19 Vaccination Drive*. (October 2020) Online at id.usembassy.gov.

⁴ Miglani, Sanjeev & Kumar, Manoj. *Indian hospitals turn away patients in COVID-19 'tsunami'*. (April 2021). Online at reuters.com

⁵ Göran Collste, "Where You Live Should Not Determine Whether You Live". *Global Justice and the Distribution of COVID-19 Vaccines*, *Ethics & Global Politics* 15, no. 2 (April 3, 2022): 43–54, <https://doi.org/10.1080/16544951.2022.2075137>.

Sufficientarianism, for example. The COVID-19 pandemic caught many countries unprepared and required a rapid response by its governments. As a result, millions of people died and countless millions more suffered. Hindsight allows for a critical evaluation of more effective strategies to address global health crises.

Pandemic Response

Before we are able to consider how to best address health care disparities, we must determine the missteps taken along the way during the COVID pandemic that led to unequal distribution in the first place. Pandemic planning can be broken down into three stages: first, pre-pandemic preparedness for public health crises; this can be understood as private national funds and medical supply reserves or as global preparedness planning as established by international organisations such as WHO; the second stage encompasses the mid-pandemic strategies countries adopted to respond to a pandemic (ranging from lockdowns to mask mandates and finally vaccination campaigns); and the third stage is post-pandemic, the efforts to recover and to rebuild medical reserves to prepare for the next public health crisis. At all stages, we can see points where global cooperation succeeded and failed. Our paper will focus on the second step: responses to the pandemic.

Throughout the pandemic, a country's ability to manage outbreaks and suppress the death toll in many cases was proportional to the pandemic response strategy it implemented. In the case of the COVID pandemic, countries' response strategies can be categorised into three main groupings: first, the "Zero-COVID" policy to enforce extreme measures with the goal of ensuring not a single citizen died of COVID, which was adopted by countries such as China, Australia, and New Zealand with varying degrees of success; second, a "flatten the curve" strategy of periodic lockdowns and restrictions to spread out infections, but still allow for minimum constraints, this strategy was adopted by much of the US and Germany; and third, the "exposure" strategy to allow everyone to be exposed to gain immunity quickly with little or no restrictions from the government, such as we saw in Brazil.

What all these strategies have in common is that they prioritise national interests, though to varying degrees. Countries varied in regards to prioritising the physical health of their citizens, like in the zero-COVID strategies, or the economic and social productivity of the nation like in Brazil. Others tried to strike a balance between these interests by flattening the curve. But there was not one country that prioritised global obligations. Efforts were made by organisations like WHO, UN, and World Bank on global prioritising, but countries were reluctant to follow suit. While there have been calls by several countries⁶ to waive patent rights so that vaccine production could be ramped up to meet the global demand, the general mechanism for vaccine distribution and other essential healthcare equipment was left to the devices of the free market. In our paper we will engage with this phenomenon of nationalism and free market distribution critically. We will first provide a pragmatic argument for prioritising a global pandemic response strategy by analysing the impracticality of national zero-COVID strategies. The second step of our paper will be to engage with moral arguments to prioritise national interests despite the impracticality of it. Once these nationalist arguments

⁶ Crutzen, C.J. & Kucking, M. 'Mayer Brown'. *The Waiver of Patent Protection for COVID-19 Vaccines—On Practicability and Purpose of Such Measure*. (July 2021). Online at mayerbrown.com

have been dismantled, we will present and argue for an ethical approach of cosmopolitan priorities and provide a motivation for them.

The Failure of Nationalism and Free Market Bargaining

After the Coronavirus was first detected in China, it was only a matter of weeks before cases began to appear in the US and European countries.⁷ Given the highly contagious nature of the virus, it quickly spread from one host to another through airborne transmission or direct contact. The rapid spread of the virus has powerfully illustrated how much all of our lives are intertwined. UN Secretary-General António Guterres clarified in May 2020 already: “In an interconnected world, none of us is safe until all of us are safe.”⁸ Nonetheless, we saw countries attempt to disconnect. Strict lockdowns were set to eradicate the virus and strict travel restrictions imposed to prevent its return. Australia is an especially illustrative example of the short-termism of this strategy.

Through strict lockdowns and successful contact tracing, Australia had managed to keep a strict—and relatively successful—“zero-COVID” strategy. Australia’s “aggressive lockdowns quashed COVID-19 cases and allowed for the return to near-normal life from around December 2020 to May 2021.”⁹ Yet, one unvaccinated airport limousine driver ended up responsible for an infection cluster of over 80 people.¹⁰ It took only this single person, interacting with a few international airline crew members being infected, to start another COVID-19 outbreak on the zero-COVID-island. Since the Delta variant was first detected, Australia had to recognize that it is not sustainable to keep everybody in strict lockdowns for nearly a year, thus abandoning the zero-COVID strategy. Our lives are too interconnected today to fight a virus like COVID-19 on a national level. That is true for lockdowns, but also for our vaccine strategies: Scientific research has shown that low vaccination rates can be a favourable environment for the emergence of new variants, and even that slow rates of vaccination increase the probability of the emergence of a virus strain that is resistant to the current vaccines.¹¹ Despite the knowledge that the COVID-19 pandemic will not be truly over until it has been brought to tolerable levels of infection and severity of pathogenesis *everywhere* through high vaccination rates, we see a tragic lack of international cooperation when it comes to actually distributing scarce resources. The COVID-19 pandemic demands more globally coordinated efforts than we have previously undertaken.¹²

⁷ Centers for Disease Control and Prevention. Basics of COVID-19. (November 2021) Online at [cdc.gov](https://www.cdc.gov)

⁸ UN news. None of us is safe until we all are, says UN chief at EU push to end COVID-19 pandemic. (May 2020). Online at news.un.org

⁹ Cliff, Edward & Fernandes, Brian. ‘COVID Zero Is No Longer Working for Australia’. *The New York Times*. Opinion (September 2021). Online at [nytimes.com](https://www.nytimes.com)

¹⁰ abc news. Limousine driver at the centre of Bondi cluster won't be charged, Police Commissioner says. (June 2021). Online at [abc.net](https://www.abc.net.au)

¹¹ Simon A. Rella et al., “Rates of SARS-CoV-2 Transmission and Vaccination Impact the Fate of Vaccine-Resistant Strains,” *Scientific Reports* 11, no. 1 (July 30, 2021): 15729, <https://doi.org/10.1038/s41598-021-95025-3>.

¹² Slavoj Žižek, *Pandemic!: COVID-19 Shakes the World* (OR Books, 2020), <https://doi.org/10.2307/j.ctv16t6n4q>. p. 68

When it came to scarce resources, nationalist priority setting was the common response and the affluent nations were happy to use their financial bargaining power to their own advantage. For example, in March 2020, the WHO recognized a global shortage of surgical face masks.¹³ At the same time, it had become obvious that there were also not enough ventilators available globally to meet the demand.¹⁴ While production ramped up, the market was still under a lot of pressure, and prices increased exponentially.¹⁵ Financial powers decided who got the scarce medical equipment. We could see the same pattern in vaccine distribution. This obvious injustice gave rise to the initiative 'COVAX' for "global equitable access to COVID-19 vaccines."¹⁶ COVAX and its partner organisations set a goal of providing vaccine doses to at least 20% of countries' populations. The third wave of the pandemic in European countries proves, though, that not even vaccination rates of 60% to 70% are sufficient to stop the spread of COVID-19.¹⁷ The 20% goal will not curb the spreading of COVID. It is merely a performance—not a sustained act of political solidarity.

With this we have shown that the response of nations to the COVID-19 pandemic had been up to national means, not global cooperation to facilitate fair distribution of needed healthcare equipment. On the one hand, there might be a pragmatic and scientific argument against such vaccine nationalism—"none of us are safe until all of us are safe"—but on the other hand, there are good ethical reasons for such vaccine nationalism. We will present this position and critically engage with the arguments liberal nationalists make for prioritising obligations towards citizens over cosmopolitan obligations.

Arguments for Prioritising National Interests

The unique moral obligations between state and citizens has been provided, among others, by David Miller in multiple works.¹⁸ He argues that the state has a set of obligations towards those subjects under its jurisdiction that are "quasi-contractual."¹⁹ Citizens are granted social rights of citizenship, but expected to assume corresponding obligations.²⁰ Such social rights of citizenship include, for example, a right to equal opportunities in education or employment, which the state has to ensure to make true on the democratic ideal of treating each citizen as equal. However, this right to equal opportunity is tied to contributing to the public good according to one's opportunities because the relationship of the state with individuals is

¹³ WHO. *Shortage of personal protective equipment endangering health workers worldwide*. (March 2020). Online at who.int.

¹⁴ Sarah Kliff, Adam Satariano, Jessica Silver-Greenberg & Nicholas Kulish. *There Aren't Enough Ventilators to Cope With the Coronavirus* (March 2020). Online at nytimes.com.

¹⁵ Adrian O'Dowd, "COVID-19: Government Was Too Slow to Respond to Ventilator Shortages, Say MPs," *BMJ*, November 25, 2020, m4594, <https://doi.org/10.1136/bmj.m4594>. P.1

¹⁶ WHO. *COVAX—Working for global equitable access to COVID-19 vaccines*. Online at who.int.

¹⁷ Sara Berg. *AMA. What doctors wish patients knew about COVID-19 herd immunity*. (August 2021). Online at ama-assn.org/.

¹⁸ David Miller, "Immigrants, Nations, and Citizenship*," *Journal of Political Philosophy* 16, no. 4 (December 2008): 371–90, <https://doi.org/10.1111/j.1467-9760.2007.00295.x>; David Miller, "Justice in Immigration," *European Journal of Political Theory* 14, no. 4 (October 2015): 391–408, <https://doi.org/10.1177/1474885115584833>.

¹⁹ Miller, "Justice in Immigration." p. 393

²⁰ Miller, "Immigrants, Nations, and Citizenship*." p. 375

founded on a rule of give and take.²¹ Thus, the kind of pandemic assistance we discuss in this paper—HIC supporting LMIC with vaccine doses or healthcare equipment—cannot be claimed by individuals from a state that is not theirs. They have not contributed to these nations to earn such opportunities and rights in return. Against this position, though, we will hold that the vastly different ability of states to provide beneficial social contracts with good healthcare benefits, traces back to colonialism and current unjust global institutions. It is a matter of deeply entrenched injustice, and not one of a quid-pro-quo social contract.

Another argument supporting the claim that states have special obligations towards its constituents are often referred to as “liberal nationalism.”²² Proponents of this theory argue that “It is only within nation-states that there is any realistic hope for implementing liberal-democratic principles.”²³ Such principles include social justice, deliberative democracy, and individual freedom.²⁴ To exemplify how this line of argumentation works, let us review the first principle: Usually, social justice is realised in modern nation states through welfare programs, which require individuals to make sacrifices for anonymous others. In a liberal democracy, welfare systems “survive only if the majority of citizens continue to vote for them.”²⁵ Kymlicka and Straehle argue that while history suggests we show more willingness to make such sacrifices for kin and co-religionists, we are also willing to make such sacrifices if there is a) a sense of common identity or b) a sense of reciprocity.²⁶ Liberal nationalists argue that these two criteria can only be met within a nation state. This line of argumentation ties in with Miller’s argument above: individuals in a nation state enter into a quasi-contractual agreement that builds on an idea of give and take. Collste²⁷ refers to this as “a modern Hobbesian notion of a legitimate state.” On this view the state needs citizens to consent to its actions, thus it needs to appeal to the citizen’s self-interest in order to gain legitimacy. This position is also supported by Miller: “on democratic grounds, it appears wrong for someone whose interests are chiefly impacted by the policies of a particular state to have no say in determining those policies.”²⁸

While this is valid, it leaves one to wonder about all those people, who cannot claim anything ‘on democratic grounds’ before their government. Against the liberal nationalist argument, one can hold once again the unjust starting position of individuals in different nation states: Do people in LMIC or countries without democratic governments not have a right to survive the COVID-19 virus, then? We posit that they do.

Under normal circumstances, the arguments of liberal nationalists might claim certain moral validity. In this paper we do not analyse the behaviour nation states should show under “normal circumstances.” Our scope is more limited. We are interested in the behaviour of

²¹ Ibid.

²² Will Kymlicka and Christine Straehle, “Cosmopolitanism, Nation-States, and Minority Nationalism: A Critical Review of Recent Literature,” *European Journal of Philosophy* 7, no. 1 (April 1999): 65–88, <https://doi.org/10.1111/1468-0378.00074>.

²³ Ibid. p. 66

²⁴ Ibid. p. 68

²⁵ Ibid. p. 69.

²⁶ Ibid.

²⁷ Collste, “‘Where You Live Should Not Determine Whether You Live’. Global Justice and the Distribution of COVID-19 Vaccines.” p. 49

²⁸ Miller, “Immigrants, Nations, and Citizenship*.” p. 377

states during a global pandemic, where a virus as contagious as the COVID virus challenges nationalist approaches. Because even if one agrees that states have a special obligation towards its citizens, the global interconnectedness makes it necessary to keep citizens of other nations safe as well. The example of Australia illustrated this rather well: They might have lived up to their obligation to keep their citizens safe through strict lockdowns, but it was not possible to sustain this state, because COVID-19 had not been stopped everywhere. If Australia and the other HIC had contributed more towards global vaccine equity, easing the zero-COVID-strategy could have been more successful. Vaccines had already been available at this point.²⁹ With this, the point has been reached of shifting the focus to the ethical approach that we propose in this paper. The next section will sketch the approach we foresee, before we will provide the ethical arguments to truly motivate the necessary action of HIC.

The Ethical Approach to Pandemic Response

One of the main faults moral philosophers have found with nationalism is that the morally arbitrary fact of where you were born determines the quality of life—or for the case of a pandemic it might even determine whether you live. This notion evokes moral dissonance. It is a question of mere luck that one person is born in Sweden, and another person in Malawi. A person's moral worth is not determined by their place of birth. This principle is encompassed in the theory of luck egalitarianism.³⁰ Another moral principle can be the basis for the position that vaccine nationalism is not defensible: that of human dignity.³¹ Collste has argued in his recent paper "Where you live should not determine whether you live..." that these principles of luck egalitarianism and human dignity are more fundamental than those of vaccine nationalism, therefore he argues for *global vaccine Sufficiencyarianism*. This "implies that when the global population has achieved a certain level, a threshold, of vaccine distribution, political leaders in high-income countries could prioritise their own population."³² This position combines the view that nations have a global obligation to ensure the protection of human dignity—when not necessarily being obligated to balance out all implications of luck egalitarianism. Where a person is born may affect the outcome of their life, but it should not become an indication of their moral worth.

The position of global vaccine Sufficiencyarianism of Collste converges with Gillian Brock's needs-based minimum floor principles.³³ Based on a Rawlsian thought experiment, Brock argues that people would endorse a "needs-based minimum floor principle for matters of distributive justice."³⁴ In her construction of the original position, delegates join a conference. While they have relevant information on how the world functions, they know nothing about which nation they belong to or how likely it is that they belong to one and not

²⁹ European Medicines Agency (EMA) has conditionally permitted the first COVID-19 vaccine, Comirnaty, developed by BioNTech and Pfizer, in December 2020. (EMA. *EMA recommends first COVID-19 vaccine for authorisation in the EU*. News (December 2020). Online at ema.europa.eu.)

³⁰ Collste, "Where You Live Should Not Determine Whether You Live". *Global Justice and the Distribution of COVID-19 Vaccines*.

³¹ Ibid.

³² Ibid. p. 51

³³ Gillian Brock, *Global Justice: A Cosmopolitan Account* (Oxford ; New York: Oxford University Press, 2009).

³⁴ Ibid. p. 47

the other. Brock argues: "I submit we would centre the terms of agreement around two primary guidelines of roughly equal importance—namely, that everyone should enjoy some equal basic liberties and that everyone should be protected from certain real (or highly probable) risks of serious harm."³⁵ Since we live in a world where people live below this minimum floor, the main challenge to this position becomes determining how to prioritise people below the minimum floor.

Since we are interested here in the threat of infectious disease on a pandemic scale, let us consider more closely what such protection from real risks of serious harms would entail. Brock argues that: "being unable to meet our basic needs must be one of the greatest harms that we can face."³⁶ Therefore she emphasises that all delegates in her thought experiment would be "vigilant" to build a global order, in which all meeting basic needs are within every country's reach. In the instance of healthcare, to meet this minimum floor requirement, countries would need an adequate supply of basic medical equipment, trained medical professionals, and enough doses to vaccinate their population. Following Brock's argument, this would mean that HIC have an obligation to provide this level of minimum protection as a question of basic justice. In terms of distribution of face masks, ventilators and vaccines during the COVID-19 pandemic, these should have been distributed according to need, not according to financial means.

While HIC faced shortages at times creating legitimate needs, HIC were also in a position to order prolonged lock-downs by issuing work-from-home initiatives for many workers to prevent a total cessation of economic productivity and soften the blow to the economy. At this point if a person in a HIC is unvaccinated it is often for one of these reasons: 1. They are unable to receive the vaccine due to an allergy or other health issue; 2. They are hesitant and want to ensure there aren't reports of adverse reactions, but plan to be vaccinated eventually; or 3. They refuse the vaccine out of belief in the many conspiracy theories circulating around vaccination. The continuous efforts of the WHO to overcome obstacles in reaching higher vaccination rates in African countries and the Americas illustrate that some groups remain difficult to reach.³⁷ It also suggests low vaccination rates in many LMIC are still owing to the fact that many people have not yet been offered a chance to get vaccinated.

Thus, we argue that an ethical approach to global pandemic response requires HIC to contribute to international pandemic preparedness storehouses of medical supplies, such as the ones set up by the World Bank and WHO. This ensures the basic obligations of the needs-based minimum floor principle. In addition, HIC are free to have pandemic preparedness funds on a national level, as they already had, or were able to make available in the course of their response to COVID-19, as long as they have discharged their global obligations. During the course of a pandemic, an ethical approach to distribution of scarce medical resources entails transparency in the distribution process. This was one main problem during the initial bidding process for the vaccine. Pharmaceutical companies, at the time bids were placed for the first batch of vaccines, were not transparent with countries regarding how many doses would be available, how many doses countries purchased, and how many doses were going to waste.

³⁵ Ibid. p. 50

³⁶ Ibid. p. 51

³⁷ WHO. *Donors making a difference: Knocking down obstacles to COVID-19 vaccination*. (March 2022). Online at who.int

Due to this lack of transparency, the large majority of doses went to HIC. The justification for this, in part, was that these countries—US, the UK, China—were responsible for developing the vaccines, therefore, there was a sense that they were entitled to receive the largest portion of the doses. This view is supported by the ethicists Muralidharan et. al, who credit this level of entitlement to the investments the countries' government put into the development of the vaccines.³⁸ They claim the funder countries have a special claim to an extent over the resulting product, when two nations have a similar standing “based on need, equity, and other considerations.”³⁹ While other countries may have an entitlement to purchasing a portion of the dose, the funder country is entitled to determining the allotment and prioritising their own national needs. Based on the constraint they introduce for consideration of needs and equity among others, we will show that arguments like these overlook greater structural injustices in the global order. It is these greater structural injustices, as they stem from the shared colonial past and institutional structures in the present, that provide the main arguments for motivating redistribution and reform.

Arguments for Prioritising Global Redistribution

We will provide two arguments that establish that higher income countries *ought to* adopt the ethical approach outlined above. The first one relies on Collste's argument on rectificatory justice.⁴⁰ His approach builds on the *historical* roots of current inequalities stemming from colonialism. Collste argues that former colonisers have a moral duty to rectify their past wrongs, as far as they left morally relevant traces in the present. The second line of argumentation builds on Thomas W. Pogge's analysis of the global institutions.⁴¹ Thus he looks at current inequalities reiterated by *present* institutions and shows that by upholding these institutions, HIC continually make themselves guilty of trapping other countries in poverty. We argue in accordance with Pogge and Collste that affluent governments are actively involved in a global injustice, when they deny initiatives to redistribute health care resources for a more equitable distribution across the globe. It is imperative to recognize the affluent nations' role in bringing about states of unpreparedness in crisis response in LMIC and, subsequently, for the HIC to take responsibility. We must take the pandemic as a warning sign to radically rethink our global order. Both Collste and Pogge's theories are grounds for drastic change.

1) Collste

Building on Aristotle and Locke, Collste starts from the basic provision that “Someone who is injured has a right to seek reparation from the injurer.”⁴² Collste argues that the present

³⁸ Anantharaman Muralidharan et al., “Funder Priority for Vaccines: Implications of a Weak Lockean Claim,” *Bioethics* 36, no. 9 (November 2022): 978–88, <https://doi.org/10.1111/bioe.13075>.

³⁹ Ibid. p.1

⁴⁰ Göran Collste, “... Restoring the Dignity of the Victims'. Is Global Rectificatory Justice Feasible?,” *Ethics & Global Politics* 3, no. 2 (January 2010): 85–99, <https://doi.org/10.3402/egp.v3i2.1996>.

⁴¹ Thomas W. Pogge, “Eradicating Systemic Poverty: Brief for a Global Resources Dividend,” *Journal of Human Development* 2, no. 1 (January 2001): 59–77, <https://doi.org/10.1080/14649880120050246>.

⁴² Collste, “... Restoring the Dignity of the Victims'. Is Global Rectificatory Justice Feasible?” p. 86

concentration of property and wealth in the rich part of the world is at least partly the result of unjust historical acquisitions that “beg for rectifying actions.”⁴³ He shows that colonialism was overall harmful for the colonised, and thus, there is a need for some form of reparation. A proponent of ethical presentism would hold against this claim, that only living individuals should be considered in questions of justice. And people who actively participated in colonialism, or who suffered the immediate wounds inflicted by colonising powers, are no longer among us. Against this ethical presentism Collste holds: “What makes the historical injustices of colonialism relevant for the present discussion on justice is precisely the fact that, ‘it has left morally relevant traces in the present’: prosperity in the former colonial powers and poverty in the former colonies.”⁴⁴

Rectificatory justice is necessary when one country or party’s actions in the past have morally relevant consequences in the present. However, this does not solve the problem of identifying the relevant parties. Collste argues that the recipients should be descendants of the victims of colonialism, while nation states that were benefitting from the colonial structure should pay the reparations: former colonial powers have primary duties, while those countries in Europe and North America that did not have their own colonies, but nonetheless benefited economically from colonialism have secondary duties, because they were also “part of the colonial structure.”⁴⁵ The insistence that there is a moral duty to rectify injustices inflicted on others during colonialism based on the morally relevant traces in the present, also suggests that the means of rectification also depend on the kind of morally present traces: these can be economic–cyclical poverty–cultural, or political.⁴⁶

For the case of the COVID pandemic, the lack of infrastructure in many LMIC has been a major obstacle to providing vaccine equity. The COVID-19 vaccines, for example, require constant cooling. This is a challenge, in places where electricity is not reliable, and when roads are in such a bad state that the last mile of the supply chain loses valuable time. Research shows that, “Supply chain inefficiencies can lead to immediate life-threatening consequences and continue to negatively impact life expectancy.”⁴⁷ This is especially true during a pandemic. In most places, colonial powers did not have intentions to build sustainable infrastructure, but to extract resources, which leads to poorer infrastructure in former colonies to this day.⁴⁸ Considering the role former colonial powers have played in establishing inadequate institutions and infrastructure, we could argue based on Collste, that those states that had benefited from the colonial structure, have a duty to rectify these past wrongs by providing infrastructure improvements to LMIC, to remove a major obstacle to vaccine delivery.

This outlines one motivation for HIC to contribute to the ethical approach to global pandemic response, that includes a needs-based minimum floor principle. Based on Pogge’s

⁴³ Ibid. p. 92

⁴⁴ Ibid. p. 89

⁴⁵ Ibid. p. 95

⁴⁶ Ibid. p. 90

⁴⁷ Sonak D. Pastakia et al., “Building Reliable Supply Chains for Noncommunicable Disease Commodities: Lessons Learned from HIV and Evidence Needs,” *AIDS* 32, no. Supplement 1 (July 1, 2018): S55–61, <https://doi.org/10.1097/QAD.0000000000001878>. p. S57

⁴⁸ Daron Acemoglu, Simon Johnson, and James A Robinson, “The Colonial Origins of Comparative Development: An Empirical Investigation,” *American Economic Review* 91, no. 5 (December 1, 2001): 1369–1401, <https://doi.org/10.1257/aer.91.5.1369>. p. 1375

work, we will provide a second argument for HIC to contribute to a more ethical approach, that is potentially even further reaching.

2) Pogge

Pogge argues that global poverty can be conceived as a moral challenge to HIC in two ways: either we are failing a positive duty to help persons in acute distress, or we may be failing our negative duty “not to uphold injustice, not to contribute to or profit from the unjust impoverishment of the others.”⁴⁹ The current response and the voluntary contribution to global solidarity programs like COVAX shows that we take global solidarity mostly as a positive duty. Pogge suggests, too, that the positive formulation is easier to substantiate and its implications are less far reaching.⁵⁰ The positive duty to help can be discharged easily, while the negative duty not to uphold injustices requires institutional reform, and thus requires bigger sacrifices. For the more radical approach we advocate for in our paper, it is necessary that higher income countries understand that they have a more stringent negative duty to reform global institutions, just as Pogge argues. The negative duty emerges from a state in which one party contributes to the perpetuation of the misery of the other party. Pogge provides three different grounds which show that HIC contributes to the misery in such an active way, that it constitutes grounds for a negative duty. One of these grounds are “the effects of a common and violent history.”⁵¹ We have reviewed this link above, relying on Collste’s argument. In connection to the COVID pandemic, most interesting is the first ground of injustice: the effects of shared institutions. Thus, this will be the focus here.⁵²

According to Pogge,⁵³ if we want to show that the effects of shared institutions are grounds for injustice, because they violate the negative duty of HIC to not contribute to the impoverishment of others, these three conditions must be met: 1. There ought to be a shared institutional order in the first place, which the better-off shape and impose on the worse-off; 2. This institutional order is implicated in reproducing radical inequality, because there would be an alternative under which such radical inequalities would not persist; and 3. The radical inequality is caused by this shared institutional order. Pogge substantiates the claim that these three conditions apply to the current global order as follows:⁵⁴ 1. The sharing of global institutions between HIC and the “global poor” is difficult to deny, when one considers how dramatically consumption and investment choices, export and import patterns, and political and military decisions reached in HIC affect the lives of the global poor. Considering the concentration of economic and military power in the HIC, they control the rules of the institutions governing the global interactions. 2) Pogge shows that the second condition is met, by proposing the Global Resource Dividend (GRD) as an alternative system which would establish a global order that does not perpetuate the same radical inequality. 3) The cyclical

⁴⁹ Pogge, “Eradicating Systemic Poverty.” p. 60

⁵⁰ Ibid. p. 60

⁵¹ Ibid. 61

⁵² For the purpose of completeness: the third ground that Pogge identifies on which affluent nations violate their negative duty is through “the uncompensated exclusion from the use of natural resources.” (Pogge. p. 61)

⁵³ Ibid. p. 61

⁵⁴ Ibid. pp. 61-61

nature of poverty suggests strongly that the conditions of such an “abysmal social starting position” determines your chances of building a better life rather than your abilities or ambition. Pogge thus concludes that affluent countries indeed neglect their negative duty not to uphold, contribute, or profit from the impoverishment of others, by using their power to maintain the same global institutions that benefit them.

This directly impacts the validity of the argument on funder priority, which Muralidharan et al.⁵⁵ have brought forth and which has been reviewed above. They argue that it is fair, if those countries who invested in the vaccine development take a certain-balanced with need and equity-principles- priority in vaccine distribution. However, they overlook that the ability of some countries to make such investments stems from an unjust global institutional order, which leaves many other countries entirely unable to do the same. But vaccine development and pandemic response is not only a matter of economic resources. It is also a matter of healthcare institutions. A broad body of literature draws attention to the problem of brain drain in the healthcare sector. Among them, for example, Sager⁵⁶ argues that primary attention in ethical accounts should not scrutinise individual decisions of skilled workers to migrate, but that it must be examined if these decisions are based on just structural conditions. He shows that, “capitalist expansion has structured migration networks so that developing countries and their migrants have mostly had to adapt to imposed conditions rather than to negotiate fair terms.”⁵⁷ And he is clear about the responsibility higher income countries have in this context:

In some cases, the exodus of skilled workers, particularly from small countries with relatively little educational infrastructure, exacerbates wider development problems. When this occurs, there is an obligation to structure global institutions so they do not predictably harm the worst off members of the human population by making it unlikely that the people best placed to help are most likely to leave. Since migration and development policies influence each other, the goal is to promote positive feedback loops.⁵⁸

Thus the lack of skilled workers in the healthcare sector among many LMIC constitute an injustice, as they result from an unjust global order.

To return to Pogge’s argument that rich countries have a negative duty to reform this global institutional order hinges on the condition that, “the status quo can be reformed.”⁵⁹ Pogge proposes for this the Global Resources Dividend (GRD). In the more particular case of the COVID vaccines, we have sided with vaccine Sufficientarianism as a feasible alternative. Pogge’s argument for a negative duty to reform global institutions, and Collste’s argument for the responsibility to rectify the wrongs of colonialism, provide substantial grounds for higher income countries to recognize that they ought to follow a more ethical approach, like the one outlined in the previous section.

⁵⁵ Muralidharan et al., “Funder Priority for Vaccines.”

⁵⁶ Alex Sager, “Reframing the Brain Drain,” *Critical Review of International Social and Political Philosophy* 17, no. 5 (September 3, 2014): 560–79, <https://doi.org/10.1080/13698230.2014.919061>.

⁵⁷ Ibid. p. 573

⁵⁸ Ibid. p. 573

⁵⁹ Pogge, “Eradicating Systemic Poverty.” p. 66

Let us move back from the theory to the particular case at hand: the appropriate response to the COVID-19 pandemic in light of these institutional injustices. In the last section we will use the example of vaccine distribution, to illustrate further, how the global mismanagement of the pandemic started much earlier than late 2019.

Current Vaccine Rollout: Three Areas for Reform

A prime example of disparity in distribution has been the inequality in vaccine distribution. In applying Brock's minimum floor principle, which aligns with the vaccine Sufficientarianism proposed by Collste,⁶⁰ to the vaccine distribution would prioritise ensuring certain thresholds are met globally, and may look along the lines of the following example. Moving forward, the kind of radical reform of medical supply chains that our argument implies will require improvements in three areas: first, more equal distribution of existing vaccine doses and other necessary medical supplies; second, stable infrastructure to mobilise and healthcare staff to administer vaccine doses efficiently; and third, suspension of patent protections and sharing of vaccine formulas between pharmaceutical companies. All these suggested improvements require a lasting transformation of our global institutions.

The market for COVID-19 vaccination has disproportionately disadvantaged developing countries. Nearly two years after the first vaccine was given, the continent of Africa has managed to fully vaccinate only 22.7% of its population.⁶¹ The African Union set a goal to vaccinate 60% of the continent's population by June 2022 in order to achieve herd immunity—a goal they failed to meet due to a lack of access to doses and a lack of medical professionals able to administer doses. Africa's disadvantage in vaccine distribution was not only a result of a lack of money to buy the doses, but a lack of bargaining power during the initial distribution due to national priority setting in global institutions. Given the fact that Moderna and Pfizer are both American companies, the US was able to ensure they secured more than enough doses for their citizens first.

As we have noted earlier, COVAX aims to provide only enough vaccine doses for 20% of countries' populations. We argue that this is an insufficient goal. The Sufficientarian would say the COVAX level should have been at least 60%. In addition, they would set more ambitious goals for distribution of vaccines that would include donating all surplus doses, waiting to vaccinate kids and lowering age limits for vaccinations only once elderly, immunocompromised, and essential workers world-wide are vaccinated. Vaccinating the nation's population is the most important step in recovery because it prevents spread and reduces the chance of death. Thus it is a crucial measure to respect one of the basic principles of human dignity and luck egalitarianism.⁶²

The current distribution of the vaccine has been a result of free market Capitalism as each country bid for an allotment of the vaccine doses as they became available. Out of the 11 billion vaccine doses to be created by the end of 2021, over 9.9 billion were purchased by HIC-

⁶⁰ Collste, "Where You Live Should Not Determine Whether You Live". Global Justice and the Distribution of COVID-19 Vaccines."

⁶¹ AfricaCDC. 'Africa CDC COVID-19 Vaccine Dashboard'. *African Union CDC*. africacdc.org.

⁶² Collste, "Where You Live Should Not Determine Whether You Live". Global Justice and the Distribution of COVID-19 Vaccines."

i.e. with the majority going to the U.S., Canada, the UK—and the remaining 1.1 billion were divided up among developing countries.⁶³ Without consideration of global justice and oversight in the allocation process, distribution inequity is bound to occur.

The main problem with distribution as it stands is the glaring inequality in which countries are able to recover from the pandemic. Countries able to attain herd immunity and reduce the numbers of reported cases are able to save lives and start repairing their economy. Many countries struggling to vaccinate their population will only be left further behind, exacerbating already existing inequalities. Vaccine distribution is an issue of global distributive justice, but also an issue of institutional reform and rectificatory justice. Pharmaceutical companies plan to create enough vaccine doses to vaccinate the world's population before the end of 2022. However, that vaccination goal is unlikely to be reached, not because of a lack of doses, but because of poor distribution planning and rollout. Every month the U.S. throws out millions of doses either because patients have missed their scheduled appointments to receive their vaccine or because vaccination sites over prepared and ordered more doses than they needed.⁶⁴ These wasted doses could have otherwise been administered in countries that have desperate needs.

Therefore, we argue that HIC should redistribute the excess vaccine doses to LMIC rather than letting doses go to waste. Redistribution would not only uphold every human's right to life and right not to suffer from a serious illness, but also be more efficient. Poor planning on health officials' part and a lack of transparency of excess supply has contributed to an inefficient distribution. While many doses have been donated, there has been a lack of transparency on the exact surplus of doses HIC possesses. With the global death toll of the COVID-19 pandemic topping over 6.5 million deaths, the world can't afford to waste doses.⁶⁵

Second, we argue there is a need for improvement in the area of necessary infrastructure to mobilise medical supplies and healthcare staff to administer vaccine doses. Here, the WHO estimated in December 2021 "a US \$1.3 billion shortfall in operational costs, including cold-chain logistics and travel costs and payment for vaccinators and supervisors, as well as a looming shortage of syringes and other crucial commodities."⁶⁶ It is not enough to ensure countries receive a supply of doses. Careful planning and development of a strategy to bring the vaccine to the people is as important. One key lesson from the roll-out in Africa was that those countries which had a cohesive plan on how to mobilise and utilise the vaccine, fared much better.⁶⁷ Another benefit was that many African countries already have experience with mass vaccinations, therefore having some warehouse infrastructure in the rural areas already. Yet, it is not always possible to ensure trained professionals are available to administer doses and people in rural areas often lack access to distribution sites. Lack of medical staff is often the result of other injustice like limitations in higher education and brain drain, as our

⁶³ World Bank Group. 'Absolutely Unacceptable' COVID-19 Vaccination Rates in Developing Countries | The Development Podcast. Podcast (August 2021). Online at worldbank.org

⁶⁴ Ibid.

⁶⁵ Elflein, John. *Number of novel coronavirus (COVID-19) deaths worldwide as of December 16, 2021, by country*. (December, 2021). Online at statista.com.

⁶⁶ *ibid.*

⁶⁷ WHO. Key lessons from Africa's COVID-19 vaccine rollout. Press Release (December 2021). Online at afro.who.int.

brief discussion on Sager⁶⁸ illustrated. This shortfall in organizational execution is a testament to the argument we have made above and throughout this paper: In order to enable effective pandemic response all over the globe, we need to address the systemic injustices that keep LMIC in a state of poverty.

Lastly, it is important to reconsider the protections governments have in place for patents. In times of peace, patents are meant to protect a company's intellectual property and ensure a company is able to profit off of their inventions. However, in times of a pandemic when there are mass casualties, pharmaceutical companies ought to suspend their right to profit for the sake of saving lives. In the US in May 2021, the Biden administration expressed support for an initiative to waive intellectual property protection.⁶⁹ A measure to suspend intellectual property for the vaccine that was proposed by India and South Africa, but was eventually blocked by the European Union. The strongest argument in contention was that suspending the patents would prevent innovation in health crises. It is time to shift our understanding of the pharmaceutical industry away from a pursuit of exponential profits. A radical notion, we're sure. But the task of the pharmaceutical industry, first and foremost, should be to save lives by inventing life saving medicine—a task that only they can perform.

Perhaps it is naive to assume a massive corporation like the pharmaceutical industry will act benevolently on behalf of developing countries and put considerations of profits second. However, it is not unreasonable to expect countries to act out of self-interest. It is in HIC's best interest to reach an end to the pandemic and in order to do so, developing countries will need to be able to contain the virus. However, bringing the pandemic to an end is an insurmountable task without global collaboration.

Conclusion

In concluding this paper, we have looked at how national priority setting and free market bargaining are insufficient in times of global health crises. We have considered how radical redistribution and institutional restructuring is necessary to respond to this pandemic ethically. And further, how investment in infrastructure will be required to better prepare LMIC for the next pandemic. We have shown that high income countries have an obligation to aid the developing world in achieving their goals. And how advancement of LMIC healthcare systems is in the global best interest. We argue that vaccines and medical equipment should have been distributed according to Brock's needs-based minimum floor principles, thus defending positions of vaccine Sufficiency. HIC ought to adopt such a strategy based on, 1. Their duty to rectify past injustices from colonisation, as Collste presents it, and 2. a negative duty not to uphold unjust institutions and to contribute to radical inequalities, as Pogge's work establishes. We advocate that for the future a drastic institutional reform of the global health system order is needed. Three practical steps in the vaccine rollout are outlined to start: HIC should redistribute the excess vaccine doses to LMIC rather than letting doses go to waste; necessary infrastructure to mobilise medical supplies and healthcare staff to

⁶⁸ Sager, "Reframing the Brain Drain."

⁶⁹ Kaplan, Thomas, et al. "Taking 'Extraordinary Measures', Biden Backs Suspending Patents on Vaccines". *The New York Times*. (May 2021). Available at nytimes.com.

administer vaccine doses is necessary; and patents should be suspended to prioritise saving lives.

Throughout this paper we have shown the contributing factors that have inculcated wealth disparity and inequity of healthcare distribution. Further, we have shown this inequality has resulted in challenges for developing countries to survive a pandemic—an unacceptable violation of the basic principles of human dignity and luck egalitarian principles. High income countries have a moral duty to assist LMIC in the time of a pandemic in order to prevent mass casualties. At the forefront of decision making, we argue, should be the acknowledgement of the rectificatory obligations former colonial powers have and their negative duty not to uphold unjust institutions that contribute to the impoverishment of the global poor. Wealth disparity between countries and their origins must be taken into account when HIC are strategizing and building infrastructure.

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