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Poverty and Global Health Inequalities: A Case for Vaccine Justice in Nigeria

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Abstract

In line with the underlying principle of the Sustainable Development Goals and to recover from the COVID 19 pandemic, the world needs coordinated global health frameworks and practices that reduce to its barest minimum, health inequalities which affect poverty levels of both individuals and countries. With this as a backdrop, using Dependency theory as theoretical frameworks for analysis, one investigates the relationships between the two development concepts and the power play in the global health scenario to ascertain the effects they share and how these could be used as a frame of reference to address the power play behind the slow rate of vaccine roll-out in tackling the pandemic. With the human right approach, the paper would also elucidate on how health is a human right that should not be politicized but upheld at all times. The study used an analytical research methodology to identify process and analyze the problems at stake. Secondary sources were used. These were materials from relevant authorities on the issues, statistics, and analysis thereof to make inferences that exposed the problems at stake. However, the study showed that rich countries are using their economic might to exclude and deprive the poorer nations of the human right – health. The researcher argues for vaccine justice as the way out of the pandemic in Nigeria.

Keywords: *Poverty, Global Health Inequalities, COVID 19 Vaccines, Dependency Theory.*

1. Introduction

The commitment to "leave no one behind" is a cornerstone of the 2030 Agenda for Sustainable Development Goals. But within and between countries, inequalities act as both visible and concealed barriers to attaining the Sustainable Development Goals (World Health Statics, 2021). Poverty and health have been central to development. Through the Millenium Development Goals, Sustainable Development Goals and other global, regional, and national targets, resources have been channeled towards tackling those (Buse & Hawkes, 2015). Poverty is one of the major causes of ill health as well as an obstacle to availability, accessibility, and affordability of health care. On the other hand, ill health reinforces poverty levels among individuals and communities especially the poor. Globally health is a sector where significant inequalities persist. Differences in the social, political, economic, cultural, and environmental determinants of health, affect a significant proportion of the world population.

This paper will explore the relationship between poverty and global health inequalities and in the light of the problems with the availability, accessibility, and affordability of COVID 19 vaccines, and how health inequalities strengthen poverty. The paper will further use the dependency theory of development to examine the power play within the global health scene and through the human right approach, argues for a more equitable and just frameworks for addressing poverty and health issues particularly in Nigeria.

2. Theoretical Frameworks

One would use the Dependency theory to understand what goes on in global health inequalities. This is so because, given the complexity of the contemporary world order conditioned by the emergency of neoliberal globalization and its attendant institutions championing the school of thought, there is a divide in the relationship that exists between countries in the world. These divides give rise to alliances of dependency and inequalities in world economies. So, dependency theory would bring out succinctly the intricate nature of the relationships and alliances and explain the imbalances inherent thereof.

Dependency theory shapes a certain structure of the world economy such that it favors some countries to the detriment of others and limits the development possibilities of the subordinate economies (Santos, 1971). A situation of dependence is one where "the economy of certain countries is conditioned by" development processes elsewhere (Kvangraven, 2020). In this case, the economy of the South is conditioned by the development of the economy of the North to which the former is subjected such that any disturbance in the core countries will automatically have a negative effect on the periphery.

Dependency theory was created in part as a response to the Western-centric mindset of modernization theory. It states that global inequality is primarily caused by core nations (or high-income nations) exploiting semi-peripheral and peripheral nations (or middle-income and low-income nations), which creates a cycle of dependence (Hendricks 2010). As long as peripheral nations are dependent on core nations for economic stimulus and access to a larger piece of the global economy, they will never achieve stable and consistent economic growth in a self-determined sense.

Dependency theorists often draw a connection between the role of the capitalist system and the underdevelopment of the periphery (Farny, 2016). Dependency theory attempts to place low- and middle-income countries into the global system through chains of dependency which led to their impoverishment. The core industrialized countries were experiencing growth and economic development through the exploitation of the non-industrialized peripheral countries (Willis, 2011, Desai & Potter, 2014). In addition, large corporations outcompeted small companies. The resulting monopolization restricted competition, and corporations accumulated large surpluses from the attendant excess profits, with the consequence that capitalist economies tended toward underconsumption and economic stagnation.

At first glance, it seems this theory ignores the formerly low-income nations that are now considered middle-income nations and are on their way to becoming high-income nations and major players in the global economy, such as China. But some dependency theorists would state that it is in the best interests of core nations to ensure the long-term usefulness of their peripheral and semi-peripheral partners. Following that theory, sociologists have found that entities are more likely to outsource a significant portion of a company's work if they are the dominant player in the equation; in other words, companies want to see their partner countries healthy enough to provide work, but not so healthy as to establish a threat (Caniels & Roeleveld 2009).

Following the world-system school of thought, Arno Tausch draws a connection to dependency theory and concludes that "poverty and backwardness in the "periphery" and semi-periphery are caused by the very peripheral or quasi peripheral position that these nations or regions always had in the international division of labor since the beginnings of the world system in 1492" (Tausch 2010). Tausch highlights, "a high penetration by foreign capital, a heavy technological dependence from the leading countries, the overall subordination of the productive capacities of the country towards the interests of the evolving international division of labor, [and] the concentration of exports on a few commodities and recipients" as the main features of the periphery and semi-periphery countries (Tausch 2010).

Poverty is the state of not having enough material possessions or income for a person's basic needs. It is a state/condition in which a person or community lacks the financial resources and essentials for a minimum standard of living (Chen, 2020). Taking a wholistic approach to the issue, one would define it as a state of lack, deprivation, or exclusion from social, economic, political, cultural, and environmental factors that a person or a community needs to realize its potentials. Health is the state of being free from illness or injury. It is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." (WHO, 1948). Furthermore, it is "a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities." (WHO, 1986). So, health is both a disposition and concrete means to boost an individual's/community's function rather than an end. It is a means to lead a full life with meaning and purpose.

Poverty is a major cause of ill health and a barrier to accessing health care when needed. (World Bank, 2014) Poverty is related to health in the sense of lack, deprivation or exclusion of availability, accessibility and affordability of conditions and materials that ensure physical, mental, social, economic, and environmental wellbeing. Ill-health, in turn, is a major cause of poverty. This is partly due to the costs of seeking health care, which include not only out-of-pocket spending on care (such as consultations, tests, and medicine), but also transportation costs and any informal payments to providers. In addition, poor families coping with illness might be forced to sell assets to cover medical expenses, borrow at high interest rates or become indebted to the community (World Bank, 2014).

Globally, poverty and ill-health are intertwined (Wagstaff, 2002). The causes of poor health for millions globally are rooted in political, social, and economic injustices (Roberts, 2018). Poor countries tend to have worse health outcomes than better-off countries. Within countries, poor people have worse health outcomes than better-off people. This reflects a causality running in both directions. Illness or excessively high fertility may have a substantial impact on household income (World Bank, 1999, Bloom & Sachs, 1998) and may even make the difference between being above and being below the poverty line (Eastwood, & Lipton, 1999). Ill-health is often associated with substantial health care costs (Narayan, et al., 2000). But poverty and low income also cause ill-health (Pritchett & Summers). Poor countries, and poor people within countries, suffer from a multiplicity of deprivations that translate into high levels of ill-health (World Bank, 2000). So, Poverty is both a cause and a consequence of poor health. Poverty increases the chances of poor health. Poor health, in turn, traps communities in poverty (Roberts, 2018). Countries/individuals on the periphery who are poor suffer more from ill health than those on the core this is as a result of among other things, lack of availability, accessibility, and affordability of health care services.

Health Inequalities: Issues from COVID 19 vaccine.

The term health inequality generically refers to differences in the health of individuals or groups (Kawachi, et al 2002). Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups (PHS, 2021).

They are systematic differences in the opportunities to achieve optimal health, leading to unfair and avoidable differences in health outcomes (Braveman, 2006; WHO, 2011). Health inequalities are about differences in the care received and the opportunities to lead healthy lives, both of which can contribute to people’s health status.

Factors like income levels, urban/rural dwelling, sex, ethnicity or disability, socially excluded groups, like people experiencing homelessness are causes of health inequalities (PHS, 2021). Structural differences at personal, interpersonal, institutional, and systemic levels can cause health inequalities too. Like racism, sexism, classism, xenophobia, and homophobia.

Policies (organizational, international, national, state to community) are critical drivers of structural inequalities. The social, environmental, political, economic, and cultural determinants of health are the terrain on which structural inequalities produce health inequalities. These determinants are the conditions in which countries/individuals at the periphery live - access to good food, water, and housing; the quality of schools, workplaces, and neighborhoods; and the composition of social networks and relations (WHO, 2011).

In the contemporary world order, the socio-economic and political relationships in the world is still dominated by the categorization of countries that have a shared experience of colonization and economic dependence into one single category as opposed to adopting a more reasonable perspective of equal and equitable relationships in dealings with countries irrespective of their past experiences. This explains the fact that the feature of the countries of the periphery have in common is the dependency on the core countries. Theotonio Dos Santos explained that, “the relation of interdependence between two or more economies, and between these and world trade, assumes the form of dependence when some countries (the dominant ones) can expand and can be self-sustaining, while other countries (the dependent ones) can do this only as a reflection of that expansion, which can have either a positive or a negative effect on their immediate development.” (Dos Santos 1970).

Although originally dependency theorists argued that the ideal way to break out of the dependency trap and end global inequality is for the periphery to separate from the core, the post-Cold War era led to further integration rather than separation (Sekhri 2009). One may argue that while some countries of the Global South, mostly those of East Asia, have been able to use the benefits of globalization for their own economic growth and adapt their economic policies accordingly, for other countries “globalization has meant rather the imposition of neoliberal structural adjustment regimes by debt regulating International Financial Institutions” (Randall 2004). This proves that just because some countries seem to be breaking out of the dependency trap does not mean that a trap never existed or that dependence can be fully eliminated. In addition, one also has to consider that the North-South dependency relationship does not only create inequality between the countries of the North and the South, but also in between the countries of the South.

The existence of health inequalities means that the right of everyone to the highest attainable standard of physical and mental health is not being enjoyed equally across the population (PHS, 2021). The persistence of health differences based on nationality, race/ethnicity, or other social factors raises moral concerns, offending many people's basic notion of fairness and justice (Whitehead, 1992, Sen, 2002). Although countless resources and outcomes are unevenly distributed across nations and social groups, health differences can be viewed as particularly objectionable from a human rights perspective (Sen, 2008, Pillay 2008).

With reference to COVID 19 vaccines, it is on record that within a year of the first reported case of COVID-19, the Pfizer-BioNTech vaccine became the first fully tested immunization to be approved for emergency use against the deadly virus (Liao, 2021). This was a breakthrough in global health. However, demands to treat vaccination as a global public good stand in stark contrast to global political interests of rich nations, individuals, organisations, and the disparity in economic resources shows that the playing field is not level in terms of resources to acquire the vaccine.

The first issue is that of access. Which individual(s)/countries should receive the initial doses of any vaccine? To what extent will wealthier countries crowd out poorer ones? Will countries let geopolitics intrude, sharing the vaccine with friends and allies while forcing vulnerable populations in adversary countries to the back of the line? So, far, rich/core nations/organisations have crowded out the poorer/periphery nations to the extent that many rich nations have started administering third booster vaccines to their populations, while only 3% of people in low-income countries have received a first dose (Our World in Data, 2021). The second issue is, vaccine hoarding/nationalism where rich nations bought up more than their fair share of vaccine doses relative to their populations, securing enough doses to vaccinate their populations several times over. Meanwhile, low- and middle-income countries have struggled to secure enough doses to protect their most at-risk individuals, such as health care and other frontline workers, and older people (Liao, 2021).

To help prevent this, the COVID-19 Vaccine Global Access Facility, known as COVAX, was created to help low- and middle-income countries vaccinate their populations through subsidised costs from rich countries. The scheme hopes to distribute enough vaccines to protect at least 20% of the population in 92 low- or medium-income countries, to provide two billion doses of vaccines worldwide in 2021, and 1.8 billion doses to 92 poorer countries by early 2022 (BBC, 2021).

COVAX has been criticised for being slow. Some initial targets were missed, partly because of the poor health infrastructure in many of the recipient countries, and partly because of vaccine hesitancy. Too many donations have come in small quantities, at the last minute and with little time left before they expire. This makes it very hard to get them to where they are needed (BBC, 2021). Third issue is high vaccine prices. Pharmaceutical companies would expect to recoup their investment in research and development, along with the costs of production and distribution before profit is introduced. The Fourth is, intellectual Property Right (IPR). So far, up to 1,000 patents are connected to masks alone. IP like patents, copyrights, designs can enhance or hinder the manufacturing of vaccines, masks, diagnostic tests, medicines, ventilators, and other equipment necessary to fight the pandemic (Correa, 2021).

As a solution, developing countries have argued for "patent waiver", the suspension of the obligations under the TRIPS Agreement to facilitate sharing of technologies, increase in production and reduced cost of vaccines. But there is resistance from developed countries, and the process is still blocked at the WTO (Hassan, 2021). Also, governments might be influenced by strong lobbies of the pharmaceutical industry who argue that the waiver would deter future innovation (El Gharib, 2021).

The Case for Vaccine Justice

The Sustainable Development Goals Nos. 1 (No poverty) and 3 (Good health) and other related goals and targets cannot be achieved if the structures and policies that deprive and exclude some individuals/countries are not addressed. Health inequalities go against the principles of social justice because they are avoidable. They do not occur randomly or by chance. They are determined by human-induced circumstances that disadvantage individuals/countries and limit their chance to live longer, healthier lives.

The right to health is a fundamental human right enshrined in the United Nations General Assembly's Universal Declaration of Human Rights in 1948 (WHO, 1947, UN, 1948) and has since been reflected in national constitutions, treaties and domestic laws, policies, and programs in countries around the world (Pillay, 2008), emphasizing the unique value societies place on health. Increasingly, health equity itself is also valued. It means the right of everyone to the highest attainable standard of physical and mental health. It is an inclusive right. So, it is not just the health service that should meet these standards, all the things that influence our health (socio/cultural, political/economic, cultural, and environmental) should be accessible, available, affordable, and high quality (PHC, 2021). For instance, the World Health Organization recognizes health equity as a priority, reflected in part by its formation of the Commission on Social Determinants of Health in 2005. This commission gathers and synthesizes global evidence on social determinants of health and recommends actions that address health inequities (Marmot et all 2008). Similarly, the United Nations (UN) has also placed explicit value on equity. The UN's Millennium Development Goals (MDGs), which expired at the end of 2015, focused on average-based targets that obscure inequalities. In the post-MDG era, the UN has included equity in its post-2015 sustainable development agenda. One of the six ‘essential elements’ that form the core of the post-2015 negotiations focuses on fighting inequality, in part by addressing gender-related health disparities and inequitable access to health care (UN, 2004).

The United Nation’s Sustainable Development Goal No. 3 calls for good health and well-being for all, which cannot be achieved if countries/organisations adopt a mentality of vaccine nationalism rather than supporting an equitable global response to COVID-19 that ensures the protection of all people. “Vaccine nationalism only helps the virus propagate” (Shen, 2021).

On the economic level, Global economic recovery is at risk if vaccines are not equitably manufactured, scaled up and distributed. (WHO, 2021). The world economy is set to lose trillions in GDP because of delayed vaccination timelines, with developing economies bearing most of the losses due to the uneven rollout (EIU, 2021). Countries that are not able to inoculate 60% of their population by mid-2022 will lose $2.3 trillion between 2022 and 2025. Emerging countries will shoulder around two-thirds of these losses, further delaying their economic convergence with developed countries (EIU, 2021). This shows that the economic impact of COVID pandemic will be hard on poorer countries if the rate of vaccination is not improved.

The blocking of patent waiver by rich countries will not only slow the pace of vaccine production, distribution, and administration but it will continue to hurt everybody because the world is interconnected, nobody is safe except everybody is inoculated. Also, if the rate of vaccination is delayed, more variants of the virus keep emerging posing greater threats to everybody. So, in addition to lifting of full implementation of TRIPs flexibilities, finance, and distribution of health care – technology, innovation, R&D, equipment, capacity building of personnel should no longer be profit-based but should become a global public good.

Vaccines should be treated as a global public good. This is so because, everyone, everywhere, who needs it, must get a safe and effective vaccine and have access to diagnostic tools and treatments, free of charge at the point of delivery. Thus, vaccine universalism/multinationalism with fewer or no barriers in terms of availability, accessibility, and affordability. This would reduce health-induced poverty as well as elimiate health inequalities.

WHO (2021) attests that there are enough doses of vaccines globally to drive down transmission and save many lives, if they go to the people who need them most around the world. This offers the best hope for slowing the coronavirus pandemic, saving lives, and securing a global socio-economic recovery.

The politics and vaccine diplomacy are possible because the scenario has been that the way industries are structured globally still reproduce relations of dependence and leaves workers in developing countries especially exposed during the pandemic. While the world experienced deepening of global economic integration since the 1970s, which has been associated with an increase in efficiency and 'flattening' of the world, the spread of global value chains involves rigid power imbalances and deep vulnerabilities for those at the bottom of the hierarchy (Kvangraven, 2020). This calls for more creative thinking on how we can allow for a rebalancing of production so that industry in the developing world can be more sustainable, secure, and more oriented towards domestic needs. Many developing countries have been able to move into just-in-time manufacturing, but this production is still characterized by relatively low-skilled and low-tech work and a heavy reliance on companies concentrated in the center. Therefore, as global demand grinds to a halt, manufacturing workers in the periphery are seeing their jobs disappear as multinational corporations cancel their orders.

In addition, insight from dependency theory shows that developing countries continue to be vulnerable to financial cycles generated by the center. In the wake of the COVID-19 pandemic, there have been dramatic reversals of capital flows, if not the largest outflow ever recorded. Furthermore, many developing countries have experienced currency depreciations as well as severe debt and liquidity problems. As the much-needed fiscal space of developing poor countries like Nigeria constrained by these external factors, activists, academics, and policymakers have called for debt moratoria, IMF support, and debt relief as necessary policies (Kvangraven, 2020).

Not only does the structure of the global financial system make developing countries in Africa more vulnerable to shocks and capital flight, but it also makes it particularly difficult to organize an effective response. So, taking such a global and structural view of the world economy will be necessary to make sure the pandemic does not drastically exacerbate existing inequalities. This leads us to the opportunity of changing the global socio-economic and political architecture for developing countries.

3. Conclusions

Poverty and health are intertwined. Poverty causes ill health and ill health reinforces poverty. Poor individuals/countries like Nigeria are exposed to lack of availability, accessibility, and affordability of health care; this in turn deepens the level of poverty on the individuals and countries alike.

Taking COVID 19 vaccine as a health inequality, rich countries are hoarding vaccines and protecting the profits of their pharmaceutical corporations instead of saving lives of poorer nations. Health is a human right that needs to be protected. Also, diseases/viruses have no boarders and can be contracted by anybody at any time, so, no one is safe until everybody is safe in the world.

Impacts of poverty to health and vice versa should be eradicated through "global solidarity and shared responsibility" (Ottersen et al, 2014, p.1), financing and fair distribution of health care – technology, innovation, equipment, medicines/vaccines, and personnel. Health should be shielded from the realm of politics because vested interests destroy lives.

COVID 19 is driving home the urgency of unity and internationalism in tackling health issues. It gives us lessons to ponder about as regards ending global health inequalities. It pushes for a change in the global soci0-economic and political architecture, striking our racial, gender discriminatory reasonings and post-colonial attachments and allies in global relationships while bringing to fore global new green deal, reform of the international monetary system, reform of global systems of food production, and reform of governance of international trade and intellectual property rights.

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