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Analysis Covid-19: The Road to Equity and Solidarity

Political economy of covid-19: extractive, regressive, competitive

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Jesse B Bump, executive director¹, Fran Baum, professor², Milin Sakornsin, senior international relations officer³, Robert Yates, senior fellow⁴, Karen Hofman, professor⁵

[Author affiliations](#)

Correspondence to: J B Bump bump@hsph.harvard.edu

The political economy of covid-19 reflects longstanding patterns of resource extraction linked to racial discrimination, marginalisation, and colonialism, write **Jesse Bump and colleagues**

The common challenge of covid-19 has produced very different outcomes around the world, leading to many questions about the determinants of national performance and shortcomings in global performance. Problems of reporting and standards do not make precise comparisons easy, but few would disagree that the roughly 1400 deaths reported by South Korea, Thailand, and Vietnam together represent far better results than the roughly 700 000 deaths reported by Brazil, the United Kingdom, and the United States.¹ Adjusting these figures for population—the first group has about a third of the citizens of the second group—does not explain why covid-19 mortality differs by a factor of nearly 500. Neither typical proxy measures such as gross national income per capita nor national rankings on the 2019 Global Health Security Index have any meaningful association with performance on covid-19.²

The seeming uncertainty in the determinants of national achievement contrasts with the familiar pattern of subnational outcomes in places where covid-19 has taken hold: morbidity and mortality are far worse for indigenous people, migrants, black people, and other victims of racism, discrimination, and marginalisation.³⁴⁵⁶ This pattern reflects underlying inequality in opportunity, education, wealth, and access to care, and in physical distancing policies that have forced people to rely on their own resources. The risks of economic disruption and

disease transmission have disproportionately affected people in lower paid service sector jobs, where many already marginalised citizens find their employment. Domestically, the toll of covid-19 has been regressive, meaning that poor and marginalised people have suffered disproportionately more than rich people. Internationally, many countries have adopted a competitive attitude, competing against others for access to supplies or commercial advantage in pharmaceuticals.⁷ This nationalistic competition is contrary to global interest and is likely to harm countries and citizens of the global south.⁷ The countries most likely to be deprived of vaccines, medicines, and supplies are those with the least economic and political bargaining power.

Colonialism and the political economy of extraction

To examine these patterns of covid-19 more closely is to ask about the political economy of the disease, which refers to the distribution of the effects of covid-19, the behaviour of nations, and the power relationships that these factors reflect. Overall, we interpret the broad patterns in the regressive distribution of disease and the competitive scramble for vaccines and supplies to indicate that the political economy of covid-19 is the political economy of extraction, following longstanding patterns of exploitation. Extractive relationships are fundamentally unequal and are the opposite of the collaborative fairness embodied in the general ideals and ethics of public health and in the specific calls for solidarity and cooperation made by the World Health Organization and nearly every country in a lengthy resolution at the 2020 World Health Assembly.⁸ Where collaborative relationships are based on shared values, common benefits, and equitable progress, extraction is oriented around benefits for elite groups at the expense of others, divides society into the haves and have nots, and is defined by permanent inequity. Yet in many countries, the unequal toll of covid-19 has exposed extractive domestic economic structures that disproportionately disadvantage the same racial and ethnic groups that were exploited under slavery or colonialism, and revealed inadequacies in social safety nets. Covid-19 has provoked competitive, individualistic foreign policies as well. These attitudes are in opposition to public statements of solidarity and the advocacy of civil society groups and United Nation agencies for an affordable and universally available vaccine.⁹¹⁰¹¹

Internationally, the political economy of covid-19 reflects global patterns of extraction that were established in colonial times, some of which have continued since colonised countries became independent, including some embodied in medicine and public health. These patterns have important consequences in three areas: they undermine solidarity, increase economic inequalities, and amplify other vulnerabilities. Colonialism was built on extraction and based on ideas of cultural superiority that made solidarity unthinkable for dominant countries.¹²¹³ These processes of colonialism and extraction and their effects explain much about the inequitable political economy of covid-19 and point to some possible remedies.

Low solidarity

The so called global health model presumes a north to south diffusion of ideas and resources “based in large part on technical assistance and capacity building by the US, the UK, and other rich countries.”¹⁴ The arrival of covid-19 suddenly made many of these countries with a strong presence in global health focus on their own domestic vulnerabilities. This domestic focus revealed another persistent colonial attitude: poor countries exist to serve rich ones. In an April 2020 French television discussion, one physician suggested that clinical trials should be conducted in Africa “where there are no masks, no treatments, no resuscitation.” This exploitative attitude was explained with reference to past HIV trials carried out in commercial sex workers “because we know that they are highly exposed and that they do not protect themselves.”¹⁵ Although few in global health would agree with these attitudes, the emphasis of the health sector on diseases and biomedical factors is a continuation of the colonial preference to overlook its own extractive economic policies and negative effect on the environment and other social determinants of health.¹⁶ By contrast, many countries in the global south have public health containment

strategies developed through considerable experience with epidemic diseases including HIV infection, Ebola virus disease, Rift valley fever, and severe acute respiratory disease. Some African countries are pursuing inexpensive, effective strategies such as using community health workers for covid-19 track and trace.¹⁷ However, in keeping with the old colonial pattern of the flow of knowledge from north to south, these ideas and strategies have struggled to gain visibility in mainstream global health discussions.¹⁸

Economic inequalities

The global economic disruption caused by covid-19 has harmed poorer people and poorer countries the most, particularly in Africa, pushing an estimated 100 million people into extreme poverty in 2020 and reversing more than two decades of progress.¹⁹ Famines again threaten to affect countries across Africa and the Middle East as the virus destroys lives and livelihoods.²⁰²¹²² The World Food Programme estimates that the pandemic will force as many as 272 million people into acute food insecurity.²³ Avoiding additional damage to the economies of the global south will be possible only if new diagnostic tests, drugs, oxygen, and vaccines are made available in an equitable way. Many countries are collaborating to find solutions: Brazil, South Africa, and Egypt are among the 40 countries where vaccine trials are taking place. However, none of these countries has guarantees that they will receive a vaccine in any quantities, even though the trials are proving successful. The Covax facility²⁴ includes an advanced market commitment under which rich countries pay in first to help provide vaccines to low and middle income countries. However, the exact financial relationships that convert these resources into a subsidy for pharmaceutical industry research are unclear and thus far have not included any details on ownership of intellectual property rights for any successful vaccines. Long term extractive relationships underpin these inequalities, including the capacity to negotiate payment ahead of time for vaccines. For example, Canada could afford to reduce the risk that some vaccines may not be proved efficacious and the risk of production delays by ordering five times more vaccine doses than it needed. On the other hand, nearly all low and middle income countries have been forced to wait in line to see what they can negotiate later, and wait for Covax to cover one fifth of the needed doses as it has pledged.²⁵ These are typical colonial relationships in which the resources of low and middle income countries are exploited by international private industry while their citizens remain dependent on the charity of rich countries.

Increased vulnerabilities

Colonial patterns increase vulnerability to covid-19 as well. Since the early 1900s, colonial industries such as mining have been linked to silicosis, tuberculosis, and other respiratory problems that increase vulnerability to covid-19.²⁶²⁷²⁸ Similarly, sugar production has been a historic mechanism for extracting wealth from the communities that produce it,²⁹ and products made from it, such as sugary drinks, alcohol, and many ultraprocessed foods, are risk factors for the exact comorbidities that contribute to worse covid-19 outcomes. About half of all covid-19 deaths recorded globally have occurred in patients with diabetes and hypertension and increasingly these products are sold in sub-Saharan Africa, Latin America, and India, creating new threats to health.³⁰ Some companies making these products are using the pandemic to build their brands using strategic corporate social responsibility by providing “essential support” in the form of meals and hospital equipment, especially in the global south where resources are scarce.³¹

Road ahead

The longstanding patterns of extraction, the resulting vulnerabilities, and the specific problems presented by covid-19 all point to the need for change. In nearly all instances, these are changes that governments have committed to in the past but have not actually pursued. For example, countries committed to achieving universal health coverage (UHC) for their population at the 2019 United Nations General Assembly. Domestic inequalities are made worse by the current absence of UHC in many settings, which also impedes pandemic response since

people excluded from healthcare because of cost and other barriers cannot seek care or self isolate when infected. Governments should prioritise pooled resources to provide full population coverage of a comprehensive package of health services, including vital public health services needed to prevent pandemics and basic primary healthcare needed to maintain wellbeing. Such coverage can be achieved only through progressive public financing. To be fair and effective, UHC must include marginalised groups, such as migrants, refugees, indigenous people, and people working in the informal sector. For those who have suffered most from extraction, including indigenous people, solutions must include enfranchisement with settlement of land rights and the provision of culturally appropriate services.³²

Internationally, colonial patterns persist in many complex ways, although their consequences in systematically disadvantaging formerly colonised people and places is clear. The Commission on the Social Determinants of Health concluded in 2008 that health equity could not be achieved without dramatic redistribution of power and resources.³³ The geopolitics of the covid-19 pandemic have shown that much work remains to be done in this respect. In the past three decades our world has grown more unequal,³⁴ multinational corporations have flourished in a very deregulated global economy,³⁵ and even as millions suffer and die now, many very rich people have become even more wealthy during the pandemic.³⁶ Over the past few decades the planet's natural resources—necessary to sustain all life—have been depleted to dangerous levels, threatening human and planetary health alike.³⁷ The common thread in these problems is the need for governance reform. Helpfully, the mechanisms that could be used to regulate the practices of transnational corporations have been described³⁸: these include reporting, reviewing, monitoring, and managing conflicts of interest; stopping the revolving door between transnational corporations and governments; protecting whistleblowers; and restricting and requiring full disclosure of lobbying activities. Similarly, the Transnational Institute has proposed binding treaties to regulate transnational corporations.³⁹

Governance reform at the multilateral institutions would help advance the participation and power of low and middle income countries, including those formerly colonised. This reform would diversify the ideas and knowledge available for consideration and enable learning from the best examples, such as how African countries created a common marketplace to share access to scarce supplies at fair, fixed prices.⁴⁰ Or how Senegal engaged communities to increase communication, case detection, and coordination for physical distancing and other policies.⁴¹ Traditional donor activities, which have included support of the African Centres for Disease Control, can still play a role, but more equitable governance of international institutions is a prerequisite for improving the global response to pandemics. Making international decision making democratic could support international collective action to empower WHO and assert the priority of health over commercial interests in international trade, and the joint pursuit of vaccines and other health technologies coupled with equitable distribution schemes. Some encouraging signs have emerged of progress towards these goals such as the ACT-Accelerator and the Covax facility, but the behaviour of some national governments (notably the US and UK) and powerful pharmaceutical groups is not fully supportive.⁴²⁴³⁴⁴ Most crucially, these competitive actions in relation to vaccines are just one example of how unequal political and economic power linked to colonisation create health inequities between nations. These health differences will be solved only with far reaching reform of global economic and political systems. In our view, making governance of multilateral institutions democratic would be a good first step to reform, including equalising the opportunity to serve on the UN Security Council, the Executive Board of WHO, and the other decision making bodies of the international governance system. As a step towards economic redistribution, G7 and G20 countries should cross subsidise vaccine purchases for low and middle income countries and ensure long term availability by enforcing compulsory licensing as they have already pledged to do through the World Trade Organization. The shared disaster of the covid-19 pandemic has drawn attention to the many regressive realities of our world, each one calling for immediate reform in the governance of

global health. Without such measures, the unfair, extractive, and regressive patterns of the past will continue to plague the present.

Key messages

Countries have had very different experiences with covid-19, raising questions about its political economy and the determinants of performance

The burden of covid-19 follows extraction patterns dating from colonial times, with the worst outcomes suffered by marginalised people and poorer countries

Competitive attitudes by some countries have undermined the international response

Progress in public health requires governance reforms at multilateral institutions and international redistribution mechanisms

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Footnotes

- Contributors and sources: JBB has expertise in colonial and postcolonial history and has published widely on global health policy and international institutions in health. FB has published extensively on the socioeconomic determinants of health. MS has analysed the political economy of global health and has experience in international global health policy making. RY has long experience in global health policy and special expertise in the political economy of universal health coverage. KH has published extensively on the commercial determinants of health and the political economy of public health policy. The article was conceived jointly by JBB, FB, MS, RY, and KH. JBB wrote the initial draft using inputs from FB, MS, RY, and KH. All five authors revised and edited the article to produce a final draft. JBB is the guarantor.
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