COVID-19 Vaccine Access Inequity:

Philippines and Developing Countries vs. Wealthy Nations

A Comprehensive Analysis of Speed, Price, Quantity, and Logistics

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Executive Summary

This report examines the extent to which poorer countries like the Philippines experienced more difficult access to COVID-19 vaccines compared to wealthy countries. The analysis covers four key dimensions: speed of access, pricing disparities, quantity available, and logistical challenges. The evidence demonstrates substantial inequities across all dimensions, though the causes and appropriate policy responses remain subjects of ongoing debate.

1. Speed of Access

The Philippines experienced substantial delays compared to wealthy nations. While wealthy countries began vaccinating in December 2020, vaccination in the Philippines started in March 2021.[1] The country had to wait for vaccines from wealthy nations despite being one of the hardest hit countries in Southeast Asia in 2021.[2]

Vaccinations had not yet begun in the Philippines as of early January 2021 and were not expected to start for several months.[3] This delay occurred despite the Philippines having over 3.5 million confirmed COVID-19 cases and around 54,003 deaths by early 2021.[4]

2. Price Disparities

Price inequities were stark and systematic, with developing countries consistently paying more per dose than wealthy nations:

Country/Region	Vaccine	Price per Dose	Notes
South Africa	AstraZeneca	$5.25	vs. $3.50 in Europe
Uganda	AstraZeneca	$7.00	Nearly double EU price
South Africa	Moderna	$30-42	vs. $32-37 in high-income countries
Europe	AstraZeneca	$3.50	Lower than developing nations
African Union	Pfizer/BioNTech	$6.75	6x estimated production cost

Analysis showed vaccines could be produced for as little as $1.20 per dose, yet COVAX (the global vaccine access facility) paid nearly five times more.[5] The most expensive vaccines were up to 50 times higher than the pre-pandemic median price of $0.80 per dose for non-COVID vaccines in developing countries.[6]

Moderna and Pfizer were charging governments as much as $41 billion above the estimated cost of production.[7] Despite substantial public funding ($8.3 billion for mRNA vaccine development), pharmaceutical companies charged premium prices to developing nations.[8]

3. Quantity and Supply

Supply disparities were dramatic and resulted from wealthy nations securing advance purchase agreements:

Global Hoarding: Wealthy nations representing just 13% of the world's population cornered more than half (51%) of promised doses from leading vaccine candidates.[9] Pfizer and Moderna sold over 90% of their vaccines to rich countries.[10]

Vaccination Rate Disparities: By late 2021, only 52% of the Philippines population was fully vaccinated, compared to 78% in high and upper-middle income countries.[11] High-income countries administered 69 times more doses per inhabitant than low-income countries.[12]

COVAX Shortfalls: The COVAX initiative, designed to help countries like the Philippines, repeatedly had targets cut back due to production issues, export bans, and vaccine hoarding by wealthy nations.[13] COVAX could at best vaccinate only 23% of low- and middle-income countries by end of 2021.[14]

Philippines-Specific Impact: By August 2021, only 40.4 to 44.1% of the adult population in the Philippines had received at least one COVID-19 vaccine shot.[15] There were significant regional disparities within the country: 93% of residents in Metro Manila were fully vaccinated compared to only 10.9% in predominantly Muslim regions in southern Philippines.[16]

4. Logistical Challenges

The Philippines faced multiple logistical obstacles that compounded access difficulties:

Cold Chain Infrastructure: Approximately 65% of rural health facilities in the Philippines lacked proper refrigeration systems.[17] Globally, two-thirds of the world's population lived in countries lacking the cold chain logistics infrastructure required for ultra-low temperature vaccines.[18]

Air Freight Capacity: Overall air freight capacity was approximately 30% below 2019 levels during the pandemic, and charter rates increased 100-500%.[19] This significantly impacted the speed at which vaccines could reach developing nations.

Last-Mile Delivery: As an archipelago nation, the Philippines faced additional challenges in distributing vaccines to remote islands. DHL's CEO noted that the main challenge was 'last-mile delivery from warehouses to doctors because it is difficult to transport minus 70 degrees products.'[20]

Government Response: Philippine President Duterte expressed frustration over how some countries 'shanghaied' the vaccine supply,[21] reflecting widespread sentiment about 'vaccine apartheid' or 'vaccine nationalism.'

5. Are These Conclusions Disputed?

The basic facts about vaccine inequity are not disputed. The disparities in access, speed, price, and quantity between wealthy and poorer countries are widely acknowledged across sources, including by pharmaceutical companies, governments, international organizations, and academic researchers.

However, there is significant debate about several aspects:

Areas of Disagreement:

1. Explanations for Why Inequity Occurred:
• Some emphasize 'vaccine nationalism' where countries prioritized their own populations[22]
• Others argue this was natural political behavior, noting governments follow political ethics not medical ethics[23]
• Some blame pharmaceutical companies' profit motives, noting companies were selling vaccines 'depending on the estimated profit while excluding the requirement to distribute towards impoverished countries'[24]
• COVAX's governance structure itself has been criticized as undermining equity goals[25]

2. Whether Intellectual Property (IP) Waivers Would Help:
• Opponents argue a waiver would discourage future innovation without solving supply problems, claiming pharmaceutical companies already had every incentive to produce maximum quantities[26]
• Proponents counter that unused capacity existed in countries like Bangladesh, Canada, and Israel that could have been used for production[27]

3. Who is Primarily Responsible:
• Some blame wealthy governments for hoarding
• Others blame pharmaceutical companies for profit-driven allocation
• Some scholars conclude pharmaceutical companies 'failed to fulfill the implied responsibility of combating inequitable vaccine distribution'[28]
• Still others see it as systemic failure of global governance

4. Whether Vaccine Hoarding Occurred:
• Some defend wealthy countries' over-purchasing as 'hedging against the risk of vaccine development failures' rather than hoarding, noting only 7% of vaccine candidates complete development[29]
• Critics point out that Canada ordered five times more COVID-19 vaccines than its population

What's NOT Disputed: The empirical reality is universally acknowledged. WHO's Strategic Advisory Group confirmed that 'high-income countries have administered 69 times more doses per inhabitant than low-income countries,'[30] and COVAX's impact was 'muted by supply-chain issues, vaccine nationalism, the decision by some countries to halt the export of vaccines, and queue-jumping by wealthy countries.'[31]

The debate centers on interpretation, blame, and solutions—not on whether the inequity itself existed.

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