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SPOTLIGHT 1: The European Union's vaccine procurement: Solidarity in crisis or crisis in solidarity?

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Introduction

Despite its bumpy start, the European Union's (EU) procurement of vaccines during the Covid-19 pandemic is now widely hailed as a success. In June 2020, the member governments 'agreed on the need for joint action to support the development and deployment of a safe and effective vaccine against Covid-19 by securing rapid, sufficient and equitable supplies' (European Commission, 2020a). By the end of 2020, the EU had secured a total of 2.6 billion doses from six vaccine developers. By the end of summer 2021, the EU reached its target of fully vaccinating seventy per cent of its adult population (Guarascio, 2021a).

The joint procurement scheme, which guaranteed the proportional distribution of vaccines to the same conditions, meant that smaller and poorer EU countries were able to receive vaccines more quickly than if they had procured them unilaterally. By implication, the larger and wealthier member states relinquished doses they could have received if they had procured them unilaterally. In other words, the EU's vaccine procurement scheme is considered to have been an act of solidarity of larger European countries with smaller ones. This spotlight explores the concept of solidarity, how vaccine solidarity was achieved and how it held up during the EU's pandemic response.

Drawing on Sangiovanni's (2013) account of global justice in the EU, we define solidarity as morally grounded demands for 'a fair return in the mutual production of important collective goods.' Accordingly, shared humanity creates a general duty to assist other people regardless of citizenship, gender, race, or any other attribute. More demanding solidarity claims beyond humanitarianism must be grounded in institutions and practices that go beyond transactional relationships, namely those that serve the production of common goods. By contributing to the generation of such goods, actors 'gain a stake in the fair share of the benefits made possible by them and an obligation to shoulder a fair

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share of the associated burdens' (Sangiovanni, 2013, p. 220). From this internationalist perspective, demands for solidarity can exist concurrently, albeit to different degrees, at multiple levels.

There is wide consensus that the EU is more than a transactional community. Its Member States have surrendered a significant amount of their sovereignty to produce important collective goods that are essential to the welfare and security of Europe. Chief among these collective goods are the Single Market and currency as well as the area of freedom, security, and justice, including the Schengen free travel zone. At the same time, the participation in the production of these goods involves both benefits and significant risks, as the Eurozone and the 2015 refugee crises have shown. The institutions and practices of the EU that come from the joint production of these important collective goods generate demanding claims for solidarity that go beyond basic humanitarianism, and the Covid-19 pandemic served as a significant test of these institutions and practices.

Health solidarity pre-Covid

Prior to the Covid-19 pandemic, the EU complemented national health policy by aiming to foster cooperation between Member States and with third countries, setting standards of quality and safety regarding certain medical and biomedical products, and adopting incentive measures to improve human health and combat cross-border health threats (Treaty on the Functioning of the EU, Article 168, Chamorro, 2016). Shortly after the H1N1 pandemic, the EU (2013) adopted a Decision on serious cross-border threats to health, to enhance its preparedness for and response to communicable disease outbreaks.

The EU Joint Procurement Agreement (JPA) was created one year later to enable Member States to engage voluntarily in joint procurements of medicines, medical devices and all other services and goods that can be used to respond to cross-border health threats (European Union, 2014). Its objective is to improve the security of supply and Member States' preparedness to mitigate serious cross-border threats to health by strengthening solidarity through more equitable access to specific medical countermeasures and balanced prices for participating countries (Azzopardi-Muscat *et al.,* 2017; Filia and Rota, 2021). By sharing risks and leveraging economies of scale, it was especially attractive to smaller Member States as it enabled price savings, reductions in operational costs and administrative burdens, and access to professional expert networks. It aimed to avoid competition for scarce resources among purchasing states (Glencross, 2020).

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Although the EU JPA provided a ready-to-use instrument for joint procurement in the event of a cross-border threat to health, it was not without controversy and inherent limitations. Primarily its non-exclusivity – which allowed especially larger Member States to engage in parallel negotiations with the same manufacturer for the same product – seriously undermined the solidarity and equity objectives. In addition, participation in the JPA remained voluntary, thus limiting the incentive for bigger Member States to join common procurement initiatives (Filia and Rota, 2021).

Solidarity in the EU's pandemic response

The outbreak of the Covid-19 pandemic dramatically changed this state of play. The characteristics of this fast-spreading pathogen affecting countries worldwide reflected global vulnerabilities regarding pandemic preparedness and response. The EU, as an integrated open market, a densely populated open border area and travel hub, was hit especially quickly and hard. As the Covid-19 crisis engulfed the rest of the world, an unprecedented race to develop vaccine candidates (Le *et al.,* 2020) and acquire vaccine doses ensued. Several countries launched state-backed initiatives to help companies develop Covid-19 vaccines that would gain them priority access to future products (Lancet Commission, 2021).

The EU was therefore confronted with a dual challenge: first, to ensure equitable access while not all Member States could fund vaccine research and development equally, and second, to enable rapid access while competing against stronger actors such as the United States (US) (Funk *et al.,* 2020). At first, the EU response to the pandemic was uncoordinated with little solidarity between Member States (Herszenhorn *et al.,* 2020). Several Member States established border controls and banned exports of medical equipment to other EU countries (Dimitrakopoulos and Lalis, 2020; Hackenbroich, 2020). Larger Member States such as France, Spain and Germany began to engage in independent talks with vaccine manufacturers (Deutsch and Wheaton, 2021). In June 2020, France, Germany, Italy, and the Netherlands announced the creation of the Inclusive Vaccine Alliance. However, despite statements suggesting that the Alliance was negotiating vaccine doses for all Europeans and that it remained open to all other EU Member States (Furlong, 2020), several smaller countries saw this as a threat (Deutsch and Wheaton, 2021). Representing 4/5 of the EU's largest economies and almost a 1/3 of the EU's population, it was seen as a powerful bloc that could undermine vaccine access for other Member States.

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To prevent any further fragmentation, the European Commission worked on the development of a common EU vaccine strategy. On 9 June 2020, Denmark initiated a letter to the Commission, supported by Germany, France, Poland, Belgium, and Spain, calling for a coordinated EU strategy on vaccine development, 'possibly' with EU funds to allow for a quick reaction (Momtaz, Deutsch and Bayer, 2020). However, a few days later, the Alliance undermined the Commission's legitimacy as a vaccine negotiator for the whole of the EU when it announced a deal with AstraZeneca to procure up to 400M vaccine doses (AstraZeneca, 2020). The parallel development of two competing procurement tracks enhanced uncertainty and threatened to obstruct access to vaccines among smaller Member States.

The European Commission (2020a) asserted its role as the exclusive negotiator on 17 June 2020 when it presented its EU Strategy for Covid-19 vaccines. In its Decision 4192/2020, the Commission (2020b) formulated a mandate to negotiate and conclude Advance Purchase Agreements (APAs) with vaccine manufacturers on behalf of Member States. In addition, it allocated €2.1 billion from its €2.7 billion Emergency Support Instrument to cover some of the upfront costs to de-risk essential investments of vaccine manufacturers in future APAs. By late June 2020, the Alliance eventually stopped its work. The Commission took over its negotiations with Johnson & Johnson and the deal with AstraZeneca (Deutsch and Wheaton, 2021).

During the negotiations, the EU's APA mechanism worked as a single central procurement mechanism for its Member States. The Commission covered part of the up-front costs needed to secure the APAs. In contrast to the JPA, the APA contained an exclusivity clause (Article 7) that prevented states from launching parallel negotiations with the same manufacturers for a similar product. The allocation of doses was to be based on a pro-rata population distribution key. Once vaccines were approved by the European Medical Agency, participating Member States could decide on their own vaccine mix, acquire their share of doses directly from the manufacturer and pay the uniform purchase price. Once purchased, these doses could be redistributed, resold to other participating Member States or made available to the global solidarity effort. Drawing on the Commission's negotiation expertise and economies of scale enabled EU members to leverage its market of 500M people to obtain favourable prices and liability conditions 'irrespective of the size of their population and their purchasing power' (European Commission, 2020a). The EU vaccine pool was also opened to members of the European Economic Area (Iceland, Liechtenstein, Norway) as well as Monaco and San Marino (Criric, 2022).

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Fragile solidarity during the vaccine rollout

Several commentators criticised the Commission for approaching the negotiations as a trade matter rather than a matter of crisis procurement, prioritising price over pace (Halloran, 2021, p. 77). This criticism increased when the EU's procurement effort suffered a serious setback in the early days of 2021. Following AstraZeneca's announcement in January that it would fail to deliver its EU doses on schedule, the ensuing supply bottleneck derailed Member States' rollout and put them weeks behind the US and UK. Considering the difficulties related to AstraZeneca shipments, Hungary, which eventually left the APA in May, and the Czech Republic decided to turn to vaccines manufactured in Russia and China. Equally frustrated with the short supply, Denmark and Austria turned to Israel to discuss the joint development of a second-generation vaccine (Petrequin and Moulson, 2021). Further tensions arose in March 2021 as BioNTech scaled up the production and shipment of its vaccine. The member states whose vaccine mix contained substantial amounts of BioNTech now experienced a rapid acceleration of their vaccine rollout, while those that had placed their bets on AstraZeneca were falling further behind. By late March, EU leaders confirmed the Commission's methodology of a pro-rata population key for the allocation of vaccines but asked EU ambassadors to allocate, in the spirit of solidarity, 10M additional Pfizer doses to countries whose vaccination campaigns heavily relied on AstraZeneca (European Parliament, 2021).

As supply issues subsided in summer 2021 and the whole of the EU steadily closed the gap on the British and American campaigns, more commentators began to praise the EU's joint procurement as a success and act of solidarity with smaller and poorer Member States (Marcus, 2021; Cameron, 2021). Although EU-wide solidarity was severely tested and several governments shifted the blame for some of their own failures onto EU institutions, it is notable that the larger Member States allowed the Commission to assume their place in the negotiation queue with manufacturers and respected the exclusivity of the deal that the Commission had negotiated.

Global solidarity

While there was solidarity, albeit frail, within the EU, the WHO criticised rich industrial nations for their lack of solidarity with poorer developing countries. Even if principles of solidarity may be less demanding beyond the EU level, it is doubtful whether the EU's (and other developed nations) aid to the global pandemic response met even minimal standards of humanitarian assistance. Indeed, most of the EU's exports (sold or shared)

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went to other high-income countries (Guarascio, 2021b). In many cases, the EU's own supply issues held up promised donations to its neighbouring countries, which ultimately turned to Russian or Chinese vaccines instead (Guarascio and Murphy, 2021). While the EU donated €3bn to COVAX, the WHO-led vaccine alliance with the goal of providing equitable global access to the Covid vaccines, its Member States also hoarded doses for boosters and future waves. As a result, many healthcare workers in developing countries were still waiting for their inoculation as EU countries (and many other industrialised countries) discarded millions of expired doses (Oxfam, 2022).