#1397 Vaccine Rollout Once Again Exposes the Divide in Our Global Medical Apartheid

JAY TOMLINSON - HOST, BEST OF THE LEFT: [00:00:00] Welcome to this episode of the award-winning Best of the Left Podcast, in which we shall learn about the rollout of COVID-19 vaccines in the US and around the world, as the legacies of colonialism and racism predictably play themselves out between white and Black in the US, Israeli and Palestinian in the middle east, and the global north and global south more broadly.

Clips today are from CounterSpin, On the Media, the Rachel Maddow Show, Democracy Now!, Citations Needed and Start Making Sense.

Elisabeth Rosenthal on Troubled Vaccine Rollout - CounterSpin - Air Date 1-15-21

JANINE JACKSON - HOST, COUNTERSPIN: [00:00:32] Where you see phrases in stories like "the administration of vaccines has met with delays and roadblocks" -- that passive voice is safe, but the opposite of that isn't necessarily "finger-pointing", another word we're seeing a lot -- is just trying to understand where the breakdowns or flaws in the system are so they can be addressed. I think it's understood that this process was going to present challenges, as we say, but what would you identify as the primary factors that have made it more confusing, more chaotic than it needed to be?

ELIZABETH ROSENTHAL: [00:01:10] Sure. I would say this is not rocket science. It's complicated logistics, but not even that complicated.

I mean, the basic problem is a lack of central strategy. You can argue that a lot of different kinds of algorithms should dictate who gets the vaccine. And instead of deciding nationally with the best experts how we want to do it, basically the feds have sent to the States; the States decide how they want to allocate it to the counties; the counties decide how they want to allocate it to hospitals and likewise to nursing homes and CVS. And it's just predictable chaos without a central plan, which people can trust. And the newest wrinkle in this today -- which I have smoke coming out of my ears for -- is, all of these governors and mayors have announced that, okay, starting this week, January 11th, folks over 75 or over 65 will be able to sign up for the vaccine. Well, good luck with that. I compare it to trying to get a delivery from Whole Foods during the beginning of the pandemic, you know, you have to be tech-savvy, sitting there when the slots are released, refreshing your web browser. That is a crazy way to do a vaccine program.

And I think one thing that would have made this whole thing better was a central kind of strategy where everyone knew where they stood. And if someone says to me, okay, you're going to get your vaccine in April, I can be okay with that because I can at least know exactly when and where it's coming, rather than this current turmoil, where we have -- literally these are the stories we are hearing at Kaiser Health News today, where I'm currently editor-in-chief. A doctor's office will get a call from a hospital saying, Hey, we have six extra doses. Send your staff over here. Or there'll be an announcement at a Giant supermarket saying, Hey, we've got four extra doses; come one, come all! You hear of one nursing home getting everyone vaccinated, and another one 10 miles away, which is presumably not as well

connected or in a different county that's doing things differently, having no idea when they're getting vaccine. So that introduces chaos, introduces anger, and we just have to be slow and plotting and systematic about the way we do this in a rapid way.

So how's that for a challenge?

JANINE JACKSON - HOST, COUNTERSPIN: [00:03:46] Well, particularly at a time where public trust is obviously going to be paramount? You have to trust that there is a plan, but first I wanted to say it can be hard for some people to see the unfairness in that "first come first served." It sounds like it's equitable; of course it's not at all equitable, both in terms of, as you say, having to be tech savvy enough to get in line on the website or sign up and then know when you're supposed to show up to someplace. But also of course, a lot of folks -- we're talking about undocumented workers, we're talking about homeless people, a lot of the folks who should be getting vaccinated, they're just left out entirely. There's no incentive in that sense to, to reach them, particularly if the federal government is going to be counting how quickly you can say you're vaccinating folks.

ELIZABETH ROSENTHAL: [00:04:40] Yes. And I think we know there's more vaccine skepticism generally in those populations, which makes it even more troubling. I mean, boy, you have to be good at playing the game of accessing health care in the US, as you said, you need to be tech savvy.

So what does that mean? It means maybe 80-year-olds are not as good as the 65-year-olds, or an 85-year-old who has a 30-year-old grandson who can snag and appointment is in much better shape. So you're kind of favoring the well-educated, well-connected, well-hooked up to the internet. And then, P.S., we've seen in some states like New York where you officially get an appointment, but it's not really timed. So there are these long lines. So many people, particularly low-income people, have to work. So they need an appointment time if you want this to go smoothly, or good weekend in the evening time, there are ways to do this well and other countries are doing so, but we are not.

JANINE JACKSON - HOST, COUNTERSPIN: [00:05:53] Well, but you say "central plan." What are you, some kind of communist? Now your book is about the businification of healthcare. I wonder what role you see that playing in all of this, in terms of the development of the vaccines and their distribution?

ELIZABETH ROSENTHAL: [00:06:11] Well, no, I'm, I'm certainly not a communist. Or a socialist. But being a capitalist doesn't mean you don't plan. It should mean the opposite, right? But instead of planning, having a government plan, we've let every company -- and I will call hospitals companies for the purpose of this interview and doctor's office -- go it on their own, and nursing homes.

So for example, What did many hospitals in New York do? There was a great New York Times article about this. They gave it to their entire staff, including people who'd been working from home for the last eight months. Now that's what a company would do. You would protect your own before you protected your vulnerable patients. A hospital that really cared about its community would say yes, we want these frontline workers who have COVID exposure to be vaccinated, but then next we're going to look to our vulnerable cancer patients who may be in here every week for chemotherapy, or vulnerable people with bad lung disease.

And we did not see that happening at many, many hospitals.

JANINE JACKSON - HOST, COUNTERSPIN: [00:07:25] Do you think part of the problem, or I guess maybe I think part of the problem was the setup of vaccine was presented as the light at the end of the tunnel, you know, for a scientifically under-informed, and to some degree politicized, public, it was going to be something that would put an end to arguments about what we needed to do societally, since we could do this thing individually or not. In a way, public health as a thing, kind of like democracy, it seems as being tested.

ELIZABETH ROSENTHAL: [00:07:59] Yes. We have chosen the most profitable form of ending the pandemic, which is a vaccine. And you know, the fact that we've gotten vaccines at record pace, I'm not going to say that's a bad thing. It's a good thing. And that was one way to solve the problem.

But why can these other countries be more methodical and systematic? It's partly because they have central planning, but it's partly because COVID never got out of control there. So we are desperate for a solution. This is the only solution given how out of control we've let this become as a result of not being good at public health.

And so there's a kind of feeding frenzy for how to distribute it and who should get it. And survival of the fittest in a way, and that's not very good.

The Perils of Pandemic Doomsaying (and Other Covid Messaging Mix-Ups) - On the Media - Air Date 1-29-21

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:08:52] In your newsletter, Insight on Substack, you quote David Leonhardt of The New York Times, who says: a version of the mask story is repeating itself. This time, he said, it involves the vaccines. Once more, the experts don't seem to trust the public to hear the full truth. What is the truth that we're not hearing?

ZEYNEP TUFEKCI: [00:09:15] What he's trying to get at is the framing around the vaccines. We have hit, unexpected, amazing home runs with these vaccines. The first two that have been authorized in the United States, the Pfizer, Biotech and Moderna. You don't get any COVID at all for 95 percent of the people and for the rest of the five percent in both the Moderna trial and the Pfizer trial, there's about sixty thousand people total out of that sixty thousand total, there was a single severe case among someone who was vaccinated.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:09:50] Even among the five percent for whom it wasn't, quote, effective, their cases were mild except for a single case.

ZEYNEP TUFEKCI: [00:09:59] One case qualified as severe, and her clinical description was that her oxygen saturation got down to ninety three percent. But she didn't need any other medical attention. She didn't need to be hospitalized. And that's the only case. Now, contrast that with the messages full of well, we don't yet know if they prevent transmission or you can't take your masks off yet or you can't do this and you can't do that. Those things aren't completely false, but they have to be framed correctly. We do think it's going to blunt transmission. We just don't have an exact number yet. In the preliminary study, Moderna found that even asymptomatic infection was down by two thirds. So that's really strong at

suggesting that it's going to blunt transmission somewhat. Publicly, we will probably be wearing masks for a while because in public, you don't want to create two classes of people and you also don't know like who's vaccinated, but of all the things to emphasize right now, we have vaccines that are better than anything we had hoped for. Basically almost complete elimination of severe disease. So instead of celebrating this, because life is going to get back to normal when enough of us are vaccinated, it's full of headlines warning people about all the short-term limits. And a lot of anti-vaxxers have latched onto this saying if the vaccines are so good, why are there so many articles warning you nothing's going to change? People are tired and fatigued, and when we didn't get our mask messaging right, we damaged compliance and masking. And when we don't communicate the real upsides of the vaccines, when we don't get our messaging right, we do damage to trust.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:11:51] Now come the COVID variants. And let's start with the ones first encountered in the UK and South Africa. I mean, we should be worried about a more infectious strain. They are 50 to 70 percent, maybe more transmissible. We were also told, though, at the same time that they were not more deadly, but it seems that if you have more cases, it means more deaths. And I recently heard on the BBC that these strains may, in fact, be more deadly. But you've taken issue with the worries that the media are now choosing to spotlight, right?

ZEYNEP TUFEKCI: [00:12:26] Right. I started seeing the data and I thought, oops, we got adaptive evolution here. Question number one is, what do I do in the short term? You have to up your precautions because if it's transmitting 50 percent more than it used to, it means that the environment that you got away with last time, you're 50 percent less likely to get away with it. We also have seasonality working against us, right. These coronaviruses are usually seasonal, this one appears to be so. So we have the winter dry air. Well, what about the vaccine? Moderna came out with a study which was really encouraging, which showed that while both variants UK one a less so in the South African one is a little more dangerous, they were lowering the neutralizing antibodies. But neutralizing antibodies are but one part of the immune system and they were so high to begin with, they were clearing the bar. So what we were hearing was that, you know what? It's going to work.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:13:30] So when you objected to the San Francisco Chronicle writing Moderna's Coronavirus vaccine protected against the mutations of the virus first detected in Britain and South Africa, but the antibodies were six times less effective at neutralizing the South African variant. It made it sound like it was –.

ZEYNEP TUFEKCI: [00:13:50] Six times less effective. They gave you the very wrong impression. The thing that went down six-fold is the neutralizing antibodies, that doesn't really translate into vaccine efficacy. I mean, I realize this is kind of getting into the technical weeds of immunology, but if you're writing a headline, that's what you should know. If you just put a six-fold decrease in the headline, you're going to freak people out because people are going to think, wait, like did we go from, you know, 90 percent to 30 percent?

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:14:20] So how effective is it?

ZEYNEP TUFEKCI: [00:14:22] Most people think it might go from, say, ninety five percent to say 90 percent. Nobody's expecting to go down to 30 percent. So the correct message is you and I should not be discussing neutralizing antibodies. It's not the public's area of expertise, and I'm just telling you what the scientists have told me. It will have a small effect. Plus,

Moderna said they were working on a booster for the new variants, and a lot of people were saying, well, if they're working on a booster, that means this one doesn't work, whereas they clearly said, you know, we're just kind of keeping an eye on this. So my sense from seeing that press release and the paper, they put the paper out to us, it was like: "this is great," and they're already working on the booster. That's exactly what they should be doing.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:15:14] Some other framings you didn't like. Vaccines have been oversold as the pandemic exit strategy. From the Financial Times and a tweet from NPR which said, Moderna finds COVID-19 vaccine less effective against variant.

ZEYNEP TUFEKCI: [00:15:29] It's fine to say the efficacy will take a marginal hit and also to tell people the variant is a real threat. You're unvaccinated now. If you're like most Americans, you've got to be more careful. Let's be straight, let's say the good stuff, let's not give misleading information. Let's not put six-fold decrease in net neutralizing antibodies in a headline, as if that's something the public should be expected to understand. And that's going to make people not want to take the vaccine when they should jump at it. The media has to examine how it switches, like there's this hearding effect, where they dismissed the pandemic risk. They dismissed masks. They did this for a long time, and then when it flipped, there's a lot of doom saying now. I'm seeing articles saying vaccinations are not going to get us out of it.

Yes, it will. The problem is we don't have enough.

Racial Disparities Already Taking Shape In Covid Vaccination Rates - MSNBC - Air Date 2-6-21

RACHEL MADDOW - HOST, THE RACHEL MADDOW SHOW: [00:16:27] Because of racial and economic disparities in this country, white Americans are just getting sick and dying less than Americans of color are in this pandemic. It's been like that since day one of the pandemic.

The present fight, the thing we ought to be able to stop even before it starts, because we know to watch for it and we can see it take shape at the early days, is that we're seeing exactly the same inequities play out right now when it comes to access to the vaccine. We haven't been rolling out the vaccines for very long. Right? But look at the disparities we've got already. It's something that's taken place just over a matter of weeks.

Look at Pennsylvania: 11% of the population of Pennsylvania is Black. But Black Pennsylvanians make up 3% of the people who've been vaccinated. Look at Louisiana: 32% of the population in Louisiana is African-American, but they make up only 13% of the people who've been vaccinated. Delaware, where 22% of the population is Black, the percentage of people in Delaware who got the vaccine is 6%.

And yes, some vaccine hesitancy in communities of color may be partly to blame here, but beyond that, there really are very clear barriers for entry to getting a vaccine that really do disproportionately affect people of color. In most places to get the vaccine, you need to register online. Well, in order to do that, you need to be able to afford access to the internet.

Can't afford wi-fi? Don't have a smartphone? Good luck getting the vaccine in those places.

Other vaccine sites are drive-through only; you show up in a car, roll down your window, roll up your sleeve -- for that, you obviously need to own a car just to access a life-saving vaccine.

More people of color have been getting sick. More people of color have been dying. And now, right now, fewer people of color are getting the vaccine. Vaccine inequity is a problem all over the country right this second. It is not a long-standing problem, 'cause we've only had this vaccine for a few weeks. But we are already making the same mistakes as a country that we did did throughout the pandemic that got us to these terrible health and death disparities that we've seen over the course of the past year.

A Pastor's Plight to Address Vaccine Skepticism in Black Communities - On the Media - Air Date 12-4-20

BOB GARFIELD - HOST, ON THE MEDIA: [00:18:38] Depending on which survey you look at between 50 and 70% percent of the public in general is willing to be vaccinated with one of these new COVID vaccines, but only 32 percent of black Americans. How did we get here?

FATHER PAUL ABERNATHY: [00:18:58] In my conversations in the community, I think there are three primary reasons why there's a lack of trust in the vaccines in the black community. First would be a history of clinical abuse. Now I think we can talk about things like the Tuskegee experiment and the mark that is left on the psyche of the African-American community. But we have to go beyond that, because there's the lived experience of clinical abuse, even in our own day and age. We can reference the studies about African-Americans being less likely to receive pain medication than whites and various other studies around health outcomes and the experiences of African-Americans in the health care system. And so this is the first reason.

A second reason would be a mistrust of government. People see government involved in the inception and distribution of this vaccine, and as they see that, they also again reflect on their experience with the government. Many failed government systems in in our communities, communities that are underserved, communities that have poor education, high unemployment rates, high rates of gun violence. And so it looks as though government policy has failed this community. And so when they see the government involved in vaccine, there's right away a mistrust of the vaccine because there's mistrust of the government.

And thirdly, I have heard people talk about a mistrust of corporate America. People understand that there are corporations that are developing vaccines. And so there's this sometimes notion that this vaccine is being pushed to make those who are rich, richer. Many people who don't have much they're not so willing to put themselves in a position to receive a vaccine ultimately to make somebody else rich. And so, just in my anecdotal experience, these are the three primary perspectives that I do believe cloud people's trust of these vaccines.

BOB GARFIELD - HOST, ON THE MEDIA: [00:20:43] You're in Pittsburgh where there's yet another wrinkle that I believe has manifested itself, and that is that the universities are also viewed with suspicion because they're the primary funders of gentrification swallowing up whole neighborhoods. So, you're asked to go to a university to get your vaccine. And they're kind of already viewed with suspicion.

FATHER PAUL ABERNATHY: [00:21:08] There's no question about it. Universities, although, you know, very often they claim to be places of enlightenment. Whenever we really look into how they really, you know, live the citizenship in our communities out, it's very often detrimental to those who really suffer the most among us. I think it's also compounded by the fact that there have been historically many researchers who have come into our communities, who have conducted countless hours of research, and the results of that research has served our community in absolutely no way. It's got to be a reckoning for our relationship with these universities. We can't just say these universities are going to help us, you know, promote and disseminate the vaccine. We have to say if these universities are going to embrace their obligation to serve the most vulnerable in this time of great need, we have to do so in the context of a reckoning. That I think is part of a broader national reckoning, where we have to understand that there has been too much that's too injust for too long. This vaccine gives us an opportunity to begin to have those conversations on a more serious level.

BOB GARFIELD - HOST, ON THE MEDIA: [00:22:17] So what you've described is, you know what, in a PowerPoint presentation they'd call headwinds. There are many obstacles to widespread acceptance of any of the COVID vaccines in the black community. What are you doing and what are you proposing to cut through those winds?

FATHER PAUL ABERNATHY: [00:22:38] The vaccine collaborative, there's weekly meetings essentially. Where community members and researchers are brought together to essentially strategize, plan and report out on the success of recent strategies implemented on the ground. And when the vaccine trials were made available, there was three percent minority participation. And so, we mobilized the community health deputies and set them out.

BOB GARFIELD - HOST, ON THE MEDIA: [00:23:01] Now, we're not just talking about apostles of mask wearing and social distancing. We are talking about where the rubber really meets the road. Vaccine experimentation. You mobilized people to actually sign up for clinical trials.

FATHER PAUL ABERNATHY: [00:23:19] I've seen some of these community health deputies themselves initially were not warm to the idea of vaccines, in particular vaccine trials. You know, I've seen this community hub deputies actually go out and engage folks and really ask them the question: would you do this? And if not, why? And one of the things that's been most remarkable to see, you know, I can think of one example where a community health deputy posed the question, why really would you not do that? Well the woman answered, Well, you know, I haven't seen the results of any of this and I just don't trust it. You know, the response was, well, do you know this is phase three trials explaining that phase one trial is high risk, low benefit, but phase three trial is actually high benefit, low risk. If we could get you the results from phase one or phase two, could that help alleviate some of your concern about this particular Phase three trial? And you have to see the woman pause and say, you know, if you got me some of that information. I might consider it. And that's the kind of interaction that I've seen makes all of the difference on a street here in our community. After the first week we went from three percent to eight percent enrollment of minority participation. So that was the first indicator that we had that this method was actually much more effective than some of the other methods we had previously tried.

BOB GARFIELD - HOST, ON THE MEDIA: [00:24:45] If you were the Sultan, what would you tell the people who are charged with the logistics of a vaccine rollout, particularly in predominantly black communities?

FATHER PAUL ABERNATHY: [00:24:56] Yes, I would tell those in charge of distribution that we've got to find those places that are, well, trusted places in the community that can become vaccine distribution sites. I know that there's challenges with that, I know in terms of refrigeration, there's probably other logistical challenges. In addition to that, these efforts should really be done in coordination with community members who are essentially opinion leaders who are deputized to become champions of the vaccine. These are some of the things that I think can greatly help vaccine distribution in these communities.

"Medical Apartheid" - Israeli Vaccine Drive Excludes Millions of Palestinians in Occupied Territories - Democracy Now! - Air Date 1-5-21

AMY GOODMAN - HOST, DEMOCRACY NOW: [00:25:32] Can you explain what is happening? How has Israel become the country that has vaccinated more of its population than any country in the world, and yet Palestinians are not getting vaccinated? Who's in charge of this program? Who should be?

DR. MUSTAFA BARGHOUTI: [00:25:49] Well, thank you, Amy. I'm glad to be with you.

Israel actually is violating international law, because it is denying its responsibility as an occupying power. Israel managed to get 14 million vaccines for the Israelis and those who hold Israeli IDs, but gave nothing to Palestinians. So, practically, they are vaccinating 8 million Israelis and not vaccinating 5.3, 5.2 million Palestinians living in the Occupied Territories.

More than that, this system of racial discrimination, which can only be compared, in my opinion, to apartheid system, is doing something horrible in the West Bank. Seven hundred fifty thousand illegal settlers, as you said, are getting the vaccines now; 3.1 million Palestinians in the West Bank are getting nothing. More than that, in the Israeli prisons, Israel ordered the guards in the prisons to get the vaccine, and probably the Israeli criminal prisoners, but the Palestinian prisoners, 5,000 of them, are getting nothing. What can be more clear here than that this confirms that this is really a system of racial discrimination?

And when they speak that the Palestinian Authority is responsible, this is totally misleading. First of all, the Palestinian Authority approached them, asking at least for vaccines for us, the healthcare providers, who are being infected around the clock. And Israel refused. The Palestinian Authority is in charge only of 38% of the West Bank, only. Sixty-two percent of the West Bank is Area C, under full Israeli military control, and Israel is doing nothing for Palestinians there. More than that, if the Palestinian Authority tries to import a vaccine from outside, they will need Israeli permit. And Israel did not allow any permit yet for Palestinians. Israel controls the borders, controls the imports, controls the exports.

And the biggest disaster is in Gaza, because in Gaza you have 2.1 million besieged by Israel, lacking health facilities, lacking equipment, and there, they are not getting any vaccines. And more than that, 70% of them are refugees displaced from their land in 1948. When you tell

them, “Go and quarantine,” I don’t know how they can do that, if you have 10 people living in two rooms. It’s impossible.

The problem is that the rate of infection today in the West Bank and Gaza is 36%, while in Israel it’s 4.5%. Israelis are getting the vaccines, and Palestinians are getting nothing.

JUAN GONZALEZ - HOST, DEMOCRACY NOW: [00:28:43] But, Dr. Barghouti, isn’t it in the interest of Israel, from a public health perspective, even if they want to pursue this continued antagonistic policy toward the Palestinians, to have the Palestinians vaccinated, to reach herd immunity in the total area?

DR. MUSTAFA BARGHOUTI: [00:29:09] You’re absolutely right. In my opinion, Netanyahu and his government — this man is so racist. He only thinks of himself. He only thinks of his political future. He only thinks of escaping the criminal charges against him and being reelected again. And all he does is to satisfy the Israeli right-wing voters.

In reality, what his government is doing is actually hurting the Israelis, as well, because you cannot reach herd community if you have 8 million people vaccinated and 5.2 million people not vaccinated, especially that 130,000 workers will continue to go to Israel for work and will interact with Israelis, of course, and there are 750,000 other Israelis, illegal settlers, in the West Bank, who will continue to commute and communicate with the 3.1 million unvaccinated Palestinians. So, practically, this is a crime against Palestinians and a crime against the health of Israelis. It’s a violation of the international law, but also it’s, in my opinion, the worst crime against medical ethics, which says nobody should be discriminated against because of anything, which says, “Do no harm, and help people as much as you can, as a health professional.

Vaccine Apartheid: US Media's Uncritical Adoption of Racist "Intellectual Property" Dogma Part 1 - Citations Needed - Air Date 1-27-21

ADAM JOHNSON - HOST, CITATIONS NEEDED: [00:30:32] Dean Baker wrote about this very thing in early December last year in the *New York Times*, along with public health activist Achal Prabhala and another economist Arjun Jayadev, in an opinion piece headlined this: "Want vaccines fast? Suspend intellectual property rights." It argued as I'm sure it comes as no surprise that that what is the way to get the most vaccines available to the most people. And as they say, "otherwise, there won't be enough shots to go around even in rich countries ." Now, this PR effort in the eighties and nineties to really push this idea of intellectual property really created this new trade regime that Pfizer unsurprisingly is now exploiting much as it was designed to deliberately undercut efforts to get cheaper vaccines to poor countries.

So Pfizer, Moderna, pretty much the entire US pharmaceutical industry is going all out opposing a proposal currently put forward to the WTO by India and South Africa that they proposed back in October that would suspend enforcement of patents for COVID-related treatments. Seems pretty fucking obvious, but so far the European Union, Great Britain, Norway, Switzerland, Japan, Canada have successfully blocked this proposal.

The proposal itself would allow for the expanded production of cheaper, generic versions of the COVID vaccine, saving many thousands of lives, obviously. The fact that this is not a given -- this should have happened even before there were vaccines available, even before they were in process, obviously -- this work should be done with open source data, shared intellectual property, working across governments, across countries, across companies. That should happen. The fact that countries are not scrambling to share as much vaccine info as possible is appalling. And yet, remember this is not the inevitable state of things. Intellectual property rights are a thing that were determined to matter by the people who would profit most from them.

NIMA SHIRAZI - HOST, CITATIONS NEEDED: [00:32:46] For decades, many others have argued that IP law is inherently neo-colonial and is a product of neocolonialism if not just colonialism, plain and simple. A University of Glasgow School of Law paper written in 2010 by Andreas Ramadhan said, "an essential instrument in the process of neocolonialization by economic means is the establishment of a legal framework of international trade which confers legal, enforceable rights that support and safeguard economic penetration and control. This includes as a prerequisite for the making of a 'informal empire' like in colonial times, the creation of property rights in the guarantee and protection of foreign property rights' independent regions. However, unlike in the colonial era, the most important property rights which fulfill this role in the 21st century are intellectual property rights. This is because of intellectual property rights do not attach to nations. How Western in nature TRIPS effectively is can be shown by the fact that Western national legal systems have had to adopt little to TRIPS. While for example, Latin America and Caribbean states have had to make significant changes in their intellectual property laws to implement the minimum standards, more recently TRIPS also served as a bottom line for further extension of IP protections which the developed world continues to push for bilateral TRIPS-Plus agreements with countries of the developing world. And so, here you have this fundamentally colonial, fundamentally racist set-up here that every major "democracy" in the global South: Brazil, India, South Africa, pretty much every African country there is says, Hey, this is super bad and racist. We should get rid of it. And it's simply not part of the conversation.

So, there's now an effort, a grassroots effort, to get Joe Biden, now that he's in the White House, to backtrack on Trump's approach to this -- Western Europe, Japan, other colonial powers' approach to IP -- or to sort of loosen the rules a little bit. And activist groups, such as Doctors Without Borders, progressives in Congress, the National Coalition for Black Civic Participation, Speak Up Africa, countless activist groups have been begging for new President Joe Biden and American leadership and people in Congress to rethink the obsession with and the defense of intellectual property rights and to make sure that we begin to put it in racial terms because those are the terms at which it was created.

ADAM JOHNSON - HOST, CITATIONS NEEDED: [00:34:56] As we've said, these kinds of calls to loosen or eliminate these IP law restrictions are not new. You saw something similar when the AIDS epidemic was ravaging South Africa, and pharmaceutical companies were charging exorbitant amounts of money for the intro retroviral treatments that could have been made locally in South Africa for a fraction of the price, distributed for a fraction of the price. And yet, they were prevented explicitly from doing so back in 1999, when Al Gore, then Vice President Al Gore, was hitting the campaign trail for the 2000 presidential election. He

actually faced protests because of his opposition to freeing up patents for HIV and AIDS treatment in South Africa.

NIMA SHIRAZI - HOST, CITATIONS NEEDED: [00:35:47] This is an article from the Guardian from 1999: "US pharmaceutical companies, which hold the patents for many of the drugs, challenged the law of South African courts, which was a new law that reversed their patent protections, 'on the grounds that it infringed on intellectual property rights.' they also called on Washington to fight for their interests. Mr. Gore, at that point he was running for president; he was Vice President, took a leading role in negotiations with President Thabo Mbecki. According to a State Department report last February, Gore played a key part in a "insidious, concentrated campaign" to pressure the government of South Africa to change the law. The main drug manufacturer lobby, the Pharmaceutical Research and Manufacturers of America ("PhrMA") is a contributor to the Gore campaign, and one of its lobbyists is Anthony Podesta, the brother of White House Chief of Staff John Podesta, a friend and advisor to Mr Gore. And so, he was met with protest on the campaign trail by ActUp, the gay and AIDS activist group that now sort of lives in lore as a sort of product of courage, but they were fighting in solidarity with AIDS sufferers in Africa, in South Africa. So, the suffering of people in the global South from these conditions has always been inextricably linked to the defense of big pharma and the defense of intellectual property rights in the United States. And attempts to reform these systems have been very token and useless at best as evidenced by the fact that in the years 2020 and 2021, these major countries like South Africa and India are having to go hat in hand to the WTO and beg America and Europe, European countries, to stop defending these IP protections at the World Trade Organization.

Now, one thing to note here is that it's not even just about profiteering off of the vaccine itself, because I think sometimes people assume that's the end game. That's actually, I think, a fairly small part of it. And I think if you talk to activists, they don't think that Pfizer and Moderna are going to be making a ton of money directly off of the vaccine itself. What they don't want to do is create a precedent. They don't want to create what they view as being a slippery slope to situations where the maximizing of profit is somehow undermined.

And so, this is a scenario where people are beginning to see, man, this doesn't make any sense. This doesn't make any sense that we would prevent other people from manufacturing and producing a drug that could benefit millions of people. And that's a very dangerous, slippery slope where so many of these people are obsessed with precedent and the general ideological framework around the protection of IP that they spent so many lobbying hours and money to set up in the nineties. And you saw this with AIDS, too. We can't do it because once we do that, we've got to do this, and they've got to open up for malaria drugs, you got to for this, for cancer treatment, and that's just not acceptable to these people, and the sanctity of intellectual property as somehow sacrosanct, something that can't be undermined, is something that people just aren't willing to criticize.

Who Owns the COVID-19 Vaccines? - On the Media - Air Date 1-29-21

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:38:27] I don't entirely understand what the data has to do with monopoly ownership of the drug, because. The data refers to how it's worked out in the trials, not how it was made or what its components are or any of that.

DEAN BAKER: [00:38:42] Well, to my view, there's not a good argument for keeping the data secret, but most of the drug companies insist on that.

And there's a very pernicious reason as to why they might want to keep it secret. And that's, why they may look to misrepresent the safety or effectiveness of their drugs. That's a big part of the story of the opioid crisis. You know, Purdue Pharma, which was one, of course, the big opioid manufacturers from the first day– this was selling as a generic, anyone could produce it – they wouldn't have a big incentive to go out and market and tell doctors, oh, don't worry, it's not addictive. They wouldn't be doing that. My view is, why don't we just pay for the research up front? Then you don't have that issue. And that's exactly what we did with Moderna. We paid for the research up front. We still gave them a patent monopoly, which makes zero sense, but if you pay for the research up front, then they don't have costs to cover. Currently, the government spends roughly 45 billion a year on biomedical research. If you look at what the industry spends, it's roughly 90 billion. So more or less, twice that amount. Now, suppose we look to replace what the industry spends. We were spending, say, somewhere around 130, 140 billion a year in prescription drug research and development. Well, then we would have paid for the companies in advance to do the research. Once it was approved, it could be sold as a generic from the first day.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:40:04] What these manufacturers become essentially are research companies. They stand to make far less money from the actual sale of the drug that they were paid to create.

DEAN BAKER: [00:40:18] And to my view, that's exactly what we want. I'm not looking to put any of these companies out of business, Pfizer, Merck, all the big companies, presumably would want to stay in business. They've had years of experience doing research, so they would put in bids on these contracts. They're going to research cancer drugs. You know, in my view, if they're asking me to design the system, everything's open source. So as soon as you get a lab result, you put it up on the web so everyone could see it.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:40:44] In your scenario, which I really I love. It's so socialist.

DEAN BAKER: [00:40:48] It's just the different type of capitalism. I'm not concerned that they could make as much profit as they do under the current system. I mean, maybe they will. I frankly hope they don't.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:40:59] We're talking about serving the public.

DEAN BAKER: [00:41:00] Yes, that that's our goal in designing the system. And we always have to remember patent monopolies are government policy because again, I don't know how many times I've argued with people on the go. You want to interfere with the market? I'm sorry, a patent monopoly is from the government. So, we're already interfering with the markets, we're deciding how best to do it.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:41:16] The situation that we're in now wasn't inevitable. Back at the beginning of the pandemic, the WHO set up a COVID-19 technology access pool to promote the sharing of knowledge. And there were early reports

about how the pandemic was going to change how the world does science, make it more collaborative.

DEAN BAKER: [00:41:37] There was a lot of cooperation early on that many scientists talked about. There were a lot of developments that were posted on the web, you had international cooperation, scientists in Europe and China and the United States. But then we quickly huddled down, you had the companies saying, – OK, we're going to work on this, we're going to work on that – they wanted to get patent monopolies and have vaccines, treatments that would allow them to make lots of money. And what in principle we would've wanted to see was collective sharing of knowledge and also open access to technology so that when these vaccines were being developed, anyone with the means to produce the vaccines would have been able to. We would have liked to have hundreds of millions of each of these vaccines available, maybe even billions at the point where they were approved. Maybe we would have made eight hundred million, a billion doses of the vaccine. And it gets to December. And turns out FDA looks at it and they say it's a no go. Well, that's unfortunate. But you go, OK, so the vaccines cost roughly two dollars each to produce, again, not an exact figure, but ballpark number. So we threw two billion dollars in the garbage. We've spent, in the US alone, somewhere in the order of five trillion dollars now, in COVID relief.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:42:53] This past October, there was a proposal put forward by India and South Africa asking the WTO to exempt member countries from some forms of intellectual property enforcement. Which would allow them to produce generic versions of COVID vaccines and treatments, and that was an immediate no go. But aren't there global provisions for emergencies just like this?

DEAN BAKER: [00:43:24] Yeah, this is a fascinating question. So, the TRIPS accords, trade related aspect of international property, part of the WTO as of 1995. Those require all countries to adopt US style patent laws, but they have special permission during emergencies to override those patent laws. Then special permission has very, very rarely been invoked, and the reason for that is the United States and I suspect European countries as well, have basically threatened retaliation.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:43:57] What kind of retaliation? Denying the drugs, they're not giving them anyway.

DEAN BAKER: [00:44:01] Various forms of trade retaliation. This came up with South Africa in the 1990s. We threatened to put up tariffs because they were going to do that on a drug that was used to treat AIDS patients. And this was, I think, 1999. Bill Clinton was still president then. The US threatened them with retaliation, where we would make it more difficult for them to export items to the US. Al Gore, of course, was running for president in 2000, a number of AIDS activists went to his speeches and they protested, and Clinton backed down on it because it was hurting Gore. Gore didn't want to be associated with it. I forget whether they actually issued the compulsory license because, again, you get this this dance where countries threatened to issue compulsory licenses and then often to prevent that from actually happening, the company agrees to radically reduce the price that that's happened several times.

BROOKE GLADSTONE - HOST, ON THE MEDIA: [00:44:52] I don't know if Pfizer or Moderna or Johnson & Johnson, if that one comes out, could even do the little jig of saying, oh, no,

we'll drop the prices, because they can't make enough. We're talking about hundreds of thousands of potential lost lives.

DEAN BAKER: [00:45:11] The pharmaceutical industry is saying, oh, well, it's complicated technology. They couldn't possibly produce it. Well, first of all, India, Brazil, some of the other countries in the developing world, they have very high-tech manufacturers. So, they're not working with sticks and rocks. India's generic manufacturers are as good as anyone in the world. Now do their facilities up and running? Probably not, they would have to retool them. So, what's the timeline we're talking about? Well, I'm not an expert in the technology, but what we do know is none of these vaccines existed back in March of last year and they were able to produce hundreds of millions of doses by November. What that tells us is in eight months, we could have hundreds of millions of doses if we had new factories ready to produce the stuff and maybe quite a bit sooner. I mean, I'd love to say that, well, eight months would be too late. We already have the pandemic under control, but I don't think anyone really believes that. So if if we said, OK, today, you know, we're going to allow anyone in the world who has the ability to produce this to go ahead and start converting a factory.

That would be a huge thing in terms of controlling the pandemic.

Vaccine Apartheid: US Media's Uncritical Adoption of Racist "Intellectual Property" Dogma Part 2 - Citations Needed - Air Date 1-27-21

ADAM JOHNSON - HOST, CITATIONS NEEDED: [00:46:18] To me, the big, from a messaging perspective or a PR perspective, the big bullshit factor in all this is that ever since the Georgia Floyd -- we talked about this at the beginning here -- but ever since the George Floyd protest in May and June of last year, everybody and their mother was talking about White supremacy. Wells Fargo was talking about White supremacy. Nike was talking about White supremacy. It sort of became trendy to kind of talk about this in an abstract term. And you know, most of that's good. Those kinds of public conversations, even if corporations cynically exploit them or whatever, it's better than the other thing.

And then you see this emerging vaccine apartheid happen at the same time. And then you see the *New York Times* say that poor countries won't get it till 2024 in the fine print. Oh, well, 27 of the 28 poorest countries are in subSaharan Africa. So, basically what we're talking about is a racial apartheid regime. We can speak in code and talk about poor and rich and developed and underdeveloped and all the kinds of stuff, but basically, per usual, the legacy of colonialism, Black and Brown people are going to get fucked over, and White people are going to be golden. And in fact, I'm going to have nine vaccines for myself, right? And we act like this is the *de jure* or *defacto,* I think *de jure,* I think the WTO is largely set up under a racial regime from the beginning, as I believe the post-World War II economic order was, we can get into that later. But it's shocking to me, even as cynical jaded media critic, it's shocking to me how little we talk about this in racial terms, how some dipshit on Twitter says something and it's the outrage of the day, and that's good. You know, I have no problem with that, but here we have an economic system that is going to kill hundreds of thousands if not millions of people based on a racist system that is, again, either *de jure* or *de facto,* I think it's both, and no one seems to frame it as a racial issue. When the *New York Times* reports on

it, it's ho-hum! Handwring! Poor people are going to die, and it's like, they're dying because they're Black, and as a system, we don't give a shit about Black people, whether they're in Africa or the United States. Why is that? Why do you think this is not framed in more starkly racial terms? I can't. To me, the term vaccine apartheid, I think is completely the correct term because it is an apartheid regime. And from your work, is there something to be gained by more aggressively looking at this in a racial lens and putting this in the context of racial justice so we don't act like again, this is just some law of nature that we study and we can kind of handwring about it, but there's nothing really we can do about it.

What do you think the utility is of putting it in those terms?

HEIDI CHOW: [00:48:43] Yeah, no, the term vaccine apartheid actually was used by the South African delegation at the World Trade Organization in the meeting just before Christmas when they were discussing the proposal to suspend patents during the pandemic, he actually said that the current situation where we're seeing bilateral deals being done and rich countries ignoring global collaboration actually reinforces a vaccine apartheid and enlarges chasms of inequity. So, actually, when a South African says that, you really have to take notice. And I think you're right. There is an unspoken undercurrent of what we're seeing is that lives across the global South matter a lot less than the lives of those in the rich North, and the lives of those in the global South, the Latinos, the Asians, the Black people, they seem to matter a lot less, they mattered a lot less during the HIV crisis of the 1990s that we've talked about. They matter a lot less when we're talking about dealing with cancer like I've mentioned, when we talk about hepatitis C and for all the other access issues that we're seeing, but we're also seeing it for things like, do you know, in global public health terms, there's actually a term called 'neglected diseases.' And what that means is that these are conditions that affect people in the global South but don't affect people in the rich North and in which we have zero investment to actually come up with treatments to save their lives.

And so I think the fact that we even have that category called neglected diseases, I think is, when I first heard it, I was completely shocked. I couldn't believe that we would value people's lives so little and that we wouldn't even bother to work out how we can treat certain conditions. So globally, we have about 4% of newly approved drugs which are for conditions that affect only poorer countries. And so, I think that the system that we have in place is driven by this market logic that reinforces that racial prejudice, because the pharmaceutical industry, the global pharmaceutical industry, is not actually based on the human right to health. It's not based on every individual having the right to access medicines, which is a vital part of the idea around rights of health. And instead, we have a pharmaceutical system that's based on a financial logic which says that whoever has the most power and has the most wealth get to live. And so there's something really wrong in that system in itself. Like you said, it's a racist model. It's an elitist model. It's not a model that's about human rights. It's a model essentially about extractive profits. And so there's a real tension in that model. And, you know, as something our organization has been doing the last few years is really pushing for alternatives and saying, actually, we need to transform this system. How can we even live with this system? For too long, we have sacrificed public health for market logic, and people are dying as a result of that. And there's just something so crazy in that. I mean, for me, there's a real moral and solidarity argument to say why we need to have equity in our global health system and equity in access to medicines. But certainly for something like COVID, what we see is it's more than just being moral and having solidarity with our fellow brothers and sisters across the world wherever they live. There's

also actually a real public health argument here because actually when it comes to things like COVID vaccines, if you leave large parts of the world without a vaccine, you're just allowing the virus to continue to spread and to transmit and ultimately to mutate. So, all these vaccines that we're holding in the rich countries, they're going to be rendered potentially ineffective when we're faced with different variants and mutations.

And so, it really underscores the saying that's been said quite a lot in WHO and even with political leaders who say no one is safe until everyone is safe.

That's one of the things that I'm hoping tht does come out at the COVID-19 crisis, you know, in that more than ever, we are all tied together. And actually this is not about sustaining a world where we have those who have and those who haven't, where we have those who can get vaccines and those who can't. Actually, that doesn't really benefit anyone ultimately.

Vaccine Priorities: Politics and Ethics. Gregg Gonsalves on Covid-19 - Start Making Sense - Air Date 12-30-20

JON WIENER - HOST, START MAKING SENSE: [00:52:34] Well, the CDC recommended that coming after the healthcare workers and residents of nursing homes should be two very different groups: people who are 75 and older, we're told there's 20 million of those, and 30 million people who are frontline essential workers. This is first responders, grocery store workers, public transit and postal workers, teachers, daycare providers. States don't have to follow this priority but a lot of them probably will. The question of who should come first and who should come next? Is that a question we should leave to the scientists?

GREGG GONSALVES: [00:53:15] There's lots of trade-offs in figuring out who gets vaccines in in a situation of scarcity like we have now. We don't have enough vaccines to go around. And so they're trying to thread the needle. They're trying to figure out, do you do it based on mortality? Maybe you should give it to everybody over 65. But then suppose you want to keep the trains literally running on time and schools open and daycares open and your grocery store open. Maybe then you make a question about societal functioning.

If we knew these vaccines prevented infection, maybe there'd be a case for not just looking at mortality but looking for where there's heavy concentrations of transmission in different occupational sectors, different kinds of settings. So, there's lots of things to think about in terms of these trade-offs, and the CDC did a reasonable job with it. The States are going to do their own sort of variations on the theme. The big question is why we're in this situation today where we're having to do this sort of make these Sophie's choices when we could have scaled up our production in a much more robust fashion and more importantly, gotten our delivery and implementation in order. You know, lots of vaccines are being sent out by the federal government. Not that many have gotten into the arms of the people who need them yet. So, there's a bottleneck post-supply that we have to address.

JON WIENER - HOST, START MAKING SENSE: [00:54:31] I want to just look at the question of the essential workers for another minute. Another factor that separates them from the over-75 group is if you're over 75, you can stay home. If you're an essential worker, we don't want you to stay home. We want you to go to work, and therefore we want you to put yourself in a position where you're more likely to be exposed. And the kind of people who do

essential work are working class people who are more likely to become superspreaders because they're in contact with many more people during the day than the over-75 people staying home. They live in multi-generational families more frequently, in crowded housing much more frequently. On the other hand, as you say, if they get the disease, they're more likely to recover than people who are over 75. And it seems to me, this isn't really a question for science. This is a question about ethics.

GREGG GONSALVES: [00:55:32] It is, but public health is not just a scientific field. It's hemmed in by politics on every side. It's not just ethics because there's some data that you can use to understand what risk is. Mortality, you're saying certain professions are more likely to be exposed to the virus, but we can figure that out by looking at transmission patterns, looking at mobility patterns, looking at other sorts of epidemiological information. So, these are societal choices we're making, not just epidemiological ones, but they have to be informed by evidence to the greatest deal possible. And the reason that it's left of the states: the states are going to have to make the real hard choices about what to do with limited supply.

The CDC is trying to give good guidance based on reasonable, scientific grounds. And, you know, people study these issues as a matter of academic discipline within public health. Public health isn't just epidemiology. There's bioethics; there's whole set of disciplines under the giant umbrella of public health that have been part of these deliberations, and this thinking, not just in the past six months, but for years and years and years about how to sort of deal with these kinds of choices in the midst of scarcity.

I learned from the *New York Times Magazine* panel that you were part of on Sunday that there's some fascinating evidence your profession has come up with about the concept of the over-75 group as being the most endangered. The average age of death from COVID for a White person is 81, but for a Latino person, it's 67; for a Black person it's 72. So, many Black and Latino people who die of COVID never make it to 75. Is that right?

Yeah. That's what, I think it was my colleague from Illinois who talked about this, what she's thinking about to doing in her state, because the prognosis for people with COVID under different racial and ethnic groups is disparate as we've talked about it. And one of the other things that's been talked about in the context of vaccine allocation is how do you deal with these health disparities. And it's not just essential workers or over 75's, because not all essential workers and all over-75's have the same kind of risk. Some of it's driven by minority status, ethnic status, but some of it's dealt with by preexisting conditions and other sorts of determinants of health. So I think one of the things that I was hoping to get across in the conversation with the *New York Times* was that it's pretty complicated stuff.

These are hard social and epidemiological choices, and there's no optimal answer. You are making value judgments, but reasonably informed judgments based on ethical principles, on scientific evidence ,on political reality.

"A Moral Catastrophe": Africa CDC Head Says Lack of Vaccines for the Continent Will Imperil World - Democracy Now! - Air Date 2-5-21

AMY GOODMAN - HOST, DEMOCRACY NOW: [00:58:30] In a webinar last month about Africa's COVID-19 vaccine financing and deployment strategy, South African president Ramaphosa, who's also the outgoing chair of the African Union, that's holding its meeting this weekend, said, quote, "The painful irony is that some of the clinical trials for these vaccines were carried out in Africa." So, Dr. Nkengasong, talk about that. Talk about Africa being used as the experimentation site, but then, when it comes to reaping the benefits of the vaccines that prove to be safe, you're last in line.

JOHN NKENGASONG: [00:59:06] I think it's unfortunate. When I used the word that we may be heading towards a "moral catastrophe," I meant it. In 1996, when drugs to treat HIV were available, it took 10 years before those drugs were finally accessible on the continent. And between 1996 and 2006, 12 million Africans died — and, I underline, unnecessarily. I think we should really make sure that the history, that sad page of our history, does not occur again, especially with this pandemic. So I think we are very, very worried that we may be heading towards that direction if something is not done and done urgently.

I think, in 1963, Martin Luther King said, mentioned or characterized the challenges that they had at that time as the "fierce urgency of now." I don't know of any situation that we are living with today that doesn't meet that scenario other than rapid and timely access to COVID vaccines broadly, not just in the developed world, but in developing countries.

And President Ramaphosa and Chairperson Moussa Faki of the African Union Commission are leading a charge to make sure that Africa is really not lagging too much behind. We have secured 270 million doses of vaccines and an additional 400 million doses of vaccines from the Serum Institute in India. So we are making some progress in that area, but it will not be easily distributed. We have to mount an extraordinary, historic effort to vaccinate up to about 30% of our population before December in order to begin to slow down the spread of the pandemic in Africa; otherwise, the consequences will be very, very devastating on our continent.

AMY GOODMAN - HOST, DEMOCRACY NOW: [01:00:51] So, talk about the deals that must be made with pharmaceutical companies and other countries. I mean, you have places like Canada and the United States that ultimately are ordering hundreds of millions of vaccines. And actually, I think in Canada it's something like — will have enough to vaccinate their population four or five times, before you see countries getting vaccines in Africa. So, what kind of responsibility does a country like the United States have? Here in this country, people are saying, "No, we can't get vaccines. Why should we care about what's happening in Africa?" Explain why Africa is so critical.

JOHN NKENGASONG: [01:01:33] Africa is so critical because we are part of the globe, and Africa is a continent of 1.3 billion people. And again, we live — we are seeing and witnessing a virus that is spreading very quick. The globe, as a whole, has recorded more than 100 million cases of COVID-19 in just one year. So, that is extraordinary. The last time we saw such a fast-moving and impactful virus was in 1918 during the Spanish flu pandemic. So, it is a threat globally.

I think it has to be very clear that no part of the world will be safe until all parts of the world are safe. I think we are in this together. We either come out of this together or we go down together. There is no middle ground in this. So, that is why the United States, Canada and

other developing worlds must work collaboratively and in a coordinated fashion with the African continent, so that we begin to get timely access to the vaccines.

The countries that have secured additional or excess doses of vaccines can do a very simple thing and the right thing, so that history will remember them right: to reallocate those vaccines into either the COVAX Facility or the mechanism that the African Union has put in place so that we can begin to rapidly vaccinate our people. I use the word “rapidly” purposefully. If we have vaccines later in the year, they become meaningless for us. We have to have vaccines now, so that we start vaccinating our people on a large scale and then stop the spread of the new variants that you just indicated earlier.

Summary

JAY TOMLINSON - HOST, BEST OF THE LEFT: [01:03:04] We've just heard clips today, starting with *CounterSpin* explaining the troubled vaccine rollout. *On the Media* discuss the messaging breakdowns plaguing our understanding of the vaccines. Rachel Maddow introduced the racial divide in our pandemic response. *On the Media* discussed strategies to deal with vaccine skepticism in Black communities. *Democracy Now!* discussed Israel's approach to vaccinating Israelis but not Palestinians. *Citations Needed,* in two parts, explained the immorality of maintaining intellectual property rights for the vaccine manufacturers. And *On the Media* spoke with Dean Baker about the same thing.

That's what everyone heard, but members also heard bonus clips from *Start Making Sense* in which they discuss the tangled web of vaccine distribution ethics, and *Democracy Now!* in which they speak of the coming moral catastrophe should the world fail to appropriately address vaccination needs in Africa. For non-members, those bonus clips are linked in the show notes and our part of the transcript for today's episode, so you can still find them if you want to make the effort, but to hear that and all of our bonus content, which includes a full conversations featuring myself, Amanda and our research staff, Deon and Erin, in free-wheeling conversations that sort of give you a behind the scenes look at how the show gets made and the thinking behind it, all of that can be delivered seamlessly into your podcast feed when you sign up to support the show at bestoftheleft.com/support or request a financial hardship membership, because we don't make a lack of funds a barrier to hearing more information. Every request is granted. No questions asked.

And now, briefly, we'll hear from you.

Thoughts on "moral panic" - Christina

VOICEDMAILER: CHRISTINA: [01:04:53] Hi Jay, this is Christina,

I would say that moral panic would be more like: "there are millions of babies being killed every year by abortions." Or: "Our society, God's kingdom on earth, needs to be pure so we need to discipline or expel the unclean." Or: "there are less and less good paying jobs for me every year." Or: "The other side keeps trying to take all my hard earned money away."

None of these thoughts are hateful and every time the left classifies these thoughts as hateful they are attacking right morals. Christian morals. By the way, losing the government is also a moral panic.

I do not remember who posited that the fight the two sides are having is a fight over framing but they are correct. Aggravating this problem is: "if it bleeds, it leads."

I wish I had suggestions on how cable news could report people coming together without calling it a puff piece. I swear, "loving your enemy" is way harder than fighting them.

Thank you, Jay.

Final comments on corporations resisting reasonable regulation to avoid setting precedents

JAY TOMLINSON - HOST, BEST OF THE LEFT: [01:05:43] Thanks to all of those who called into the voicemail line or wrote in their messages to be played as VoicedMails. If you'd like to leave a comment or question of your own be played on the show, you can record a message at (202) 999-3991, or write me a message to jay@bestoftheleft.com.

So that quick comment on moral panic, just for our context, is in response to another voicemail from the end of January, and the idea was speculation that is what we are seeing, is what the Republican party is pursuing, equivalent to a moral panic, similar to the way the War of the Worlds radio broadcast created a panic? And I went and looked up the definition or some context for that term and my ultimate conclusion was, I don't know. I'm not sure I have a good enough grasp on the concept of moral panic to comment on it. But I got some clarity when, I think it was talking with our researchers, I think maybe Deon had responded to this idea and just put it in the frame that made it click into place for me, that moral panic can be one of many tools in the toolbox of a group of people pursuing their ends.

And this message that we just heard, I think helped sort of solidify that for me. That moral panics over individual ideas, individual policy concepts, or whatever can be pursued in sort of these niche ways, but to refer to them as moral panics can still be relatively fitting. And absolutely I think pursuing a line of false hoods that leads people to believe that an election was stolen, something that is very, very dramatically impactful on the nation is absolutely in line with following the moral panic outline. Encouraging people to believe that they have morals on their side and to raise the stakes high enough that it incurs panic. So yeah, it took a couple of rounds for that to sink in, but I'm glad we finally got there.

Secondly today, I wanted to make a point, playing off of something that was said in the show. There was talk about intellectual property related to the vaccines and how the primary reason to oppose the total wiping away of intellectual property in the name of saving lives around the world is about creating a precedent. That rang so true to me, that if these companies could pursue this idea or have it imposed on them that, "look, we're going to strip you of your intellectual property rights. We're going to have the information you have spread to as many manufacturers as possible. We're going to create as much vaccine as possible all around the world simultaneously." If those drug companies thought this is going to be a one-time thing, they probably wouldn't fight it that much to be honest, but it would set a bad precedent, they fear, and they would then think what's to stop them from doing this again next time and chipping away at our profits, not just in this one-off case, but in an ongoing way.

And what it made me think about was the fight happening between Google and Australia right now. If you're not familiar with the story, Australia has come up with what I think is a pretty interesting regulatory solution to the tension between local media, local journalism, and the internet, and how it is very hard for local media outlets to survive in a globalized media environment. Especially when it happens primarily online where the news and information is almost entirely free. So the idea that they've come up with is to have a fee built in for search engines that would go to local media outlets in Australia whenever someone clicks through from the Google search engine or whatever search engine to the Australian local news site, so that the local news journalism gets a new source of revenue and the search engines, which are profiting off of the existence of that local media journalism because people are searching for it and they want to find it and Google gets to serve ads in those cases, that they are profiting off of it, but pay nothing back to what is essentially the source of their profit—the content creators.

So Australia came up with this idea and to be honest, I haven't looked deeply into the nuances of the bill and the size of the fees to be charged, but what I am willing to bet is that the fees that Australia wants to charge, the taxes to be paid to these local media entities, does not exceed the profit that Google earns on each of those search queries, because that would be ridiculous. That wouldn't make any sense. So they, as regulators would know, we just need to charge a percentage of whatever earnings the search engines are creating for themselves. But Google is responding by saying, if you put this law into practice, we will pull out of the country of Australia entirely.

Now, is that because Google could not continue to make a profit by serving search queries in Australia under this new law? Absolutely not. There is no reason to think that that would be the case. And if it were, by some strange occurrence, the solution would be to ask to renegotiate the fees or tweak it around the edge here or there. But what they are doing is trying to avoid setting a precedent. That is it. They know that they could comply with this law and still be profitable. Another one of their excuses or complaints is that it's complicated, it would be too complicated. Well, we could have a discussion about how to streamline it. We live in the 21st century and we're dealing with some of the most technologically advanced companies in the world, I bet we could figure it out. But no, they don't want to figure it out. They don't want to come to a compromise.

They are going to pull out of Australia entirely because they know that we could figure it out. They know that they could continue to be profitable by serving these search queries, but having to pay something back to the local journalism that creates the content that the people are searching for. They just don't want to set a precedent that could spread worldwide and dramatically impact their profitability. Obviously they would still be profitable, quite profitable, just not as profitable, and that's a precedent that they're not willing to set. So I just bring this up in the context of the vaccine rollout and the pharma companies to draw this parallel and point out that this is an incredibly important framing to keep with you anytime you hear about disagreements between regulators and tech companies or big companies of any kind. When the arguments being made by the companies are along the lines of "this would be too burdensome. This would hurt our profitability too much," just keep in mind, it's probably not that they couldn't go along with it, they just don't want to give an inch lest the regulators realized that what would actually be good and just would be to take a mile.

As always, I would love to hear from you on this or anything else that you'd like to comment on. Keep the comments coming in at (202) 999-3991 or by emailing me to jay@bestoftheleft.com. That is going to be it for today. Thanks to everyone for listening. Thanks to Deon Clark and Erin Clayton for their research work for the show. Thanks to the Monosyllabic Transcriptionist Trio, Ben, Dan, and Ken for their volunteer work, helping put our transcripts together. And, thanks to Amanda Hoffman for all of her work on our social media outlets, activism segments, graphic design, and so on and so on.

And of course, thanks to those who support the show by becoming a member or purchasing gift members at bestoftheleft.com/support as that is absolutely how the program survives. And now everyone can support the show and earn rewards like our super secret and highly coveted Best of the Left artwork for your phone or tablet by telling everyone you know about the show by using our Refer-o-Matic system, check that out at bestoftheleft.com/refer.

For details on the show itself, including links to all of the sources and music used in this and every episode, all of that information can always be found in the show notes on the blog and likely right on the device you're using to listen. So coming to you from far outside, the conventional wisdom of Washington, DC, my name is Jay!, and this has been the *Best of the Left Podcast* coming to you twice weekly thanks entirely to the members and donors to the show from bestofleft.com.