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Global Inequality and the Fracture of (Proactive) Solidarity

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Abstract: In this paper, I wish to examine what is meant by this new concept of "international solidarity". The study will be presented in a number of sections, beginning with a general introduction that sets out the problem and emphasizes the importance of the document produced by the United Nations Committee on the Elimination of Racial Discrimination. I will then detail certain general characteristics of the normative concept of solidarity and clarify a number of methodological assumptions and historical data. Thirdly, I will forward an in-depth discussion on the analysis of and debate around the concept of solidarity in its bioethical context, both prior to and during the pandemic. Finally, I will attempt to analyze what I call the 'rhetoric of solidarity', as set forth by international organizations and political leaders of the Global North during the pandemic, understanding it as aid in the face of the morally objectionable global inequality and injustice caused by a number of factors, the principal one being the current system of patents imposed by the WTO and the conversion of vaccines into commodities and even 'positional goods'.

Keywords: international solidarity; United Nations; bioethics; injustice

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1. Introduction

Between 11 and 29 April 2022, the United Nations Committee on the Elimination of Racial Discrimination produced a historic and opportune document, in which it expressed its deep concern "that the vast majority of COVID-19 vaccines have been administered in high- and upper-middle-income countries and that, as of April 2022, only 15.21% of the population of low-income countries has received even one vaccine dose"[1]. The statistic is unquestionable and highlights an unequal and morally objectionable distribution, which "replicates slavery and colonial-era racial hierarchies; and which further deepens structural inequalities affecting vulnerable groups protected under the Convention". The document states that this is evidence of "a global system privileging those former colonial powers to the detriment of formerly colonized states and descendants of enslaved groups".

Equating global vaccine-access inequality to colonial slavery and racism led the Committee to label this as a case of "structural inequality" that discriminates "on the grounds of race, colour, descent or national or ethnic origin", and is unable to correct the effects of racism that has its roots in slavery, colonialism, and apartheid. In addition, the powerful legal and moral tone of the document provides organizations and institutions that defend local, national, and international human rights[2] with very strong arguments in favor of renewing and increasing their demands.

The document makes a number of important points that stress the persistence of privileges. Firstly, that the majority of authorized vaccines are subject to intellectual property law, leading to unequal global vaccine distribution and, consequently, insufficient supply in certain regions of world, and that urgent action needs to be taken regarding intellectual property law. Secondly, it names a number of nations it considers responsible for this situation. Among them are Switzerland, Norway, the United Kingdom, and the European Union itself. It also emphasizes the tacit silence and complicity of the United States of America, which blocked the proposal by India and South Africa to the World Trade Organization (WTO) in October 2020 for a temporary waiver of intellectual property

protection for health technology regarding the prevention, containment, and treatment of COVID-19, a measure that had been imposed in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which was later revised in May 2021. Lastly, that such countries insist on protecting their intellectual property monopolies over COVID-19 health technologies. One such case is again the USA, which, while declaring its support for a limited exemption of vaccine patents, failed to use the tools at its disposal [1] (p. 2).

None of the above is a secret. However, acknowledging a global system of "structural" racism and identifying the obligation of nations to contribute to its eradication wherever it is present means accepting certain extra-territorial obligations in order to guarantee the implementation of economic and social rights for all, even those beyond their borders[3]. Finally, the document called for international solidarity to tackle the effects of the pandemic, especially among the marginalized.

It is not my intention to propose a new definition of the concept of solidarity, but to show that there is no unified definition in bioethical and political discourse, but some overlap as well as room for contestation of its normative implications. I wish to examine what is meant by this new concept of "international solidarity". Taking into account the scope of the above-mentioned pleas for solidarity, I will precede it with the adjective "proactive". My main aim is to ascertain what meaning we can give to international solidarity, as mentioned in the document, which admits the need for "urgent measures in relation to the intellectual property regime" [1] (p. 3). In contrast to the rhetoric regarding global solidarity expressed by some political leaders and organizations in the early stages of the pandemic, the document suggests certain causal relations and other obligations of member States. These are a tool with which to investigate, pursue, and fight inequality with regard to access to medicine and vaccines during pandemics.

The study will be presented in a number of sections, beginning with a general introduction that sets out the problem and emphasizes the importance of the document produced by the United Nations Committee on the Elimination of Racial Discrimination. I will then detail (II) certain general characteristics of the normative concept of solidarity and clarify a number of methodological assumptions and historical data. Thirdly, I will forward an in-depth discussion on the analysis of and debate around the concept of solidarity in its bioethical context, both prior to and during the pandemic. Finally, I will conclude that there is a contrast between the rhetorical use of the concept of solidarity and international aid, and the reality that there is a global enforcement of patents that prevents the production of and wider access to medicines and vaccines in poor countries.

The development, stockpiling and distribution of COVID-19 vaccines confirm the old hypothesis revived by Sandel in a most interesting book published in 2013, which makes it clear that markets are not inert [3] (p. 12). They leave their mark and expel any value they have been unable to turn into commodities, by which we mean everything that can be sold or exchanged on the market.

2. The Concept of Solidarity: A Brief Methodological and Historical Excursus

There is no doubting the important role played by solidarity in confronting the pressing social problems that arise when capitalism faces crises, such as the current health, financial, food, and climate crises. Recent waves of solidarity are, in the best of cases, "attempts to construct an institutional counter-fabric of self-defense within the existing social order, and have little to do with efforts and proposals to construct a new, alternative social order"[4] [7] (p. 222).

I will begin with a brief summary and some historic examples of the meanings contained within the current concept of social and political solidarity regarding public healthcare, before then analyzing the political and academic use of the concept during the COVID-19 pandemic. I will re-ask some of the questions raised in a powerful article by Arnsperger and Varoufakis in the first decade of this century. Does the concept serve any analytical use? Does it open new analytical perspectives that can be used to approach the

subject of health care and access to medicines in the midst of a crisis of global capitalism? [8] (p. 157).

The current concept of solidarity in social, political, and bioethical theory and philosophy is imprecise. Arguments in favor of solidarity frequently fail to define the term or resort to tacit synonyms such as altruism, reciprocity, and generosity. Nonetheless, various definitions exist. Some emphasize subjective motivational aspects, such as empathy and identification with others, and others place it within the framework of collective action and institutional groupings, whether national or international. The fact is that the word solidarity and its concept generally arise when the social fabric is disintegrating, in some cases, as a curb on dispossession, injustice, global inequality, and uncertainty, as in the current crisis of capitalism. In others, it is a way to forge community ties at times of crisis, but entails no commitment to press for more profound changes. Although the meaning of solidarity and its legal dimensions will be discussed and debated for years to come, the effort is undeniably welcome, at least in progressive political thought.

The relevance of the concept of solidarity became clear on the founding of the welfare state in the post-war years of the 20th century. The worlds of capital and labor united to agree on the establishment of important social policies, even though the idea was not to create a new, alternative social order. Authors now writing on public health issues demand solidarity, and it has been, and still is, a staple element in political discourse, documents of international organisms, and academic publications on global health prior to and during the COVID-19 pandemic crisis.

From the methodological perspective, my research is inspired by the ideas propounded by Reinhardt Koselleck, who, along with Contze and Brunner, was a pioneer of conceptual history (Begriffgeschichte). For this specific study, it is useful to recap of some of Koselleck's more methodologically interesting premises on the relationship between the fundamental regulatory political concepts and historical experience. His hypothesis is that the meaning of words and the state of things infrequently match each other or evolve uniformly and in parallel in the long term. Thus, the most important task of conceptual history is to analyze possible convergences, displacements, and discrepancies between the concept and the state of things that arise in the course of history, and without which the construction of a political and linguistic community would be impossible [9].

The documents produced by the World Health Organization (WHO) and other international bodies during the pandemic made it clear that the use of regulatory concepts such as justice and equal access to healthcare had been displaced in favor of a concept of solidarity, which was generally in line with the concept of equity. I will show that this displacement was due, among other reasons, to certain changes in the state of things related to global health and medicines, which compelled the production of a regulatory language that would adapt to the facts and, in particular, to changes within the WHO and WTO dictates on patents.

Koselleck and the members of the school worked on what they felt were the key normative concepts. It should be stressed that, while the concept of solidarity does not appear as such in the Geschichtliche Grundbegriffe, that of fraternity does. Even if we leave aside the long and fascinating dispute regarding what these key normative concepts were or should have been, I believe the idea to be methodologically very powerful, specifically in what Koselleck termed the relationship between the "experiences of the past, and expectations of the future". He states that the semantics of a concept contain past experiences, which give weight to, and sometimes condition, its expressive force. Concepts, but not words, are a receptacle that contains both past experiences and future expectations, which explains their changes over time. No less important is the observation that political-social concepts can only be interpreted within the framework of networks or structures of relationships formed by kindred concepts or counter-concepts. Using these methodological contributions, I am interested in partially reconstructing the concepts of "global solidarity" and "international solidarity" which were frequently cited in bioethical discourse, some documents, and international discourses both before and during the pandemic. The aim

is to note the differences between the various uses of solidarity as a response to a state of things such as the pandemic.

León Bourgeois, considered to be the father of solidarism in Europe, wrote the pamphlet Solidarité at the end of the 19th century. This was a time that saw the eclipse of the political fraternity spawned by the French Revolution. France, Germany, and England saw the birth of a social philosophy that aimed to provide a context for solidarity amidst the political upheavals of a Europe in which capitalism, inequality, and poverty were expanding alarmingly. This supports the thesis that solidarity is a concept that arises in times of crisis in order to reach a consensus, among other reasons because, as Bourgeois warned, "at first (the word) was used as a simple variant of fraternity. Would we be right in saying that the word articulates a new idea that implies an evolution in global thought? It is as if the very syllables could solve every problem" [10] (p. 7). During the current pandemic, something similar is happening to the word 'solidarity' and its concept as used in some political and academic discourses and texts.

The development of the concept of social solidarity across different European political-social contexts is well illustrated in Arnsperberg and Varoufakis' article from 2003, and I share their diagnosis and concerns:

> "While the consensus regarding the state's responsibility for sustaining the unfortunate and empowering the weak remained intact, the notion of solidarity invoked images of polish dissidents and striking British miners. However, for some time now the tide has been going out on many arguments in support of state-welfare systems. As it recedes, the few weedy posts it leaves behind seem to have inspired a variety of European politicians and institutions to re-evoke solidarity, often as a means of counter-balancing the heightened emphasis on entrepreneurship and self-reliance. However, it is not at all clear what calls for 'greater solidarity' could possibly mean. Is it a euphemism for organized philanthropy?"[5] [8] (p. 157).

This idea of solidarity linked to awareness of the crisis, and the result of the recognition of social vulnerability in face of increasing inequality in health has permeated the bioethical and political discourse to different degrees of radicalness before and during the COVID-19 pandemic.

3. Regarding Uses of the Concept of Solidarity in Current Bioethical Discourse

As a result of the global public healthcare crisis, solidarity has been a frequent subject in the discussion of bioethics both before and during the pandemic. Reasons of space mean that I do not intend to provide exhaustive references to or comments on the extensive bibliography, neither will I widely quote texts. In this section, I will concentrate on expounding a proposal that has gained strength in contemporary international discussion of bioethics[6]. Here, I acknowledge my debt to discussion of the subject in the Global South and particularly in my native Latin America.

The publication in 2011 of Prainsack and Buyx's "Solidarity as an Emerging Concept in Bioethics", known as the Nuffield Report, led to a wide-ranging and much merited debate on the definition and scope of the concept (or principle) of solidarity, as well as the possible contribution it could make were it to be incorporated into the theoretical framework of classical bioethical theory from the English-speaking world, that of the principles of autonomy, benevolence, non-malfeasance, and justice[7]. Chapter 7 of the report gives a definition of solidarity within the context of the Avian Flu epidemic[8].

The most impactful point of the Nuffield report is the proposal of a three-tier solidarity. This is merely descriptive and is not intended to signify a regulatory hierarchy. Level one is termed 'interpersonal solidarity'. This becomes established in increasing levels of institutionalization that range from shared humanitarian group practices (level two) to legal and contractual obligations with different scopes (level three). A clear example of this final level is the founding of public, universal health systems and the Welfare State in the European post-war years. The authors argue that the possibility of an established solidarity

in institutions with differing degrees of reach from group to national and international depends on existing interpersonal solidarity, one of the defining characteristics of which (as opposed to altruism) is that the humanitarian action is always "the recognition of relevant similarities between different groups".

As we shall see, the difference in the concept of interpersonal solidarity in terms of identification and reciprocity, symmetry of preferences, wishes and interests, and the order of preference suggested between the distinct levels of solidarity results in a pessimistic diagnosis regarding the role of solidarity in pandemics, and particularly regarding governmental calls for solidarity. All of this does not imply that the report lacks descriptive power, nor that it attributes this pessimism to other contexts of solidarity in health, such as individual participation in bio-banks, which involves paying some costs for the sake of communal benefit.

Prainsack and Buyx's definition of interpersonal solidarity is that it is "a practice that expresses the will to help others with whom they recognize a relevant similarity". When such a definition of solidarity is applied to pandemics, the authors note firstly that:

> "Pandemics raise the question about solidarity at several levels: at the level of solidarity between individuals and their willingness to accept costs to assist others in such a situation; at the level of relationships between individuals and state actors, as the latter may intrude into spheres of individual freedom and decision making for the sake of avoiding or mitigating societal harm; and at the level of relationships between countries (and other global actors). The latter dimension has received attention in the context of debates on global public health and global bioethics [. . . . .] We believe that because the recognition of sameness with others plays such an important role in fostering solidarity at the level of the individual, it is unreasonable to expect that entire populations—where risks and stakes are very unevenly distributed—will accept the costs of containing pandemics out of solidarity with each other" . . . [11] (p. 71)[9]

Therefore, given that the costs of containing pandemics should be borne by the entire population and not merely a sub-group, and that pandemics take place over a relatively short period of time in which people run common risks and have very different interests, the ability to mobilize solidarity to aid public health measures is very limited.[10]

It should be stressed that this pessimism does not mean that the authors are opposed to restrictive public health measures, nor that they exclude the role of solidarity in other areas of public health. What it does show is their conviction that, when applying the necessary measures of contention, governments should use alternative strategies that do not call for solidarity since, on an interpersonal level—necessary for the institutional establishment of solidarity—pandemics represent a case in which the mobilizing potential of solidarity to obtain desirable ends in a public health context is highly limited[11] [11] (p. 72).

In Chapter 7 of the 2011 Nuffield Report, a starting strategy is taken to be what is seen as a "hypothesis of common sense" regarding a supposed solidarity between states in pandemics. This is then questioned; given that all countries share a degree of vulnerability to a pandemic, and that all need support, it would be logical to think that they would be willing to share the risks and benefits in order to eradicate a scourge that affects humanity as a whole through international humanitarian actions in aid of the most affected nations [11] (91ff). The text eventually rejects this initial hypothesis for the following reasons: (a) because one cannot expect nations to act together in solidarity and be able to recognize a certain similarity in a relevant aspect which makes them feel connected in solidarity, as individuals commonly do; (b) because factors such as size, wealth, political structure, and infrastructure differ from country to country, thus impeding them from recognizing similarities "in relevant aspects"; and (c) because mutual assistance between countries during pandemics is more difficult to justify, given that there is no 'super-government' that can dictate and enforce global norms.

In my opinion, there are at least two problems with this argument, some of which Prainsack herself has since recognized. The first is the very definition of solidarity and, in particular, the independent explanatory variable concerning how interpersonal solidarity work; the second is to suppose that, in health questions, and particularly those related to vaccines and medicines, "we do not have a super-government that can issue and enforce global norms that oblige countries to offer mutual assistance".

Let us begin by commenting briefly on the second problem. While there is clearly no global super-government that can demand mutual aid between nations, there are institutions and organizations such as the WHO. However, recent decades have seen the WHO become subject to the dictates of the WTO, which imposes its regulations in a way that is far from democratic. This makes it more difficult for altruistic actions to become reality; a case in point is the COVAX program, the working of which has become dependent on philanthrocapitalism[12]. I will return to this point later.

In my opinion, the first problem obeys the explanatory variable in the definition of the concept of solidarity, from which the other dependent variables spring. The variable tells us that the existence (or not) of interpersonal solidarity depends on "the will of individuals to aid others with whom we feel a similarity in a relevant aspect", and that this willingness is almost exclusively moved by the subjective interests or preferences of people and states who are unaware that there may be other kinds of humanitarian needs and struggles based on reasons that are independent of individual desires and preferences.

The authors' hypothesis is that, without this willingness of individuals to help others they feel akin to (level one), shared humanitarian values (level two) cannot be created and supportive social systems such as the Welfare State (level three) cannot be constructed. The hypothesis is partly credible, but depends on an independent variable that has been insufficiently examined from the perspectives of moral psychology and human motivation; more importantly, deeper consideration of the link between the absence of solidarity and structural inequality is lacking. This criticism is valid for the report itself, although Prainsack admitted the limits of the original proposal and later assumed a more radical position, accepting, among other points, that:

> "Person-to-person solidarity is important, but focusing only on solidarity at this level risks ignoring more important systemic and structural factors. We need to address the causes of inequality and strengthen solidaristic institutions". [17] (p. 130)

And later, in a brief and radical text written with Hanna Kienzler in 2021:

> "At present, a lot of 'solidarity' in the context of global health cooperation does not deserve this title. Even political leaders who regard the pandemic as a common global threat respond by using language of 'charity', whereby high-income countries of the Global North share their left-over resources with resource-poor countries in the Global South . . . " [14] (p. 2)

I will return to this latter point in the next section.

The authors are quite correct when they refer to the supposedly co-operative nature of vaccine sharing as 'charity'. We should remember that institutional charity is a relationship between the giver and the receiver and that the receiver is unable to reciprocate. Institutional charity between unequals leads nations to assume a supposed 'debt' that can never be repaid. This debt is unjust, being the result of a prior global injustice, resulting from the global enforcement of patents of medicines

That said, and in line with the radicalization of Kienzler and Prainsack's proposal, I believe that criticisms of the Nuffield Report need to be examined in some depth. It was, and is, the report with the greatest impact in the current bioethical debate. Interpersonal solidarity was first defined and explained, later to be given form in group, legal, national, and international institutionalization. While the report took into account the purely subjective motives and reasons behind solidarity, it failed to examine structural causes such as inequality and poverty; this has the effect of transforming solidarity into international

charity. Moreover, as Prainsack later recognized, making the institutionalization of any level of solidarity depend on the existence or not of an interpersonal will that is moved by the identification of its internal motivations in the other groups impedes the recognition of structural and systemic factors. The 2011 report does not recognize the possibility of solidary actions motivated by external reasons different to one's own desires and preferences; by this, I mean the reasons that concern other groups of people with whom I cannot personally identify. As Arnsperberg and Varoufakis state:

> "Most economists would dismiss this idea and would associate non-optimising choices with bounded rationality. This is due to their insistence that reasonableness reduces to instrumental rationality [...] However, there is no reason why this identification should be taken for granted. Unlike homo economicus, reasonable people can pass judgement on their own passions or desires and one way in which they rebel against the tyranny of preference is to do what is 'right' by some group of persons who are 'entitled' to their generosity. To the extent that this 'rebellion' is expressively (as opposed to instrumentally) rational, and indeed finds expression in solidarity with sufferers of some misfortune, human motivation is under-explained unless solidarity is acknowledged as an important and distinct aspect of the human experience". [8] (p. 176)[13]

Conversely, we should remember the importance of not confusing solidarity with justice, as Ángel Puyol posits in a 2017 article from which I quote below; for example, when attempting to justify public healthcare measures that improve global health and aid in reducing healthcare inequalities, or when demanding that individuals act in benefit of the health of the overall population without the benefit to the individual being clear, as in the case of vaccinations and other restrictive measures during pandemics [18] (p. 35).

> "Justice does not necessarily include solidarity, or solidarity, justice. There can be a conflict between both. For example, organ donation is a supportive action, but making it obligatory could be unjust. Conversely, when health resources are limited, giving healthcare to someone who has freely exposed themselves to illness may seem unjust to those patients who have been unable to avoid exposure and no longer have access to these resources" [18] (p. 36).

As Puyol states, some cases of institutional solidarity, such as progressive taxation and universal public healthcare, do not necessarily depend on a personal supportive motivation, even when they can be explained in terms of solidarity. We should not forget that there is an old alternative conception of solidarity that has greater legislative power, founded on the rights of all [18] (pp. 42–43). Nonetheless, this is unfortunately not the solidarity invoked in most of the political discourse and official documents produced during the on-going COVID-19 pandemic.

4. Conclusions: Global Inequality and the Fracture of Proactive Solidarity

This study began by discussing a recent document produced by the United Nations Committee on the Elimination of Racial Discrimination calling for international solidarity and denouncing unjust vaccine distribution during the COVID-19 pandemic. This was seen to be a legacy of structural colonialism, as those nations that had been colonizers kept and stockpiled vaccines that could have been distributed to ex-colonies, now subject to the philanthropic charity of the former. The document goes further than most previous United Nations documents and, while clearly insufficient, may be a tool in the fight against discrimination in access to vaccines and medicine.

That said, what happened to the much-vaunted solidarity during the pandemic? Why are the poor of the Global South who have no access to healthcare only provided with vaccines when the hoarders donate them in the name of charity and under their own criteria? Many things happened, none of which were new, and all of which were only to be expected and were perfectly documented. One such example is the fact that, while the regulations of the WTO, which controls and administers the income produced by medicine

patents, are binding, the WHO lacks the necessary and sufficient legal means to put a real global program of health protection into practice. Furthermore, philanthrocapitalism slowly took control of the WHO, which was created in 1948 as the public organization within the United Nations that specialized in global public health. Over the last 20 years, public funding by the 194 member nations has been far lower than public or private contributions (some 80% of funding), including the philanthropic donations of Bill and Melinda Gates. As Germán Velásquez tirelessly repeats, the excessive dependence on voluntary contributions, whether public or private, makes it impossible to fix global public health priorities [19].

The pandemic proved once more that inequality kills and that, in as far as money can buy almost everything, markets become mechanisms for the distribution of goods and services, even those that were previously recognized internationally as universal rights. Furthermore, some of the vaccines—those stockpiled by the Global North, the owners of patents and makers of profits—became 'positional goods', products, and services, the value of which mostly comes from their attraction when compared to other substitute goods, things whose usefulness for an individual depends on the behavior of others[14] [21] (p. 3). This is further evidence that markets are not inert, not only do they assign goods, but they also express and promote certain attitudes with regard to the goods that are exchanged. It also shows that the greater the number of things that can be bought, the greater the power of the owners of the goods and services to dominate the rest [3] (p. 12).

What is currently happening with the WHO is a clear example of money encroaching into the internal structure of an organization that was set up to guarantee the universal right to health, medicines, and vaccines. Almost 90% of the WHO's medicine programs are directly financed by the Bill and Melinda Gates Foundation. In addition, 80% of the WHO's budget comes from voluntary public and private donations (and not from states), concentrated in various powerful countries, in the Bill and Melinda Gates Foundation, and in the pharmaceutical industry. In the case of the vaccine Alliance (GAVI, a public/private fund), 60% of its financing comes from the pharmaceutical industry itself and donors from the aforementioned countries.

The COVAX program, cornerstone of the Access to COVID-19 Tools Accelerator (ACT), which began in 2020 as a humanitarian program designed to reduce inequalities in health through which countries would receive vaccines based on a criterion of risk, population size, and availability of healthcare and basic resources, ended up in the hands of the richest countries.

However, what currently exists is a system of patents at the service of the multinational pharmaceutical companies, which undermine the initial aims of the program and impose their own interests, greatly hindering the production of all the vaccines needed. This causes shortages which, in turn, have the effect of both prolonging the pandemic and making it chronic. In addition, a system in which vaccines are allocated to the highest bidder means that a few countries corner almost all production, condemning others to an uncertain and anxious wait. Talking of equity in this scenario is mere semantic demagogy. Those who are condemning us (Big Pharma), along with the minions who protect and cover for them (Cepi, GAVI and COVAX), try to confuse us in order to justify their scandalous actions and hide injustice. Real equity and solidarity must also demand the exemption of patents and the obligatory granting of licenses to those nations that request them to produce vaccines that have been shown to be effective. The WHO, and not the WTO, should once more fulfil its role of judge and leader as it does with the validation of emergency vaccines, and regain its initial humanitarian spirit, independent of the subjective interests and motivations of interested parties.

We should be able to reclaim the history of certain international political institutions, such as the WHO, that were founded to guarantee the right to health and access to medicines deemed to be a global "common good", one that we should insist cannot become a mere aggregation or composition of mutual advantages or arbitrary interests. When the common good is seen to be a collective institution that serves subjective interests, a number of things occur. Political life is reduced to mere negotiation or becomes a private association

promoting individual interests. The crucial difference between rights and interests becomes blurred or even eliminated, as do the differences between instrumental rights, such as the right to property; non-instrumental rights, such as the right to health; and between collective negotiation and public deliberation. As Habermas said in his habilitation, it would be absurd for unions to try to use the argument of the common good to persuade business owners to reduce their desire to maximize profits. No negotiation is possible unless workers consider the maximization of profit to be an unmovable datum, neither is it possible unless business owners accept the desire of workers for salary increases. Likewise, it would be unthinkable for a member of parliament to defend a bill purely because it would greatly benefit them or their family.

I shall close with another reflection inspired by Koselleck. International solidarity regarding public health is now a concept of expectation that in no way matches the path of history. This tension between expectation and experience could lead to a new era (Neuzeit). The way in which certain concepts arise at different historical times, such as international solidarity in times of pandemics, undoubtedly shows that there is a clear awareness of the separation between experience and the prospect of expectations. It is down to political action to build a bridge that overcomes this tension.

The WHO has been colonized by "benefactor" nations that now all but own it. We feel a profound sense of loss and are perhaps even orphaned due to the absence of binding international instruments, although we can still count on others, such as the International Declarations of Human Rights. It is vital to remember that rights are not bestowed in Geneva or the WTO, rather they are won through a long and arduous struggle.

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Notes

1 Committee on the elimination of racial discrimination. "Statement on the lack of equitable and non-discriminatory access to COVID-19 vaccines", Statement2, [1] (p. 2).

2 According to the Centro de Estudios Legales y sociales in Argentina, or CELS (The Centre for Legal and social Studies of Argentina), the petitioning groups and organizations are: African Alliance; Center for Economic and Social Rights (CESR); Centro de Estudios Legales y Sociales (CELS); Global South Vaccine Equity Coalition coordinated by the Equal Health Campaign against Racism; Initiative for Economic and Social Rights (ISER); Minority Rights Group (MRG); Oxfam International; Treatment Action Campaign (TAC); and Women's Legal Centre (WLC). The petition was prepared with the support and coordination of the Global Network of Movement Lawyers, housed at the Movement Law Lab, Section 27 and the secretariat of ESCR-Net—International Network for Economic, Social and Cultural Rights.

3 This is the hypothesis presented in the 2022 CELS Document. [2]

4 The following notable texts provide a historical-social and conceptual reconstruction of the idea of European solidarity: Puyol, A, *Political fraternity. Democracy beyond freedom and equality* [4]; Muñoz Dardé, V, "Fraternity and Justice", 81–100, [5]; and, in particular, Metz's text which describes the evolution of the concept from its close relation to the fraternity of the *sans-culottes*, through the bourgeois insistence on "mutualité", the introduction of Bourgeois' new concept of solidarity, to the birth of the new concept of "*solidarité*", or solidarism with legal guarantees, from which the French "*securitè sociale*", and the Welfare State arose [6] (88).

5 However, we should remember that the European consensus regarding the duty of the State to protect needs was the result of the post-war agreement between capital and labour. It is important not to read any moralizing into the agreement.

6 I appreciate the comment of an anonymous reviewer on the importance of the Universel Declaration of Bioethics and Human Rights (UNESCO) and especially about the Article 13. For reasons of space, I focused on the recent document produced by the United Nations Committee on the Elimination of Racial Discrimination, wich states that the vast majority of COVID-19 vaccines have been administered in high- and upper-middle-income countries.

[7] On the incorporation of the principle or concept of solidarity in the theoretical framework of classical Anglo-Saxon bioethical principalism, I recommend Puyol's 2017 text.

[8] The work dedicates a special chapter to the uses of the concept of solidarity in pandemics. Barbara Prainsack returned to the subject in 2020, during the COVID-19 pandemic in a short article. Puyol's 2017 text is an excellent honing and discussion of some of the theses on regulatory and descriptive aspects of the principle of solidarity in public healthcare, and also on the importance of not confusing solidarity with justice.

[9] Section 3.6 of the Nuffield Report contains an interesting bibliography on solidarity in bioethics as a response to the global healthcare crisis. In recent years, the main debate regarding global vaccine distribution has centred on the dispute between nationalism and cosmopolitanism. This has produced a number of texts, of which I mention two representative ones here, Fergusen and Caplan [12], and Bollyky and Brown [13].

[10] Nonetheless, a short text from 2021, signed by Hannah Kienzler and Prainsack corrects the 'short-term' data for the COVID-19 pandemic. This brief but blunt text provides interesting data regarding global political insolidarity. Among their examples is the fact that the delivery of surplus vaccines to poor countries runs in parallel with the enjoyment of privileges for countries of the Global North, which permits them to negotiate lower vaccine prices; this is quite clearly the contrary of a real show of solidarity by the Global North which, if it wanted, could use its privileges to negotiate a subsidized vaccine price that would guarantee a global response to the pandemic. However, pharmaceutical companies have refused to reveal prices, they sell their products cheaper to those influential nations that can negotiate better agreements. The authors cite research into how much countries and charities pay for vaccines, while the European Community paid €3.50 per dose of AstraZeneca, the same vaccine cost Uganda €8.50 per dose [14] (p. 2).

[11] The authors' perspective responds to data and statistics valid for European countries; they would probably also be valid for the rich minorities living in big cities in the Global South whose economic status is similar to that of northern European countries. Latin-American thinkers have written interesting studies that show the opposite is true, that interpersonal and group solidarity in slums in the Global South have been able to save lives through humanitarian acts. Among them [15] (p. 8–40).

[12] Here I take Raventós and Wark's definition of philanthrocapitalism. This, as they say, assesses costs and profits in terms of results whose evaluating criteria are imposed by the supposed 'benefactors', who furthermore choose who will benefit on the basis of how quickly and efficiently the investment can be returned. These are clearly generally not the most-needy. The authors also explain that multi-millionaire benefactors, lionized with crude meritocratic arguments, have a great influence to use conditioned subsidies to distort, or even impede local research into endemic diastases, such as malaria, the disease of the poor who cannot afford medicines [16] (p.155–186).

[13] Arnsperberger and Varoufakis' article assumes knowledge of the dispute between internalists and externalists. In brief, between those who explain the reasons agents act only pursuant to their motives or wishes (internalists), and those who believe that we act for reasons that are independent of our wishes or motivations (externanalists). The article uses sound externalist arguments to rebut the thesis of instrumental rationality, or "philosophical egoism".

[14] Fred Hirsch coined the term "positional goods" in his 1976 book *The Social limits to Growth* [20], and it quickly passed into the language of the economy. The concept, under a variety of semantic guises, has an interesting philosophical-political history. For more on words that have had equivalent meaning throughout history, I recommend M. Schneider, 2007.

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