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“My Country First”: Vaccine Nationalism in England?

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ABSTRACT

This article asks what the main factors are that influence the expression of Vaccine Nationalism among the population of England. The analysis is based on data collected in 2021 as part of the project entitled World Problem, National Solutions. A set of logistic regressions test to what extent (1) personal experiences of the pandemic and respondents' vulnerability, (2) perceived threat from other nations, (3) political identities and attachment to nationalist ideology, and (4) pride in national achievement at the time of the COVID-19 pandemic affect a sample of adult respondents in England to express a form of Vaccine Nationalism. The results show that Vaccine Nationalism is not affected by personal experiences or nationalist ideology. The main impact on Vaccine Nationalism among the population comes from their political orientation and pride in national achievement during the pandemic.

At the end of March 2021, the world was in the midst of its third wave of the COVID-19 pandemic. The UK had been vaccinating its population for four months, while the European Union had been doing so for one month less. The UK reported that 38.65% of its population had received their first dose of the vaccine, and an additional 7.27% had been double vaccinated.¹ While the average number of vaccine doses in the EU was 16.64, in Serbia that number was double, with 35.23 per 100 population. Serbia's first neighbor, Bosnia and Herzegovina, had not administered any vaccine at that point, similar to the majority of countries worldwide. By midsummer 2020, that is, 5–6 months before the first COVID-19 vaccine was administered, “high-income countries accounting for just 13% of the global population had placed orders for more than half of the projected available doses in the first batches of COVID-19 vaccines.”² The UK was the largest per capita buyer of vaccines, “pre-ordering 340 million doses, or five doses per citizen.”³ The US followed by pre-ordering 800 million doses for its 330 million-strong population. By November 2021, 63% of the population of high-income countries were fully vaccinated, compared to just 1.4% of low-income countries.⁴ Two years later, by April 2023, low-income countries had managed to vaccinate only around 30% of their populations, while high- and upper-middle-income countries had vaccinated around 80%.⁵ This was seen as an expression of *Vaccine Nationalism*.

Vaccine nationalism is a phenomenon whose manifestation is identified long before the vaccine is produced, in the advanced stage of development of vaccines through contractual agreements between governments and pharmaceutical companies that produce

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the vaccine, usually known as “advance market commitments or preproduction agreements.”⁶ Hence, Vanderslott et al.⁷ define Vaccine Nationalism as “the pursuit of vaccines in the national interest, for example, through supply agreements or export bans, including where this might be to the detriment of other countries.”

Some authors called the same phenomenon “vaccine diplomacy,”⁸ others called it “crisis nationalism”⁹ and “medical nationalism.”¹⁰ Bollyky and Bown¹¹ simply called it a “my country first” approach.

This terminological diversity does not only demonstrate the authors’ creativity but mostly indicates lack of congruity between the signifier and the signified. The most commonly used term—Vaccine Nationalism—is, as exemplified by Vanderslott et al above, applied on actions of government in procuring vaccines where they have acted on the premise that their country comes first. In situations when governments are seen as national, nation and country could easily overlap and be conflated. After all, Ernest Gellner¹² famously defined nationalism as “a political principle which holds that the political and the national unit should be congruent,” that is, a principle where the government could be seen as a form of political leadership of both the nation and the state. However, nation-state governments were not the only ones who engaged in activities defined by Vanderslott et al. as Vaccine Nationalism.

In March 2021, the UK government and the WHO accused the EU of Vaccine Nationalism when it threatened to ban vaccine exports due to a dispute with AstraZeneca.¹³ EU politicians implied the same for the UK government.

Riaz et al.¹⁴ cite *Statista* data where in the period of 2020–2021 India with 3.13 billion doses was second in vaccine production only to the United States which produced 4.69 billion vaccines. Pharmaceutical companies aimed to sell their products to the highest bidder but soon found themselves caught between following rules of international trade and expressing their national loyalties. The chief executive of the *Serum Institute of India*, one of the largest pharmaceutical companies globally, stated that “at least initially, any vaccine the company produces will go to India’s 1.3 billion people.”¹⁵

It appears that what are commonly referred to as national governments were as culpable of Vaccine Nationalism as the administrations of supranational organizations and multinational corporations. This raises the question of whether the term “nationalism” is the most appropriate for characterizing this phenomenon. If a government is perceived as operating in the national interest, then all of its policies will inevitably be categorized as such. Consequently, scrutinizing governmental actions might not be conducive to assessing the degree to which nationalism, as a principle or ideology, underpins “Vaccine Nationalism.” To address this, our focus shifts to those who elect these governments.

This paper asks to which extent the adult population in England supports views that can be seen as Vaccine Nationalism and what are the main factors that contribute to the expression of such views. These questions will be answered using the data collected during the COVID pandemic in the period of March–April 2021, as a part of the project entitled *World Problem, National Solutions*.

The project encompassed five countries: Germany, Ireland, Sweden, Serbia, and England. A challenge arose in selecting the unit of analysis for the United Kingdom due to disparities in the authorities held by the Westminster government and the devolved

governments of Scotland, Wales, and Northern Ireland, particularly concerning the management of infectious disease outbreaks. Beginning in 1998, these regional governments acquired jurisdiction over devolved matters such as education, health, transportation, and justice. Their jurisdiction in emergency situations is outlined in the Public Health (Control of Disease) Act 1984 (amended by the Health Protection Act 2008) for England and Wales, the Public Health (2008) Act for Scotland, and the Public Health Act (1967) for Northern Ireland.¹⁶

Consequently, the devolved administrations shouldered responsibility for the majority of key public services impacted by the COVID-19 pandemic, while the Westminster government retained responsibility in England. The enactment of the Coronavirus Act (2020)¹⁷ further augmented the devolved governments' responsibilities. Thus, when conducting a survey that incorporates respondents' evaluations of governmental decisions, rather than contending with the intricacies of distinguishing between the prerogatives of the Westminster and devolved governments, this project chose to concentrate solely on respondents from England.

Public support for Vaccine Nationalism

In the first year of the COVID-19 pandemic the acts described as Vaccine Nationalism were involving national governments, supranational organizations, and multinational companies at level of funding, producing, procuring, and distributing vaccines. Researchers turned their attention to potential vaccine consumers as well. The prevalence of Vaccine Nationalism among the population is mostly measured as an attitude toward "the pursuit of vaccines in the national interest." For example, an international internet-based survey conducted between 24 November and 28 December 2020, with a sample of 15,536 people from 13 countries, implied that Vaccine Nationalism among the population is rare. The respondents favored the allocation of vaccines based on need, and the least popular attitude was one where priority was given to countries that developed the vaccine.¹⁸

Around the same time, in April 2021, Barceló et al.¹⁹ collected data for their cross-country experimental research—including a sample from the UK—on the question of what types of vaccines citizens are most likely to accept. They concluded that "respondents prefer vaccines developed in their own country over vaccines developed elsewhere irrespective of the objective performance of the local versus the overseas vaccines."²⁰ They also showed that respondents with higher attachment to nationalism have a higher preference than those with lower attachment to nationalism.²¹ While Van Bavel et al.²² did not focus on vaccines but on general public health behaviors—such as spatial distancing, physical hygiene, and policy support—they found that respondents "who reported identifying more strongly with their nation" are more likely to support such behavior. However, when the results of 67 individual countries are presented,²³ it showed that the impact of national identity on the support of public health behavior in the UK is comparatively low.

On 28 April 2021, *YouGov* posted a question: "Thinking about the current wave of the coronavirus in India, which of the following best reflects your view?" 34% of respondents held that "Britain should provide coronavirus vaccination doses to India,

even if this slows down the rate of vaccination here in the UK.” But 39% of the population thought that Britain should prioritize the rollout of the vaccination here in the UK, even if this means India is unable to obtain vaccine doses.²⁴ It is also interesting to note that the *YouGov* question was asked at the time when Davies²⁵ argues the public was well aware that out of 30 million administered vaccinations at that point, 13 million were *Pfizer* vaccines imported from the EU and 5 million from the *Serum Institute in India*. The question posed by *YouGov* is different in essence from the one posed by Clarke et al or Barceló et al. This question not only tests respondents’ views on “which country should be first” but it also sets the UK in the position of a donor of vaccines, of the one who distributes vaccines. In Clarke et al’s research, respondents were asked for the principle of vaccine distribution, and in Barceló et al’s research, for vaccine preference.

In that same period of March–April 2021, the project *World Problem, National Solutions* conducted survey in five European countries: Germany, Ireland, Serbia, Sweden and England. One of the questions was designed to examine respondents’ views on vaccine priority. It asked: “With the limited availability of the COVID-19 vaccine, my country should get the vaccine ... ?” with four possible answers. As [Figure 1](#) shows, in all five countries, the majority of respondents thought that their country should get the vaccine at the same time as others in Europe or others in the world.

Following Vanderslott et al’s²⁶ definition stated above, values 1 “Before any other nation” and 2 “Before neighboring nations” might indicate some level of Vaccine Nationalism, and answers 3 “At the same time as others in Europe” and 4 “At the same time as others in the world” indicate no Vaccine Nationalism. As such, we hold that the question addresses the issue of whose country is first in the line of vaccination. [Figure 2](#) shows the percentages of respondents who show no Vaccine Nationalism (0) and those who express some Vaccine Nationalism (1).

These results confirmed those from previous public opinion polls. Indeed, in all surveyed countries, the greatest percentage of respondents expressed no signs of Vaccine Nationalism. However, respondents from England expressed higher levels of Vaccine

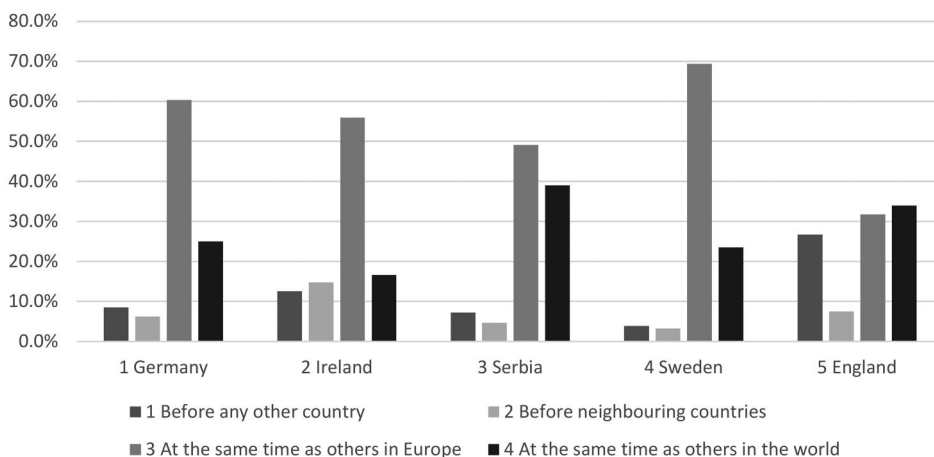


Figure 1. Vaccine priority (percentages).

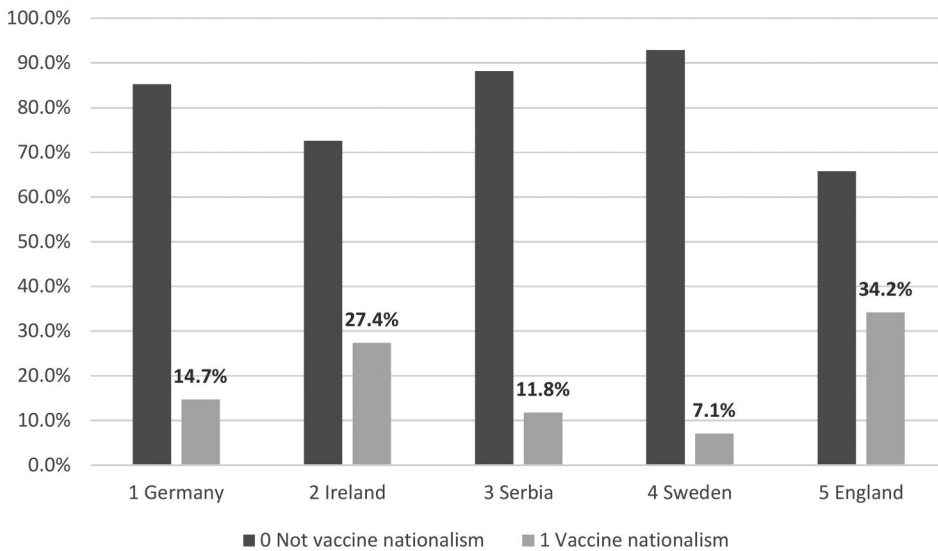


Figure 2. Vaccine Nationalism (%).

Nationalism than respondents from the other four countries (Chi-Square = 417.586, $p < .001$, Cramer's $V = .256$).

Further analysis will examine specificities of the case of COVID vaccination in England and look for factors that contribute to the expression of what we call Vaccine Nationalism among its population.

Vaccine success in England

On 18 February 2021, around three months after the approval of the first COVID-19 vaccine, in an issue of the *British Medical Journal*, Chris Baraniuk²⁷ describes the UK administration of COVID-19 vaccines as “a world-beating performance.” He explains how the British government and scientists reacted on time and worked on inventing and procuring the vaccine among the first in the world. Britain was the first to approve the COVID-19 vaccine (if we ignore Russian Sputnik V). The Department of Health and Social Care, he continues, began “planning a mass vaccination programme before confirmation of the first COVID-19 case in the UK.”²⁸ The Oxford University life scientists had their first meetings about the vaccine already on the 30th of January 2020 and three months later, they reached an agreement with the Anglo-Swedish firm, *AstraZeneca*, and signed a deal to supply 100 million doses to the UK. *The Guardian* writes: “Ministers were prepared to pay a few hundred million upfront, allowing the company to build its first virus manufacturing process, and the UK government to demand its citizens be vaccinated first.”²⁹ Interestingly, the same article quotes a former adviser at the Department of Health who claims that the Ministry and the Government were “worried about Vaccine Nationalism” coming from the US administration.

On 25 February 2022, the National Audit Office published a report entitled *The Rollout of the COVID-19 Vaccination Programme in England*.³⁰ The report states that in December 2020, the Vaccine Taskforce, who was responsible for the procurement of

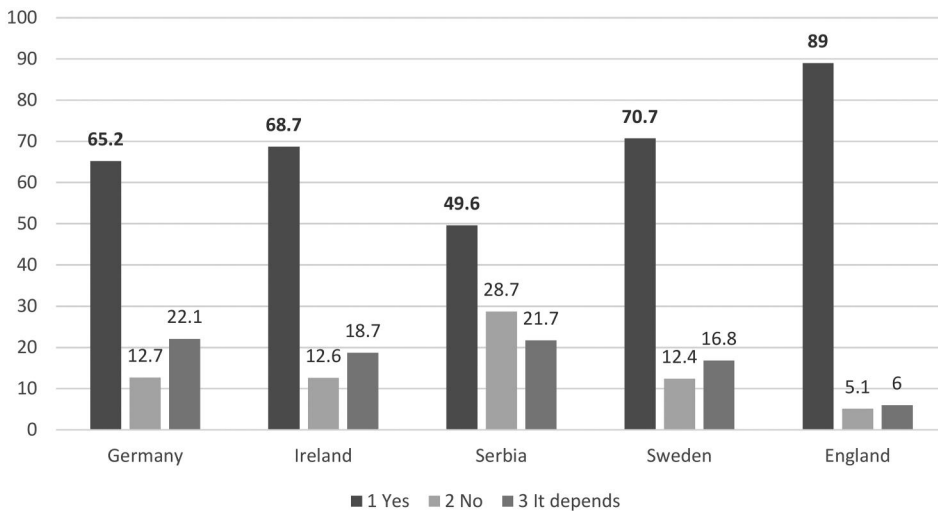


Figure 3. Once it becomes widely available, will you take the COVID-19 vaccine by country (%).

vaccines, “had seven agreements in place with seven suppliers for 357 million potential doses at an expected cost of £3.7 billion,”³¹ that is, 5.3 vaccines for each UK citizen. The report further states that by the end of October 2021, “145.9 million doses had been supplied against the UK vaccine contracts, of which 126.8 million were for UK use.”³² The difference of 19.1 million doses was donated through the COVAX scheme, which was a WHO organization with the task of providing “equitable access to COVID-19 tests, treatments, and vaccines” in the entire world.³³ That donation, according to the British PM Boris Johnson, was “a result of the success of the UK’s vaccine programme” which allowed his government to “share some of our surplus doses with those who need them.”³⁴ Davies³⁵ points that the “overwhelming reason why the UK is so far ahead with its vaccination programme is that it has received so many vaccines from the EU.”

The population of England were assured that there will be no shortage of vaccines, the vaccines were advertised as the main victory of British inventiveness and entrepreneurship. When compared with four other European countries, the population of England overwhelmingly proclaimed their willingness to take vaccine (Figure 3).

By October 2021, that is, less than a year after the administration of the first vaccine, more than 87 million doses—42 million first doses and 38 million second doses—had been administered in England.³⁶ Unlike the rest of the world, the British public did not have reasons to fear shortages of vaccines due to governmental policies and practices of vaccine procurement that could easily be labeled as a policy of Vaccine Nationalism. If the policy is nationalistic, do beneficiaries of such a policy, that is, the English public, support it, and why?

Approaches to Vaccine Nationalism

Two months after WHO’s Director-General proclaimed COVID-19 to be a pandemic and a year and a half before the first vaccine was approved in the UK, *The Lancet*

published an article entitled “Ensuring global access to COVID-19 vaccines.”³⁷ In this article, the authors are, in everything but name, appealing to the governments of high-income countries to restrain from Vaccine Nationalism.³⁸ They recalled the 2009 influenza A/H1N1 pandemic and warned that these governments should ensure there is a globally fair allocation system of vaccines. Since then, articles on Vaccine Nationalism have appeared in numerous academic journals. While nationalism as a social movement and an ideology was predominantly explored in social sciences, Vaccine Nationalism predominantly raised concern from medicine and public health experts.

Literature that appeared with the pandemic saw Vaccine Nationalism as an issue of (1) public health, (2) security, (3) ethics, and (4) of symbolism.

Vaccine Nationalism as an issue of public health

In August 2020, five months into the pandemic, WHO director general Tedros Adhanom Ghebreyesus stated that “Vaccine Nationalism only helps the virus”³⁹ as it would benefit only a few countries who would get the majority of the supply. WHO repeatedly stressed that the best way to prevent more variants from emerging is to stop the spread of the virus⁴⁰ and that could not be achieved if only high-income countries have their populations protected. The mobility of global population increases the risk of reinfection⁴¹ “if poorer countries - which are generally densely populated with weak health systems and higher disease burdens - are neglected and denied access to potential COVID-19 vaccines.” As Riaz et al.⁴² claim, Vaccine Nationalism stretches the duration of the pandemic.

That is not the only way that Vaccine Nationalism directly affects public health in less well-off countries. It also leaves their medical personnel, those that are on the front line of the pandemic, unprotected. In a press conference in January 2021, WHO brought medical workers from Uganda and Pakistan who pleaded for vaccine supplies. Michael Ryan, WHO executive director, was trying to influence high-income governments indirectly through their voters. He said that “[w]e all need to ask ourselves, ‘would I have the vaccine if I thought it meant a health worker in the south wouldn’t get that vaccine today?’ We all need to examine our own consciences, then tell our leaders what we want them to do.”⁴³ Before any COVID-19 vaccine was approved, Vaccine Nationalism was seen as the main threat to public health that cannot be addressed solely on the state level. Yet, many governments tried just that.

Vaccine nationalism as a security issue

Governments might have reacted more positively to the WHO’s appeals for international cooperation if the pandemic had not been also identified as a security issue. In the aftermath of the H1N1 pandemic, Stefan Elbe⁴⁴ argued that security, besides being a political and military problem, became a medical problem as diseases spread through the population. He introduces the concept of ‘medicalization of insecurity,’⁴⁵ where a new discourse on security emerges, and medical and health personnel become more closely engaged in the formulation of safety policies. These increasingly include pharmaceutical interventions like stockpiling billions of pills of antiviral medications. Hence,

Vaccine Nationalism, as defined above, directly contributed to the provision of security that turns bodies of citizens into battlefields: “securing the nation required the collective, mass ingestion of a pharmaceutical substance.”⁴⁶

All these symptoms of medicalization of insecurity were clearly observable a decade later during the COVID-19 pandemic when governments invested lots of efforts not only in procuring and stockpiling vaccines but also in motivating the population to be vaccinated for their own and national safety. Or as Boris Johnson put it eloquently in his 2021 Christmas address, “there is still a wonderful thing you can give your family and the whole country, and that is to get that jab.”⁴⁷

Other researchers⁴⁸ consider Vaccine Nationalism to be the primary antithesis to global health security. They argue for the “security of people, not national borders.”⁴⁹ This type of security cannot be grounded solely in national policies, as it is premised on the understanding that ‘nobody is safe until everyone is safe.’ They point at the international cooperation that finally eradicated smallpox in the 1960 in the midst of the Cold War⁵⁰ and hope that similar cooperation can eradicate COVID-19. But even the Salk-Sabin vaccine that came out of the USSR-USA cooperation in the 1960s, Moreno⁵¹ warns, was “instrumentalized in the ongoing propaganda war” between the East and the West. Vaccines developed by the opposing faction were met with suspicion, while their own vaccines were touted as evidence of the superiority of their healthcare systems.

Suspicion toward vaccines originating from less-affable countries was visible during the COVID-19 pandemic, paralleling patterns observed six decades ago. COVID-19 vaccines often gained a certain citizenship where “alternative vaccines” were deemed less secure. Pfizer-BioNTech was German, Moderna and Johnson & Johnson American, Sputnik V Russian, Oxford-AstraZeneca British, Sinopharm and Sinovac Chinese, Covaxin Indian etc. A number of research projects were dedicated to examine the level of public distrust especially of vaccines manufactured in Russia and China.⁵² These studies consistently demonstrate that the vaccine’s origin influences respondents’ preferences. Nonetheless, distrust toward vaccines was evident even in cases where ideological differences weren’t as stark. For example, French Prime Minister Macron declared the AstraZeneca vaccine “quasi-ineffective” on people older than 65, despite acknowledging a lack of official information on the matter.⁵³

The reviewed literature portrays Vaccine Nationalism as both a primary impediment to global population security and safety, as well as a strategy to ensure the security and safety of citizens within specific countries. The perception of Vaccine Nationalism—whether as an ally or a foe—could potentially hinge on individuals’ general stance toward nationalism. Those who prioritize the safety of their own group over that of the broader global populace might view Vaccine Nationalism as a constructive and perhaps essential approach. Consequently, the phenomenon of Vaccine Nationalism raises diverse ethical considerations.

Vaccine nationalism as an ethical issue

Bollyky and Bown⁵⁴ label Vaccine Nationalism as “morally and ethically reprehensible.” Abbas⁵⁵ call it a “short-sighted and risky approach.” Beaton et al.⁵⁶ also define Vaccine Nationalism as unethical from the start. They see Vaccine Nationalism as “the hoarding

of global supplies of therapeutics during a global pandemic” that “*exceeds* the bounds of acceptable partiality.”⁵⁷ From this definition, however, it is quite clear that this moral absolute is not that absolute. While they deem Vaccine Nationalism to be unethical, they acknowledge the permissibility of ‘national partiality.’ They hold that “even in a genuine crisis, national partiality is permissible only when a country takes its basic responsibility of global justice seriously.”⁵⁸ The authors fail to elaborate what makes one basic responsibility serious.

The discussion on morality of Vaccine Nationalism is grounded on the question of whether fair distributions of vaccines should be based on need or on citizenship. Jecker et al.⁵⁹ unequivocally advocate for the necessity of global vaccine distribution. They design an “ethical framework that prioritizes frontline and essential workers, people at high risk of severe disease or death, and people at high risk of infection.”⁶⁰

Emanuel et al.,⁶¹ however, categorize this stance as idealistic. They acknowledge that while both extreme nationalism and extreme cosmopolitanism lack moral justification, governments will consistently prioritize the health of their own citizens. Therefore, they construct the so-called fair priority for residents (FPR) framework that defines “the moral limits on the amount of vaccine that governments can retain for their residents.”⁶² Apparently, ethical Vaccine Nationalism allows governments to “retain COVID-19 vaccine doses for their residents only to the extent that they are needed to maintain a noncrisis level of mortality.”⁶³

Ferguson and Caplan⁶⁴ paint a picture of a “good Vaccine Nationalism” on similar basis. While the “ugly” Vaccine Nationalism denies the equal worth of persons outside its national community, and while “blind” Vaccine Nationalism recognizes that value but sees no obligation toward it, the good Vaccine Nationalism “endorses the equal worth of persons and recognizes obligations to persons and communities globally.”⁶⁵ However, these good vaccine nationalists apparently recognize their moral obligations to take care of “their own” first. Ferguson and Caplan therefore argue that nation-states have a higher association with their community of co-nationals and, in times when the vaccine is scarce, should prioritize their self-interests.

Lie and Miller⁶⁶ also attempt to find ethically sound solution to vaccine distribution that navigates the middle ground between extreme nationalism and cosmopolitanism since, as they said, “national governments have both a right and a duty to secure access to a COVID-19 vaccine for their citizens first.”⁶⁷ Only then an “appropriate weight needs to be given to national obligations of international assistance for low-income countries to mobilize resources for health.”⁶⁸ Lie and Miller argue that the COVAX partnership is that “right balance between national responsibilities for health and international commitments to global justice.”⁶⁹ Ultimately, both Emanuel et al. and Lie and Miller seem to assert that Vaccine Nationalism is ethically defensible, provided that governments participating in such practices share their excess resources.

As demonstrated, numerous authors have made efforts to formulate a vaccine distribution system that might be deemed ethically sound but none of these attempts managed to escape the clutches of state self-interest. While the pandemic brought a general outcry on Vaccine Nationalism of rich countries, experts in ethics agree that a just method of vaccine distribution cannot be designed outside the nation-state framework. Nationalism is an ideology that promotes specific meanings, values and, indeed, ethical

deliberations, largely directed toward the community of fellow nationals. They recognize that, in the end, the main players in the invention, procurement, and distribution of vaccines are nation-states whose governments invest considerable efforts in creating loyalty to and a sense of national community among their citizens. Therefore, the answer to Hassoun's⁷⁰ question of "Why are our obligations to members of the global community (...) weaker than those to our co-citizens?" is obvious from these discussions on ethics of Vaccine Nationalism. Nationalism is grounded within the same structure of modern nation-states⁷¹ and consistently places the interests of the nation above cosmopolitan communities, thereby perpetuating global disparities not only in healthcare and social provisions but also in economic, political, and military power.

Gollier⁷² warns that "the extreme form of Vaccine Nationalism in which vaccine-rich countries fully prioritize their own population before exporting their vaccine, the global death toll could be increased by 20%." It appears that most scholars consider Vaccine Nationalism to possess an ethical dimension when its extremeness is mitigated.

Vaccine nationalism as issue of symbolism

When 90-year-old Margaret Keenan received her Pfizer vaccine, some British media outlets described her as the "first person in the world to have the Covid vaccine" (*The Express*, 9 December 2020). Some were more accurate when they labeled it as "the first in the Western world" (*The Guardian*, 8 December 2020) or just "the first in Britain."⁷³ *The Mail on Sunday* (16 August 2022, p. 11) described the UK as a "Covid vaccine world-beater" since "we are the first nation to approve the double-strain superjab." Gavin Williamson, the Education Secretary, proclaimed that Britain "is getting the Covid vaccine first because it is a much better country than France and the United States" (*Daily Mail*, 4 December 2020). And in the same article, *the Daily Mail* reports that "Commons Leader Jacob Rees-Mogg called the approval of the Pfizer/BioNTech vaccine a British success and accused the European regulator of being a bit sniffy about it." *The Mail on Sunday* (27 December 2020) marked the beginning of vaccination in Europe (meaning the European Union) but "nearly three weeks after us." Even the head of the opposition, Sir Keir Starmer, thought that the vaccine rollout "has made us the envy of the world."⁷⁴

The overview of British newspaper headlines clearly exemplifies a particular form of Vaccine Nationalism where the vaccine becomes a symbol of national greatness. This form of Vaccine Nationalism was facilitated in many politicians' statements and countless newspaper headlines. Vanderslott et al.⁷⁵ looked for traces of Vaccine Nationalism among British citizens and interviewed participants in COV001, a phase I/II vaccine trial in Oxford, UK. They reported that some participants expressed views that could be seen as expressions of Vaccine Nationalism but mostly through expressions of pride in the achievement of British science and through arguing that countries that developed the vaccine should have "priority due to the use of taxpayer or government money, and the country facilities, talent and research."⁷⁶

In a survey conducted across seven high-income countries, a sample of 8,000 respondents assessed three "prioritization principles for the global allocation of COVID-19 treatments and vaccines."⁷⁷ The principle stipulating that "countries that developed the

vaccine should be given priority” ranked third in terms of acceptance, trailing behind the principles that prioritize “those in need” and those “who cannot afford them.” Nevertheless, the average level of support for Vaccine Nationalism based on “merit” ranges from 28 (95% CI 26–29) to 58 (95% CI 56–60) on the 100-point scale.⁷⁸

A brief exploration of a facet of media coverage concerning vaccine-related matters reveals a readiness to partake in a form of propaganda that portrays the development, dissemination, procurement, and distribution of vaccines as a source of national pride and accomplishment. As Chatterjee et al.⁷⁹ stated: “The scientific ability to innovate vaccines has been used as a marker of preeminence and for the construction of national identity.” In this context, Vaccine Nationalism is characterized as an approach that leverages this sense of achievement to rationalize the prioritization of vaccination. The principle of “my country first” is framed as “because it’s worth it.”

Reviewing these debates, one must wonder if, in some of them, Vaccine Nationalism is a misnomer. The first two debates about Vaccine Nationalism are focused on behaviors of governments of states, some of which might be seen as nation-states. But a pursuit of self-interest when stockpiling vaccines, for medical or security reasons, is observed among nation-state governments as much as among the leadership of supranational organizations such as the EU, where the term “nationalism” is difficult to apply. Still, support for Vaccine Nationalism for security reasons could be justified in the name of the nation but only as far as the nation is conflated with the state.

On the other hand, those debates which defend Vaccine Nationalism as ethical feed on the morality of nationalist ideology that, in its core, views “the nation as a principal unit of human solidarity and political legitimacy.”⁸⁰ This view, where the obligation to members of one’s own nation is higher than the obligation to others, is perceived as given. That obligation would then be applied to any aspects of social life, including the procurement of vaccines, and could easily be seen simply as an expression of nationalism.

The importance of symbols in the construction of national identity and solidarity is well examined within theories of nationalism. The ethno-symbolic approach⁸¹ emphasizes the importance of emotionally charged symbols—for example, pride in COVID-19 vaccine—in shaping a sense of national community, especially in times of crisis. However, national pride is not necessarily an indicator of formed national identity or nationalism⁸² but could also be seen as an expression of patriotism, one’s attachment to the state or country rather than the nation.

In the contemporary global landscape, the processes of vaccine invention, production, and distribution fall under the jurisdiction of nation-states, supranational entities (such as the EU), multinational pharmaceutical corporations, and a select few non-governmental organizations (such as GAVI, COVAX, or WHO). State governments face usual paradox when global issues, such as a pandemic, is in question: while the solution is global, their interests are local. Consequently, we contend that any nation-state endowed with the capacity to procure vaccines for its populace is likely to prioritize this action in a manner primarily aligned with self-interest. Such behavior may not inherently be driven by nationalist ideology but rather by self-preservation. It’s important to note that state governments are not elected on a global but within their own local contexts. In democratic societies, the electorate grants a mandate for governmental strategies, that

includes vaccine procurement. Therefore, while it is very difficult to ascertain whether government policies are motivated by the adherence to nationalist ideology, we could examine whether the electorate is in support of the principle of Vaccine Nationalism and for which reasons.

In this paper, therefore, our focus is not on the behavior of institutions and organizations but on attitudes of those individual citizens whose bodies, in the time of the pandemic, became a battlefield for national security and public health. Our preliminary analysis showed that about one-third of respondents from England expressed some level of Vaccine Nationalism (see [Figures 1](#) and [2](#)). The sources of that discrepancy, according to the reviewed literature, should be sought in the domain of (1) **public health**—that is, respondents' medical vulnerability and experience of the pandemic, (2) **safety**—that is, the perceived threat of the pandemic, (3) **ethical justification**—that is, their attachment to or identification with nationalist ideology that promotes national self-interest, and (4) **symbolism**—that is, a level of pride in the achievements of their country at the time of the pandemic.

Hypotheses

In search of the main factors that contribute to the expression of Vaccine Nationalism among the population, the four discussions on Vaccine Nationalism described above allow us to set four hypotheses:

H₁—MEDICAL ISSUE: respondents who had a more serious personal experience of the pandemic and are more vulnerable to the virus would be more likely to express some level of Vaccine Nationalism.

H₂—SECURITY ISSUE: respondents who hold that their nation is threatened by other nations at the time of the pandemic will be more likely to express some level of Vaccine Nationalism.

H₃—ETHICAL ISSUE: respondents who are more attached to nationalist ideology will be more likely to express some level of Vaccine Nationalism.

H₄—ISSUE OF SYMBOLISM: respondents who express more pride in the achievements of their nation will be more likely to express some level of Vaccine Nationalism.

Operationalization

In order to test these hypotheses, four sets of independent variables are selected to test to what extent they can predict the **dependent variable**. The variable Vaccine Nationalism is a dummy variable where 0 = no Vaccine Nationalism and 1 = some Vaccine Nationalism, as explained in [Figure 1](#) and [2](#) above.

Independent variables in this study are listed by the hypotheses:

To test **H₁**, personal experience of the pandemic and respondents' vulnerability will be measured through a set of variables entitled *Experiences with COVID-19* and respondents' *Socio-Demographic Characteristics*.

Respondents more vulnerable to COVID-19 would not only include those with previous medical conditions but also, for example, older respondents, of lower income and

education, living in less populated areas where medical support might be scarcer, and those who live with minor children. Therefore, Socio-Demographic Variables include Age (exact age of respondents, scale), Gender (0 = male, 1 = female, dummy), Market size (scale from 1 to 6 where 1 = less than 50 inhabitants per square km and 6 = 1,000 and more inhabitants per square km), Education (up to university/university and above, ordinal), Income (low/medium/high, ordinal), Children under 18 living in the household (0 = no children vs. 1 = some children, dummy).

Experiences with COVID-19 are measured through three variables: (1) whether the respondent has ever tested positive (dummy), (2) whether the respondent knows of anyone who died of COVID-19 (dummy), and (3) whether the respondent belongs to an at-risk group for COVID-19 complications (dummy).

To test H_2 , we will have to measure to what extent respondents feel *Threatened by Other Nations* at the time of the pandemic. Respondents were offered a set of three statements that allow them to express whether: (1) the pandemic affected the unity of their nation; (2) the crisis increased their nation's dependency on other nations; and (3) their nation is exploited by other nations. These statements are all measured on a five-point Likert scale from 1 (Strongly Disagree) to 5 (Strongly Agree).

To test H_3 , we will measure respondents' political identities and their attachment to nationalist ideology. *Political identities* include the scale of political orientation (ranging from 0 = Left to 10 = Right). The *Attachment to Nation and Nationalist Ideology* is measured using the Moreno five-point scale of national identity (ranging from 1 = English not British to 5 = British not English) and the scale of Nationalist Ideology Attachment.

Anthony D. Smith⁸³ identifies the so-called core doctrine of nationalism. He holds that every nationalism is based on the following ideas:

1. the world is naturally divided into nations, each of which has its peculiar character and destiny;
2. the nation is the source of all political power, and loyalty to it overrides all other loyalties;
3. if they wish to be free, and to realize themselves, men must identify with and belong to a nation;
4. global freedom and peace are functions of the liberation and security of all nations;
5. nations can only be liberated and fulfilled in their own sovereign states.⁸⁴

Smith acknowledges that historical instances of nationalist movements have given rise to an array of notions that align with their specific contexts, yet he regards these notions as "secondary"⁸⁵ to this core doctrine. In order to gauge respondents' alignment with the foundational principles of nationalism, Smith's assertions are distilled into a simplified four-point scale for the sake of clarity.

1. the world is naturally divided into nations;
2. if they wish to be free, people must belong to a nation;
3. loyalty to a nation is more important than other loyalties; and
4. each nation should have an independent state.

Table 1. Experiences with COVID-19 (%).

Experiences with COVID-19	Yes	No
Tested positive	11.7	88.3
Knows someone who died	30.4	69.6
In at risk group	26.3	73.7

All statements are measured on the Likert five-point scale where 1 is Strongly Disagree and 5 is Strongly Agree.

H_4 will be tested through the effect of two variables that indicate respondents' *Pride in National Achievement* during the pandemic. Respondents will be asked (1) whether their nation demonstrated self-sufficiency during the time of crisis, and (2) whether the efforts of their nation contributed to the wellbeing of all nations ($r=.183$). Both statements will be measured on the Likert five-point scale where 1 is Strongly Disagree and 5 is Strongly Agree.

Methodology

This analysis draws data from a broader project entitled *World Problem, National Solutions* conducted in the period of November 2020 until May 2022 and funded by Health Research Board (ref. 7530), Ireland. The data collection was conducted by Ipsos Geneva in the period of 8–30 March 2021 in five European countries: Ireland, Germany, England, Sweden and Serbia. The project examined to what extent perceptions of the nation and national past affect individuals' behavior during the time of the COVID-19 pandemic.

The survey used quota sampling of the general population aged from 18 to 74, and due to the size of the population, in Germany and England sample size was 2,000, and in Sweden, Serbia, and Ireland 1,000 completed questionnaires per country. The aligning of the sample and population on key variables was carried out using RIM (Random Iterative Method) weighting.

The sample of this analysis consists of 2,000 residents in England, and their average age is 44.97. 50.1% of the respondents identify as female, and 0.4% of respondents expressed their gender as non-binary. 53.65% have qualifications below university, and 57.5% live in an area with 1,000 inhabitants per square kilometer and more. Almost half of respondents (49.9%) consider themselves to be of low income. 29% of the respondents have children younger than 18 living in the household (Table 1).

If we consider that the collection of data was conducted in March 2021, respondents' experiences with the pandemic are noticeable, especially since almost a third of them claim to know someone who died of COVID-19.

Data analysis

In order to test stated hypothesis, the analysis is conducted in several stages.

First, all independent variables are analyzed using descriptive statistics which include frequencies and appropriate measures of central tendency. Independent variables are divided into two predictor sets: first one includes mostly categorical variables that describe socio-demographic characteristics of respondents and their experiences of the pandemic, and second set consists of continuous variables that indicate respondents' attitudes.

Table 2. Means of the second predictor set.

Statement	N	Mean
Threatened by other nations		
My nation will come out much more united from the COVID-19 crisis	1,951	3.09
In the COVID-19 crisis, my nation is completely dependent on other nations	1,953	2.61
In the COVID-19 crisis, other nations will take advantage of my nation	1,916	3.00
Attachment to nationalist ideology		
Moreno five-point scale of national identity	1,790	2.93
The world is naturally divided into nations	1,955	3.55
If they wish to be free, people must belong to a nation	1,875	2.95
Loyalty to a nation is more important than other loyalties	1,950	2.87
Each nation should have an independent state	1,851	3.29
Political identities		
Political orientation ^a	1,757	5.00
Pride in national achievement		
My nation does not need anyone in order to overcome the COVID-19 crisis	1,935	2.56
The efforts of my nation will help the whole world in overcoming the COVID-19 crisis	1,957	3.77

^aMeasured on 11-point scale (0–10).

Second, to test for multicollinearity between variables of the second predictor set, a linear regression analysis is conducted using SPSS. The results show VIFs of all variables around value of 1 and therefore, no multicollinearity is identified. Cronbach's Alpha is calculated for the *Attachment to Nationalist Ideology* (Cronbach's Alpha = .771, Mean Inter-Item Correlation = .456) and *Threat by Other Nations* scales (Cronbach's Alpha = .421, Mean Inter-Item Correlation = .195). Since *Threat by Other Nations* consists of three items only, low values of Cronbach's Alpha is not a surprise.

Third, bivariate analyses (correlation, t-test and ANOVA) are conducted in order to look for possible associations between variables and differences between groups.

Fourth, two hierarchical logistic regressions are conducted where the dependent variable is Vaccine Nationalism (dummy).

Results of analyses

While the socio-demographic characteristics of respondents and their experiences with COVID-19 are already described in the Methodology chapter, Table 2 shows the average answers to independent variables included in the second predictor set. While respondents seem divided on whether their nation will come out of the pandemic more united or whether other nations will take advantage of their nation, there is a slight leaning toward disagreement with the view that their nation depends on other nations. A similar division can be found when nationalist ideology is questioned, though there is a dose of agreement with the view that the world is naturally divided into nations.

The same division among respondents can be observed when their national and political identity is in question. On average, respondents are at the middle point between English and British identity and between the Left and the Right. When the issue of pride in national achievement is in question, on average, there is a dose of disagreement with the idea of self-sufficiency of their nation at the time of the pandemic, but at the same time, also a level of agreement that the efforts of their nation will help the whole world (mean = 3.77). To what extent do these views affect respondents' expression of Vaccine Nationalism?

Table 3. Logistic regression—vaccine nationalism (DV); Socio-demographic variables and COVID experiences (predictor sets).

Socio-demographic predictors	Model 1		Model 2	
	B [SE]	Exp(B)	B [SE]	Exp(B)
Age	0.005 [0.004]	1.005	.004 [0.004]	1.004
Gender	−0.723*** [0.116]	0.485	−.721*** [.121]	.486
Market size	−0.046 [0.076]	0.956	−.006 [0.048]	.994
Education	−0.378** [0.135]	0.685	−.370** [.140]	.691
Income	0.092 [0.066]	1.096	.076 [0.069]	1.079
Children under 18	.595*** [0.133]	1.812	.551*** [.134]	1.736
Tested positive			.340 [0.172]	1.404
Knows someone who died			.243 [0.127]	1.275
In at risk group			.233 [0.138]	1.263
Constant	0.908* [0.406]		.598 [0.450]	
−2 Log likelihood	1,767.383		1,656.340	
Nagelkerke R Square	.073		.085	
Hosmer and Lemeshow Test sig	.539		.588	

Robust standard errors in parentheses.

* $p < .05$;

** $p < .01$;

*** $p < .001$.

Our first hypothesis (H_1) stated that respondents who had a more serious personal experience of the pandemic and are more vulnerable to the virus would be more likely to express some level of Vaccine Nationalism. A hierarchical logistic regression was conducted to ascertain the effects of the predictor set on respondents' expression of some level of Vaccine Nationalism. The logistic regression Model 1 was statistically significant, $\chi^2(6) = 72.437$, $p < .001$, just as Model 2, $\chi^2(9) = 85.624$, $p < .001$. Model 1 explained 7.3% (Nagelkerke R^2) of the variance in Vaccine Nationalism and correctly classified 65.1% of cases. While age, income, and market size are not significant predictors, the results show that female respondents and those with higher education are less likely to express Vaccine Nationalism. The only positive predictor of Vaccine Nationalism is whether respondents have children under 18 living in the household. Those with such children are around 70% more likely to express some forms of Vaccine Nationalism.

Model 2 explained 8.5% of the variance and only slightly increased the correct classification rate to 66.7%. As none of the additional variables were significant predictors, we can conclude that personal experiences of the pandemic do not contribute significantly to the expression of Vaccine Nationalism (Table 3).

Therefore, while some forms of vulnerability (such as having a household with minor children) contribute to decreasing the likelihood of the expression of Vaccine Nationalism, personal experiences of the pandemic have no effect. Therefore, we can reject our first hypothesis (H_1).

Table 4 presents the results of the second logistic regression that was conducted to test hypotheses 2, 3, and 4. In order to examine the effect of predictors independently, a hierarchical logistic regression was conducted with three models. Model 1 examines the effect of perceptions of **Threat to one's Nation**, Model 2 adds the effect of **Attachment to Nationalist Ideology**, and Model 3 adds the sense of **Pride in National Achievement** to the predictor set. All three models proved statistically significant: Model 1 $\chi^2(3) = 123.606$, $p < .001$, Model 2 $\chi^2(10) = 254.108$, $p < .001$, Model 3

Table 4. Logistic regression—vaccine nationalism (DV); three models.

Independent variables	Model 1		Model 2		Model 3	
	B	Exp(B)	B	Exp(B)	B	Exp(B)
Threatened by other nations						
My nation will come out much more united from the COVID-19 crisis	0.358*** [0.060]	1.430	0.074 [0.071]	1.077	-0.026 [0.075]	0.975
In the COVID-19 crisis, my nation is completely dependent on other nations	-0.209*** [0.060]	0.811	-0.233*** [0.065]	0.792	-0.234*** [0.067]	0.791
In the COVID-19 crisis, other nations will take advantage of my nation	0.452*** [0.064]	1.571	0.213** [0.071]	1.238	0.154* [0.073]	1.167
Political identities and attachment to nationalist ideology						
Political Orientation (Left vs. Right)			0.209*** [0.035]	1.232	0.200*** [0.036]	1.222
Moreno's Identity Scale (English vs. British)			-0.127* [0.055]	0.881	-0.110 [0.056]	0.896
The world is naturally divided into nations			0.148 [0.081]	1.159	0.138 [0.082]	1.148
If they wish to be free, people must belong to a nation			0.208** [0.081]	1.231	0.151 [0.083]	1.163
Loyalty to a nation is more important than other loyalties			0.241** [0.080]	1.273	0.199* [0.082]	1.221
Each nation should have an independent state			0.044 [0.080]	1.045	-0.004 [0.082]	0.996
Pride in national achievement						
My nation does not need anyone in order to overcome the COVID-19 crisis					0.272*** [0.070]	1.313
The efforts of my nation will help the whole world in overcoming the COVID-19 crisis					0.309*** [0.088]	1.363
Constant	-2.496 *** [0.264]		-3.622*** [0.422]		-4.570*** [0.494]	
-2 Log Likelihood	1,516.255		1,385.416		1,357.476	
Nagelkerke R Square	.127		.251		.276	
Hosmer and Lemeshow Test significance	.012		.296		.434	

Robust standard errors in parentheses.

* $p < .05$;

** $p < .01$;

*** $p < .001$.

$\chi^2(12) = 279.410$, $p < .001$. Model 1 explained 12.7% (Nagelkerke R^2) of the variance in Vaccine Nationalism and correctly classified 66.6% of cases. Model 2 explained 25.1%, and Model 3 explained 27.6% of variance and correctly classified 70.2% and 70.4%, respectively. However, the Hosmer and Lemeshow Test for Model 1 is significant, and therefore the model is not a good fit.

The Model 3, which includes the full predictor set, adds only a small improvement in correct classification and explanation of variance. However, two indicators of **Pride in National Achievements** are the strongest predictors.

Both Model 2 and 3 show the effect of the Perception of **Threat from Other Nations**. The perception that other nations might take advantage of respondents' own nation increases the odds of Vaccine Nationalism but has minimal effect. On the other hand, the perception of dependency on other nations at the time of COVID-19 significantly decreases the probability of the expression of Vaccine Nationalism. These results suggest that H_2 —*respondents who hold that their nation is threatened by other nations at the time of the pandemic will be more likely to express some level of Vaccine Nationalism*—should be rejected. Instead, we can claim with higher certainty that respondents who perceive their nation dependent on other nations at the time of the pandemic are less likely to express any form of Vaccine Nationalism.

Model 2 shows a significant effect of **Attachment to Nationalist Ideology** on the expression of Vaccine Nationalism where respondents who are more likely to identify as English rather than British and those who place themselves on the Right side of the political spectrum are more likely to express some form of Vaccine Nationalism. Two views that are at the core of every nationalist ideology have a similar effect: the view that equates freedom of the people with belonging to a nation, and the view that prioritizes loyalty to the nation over any other loyalties. However, in Model 3, when the effect of Pride in National Achievement is controlled, only the Political Orientation and view on Loyalty remained significant predictors and neither of which, on their own, can indicate attachment to nationalist ideology. However, this Model 3 also shows that Vaccine Nationalism is more likely to be expressed by those respondents who see themselves on the right side of political orientation and who express a level of pride in national achievement and a belief in self-sufficiency of their nation in coping with the crisis. While we cannot reject H_3 —which states that *respondents that are more attached to nationalist ideology will be more likely to express some level of Vaccine Nationalism*—the effect of nationalism as an ideology on the expression of Vaccine Nationalism must be taken with caution.

Discussion

Our analysis shows that out of the four tested hypotheses on factors that contribute to the expression of Vaccine Nationalism, only two could be accepted, but one of them with a dose of caution. It demonstrated that personal experience of the pandemic does not affect respondents' expression of Vaccine Nationalism. Male respondents, those with education below degree level, and those with minor children in their households are more likely to prioritize vaccination of their own nation. While none of these social groups could be called necessarily vulnerable, we can allow that respondents could perceive their minor children as such. A more detailed analysis would be necessary to fully explore the effect of gender differences in the expression of Vaccine Nationalism. At this point, we can say that male respondents are, on average, leaning

more toward the political Right (mean = 5.23) than female respondents (mean = 4.76; $t(1,752) = 4.590$, $p < .001$), which proves to be a significant predictor of Vaccine Nationalism (see Table 4). Similarly, those who have minor children in their households are, on average, more likely to lean toward the Right (mean = 5.45) than those with no minor children (mean = 4.81; $t(1,755) = -5.663$, $p < .001$). Parents of minor children are also, on average, younger (mean = 38.91) than those without minor children (mean = 47.45, $t(1,998) = 11.335$, $p < .001$). Since the rollout of the vaccine was conducted based on age groups, younger parents could have been more concerned with their safety and therefore the safety of their children, which could make them more likely to express some form of Vaccine Nationalism.

Political identification could also be one of the reasons why those with education up to university level are more likely to express some level of Vaccine Nationalism. Further analysis shows that those with a lower level of education are, on average, more likely to describe themselves as more English than British (mean = 2.83) than those with a higher level of education (mean = 3.23; $t(1,739) = -6.439$, $p < .001$) and are, on average, leaning more toward the Right of the political spectrum (mean = 5.11) than those with higher education (mean = 4.74; $t(1,705) = 3.158$, $p < .001$).

Apart from minor children, socio-demographic characteristics proved to be weak predictors, and personal experiences of the pandemic were not predictors of Vaccine Nationalism. Therefore, factors affecting Vaccine Nationalism should be sought in the domain of attitudes and identities rather than in experiences of crisis.

Comparatively, indicators of **Pride in National Achievement** turned out to be the strongest predictors of Vaccine Nationalism while adding a minimal amount of explained variance. This notion of national self-sufficiency at the time of the pandemic is confirmed in the rejection of dependency on other nations. Yet, respondents more likely to express this view are more optimistic about the positive role their nation will play in the pandemic. Since **Attachment to Nationalist Ideology** does not significantly affect the expression of Vaccine Nationalism, we can say that this analysis confirms results of the qualitative research conducted by Vanderslott et al.⁸⁶ It seems that in the expression of Vaccine Nationalism, the vaccine is perceived as a symbol of national achievement that will benefit not only the nation but the entire world as well. On average, respondents have expressed the highest level of acceptance of this view (see Table 2), where more than two thirds of the respondents agreed with the statement. In this context, the expression of the view which prioritizes vaccination of one's own nation could be understood as an earned right. The invention of the vaccine by scientists and multinational pharmaceutical companies funded by national government seems to be translated as "a marker of preeminence and for the construction of national identity."⁸⁷

Still, unlike Moreno's Identity Scale, respondents' political orientation features as a significant predictor of Vaccine Nationalism in both Model 2 and Model 3. Respondents who are self-identifying with the Right side of the political spectrum have higher odds to prioritize vaccination of their own nation. While we do not intend to engage in the discussion on the usefulness of the left-right political scale, the impact of this categorization on the expression of Vaccine Nationalism could be a confirmation of Bobbio's⁸⁸ assumption that the political left leans toward equality and the political right to inequality in all aspects of everyday life, and therefore on issues of who should be prioritized in vaccination during a pandemic.

As we have seen, recent literature on Vaccine Nationalism focuses on public policy in high-income states that put “my country first” when procurement of the vaccine is in question, and hence points at acts of governments responsible for such policy. Chatterjee et al.⁸⁹ claim how “vaccines are political” but they fail to mention that politics is state-bound. The expression of Vaccine Nationalism is not necessarily an expression of nationalism as an ideology but “a measure of state power, both domestically and internationally.”⁹⁰

Vaccine nationalism among the population of England seems not to be a form of nationalist ideology. Rather, it is more likely to be expressed as a symbol of national achievement where the term “national” effectively means the achievement of the country. It is an expression of pride in scientists, pharmaceutical companies and the government that are perceived as “ours.” However, it is quite clear that Vaccine Nationalism was a policy of the UK government that put the interests of their citizens first. However, these governments prioritize their countries not only in the context of vaccines but extend this stance to encompass all medical resources and knowledge, as well as every facet of economic, social, or political engagement. This predisposition is widely acknowledged within the discourse on the ethical dimensions of Vaccine Nationalism. In the reviewed literature, aside from Hassoun,⁹¹ no author explicitly contests the entitlement of governments to procure vaccines for their citizens, particularly if they possess the means to do so. Many do not see procurement of more-than-needed vaccines as inherently unethical. The ethical implications of Vaccine Nationalism are primarily brought to the fore when the issue of vaccine surplus is deliberated.

The foundational tenets of free market principles remain largely unchallenged. Intellectual property rights remain uncompromised. It was only toward the close of 2022 that a compromise emerged, permitting developing countries to manufacture patented COVID-19 vaccines for the subsequent five years. Naturally, this arrangement comes with a caveat: “Rights holders will be compensated.”⁹² While the Oxford-AstraZeneca vaccine’s intellectual property rights belong to the Anglo-Swedish pharmaceutical company, researchers ascertain that approximately 97% of the funding that facilitated the vaccine’s development originated from taxpayers and charitable sources.⁹³

When explaining the causes of British success, in a private Zoom conversation with backbench MPs, Boris Johnson said: “The reason we have vaccine success is because of capitalism, because of greed my friends.”⁹⁴ It makes one wonder whether “vaccine capitalism” would be a more accurate term to describe what occurred during the COVID-19 pandemic.

Ethical approval

The study received approval for exemption from full ethical review by the human research ethics committee at University college Dublin (HS-E-21-11-Malesevic).

Disclosure statement

No potential conflict of interest was reported by the author(s).

Notes

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