THE TRANSFORMATION OF GLOBAL GOVERNANCE PROJECT

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HEALTH: CRISIS GOVERNANCE FOR A VITAL GLOBAL PUBLIC GOOD

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Disease prevention and cure: Not the hardest of all collective action problems. Disease prevention and cure does not represent a "tragedy of the commons" and is in principle not the hardest of all collective action problems. Contamination across borders as well as the significant economic spillovers of national containment measures (such as a quarantine) suggest that there are strong reasons to cooperate internationally. At the same time, there are few incentives to free ride and a common interest in sharing information, so that cooperation would appear to be easier to achieve than in other fields, such as climate action. The existence of a lively global scientific community as well as an old tradition of international cooperation in this field, going back to the 18th and 19th centuries, also forms a strong basis for coordinated evidence-based action.

The issue: Various interdependence patterns, various incentives to cooperate. At a conceptual level, the incentives to cooperate depend on interdependence patterns, which differ according to the issue at hand. Disease often develops where health capacities are the weakest, so that in controlling a disease, the outcome often depends on the weakest link ("weak link interdependence"), suggesting a strong incentive for global monitoring and support to the poorer and more vulnerable countries. In the case of vaccine research, instead, the outcome mostly depends on best shot performance ("best shot interdependence"). The positive spillovers from individual action suggest that funding by rich countries ultimately benefits everyone. Finally, in actual vaccination, there is a common interest in fighting the disease everywhere (weak link interdependence).

The institutions: the central but flawed role of the WHO. The legacy institution in health governance, the WHO, is strong on paper, but weak in practice. It operates based on an extensive legal basis and executive powers as the "directing and co-ordinating authority" in the health field, able to enact legally binding regulations (IHRs), while recent (2005) reforms granted new executive powers to its Director-General in terms of investigation, or PHEIC declaration. It is however severely affected by UN system illnesses of paralysis via the quest for consensus; it is fragmented into regional entities, each with their own managerial character; it is chronically underfunded and therefore dependent on grants from private organisations; it has no sanctioning capacity; and critically, it is limited by national sovereignty in health policy. In fact, the crisis has shown that what is mainly missing is not operational cooperation, but rather political support.

The evolution: A fragmented landscape. Today, the WHO is part of a new constellation of institutions, including focused, nimble, but more limited entities (the Coalition for Epidemic Preparedness Innovations - CEPI, GAVI - the Vaccine Alliance, the Global Fund, Unitaid), representing substantial funding efforts of multilateral agencies and institutions as well as public-private partnerships, NGOs or philanthropy, with the latter turning out to be a potent instrument for a rapid and focused response on individual health problems; a form of multilateral governance by delegation. These have often been extremely effective in their domains but remain limited in their remit and form a scattered landscape that is inadequate in facing up to the problems at hand. The core of the multilateral system, the WHO, has functions that cannot be replaced by anyone else: standard-

setting, protocols for data reporting, sharing lab results, authority to declare health emergency and ban travel to/from certain areas, etc.

The Covid record. A pandemic scoreboard would cover a number of elements: alerting to the disease; monitoring its process; norms-setting and enforcement; coordination; resource allocation and funding; and solidarity. Of these items, those that relate to international cooperation to deal with the collective action problem of disease prevention and control, have been a clear failure. There was lack of sharing of the kind of data and information that would have been necessary for the WHO to act early, of contamination control, of harmonisation of standards, coordination of control initiatives, in the allocation of PPE, respirators, and other medical equipment, as well as in monitoring. The lack of speed and frankness of decision-making at national and international level did not succeed to warn early and contain the disease. WHO governance and leadership, as well as national reactions, combined with lack of funding and broader geopolitical constraints are all valid explanations for this failure. On the other hand, instant scientific cooperation on a global scale made it possible to quickly sequence the genome and results have been remarkable in vaccine research, funding and rollout (the less than one-year period for the availability of multiple vaccines has been extraordinary). Finally, the effectiveness of collaboration in vaccine distribution within the framework of GAVI remains to be seen, as well as issues of rollout in the global south.

The way forward - a first-best approach. Looking forward, it is hard to escape the conclusion that the current governance system is not well equipped to deal with new (and possibly increasingly recurrent) pandemic emergencies. What is required is much more than marginal changes and tinkering with rules of existing institutions. A first-best approach would entail nothing less than the repositioning of global health governance in the world order, to put it at par with economic interdependence or financial stability in terms of governance, institutional backing and resources. After all, health issues have proved in this pandemic to be at least as critical; a virus shut down the world. Not least, such a fundamental reset would need to integrate more closely the health issues of developed countries with those of the developing world. This would also imply the need to think beyond narrow health policy when it comes to the prevention of pandemics. Loss of biodiversity and natural habitat is an important driver for more frequent pandemics and diseases. In terms of governance, this fundamental restet would require either a new universal framework for cooperation or at least a substantial overhaul of the WHO in terms of higher permanent funding (including via new permanent resources) and responsibilities (a new health Treaty). As the problem has been the lack of political support for reforms, this would necessitate a political push from the heads of state and government (presumably from the G20) at least as strong as the impetus provided in the immediate aftermath of the global financial crisis.

Settling for second-best? Political realities on the sovereignty issues that many nations perceive to be surrounding health suggest a second-best approach should also be envisaged. A successful reform at the margins of the existing system would need to build on what works and scale up successful initiatives. The first layer would be a universal mechanism for standard-setting, information-sharing, monitoring and alert on infectious diseases. It would be assigned limited responsibilities but be equipped with the legal, institutional and financial means to exercise them fully, in cooperation with a network of regional bodies. This mechanism could rely on a reformed WHO or, possibly, on an newly created institution. Building on successful existing initiatives, a second layer would include dedicated cooperation schemes (for specific research, the fight against particular diseases, capacity-building, tec..) involving on a variable-geometry basis regional institutions, governments, charities and dedicated NGOs.