THE TRANSFORMATION OF GLOBAL GOVERNANCE PROJECT

17 DECEMBER 2020 SEMINAR

HEALTH: CRISIS GOVERNANCE FOR A VITAL GLOBAL PUBLIC GOOD

Seminar insights — G. Papaconstantinou, J. Pisani-Ferry, and G. Wolff (Bruegel)

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.

Seminar Minutes

One convenor introduced the seminar by reflecting on the structure of the collective action problem that the Coronacrisis represents in international health governance. Incentives to cooperate should be stronger than in a "tragedy of the global commons" structure such as climate change: beyond curtailing the obvious spillover effects, action benefits first and tangibly a state's own citizens, and can only be as effective as its weakest link. This structure makes it kin to prudential efforts in financial governance, which are less internationally institutionalised. Despite a strong epistemic community, a long tradition of cooperation, and recent WHO reforms to reinforce its authority, international health governance is deemed to have failed to respond to the crisis with appropriate speed and transparency.

Session I – Why the collapse in cooperation?

The first speaker challenged the convenor's pessimistic analysis. They recalled the unprecedentedly short amount of time that development and rollout of vaccines and treatments has taken, the unprecedented global data-sharing and resulting scientific collaboration, and the concern shown for lower-middle income countries (LMICs). The crisis has given birth to political will in the international community to revive a stagnant WHO, as well as in the EU with plans for a Health Union. It is precisely political will that created dedicated organisations to deal with specific health governance problems the WHO could or would not deal with, with the establishment of the Global Fund, UNITAID, and GAVI: rigidities and deficiencies of the UN were bypassed "within itself", as they remain its satellite organisations, and have displayed effective operational cooperation to implement its Sustainable Development Goals.

The WHO was almost dead. Now, everyone is listening.

This success should not obscure underlying weaknesses however: this kind of fragmented multilateral governance by delegation, lacking unitary directive political will, satisfied richer countries pre-pandemic, as fairly flexible, agile and funded institutions seemed in place to remedy the problems of the distant global South. It also bypassed addressing structural problems of WHO governance: it has no independent monitoring and sanctioning capacity, its unitary capacity is hampered by its regional sub-bodies, and it is severely underfunded. Philanthropy emerged to fill this gap, but earmarks funds according to its own interests. Operational cooperation has been effective until now, if not entirely centred around the WHO, but has met its limits with the pandemic, as countries in the global North scramble to face a situation they did not believe could really happen to them, despite expert advice and forewarning events (Ebola, SARS-1).

The second speaker echoed the first speaker's point on the relative unpreparedness of more developed countries; LMICs that have underperformed have done so because of a lack of or obstructionist political will, as in Brazil. They noted that for all the concern displayed towards LMICs, they will still suffer from vaccine inequality: richer countries will receive vaccines earlier, in a wider variety than that afforded to them due to costs and physical constraints (e.g. ultra-refrigeration). This will have amplifying effects on global inequality.

One participant identified four significant failures that hampered collective action in the face of the Coronacrisis. First, the WHO relies for monitoring on member state bodies, on whom governmental pressure can be exerted. Extraordinarily, it is allowed to consider non-state sources, but this is politically delicate, as the early stage of the crisis showed with China's disqualification of Taiwanese data. Second, the timing and responsibility for triggering a Public Health Emergency of International Concern (PHEIC) is equally politically delicate. Third, there was a lack of incentive to prepare for a pandemic, including in many LMICs due to their other pressing concerns. Finally, supply chains for basic health materials suffered strain from competing procurement demands, resulting in unequal

distribution. To ensure this is not the case for vaccines, COVAX is meant to pool the purchasing power of its participants and ensure equal distribution: it is the "vaccines pillar" of the Access to COVID-19 Tools Accelerator (ACT-A), a multi-stakeholder partnership to strengthen health systems, and develop diagnostics, treatments, and vaccines. It is coordinated by GAVI, the Coalition for Epidemic Preparedness Innovations (CEPI) and the WHO, and is funded not only by member states but also by multilateral and regional development banks.

Discussion proceeded with participants striking a nuanced position between optimism at unprecedented successes and disappointment at manifest governance failures in the face of geopolitics. The temporal dimension was pointed out: like in the global financial crisis, initial uncertainty first impulsed uncoordinated (or even predatory) national reactions, where prisoner's dilemma-type thinking takes over, and institutions must learn by doing. More or less rapidly, however, flexible and solidary cooperation emerges, but its dissipation (as with the development of effective vaccines) is accompanied by rising selfishness and the reemergence of the "paradox of sovereignty": states are bound to signal support to their citizens in priority, even if collective international action ("restricting" sovereignty) would address the problem better. International organisations remain dependent on states for authority; whereas American withdrawal from the WHO can written off as Trumpian pique and did not damage its authority too severely, the US's criticism that it undermined its own credibility by soft-pedalling China and issuing contradictory scientific advice for political reasons cannot. Participants criticised the low level of scientific discourse and political leadership in some countries, and compared the authority positions and leadership of Christine Lagarde and Dr. Tedros in their respective situations of crisis; she "told the truth to power", he did not.

One participant remarked that while information-sharing was indeed impressive, little of it filtered to political and policy levels in useable time; this is a failure specifically for the EU, which has legal basis to assume this competence. Another cautioned that structures of collective action problems in global health will depend on the nature of the problem (infectious vs non-infectious diseases, airborne or not, relative virulence, etc. It was pointed out that funding to combat infectious diseases, public and private, is extremely low). A third discouraged institutionalising the COVAX facility, recommending instead to regionalise health governance in existing economic blocs (EU, NAFTA-MUSCA, ASEAN, AU, etc) rather than WHO regions.

The first speaker stressed the necessity of analytically separating questions of how to help LMICs and why richer countries were ill-prepared. They highlighted their view that Ebola is an inappropriate analogy, and that the WHO was moribund before a concerted effort by France, Germany and the EU to revivify it. A convener agreed that fresh delegation of authority to an international organisation from its member states seems to require crisis: as with the IMF, so with the WHO. Optimal institutional mix is the key question, as institutionalisation can be pursued either multilaterally or in variable geometry constellations. The emergence of a vaccine should not obscure the failure of prevention and management of the crisis.

Session II – How to rebuild?

The first speaker returned to the roots of the crisis, diagnosing that continual interconnection and encroachment on nature has created an environment where contagion spreads farther and faster. Reduced state capacity in this domain becomes another fertile bed for populist political exploitation. Vaccines will not bring back "business as usual", and health governance needs wholesale reform. Continuous reform of the WHO, a post-WW2 institution, has only exhausted it and shown it to not be fit for purpose for a globalised world. International health governance should not adapt to global governance imperatives; global governance should adapt to international health imperatives, as it has for those of trade and finance. Preventing and better mitigating similar future health crises is just as imperative, because shutdowns have been extremely socially and economically damaging. The question of funding of crucial: as it is, international health governance bodies, woefully underfunded

by member states (and sometimes at existential threat from the withdrawal of one, i.e. the US), are beholden to the pet projects of private interests; though laudable, they do not always correspond to actual or eventual needs of LMICs. The WHO is now primarily funded by the Gates Foundation, and its second-largest contributor is Germany. International health should enjoy funding independent of international events and political cycles, perhaps through a transnational tax on transactions; the speaker noted that UNITAID is partly funded in this way (by a levy on airline tickets, pioneered by France and adopted in some West African states, Chile, and South Korea). The WHO is clunkily bureaucratic and undemocratic: international health governance, on the whole, must be democratised.

We can't just tinker with what we have for health governance.

To a question by a convenor on the efficiency of clubs and targeting key actors, the second speaker argued that the WHO, for all its failures, continues to assume irreplaceable, multilateral functions, especially for monitoring: elaborating, harmonising and disseminating international standards, protocols for data reporting, sharing of lab results, etc. Politics is inescapable, and domestic attentions are elsewhere, so we will only see tinkering reform. Yet there is hope for WHO standards, if better surveillance can established; perhaps by a separate organisation, on the model of the FSB for finance. CEPI is an example of an effective initiative for preparedness, and should be transposed on a wider scale to antiviral treatments. The speaker concurred that financing of international health is the crucial question, as is how to improve incentives to do so for preparedness and response efforts.

It remains an open question whether the Coronacrisis is an exceptional, once in a century event, but scientific indicators do not invite optimism. It is the second coronavirus outbreak causing severe acute respiratory syndrome (SARS), after the first epidemic in 2003: hence its scientific name, SARS-CoV-2. Coronaviruses are endemic and mutatory, and there is no reason to believe this one is different: indeed, it has already mutated to an even more virulent strain. Moreover, there exists a growth trend of emerging and re-emerging diseases correlated with globalisation, as well as increasingly dire warnings about antimicrobial resistance: according to one participant, this will certainly be a future global health crisis.

Discussion circled back to the reasons for failure, in order to think about how to rebuild, with a mind towards preparedness for future events. One participant noted that the WHO had made repeated assessments that many of its member states, including those of the EU, were not compliant with its International Health Regulations (IHR), its legal instrument defining states' rights and obligations in handling potentially transnational public health events and emergencies. Furthermore, the health crisis quickly became a multi-sectoral crisis as global value chains, especially for protective equipment (masks), initially underwent severe stress, and are now under pressure as calls to reshore production nationally strengthen, especially for vaccines. This is short-sighted, as a regional view is more appropriate. National preparedness, in line with commitments made to WHO guidelines, as well as sectoral cross-effects must be addressed; but reform of global health governance must have a manageable scope to be feasible. The crisis is an occasion to commit to, at least, pandemic preparedness and management.

Participants were divided on whether to concentrate on the WHO as a focal institution. Some argued that while the G20 ministerial meetings had thus far been ineffective, new life could be breathed into them, especially considering the entanglement of health and social and economic issues. The G7 could also be called on, as the US will likely cease obstruction with a new administration. International financial institutions like the World Bank and the IMF must rethink their "health economics" paradigm, and perhaps revise their charters, to truly take this intrication into account. One participant interjected that the IMF has the best existing self-financing model, and devising an international tax to fund health services seems unfeasible. One participant questioned the difference in treatment between financial and health crises, noting that vast sums were quickly mobilised for the global financial crisis whereas CEPI and the COVAX facility still have to beg for money. Regional

blocs could also be leveraged, especially the EU: it was one of the initiators of ACT-A, and its Health Union proposals package is welcome in this respect.

The conveners concluded that the present international health governance architecture may be fundamentally unfit for purpose, necessitating more of a rebuild than a repair. Shared interest in cooperation, especially because of the broadness of the issue and the potential for recurring crises, does not translate to effective incentives to do so, and sovereignist reflexes and ideas remain a key sticking point. A focal institution with a clear mandate, political will to back it up, and secure and adequate funding are still sorely lacking.

Programme

Thursday 17 December 2020

16.30-16.40 Welcome and introduction

16:40-17:30 **Session I – Why the collapse in cooperation?** What lessons can be drawn and what coalitional strategies should be pursued from the Covid-19 pandemic health governance?

17:30-17:40 Break

17.40-18.20 **Session II – How to rebuild?** How can states and international organisations rebuild a better international health regime; with what protection, accountability, inclusiveness?

18:20-18:30 Concluding remarks

- **Participants**

Anne Bucher	Former DG Health, European Commission
Adrien Bradley	Robert Schuman Centre for Advanced Studies, EUI
Monica De Bolle	Peterson Institute for International Economics
Luc Debruyne	CEPI - The Coalition for Epidemic Preparedness
Maria Demertzis	Bruegel
Werner Ebert	German Ministry of Finance
Amanda Glassman	Center for Global Development (CGD)
Ellen Immergut	EUI
Kelley Lee	Faculty of Health Sciences, Simon Fraser University
Isabel Mota	Calouste Gulbenkian Foundation
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Marisol Touraine	Former French Minister of Social Affairs; UNITAID
Reinhilde Veugelers	Bruegel
Harald Waiglein	Austrian Ministry of Finance
Guntram Wolff	Bruegel
Ben Wreschner	Vodafone