

# COVID-19 and the Trials and Tribulations of Global Health Governance<sup>1</sup>

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## Abstract

*The COVID-19 pandemic has brought to the fore significant shortcomings in global health governance. Faced with the rapid international spread of the virus, international actors unsuccessfully attempted a coordinated international response to tackle the COVID-19 outbreak and its far-reaching repercussions. The present article aims to shed light on certain flaws in the existing global health governance architecture that have thwarted both formal – the World Health Organization and the United Nations – and informal international actors – the Group of Seven and the Group of Twenty – in steering the international community through the current global health crisis. It first examines the actions taken by these actors during the COVID-19 pandemic and assesses why they fell short in steering a coordinated international response. Having identified individual states as the real culprits for the inadequate performance, the article discerns the underlying causes of individual states' hindering of global health multilateralism. Subsequently, it underscores why global health multilateralism remains necessary in a post-COVID-19 world and which international actors should play an active role therein. To conclude, suggestions are given on how the global health governance architecture should be strengthened in a post-COVID-19 world.*

**Key words:** global health governance; global health actors; multilateralism; policy; COVID-19; World Health Organization; United Nations; Gx system

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## Introduction

COVID-19 has spread around the world with such speed and vehemence that it has left governments and multilateral organizations scrambling to formulate a timely response. Initially, a coordinated international response was absent. Tedros Ghebreyesus, the director-general (DG) of the World Health Organization (WHO or Organization), raised deep concerns on 11 March 2020 about the “alarming levels of inaction” in response to the outbreak, resulting in the announcement by the WHO that COVID-19 constituted a pandemic in the hope to awaken much needed international action [WHO, 2020a].

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<sup>1</sup> The editorial board received the article in April 2021.

COVID-19 has rapidly become a global phenomenon with severe repercussions. A flip side of globalization, increasing interdependence means that eradicating the virus in one or more individual states will not constitute a solution if other states remain unable to contain their COVID-19 cases. An integrated universal approach needs to be taken so that both developed and developing countries have the necessary tools to fight the pandemic at home. A coordinated international response should not only aim to address health-related issues but should also tackle the socio-economic consequences of COVID-19. To accomplish this, there is a clear need for leadership in global health governance. Only a small number of actors have the potential to take on an international leadership role when a global pandemic is raging. Regretfully, as this article will demonstrate, these actors fell short in effectively fulfilling a leadership role at the outset of the pandemic in early 2020.

The present article sheds light on certain flaws in the existing global health architecture that have thwarted – and continue to thwart – international actors in providing the necessary guidance and direction for a coordinated international response to the COVID-19 pandemic. We ask ourselves the following questions: why has global health multilateralism failed to provide an adequate, coordinated and timely response to COVID-19? What does this failure tell us about the flaws of today's global health governance architecture? And, what can be done to strengthen this architecture?

To answer these questions, this article will make a distinction between formal and informal international actors in global health governance, and it will mainly assess the activity on the part of specific international actors that are sufficiently powerful to direct broad multilateral cooperation in a health crisis. Our analysis first considers formal actors, with specific attention to the efforts of the WHO and the United Nations (UN) to steer a coordinated COVID-19 response and their shortcomings in trying to do so. Thereafter, we focus on the efforts – and shortcomings – of the Group of Seven (G7) and the Group of Twenty (G20) to develop a coordinated international response. Our analysis is limited to activities and conduct in 2020, the first year with COVID-19. Having identified the flaws of these four actors in directing and guiding multilateral cooperation as COVID-19 began to circulate internationally, we identify the underlying causes thereof. Last, we underscore why global health multilateralism remains necessary in a post-COVID-19 world and which international actors should play an active role therein. We provide a number of suggestions on how to strengthen global health multilateralism and international health actors so as to provide for a more robust global health governance architecture.

## Formal International Actors in Global Health Governance and COVID-19

### ***Formal International Actors in Global Health Governance***

Two prominent formal international organizations take up a key position in global health governance due to their unique role and past experience providing overall guidance and direction during international health crises: the WHO and the UN. Their broad mandates and global membership allow them to set priority areas and induce other international actors to implement or support health initiatives.

The WHO was established with the idea of being the single international organization within the UN framework to cover public health [Renganathan, 2013, p. 175]. Of special interest in the fight against pandemics is the WHO's central responsibility for the global regime on the international spread of disease [Burci, 2020a; IHR, 2005]. In line with this responsibility, the WHO has overseen the development of the International Health Regulations (IHR) with

its aim “to prevent, protect against, control and provide a public health response to the international spread of disease” [Burci, 2020a; IHR, 2005, foreword; Renganathan, 2013, p. 182].<sup>2</sup>

Other bodies within the UN have also played a guiding role in health governance. Notably, UN member states have placed health issues on the agendas of both the UN General Assembly (UNGA) and the UN Security Council (UNSC) [Blouin, Pearcey, Percival, 2013, p. 199].<sup>3</sup> Before 2020, member states used the UNGA to mobilize eight high-level fora on specific global health issues;<sup>4</sup> the UNSC, for its part, elevated health crises to the realm of international peace and security on four separate occasions<sup>5</sup> [Ibid., pp. 202–4; Harman, 2020; Security Council Report, 2020; UN, 2020r].

## Shortcomings of the WHO and the UN in Steering a Global COVID-19 Response

### WHO

Looking back, one cannot fail to notice serious shortcomings in the WHO’s initial response to the COVID-19 outbreak and, arguably, even later on. Two such shortcomings, as early as January 2020, were its slowness in declaring a public health emergency of international concern (PHEIC) and its attitude toward China’s lack of transparency and information sharing. First, it took the WHO’s DG approximately one month after the Organization’s first alert about the novel virus to declare a PHEIC, notwithstanding evidence of human-to-human transmission, the spread of the virus to other continents, and reporting on deaths [WHO, n. d., a]. In light of the available factual and scientific information, it should be asked why the DG did not declare a PHEIC sooner.<sup>6</sup> Second, the WHO also fell short in the way it responded to (the lack of) information sharing by China on the novel virus. In spite of, inter alia, reports from inside the country questioning whether the government was fully transparent about all deaths and the government’s repeated refusal of assistance from outside experts, the WHO did not reprimand

<sup>2</sup> Article 21(a) and 22 of the WHO’s constitution confers upon the World Health Assembly the authority to adopt regulations “designed to prevent the international spread of disease” [WHO, 1948].

<sup>3</sup> Other parts of the UN family, such as the Joint United Nations Programme on HIV/AIDS and the United Nations Population Fund, promote and protect global health as well [UN, 2020a]. The World Bank also has financing instruments to provide funds to the poorest countries in case of outbreaks, for example, the sale of pandemic bonds to support the Pandemic Emergency Financing Facility. Plans for a second sale in 2020 were called off after the pay-out of the first bonds due to COVID-19 raised criticism [Hodgson, 2020].

<sup>4</sup> One Special Session on the Problem of HIV/AIDS in All Its Aspects (June 2001) [UN, 2020b] and seven High-Level Meetings focusing on HIV/AIDS (June 2006), Non-Communicable Diseases (September 2011, July 2014 and September 2018), Antimicrobial Resistance (September 2016), Tuberculosis (September 2018) and Universal Health Coverage (September 2019) [Blouin, Pearcey, Percival, 2013, p. 202; UN, 2020c; 2020d; 2020e; 2020f].

<sup>5</sup> See UNSC Resolution 1308 (2000) [UN, 2020m], which encouraged voluntary HIV/AIDS testing and counselling for peacekeeping troops; UNSC Resolution 1983 (2011) [UN, 2020n], which encouraged the incorporation of HIV prevention, treatment, care and support in the implementation of mandated tasks of peacekeeping operations; UNSC Resolution 2177 (2014) [UN, 2020o], which determined explicitly that it was the unprecedented extent of the Ebola outbreak in Africa that constituted a threat to international peace and security; and UNSC Resolution 2439 (2018) [UN, 2020p], which condemned attacks by armed groups in the Democratic Republic of the Congo and their role in exacerbating the Ebola virus outbreak and urged all parties to the armed conflict to ensure full, safe, immediate and unhindered access for humanitarian personnel and medical personnel to patients and others in need [Harman, 2020; Security Council Report, 2020].

<sup>6</sup> Arguably, DG Ghebreyesus’ slow declaration of a PHEIC can be partially explained by his inclination to await the expert opinion of the Emergency Committee to shield himself from any future accountability. Burci noted in this respect that “[t]he DG until now has always “rubber-stamped” the EC’s conclusions, thus seeking political cover” [2020a].

China or strong-arm it into being more forthcoming [Joseph, Thielking, 2020; The Associated Press, 2020]. Strikingly, the DG chose instead to laud China for its fast outbreak response and transparency in those initial days [WHO, 2020b].

Nonetheless, the perceived flaws in the WHO's response to the COVID-19 outbreak are not solely attributable to its current leadership. The shortcomings also stem from limitations inherent in its governance structure and in the IHR. Without aiming to be exhaustive, we provide a number of illustrations to substantiate this point. The Organization's effectiveness has, for one, continuously been affected by its strong dependence on voluntary contributions by members [Gostin, 2020], which keeps it from criticizing large donor countries, like China, out of fear of funding cuts. Many of the WHO's perceived shortcomings can also, arguably, be traced back to limitations that stem from flaws in the IHR's design or from challenges in their implementation. On the one hand, these limitations can be traced back to member states' refusal (or lack of foresight) to transfer more authority to the Organization. To illustrate, the January 2004 draft text of the IHR (2004 Draft IHR) provided the WHO with more powers to use non-governmental sources of information in its global surveillance. As observed by Fidler, the 2004 Draft IHR stated that the WHO "may validate these reports" through verification procedures included in the IHR [2005]. Due to sovereignty concerns, this provision was ultimately revised in the adopted IHR whereby, before acting on such reports, the WHO is now first required to attempt to obtain verification of such reports from relevant members [Ibid.]. The same 2004 Draft IHR entrusted powers upon the WHO to conduct in-country studies to assess whether appropriate measures were introduced to control a PHEIC [Ibid.]. Again, due to sovereignty concerns, this provision was revised and the IHR now fails to extend such investigatory powers upon the WHO without prior consent by a member. The Organization, thus, hinges profoundly on individual states' willingness to share information and grant it access to perform its functions in full, as also demonstrated during the current pandemic [Taylor, Habibi, 2020]. China repeatedly refused access for international experts to visit Wuhan for fact-finding purposes in January 2020, and it also obstructed independent investigations later on [The Associated Press, 2020].<sup>7</sup> Overall, the WHO was – and remains – overly dependent on China's goodwill to obtain all relevant information regarding COVID-19, thereby curbing swift and effective early action.<sup>8</sup> The shortcomings in the Organization's COVID-19 response are also the consequence of members' inadequate compliance with the obligations they have committed to under the IHR. There are, for instance, large gaps in the implementation of capacity building measures by individual states, which they have committed to under the IHR, leaving national healthcare structures vulnerable [Bartolini, 2021].

Without trivializing individual states' concerns, the limitations in their transfer of authority and their falling short of meeting their commitments undercut the WHO from performing its functions to the fullest extent possible. Moreover, individual states circumvented WHO guidance and advice early on through their harsh criticism and self-serving conduct, which further undermined the WHO's credibility to lead a COVID-19 response. Nonetheless, the Organization should be strongly commended for what it did accomplish during the pandemic, *inter alia*, by providing guidance and advice, supplying resources and workforces on the ground, and accelerating the development of diagnostics, vaccines and therapeutics.

<sup>7</sup> In January 2021, another WHO team failed to visit China because their visas did not get approved [Sheperd, 2021].

<sup>8</sup> While the WHO's praise of China's outbreak response and transparency, especially in January 2020, gave rise to severe criticism that it was overly deferential to China, arguably, the WHO extended such praise because of its strong dependency on China to share information. Interestingly, later interviews and the WHO's internal documents indicate that the WHO was also frustrated with China's lack of transparency but used praise as a tactic to coax out more information [The Associated Press, 2020].

**UN**

The UNGA and UNSC also responded to COVID-19. To date, the UNGA has adopted eight resolutions in relation to the pandemic. However, their timing and content indicate that the UNGA did not immediately succeed in directing a coordinated international response in early 2020. The first four resolutions (two in April and two in September) mainly emphasized the overall need for global solidarity and international cooperation to respond to the pandemic [UN, 2020h; 2020i; 2020j; 2020k]. A careful examination sheds doubt on their ability to guide much-needed global coordination and cooperation. The first two resolutions, adopted in April 2020, merely contain affirmations of good faith principles and a recognition that global solidarity is needed in the response [Syam, 2020, pp. 6–7; UN, 2020h; 2020i]. They failed to recommend specific measures to respond to the pandemic and failed to clarify and delineate the roles which the WHO and UN should play [Syam, 2020, p. 6–7]. The two resolutions adopted in September 2020 remain inadequate to steer coordinated international actions [UN, 2020j; 2020k]. The UNGA Omnibus Resolution adopted in September 2020 confirmed the WHO’s “constitutional mandate... to act, inter alia, as the directing and coordinating authority on international health work” [Syam, 2020, p. 5; UN, 2020j, p. 3]. The other resolution adopted on the same day listed a number of priorities for which coordinated action needs to be taken [Syam, 2020, p. 6; UN, 2020k, pp. 2–3]. Nevertheless, it lacked specificity on how these priorities should be dealt with or which international actors should focus on them [Syam, 2020, p. 6]. In December 2020, three additional resolutions were adopted addressing challenges faced during the pandemic by two specific groups, namely seafarers and women and girls [UN, 2020s; 2020t; 2020u]. The eighth resolution in relation to COVID-19, also adopted in December 2020, highlighted the importance of affordable healthcare for all and underscored the importance of monitoring the impact of COVID-19 [UN, 2020v]. The UNGA adopted another resolution that month, which declared the period 2021–30 as the UN Decade of Healthy Ageing [UN, 2020w]. The UNGA also held a High-Level Special Session in Response to the COVID-19 Pandemic on 3–4 December 2020 that served to galvanize collective and multilateral action [Lederer, 2020; UN, 2020q].<sup>9</sup>

The UNSC adopted a resolution in respect of COVID-19 on 1 July 2020. Resolution 2532 (2020) demanded a general and immediate ceasefire in all situations on the UNSC’s agenda and called upon all parties to armed conflicts to engage immediately in a 90-day humanitarian pause [Security Council Report, 2020; UN, 2020l, Preamble]. It recognized that “the unprecedented extent of the COVID-19 pandemic is likely to endanger the maintenance of international peace and security” [UN, 2020l]. While the UNSC should be commended for elevating the COVID-19 pandemic to the realm of international peace and security, its leadership role during the COVID-19 pandemic is open to criticism given the protracted delay in adopting the resolution and its rather cautionary wording. As the primary guardian of international peace and security, the UNSC should have reacted well before seven months into a global health crisis. The UNSC failed to pass a resolution sooner due to the open hostility between two of its permanent members, the United States (U.S.) and China [Pobjie, 2020]. There was prolonged disagreement on how to refer to the virus and whether to refer to the WHO at all [Ibid.]. Notably, the U.S. vetoed an earlier draft in May 2020 because it was against any reference to the WHO [Borger, 2020]. Even a formulation that sought a compromise between the U.S.’ and China’s position by referring to “*specialized health agencies*” instead of the WHO was not acceptable to the U.S. [Ibid.]. In light of the significant delay in adopting Resolution 2532 (2020), it could at least have been expected that it would include strong wording recognizing COVID-19 as an

<sup>9</sup>A summary of the special session was circulated on 9 March 2021 [UN, 2021b].

actual threat to international peace and security. However, compared to the wording used six years earlier in Resolution 2177 (2014) [UN, 2020v], where the UNSC determined “that the unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security,” the formulation in Resolution 2532 that the COVID-19 pandemic was “likely to endanger the maintenance of international peace and security” was rather inapt.

### ***Interim Conclusion***

The actions taken and measures adopted by the WHO, the UNGA and the UNSC fell short in generating a timely or adequate coordinated international response during the initial months of the COVID-19 pandemic. Clearly, solely blaming the WHO or other UN bodies for their limited guidance in the first months of the pandemic would not be fair. Their decision-making abilities were held hostage to a large extent by member states. R. Basrur and F. Kliem accurately observed that, at best, both institutions merely fulfilled a supporting role in the initial efforts to curb the outbreak [2020].

## **Informal International Actors in Global Health Governance and COVID-19**

### ***Informal International Actors in Global Health Governance***

Over the past decades, global health governance has become increasingly characterized by the involvement of a plethora of informal actors [Kelley, 2011, p. 435; Szlezák et al., 2010, p. 1; Youde, 2018, p. 75]. While the latter typically do not have the ability to take on the leadership role that is required to guide the global health system when facing a pandemic, two informal actors arguably do have the international acclaim and power necessary to fulfil such a role: the G7 and the G20.<sup>10</sup> Their informal nature, bringing together a club of powerful states, allows them to focus on agenda setting, policy coordination, consensus building and the allotment of tasks and priorities to other international actors [Woods, 2011, p. 37, Wouters, Geraets, 2013]. While not outright global health actors per se, the G7 and G20 have previously made commitments regarding global health [Cooper, 2013; Lucas, 2019]. In recent years, both have continuously emphasized strengthening the response to public health emergencies as one of their health-related priorities [Lucas, 2019]. However, pandemic prevention, control and response are not central to their purview.

### ***Shortcomings of the Gx System in Steering a Global COVID-19 Response***

#### ***G7***

In light of the unfolding global health crisis, G7 leaders held a call on 16 March 2020, although their annual summit was only scheduled for June 2020 [Wintour, 2020]. Later that day, they issued a joint statement on COVID-19 expressing their full support for “the WHO in its global mandate to lead on disease outbreaks and emergencies with health consequences” and calling on the G20 to support and amplify the G7’s efforts to restore and expand economic

<sup>10</sup> One could consider the Global Health Security Agenda (GHS), with its key objective the improvement of the global implementation of the IHR and thereby the enhancement of country capacities to prevent, detect, control and respond to infectious diseases, as another informal group that could have taken on a leadership position during the pandemic. Nonetheless, this did not occur as even before the COVID-19 pandemic international action by the GHS seemed to have waned due to funding cuts.

growth [G7, 2020a]. G7 leaders also committed to “doing whatever is necessary” to guarantee a strong, coordinated international response [G7, 2020a; Wintour, 2020]. In retrospect, though, these were empty promises.

The joint statement of 16 March 2020 is the only common declaration on COVID-19 that G7 leaders were able to agree on in 2020. Afterward, internal disagreement prevented the G7 from forming a united front in the fight against the pandemic. At a virtual meeting one week later, G7 foreign ministers were unable to reach agreement on how to refer to the coronavirus in a joint statement, resulting in the issuance of several separate statements [Marquardt, Hansler, 2020].<sup>11</sup> A meeting on 16 April 2020 again failed to produce a joint statement, although several members did issue separate statements in which they voiced the need for a coordinated international response [10 Downing Street, 2020; Bundesregierung, 2020; European Council, 2020]. Interestingly, the statement published by the U.S. noted that much of the conversation during the April meeting revolved around the lack of transparency and mismanagement of the WHO [Wingrove, Donahue, 2020]. In stark contrast thereto, German chancellor Merkel’s spokesperson stated that she had expressed her full support for the WHO during the same meeting [Ibid.]. Further action by the G7 could have been expected to take place during its annual summit in June 2020 but the in-person meeting was called off by President Donald Trump, its host, due to the pandemic [Shalal, Mason, 2020]. He later unsuccessfully tried to revive the idea for an in-person meeting and even extended an invitation to Russia, which has not been a part of the G7/G8 since 2014 [Ibid.].<sup>12</sup> No further initiative was taken before the United Kingdom took over the G7 presidency in 2021 [Ibid.].

## G20

Several initiatives have been taken by the G20 to develop a coordinated response to the COVID-19 pandemic and its intertwined health, social and economic impacts. At first glance, the G20 should be commended for its efforts. For instance, it approved the Debt Service Suspension Initiative (DSSI) on 15 April 2020 [G20, 2020b; Reuters, 2020], which aims to help the world’s poorest countries cope with the economic impact of the health crisis [Ibid.].<sup>13</sup> Moreover, in its statement on COVID-19, agreed on 26 March 2020 during the extraordinary leaders’ summit, G20 leaders called upon “the WHO, IMF, WBG, and multilateral and regional development banks... to further step up coordination of their actions, including with the private sector, to support emerging and developing countries facing the health, economic, and social shocks of COVID-19,” which encouraged coordinated initiatives by international actors [G20, 2020a]. For one, the Asian Infrastructure Investment Bank responded to this call shortly afterward by launching a crisis recovery facility that offers financing to public and private sector entities adversely impacted by the pandemic [AIIB, 2020].<sup>14</sup> Another example is the Access to COVID-19 Tools (ACT) Accelerator, launched by the WHO, the European Commission, France and The Bill & Melinda Gates Foundation on 24 April 2020 [WHO, 2020c]. The ACT

<sup>11</sup> The U.S. State Department had pressed to refer to the coronavirus as the “Wuhan virus” but this was met with strong pushback from other foreign ministers [Marquardt, Hansler, 2020].

<sup>12</sup> The plans to hold a June summit were eventually postponed indefinitely after Merkel declined to attend the physical meeting given the raging pandemic, and frosty reactions were given toward the inclusion of Russia by Germany and others [Karnitschnig et al., 2020; Shalal, Mason, 2020].

<sup>13</sup> The debt suspension has been extended until at least 30 June 2021 [Reuters, 2020].

<sup>14</sup> While perhaps not following directly from the G20’s call, other multilateral development banks and regional groupings also established funds or extended financing in response to the COVID-19 pandemic in March and April 2020, for example, the World Bank’s Health Emergency Preparedness and Response Multi-Donor Fund, grants by the Asian Development Bank, the ASEAN Response Fund, and the African Union COVID-19 Response Fund.

Accelerator is a global partnership with the aim of accelerating the development, production and equitable access to COVID-19 tests, treatments and vaccines [WHO, n. d., b].

Nevertheless, upon closer inspection, the G20 did not fulfil its leadership role to the extent that could have been hoped for. While the DSSI is a commendable initiative, its implementation by individual states has shown cracks in their generosity. Thus, the G7 finance ministers, in a joint statement of 25 September 2020, “strongly regret[ted] the decision by some countries to classify large state-owned, government-controlled financial institutions as commercial lenders and not as official bilateral creditors... thus significantly reducing the magnitude of the initiative and the benefits of the DSSI for developing countries” [G7, 2020b]. While no explicit reference was made to China, G7 officials confirmed that this communication was directed toward China, which had failed to include particular state-owned banks and government-controlled entities as creditors in the DSSI [Shalal, Kajimoto, Thomas, 2020]. In addition, the UN secretary-general urged the G20 on 20 November 2020 to expand the scope of the DSSI to all developing and middle-income countries in need [UN, 2020g]. G20 finance ministers did agree to the Common Framework for Debt Treatments beyond the DSSI on 13 November 2020, which attempts to deal with the aforementioned problem, but other concerns remain, such as absence of mandatory participation by private creditors [G20, 2020c].

The aims of the ACT Accelerator partnership are laudatory. However, while its initial launch was influenced by the G20’s call for the international community to step up international coordinated responses [WHO, 2020c], G20 members failed to fully endorse this initiative in the swift and expeditious manner required by the circumstances. Prior to the G20 Riyadh summit on 21–22 November 2020, G20 members were fully aware that a large funding gap existed in the ACT Accelerator. Various prominent international leaders called on G20 members to commit to plugging the funding gap during their annual summit [Nebehay, 2020; WHO, 2020d]. The leaders’ declaration agreed at the G20 Riyadh summit states that “[w]e will spare no effort to ensure... affordable and equitable access [to COVID-19 diagnostics, therapeutics and vaccines] for all people... In this regard, we fully support all collaborative efforts, especially the Access to COVID-19 Tools Accelerator (ACT-A) initiative and its COVAX facility... We commit to addressing the remaining global financing needs” [G20, 2020d]. These statements regretfully did not contain concrete financial commitments (for example, to funding amounts or deadlines) [Nebehay, 2020; WHO, 2020d]. In addition, while this excerpt indicates the full support of G20 members for the COVAX facility and the vaccines pillar of the ACT Accelerator, one could sense a hint of hypocrisy originating from the U.S. and Russia, both G20 members who, unlike over 180 other countries, had not yet signed up to the COVAX facility at the time of this G20 declaration.<sup>15</sup>

When scrutinizing the G20’s leadership role, one must also consider initiatives that were *not* taken. For one, the G20 has repeatedly been asked to support a new allocation of special drawing rights or a reallocation of unused special drawing rights at the International Monetary Fund (IMF) [Nye, 2020]. While the G20 discussed this, it failed to reach consensus in 2020 due to the U.S. blocking such action [Ibid.]. In addition, the G20 could have been a driving force for high-income countries to assist in distributing medical equipment where it was most needed in the early days of the COVID-19 outbreak. However, in stark contrast thereto, individual G20 members, such as France and Germany, initially imposed export controls on medical equipment, thereby undermining any collective approach on this matter [Guarascio, Blenkinsop, 2020].

<sup>15</sup> One of President Joseph Biden’s first acts in office in January 2021 was signing up the U.S. to COVAX. Russia has not signed up to date.



### ***Interim Conclusion***

Both the G7 and G20 have convened since the initial COVID-19 outbreak, confirming an awareness on their part that providing guidance on a response to the global health crisis fell, at least partially, within their responsibility. However, like the WHO and UN bodies, the G7 and the G20 encountered significant hindrance by individual states when trying to guide and direct an early, coordinated international response in 2020.

## **Individual States' Interests and How to Strengthen the Global Health Governance Architecture**

In the preceding sections, we queried whether prominent formal and informal international actors were able to direct and guide a coordinated international response to the COVID-19 pandemic in 2020. By critically reviewing a number of actions taken and instruments adopted by these actors, we concluded that none were able to adequately fulfil a leadership role in the initial months of the COVID-19 pandemic. Each suffered significant interference by member states in trying to shape and guide coordinated multilateral cooperation.

### ***Underlying Causes for the Lack of a Timely Coordinated International COVID-19 Response***

Zooming in on these states, one wonders what the underlying causes were for their thwarting of collective international action by choosing protectionism over multilateralism.

#### ***III-Preparedness of the Global Community***

Arguably, before the COVID-19 outbreak, states (especially in the West) harboured a feeling of unsubstantiated safety, considering themselves well-prepared against an outbreak of a contagious disease.<sup>16</sup> In their defence, the WHO was a long-established international organization they helped create to prevent, prepare for and respond to disease outbreaks. In the wake of previous epidemics, the WHO had learned from experience and revised or implemented new instruments to guarantee a public health response in case of emergencies. Two important examples are the revision of the IHR in 2005 and the WHO Health Emergencies Programme (WHE) which was established in 2016, streamlining the WHO's emergency response efforts. Nonetheless, in 2020, the world found that these (and other) instruments did not generate a sufficiently prepared and response-ready environment capable of addressing a wide-scale pandemic.

While the IHR entrusts strong powers to the WHO and its DG in the wake of an international health crisis, its provisions allow significant leeway for individual states, which they have taken full advantage of during the COVID-19 pandemic. We discussed before several IHR provisions that show the limits to how much authority states wished to entrust to the Organization.<sup>17</sup> Moreover, even for those provisions in the IHR that instil obligations upon members, the implementation proved to be lacking. An example is members' responsibility to implement minimum core capacity building measures in their national healthcare systems. The WHE is another strong instrument to help individual states respond to health emergencies when the situation is most dire. It has equipped the WHO with strong operational capacities in the field, the implementation of which started in 2016 and continued during the COVID-19 pandemic. It

<sup>16</sup> Remarkably, the Global Preparedness Monitoring Board (GPMB) already reported in 2019 that “[t]he world is not prepared for a fast-moving, virulent respiratory pathogen pandemic” [GPMB, 2019].

<sup>17</sup> See *supra* Section 2.

is, however, not yet fully delivering on its ambition due to, among other things, vacant positions in its workforce and underfunding [WHA, 2020].

Overall, states were short-sighted in believing themselves prepared to swiftly respond to a global pandemic. WHO members expected the WHO to prevent, control and swiftly respond to the COVID-19 outbreak given that they had tasked it with this role through the creation of the Organization. While its membership did provide the WHO with elaborate powers in its constitution and in the IHR, the limitations to these powers and the ability of states to circumvent them prevented a satisfactory performance of its role as leading global health actor.

Nonetheless, individual states were also taken by surprise by the scale and speed of the current pandemic. States had taken certain steps to prepare for international disease outbreaks but, arguably, a global and prolonged pandemic like COVID-19 was not envisioned. This could also help to explain why, for example, the IHR has not been fully capable of responding to the pandemic. Its provisions had been negotiated with the aim of preventing, preparing for and responding to an international health emergency of a much smaller scale than COVID-19 [Burci, 2020b]. In light of the overall surprise and ill-preparedness to face a wide-scale pandemic, individual states took on a crisis management role in the early months of 2020, whereby their primary focus was to put out the fire and only thereafter to consider more long-term coordinated solutions.

### *Rise in Populism, Nationalism and Authoritarianism*

Another factor is the overall political climate currently confronting the world. Recent years have witnessed a rise in populism, nationalism and authoritarianism in a considerable number of states. Throughout 2020, various states that have historically played an important role in international decision-making had leaders who promoted such politics and did not disguise their political dissatisfaction with multilateralism.

The U.S. has arguably been the most polarizing force on the international level. While (former) President Trump chose to ignore the seriousness of the threat during the initial stages of the COVID-19 outbreak, he quickly changed his narrative by politicizing the pandemic once he faced an onslaught of COVID-19 cases throughout the United States. He also resorted to unilateralist measures by, inter alia, imposing travel restrictions and trying to obtain exclusive access to a coronavirus vaccine [Hernández-Morales, 2020]. A similar stroke of populism and pushback against the liberal order characterized the actions of Brazil's president Jair Bolsonaro, who denied the seriousness of the pandemic and brushed aside recommended protective measures such as social distancing [Rachman, 2020]. On their part, President Putin in Russia and President Erdogan in Turkey used the COVID-19 pandemic to tighten their grip on power in their respective countries through the use of propaganda and repressive measures [Walsh, 2020]. Surprisingly, even states that are traditionally among the strongest supporters of the liberal international order resorted to nationalist and protectionist measures at the outset of the pandemic. Examples were the export controls on medical equipment by European countries, notably France and Germany, and the refusal to voluntarily provide such equipment to Italy when it was in dire need thereof [Guarascio, Blenkinsop, 2020; Herszenhorn, Paun, Deutsch, 2020].

### *Leadership Vacuum*

The retreat inward by states during the COVID-19 outbreak, even by some of the most fervent supporters of multilateralism, can also partially be explained by a leadership vacuum on the international level. The U.S. was the long-standing hegemon among international actors,

which took it upon itself to guide the international community on global strategies to overcome former crises. During the Trump administration (2017–21), the world witnessed an accelerated retreat inward by the U.S. and its prioritization of its own interests at the expense of the liberal international order. Faced with the COVID-19 pandemic, the U.S. continued down this path and failed to take on the leadership role it previously fulfilled in global crises. Unfortunately, there was no other state with the leadership capabilities to brand the COVID-19 response as the highest priority for the international community.

### ***Moving Forward: How to Build a More Robust Global Health Governance Architecture?***

#### *Revisiting Global Health Multilateralism*

The inclination of states to go for domestic approaches and the international leadership vacuum, combined with the overall ill-preparedness of the international community for a widespread pandemic, should not necessarily signify a rejection of multilateral cooperation in global health matters. In our view, multilateralism aimed at addressing global health issues will persist beyond the current pandemic.

While, as demonstrated above, action both by prominent formal international organizations and informal international bodies fell short at the time of the initial outbreak of the coronavirus, it should be stressed that once the COVID-19 crisis was well underway, formal and informal actors realized the need for, and started to endorse, multilateral cooperation aimed at addressing specific repercussions of the pandemic – be it economic, health-related or otherwise. Specific examples are the creation of emergency funds or debt suspension initiatives by the WHO and the G20 and health guidance and advice on the WHO's website. Moreover, the global health architecture consists of a far more diverse set of formal and informal international health actors. While these other actors did not have the capability to steer an overall coordinated response, they did choose to join forces and cooperate in the wake of the pandemic. Examples are the promotion of vaccine development and equal access by the COVAX facility, the various emergency funds offered by international financial institutions and the funding of innovative research through the BRICS (Brazil, Russia, India, China and South Africa) Science, Technology and Innovation Framework's call for multilateral research projects [BRICS STI, 2020].

It is promising that, particularly in 2021, states seem to gravitate again toward multilateralism in response to the pandemic. Zooming in on the formal and informal actors examined in this article, we have already seen that the UNGA adopted two important health-related resolutions at the end of 2020.<sup>18</sup> In 2021, the UNSC unanimously adopted Resolution 2565 (2021) that called for strengthened international cooperation to facilitate equitable and affordable access to COVID-19 vaccines in armed conflict and post-conflict situations, and during complex humanitarian emergencies [UN, 2021a]. It also recognized the role of extensive immunization against COVID-19 as a global public good for health. G7 leaders were able to agree again on a joint statement on 19 February 2021 in which they recommitted to multilateralism through cooperation with the G20 and reiterated their support for the leading and coordinating role of the WHO [G7, 2021]. G20 finance ministers finally indicated their support for a new allocation of IMF special drawing rights on 26 February 2021 [G20, 2021]. They also designated granting equitable access to safe vaccines for all countries as a top priority and established a G20 High Level Independent Panel to promote preparedness against future pandemics [Ibid.]. States and regional groupings committed to additional funding for the COVAX facility. The U.S. under the

<sup>18</sup> See supra Section 2.

Biden administration has recommitted to multilateralism as well, as demonstrated by it signing up to the COVAX facility and the retraction of the country's withdrawal from the WHO.

While these examples show improvement of multilateral efforts on the part of states, interference can regrettably still be observed, as shown by the harm caused by vaccine nationalism.

### *Strengthening Formal and Informal International Health Actors*

Notwithstanding recent improvements in multilateral efforts, the review of the initial COVID-19 responses in 2020 by the WHO, the UNGA, the UNSC and the Gx system shows that there is an urgent need to strengthen the global health governance architecture. Such strengthening is required to ensure that multilateralism constitutes the primary working mode of states when faced with a global pandemic in the future.

To compel rapid collective action by states when faced with a future disease outbreak, global health governance needs to have actors and instruments in place that have the power and authority to galvanize states into multilateral and coordinated action over self-interested and protectionist measures. How can the international community attain this? It needs to improve the level of worldwide preparedness. Recognizing that complete preparation will never be attainable, global efforts still need to be scaled up to generate an international environment with actors well-prepared in case of a contagious disease outbreak that can only be contained collectively. There is not just one instrument or body that can help to achieve this. It will take effort on the part of many. We list below a number of efforts and reforms that could play a part herein.

First, there is an obvious need to ramp up available funding for health initiatives. In terms of prevention and preparation, on the national level, especially poorer countries need financial assistance to install minimum core health capacities. On the international level, the WHO would benefit from increased funding by its member states in order to operate efficiently and decide more easily and independently its own course of action.

Second, a key course of action to better position the world in the face of a future pandemic is strengthening the WHO on numerous fronts. This can be achieved by, inter alia, revising the IHR and further operationalizing the WHE. Steps are already underway in this regard by ongoing review committees. Specifically, for the IHR, the limitations faced by the WHO during the COVID-19 pandemic should serve as a point of departure for considering how these could be revised. For example, states should allow the Organization to communicate with the public about non-governmental sources of information without first requiring it to verify such information with the states concerned. Another clear point for improvement is the system of alert under the IHR. Given that limited heeding was given to the PHEIC declaration in contrast to the use of the word pandemic, discussions are currently ongoing to amend this system of alert into a multilayered one. Whatever the outcome may be of these discussions, it would serve the WHO well to clearly communicate to individual states that any type of alert by the Organization in the future merits attention and rapid mobilization of resources.

Third, the international community should create additional actors and instruments to further strengthen overall preparedness. Several suggestions in this respect have already been floated; below, we highlight four that warrant strong consideration. First, the international community should actively work to negotiate and conclude a new international treaty for pandemic preparedness and response, an idea first raised by European Council president Charles Michel in November 2020. Such a treaty would aim to “foster an all-of-government and all-of-society approach, strengthening national, regional and global capacities and resilience to future pandemics [WHO, 2021]. A second normative instrument well worth considering is the adoption of a framework convention on global health in order to (start to) address the full spectrum of actions that affect health. Third, global preparedness could also be strongly enhanced by means

of new actors that reinforce the WHO, such as an intergovernmental panel on health threats and a global health board. The former suggestion draws inspiration from the Intergovernmental Panel on Climate Change (IPCC) and a previous call to establish an intergovernmental panel on antimicrobial resistance [Monti Commission, 2021; Woolhouse, Farrar, 2014]. The panel could marshal data to assess risks generated by human activities and formulate proposals to reduce such risks [Ibid.]. The suggestion of a global health board clearly draws inspiration from the Financial Stability Board (FSB) set up in 2009 and calls on the G20 to create a forum that identifies vulnerabilities and threats to global health [McGahan, 2020; Monti Commission, 2021]. The board's mandate could authorize it to set global standards, assess emerging threats and review country-level implementation of standards [McGahan, 2020].

Throughout history, we have seen the international community come together after times of crisis with the aim of preventing or preparing for future hardship. To illustrate, after World War II, the international community founded the UN for the purpose of maintaining international peace and security and after the SARS outbreak, the IHR negotiating process regained traction and resulted in the adoption of the revised IHR to better prevent, prepare for and respond to the international spread of infectious diseases. Similarly, world leaders need to realize that now is the time to act to strengthen the global health architecture given that political momentum exists today. In the words of the Global Preparedness Monitoring Board, in 2019: "For too long, we have allowed a cycle of panic and neglect when it comes to pandemics: we ramp up efforts when there is a serious threat, then quickly forget about them when the threat subsides. It is well past time to act" [2019, p. 6].

## Conclusion

States initially reacted to the COVID-19 outbreak by favouring unilateral and protectionist measures. Such a reaction was amplified by the fact that the international community was, in general, ill-prepared for a pandemic of such scale. States' actions took place in the absence of international leadership uniting countries and spurring global cooperation toward a common goal. This self-interested behaviour undermined multilateral cooperation, especially in the initial days of the COVID-19 pandemic: the WHO, the UNGA, the UNSC, the G7 and the G20 were significantly thwarted in their ability to guide a coordinated international response to the COVID-19 outbreak.

To prevent states from undermining coordinated multilateral action when confronted with a future disease outbreak, the global health governance architecture urgently requires strengthening. This article has offered some suggestions for reform of international health actors and instruments. The overall aim of such reforms is to galvanize states, but also other international actors, into multilateral action immediately when faced with future health crises. The occurrence of future pandemics is not a question of if, but when. Therefore, it is of the utmost importance that the global health system and the international community be better prepared than at the time of the COVID-19 pandemic and draw the necessary lessons from it.

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