Background Memo
# *Reforming Global Health Governance*

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The COVID-19 pandemic is straining the global health governance framework, raising the question of necessary structural reforms.

## Global Health Governance Is a Microcosm of Global Governance

The structural challenges of the global health governance framework mirror challenges in other global commons governance frameworks, such as human rights, climate change, tax justice, and nuclear nonproliferation. Four major structural challenges in governing the global commons come into play with health.

First, there is a long-standing debate between the rights and duties of nation-states regarding the health of their own citizens and for citizens of other countries. Second, power, legitimacy, and resources belong more to nation-states than to global health organizations. Third, rising nationalism reduces global health collaboration. Fourth, the lack of mechanisms to hold countries accountable for minimum health standards lowers investment in public health.

These four structural challenges are visible in the revised International Health Regulations (IHR), approved by the World Health Organization (WHO) in 2005 and tested during the MERS, Zika, Ebola, and COVID-19 outbreaks. Although voluntary external evaluations of national capacity have taken place since 2009 in many countries, national progress in strengthening capacity has been patchy, uneven, and often poorly funded. Intercountry disparities in public health resources, capacities, and outcomes are difficult to resolve, even with legally binding international instruments such as the IHR.

Therefore, the WHO and IHR are intermediate steps toward a robust global framework to detect and respond to outbreaks with pandemic potential. Any real or perceived failures of this framework can be partially explained by the four structural challenges of governing the global commons.

*Rights and Duties of States: Domestic or Foreign?*

A major hurdle to greater health cooperation is the self-interest of nation-states and their political duty and desire to care for their citizens first. Therefore, a set of policy options, incentives, and disincentives should be implemented to encourage enlightened self-interest, enable collaboration, and allocate resources (like

vaccines) equitably. In large part, this would require persuading, encouraging, or educating nation-states on their duties to the global commons.

Resistance from nation-states against global collaboration can be addressed with a multi-year communications, advocacy, and lobbying campaign by international and domestic civil societies. The judicious involvement and moral leadership of the UN General Assembly, global powers like the United States, China, and the European Union, and major donors are crucial to break any impasse.

The term "building back better" applies not only to resilient health systems and pandemic responses but also to the entire global governance framework. Any reforms of the WHO or the global health governance framework do not exist in a vacuum and should therefore be accompanied by concurrent reforms in the global governance architecture writ large.

*Power, Legitimacy, and Resources*

The global health governance framework has many stakeholders, most laboring under a lack of power, legitimacy, and resources. Although the WHO is the preeminent and oldest actor, many new actors have emerged since the 1990s. Nonprofits (e.g., Bill & Melinda Gates Foundation and GAVI, the Vaccine Alliance), development banks (e.g., World Bank and International Monetary Fund), other UN agencies (e.g., UN Development Program and UN International Children's Emergency Fund) and country-level development agencies (e.g., Japan International Cooperation Agency and U.S. Agency for International Development) play important roles in global health, with varying levels of power, influence, legitimacy, and resources.

Although deemed imperfect by many, the WHO is indispensable as the lead global health agency to coordinate this fragmented landscape. There are twenty-two functions in the WHO [constitution](#), and the first is "to act as the directing and coordinating authority on international health work." (Pandemics only appear in seventh place, "to . . . eradicate epidemic, endemic and other diseases.") This comprehensive mandate is aspirational and necessary, but not matched by funding realities.

The WHO is underfunded for the work it is expected to perform, and its funding mix is unreliable and often targeted to donor priorities. Assessed contributions from member states contribute only approximately 20 percent of the WHO's budget, while 80 percent of WHO funding is from earmarked voluntary contributions, with charities or foundations being four of the [top ten funders](#). Therefore, priority-setting and resource allocation exercises could be supply-led rather than demand-led, leading to questions about conditionality of aid and aid dependence.

For the WHO to function as intended, other global health stakeholders need to demonstrate moral leadership and humility by accepting the first-among-equals role for the WHO. All stakeholders should work collaboratively to strengthen the WHO's capacity, stature, and effectiveness. Only with a recognized leader can there be meaningful progress in a fragmented landscape.

*Rising Nationalism*

De-globalization is combining with rising nationalism to reduce global health collaboration. The rise of populist leaders and their protectionist-nationalist rhetoric and actions have created a rightward trend in many government policies worldwide. The existential threat of COVID-19 has accelerated these tendencies, manifested in countries monopolizing scarce medical equipment in the initial stages of the pandemic and signing solo deals with vaccine companies for preferential access, also known as vaccine nationalism.

A strategy to counter the harmful effects of rising nationalism should consider ways to bind nation-states in global decision-making processes. This would provide rational self-interest to participate more deeply in global decisions. This extremely difficult process should consider issues of equity and provide enough incentives for countries' cost-benefit analyses to favor more global collaboration.

For global health, countries and the WHO often work together to clarify roles and expectations, which could differ between countries. At the same time, the WHO could reciprocate by appropriately reforming its constitution, optimizing the semi-autonomy of its six regional offices, and providing a decolonized, bottoms-up approach to collaborative decision-making. Increasing global collaboration can take place only when nation-states have a stake in the global decision-making, instead of being left to implement top-down decisions.

*Lack of Accountability*

Policy options for the above structural challenges culminate in the trickiest final difficulty: how to assure accountability for national progress toward universal health coverage (UHC) and health-systems strengthening in general and pandemic preparedness in particular.

As in other areas of international relations, a combination of incentives, disincentives, and moral leadership are crucial to encourage or enforce adherence to minimum international standards. The IHR and Universal Periodic Review process for the Sustainable Development Goals are existing entry points to increase accountability for national health progress.

Some new tools that could be adapted include internationally binding health targets similar to the Paris accord's Nationally Determined Contributions, treaties such as the Framework Convention on Tobacco Control, a health condition to any loans or bailouts from Bretton Woods institutions, or commitments from large asset managers like Blackrock and the California Public Employees' Retirement System to include health in their environmental, social, and governance investment criteria.

A reasonable place to start could also be minimum national health spending, modeled after NATO's rule of spending 2 percent of gross domestic product (GDP) on defense. The sources and uses of funds are as important as the amount, but this can be implemented by technocrats after the political decision is made to commit a certain percentage of GDP to public health-care systems.

Crucially, national governments and international institutions should build new sets of norms and standards in health, including incentives and disincentives, because traditional tools for errant countries, such as sanctions and boycotts, are not only ineffective but also dangerous if applied against a country that fails to meet health progress targets, as the citizens will suffer first from health underinvestment and then from sanctions.

**Structural Reforms for WHO Are Overdue, and COVID-19 Is Accelerating the Urgency**

The absence of deep reforms predates COVID-19, and various directors general have attempted structural WHO reforms with little success. The independent panel evaluating WHO's performance during the COVID-19 pandemic, chaired by Helen Clark and Ellen Johnson Sirleaf, could reveal some of the structural inadequacies of the global health framework related to the WHO.

It will likely also demonstrate how well-meaning and necessary new structures that are being set up in the wake of COVID-19 (e.g., the Access to COVID-19 Tools Accelerator and COVAX Facility for vaccines) are

only temporary Band-Aid resolutions for deeper problems. The scale and effects of COVID-19 require that these immediate resolutions overcome existing structural challenges, and are implemented in ways that feed into an enduring reform strategy. This is crucial as some of these emergency resolutions could continue even though their original mandate is time limited.

The WHO, IHR, COVAX Facility, and other global health actors are imperfect health instruments that cannot carry the burden of structural gaps in the broader global governance framework. By keeping the four structural challenges at the forefront, governments and international institutions can devise innovative and realistic changes to existing global health governance framework.

With these changes, the multilateral system and national governments can better prevent, anticipate, detect, and respond to pandemics, including in the development and equitable distribution of vaccines and other health-care resources, keeping the world safe.