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Global Governance of Health and Sovereignty: An Agenda for Reforms

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Abstract: The world has been plagued by pandemics earlier leading to the evolution of several mechanisms and institutional structures for controlling the spread of pandemics. Creation of the World Health Organization was a development emerging from the efforts to control the spread of diseases and it was charged with the mandate of governance of health at a global level. The spread of Covid-19, however, shows that the present structure of the governance of global health is ill-suited to the task. The paper discusses the present architecture of the global health governance. It discusses the impact of the concept of *Westphalian sovereignty* on this global health architecture and advances the suggestion that the global health governance architecture should be based on the principle of *the duty to cooperate* rather than attempts to modify the *Westphalian sovereignty* that forms the basis of international relations with the opt-out mode of ratification of treaties.

Keywords: health governance; Sovereignty; Duty to Cooperate; International Health Regulations; World Health Organization

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I. Introduction

Public health in supranational terms had been the concern of countries[1] from at least the 14th century when the term "quarantine" was coined to protect domestic populations against "foreign" diseases such as plague.[2] Trade and social relations between countries led to diseases spreading through sailors and travelers, who travelled from one country to another.[3] This necessitated steps by countries to isolate suspected travelers to prevent the spread of diseases in their respective jurisdictions.[4] However, in spite of the measures adopted, the diseases continued to spread.[5]

While the diseases had been in existence from the early times and had been traversing far and wide, yet there are only a couple of instances, separated by extended timelines, of such diseases travelling

[1] Domestic public health has always been the concern of the respective countries.

[2] World Health Organization, (2004). Globalization and Infectious Diseases: A Review of the Linkages. TDR/STR/SEB/ST/04.2. Special Topics No. 3, Social, Economic and Behavioural Research (SEB) UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), World Health Organization.

[3] World Health Organization, (2004).

[4] World Health Organization, (2004). "By the 7th century, China had a well-established policy of detaining sailors and foreign travelers suffering from plague."

[5] World Health Organization, (2004).

across nations, resulting in pandemics causing global misery and deaths (LePan, 2020). The incidence of movement of diseases increased with the emergence of faster means of communication, when travel became faster and more frequent between different nations across the globe (Sheel, 2020). The increase in rate of globalization, through the Internet and trade linkages is further likely to increase the incidence of epidemics[6] and the implications of such increased incidences of epidemics would be huge in terms of economic costs.[7]

Spread of communicable diseases is dependent upon the agency of transmission. If the transmission channels are identified and inhibited, the chain of transmission can be broken. Transmission is also dependent upon the immunity of the host, population of the pathogen and the environmental factors. Depending upon the route of transmission and the factors increasing the susceptibility to infections, methods can be devised that could control the rate of infection and thereby the degree of disease in a population. Globalization has an impact on the social, environmental and biological factors that are important in disease epidemiology.[8] The rapidly changing environments — human, economic, social, etc., — render the policies for disease control and prevention increasingly outdated, thereby requiring continuous revisions.[9] In such an environment, it is necessary that a global body be vested with functions to control the spread of diseases at a global level. The next part of this section looks at the emergence and functioning of the WHO — the specialized United Nations agency vested with the function of looking into the health aspects.

[6] World Economic Forum 2019. Outbreak Readiness and Business Impact: Protecting Lives and Livelihoods across the Global Economy. White Paper published by World Economic Forum in collaboration with Harvard Global Health Institute. The document says that the "The number and diversity of epidemic events has been increasing over the past 30 years, a trend that is expected to intensify," because of "increasing trade, travel, population density, human displacement, migration and deforestation."

[7] World Economic Forum 2020. Global Health Security: Epidemics Readiness Accelerator. World Economic Forum website. Available at: https://www.weforum.org/projects/managing-the-risk-and-impact-of-future-epidemics [Accessed 09.09.2023].

[8] World Health Organization, (2004).

[9] World Health Organization, (2004).

II. Emergence of Global Health Governance

The roots of the emergence of the WHO lay in the pandemics that had ravaged the world during the modern times,[10] and which could not be controlled by the quarantine measures that were resorted to by the countries. The countries realized that controlling epidemics independently is beyond the capability of any individual state and, therefore, a joint effort by different nations is mandatory.

The emergence of new diseases and the transmission of diseases from foreign shores was a foregone conclusion with increasing international trade and commerce. Industrial revolution at the beginning of the 20th century had resulted in the development of large cities that had large populations of laborers living in close vicinity of each other (Clift, 2013), which increased the likelihood of transmission of disease. Increased trade and commerce due to the development of technologies and through fast moving ocean carriers brought closer the erstwhile countries that used to be far separated due to the width of the oceans. This led to the transmission of diseases to shores that were out of the way of such transmission since the diseases, that would have earlier manifested themselves in the sailors due to the long time on the oceans, remained hidden now making the detection and spread of such diseases difficult (Clift, 2013).

As the result of this realization, the States convened international sanitary conferences during the period of 1851–1900.[11] These sanitary conferences were hosted amongst the European States as they were the primary States that were engaged in trading and colonial relations with other states and hence had greater susceptibility to incoming pestilence.

However, following the lead of the European nations, a group of "South American" states also entered into an agreement amongst themselves in the 1880's.[12] Similarly in 1902, a group of "American republics" entered into an agreement at Washington D.C. (Clift, 2013).

[10] These diseases were Cholera, The Third Plague; Yellow Fever; Russian Flu in the 19th Century and the Spanish Flu in the early 20th Century.

[11] 10 sanitary conferences were organized during the period. The 11th sanitary conference was organized in 1903.

[12] World Health Organization, (2007). The World Health Report 2007: A Safer Future: Global Public Health Security in the 21st Century World Health Organization.

The result of those agreements and conferences was the establishment of "Pan American Sanitary Bureau" in the United States and "Office International d'Hygiène Publique" (OIHP) in Europe.[13] These meetings and conferences also led to the agreement on the International Sanitary Convention that was signed in 1903 (Clift, 2013). The Convention required the participating States to inform other States of the first appearance of the disease with pandemic potential in their areas (these diseases specifically included plague, cholera and yellow fever)[14] and this information was followed by actions taken by the States concerned to prohibit entry of articles from the contaminated areas.[15] The emergence of international sanitary regulations and the health organizations pointed to a new emerging reality of international cooperation between the States on matters of health and for the control of spread of diseases.

Although limited to their respective continents, those organizations could be called as a precursor to the League of Nations Health Organization that was established after the First World War to address the health challenges in different countries that were brought about by the destruction of the health infrastructure in those countries due to the war, resulting in rapid spread of the epidemics.[16]

The League of Nations Health Organization was succeeded by the World Health Organization in 1948 and it first adopted the International Sanitary Regulations that were later replaced by the International Health Regulations of 1969. The health regulations were later revised in 2005 (Gostin et al., 2015).

However, the transition from the League of Nations Health Organization to the World Health Organization was not a simple procedure. There were three organizations that existed during the period. The first organization was founded in the Americas and it was called the Pan American Sanitary Bureau (PASB) later renamed to the

[13] OIHP was later dissolved.

World Health Organization, (2020a). Archives of the Office International d'Hygiène Publique (OIHP). World Health Organization website. Available at: https://www.who.int/archives/fonds_collections/bytitle/fonds_1/en/ [Accessed 15.08.2023].

[14] World Health Organization, (2020a).

[15] International Sanitary Convention, 1951, 35 Stat. 1770; Treaty Series 466.

[16] World Health Organization, (2007).

Pan American Sanitary Organization (PASO) and finally to the Pan American Health Organization (PAHO). The second organization was named the Office International d'Hygiène Publique (OIHP) and it was based in Paris. The last organization was named the League of Nations Health Organization (Clift, 2013).

Subsequent to the coming to the existence of the League of Nations Health Organization, the OIHP was given an advisory capacity to the League Health Organization.[17] After the emergence of the WHO, the OIHP was dissolved.[18]

Subsequent to the Second World War, at the United Nations Conference in San Francisco in 1945, an idea was floated for the establishment of an international health organization. For establishing a health organization, the International Health Conference was convened from 19 June to 22 July 1946.[19] The Conference resulted in the establishment of the WHO and the integration of the OIHP, League of Nations Health Organization and the United Nations Relief and Rehabilitation Administration (UNRRA) activities with the activities of the WHO (Clift, 2013).

In April 1948, the first World Health Assembly was convened in Geneva (Clift, 2013). Over the years, the WHO has not remained the exclusive body for managing health at the global level. A large number of other bodies emerged — private as well as inter-governmental in nature. As a part of its efforts to reduce poverty and promote development, the World Bank entered into the health field and started funding new initiatives. Similarly, other bodies and initiatives have also come into operation for managing health at the global level. A few of them could be recounted here: the Joint United Nations Programme on HIV/AIDS (UNAIDS), the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization), the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund), and UNITAID; Medicines for Malaria Venture or the Drugs for Neglected Diseases initiative (Clift, 2013).

[17] World Health Organization, (2007).

[18] World Health Organization, (2020a).

[19] World Health Organization, (2020b). Constitution. World Health Organization website. Available at: https://www.who.int/about/governance/constitution [Accessed 15.07.2023].

In addition, several new initiatives have come up within the WHO, such as Stop TB Partnership or Roll Back Malaria in partnership with national governments and non-governmental organizations (Clift, 2013). Private entities have also become a part of the global health governance architecture because of the funding support that they provide, namely: the Bill and Melinda Gates Foundation (Clift, 2013). The World Health Organization that came into existence had its structure and governance model suited to the task at hand, namely, controlling the spread of diseases and ensuring health for everyone. The next section deals with the structure and the governance of the World Health Organization.

III. The Structure and Governance of World Health Organization

The World Health Organization has a structure with separate bodies having different sets of powers to fulfill the mandate of the organization. The structure and functions of different bodies that constitute the World Health Organization have to be viewed keeping in mind that the organization was operating in the context of wide differences between the health governance capacities of different countries that emerged after the Second World War. And the organization sought to regulate an activity which the States regarded as laying exclusively within their sovereign domain. The WHO is composed of three organs:[20]

a. The World Health Assembly
b. The Executive Board and
c. The Secretariat.

III.1. The World Health Assembly (WHA)

The World Health Assembly (WHA) is the supreme governing body of the WHO. It is composed of delegates representing the Member States.[21] The powers of the World Health Assembly as stated underneath reflect the importance that members have attached to the function of the World Health Organization. It has been provided with the powers of

[20] Constitution of the World Health Organization, 1946.
[21] Constitution of the World Health Organization, 1946.

adoption of conventions or agreements on matters within the competence of the organization.[22] It has the authority to adopt regulations on a host of matters[23] that, though largely technical in nature, are reflective of the importance that the members place upon the technical competence of the organization as regards health governance and the role of the organization in preventing the spread of diseases.

From a utilitarian point of view, this part of the mandate of the World Health Organization to make regulations concerning technical matters can be stated to be the *raison d'être* of the World Health Organization. The other functions of the World Health Organization are merely supportive to this main function.

Finally, it has the powers to make recommendations to any member on matters that fall within the competence of the organization.[24] A cumulative analysis of the powers of the World Health Assembly leads to the conclusion that, while adoption of the regulations on technical matters is the primary function of the Health Assembly, it has been vested with the authority and necessary legal powers, to the extent possible under international law, to secure enforcement of those regulations. It does not have the powers to direct its members as it would run counter to the norms of sovereignty, but it was provided with the powers to recommend (Dupuy, 1990; Thürer, 2009).[25]

The functions of the WHA, beside the routine organizational functions[26] and functions related to it being the supreme decision-

[22] Constitution of the World Health Organization, 1946, Art. 19.

[23] Constitution of the World Health Organization, 1946, Art. 21.

[24] Constitution of the World Health Organization, 1946, Art. 23.

[25] Recommendations are not required to be adopted or followed compulsorily by the party concerned but recommendation do carry a certain amount of moral sanctity which forces a member to carry out the recommendation and non-observance of the recommendation carries with it reputational costs.

[26] The following are the functions of the World Health Organization.

— to name the Members entitled to designate a person to serve on the Board;

— to appoint the Director-General;

— to review and approve reports and activities of the Board and of the Director-General and to instruct the Board in regard to matters upon which action, study, investigation or report may be considered desirable;

— to establish such committees as may be considered necessary for the work of the Organization;

— to supervise the financial policies of the Organization and to review and approve the budget.

making body of the WHO, also include the functions for ensuring health governance at the global level. These functions include bringing to the attention of the member and of international organizations,[27] including interaction with the General Assembly and other bodies of the United Nations, matters related to health. The WHO acts on the recommendations of international organizations and reports to them on the actions taken on their recommendations.[28] It conducts research on matters related to health and undertakes action on matters that advance the objective of the World Health Organization.[29]

From the above discussion, it is evident that the role of the World Health Assembly is to undertake all actions that have a bearing on the advancement of the objective of the World Health Organization, which is of global health governance. The WHA was provided with overarching powers of entering into treaties and agreements, enacting regulations, and providing recommendations to the members on the implementation of the objectives related to global health governance. The functions that the body was vested with does justice to the powers that the WHA was provided with to implement the recommendations given to the WHA by the General Assembly and other bodies of the United Nations. In addition, the WHA needs powers to carry out the objectives of the Organization.

III.2. The Executive Board (the Board)

The Executive Board of the WHO is the executive body of the WHO tasked with the primary function of carrying into operation the policies as decided by the WHA. The Board is composed of 34 persons, designated by an equal number of Members who have been elected on the principle of equitable geographical representation.[30] Article 29 provides that the powers of the Board shall be the powers that were delegated to it by the WHA and it shall exercise those powers on behalf of the WHA.[31]

[27] Constitution of the World Health Organization, 1946, Art. 18(g).
[28] Constitution of the World Health Organization, 1946, Art. 18(i).
[29] Constitution of the World Health Organization, 1946, Art. 18(k) and (m).
[30] Constitution of the World Health Organization, 1946, Art. 24.
[31] Constitution of the World Health Organization, 1946, Art. 29.

The function of the Board is primarily to act as the executive organ of the WHA[32] and carry out into action the decisions and the policies of the WHA.[33] It also acts as an advisory body tasked with the function of advising the WHA on questions that are referred to it by the Assembly[34] or even on its own initiative.[35] Another important function that the Board executes is initiating emergency measures within the competence of the organization, to deal with emergency situations or when immediate actions are required.[36] Under its emergency measures powers, it may authorize the Director-General with the powers for epidemics control, providing health relief in case of calamities and organizing research activities to address an urgent health issue.[37]

III.3. The Secretariat

The Secretariat is composed of the Director-General and technical and administrative staff of the organization,[38] with the Director-General being the chief technical and administrative officer of the organization. The Director-General is also an ex-officio secretary of the Health Assembly, the Executive Board, Commissions and Committees of the Organization and the Conferences that are convened by the Organization.[39] Besides primary administrative functions,[40] the Director-General, subject to the agreement with the members, may have direct access to the health departments of the Member States and to their governmental and non-governmental health organizations.[41] In a similar fashion, the Director-General may also establish relations with international organizations whose activities come within the competence of the Organization.[42]

[32] Constitution of the World Health Organization, 1946, Art. 28(b).
[33] Constitution of the World Health Organization, 1946, Art. 28(a).
[34] Constitution of the World Health Organization, 1946, Art. 28(d).
[35] Constitution of the World Health Organization, 1946, Art. 28(e).
[36] Constitution of the World Health Organization, 1946, Art. 28(i).
[37] Constitution of the World Health Organization, 1946, Art. 28(i).
[38] Constitution of the World Health Organization, 1946, Art. 30.
[39] Constitution of the World Health Organization, 1946, Art. 32.
[40] Constitution of the World Health Organization, 1946, Art. 31.
[41] Constitution of the World Health Organization, 1946, Art. 33.
[42] Constitution of the World Health Organization, 1946, Art. 33.

III.4. Regional Organizations

Regional organizations within the overall framework of the WHO are provided for in the constitution of the WHO for meeting the specific needs of an area.[43] Such geographical areas may be demarcated by the WHA, where a regional organization can be established by the WHO.[44] These regional organizations, while being an integral part of the WHO[45] and its office subject to the general authority of the Director-General of the organization,[46] are independent in their sphere of action.

Regional organizations have a regional committee and a regional office.[47] States in the region are members or associate members of the regional organization.[48] A regional director is appointed by the Board in agreement with the regional committee[49] and a regional office is an administrative organ of the regional committee.[50] The regional committee is subject to the general authority of the Director-General[51] and, in addition to its functions as the administrative organ of the regional committee, it carries out the decisions of the WHA and the Board.[52]

The functions of the regional organizations are regional in nature. Besides the management of routine activities of the regional office, they deal with activities related to health in the region, which is likely to promote the objectives of the organization in the region. A regional office is required to cooperate with the regional bodies of United Nations Organization and other specialized agencies on matters of regional health importance.[53]

[43] Constitution of the World Health Organization, 1946, Art. 44.
[44] Constitution of the World Health Organization, 1946, Art. 44(b).
[45] Constitution of the World Health Organization, 1946, Art. 45.
[46] Constitution of the World Health Organization, 1946, Art. 51.
[47] Constitution of the World Health Organization, 1946, Art. 46.
[48] Constitution of the World Health Organization, 1946, Art. 47.
[49] Constitution of the World Health Organization, 1946, Art. 52.
[50] Constitution of the World Health Organization, 1946, Art. 51.
[51] Constitution of the World Health Organization, 1946, Art. 51.
[52] Constitution of the World Health Organization, 1946, Art. 51.
[53] There are several other functions but these are important functions as far as regional bodies are concerned.

IV. Health Governance through International Health Regulations

The International Health Regulations (IHR), due to the adoption mechanism of the regulations at the WHO, form a different type of the Treaty Law that forms the foundation of international law.[54] The adoption mechanism of the conventions, agreements, and regulations at the WHO is based upon the opt-out mechanism. The regulations enter into force for all members, once they have been adopted by the World Health Assembly, except for members that have notified the Director-General of their reservations to the regulation or the rejection of the regulations.[55] Even the entry of reservations may not preclude the entry into force of the regulation against the concerned member if the reservations are not such that they are incompatible with the purposes of the treaty (Edwards, 1999).[56]

The IHR came into existence in 1969 and they were later modified in 2005 (Gostin et al., 2015). These regulations were adopted by the WHO under Art. 21 of its Constitution (Gostin et al., 2015). International borders are not much helpful in controlling the spread of diseases; coordination at the international level is required to prevent such spread. In such circumstances, it is necessary that any outbreak of such diseases is notified immediately and steps are taken to prevent its spread. The IHR of 1969 came up for achieving the purpose of preventing the

[54] Under Art. 21 of the Constitution of the World Health Organization, the WHO has the authority to adopt regulations. Art. 21 provides for the following.

"The Health Assembly shall have authority to adopt regulations concerning:

(a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;

(b) nomenclatures with respect to diseases, causes of death and public health practices;

(c) standards with respect to diagnostic procedures for international use;

(d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;

(e) advertising and labelling of biological, pharmaceutical, and similar products moving in international commerce."

[55] Constitution of the World Health Organization, 1946, Art. 22.

[56] This is allowed by Art. 19 of the Vienna Convention on the Law of Treaties, 1969, 1155 UNTS 331.

spread of diseases.[57] However, the IHR failed to serve their purpose since the development of technology had shortened the time taken for international trade and travel, which in most cases is quite a short period compared to the incubation period for the diseases. Similarly, the development in communication technologies also revolutionized the transmission of information and almost instantaneous transmission of information can result in a spread of panic that can lead to great harm to trade and commerce. Since the incubation period of any disease is comparatively long compared to time taken for travel, it is difficult to screen out carriers of diseases unless highly sensitive tests are carried out. The results of the tests arrive only a few days later. In such circumstances, it became necessary to revise the IHR, which was done in 2005, and revised regulations came into force in 2007.

The revised IHR "provide[s] a legal framework for reporting significant public health risks and events that are identified within national boundaries and for the recommendation of context-specific measures to stop their international spread, rather than establishing pre-determined measures aimed at stopping diseases at international borders."[58] Article 2 of the International Health Regulations states that the purpose of IHR is to "prevent, protect against, control and provide a public health response…" and it is restricted to public health risks without imposing unnecessary restriction on travel and trade.[59]

The salient features of the revised IHR of 2005 can be discussed as follows:[60]

a. The scope of the IHR has been broadened to include "illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans," from specific diseases or specific manner of transmission. This definition of disease moves away from defining diseases only in terms of infectious diseases. It is

[57] World Health Organization, (2007).

[58] World Health Organization, (2007).

[59] World Health Organization, (2016a). Meeting Report. WHO Informal Consultation: Anticipating Emerging Infectious Disease Epidemics. WHO/OHE/PED/2016.2.

[60] International Health Regulations (2005), 2509 UNTS 79.

broad enough to include within its ambit the harm resulting from even accidents or acts such as nuclear incidents.[61]

b. Under the Regulations State Parties are obliged "to develop certain core capacities" for surveillance and response. The core capacities that need to be developed have been provided in Annex 1 of the document. The revised IHR have shifted the focus from introducing measures to control the spread of diseases through measures taken at the port of entry to developing core capacities among states so that the diseases are controlled at their source and for ensuring the objective of "health for all."[62]

c. State parties are also obliged, under Art. 6, to report to the WHO, on the basis of predetermined criteria, as provided in Annex 2 of the document, any incident that could constitute a "public health emergency of international concern." The State Party concerned shall also have to provide, under Art. 7, all relevant public health information.

d. The Regulations also provide that the WHO has authority to take into account the reports from non-official sources,[63] but before taking any action, verification of such a report has to be sought from the States concerned.[64] The provision was included in the IHR in response to the approach of the states of delayed reporting of such events of international importance because of the perception that it would have an adverse effect on their economy by limiting travel and trade to and from their country.[65]

e. The regulations also provide for the procedures for the determination of an event constituting a "Public Health Emergency of International Concern" by the "Director — General." The regulations similarly provide for the declaration of "temporary measures" by the "Director General" after seeking the views of the emergency committee.[66]

[61] World Health Organization, (2007).

[62] World Health Organization, (2007).

[63] World Health Organization, (2016b). International Health Regulations, World Health Organization, Art. 9.

[64] World Health Organization, (2016b), Art. 10.

[65] World Health Organization, (2007).

[66] World Health Organization, (2016b). Art. 12.

f. The IHR under Art. 12 calls upon the State parties to ensure that the "human rights" of the travellers are observed and unnecessary hardships are minimized for them.

g. Article 4 of the regulation provides for the establishment of National IHR points and WHO IHR Contact points. The purpose of the points is to ensure communication between the national and international contacts so that timely information and effective strategies can be provided for management of diseases and implementation of the regulations.

While the revised IHR is a development on the original IHR, yet there are several drawbacks that have become evident over a period. Some of these are:[67]

a. The revised IHRs are still focused on incident based "public health emergencies. They have to be reframed to look into all "public health emergencies" such as those owing to climate change, development of microbial resistance. These emergencies develop over a period of time, sometimes for a period of decades.

b. The present regulations have for their focus a response at an international level — a global coordinated response headed by the WHO (Evaborhene et al., 2023).[68] The regulations need to develop national capacities — not just core capacities — but capacities so that pestilence can be managed within the States themselves.

c. The new regulations would have to be based on a shared knowledge infrastructure and a highly trained multilateral global response team that has ample resources, both financial and political, to tackle the disease before its spread.

d. The new regulations would be based on the ability to predict a pestilence before it erupts and a global health response has to be managed at the United Nations level instead of the World Health Assembly level.

[67] World Health Organization, (2016a).

[68] A global response to spread of diseases which was the intention of the drafting of the IHR was not visible in the global response to the Covid-19 pandemic largely due to the fragmentation of the world order with States going their individual ways to counter the pandemic leading to a national rather than a global response.

However, the IHRs failed to serve the purpose for which they were drafted (Lazarus et al., 2024).[69] The health regulations failed at all level — States did not inform the global body timely of the spreading pestilence (Taylor, 2002); a global response to the spreading pandemic was severely lacking with States adopting a nationalist response rather than a global one and the WHO appeared severely handicapped in coordinating the national responses (Gostin et al., 2023). The absence of coordination was visible in the Access to Covid-19 Tools Accelerator (ACT-A). ACT-A was brought into existence to reduce the inequitable access to medicines. However, it failed to serve the purpose, since the geopolitical tensions and nationalist policies of the Member States severely undermined the capacity of the WHO to deliver a structured global response (Gostin et al., 2023).

V. The Principle of Sovereignty and International Health Governance

Microbes, of course, do not recognize geographical boundaries (Aginam, 2002). Hence, the concept of sovereignty is alien to the spread of diseases. Global health issues should not be allowed to be held hostage to the *Westphalian* concept of sovereignty. The resistance on the part of China to report the incidence of disease (Covid-19) and its subsequent attempts to prevent investigation into the origins of the disease[70] may be attributed to the recognition of sovereignty as an essential part of

[69] It is also important to note here that IHRs came into operation in the environment of a bipolar world order and the later amendments took place when unipolar hegemonic world order was at its peak. The new reality of a multipolar world order would necessary require some changes to the structure of the treaty where instead of a global center for disease response and preparedness, multiple centers should be present whose activities may be coordinated at a global level.

[70] BBC News Service. 24 April 2020. Coronavirus: China rejects call for probe into origins of disease. BBC News Services website. Available at: https://www.bbc.com/news/world-asia-china-52420536 [Accessed 19.09.2023]. Later on, China did allow the WHO investigators to visit China for Covid-19 Investigation; Associated Press. 10 July 2020. WHO Experts to visit China to plan Covid-19 investigation [Online]. The Times of India World. Available at: https://timesofindia.indiatimes.com/world/rest-of-world/who-experts-to-visit-china-to-plan-covid-19-investigation/articleshow/76891951.cms [Accessed 19.09.2023].

Chinese Statehood and, therefore, China's internal health rules are not to be amenable to dictates from international organizations (Stevenson and Cooper, 2009).

Globalization has resulted in increased transnational linkages, which has led the dilution of the watertight compartmentalization that characterized the conception of state sovereignty (McGrew, 2001).

These transnational linkages were not confined to the ideas circulated among the States through the transnational epistemic communities, but these linkages progressively started extending to trade, finance, etc. There has been a resultant loss to the state authority due to these transnational linkages and this has been reflected in the fashion States are expected to cooperate in controlling health crises, since the pathogens causing health crises can easily travel on the back of interstate travel and interstate trade. In this new world order, it is difficult for a State to provide security or governance effectively on its own without cooperation with other States (Slaughter, 2004).

Another corresponding development that has moved in parallel with the dilution of state sovereignty is the emergence of other actors on the global level that deal with the governance of health. These actors work on a supra-national level and are composed of private parties rather than the sovereign States (Fidler, 2007). They derive their legitimacy not on the workings of international law, but the legitimacy that the larger global society provides to their actions by acknowledging their work, recommendations, etc.

The Pandemic Fund (earlier known as the Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response) can be referred to as an example (Boyce et al., 2023). It would work as a partnership of donor countries and co-investor countries and civil society organizations. The governing board of the Pandemic Fund would be composed of 21 members with 18 seats reserved for donor/co-investor countries, one seat reserved for each "civil society organization" from the global north and the global south respectively and one seat reserved for philanthropies.[71] The World Bank would serve as a trustee

[71] World Bank Group, (2024). The Pandemic Fund [Online]. World Bank Group. Available at: https://fiftrustee.worldbank.org/en/about/unit/dfi/fiftrustee/fund-detail/pppr [Accessed 16.11.2024].

of the Fund, whereas the Technical Advisory Panel would be headed by a representative from the WHO. The implementing agencies of the Fund include not only the inter-governmental organization alone, but also public-private partnerships such as the Coalition for Epidemic Preparedness Innovations (CEPI).[72] This emergence of the heterogeneity of actors in the field of health governance is leading to a transition from a Westphalian model of sovereignty to a post-Westphalian model of sovereignty.[73]

This emerging model of sovereignty is different from the Westphalian model. It is based on following the universal norms of transparency in governance, and the norm of maintaining transparency is imposed upon all nation states (Stevenson and Cooper, 2009). This model does not exclusively rely upon the information provided by the States but also upon other sources of information diluting the very concept of the state exclusivity in its internal affairs.[74]

As regards the norms affecting health governance, the post-Westphalian model emphasizes upon predicating global governance of health on the firmament of human rights, following the global norms of health governance and maintaining transparency in those norms (Stevenson and Cooper, 2009). Following the global governance norms implies that state sovereignty is diluted entailing certain sovereignty costs (Hathaway, 2008), which is reflected in essential state authority being delegated to international institutions (Hathaway, 2008, p. 115).

Generally, once certain authority over the erstwhile sovereign matters of State is granted to an international institution, it extends itself and abstracts too much power from the state authorities and vests it with itself under the international law (Hathaway, 2008, p. 115). This vesting of State authority is supported by the emerging non-state actors on the global governance firmament who support it because the States concerned have failed to provide effective governance to their people.

[72] CEPI, (2024). CEPI website. Available at: https://cepi.net/cepi-officially-launched [Accessed 16.11.2024].

[73] These actors are such as the Bill and Melinda Gates Foundation.

[74] World Health Organization, (2020c). Global Partnerships: A network of networks. World Health Organization website. Available at: https://www.who.int/csr/about/partnerships/en/ [Accessed 19.09.2023].

This leads to a certain level of distrust among the developing countries regarding the intentions of the developed countries in following the post-Westphalian model of governance (Mayank and Saxena, 2020).

The developing countries doubt that the developed countries are using the norms of the new model to control the internal governance architecture of the developing countries and this is a disguised attempt to promote colonialism through the backdoor (Stevenson and Cooper, 2009). This perception is further exacerbated by the decline in the accessed contributions by the Member States; entities providing voluntary contributions have started playing a greater role in the governance of the WHO (Eckl and Hanrieder, 2023) particularly through the financing of consulting services provided to the WHO (Eckl and Hanrieder, 2023).

The resistance of States, based on the principle of sovereignty where States regard following the rules set by international organizations as affecting their essential attributes of sovereignty, has to be addressed as far as global health governance is concerned. It is necessary to identify principles and strategies to overcome the resistance of the States to following the common principles or strategies provided by the international organizations (Stevenson and Cooper, 2009). There are three strategies to address sovereignty with the requirement of global cooperation (Stevenson and Cooper, 2009). First, instead of attempting to make the national health systems homogenous according to a global order, the heterogeneity of national health systems should be recognized and respected along with the requirement of national authorities to regulate the system according to their needs and capacity, so long as the essential elements or the fundamental principles of the global health governance that affect the spread of disease from one nation to another are recognized. Second, services of transnational epistemic communities should be utilized to embed the recognized norms of health governance within the national architecture of health governance. The last strategy states that the structural inequities between different international regimes have to be addressed to build trust between different stakeholders of global governance of health (Stevenson and Cooper, 2009).

VI. The Two Axes of International Health Governance

The international health governance as of now is organized along two axes: 1. the horizontal governance pattern; and 2. the vertical governance pattern. Horizontal governance implies regulating health threats through bilateral or regional agreements (Fidler, 2003). Vertical health governance on the other hand is the regulation or governance of health by international health agencies at the global level. Vertical health governance is regarded as a better scheme when it comes to reduce the spread of the disease (Gostin, 2004) and the World Health Organization attempts to attain the objective of vertical health governance through the aid of the International Health Rules. This vertical health governance is sought to be promoted through the "opt-out" mechanism to ratification of conventions, agreement and regulations set forth in the WHO constitution. Opt-out mechanisms provide a greater observance of the rules by the member parties in contrast to the traditional opt-in mechanism of acceptance of treaties wherein parties have to accede to a treaty to be considered to be bound by the term of the treaty (Taylor, 2002).[75]

In the case of the opt-out mechanism the parties are automatically bound by the terms of the treaty unless they provide an explicit direction to be considered not to be bound by a treaty. In cases of health, it is difficult for a party to opt-out of a treaty in the light of the negative publicity that it would generate and therefore the chances of parties accepting the terms of the treaty is considerably high in the case where opt-out mechanism is adopted for treaty adoption (Fidler, 2005, p. 325). On the other hand, it is also to be understood that regulations do not have the same significance as the treaty law (Amerasinghe, 2005). The international health regulations constitute the secondary law of the WHO and do not have the primary authority of the treaty law (Bogdandy and Villarreal, 2020).

[75] Though the organization has adopted the opt-out mechanism for bringing in international rules, yet its opaqueness in working is hindering the very structure of governance it was trying to promote. States would ignore rules that are legislated through the opt-out mechanism if the organization also adopts the method of opaqueness in its governance.

This normative authority of the WHO in creating laws for international health governance through the opt-out mechanism is highly unusual in international relations, since it requires its members to indicate their rejection of an agreement that has been negotiated within the auspices of the WHO in order not to be bound by the agreement (Gostin et al., 2015). Where a member does not accede to the agreement, the member has to indicate its reasons for doing so. This mechanism is different from the mechanism that is followed in other international organizations in the sense that a positive accession to the agreement or the treaty is required for the party to be obliged to carry out its duties under the agreement and this indicates the importance of vertical governance of health in international affairs (Gostin, 2004).

While the IHR has been accepted at the international level through the opt-out principle as detailed above, but still while the states do not opt-out of the WHO conventions, regulations, etc., for fear of incurring reputational costs, they rarely follow the dictates of these regulations. Spagnolo calls it a pathological lack of compliance (Spagnolo, 2018). He offers that countermeasures can be used by an international organization in such cases, however such a mechanism of using counter measures do not even exist within the structure of the WHO and the WHO can at the most, suspend the rights of the offending member to take part in the activities of the organization (LePan, 2020).

Such an action may not even have an impact on the Member States as the recent announcement of withdrawal of the United States from the WHO exemplifies (Letzter, 2020). On the other hand, the same may also have an impact on the finances of the WHO (Letzter, 2020).[76] The articles of the Constitution of the WHO provide for a very limited set of actions that the organization can undertake against States that indulge in violations of the health regulations.[77] This non-observance of the IHR and absence of an effective mechanism to ensure such compliance begs the question what the remedies are, when, because of the non-

[76] The US is the largest contributor to the funds of the WHO.

[77] Article 7 only provides for the suspension of voting rights and privileges to which a member is entitled. Invoking Art. 7 against a member may only lead to a loss of face for the member concerned. Thus, the only option that the organization is left with the naming and shaming of the member concerned.

observance of the mandate of the IHR, the entire world may start facing problems. States may avoid opting-out of the conventions, agreements, and regulations of the WHO out of reputational costs that it entails, but merely having an international regulatory document without the necessary will or resources to see through its implementation is not likely to produce optimal results (Mayank and Saxena, 2023, pp. 148–164).

VII. Suggestions and Conclusions

Gostin suggests that a new conception of global health is required, and this new conception should be based on the rule of international law (Gostin, 2004, p. 2623) so that it avoids the limitations of sovereignty and horizontal governance (King and Lugg, 2023).[78] Additionally, a new conception requires the States to move away from insistence on sovereignty turning to a non-coercive model for promoting global health governance adopted to encourage the States to play their roles in collective health security (Calain, 2007). To attain this objective, the international health governance architecture may utilize the normative order that has been promoted by the regime of the international environmental law enshrined in the principle of *the duty to cooperate*.

The principle of *the duty to cooperate* has its emergence in the field of International Environmental Law, wherein States have an obligation to prevent transboundary harm resulting from activities within their jurisdictions, along with an obligation to cooperate to reduce the risk of harm through cooperation (Jervan, 2014). The principle of the duty to cooperate has emerged through various judgments of the International Court of Justice exemplified by the three cases, namely: *Trail Smelter case,*[79] *the Corfu Channel case*,[80] and *the Lake Lanoux case*.[81] In all

[78] It is also important to understand here that criticism of a technocratic institution such as the WHO, which is regarded as one of the most legitimate institution would increase during the period of crisis such as that of "Covid-19" and this criticism should not become the sole grounds of initiating reforms.

[79] United States v. Canada (Trail Smelter Arbitration). Arbitral Trib., 3 U.N. Rep. International Arbitration Awards 1905 (1941*)*.

[80] Corfu Channel Case (United Kingdom v. Albania) (Merits) [1949] ICJ Rep. 4.

[81] Spain v. France (1956) 24 I.L.R. 101.

the three cases, the common thread was that the States cannot carry out activities or permit their territories to be used for activities that may have an adverse transboundary effect. International environmental treaties have also advocated the principle of the duty to cooperate. Thus, Art. 21 of the Stockholm Declaration[82] states:

States have, in accordance with the Charter of the "United Nations" and the principles of international law, the sovereign right to exploit their own resources pursuant to their own environmental policies, and the responsibility to ensure that activities within their jurisdiction or control do not cause damage to the environment of other States or of areas beyond the limits of national jurisdiction.

Whereas, principle 22 of the same Declaration calls upon the States to:

Cooperate to develop further the international law regarding liability and compensation for the victims of pollution and other environmental damage caused by activities within the jurisdiction or control of such States to areas beyond their jurisdiction.

Pathogens in one State have the potential to cause harm in another State. Under the prevailing international norms of prevention of transboundary harm, States have the obligation to prevent such transboundary harm by ensuring cooperation with the concerned States employing such methods as information sharing. Under the reigning principle of sovereignty, a State may set lax health standards for its citizens, thereby leading to the spread of diseases or may impose excessively strict standards that may lead to restrictions on travel and affect human rights of individuals (Gostin, 2005, p. 413).

Similarly, assertions of sovereignty may take the form of denying cooperation in preventing or taking steps for controlling the spread of the disease. The effect of action at the level of one State under the rubric of sovereignty which demands non-interference in those matters can affect the health in another State as is visible in the trans-boundary harm that is caused in environmental matters.[83]

[82] United Nations Conference on the Human Environment, UN Doc A/RES/2994 (15 December 1972).

[83] United States v. Canada (Trail Smelter Arbitration).

Therefore, in the field of international health governance, the principle of sovereignty should be tempered with the normative order of the duty to cooperate (Gostin et al., 2024). International law does provide a State with the authority to regulate its internal affairs under the principle of sovereignty, but the same international law has also vested a State with the duty to cooperate. In the Pulp Mills case,[84] the Court had stated that "the procedural duties to notify, inform and cooperate were grounded in a principle of prevention, which as a customary rule had its origin in "the due diligence that is required of a State in its territory." Thus, instead of following the opt-out mechanism prescribed in the Constitution of the WHO for adoption of conventions, agreements, and regulations, the duty to cooperate principle of the international environmental law would better acceptability among nations. The opt-out mechanism imposes a threat of negative publicity and reputational costs. States cannot be held as free when they are forced to follow the dictates of an international organization through the threat of negative publicity. On the other hand, the duty to cooperate does not impose the threat of negative publicity and encourages a State to contribute to the extent of its capacity demonstrating better chances of encouraging compliance. States can be encouraged to adopt the duty of cooperation in international health governance through the circulation of ideas in the transnational epistemic communities in the same fashion as it is carried out in the field of environmental governance. This could very likely address the lack of non-compliance (Kavanagh et al., 2023)[85] with the mandates of IHR as well the absence of the principle of vertical governance in the field under consideration.

[84] Pulp Mills on the River Uruguay (Argentina v. Uruguay) (Judgment) ICJ Rep 2010, p. 14.

[85] In the pandemic treaty, however, the proposals are to create a Conference of Parties (COP) that would work similarly to peer review mechanisms of the FSB followed by an implementation and compliance committee authorized to issue recommendations based on the submissions received from the parties.

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