The futility of the pandemic treaty: caught between globalism and statism

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At a Special Session of the World Health Assembly (WHASS) in 2021, member states agreed by consensus to establish an intergovernmental negotiating body (INB) to draft a convention, agreement or other international instrument for pandemic preparedness and response under the Constitution of the World Health Organization (WHO).[1] This so-called 'pandemic treaty' was proposed by Chile and the EU, and has subsequently gained public endorsement by multiple world leaders and the WHO.[2] The underlying logic to which these supporters subscribe is that global governance failed during COVID-19, and a treaty is required to add political commitment to the technical knowhow which already exists to mitigate future challenges in preventing, detecting, responding to and recovering from pandemic events. These challenges include limited robust data; difficulties in sharing pathogens and associated data; lack of cooperation and coordination between governments; and states being overly focused on national protectionism, reflected in measures such as export bans, border closures and ongoing inequities in vaccine distribution,[3] to the detriment of 'global' health. Proponents argue that such a treaty, rooted in 'norms of solidarity, fairness, transparency, inclusiveness and equity', can be the cornerstone of future global health security, and that this will overcome many of the shortcomings seen in the response to COVID-19. They grandly declared: 'Our solidarity in ensuring that the world is better prepared will be our legacy that protects our children and grandchildren and minimizes the impact of future pandemics on our economies and our societies.'[4]

This sounds inspiring, and in the wake of COVID-19, it is indeed of paramount importance to develop appropriate global solutions to mitigate future global health crises, and to ensure that such mechanisms are rooted in global equity. However, there is a clear mismatch between the problems witnessed during the

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[1] World Health Assembly (WHA), 'The world together: establishment of an intergovernmental negotiating body to strengthen pandemic prevention, preparedness and response', 28 Nov. 2021, SSA2/CONF./1Rev.1.

[2] Joint statement by heads of states and World Health Organization (WHO), *COVID-19 shows why united action is needed for more robust international health architecture* (Geneva: WHO, 30 March 2021).

[3] Sara E. Davies and Clare Wenham, 'Why the COVID-19 response needs International Relations', *International Affairs* 96: 5, 2020, pp. 1227–51.

[4] Joint statement by heads of states and WHO, *COVID-19 shows why united action is needed*.

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response to COVID-19 (and global health security more broadly), rooted in state-centric security policy, and the proposed treaty, which purports to take a globalist, quasi-cosmopolitan approach to pandemic preparedness and response.[5] We do not believe that a pandemic treaty will deliver what is being extolled by its proponents, or that it will solve the multiple problems of global cooperation in global health that supporters believe it will.

To demonstrate this, we consider the academic and policy discussions for this treaty within a globalist vs statist approach. We analyse the proposed content; the type of instrument proposed; the location of its governance; and the purported failures of the International Health Regulations (IHR) which the treaty intends to solve. In so doing, we highlight the misalignment between the treaty proposal and the actual problems of global health governance. Drawing on empirical examples from international law and international relations, we show that multiple structural challenges have yet to be adequately understood and addressed within the plans for such a treaty, and thus barriers will remain in any new governance arrangement.

Globalist vs statist global health governance

Global health governance can be conceptualized in multiple ways; yet at the centre of most understandings is a tension between globalist and statist approaches.[6] Statist understandings are primarily security-focused, taking as the unit of analysis the state in the Westphalian system. Globalist approaches are focused on the rights of individuals, grounded in norms of cooperation, solidarity and shared liberal democratic values that seek to govern transnational issues in global health for all, noting that nationalistic policy-making is insufficient to address global concerns.[7] The globalist approach shares many overlapping values with that of a transnational cosmopolitan, medical humanitarianism or moral egalitarian world-view, rooted in the Kantian logic of universal community, whether this is expressly acknowledged or not: that we all exist as individuals within a single global community,[8] within which all people ought to have the same chance to access public and private goods that promote health, reduce disease risks and protect from health threats, regardless of where they live. More specifically, according to this approach the global community, composed of states, international organizations, philanthro-

[5] Sara E. Davies, 'What contribution can International Relations make to the evolving global health agenda?', *International Affairs* 86: 5, 2010, pp. 1167–90.

[6] Davies, 'What contribution can International Relations make to the evolving global health agenda?'.

[7] Jeremy Youde, *Global health governance* (Cambridge: Polity, 2012); Gorik Ooms, 'From international health to global health: how to foster a better dialogue between empirical and normative disciplines', *BMC International Health and Human Rights* 14: 1, 2014, DOI: 10.1186/s12914-014-0036-5; Richard Dodgson, Kelley Lee and Nick Drager, *Global health governance: a conceptual review* (Abingdon: Routledge, 2017).

[8] Raphael Lencucha, 'Cosmopolitanism and foreign policy for health: ethics for and beyond the state', *BMC International Health and Human Rights* 13: 1, 2013, DOI: 10.1186/1472-698X-13-29; Garrett Brown and Samuel Jarvis, 'Motivating cosmopolitanism and the responsibility for the health of others', in Richard Beardsworth, Garrett Brown and Richard Shapcott, eds, *The state and cosmopolitan responsibilities* (Oxford: Oxford University Press, 2019), p. 203; Sophie Harman and Clare Wenham, 'Governing Ebola: between global health and medical humanitarianism', *Globalizations* 15: 3 2018, pp. 362–76; Thomas Pogge, 'Cosmopolitanism and sovereignty', *Ethics* 103: 1, 1992, pp. 48–75.

pies, private-sector concerns and NGOs, should work collaboratively based on shared ideals of health to ensure the provision of health and well-being, considering the global population of individuals, rather than national borders or the protection of their 'own citizens' alone. It is this dichotomy between the unit of analysis of the individual present in globalist approaches to health, compared to the state-centric model of global health security, that fundamentally challenges global cooperation within a pandemic treaty.

Globalist conceptions have been the basis of much international cooperation in health matters, particularly in programmes based on overseas development aid, or in support provided by high-income countries to low- and middle-income countries in tackling health concerns which are found only in the global South. Here, such a framing of rights, equity, solidarity and shared goals is omnipresent, as donors and recipients alike seek to improve the health of individuals. Moreover, while a rationalist would contend that states comply with international law only on the basis of coincidence, cooperation, coercion and consent,[9] and that states' self-interest and power capabilities can lead them to depart from international law,[10] the concept of international law, and a rules-based approach to global governance, tend to align with globalist perspectives, owing to the 'pull mechanism', grounded in the 'internalized habit' of international law that prompts governments to comply with obligations rooted in that law.[11]

However, this world-view is very different from that underlying the statist approach to global health security. For many (high-income) states, preventing, detecting and responding to disease outbreaks is rooted in state-centric visions of national security. By engaging with global pandemic preparedness and response efforts, states protect their populations and economies from infectious disease threats.[12] Indeed, during COVID-19 we have seen the true extent of this: from the very early stages of the pandemic we saw a retrenchment from a shared global vision of support for those most in need to an ineffective 'nation-state first' approach.[13] Governments across the world have each charted their own course in the pandemic, implementing border restrictions,[14] departing from WHO guidance and obligations under IHR (2005), and in the process rejecting the globalist rhetoric of 'all in this together' and focusing instead on their own populations and their immediate short-term needs, as well as what they need to do to gain political support and win elections, rather than the global good of the

[9] See e.g. David Armstrong, Theo Farrell and Hélène Lambert, *International law and international relations*, 2nd edn (Cambridge: Cambridge University Press, 2012); Anne van Aaken, 'Rationalist and behaviouralist approaches to international law', in Jeffrey L. Dunoff and Mark A. Pollack, eds, *International legal theory: foundations and frontiers* (Cambridge: Cambridge University Press, 2021).

[10] Van Aaken, 'Rationalist and behaviouralist approaches to international law'.

[11] See e.g. Harold Hongju Koh, 'Why do nations obey international law?', *Yale Law Journal* 106: 8, 1997, pp. 2598–659; Martti Koskenniemi, 'The mystery of legal obligation', *International Theory* 3: 3, 2011, pp. 319–25.

[12] Colin McInnes and Kelly Lee, 'Health, security and foreign policy', *Review of International Studies* 32: 1, 2006, pp. 5–23; Simon Rushton, 'Global health security: security for whom? Security from what?', *Political Studies* 59: 4, 2011, p. 779; Sara E. Davies, 'Securitizing infectious disease', *International Affairs* 84: 2, 2008, p. 295.

[13] Clare Wenham, 'What is the future of UK leadership in global health security post COVID-19?', *IPPR Progressive Review* 27: 2, 2020, pp. 196–203.

[14] Elżbieta Opiłowska, 'The COVID-19 crisis: the end of a borderless Europe?', *European Societies* 23: sup1, 2021, pp. S589–S600.

single global community. The starkest example of this is the ongoing vaccine nationalism that many western states continue to exhibit. There are clear cosmopolitan arguments that the fairest distribution of vaccines would be to give them first to health care workers and those most clinically vulnerable globally; indeed, the COVAX initiative was created to achieve this, grounded in globalist ideals. Yet western statist approaches to global policy-making have undermined COVAX by dominating the limited supply of vaccines through advance purchase agreements to meet domestic needs, including the provision of boosters, directly inhibiting access to vaccines in low- and middle-income countries.[15] The outcome is that case fatality rates will continue to vary wildly between high- and low-income settings, and the increased risk of new variants will prolong the pandemic.

The beginning of global health governance

The roots of international cooperation in responding to infectious disease were put down at the International Sanitary Conferences (ISC) beginning in 1851, through which European states and city-states sought to establish mechanisms to reduce the spread of disease with minimal disruption to trade, something the modern-day IHR still seek to do. In 1951, the World Health Assembly, in adopting the International Sanitary Regulations, sought to place the WHO at the centre of this international disease governance by harmonizing the old ISC instruments, as well as regional arrangements, under one global instrument, ultimately culminating in the IHR, the current governance instrument for pandemic preparedness and response.[16]

In adopting the IHR, member states and the WHO recognized the need to balance political drivers with those of public health and trade, or, in other words, the need to promote globalist approaches and cosmopolitan ideals to the status of international law in dealing with infectious disease outbreaks, and to overcome the statist security constraints inherent in the confines of the Westphalian system more broadly—constraints that continue to plague the world in the COVID-19 pandemic.[17] The formulation of the IHR has been a dynamic process whereby the WHO has sought to develop the regulations in the light of real-world occurrences where their limitations have been felt and to reform them accordingly; the statist vs globalist tension is not new, and if it is not meaningfully addressed it will hamper negotiations towards any pandemic treaty. Indeed, despite inter-

[15] Mark Eccleston-Turner and Harry Upton, 'International collaboration to ensure equitable access to vaccines for COVID-19: the ACT-accelerator and the COVAX facility', *Milbank Quarterly* 99: 2, 2021, pp. 426–49.

[16] Mark Eccleston-Turner and Clare Wenham, *Declaring a Public Health Emergency of International Concern: between international law and politics* (Bristol: Bristol University Press, 2021).

[17] Sara E. Davies, Adam Kamradt-Scott and Simon Rushton, *Disease diplomacy: international norms and global health security* (Baltimore: Johns Hopkins University Press, 2015); David P. Fidler and Lawrence O. Gostin, 'The new International Health Regulations: an historic development for international law and public health', *Journal of Law, Medicine and Ethics* 34: 1, 2006, pp. 85–94; Lawrence O. Gostin and Rebecca Katz, 'The International Health Regulations: the governing framework for global health security', *Milbank Quarterly* 94: 2, 2016, pp. 264–313; Rebecca Katz and Julie Fischer, 'The revised International Health Regulations: a framework for global pandemic response', *Global Health Governance* 3: 2, 2010, pp. 1–18; Sara E. Davies, 'The international politics of disease reporting: towards post-Westphalianism?', *International Politics* 49: 5, 2012, pp. 1–18.

national cooperation spanning over 150 years in infectious disease control, the central tensions remain largely unchanged from those at the first ISC. How do we encourage states to cooperate in the management of cross-border infectious disease threats, and not engage in statist, nationalistic responses? Moreover, what incentives can we offer to governments of all political persuasions to commit themselves to globalist norms, rather than prioritizing short-term realist goals of state security during a pandemic?

More generally, international cooperation around infectious disease management has generally taken the form of soft law obligations, particularly at the WHO, such as the Pandemic Influenza Preparedness (PIP) Framework, or through guidelines and frameworks developed by WHO headquarters and regional and country offices, and resolutions of the WHA.[18] While these are clearly globalist in nature, in that they seek to create a harmonized or equitable response to infectious disease outbreaks, doubts had been raised regarding the extent to which statist responses might undermine such globalist mechanisms during a health emergency.[19] To date, the WHO has made use of its treaty-making powers only once, through the Framework Convention on Tobacco Control (FCTC).[20]

This division between statist and globalist views of infectious disease control is in many ways unsurprising, and any analysis of global health, indeed of international relations more broadly, shows that the foundations of globalist cooperation are on shaky ground;[21] nevertheless, this division seems to loom quite starkly as the elephant in the room for the pandemic treaty. What has not been made clear is how the globalist nature and content of the proposed treaty can be accommodated by the statist approach to global health architecture and treaty negotiating.

Pandemic treaty proposals

The EU, an original proponent of the proposal, has suggested that the treaty should focus on early detection and prevention; resilience to and response to pandemics, including universal access to medicines, vaccines and diagnostics (despite the rampant vaccine nationalism which many vocal proponents of the treaty have engaged in throughout COVID-19); a stronger international health framework with the WHO at the centre; a 'one health' approach—which seeks to incorporate environmental and animal health factors into public health; better use of digital technology for data collection and sharing; resilient supply chains and coordination of R&D; pathogen and genomic data-sharing; stronger health

[18] Sharifah Sekalala, *Soft law and global health problems: lessons from responses to HIV/AIDS, malaria and tuberculosis* (Cambridge: Cambridge University Press, 2017).

[19] Michelle Rourke, 'Access by design, benefits if convenient: a closer look at the Pandemic Influenza Preparedness Framework's standard material transfer agreements', *Milbank Quarterly* 97: 1, 2019, pp. 91–112; Mark Eccleston-Turner, 'The Pandemic Influenza Preparedness Framework: a viable procurement option for developing states?', *Medical Law International* 17: 4, 2017, pp. 227–48.

[20] Framework Convention on Tobacco Control (2003), 2302 UNTS 166. A subsequent Protocol to the FCTC has also been opened for signature and ratification: Protocol to Eliminate Illicit Trade in Tobacco Products (2012), 2225 UNTS 209.

[21] Julio Frenk, Octavio Gómez-Dantés and Suerie Moon, 'From sovereignty to solidarity: a renewed concept of global health for an era of complex interdependence', *Lancet* 383: 9911, 2014, pp. 94–7.

systems and reporting mechanisms; and restoring trust in the international health system.[22] The Independent Panel for Pandemic Preparedness and Response (IPPPR) has further recommended that the treaty should consider mechanisms for financing pandemic preparedness and response, R&D, technology transfer, capacity-building, and reinforcing legal obligations and norms of global health security, proposals which have been supported by a flurry of academic commentary on the matter.[23] The WHO and a small collection of heads of state, keen to claim the governance space for such a policy development amid their COVID-19 legitimacy crisis, have added to these proposals that 'such a treaty should lead to more mutual accountability and shared responsibility, transparency and cooperation within the international system and with its rules and norms'.[24]

However, ultimately, regardless of such recommendations from international bodies, the content of any treaty will be determined by states. From member-state position papers, the work of the Member States Working Group on Strengthening WHO Preparedness for and Response to Health Emergencies (WGPR), and statements at the WHASS, it is possible to gain a clearer understanding of the substantive content states are *proposing* should be covered by the treaty. It has been proposed that the treaty should cover access to medical equipment and countermeasures, including vaccines, diagnostics and treatments;[25] capacity-building and standard-setting of health care systems;[26] cooperation in research

[22] European Council, *An international treaty on pandemic prevention and preparedness* (Brussels, 2021).

[23] Sara Davis et al., 'An international pandemic treaty must centre on human rights', *British Medical Journal*, 10 May 2021, https://blogs.bmj.com/bmj/2021/05/10/an-international-pandemic-treaty-must-centre-on-human-rights/ (Unless otherwise noted at point of citation, all URLs cited in this article were accessible on 29 Jan. 2022.); Haik Nikogosian and Ilona Kickbusch, 'How would a pandemic treaty relate with the existing IHR (2005)?', *British Medical Journal,* 23 May 2021, https://blogs.bmj.com/bmj/2021/05/23/how-would-a-pandemic-treaty-relate-with-the-existing-ihr-2005/; Gian Luca Burci, Suerie Moon, Alfredo Carlos Ricardo Crosato Neumann and Anna Bezruki, *Envisioning an international normative framework for pandemic preparedness and response: issues, instruments and options* (Geneva: Graduate Institute Geneva, 2021); Sakiko Fukuda-Parr, Paulo Buss and Alicia Ely Yamin, 'Pandemic treaty needs to start with rethinking the paradigm of global health security', *BMJ Global Health* 6: 6, 2021; Jorge Vinuales, Suerie Moon, Ginevra Le Moli and Gian Luca Burci, 'A global pandemic treaty should aim for deep prevention', *Lancet* 397: 10287, 2021; Suerie Moon and Ilona Kickbusch, 'A pandemic treaty for a fragmented global polity', *Lancet Public Health* 6: 6, 2021, pp. E355–6; Thomas R. Frieden and Marine Buissonnière, 'Will a global preparedness treaty help or hinder pandemic preparedness?', *BMJ Global Health* 6: 5, 2021, e006297; Swee Kheng Khor and David L. Heymann, 'Pandemic preparedness in the 21st century: which way forward?', *Lancet Public Health* 6: 6, 2021, pp. E357–8; Faouzi Mehdi, Ahmed Mohammed Obaid Al Saidi, Fawsiya Abikar Nur, Yves Souteyrand, Jean Jabbour, Mamunur Malik, Abdinasir Abubakar, Wasiq Khan, Richard Brennan, Rana Hajjeh and Ahmed Al-Mandhari, 'An international treaty for pandemic preparedness and response is an urgent necessity', *British Medical Journal,* 23 May 2021, https://blogs.bmj.com/bmj/2021/05/23/an-international-treaty-for-pandemic-preparedness-and-response-is-an-urgent-necessity/.

[24] Joint statement by heads of states and WHO, 'COVID-19 shows why united action is needed'.

[25] Government of India, 'Approach on WHO reforms', New Delhi, 2021; EU, 'EUMS's initial views on a possible structure and content of a pandemic treaty', Brussels, 31 Aug. 2021. The issue of equitable access was raised by a number of states at the WHASS, including Nepal, Andorra, Syria, Sudan, Costa Rica (on behalf of the Group of Friends of the Pandemic Treaty), Botswana (on behalf of the African Union), Slovenia (on behalf of the EU) and the United States.

[26] Government of India, 'Approach on WHO reforms'; WHO Africa Group member states, 'Non-paper by the Africa Group member states', Geneva, 19 Oct. 2021; Government of Japan, 'Japan's priorities on the WHO review/reform (version 2.0)', Tokyo, 25 Dec. 2020. Health system strengthening was also proposed at the WHASS by Brazil, Slovenia, Pakistan, Argentina, Indonesia and many other states.

and technology;[27] a 'one health' approach;[28] data-sharing;[29] reform of the WHO alarm mechanism, the public health emergency of international concern declaration process and travel restrictions;[30] and cross-cutting issues, such as accountability, investment in health systems, increased power for the WHO and increased global coordination.[31] Issues beyond the typical boundaries of health, such as trade and supply chains and international travel, have also been raised as potential substantive topics for the treaty to address.[32] Finally, many member states framed the development of a treaty in terms of human rights, solidarity and equity, including redressing failures that have occurred during COVID-19.[33] Collectively, these proposals remain aspirational; this proposed content for the treaty text will be subject to further definition, discussion and negotiation.

Beyond these substantive content proposals, states have clarified their expectations that any treaty must work in conjunction with the 2005 IHR;[34] have legally binding enforcement mechanisms, a strong secretariat and clear metrics for monitoring and evaluation; involve heads of state and not simply public health professionals;[35] form part of broader WHO reform efforts; have both technical guidance and political engagement; be flexible enough to accommodate minilateral clubs within broader global health governance; address material conditions to facilitate adherence;[36] and not focus solely on the global level, but require action at national level and state buy-in domestically.[37]

This range of proposals shows that the precise diagnosis of the weaknesses of the international response to the COVID-19 pandemic and global health governance more broadly is far from complete. While we do not suggest that all these ideas

[27] WHO Africa Group member states, 'Non-paper by the Africa Group member states'; Ghana, submission to WHASS, Geneva, 29 Nov. 2021.

[28] WHO Africa Group member states, 'Non-paper by the Africa Group member states'; Governments of France and Germany, 'Non-paper on strengthening WHO's leading and coordinating role in global health with a specific view on WHO's work in health emergencies and improving IHR implementation', Geneva, 2021; EU, 'EUMS's initial views on a possible structure and content of a pandemic treaty'.

[29] EU, 'EUMS's initial views on a possible structure and content of a pandemic treaty'; Governments of Botswana, Nepal, Oman and Switzerland, 'Non-paper: WHO's work in health emergencies and IHR revision', Geneva, 2021; UK, submission to WHASS, Geneva, 29 Nov. 2021; Canada, submission to WHASS, Geneva, 29 Nov. 2021.

[30] Governments of Botswana et al., 'Non-paper'; Governments of Chile, Ecuador, Guatemala, Peru and Uruguay, 'Strengthening international health protection architecture', Geneva, 2021; Government of the United States of America, 'Amendments of the International Health Regulations 2005', Washington DC, 2021.

[31] Governments of France and Germany, 'Non-paper on strengthening WHO's leading and coordinating role'; Government of the United States, 'Amendments of the International Health Regulations 2005'; Government of the United States of America, submission to WHASS, Geneva, 29 Nov. 2021.

[32] Governments of Botswana et al., 'Non-paper'.

[33] Human rights was raised at WHASS by, among others, Portugal and the Netherlands; solidarity by Chile, Fiji, Ecuador, Egypt, Algeria, Norway, Mozambique, El Salvador, Nigeria, Albania and many more; and equity by over 60 member states, including Gabon, Dominican Republic, Namibia, Tanzania, Mauritania, UK, Georgia and Tonga.

[34] Raised at WHASS by Russian Federation, Estonia, Philippines, Japan, Iraq, Malaysia and Cambodia.

[35] Government of Jamaica, submission to WHASS, Geneva, 29 Nov. 2021; Government of Brazil, submission to WHASS, Geneva, 29 Nov. 2021.

[36] Government of Maldives, submission to WHASS, Geneva, 29 Nov. 2021; Government of Singapore, submission to WHASS, Geneva, 29 Nov. 2021.

[37] Government of Malawi, submission to WHASS, Geneva, 29 Nov. 2021; Government of the Philippines, submission to WHASS, Geneva, 29 Nov. 2021.

will make it into a treaty, we do see a very real risk of so much being proposed for inclusion within a single accord that it seems unlikely that it will be able to achieve it all. Moreover, if the proposed substantive content does make it to the drafting and negotiation process of the INB, it is unlikely that this process will see consensus among member states reached on these issues, and that in turn will limit ratification of any treaty nationally, particularly if the contentious issues are seen to impinge on trade or sovereignty.[38] To put the point simply, the content of the pandemic treaty currently being proposed is at its heart a globalist project, seeking to improve health for all, allow equity in preparedness for and response to future pandemics, and asserting at its core the universality of human populations. Even within states we see tension between health and development ministries, and between cabinets and foreign ministries, on such issues. Championing solidarity and equity requires states to depart from state-centric policy-making and focus on the global, something states have been unable or unwilling to do in global health governance to date, and indeed during the COVID-19 pandemic. Until such tension between statist reality and globalist ideals is addressed, any pandemic treaty will remain impossible to implement. To move forward, rich countries must answer the question of what they are willing to give up nationally in order to be better prepared internationally for future pandemics. Statist policy-making during COVID-19 has shown the answer to be: not much.

Treaty design

Globalist proponents of the treaty have focused on a legally binding mechanism to ensure state accountability to the treaty text. However, at the WHASS, the language of 'a legally binding instrument to be adopted under Article 19 of the WHO Constitution' was changed to 'WHO convention, agreement *or other international instrument* … with a view to adoption under Article 19, *or under other provisions of the WHO Constitution as may be deemed appropriate by the INB*' (emphasis added), meaning that the resulting 'pandemic treaty' may not actually be a treaty at all, but some other instrument, lacking the legally binding force of a treaty. Current proposals are being considered within a framework convention approach, as exemplified in connection with the WHO by the FCTC, and within the wider UN architecture by the UN Framework Convention on Climate Change (UNFCCC) and Convention on Biological Diversity (CBD). A framework convention approach to treaty-making allows potential state parties to reach consensus on high level legally binding principles and commitments, such as globalist ideals of 'solidarity' and 'equity', in the initial negotiations; then, at a later date, agreements can be reached which embody these principles in detail. Importantly, this approach allows states to pick and choose to which protocols within the treaty they wish to be party, leading to different states ratifying different elements of the overall treaty package, enabling a broad consensus

[38] Remco van de Pas, Priti Patnaik and Nicoletta Dentico, *The politics of a WHO pandemic treaty in a disenchanted world*, G2H2 report (Geneva, Nov. 2021).

approach to norms of international law-making, but with national differentiation in respect of specific obligations.

For example, in the CBD and its associated Nagoya Protocol there are essentially three distinct legal regimes: CBD alone (73 state parties), the CBD plus Nagoya (123 state parties), and neither CBD nor Nagoya (United States and Holy See). For a global treaty aiming to prevent, detect and respond to emerging infectious disease, dependent on global uptake, such fragmentation in ratification of different parts of a pandemic treaty could be disastrous, and indeed could spell the undoing of the treaty itself. Imagine the scenario where an outbreak emerges in a location which has not ratified the treaty protocol requiring prompt sharing of pathogen genetic sequences; there would be no consequences grounded within the pandemic treaty to hold that state to account. Or consider a scenario in which a state has not ratified obligations in respect of the equitable distribution of diagnostics, treatment or vaccines during a health emergency, and instead chooses to stockpile; such action would raise questions regarding the overall utility of the treaty in a health emergency. Thus, while a framework convention may seem appealing from a 'get it done' perspective, building on contemporary political momentum, its inability to create a harmonious international legal regime could leave significant gaps in the global governance of disease. Moreover, protocols take considerable time to construct; the first protocols to the UNFCCC and the CBD were not adopted until, respectively, three and seven years, and did not enter into force until ten and eleven years after agreement on the parent conventions. A framework convention approach *could* be viable, if states could agree on short, definite timelines for negotiating further protocols, although this does not deal with the inevitable divergence among states in respect of the adoption and content of protocols.

Interaction with the IHR

The IHR, while lambasted for not mitigating the spread of COVID-19, neatly demonstrate the tension between the statist and globalist approaches in global health. Indeed, the IHR Review Committee on the Functioning of the Regulations during COVID-19 concluded that the problem lay not with the IHR as formulated *per se*, but that *implementation* of the IHR by states is poor; and it is this lack of implementation and compliance that has underlain the disastrous response to COVID-19. Indeed, the IPPPR and the Independent Oversight Advisory Committee of the Health Emergencies Programme have further highlighted poor compliance with the IHR and with WHO guidance as being central to the failures of the response to COVID-19. Here we see the IHR, an instrument rooted in a globalist, rules-based approach to infectious disease, which seeks to encourage states to prioritize pandemic control over state sovereignty, being undermined by statist prioritization of security within global health.

Yet any agreement must seek to be compatible with article 57 of the IHR, which stipulates that 'the IHR and other relevant international agreements should be interpreted so as to be compatible', and that 'the IHR shall not affect the rights

and obligations of any State Party deriving from other international agreements'. Concerns were raised during the IHR negotiations that the subject-matter of the regulations would overlap with issues covered by other instruments of international law[39]—and a pandemic treaty, particularly one adopted as a framework convention with multiple protocols, will only add to this fragmentation. Indeed, the issue of fragmentation being exacerbated by the pandemic treaty was raised by Russia, Pakistan, France and numerous other states at WHASS.[40]

Within international law, legal agreements should first be interpreted in line with the principle of 'mutual supportiveness', which presumes against conflicts between legal regimes. Second, potentially conflicting instruments should not be read in a manner that seeks either to add to or to diminish rights and obligations provided for in other treaties. However, the international legal landscape for health emergencies is already deeply fragmented, made up of a multitude of instruments deriving from multiple organs of the international system, including the WTO TRIPS Agreement, resolutions of the United Nations Security Council (UNSC), the CBD, the IHR, resolutions of the WHA, the Agreement on Sanitary and Phytosanitary Measures, and resolutions of the UN General Assembly. Given how broad is the list of substantive topic areas the treaty is seeking to address, its potential interaction and engagement with each of the above regimes need to be considered and harmonized. This is especially relevant for multisectoral issues such as one health that directly address multiple regimes.[41]

Harmonizing different legal regimes is a monumental task, and in reality the pandemic treaty is likely only to make an already fractured international governance system all the more fractured. If states can choose between different instruments such as the IHR, a new treaty, its protocols, or some combination of these, fragmentation will increase, with negative implications for pandemic preparedness and response.

Alternatives to a new treaty

A potential alternative to the treaty would be to update the IHR, making them more relevant, and addressing the governance and compliance gaps, moving them beyond the current 'name and shame'.[42] Indeed, as the WGPR highlighted, out of the 131 recommendations they made, 101 appear to be met by implementing or building on current frameworks, and only 30 actually require a new instrument.[43]

[39] Barbara von Tigerstrom, 'The revised International Health Regulations and restraint of national health measures', *Health Law Journal* 13: 35, 2005, pp. 35–76.

[40] Submissions to WHASS, Geneva, 29 Nov. 2021.

[41] Arne Ruckert, Carlos Gonçalo das Neves, John Amuasi, Suzanne Hindmarch, Christina Brux, Andrea Sylvia Winkler and Hélène Carabin, *One Health as a pillar for a transformative pandemic treaty*, Global Health Centre policy brief (Geneva: Graduate Institute Geneva, 2021), https://www.graduateinstitute.ch/sites/internet/files/2021-11/policybrief-onehealth-v3.pdf.

[42] Sara E. Davies, 'Nowhere to hide: informal disease surveillance networks tracing state behaviour', *Global Change, Peace and Security* 24: 1, 2012, pp. 95–107.

[43] WHO, 'Member States Working Group on Strengthening WHO Preparedness for and Response to Health Emergencies (WGPR): preliminary findings from COVID-19-related recommendation mapping' (Geneva, 26 Aug. 2021).

Moreover, deeper analysis has shown that most of these 30 could be met through the IHR functioning as originally intended, for example through improvements to the National Focal Point—the national centre of office which shall be accessible at all times for communications with the WHO regarding events under the IHR, sustainable financing, community participation and human rights; thus 'the only point amongst the recommendations which requires a framework convention is the recommendation which states that there must be an establishment of a new framework convention'.[44]

However, opening the text of the IHR for renegotiation runs the risk of not simply adding more tenets, but losing some of the current content during negotiations. For many, the balance between statist and globalist visions within the IHR was tenuous at best, and given the approaches taken by national decision-makers during COVID-19, it is not hard to imagine that they might seek to reduce the power of the IHR and/or WHO in favour of further legitimizing state-centrism during a pandemic. A halfway house that would avoid opening up the IHR to (re) negotiation would be to assemble a review conference to tweak the IHR regularly, ironing out issues which emerge. This model is well used for the Biological Weapons Convention, which has biannual meetings to re-establish procedures and norms associated with the treaty.[45] A mechanism currently planned is a 'universal periodic health review', which could include peer reviews, reports by special rapporteurs, experts and civil society groups, and incentives and provision of financial assistance to fill identified gaps. However, this again takes a globalist world-view, and assumes that states would be willing to undergo such a review, and subject themselves to peer scrutiny of their systems and processes, for the greater good of global pandemic preparedness.

A further argument against working through the IHR is that the regulations are seen as a political 'dead horse', perceived to have failed during COVID-19 (and arguably before that), and indeed implicated in broader tensions in respect of the legitimacy of the WHO in global disease control. Seeking to reform them may be a dubious exercise if they are seen as not worthy of revival, and thus a new treaty may be more politically palatable. This may be particularly true among those states that failed to comply with IHR during COVID-19, and now want to be seen to be doing something to mitigate future pandemics. However, the mandate and legitimacy of the IHR are built upon a long history of international cooperation to minimize and prevent the international spread of disease,[46] and the results of this historic work should not be cast aside too easily.

[44] Nithin Ramakrishnan and K. M. Gopakumar, 'WHO: working group bureau questions on pandemic treaty prejudge outcome', *Third World Network Info Service on Health Issues*, Geneva, 1 Sept. 2021, https://www.twn.my/title2/health.info/2021/hi210901.htm.

[45] Rebecca Katz, 'Pandemic policy can learn from arms control', *Nature* 575: 7782, 2019, p. 259.

[46] David P. Fidler, 'From International Sanitary Conventions to global health security: the new International Health Regulations', *Chinese Journal of International Law* 4: 2, 2005, pp. 365–92.

Implementation

Notwithstanding limitations within the substantive content of the IHR and/or the pandemic treaty, the most pressing limitation is compliance, which requires statist governments to abide by globalist norms and law for preventing, detecting, responding to and recovering from future health threats. This issue was raised by several states during the WHASS, including the United States and Malaysia, along with the WHO regional directors for the Eastern Mediterranean Regional Office and Europe.[47] It has become something of a cliché that 'almost all nations observe almost all principles of international law and almost all of their obligations almost all of the time',[48] but non-compliance with the IHR, rooted in the prioritization of state security—particularly during an emergency—has plagued the WHO for more than 50 years. This raises the question of what, if anything, a pandemic treaty can do differently to address the problem of compliance. There are two key options: incentives and sanctions.

Incentives could be designed to ensure that governments adhere to the pandemic treaty, whatever the content might be. For example, if a barrier to implementing effective surveillance systems is financing, a 'carrot' would be to ensure that funds are available to help with system-wide development. Similarly, if prompt reporting and sharing epidemiological data is seen as counterproductive to national (economic) security, financial or human resources could be made available upon the submission of such reports, mitigating the sting of any trade challenges. Little of this support for capacity-building was present in the text of the 2005 IHR, despite pressure for it from low- and middle-income countries.[49] Any incentive would need to be significant, so long-term sustainable financing mechanisms would need to be employed. These could come from Bretton Woods institutions such as the IMF, in the form of special drawing rights, or from the World Bank in the form of loans; or indeed a new pooled insurance mechanism for pandemics could be established to share the costs of the risks associated with infectious disease outbreaks, while simultaneously using these financing resources to encourage compliance with a pandemic treaty. High-income countries, however, may not be motivated by financial resources in the same way as their lower-income counterparts, warranting consideration of non-financial incentives for compliance.

Sanctions for non-compliance are the alternative, yet these seem politically unsellable in the present climate. Moreover, sanctions may lead to greater concealment of outbreaks by states not wishing to be punished. Given the WHO's current lack of enforcement power, coupled with a lack of financing, it appears that a pandemic treaty under the aegis of the WHO would merely maintain the status quo in compliance. Member states have disregarded the IHR's temporary recommendations during emergencies, favouring a statist perspective, and a future pandemic treaty will not change this dynamic. Indeed, states are highly unlikely to agree to a treaty sanctions regime for this very reason. Statist policy-makers

[47] Submissions to WHASS, Geneva, 29 Nov. 2021.
[48] Louis Henkin, *How nations behave: law and foreign policy* (New York: Columbia University Press, 1979).
[49] Eccleston-Turner and Wenham, *Declaring a Public Health Emergency of International Concern*.

want freedom to depart from their treaty obligations when it suits them, just as they do under the current IHR framework.

Governance

The question of compliance and accountability raises further questions about the governance of the treaty itself. Early treaty discussions focused on the location of a pandemic treaty, with some suggesting it could be done outside the WHO. For this treaty to have teeth, the organization that governs it needs to have power—either political or legal—to enforce compliance. In its current form, the WHO does not possess such powers. The manner in which states departed from WHO guidance during COVID-19 (and indeed earlier) demonstrates that there is a big problem with the legitimacy of the WHO in the eyes of the global community. Schwalbe and Lehtimaki state that 'a treaty negotiated under the auspices of the WHO, which has little authority of its own and instead reflects the interests of its member states, will be unlikely to make the sweeping changes that are urgently needed'.[50] Indeed, the WHO takes a globalist, cosmopolitan world-view, its mandate asserting that the 'highest attainable standard of health is one of the fundamental rights of every human being';[51] and yet for this treaty to work, it needs to be able to hold its members to account for statist behaviour. Notwithstanding the statist vs globalist tension, a pandemic treaty governed by the WHO will inevitably be beset by further challenges, and may be a litmus test for organization as a whole, as Klabbers has noted:

> When organizations start to … impose and monitor sanctions regimes … discussions will start about how they do so, and whether they do so well enough to merit further support. They operate, so to speak, on the market of legitimacy, and legitimacy, however precisely conceptualized, is a scarce resource.[52]

The WHO is seen by many as a location of 'low politics', the remit of health ministers rather than heads of state. A weak WHO housing the accord risks the overall power of the treaty waning, when negotiated and ratified, if it cannot enforce obligations or hold states to account for non-compliance. Moreover, the weakness of the WHO may in turn limit the treaty's exercise of its powers to govern trade and intellectual property, and make meaningful steps around compliance and sanctions, all of which appear among the proposals for the treaty contents, and yet fall outside the WHO's mandate and remit.

If the pandemic treaty takes a multisectoral approach, the WHO would need to govern not only health decision-making in states, but also other regimes (e.g. animal health and environmental policy, trade and intellectual property rights surrounding access to medical counter-measures, and the biodiversity implications

[50] Nina Schwalbe and Susanna Lehtimaki, 'The world should treat pandemics like it treats chemical weapons', *Foreign Policy*, 14 April 2021, https://foreignpolicy.com/2021/04/14/pandemic-treaty-who-tedros-china-transparency-inspections-data-covid-19-coronavirus/.

[51] Preamble, constitution of the World Health Organization (1946), 14 UNTS 185.

[52] Jan Klabbers, 'The paradox of international institutional law', *International Organizations Law Review* 5: 151, 2008, p. 169.

of pathogen-sharing). The WHO does not at present have the capacity to do so, and other international organizations will not accept an expansion of its mandate. What is more, the WHO is chronically underfunded: it has tried to increase its financing, yet this is challenged by the division between assessed and voluntary contributions, the former being at the discretion of the WHO to spend, and the latter being ring-fenced for programmes aligning with donor priorities, another example of statist approaches to policy-making within a globalist institution.[53] States have perpetuated this lack of financing; and without adequate funding, the WHO remains unable to mount a meaningful response to any pandemic, or to be seen as a credible repository for governance of the pandemic treaty. This point is particularly pertinent when considering the tension between the globalist views of global health governance that are central to WHO activities, and the more securitized, state-based responses evident in states' responses to COVID-19.

Some commentators have argued that the treaty itself might be an instrument for strengthening the WHO's position in global health governance. Duff and colleagues argue that the WHO needs to have the authority to coordinate an international response to a pandemic; be able to enforce treaty requirements; be politically independent and thereby able to make the best public health decisions; have a sustainable source of financing; represent all states; and be multisectoral.[54] Indeed, many statements at the WHASS focused on how to strengthen the WHO to facilitate the treaty in a meaningful way, as well as on what the treaty might offer the WHO in terms of legitimacy-building. The very point that the organization might need to be strengthened as part of a treaty-making process is a pertinent one. The mere fact that this is being considered speaks volumes about the WHO's inability to manage a treaty of this magnitude and importance. Alternatively, it may be that statist policy-makers want to place the treaty in a weak institution with no meaningful accountability and compliance mechanisms, so as to be free to disregard any obligations during a health emergency. Thus it could be a strategic move by some high-income governments, currently championing the WHO as the home for the treaty, to appear to be promoting globalist ideals of global health governance, while knowing full well that they will never comply with the treaty they are championing, especially around issues of equity and access to medical counter-measures.

We do not wish to dismiss the idea of a more powerful WHO acting on the international stage; however, there is very little evidence to support the idea that this is what *states* want. Indeed, the 2005 revisions to the IHR, developed after the SARS outbreak, contain underdeveloped governance and compliance structures,

[53] Kristina Daugirdas and Gian Luca Burci, 'Financing the World Health Organization: what lessons for multilateralism?', *International Organizations Law Review* 16: 2, 2019, pp. 299–338 at p. 300.

[54] Johnathan H. Duff, Anicca Liu, Jorge Saavedra, Jacob Batycki, Kendra Morancy, Barbara Stocking, Lawrence Gostin, Sandro Galea, Stefano Bertozzi, Jose Zuniga, Carmencita Alberto-Banatin, Akuka Sena Dansua, Carol del Rio, Maksut Kulzhanov, Kelley Lee, Gisela Scaglia, Cyrus Shahpar, Andrew Ullmann, Steven Hoffman, Michael Weinstein and José Szapocznik, 'A global public health convention for the 21st century', *Lancet Public Health* 6: 6, 2021, pp. E428–33; Germán Velásquez and Nirmalya Syam, 'A new WHO international treaty on pandemic preparedness and response: can it address the needs of the global South?', South Centre Policy Brief no. 93, 10 May 2021.

despite their focus on pandemic prevention and the cross-border spread of health emergencies.[55] Moreover, the balance of power between the WHO and states in terms of reporting and information-sharing during a health emergency remained a key tension in the IHR negotiation, between the best public health approach and the state's sovereign prerogative.[56] Given the response to COVID-19 and the abandonment of the WHO by many members pursuing their statist responses to the pandemic, it seems unlikely that member states will be willing to give the globalist institution more power in the future—even though this might make the world better prepared for the next pandemic.

Other suggestions have been made: among them, that the treaty either be hosted within another UN institution or that a Global Health Threats Council be created,[57] modelled on the UNSC, which would enjoy similar powers and have buy-in from the 'highest echelons of power';[58] this, indeed, would be much more closely linked to norms of national security, rather than cosmopolitanism. While this option may be attractive from an enforcement perspective, ensuring the political salience of the treaty, it is not without its own difficulties. Setting up new institutions is a significant commitment, perhaps bigger than negotiating a new treaty, especially if that new institution is to have powers similar to those of the UNSC; and it will take time, institutional memory and sustainable funding to manage the unruly process of negotiating and implementing a pandemic treaty. At the same time, any new institution will contribute to more fragmentation in the global health architecture and will weaken WHO authority, and there is very little evidence that states are willing to cede sovereignty to a new institution. Indeed, all the evidence suggests that member states are not willing to cede much sovereignty in the health emergency space at all; statist policy-making in health remains the dominant behaviour in a world of globalist rhetoric.

Conclusion

The Group of Friends of the Treaty argues that 'the world cannot afford to wait until the COVID-19 pandemic is over to start planning for better pandemic preparedness and response and implementing the lessons learnt from this crisis', adding that 'key to the success of this endeavour will be a collective approach that puts aside "business-as-usual"'. However, many states championing the treaty are not suffering the downstream effects of vaccine nationalism, inaccessible oxygen, lack of funds to support health system surge capacity, etc. As Ramakrishnan argues, 'This argument is disingenuous. How can we learn from lessons of the current crisis when international agencies and the international community have so far failed on global solidarity and equitable access, and instead persisted with "business as usual" approaches?'[59] This comment underlines the key tension of the

[55] Eccleston-Turner and Wenham, *Declaring a Public Health Emergency of International Concern*.
[56] Davies et al., *Disease diplomacy*.
[57] Nikogosian and Kickbusch, 'How would a pandemic treaty'.
[58] Independent Panel for Pandemic Preparedness and Response, 'Second report on progress', Geneva, Jan. 2021.
[59] Nithin Ramakrishnan, K. M. Gopakumar and Sangeeta Shashikant, 'WHO: should members pursue a

proposed pandemic treaty. Its approach is rooted in globalist ideals of what the perfect pandemic governance should look like; yet it seems to have little regard for the realities of the statist, securitized landscape that exists for responding to pandemic threats. Current plans do not support the needs of states globally who need to end this pandemic first, and do not have the resources to do so due to statist responses to finite resources by high-income countries. The globalist norms of international solidarity and equitable access that world leaders place at the centre of the pandemic treaty proposals seem quite distant from the realities of the pandemic response in which many states are currently living. It doesn't take a big leap of understanding to see why some governments may see this as a token effort, and do not believe that negotiating a new treaty will lead to meaningful change.

Thus an alternative way to look at this push for the pandemic treaty is as a distraction from the current failure of global governance. While it may appear unsurprising that the response to failed global governance is to create new mechanisms for global governance, it does at least on the surface appear to show states in the global North 'doing something'. However, high-income states cannot simply 'treaty themselves out' of a pandemic.[60]

The fundamentals of the treaty remain a challenge, with talk of solidarity a distant dream for those living the reality of the nation-first approach to COVID-19. Beyond the bigger picture, after the INB launches the zero draft of the pandemic treaty in August 2022, it will probably take years to negotiate, given the scope of the proposed content, and through such laborious negotiation the scope and power of the document will be limited, rendering meaningless any authority to bind states. Globalist, cosmopolitan visions championed by public health communities, at odds with national security strategies, will simply go unratified or unimplemented. Hence, we fear the process will simply cost a lot of time and money, without fundamentally changing the ways in which states respond to emerging infectious diseases or the underlying inequalities which blight the global health system, however well meaning its negotiations and despite its work being rooted in globalist understandings of health. Also, the world in its current state cannot wait until 2024 for a pandemic treaty to be negotiated to bring about fundamental impacts on behaviours in international disease prevention and response.

This lack of viable options speaks to the broader problems within the global governance of disease: that global processes for health cooperation rooted in a globalist vision of the individual and health equity are fundamentally at odds with the Westphalian state-based system in which we live, which prioritizes state security and the health of a selected few at all other costs. Even something as big as a major global pandemic is not sufficient to get governments to think beyond national interests.[61]

pandemic treaty in the midst of a global pandemic?', *Third World Network Info Service on Health Issues*, May 21/07, 12 May 2021, https://www.twn.my/title2/health.info/2021/hi210507.htm.

[60] Unni Karunakara, 'Europe cannot "treaty" itself out of the pandemic', *Health Policy Watch*, 30 Nov. 2021, https://healthpolicy-watch.news/europe-treaty-pandemic/.

[61] Davis et al., 'An international pandemic treaty must centre on human rights'; Moon and Kickbusch, 'A pandemic treaty for a fragmented global polity'.