# RE-IMAGINING POSSIBILITIES OF GOVERNANCE FOR GLOBAL HEALTH

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**Transcript of Remarks**

Thanks very much. I also want to add my thanks to the University of Georgia and the Dean Rusk International Law Center for the invitation to participate, as well as to Sarah Quinn, in particular, for her extraordinary organization of this conference.

I am going to broaden the question and my response because I think how we define the question reveals some of our ethical and normative commitments. I'd like us to think not just about "global healthcare governance," as the panel is titled, but *global governance for health*. And I'd suggest we think not just in relation to a narrow understanding of pandemic preparedness but more broadly in terms of health system resilience.

My short answer to the question that you posed, Fazal, as to why the structures in place failed to prevent this pandemic, is that it failed because they are manifestly dysfunctional. In contrast to what Ben Mason Meier said, I would say that this pandemic has not so much "shaken the foundations of global health governance" but rather, it has revealed the foundations of those multilateral governance structures to be fundamentally colonialist, and the architecture to be neoliberal. I would argue that we find ourselves in a multilateral order that is very, very far from the one that we imagined 75 years ago as a guarantor of peace, justice, and security.[1]

I want to be clear that I say that as a committed multilateralist. I teach international human rights law and comparative constitutional law relating to health, as well as being an advocate and practitioner. I'm on a number of World Health Organization ("WHO") technical advisory groups, as well as the United Nations ("UN") Secretary General's Independent Accountability Panel for Women's, Children's, and Adolescents' Health in the Sustainable Development Goals ("SDGs") and I work with an organization called Partners in Health, which is a global health and social justice organization. [2] So, my remarks should be taken as those of someone who is deeply distressed by the state of affairs that we find ourselves in. At the same time, I am radically optimistic that we can do more than tweak around the edges.

I wholeheartedly agree with what Tom Bollyky said, that reforming the IHR, while important, is not remotely going to approach the sorts of changes that we actually need for better responses, not just to future pandemics (which invariably we will face) but to all of the other intersectional threats that we face from climate

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[1] *See, e.g.,* U.N. Charter art. 1, ¶ 1–4.

[2] *Alicia Ely Yamin*, INDEP. ACCOUNTABILITY PANEL FOR EVERY WOMAN, EVERY CHILD, EVERY ADOLESCENT, https://iapewec.org/about/members-2/alicia-2/ (last visited Feb. 11, 2021).

change, from forced migration, and from staggering social inequalities within and between countries.

So, in my few minutes of remarks, I thought I would borrow from some of the exchanges between Sandy Levinson and Jack Balkin on democracy and dysfunction[3] in our U.S. constitutional framework, which I imagine is required reading in most constitutional law courses these days.

Levinson and Balkin exchange views on the diagnosis—and therefore remedy—for democratic dysfunction in the U.S. system. Levinson views it as structural, requiring structural fixes. Jack Balkin takes the position of a political scientist, which is that we need more representation more agency to combat what he calls "constitutional rot."[4] In the context of global governance for health, I would say that it's a little bit of both.

On the one hand, there has been a profound de-democratization in global governance over the last twenty to thirty years, which has accelerated since the turn of the millennium.[5] Global governance was never really democratic because it was always built on a neo-colonialist foundation designed to favor the interests of the powerful states in the economic North. States were meant to act as principals while international organizations were largely relegated to the role of agents enacting the preferred agendas of powerful states.[6]

Nonetheless, encroaching neoliberalism beginning in the 1980s and reforms, such as the UN Global Compact[7] and the signing of the Framework for Engagement with Non-State Actors,[8] have resulted in philanthro-capitalists, such as the Gates Foundation—now the second largest donor to the WHO—and corporations, to take a much more prominent role.[9] At the same time as the economic clout of non-state actors grew, the same neoliberal policies that increased private actors' private economic power often left states with less fiscal space and public capital to invest in international organizations—and global health.[10] Thus, it is

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[3] *See generally* SANFORD LEVINSON & JACK M. BALKIN, DEMOCRACY AND DYSFUNCTION (2019).

[4] *Id.*

[5] *See generally* CHELSEA CLINTON & DEVI SRIDHAR, GOVERNING GLOBAL HEALTH: WHO RUNS THE WORLD AND WHY? (2017) (discussing relationship between states and international organizations).

[6] *Id.*

[7] *See The Ten Principles of the UN Global Compact*, U.N. GLOB. COMPACT, https://www.unglobalcompact.org/what-is-gc/mission/principles (last visited Feb. 13, 2021) (outlining ten principles of the UN Global Compact relevant to corporate strategy, policy, and culture).

[8] *See* World Health Assembly, *Framework of Engagement with Non-State Actors*, WHA69.10 (May 28, 2016) (clarifying how the WHO should interact with Non-State actors).

[9] *See* Anne-Emanuelle Birn, *(Re-)Making a People's WHO*, 110 AM. J. PUB. HEALTH 1352 (2020).

[10] ALICIA ELY YAMIN, WHEN MISFORTUNE BECOMES INJUSTICE: EVOLVING HUMAN RIGHTS STRUGGLES FOR HEALTH AND SOCIAL EQUALITY 56–60 (2020).

not a surprise that assessed commitments have perpetually declined while 'voluntary contributions' have increased as a percentage of the budgets of WHO and other international organizations.

These trends are deeply related to the reasons why the International Health Regulations (IHR) have been largely irrelevant to state actions in this pandemic and why the WHO does not have the kind of authority to make decisions that some of my colleagues seem to think it has—and which I would like it to have.

That is, we can think about governance in a very kind of simplistic reductionist way as who decides, based on what criteria, and what are the distributional consequences and accountability for those decisions. Thus, at a very basic level, the fact that there is much less centralized funding means fragmented authority for decision-making, and fragmented initiatives.

The fragmentation of the agendas has unquestionably exacerbated vertical, siloed programming among programs within the WHO—and among different agencies implementing development agendas. We learned from the Millennium Development Goals that these vertical programs are unfit for the purpose of building health systems, even if greater sums are added to HIV/AIDS programs or TB programs.[11] Even if the Sustainable Development Goals now calls for Universal Health Coverage, the global governance for health functions is ill-equipped to meet the systemic challenges to UHC (and pandemic preparedness), much less to address these protracted-entrenched, multi-sectoral problems such as climate justice.

It is also extremely difficult in the baroque architecture of global health to trace accountability relationships.[12] For example, WHO may fund GAVI, the Global Vaccine Alliance, or UNAIDS for some things; GAVI may receive funding from the Gates Foundation which then goes to the WHO. Trying to disentangle the sources, channels and outcomes in global health is rather like looking at a Bryce Marden painting where you can't really figure out where one thread starts and another stops. In turn, this makes meaningful accountability near impossible under current governance structures.

The dependence of the WHO (and other institutions) on philanthropic, corporate, and governmental largesse to fund it leads to the WHO finding itself needing to be obsequious to its largest donors. Tom Bollyky already alluded to the question of WHO's suboptimal transparency with respect to China's behavior early on in the pandemic. But China is far from a unique example. Another notorious example that has emerged is the one in which the person who was in charge of pandemic preparedness in Italy from about 2011 to 2015 later moved

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[11] *Id.* at 130–31.

[12] *See* INDEP. ACCOUNTABILITY PANEL FOR EVERY WOMAN, EVERY CHILD, AND EVERY ADOLESCENT, 2018 REPORT: PRIVATE SECTOR: WHO IS ACCOUNTABLE? FOR WOMEN'S, CHILDREN'S AND ADOLESCENT'S HEALTH (2018) (discussing the challenges of connecting the private sector to global health institutions).

to the WHO and then was seconded back to Italy to assess its performance during the early stage of the pandemic, which ended up in falsified reports among other things.[13] There are numerous examples of conflicts of interest and problems that have emerged from the WHO being so beholden to its large donors (both certain states and also private actors). These are the circumstances that deform the agenda global health, far beyond but including setting the stage for poor performance in pandemics.

Beyond fixing 'rot' within different organizations, some of the problems that led to failure in COVID (and beyond) require *structural changes*. In my view, these are rooted in global economic governance norms that go way beyond the IHR reform. That is, as taxation rules have evolved to favor private capital over preserving public fiscal space, rigid interpretations of intellectual property have been encoded in trade agreements, financial deregulation has made for enormous volatility in the ability states exercise control over their economic and health policies; and countries across the global south have been crippled by debt and austerity, it has affected both the capacity of states to address their national health systems and public health, as well as global governance for health.[14] What we are seeing now with the COVID-19 vaccine debacle is not just a crisis of global health governance, but a result of decades of decision-making processes favoring corporate claims to intellectual property over global public goods. It is also the culmination of the growing and outsized influence of the Gates Foundation in having global institutions turn to a system based on private pharmaceutical IP holders (COVAX) versus a technology access pool (C-TAP).[15] These are the rules that shackle and limit supply of health technologies, which desperately need to be expanded in the face of a global pandemic. As time is short, I very much hope we can talk about this in the discussion.

In my view, the inflection point caused by this sweeping pandemic requires far more than tinkering with the IHR. It calls on us to re-think these fundamental rules that create the architecture of global governance for health. If these legal regimes can evolve in one direction, they can also be modified in other directions that advance of more just political economy in global health. We have seen transformative change before, for example after HIV/AIDS. We must not waste the opportunity forged by this ravaging crisis to rethink what is required to

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[13] Senior WHO Official Under Investigation by Italian Judiciary, SWISSINFO (Apr. 16, 2021), https://www.swissinfo.ch/eng/senior-who-official-under-investigation-by-italian-judiciary/46537310.

[14] *See generally* ALICIA ELY YAMIN, WHEN MISFORTUNE BECOMES INJUSTICE: EVOLVING HUMAN RIGHTS STRUGGLES FOR HEALTH AND SOCIAL EQUALITY 56–60 (2020).

[15] *See* Rohit Malpani, Brook Baker & Mohga Kamal-Yanni, *Corporate Charity—Is The Gates Foundation Addressing Or Reinforcing Systemic Problems Raised By COVID-19?*, HEALTH POL'Y WATCH (Oct. 31, 2020), https://healthpolicy-watch.news/gates-foundation-address-systemic-covid-19/.

democratize global governance for health more broadly than IHR reform or pandemic preparedness.