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THE WHO—DESTINED TO FAIL?: POLITICAL COOPERATION AND THE COVID-19 PANDEMIC

By Eyal Benvenisti*

ABSTRACT

In this essay, I argue that the World Health Organization (WHO) has not been equipped with the necessary authority to adequately fulfill its mission. The WHO was built on the mistaken assumption that attaining adequate global health is a matter of high-level coordination. However, the challenge of global health governance is, crucially, also one of complex *political cooperation*. I distinguish between different types of cooperation problems faced by the WHO and explain why achieving global health calls for intrusive powers by a governing authority—powers that the WHO does not enjoy.

INTRODUCTION

The criticisms leveled at the World Health Organization (WHO) since the onset of the Covid-19 global pandemic in early 2020 are fundamentally misguided. Undoubtedly, in this instance, the organization failed to meet its overarching objective—“the attainment by all peoples of the highest possible level of health.”¹ It not only reacted slowly to information about an outbreak of coronavirus in China but also offered imprudent advice—exhorting states to avoid travel bans, even after China had imposed a lockdown in Wuhan.² But these errors of judgment, betray a more fundamental flaw: the very design of the WHO is not fit for purpose in relation to the challenges it faces. The organization was designed on an assumption that the improvement of global health was the shared goal of all nations, that fighting disease was an effort to which all are committed, and that more affluent countries would help those with limited resources in this complex endeavor.

Given this assumption, the underlying premise of the visionaries behind the WHO was that the primary challenge in the pursuit of global health was how to coordinate nations’ efforts effectively. A coordination problem requires a collective decision on which course to take, which expert theory to follow, or which standard to adopt. Once agreed, everybody shares the incentive to follow that standard. Hence, the founding fathers of the WHO Constitution perceived it as a

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¹ The World Health Organization Constitution (1948), Art.1.

² “Wuhan lockdown ‘unprecedented’, shows commitment to contain virus: WHO representative in China” Reuters, January 23, 2020, at <https://www.reuters.com/article/us-china-health-who-idUSKBN1ZM1G9>. The WHO’s updated advice did not include restrictions on international traffic (“Updated WHO advice for international traffic,” at <https://www.who.int/news-room/articles-detail/updated-who-advice-for-international-traffic-in-relation-to-the-outbreak-of-the-novel-coronavirus-2019-ncov-24-jan/>).

body that could represent humanity by taking a science-based approach—one that transcended politics.³

But the Covid-19 pandemic has vividly demonstrated that the underlying challenge of improving global health is not one of poor coordination among scientists, nor even one of lack of scientific cooperation. Rather, the WHO's efforts to combat the pandemic have been plagued by competing economic, political, and social demands—in short, a lack of *political* cooperation.⁴ And, just as we have witnessed in other global-scale cooperation problems—such as climate change—even if everybody knows what needs to be done, at least some have the incentive to “cheat”. Fighting pandemics poses collective risks to human society, but some are more vulnerable than others, and the associated costs—of prevention and treatment, for instance—are not shared equally. Seeking to protect their citizens or outdo competitors, states are primed during pandemics to take defensive action, such as underreporting outbreaks or closing their borders pre-emptively,⁵ while powerful lobbies also weigh in to steer national and global policies in their favor.⁶

This paper analyses the type of challenges that global health management poses and to demonstrate that the WHO was not designed to wield the tools necessary to meet them. To substantiate this claim, I survey the functions of international organizations (IOs), distinguishing between the two fundamental types of challenge they address: coordination and cooperation (Part I). I explain why each of these two challenges requires distinct organizational tools, and then apply these insights to the challenges posed by global health management. In Part II, I examine the design of the WHO and argue that it was never conceived to fulfill the crucial role of ensuring international political cooperation in times of crisis. The opportunity to endow it with tools to effectively manage pandemics, and thereby to endorse the creative approach adopted successfully during the 2003 SARS pandemic, was passed-on in 2005: the WHO's member states refused to commit to cooperation and submitted the International Health Regulations (IHR) to extensive revisions. It is as a result of this refusal that the WHO now has such limited capacity to guarantee inter-state coordination, let alone to attempt to secure political cooperation. Part III concludes.

I. GLOBAL HEALTH MANAGEMENT: BETWEEN COORDINATION AND COOPERATION

Coordination and Cooperation Distinguished

International organizations (IOs) seek to resolve different types of global challenges that reflect complex issues situated between two poles: coordination problems and cooperation

³ See *infra*, notes 8, 24-25 and accompanying text.

⁴ On the distinction between coordination and cooperation, see Duncan Snidal, *Coordination Versus Prisoners' Dilemma: Implications for international Cooperation and Regimes*, 79 AMERICAN POLITICAL SCIENCE REVIEW, 923 (1985).

⁵ Patrick Zylberman, *Civilizing the State: Borders, Weak States and International Health in Modern Europe*, in MEDICINE AT THE BORDER: DISEASE, GLOBALIZATION AND SECURITY (Alison Bashford ed., 2007); ALISON BASHFORD, IMPERIAL HYGIENE, 115–36 (2004). (on disease as a motivation for states to enhance control of borders).

⁶ Rob Davis & Jasper Jolly, *Aviation Bosses Raise 'Serious Concern' Over UK Quarantine Plans*, THE GUARDIAN, May 11, 2020, at <https://www.theguardian.com/business/2020/may/11/heathrow-calls-for-urgent-plan-to-restart-more-flights>.

problems.⁷ Coordination problems derive from the collective need to agree on certain rules, such as which metrics to use or what language to speak between all parties to the agreement. While parties may have diverse preferences, they share the interest of searching for a common rule. Therefore, coordination problems tend not to require monitoring and enforcement of the rules.

The drafters of the WHO Constitution saw its task as managing global coordination to eradicate disease. Hence, they designed an institution that would promote knowledge about diseases and how to avoid them, through a set of rules based on medical expertise.⁸ In this foundational model, politics are sidelined.

But, as early as the nineteenth century, from the initial efforts to regulate global health management, it was evident that this goal presents not only coordination problems but also requires political cooperation. Cooperation problems are usually rooted in endemic conflicts of interest, as it is strategically advantageous for every actor to “cheat,” regardless of whether its partners cooperate or not. A state may be minded to pollute a shared lake while others pay to treat their sewage, to subsidize its own industries while others open their markets to imports, and so on. Hence, to facilitate cooperation, it is not enough to set the rules and expect everybody to follow. Instead, it is crucial to set up effective monitoring and enforcement mechanisms to ensure compliance.

The management of global health risks poses both types of problem. Health is a coordination game, because actors need to know what the health risks are and the correct ways to treat the disease in question. A global body can reduce health risks by identifying pathogens and disseminating information about the most effective ways to remedy them. It can also resolve coordination problems for those active *within* states,⁹ e.g., by providing useful information to civil society activists seeking to curb the inordinate political power of lobbies such as tobacco companies, infant formula producers, or big pharma companies. For example, it can set global standards on advertising particular products known to carry health risks or issue recommendations about breastfeeding.¹⁰

But global health also poses a set of inter-state cooperation problems, as states have different capabilities and vulnerabilities that shape their responses to various health risks and burdens. These differences create externalities, as one state can impose risks on another: often, states conceal outbreaks to avoid becoming “the target of other states’ costly [trade] barriers.”¹¹ Furthermore, scarcity problems plague the attainment of global health goals particularly in times of pandemics as states may hoard medical equipment, profiteer off in-demand resources, and limit their export.

⁷ On these two problems as two “polar” situations, see Snidal, *supra* note 4, at 937.

⁸ MARCOS CUETO, THEODORE M. BROWN, AND ELIZABETH FEE, *THE WORLD HEALTH ORGANIZATION: A HISTORY* 32-33, 39-40 (2019); David Macfadyen, *The Genealogy of WHO and UNICEF and the Intersecting Careers of Melville Mackenzie (1889-1972) and Ludwik Rajchman (1881-1965)* (Sep. 2014) (unpublished M.D. dissertation, Glasgow University) (<http://theses.gla.ac.uk/5625/>).

⁹ BETH A. SIMMONS, *MOBILIZING FOR HUMAN RIGHTS: INTERNATIONAL LAW IN DOMESTIC POLITICS*, 125–48 (2012).

¹⁰ Tatiana Andia and Nitsan Chorev, *Making Knowledge Legitimate: Transnational Advocacy Networks’ Campaigns Against Tobacco, Infant Formula And Pharmaceuticals*, 17 *GLOBAL NETWORKS*, 255 (2017).

¹¹ Catherine Z. Worsnop, *Concealing Disease: Trade and Travel Barriers and the Timeliness of Outbreak Reporting*, 20 *INTERNATIONAL STUDIES PERSPECTIVES*, 344, 345 (2019).

Global Health poses a Complex Set of Cooperation Problems

In the context of global health, there are specific factors that shape states' incentive to cooperate at all. The extant literature on global cooperation emphasizes the following as being influential: the number of participants (whether a bilateral or multi-party game); their expectation that they will repeat their engagement on an issue indefinitely; and the quality of the information they have about the performance of their partners.¹² Mancur Olson also emphasized relative power within communities as a factor that can encourage or hinder the possibility of overcoming collective action problems, as even just a few out of several actors—provided they are sufficiently powerful—could unilaterally bear the collective burden of obtaining the public good.¹³ This literature has been invoked by international relations theorists to explain the benefits of IOs and to indicate which tools they should be equipped with to ensure their effectiveness.¹⁴

Beyond the number of parties, the information to which they have access, and their relative capabilities, there are additional antecedent factors that help predict successful cooperation: (1) scope (whether single-issue or multiple issues); (2) frequency of iterations; and (3) relative vulnerability of the parties. As I briefly outline here, in the context of global health, these factors predict enormous challenges for cooperation.

(1) Scope: Single-issue cooperation involves one shared challenge that poses a collective action problem, such as the management of a specific stock of fish (e.g. Bluefin tuna,¹⁵ or whales¹⁶) or weapons (anti-personnel landmines,¹⁷ or chemical weapons¹⁸), as opposed to topics that interface with several other aspects of human activity (such as freshwater, which impacts demand on land, economic development, human rights, tourism, and so on). Elinor Ostrom has shown that a single issue to which only a few parties have access (e.g. certain fisheries, or oil) can yield robust cooperation between them.¹⁹

(2) Frequency: Since an iteration of exchanges that runs indefinitely is key to the evolution of cooperation, frequently-iterated exchanges, such as during the 1916 trench warfare, are likely to yield stable cooperation, even spontaneously. But when the iterations are intermittent and infrequent, cooperation is less stable and actors must find ways for parties to signal their continuous commitment.

¹² THOMAS SCHELLING, *STRATEGY OF CONFLICT* (1960); RUSSELL HARDIN, *COLLECTIVE ACTION* (1982); ROBERT AXELROD, *THE EVOLUTION OF COOPERATION* (1984); MICHAEL TAYLOR, *THE POSSIBILITY OF COOPERATION* (1987).

¹³ MANCUR OLSON, *A THEORY OF COLLECTIVE ACTION* (1965).

¹⁴ E.g., Robert O. Keohane, *International Institutions: Two Approaches*, 32 *INTERNATIONAL STUDIES QUARTERLY*, 379 (1988); Helen Milner, *International Theories of Cooperation among Nations: Strengths and Weaknesses*, 44 *WORLD POLITICS*, 466 (1992); Barbara Koremenos, Charles Lipson & Duncan Snidal, *The Rational Design of International Institutions*, 55 *INTERNATIONAL ORGANIZATION*, 761 (2001); Kenneth W. Abbott & Duncan Snidal, *Why States Act through Formal International Organizations*, 42 *JOURNAL OF CONFLICT RESOLUTION*, 3 (1998).

¹⁵ *Convention for the Conservation of Southern Bluefin Tuna* (1993).

¹⁶ *International Convention for the Regulation of Whaling* (1946).

¹⁷ *Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction* (1997).

¹⁸ *Convention on the Prohibition of the Development, Production, Stockpiling and Use of Chemical Weapons and on their Destruction* (1993).

¹⁹ ELINOR OSTROM, *GOVERNING THE COMMONS* (1990).

(3) Relative vulnerability: Equal vulnerability occurs in situations of perfect reciprocity, when all parties can effect an outcome or benefit or suffer from it equally, such as fighters in their trenches, or riparian states sharing a lake. In contrast, in situations of unequal vulnerability, such as with respect to climate change, the inclination to cooperate will differ. Parties locked in a situation of relative vulnerability might succeed in identifying other areas where they have opposing vulnerabilities (such as pollution and transport along a shared river) and thereby “enhance or create a zone of possible agreement,”²⁰ but at the cost of increasing the complexity and interrelatedness of the issues the IO is required to address.

The greater the extent to which an issue is single-faceted, elicits frequent indefinite iterations, and generates equal vulnerability among parties, the easier it is to ensure cooperation, perhaps through the simple promise of reciprocity and without the need for a global institution to ensure compliance. The more multifaceted, infrequent, and reflective of unequal vulnerabilities the issue is, the more challenging cooperation becomes. Global health management offers one of the more challenging cooperation problems along all these axes. A very large number of states face multiple forces at play (economic, social, cultural, and other considerations beyond the medical). The interaction, while indefinite, is infrequent because the rate of pandemics is rather low.²¹ Finally, states’ vulnerabilities differ fundamentally: since the nineteenth century, most pathogens have originated in a few developing countries that externalized the risk on others, while the rest would close their borders, even preemptively, harming their trade partners in turn. These “upstream–downstream” relations have since become more complex, with states that are both sources of pathogens *and* exporters on which other states depend, and others who are “super-spreaders,” given their dense economic networks. States also differ in their ability to adapt to health risks or their willingness to tolerate such risks.

This brief survey shows that IOs charged with managing global health must have the tools to overcome the most complex cooperation problems among mutually-distrustful sovereigns. They must have independent and impartial global regulators with access to independent sources of information that they can share with all states. They must have norms and systems via which to share the burdens and benefits of global health goods, coupled with mechanisms to increase the frequency of iterations and to monitor and enforce compliance with such norms. Part II shows that the WHO was never designed to have these resources.

II. THE WHO: BETWEEN EXPERTISE AND POLITICS

The Promise of Expertise

Among the WHO’s functions are “to assist Governments, upon request, in strengthening health services; ... to furnish appropriate technical assistance and, in emergencies, necessary aid

²⁰ James K. Sebenius, *Negotiation Arithmetic: Adding and Subtracting Issues and Parties*, 37 INTERNATIONAL ORGANIZATION, 281, 314 (1988); Koremenos *et al.* (*supra* note 14).

²¹ Council of Economic Advisers, Executive Office of the President, *Mitigating the Impact of Pandemic Influenza through Vaccine Innovation*, September 2019, at <https://www.whitehouse.gov/wp-content/uploads/2019/09/Mitigating-the-Impact-of-Pandemic-Influenza-through-Vaccine-Innovation.pdf> (the US Council estimated: “a 4 percent annual probability of pandemic influenza”).

upon the request or acceptance of Governments;”²² Its personnel are mainly technicians, “chosen from among persons most qualified by their technical competence in the field of health.”²³ The scientific–technical aspect of the organization is also reflected in the authority of the World Health Assembly (the WHO’s policy-setting body) to issue norms through a two-thirds majority of members acting and voting, binding all states parties without ratification unless they formally opt-out.²⁴

There is an optimistic premise here that, once expert science directs the way, all will follow its lead and adopt whatever measures the WHO deems necessary. The WHO was thus designed to respond only to the *coordination* of global health problems. Under this paradigm, there is no space for politics, and governments should simply be willing to cede authority for the global body to act without pre-approval.²⁵ It is for this reason that monitoring and enforcement tools are entirely absent from the WHO’s repertoire.

For the industrialized West, such a body was probably deemed non-constraining when it was created in the late 1940s. Science was seen as consonant with Western preferences;²⁶ the WHO was expected to primarily address health standards in developing countries;²⁷ and, as a US-dominated body, it served (or domestically presented as serving) Western efforts to demonstrate their commitment to the global poor against Soviet intentions.²⁸ The regulation of the possible (Western) responses to pandemics through trade and travel bans—which previously acted as the prime motivation for global health regimes²⁹—was diverted to the newly-formed GATT (which acknowledged the right to balance trade against the protection of human life).³⁰ More profoundly, the WHO ensured the free flow of information from poorer countries (the source of the pathogens) to alert the West, which would respond by imposing costly trade and travel restrictions on the source state and developing vaccines that would be prohibitive for the South.³¹ The WHO, in this regard, served as a useful warning alarm to the rich states parties

²² WHO Constitution, *supra* note 1, Art. 1 & 2.

²³ *Id.*, Art. 11.

²⁴ Armin von Bogdandy & Pedro Villareal, *International Law on Pandemic Response: A First Stocktaking in Light of the Coronavirus Crisis*, Max Planck Institute for Comparative Public Law & International Law, Research Paper No. 2020-07, at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3561650.

²⁵ According to the WHO Constitution, Art. 28(i), the Executive Board has authority “to take emergency measures within the functions and financial resources of the Organization to deal with events requiring immediate action.”

²⁶ Melville D. Mackenzie, *Today’s Global Frontiers in Public Health*, 35 AMERICAN JOURNAL OF PUBLIC HEALTH, 100, 104 (1945) (“In practice it is impossible to expect more developed countries to be overruled by the votes of nations less developed from a medical and social point of view.”). Elizabeth Fee, Marcu Cueto, and Theodore M. Brown, *At the Roots of the World Health Organization’s Challenges: Politics and Regionalization* 106(11) AM J PUBLIC HEALTH 1912, (2016) (in the early years, Europeans constituted the majority of the WHO staff, while the recruitment of a few medical experts from developing countries “was criticized for depleting precarious health systems of valuable individuals”).

²⁷ Mackenzie, *supra* note 26, at 104–05.

²⁸ Fee *et al.*, *supra* note 26, citing US politicians linking national security and the worldwide struggle against disease and poverty (“Disease and poverty must be fought [because they] “feed communism”).

²⁹ Valeska Huber, *The Unification of the Globe by Disease? The International Sanitary Conferences on Cholera, 1851–1894*, 49 THE HISTORICAL JOURNAL 453, 456 and 471 (2006).

³⁰ David P. Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT’L L., 325, at 336-37 (2005).

³¹ Until Indonesia demurred in 2006, leading to an arrangement with limited results. See Michelle F. Rourke, *Access by Design, Benefits if Convenient: A Closer Look at the Pandemic Influenza Preparedness Framework’s Standard*

without committing them to share the risks and burdens of pandemics. Nevertheless, developing countries embraced the new body, and, indeed, Brazil and China tabled in 1945 the proposal for setting up an international health organization,³² because they saw it as their key to modernity.³³ Perhaps it was this meeting of different interests that obscured the fact that global health management is something more complex than a-political coordination effort.

Covid 19 is not the first time that this vision was put to the test. Among earlier cases there is one that stands out – the SARS outbreak in 2002–2003 – because it remains a marker of success for what the WHO can achieve when it expands its authority. It is to this case that we now turn.

Activism during the SARS Pandemic: Functionalism Gone Ultra Vires?

When the WHO responded swiftly and effectively in response to the SARS outbreak, it demonstrated what an independent, resourceful global body can achieve.³⁴ The aftermath also showed the implications for states that prefer short-term gains and have no faith in the WHO. The organization was directed by a seasoned politician (Gro Harlem Brundtland, formerly Norway’s PM) and by resourceful and committed medical experts operating in China, Hong Kong, and Vietnam. In a matter of weeks, overcoming lack of cooperation and even resistance by governments, the WHO obtained independent information and acted on it by issuing public advisories and drafting teams of experts into countries to ensure that they were following effective policies. It resorted to public shaming of China and even issued an ultimatum to elicit its cooperation.³⁵ The *Washington Post* aptly likened the WHO to “the natural if unelected leader of a crowded lifeboat [that] gave orders that no one wanted to be the first to disobey.”³⁶

Was the WHO acting within its powers? The general jurisprudence concerning powers of IOs, which celebrates “functionalism,” would probably be supportive of such permissive interpretations of IO powers as “essential to the performance of [their] duties.”³⁷ But at the time

Material Transfer Agreements, 97 THE MILBANK QUARTERLY, 91 (2019); Mark Eccleston-Turner, *The Pandemic Influenza Preparedness Framework: A Viable Procurement Option for Developing States?*, 17 MEDICAL LAW INTERNATIONAL, 227 (2017).

³² Cueto *et al.*, *supra* note 8, at 37-38.

³³ See SUNIL AMRITH, *DECOLONIZING INTERNATIONAL HEALTH*, 159 (2006); Randall M. Packard, *Civilizing the State: Borders, Weak States and International Health in Modern Europe*, in *INTERNATIONAL DEVELOPMENT AND THE SOCIAL SCIENCES*, 94 and 96 (Roger Cooter & John Pickstone eds., 1998).

³⁴ This was not the only case of effective intervention. During 2003 it also publicly criticized Indonesia for refusing to cull flocks of infected birds, and the pressure led to compliance: MARK W. ZACHER & TANIA J. KEEFE, *THE POLITICS OF GLOBAL HEALTH GOVERNANCE*, 60 (2008).

³⁵ For the reaction of the WHO to the SARS pandemic, see DAVID P. FIDLER, *GOVERNANCE AND THE GLOBALIZATION OF DISEASE* (2004). See also SARA E. DAVIES, ADAM KAMRADT-SCOTT, AND SIMON RUSHTON, *DISEASE DIPLOMACY: INTERNATIONAL NORMS AND GLOBAL HEALTH SECURITY*, 43–73 (2015).

³⁶ David Brown, *The SARS Triumph, And What It Promises*, THE WASHINGTON POST, July 20, 2003, at B01.

³⁷ *Reparations for Injuries Suffered in the Service of the United Nations*, Advisory Opinion, 11 April 1949, ICJ Reports (1949) 174, 183. See Adam Kamradt-Scott, *The Evolving WHO: Implications for Global Health Security*, 6:8 GLOBAL PUBLIC HEALTH, 801 (2011) (suggesting that WHO actions might have been covered by implied emergency powers for it to take all measures necessary to avert an impending global health threat). On functionalism generally, see Jan Klabbers, *The EJIL Foreword: The Transformation of International Organizations Law*, 26(1) EUROPEAN JOURNAL OF INTERNATIONAL LAW, 9 (2015); EYAL BENVENISTI, *THE LAW OF GLOBAL GOVERNANCE* (2014).

even supporters of the WHO leadership noted that it acted beyond its mandate and “without deference to the sovereignty of affected states.”³⁸

Reasserting Sovereignty: The IHR (2005)

Initially, most member states were supportive of how the WHO had handled the SARS pandemic. However, a year later, when debating major revisions to the IHR (to extend the scope of the 1969 Regulations and develop a new legal framework for them), “governments had collectively agreed to impose new restrictions on the Director-General’s autonomy.”³⁹ This agreement reflected their inability to overcome a fundamental, intractable conflict: developed states wanted the WHO to have greater access to non-state-based information about impending health risks but limited authority to censure their protective measures, while developing countries insisted that the WHO remain dependent on information only they would provide, and demanded more accountability from states blocking trade.⁴⁰ The outcome was an agreement to “reify member states’ sovereignty.”⁴¹

The revised IHR thereby undercut the WHO’s authority to offer a swift and resolute response to outbreaks. In a significant departure from the 2004 draft,⁴² the IHR also undermined the WHO’s very basic function of providing information to facilitate coordination. The WHO now has to consult with a source state before exercising its powers,⁴³ and its freedom to obtain independent information from sources other than the affected state government is severely limited.⁴⁴ Furthermore, the WHO may share such information with other states only after the source state refuses to collaborate and only “when justified by the magnitude of the public health risk.”⁴⁵ Crucially, the WHO has a legal duty to reveal to the source state any independent sources

³⁸ FIDLER, *supra* note 35, at 142.

³⁹ Adam Kamradt-Scott, *The International Health Regulations (2005): Strengthening Their Effective Implementation and Utilisation*, 16 INT’L ORG. L. REV., 242, at 255-56 (2019). For a legal analysis of the IHR, see J. Benton Heath, *Pandemics and Other Health Emergencies*, in OXFORD HANDBOOK OF INTERNATIONAL LAW AND GLOBAL SECURITY (2020, forthcoming), at <https://ssrn.com/abstract=3574149>. For generally supportive assessments of the IHR, see David P. Fidler & Lawrence O. Gostin, *The New International Health Regulations: An Historic Development for International Law and Public Health*, 34 (1) J. LAW MED ETHICS, 85, 86 (2006) (referring to the IHR as “radically depart[ing] from the traditional approach ... transform[ing] the international legal context in which states will exercise their public health sovereignty in the future ...”). See also Stefania Negri, *Communicable Disease Control*, in RESEARCH HANDBOOK ON GLOBAL HEALTH LAW (Gian Luca Burci & Brigit Toebes eds., 273–78 (2018) (“Landmark innovative instrument”).

⁴⁰ CHRISTIAN KREUDER-SONNEN, EMERGENCY POWERS OF INTERNATIONAL ORGANIZATIONS 162 (2019).

⁴¹ Kamradt-Scott *supra* note 37, at 806.

⁴² WHO Intergovernmental Working Group on the Revision of the International Health Regulations, IGWG/IHR/Working Paper/12.2003, January 12, 2004, at https://www.who.int/csr/resources/publications/IGWG_IHR_WP12_03-en.pdf. See also two subsequent meetings including summary reports of the regional consultations, at <http://apps.who.int/gb/ghs/e/>. The verbatim records of the regional meetings and plenary sessions remain classified (KREUDER-SONNEN, *supra* note 40, at 164).

⁴³ IHR Art. 12 (the Director General must consult with the Emergency Committee and with the source state before declaring emergency). For criticisms of the composition of the Emergency Committee, see Benton Heath *supra* note 39, at 14–17.

⁴⁴ Art. 9 IHR (the WHO “may take into account reports from sources other than notifications or consultations [with the source state]” and “then communicate [such] information on the event to the [source] state”; “[b]efore taking any action based on such reports, [to] consult with and attempt to obtain verification from the State Party in whose territory the event is allegedly occurring”).

⁴⁵ IHR Art. 10. See also Art. 11.

of information (unless “it is duly justified” in maintaining their confidentiality). This requirement naturally has a chilling effect on the potential contribution of whistleblowers.⁴⁶

Moreover, the IHR limit the WHO’s authority to issue travel advisories. The need to rely on Emergency Committees in response to outbreaks has turned into an invitation for political⁴⁷ and economic interests⁴⁸ to intervene in expert decision-making. Yet, the IHR do not fetter the discretion of states to adopt whatever trade-restricting measures they deem fit.⁴⁹ This is reflected in Article 43 of the Regulations, which allows states parties to “implement[] health measures in accordance with their relevant national law and obligations under international law, in response to specific public health risks or public health emergencies of international concern, which: (a) achieve the same *or greater* level of health protection than WHO recommends; or [...] are otherwise prohibited under [specific IHR provisions], provided such measures are otherwise consistent with these Regulations.”⁵⁰ The Article requires that those measures shall not be more restrictive, invasive or intrusive “than reasonably available alternatives that would achieve the appropriate level of health protection.”⁵¹ But the WHO has no weight with which to sanction states taking such measures. Its only authority is to “request that the State Party concerned reconsider the application of the measures,” if and when it complies with the duty to report such measures.⁵²

In other words, the IHR both restricted the WHO’s coordination function by limiting information and also undermined its cooperation-ensuring function by constraining the freedom of WHO leadership to act promptly vis-à-vis states’ non-cooperative behavior. The consequences of the IHR were laid bare in all subsequent pandemics. Two searching review processes set up by the WHO noted the institutional limitations. The IHR Review Committee established in the wake of the Swine Flu pandemic noted that “[t]he most important structural shortcoming of the IHR is the lack of enforceable sanctions,”⁵³ and recommended (only) that the WHO try to shame states that adopt excessive measures.⁵⁴ While the 2015 Report of the Ebola Interim Assessment Panel⁵⁵ was ambitious, offering a universalist vision of “shared sovereignty” for interpreting the IHR as a vehicle for “international collective action and effective and efficient governance of the global

⁴⁶ IHR Art. 9.

⁴⁷ According to IHR Art. 48, A representative of the affected state must be involved.

⁴⁸ Abigail C. Deshman, *Horizontal Review between International Organizations: Why, How, and Who Cares about Corporate Regulatory Capture*, 22(4) EUROPEAN JOURNAL OF INTERNATIONAL LAW, 1089 (2011).

⁴⁹ As ZACHER & KEEFE (*supra* note 34, at 69–70) rightly point out, the IHR “gave countries significant leeway in adopting more stringent measures. All that was required of states was that they discuss the more stringent measures that they intended to implement with WHO officials. In other words, states’ sovereign rights of legislation have won out in the debate over excessive measures.”

⁵⁰ IHR Art. 43.

⁵¹ *Id.*

⁵² IHR Art. 43 Section 4.

⁵³ WHO, *Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009*, Document A64/10 (May 5 2011).

⁵⁴ *Id.*

⁵⁵ WHO, *Report of the Ebola Interim Assessment Panel* (July 2015), at <https://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>.

health system,”⁵⁶ the final Report of the Review Committee stopped short of suggesting reform.⁵⁷

III. CONCLUSION

This analysis suggests that criticisms leveled at the WHO since the onset of the Covid-19 pandemic are fundamentally misguided. Undoubtedly, the organization failed to lead the world to “attain ... the highest possible level of health.”⁵⁸ But the failure lies with the member states who designed it. They created a body that is not equipped for the challenges it faces. International Relations theorists assume that IOs are rationally designed to fit specific purposes.⁵⁹ The discrepancy between the stated goals of the WHO and its design—whose flaws were built-into the original (1948) concept and were later compounded in the adoption of the IHR (2005)—could either suggest that the assumption about rationality is misguided or that the WHO’s designers tolerated the likelihood that it would fall short of its stated objective.

Thus far, member states have shown no political will to re-fit the WHO to meet its complex task of securing inter-state cooperation. Will the various failures at the international and national levels to cope with the recent pandemic bring states closer to recognizing that the adoption of the concept of “shared sovereignty” is in their own long-term interests?

⁵⁶ *Id.*, at 10.

⁵⁷ WHO, *Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response*, Document A69/21 (May 13 2016).

⁵⁸ WHO Constitution, Art.1.

⁵⁹ Koremenos *et al.*, *supra* note 14, at 762.