Solidarity in a Hierarchical World? Rethinking the Ethics of Global Health Governance

https://www.e-ir.info/2024/07/27/solidarity-in-a-hierarchical-world-rethinking-the-ethics-of-global-health-governance/

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The 77th World Health Assembly (WHA)—the annual meeting of member states of the World Health Organization (WHO)—concluded on the 1st of June 2024. At this high-level meeting, after four days of intense negotiations (and many years of back-and-forth discussions preceding it) the Assembly made two major decisions. First, to adopt several amendments to the International Health Regulations (IHR), that is, the international legal rules governing the rights and responsibilities of states with respect to disease outbreaks. Secondly, to extend the mandate of the Intergovernmental Negotiating Body (INB) for a further year to finalise its work of developing a new Pandemic Agreement (sometimes referred to as the 'Pandemic Treaty'). The IHR amendments have been heralded as a success of multilateralism, while the extension of the INB at least avoided an embarrassing collapse after multiple years of fraught and contentious debates over the content of the Pandemic Agreement.

Both these processes, aimed at developing and augmenting rules and norms of cooperation to address disease outbreaks—prompted by the devastating global impact of the COVID-19 pandemic—are couched (at least rhetorically) in terms of various ethical commitments and imperatives that we want to explore in this article, as a lens into the wider ethics of global health governance. When we speak of the ethics of global health governance, we mean the moral principles on which the idea that health issues require some form of collective action are based, and the consequences of these principles on questions of rights, responsibilities, distribution of resources, justice, and so forth. We look at some of the key amendments proposed (and, in the case of the IHR, adopted) in these two side-running processes of international law and the ethical principles that underpin them. Through this exploration of key ethical questions at the heart of the IHR and Pandemic Agreement negotiations, we demonstrate that there are ethical limits to these state-based processes. We do so by drawing attention to the gaps between the *rhetoric* of global health cooperation and solidarity and its *practice*, as well as the systemic dimensions of global ill-health that are left unaddressed by these rule- and norm-setting exercises which take place in an international order shot through with extreme hierarchies of power and resources.

Ideas of solidarity in the Pandemic Agreement & amended International Health Regulations

The COVID-19 pandemic clearly demonstrated the challenges to solidarity and cooperation in global health governance. Distrust and scapegoating of international organizations like the WHO by Jair Bolsonaro and Donald Trump (among others), the failure to implement a waiver on intellectual property rules to ensure that health technologies could be shared, global vaccine inequity (partly a result of the lack of a waiver), hoarding and commandeering of other biomedical products, and more, all suggest a breakdown in cooperation and flouting of ideals of solidarity.

Yet, these failures also catalysed attempts to create more binding and rigid instruments to increase international cooperation for when the next pandemic inevitably occurs. Following a special session of the WHA in November 2021, WHO member states formally began negotiating the terms of the Pandemic Agreement and simultaneously proposed revisions to the IHRs. These negotiations stemmed from the recognised shortcomings of the IHRs (which were last updated in 2005) and member state dissatisfaction with their adequacy during the COVID-19 pandemic. With these dissatisfactions in mind, the proposed Pandemic Agreement would be a legally binding instrument to

strengthen the global response to future disease outbreaks, while working alongside new IHR amendments aimed at fostering scientific data sharing and equitable access to medical countermeasures.

In the several drafts of the Pandemic Agreement that have so far been published, the IHR amendments, as well as the speeches and statements around them, there is a notable and new commitment to ethical principles such as 'solidarity, fairness, transparency, inclusiveness and equity'. Indeed, principles of equity and solidarity feature prominently, such as in the guiding principles of the draft Pandemic Agreement text, which asserts 'equity as the goal and outcome of pandemic prevention, preparedness and response, ensuring the absence of unfair, avoidable or remediable difference among groups of people', and aims for 'solidarity, transparency and accountability' in the work to achieve that equity.

The inclusion of these principles speak to the widespread anger—especially from the majority world—at the inequities of information sharing, the restrictions of intellectual property rights, and vaccine development and distribution during COVID-19. Indeed, many of the draft Treaty articles are particularly aimed at bringing these ethical commitments to fruition, particularly with respect to technology and know-how transfer. Under Article 11, states are reminded of their rights to use flexibilities in the Trade-Related Aspects of Intellectual Property (TRIPS) agreement and encouraged to implement intellectual property waivers. Meanwhile, Article 12 contains a critical cornerstone of the draft agreement, namely the creation of a new Pathogen Access and Benefit Sharing (PABS) system aimed at enhancing the sharing of pathogen data but with reciprocal commitments to ensure, 'on an equal footing, equitable, fair and rapid sharing of monetary and non-monetary benefits, including timely, effective and predictable access to relevant diagnostics, therapeutics or vaccines' produced from the pathogen samples. The PABS system, especially, is seen as a key outcome of the negotiations so far and necessary inclusion in the final Treaty, especially by states in the majority world. For example, for health officials from Kenya and South Africa, the resource-sharing mechanism is considered essential and 'the heart' of the Treaty.

The IHR amendments similarly nod to the importance of equity and solidarity. Unlike the 2005 revisions that reinforced a more technocratic approach, the new drafted revisions explicitly draw upon the importance of 'full respect for the dignity, human rights and fundamental freedoms of persons'. There are key parallels between the two instruments, mainly around the significance of resource sharing. Although the Pandemic Agreement sets out duties mainly for member states, the revised IHRs appears to bolster the technical authority of the WHO, placing it at the forefront of these equitable aspirations. As stated under Article 13 of the revised IHRs, the WHO aims to play a coordinating role in driving equitable access to health products during a public health emergency response, even in challenging humanitarian and fragile settings. Similarly, Article 14 stresses the importance of multilateral engagement between WHO and other international organisations during health emergencies, while overseeing the 'application of adequate measures for the protection of public health'.

Combined, the two documents should, in theory, mean that for the poorer states that were left without essential health technologies during COVID-19 there will be less obstacles presented by intellectual property law, with more immediate and shared access to vaccines, medicines and resources. While there are of course substantial hurdles to the realisation of many of these goals—more on which later—these nevertheless represent significant changes to, at the very least, the language of the rules and norms around cooperation in the face of disease outbreaks. Some commentators hold that the centring of equity in global health law in the Treaty and IHR revisions can 'ensure justice in pandemic prevention, preparedness, recovery and response'.

What these negotiations tell us about the ethics of global health governance

The inclusion of these principles in the Pandemic Agreement and the revised IHRs, and the fact that their inclusion (and mechanisms to actualise them) were at the core of the drawn out and often very fraught (and as yet uncompleted, in the case of the Treaty) negotiations, gives us a sense of some of the wider ethical issues that arise within the governance of global health issues and can help us unpack some of these.

While there are many different ways of conceptualising and grounding these principles, with respect to disease outbreaks like COVID-19, the starting point for theorising the ethics of health governance tends to be the fact that

health issues (viral transmission is just one obvious case of this) have a cross-border nature that necessitatescooperation to address them. Others would take this utilitarian argument much further and claim that we all have a shared common humanity that makes cooperation and transnational acts of solidarity necessary, drawing on cosmopolitan ideals of helping 'distant strangers'. An alternative justification might be that health inequalities—like the disproportionate (and avoidable) realities observed during the COVID-19 pandemic—are fundamentally morally wrong (or as Jennifer Prah Ruger calls them, 'morally troubling' [p. 35]), thus requiring some form of remedial action. We may, alternatively, take a relational view on global health inequalities that focus on our responsibility and/or complicity in creating the conditions that give rise to inequalities, in other words the global social relations we are embedded within that create, uphold, or worsen health inequalities.

The ethical consequences that flow from these different (and overlapping) grounding principles, likewise depend on the ways in which we conceptualise questions of responsibility or even complicity, as well as how we think these responsibilities are best fulfilled. For example, if we commit to the idea that there *are* shared responsibilities for the governance of health at the global level purely from a pragmatic perspective—i.e., that we need global health governance because health issues are border-spanning—we might focus our disease governance efforts on shutting down international borders as soon as a new pathogen emerges. Yet border closures would quickly come up against both pragmatic difficulties (how do you do this in a densely interconnected world) and clash with other ethical principles (such as individual rights and freedoms).

Alternatively, if we hold health inequalities to be morally wrong, the remedial action to address them also very much depends on how we view the nature of responsibility for these inequalities. If health inequalities are seen as a consequence of mismanagement by individual states, conditional development aid might be the chosen remedial action. If they are seen as happenstance and natural—in the sense that not everyone can be equal, all the time—charity might be the chosen mode to address inequalities. Or, if they are seen as consequences of unjust structural dynamics, global redistribution (akin to domestic taxation) and systemic re-structuring might be necessary to ensure justice. Moreover, the most appropriate actors to address health inequalities also depends on how we view the nature of responsibility and the actors we believe are best suited to successfully achieve effective and ethical global health governance, and what the balance between states, international organizations, and non-state actors should be in this pursuit.

The ethical principles incorporated into the IHR revisions and the draft Pandemic Agreement were no different in terms of these clashes, tensions, and pay-offs between pragmatism, interests, and differing ethical commitments. The technology and know-how sharing inclusions are thus a fine balancing act between some of the equity demands of states in the majority world and the protection of intellectual property demands of—predominantly—global North states and their pharmaceutical industries. The latter commitment could be seen as a manifestation of naked self-interest, but from the perspective of a more liberal ethics the protection of private property through, for example, intellectual property regimes is seen as key to the actualisation of the common good. In other words, the way we view and judge the inequalities that became apparent during COVID-19 depends on different understandings of the ethics of global health governance.

What is missed in the discussions around the Pandemic Agreement

On the face of it, the amendments to the IHR represent significant progress in the development of the international rules governing health, and the extension of the INB mandate maintains some hope that a Pandemic Agreement might eventually be adopted. Combined, these legal and normative developments might help the WHO and member states to bring some of the abovementioned ethical commitments to fruition. But it is worth also reflecting on what is not (and cannot be) captured in these formal, high-level inter-state negotiations, and what these gaps tell us about ethics of global health governance—not least because they are gaps that also often figure in the writing of scholars of global health ethics.

We want to focus on two things here. Firstly, the artificial flattening of global health hierarchies and the material realities that shape ill-health, and secondly, the related absence of the continuing importance of race and empire to the maintenance of these hierarchies (a problem of much ethical theorising). We suggest that this absence

fundamentally challenges much of the ethical theorising around global health governance, which also indicates that some of the lofty goals of solidarity in the IHR revisions and the Pandemic Agreement will be found sorely wanting in practice (as was the case during COVID-19).

We return here to the work of Ruger, whose body of work is perhaps the most comprehensive in attempting to construct a theory of ethical global health governance. Yet, self-admittedly, Ruger's approach (combining what she calls 'provincial globalism' with 'shared health governance') 'rests on the premise that actors in the global health system will genuinely aim to achieve global health justice as opposed to self-interest or national interest alone' (p.35). In other words, *if* states and other actors in the system of global health governance could refrain from acting in their self-interest, *then* global health governance could be just and ethically sound. According to this understanding of the problems of global health governance, it is the subversion of ideals of global solidarity by states that undermines the possibility of cooperation. This is a common claim among scholars of global health governance: 'Contrasted with the cosmopolitan vision of global solidarity through international organizations, nationalist governments have subverted global health governance' (p.1616).

These arguments ring true in one sense: COVID-19 clearly demonstrated that attempts at cooperation and solidarity around border closures, data and knowledge sharing, and access to medicine and vaccines (among other things), was hampered by states acting in self-interest (for example by hoarding personal protective equipment or ensuring preferential access to vaccines).

Perhaps, in an ideal world, we could avoid these behaviours. But we have the world we have (and will always have a world shot through with unequal power relations), and engaging in this form of ideal-type theorising can run the risk of failing 'to adequately grasp the character of the injustices it purports to address' (p. 10), especially where it relies on theories for understanding injustice and institutions for rectifying it that were formed and shaped through colonial and imperial encounters. During COVID-19, this became apparent in several ways, for example in the deep-seated racism of the re-bordering of the West in response to the emergence of the Omicron variant in 2021. After the variant was identified in November of that year, Western states imposed travel bans on African countries including ones where the variant had not yet been identified, even while keeping borders open to states in the global North where the variant *had* been identified. This reinforced racist logics of Africans as 'disease-carriers', and as a threat to the 'civilised' West/Europe.

It was also apparent in the turn to a charity model for the allocation of COVID-19 vaccines through the COVID-19 Vaccines Global Access (COVAX) mechanism. While facilitating the donation of surplus vaccines on the one hand, on the other COVAX ultimately left the barriers posed by intellectual property rules to equitable vaccine distribution unchallenged. The Pandemic Agreement runs the risk of similarly promising more ethical pandemic governance through the PABS mechanism, while ultimately remaining reliant on state goodwill rather than systemic restructuring of pharmaceuticals production. Article 12 of the draft Treaty only mandates that twenty percent of pandemic-related products should be contributed to a shared pool which, while welcome if implemented, still only begins to scratch the surface of the vaccine nationalism problem evidenced during COVID-19.

Ideal-type theorising also risks underplaying the structuring power of deep-seated ideological commitments. For example, Lauren Paremoer looks at how governance initiatives aimed at improving access to antiretroviral treatments for HIV have tended towards market-based and for-profit approaches that have legitimised the positioning of economic utility and thinking at the heart of global health governance. This too is a form of ethical commitment—even if we disagree with it—grounded in the belief that the market is best for rational and efficient distribution and shapes much thinking around global health governance. This way of thinking about health governance elevates ideas around efficiency and competition and the protection of private property to exalted status and can be used to counter claims to health rights, redistribution, and systemic restructuring. Ideological commitments like it are difficult to dislodge and fundamentally shape global health policymaking.

Indeed, the hierarchal landscape of global (health) governance often plays out in the paternalistic tensions between care and control, with powerful states often deciding what's best for affected and marginalised societies, rather than fundamentally redressing the unjust structures of the global economy that cause many global health inequalities.

These hierarchies existed long before the inception of the WHO, and will continue to remain regardless of how often the International Health Regulations are adjusted, or what new legal instruments are introduced. As others have argued with respect to global health ethics, power relations don't just shape the way health is governed and the way health inequalities manifest and persist, they also shape,

the intellectual and moral frames that are used to constitute the "real"…[they] remain central to how we perceive and evaluate the significance of disparities of wealth, health, and the ecological pressures that ultimately threaten us all, although some more than others (p. 234).

Moreover, argue Benatar, Upshur, and Gill, these power relations also limit our imagination for change; by reifying these unequal power relations we might see philanthropy or technological fixes as valid responses to address these moral deficits, rather than taking seriously the need for radical restructure of the global economy, for example. Thus, while Ruger and others that make similar arguments are of course aware that their theorising is of an ideal-type and would argue they set lofty goals against which actual behaviour can be judged and, hopefully, slowly and over time be worked towards, they nevertheless risk naturalising the very systemic foundations of global health inequity. Indeed, our claim here goes beyond the idea that states act according to self-interest or national interest (although of course they often do, again as clearly evidenced by the COVID-19 pandemic). Rather, we argue that these hierarchies (emanating from long-standing processes of subjugation and marginalisation, and often underpinned by a racialised logic) so suffuse the contemporary international order that the shaping of norms and rules will consistently fold in and further solidify these same hierarchies.

Conclusion

Instead of attempting to rectify imbalances of power, both in the political and material sense, the re-negotiated IHRs and the Pandemic Agreement rely on ethical notions of solidarity and goodwill. Yet, as Anna Agathangelou argues, 'ethics is not so much claimed as performed' (p.58) and while the revisions to the IHR and the draft Pandemic Agreement make lofty rhetorical commitments, the way these commitments play out in practice will likely come up against the pre-existing hierarchies of international order. If we fail to take these hierarchies into account in our theorising of the ethics of global health governance, we risk our ethics legitimising and sustaining an unequal global order and reproducing these hierarchies. The glaringly unequal effects of the COVID-19 pandemic within and across countries, and its disproportionate impact on the global majority necessitates better, more equitable global health governance. However, writing the hierarchies of international order out of our theorising of what this governance can and should look like, risks reinscribing these hierarchies anew.

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