



THE GLOBAL HEALTH REGIME AND THE INTERNATIONAL RESPONSE TO COVID-19

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Since the first case of coronavirus (SARS-CoV-2) and the disease it causes (COVID-19) was reported in December 2019, and the subsequent declaration of a pandemic by the World Health Organization (WHO) on March 11, 2020, the countries of the world have made varying levels of progress. While some began relaxing restrictions and have gradually recommenced activities since May, making the transition to a “new normality”, others continue to struggle with the most critical phases of the pandemic, and yet others are experiencing a second wave.

As a transnational threat, the pandemic requires a global response, but the possibilities, strategies and interests of each nation are extremely divergent, and these differences have become even more marked in a globalized, unequitable world. Governance mechanisms are a reflection of this fragmentation.

The analysis paper published in June 2020 by the International Research Center (CII) of the Matías Romero Institute (IMR) focused on trends that the pandemic has accentuated in a context of modernity, and on an analysis of the State and the individual. The goal of this second paper is to analyze the foundations of the global health regime to

determine whether the international response to the COVID-19 pandemic typifies existing health structures or if any major changes have occurred. This is relevant because, while global public health governance appeared to experience a crisis (during the first few months of the pandemic), with the passing of time, most members of the international community have acknowledged the importance of operating within the parameters of the multilateral system and have begun acting in a coordinated fashion again.

The central argument of this analysis paper is that the COVID-19 pandemic has not resulted in any significant changes to the international public health regime. And although we cannot rule out political shifts within the institutions that shore up this structure for international coordination due to differences between the large powers, the principles and goals on which this regime is built essentially remain unaltered. In other words, the international public health regime has retained the support of the majority of the international community’s members and while it is in the process of revising its procedures and instruments, this revision is being conducted within existing regulatory norms and social goals.

International regimes and global governance: an analytical framework

To understand the international public health regime, we first need to explain what it consists of and what its principles are. Globalization has led to international cooperation, but also common risks. States have established structures for international cooperation and co-existence to address problems arising from political interactions and the confluence of societies and economies. These global governance mechanisms represent the sum of the efforts of actors and institutions to manage shared interests and challenges via cooperation. This has been achieved by establishing *international regimes*, which are “sets of implicit or explicit principles, norms, rules and decision-making procedures around which actors’ expectations converge in a given area of international relations.”¹

Political changes within the international system mold the procedures, rules and instruments of international regimes. Notwithstanding, political reconfigurations within these structures do not necessarily imply changes to their principles and norms. International regimes do not change when the power of their participants is modified, but when their social purpose is altered.²

Since the World Health Assembly of 1951, the main purpose of the international public health regime — represented by the WHO — has

been to establish common rules and procedures to concentrate public health information and implement epidemiological surveillance and international health measures. Furthermore, it has been established that actions to prevent and respond to international health problems should not significantly affect national economies or international trade and transportation systems.³ Since the goal is to keep the globalization system safe from health interferences and institutional disruptions, this international coordination structure is based on three normative principles: the biomedical method, the precedence of economic rationality and health as a security issue in the context of globalization.⁴

As regards the first point, WHO recommendations and the actions of governments have favored clinical medicine and individualism in public health proposals,⁵ opting for pharmaceutical tools within reach of the individual — such as vaccines, antibiotics and other medicines — to address world health problems, whereas systemic factors that pose a threat to public health, such as urbanization and poverty, and disciplines like social medicine have received less attention. Meanwhile, with reference to the second point, the public policies

[1] Stephen D. Krasner, “Structural Causes and Regime Consequences: Regimes as Intervening Variables”, in *International Organization*, vol. 36, no. 2, Spring 1982, p. 186.

[2] John Gerard Ruggie, “International Regimes, Transactions, and Change: Embedded Liberalism in the Postwar Economic Order”, in *International Organization*, vol. 36, no. 2, Spring 1982, pp. 382-385.

[3] Simon Rushton, “Global Governance Capacities in Health: WHO and Infectious Diseases”, in Adrian Kay and Owain David Williams (eds.), *Global Health Governance: Crisis, Institutions and Political Economy*, London, Palgrave Macmillan, 2009, p. 65; Andrew Lakoff, *Unprepared: Global Health in a Time of Emergency*, Oakland, University of California Press, 2017, p. 4.

[4] Kelley Lee, “Understandings of Global Health Governance: The Contested Landscape”, in Adrian Kay and Owain David Williams (eds.), *op. cit.*, pp. 28-36.

[5] Cfr. Adam Kamradt-Scott, “The politics of medicine and the global governance of pandemic influenza”, in *International Journal of Health Services*, vol. 43, no. 1, January 2013, pp. 105-121.



resulting from this international regime are based on economic utilitarianism. Health decisions have been made by weighing up the costs and risks to national economies and the international economic system, which has resulted, for example, in the prioritization of care for certain age groups, specific productive sectors and diseases with far-reaching social consequences. Accordingly, health phenomena that are potentially disruptive to the globalization system have been conceptualized as issues of international security.⁶

Part of these three normative principles that underpin the current health regime are formalized in the International Health Regulations (IHR), an instrument that is binding on all WHO Member States and that was developed “to prevent, protect against, control and provide a public health response to the international spread of

disease in ways that are commensurate with and restricted to public health risks.”⁷ The IHR were modified in 2005⁸, with a focus on four aims: 1. strengthen the basic capacities of countries to monitor and control threats to public health, 2.

[6] *Idem.*

[7] World Health Organization, *International Health Regulations (2005) Second Edition*, Geneva, 2008, p. 10, at https://www.who.int/ihr/IHR_2005_en.pdf (date of reference: January 18, 2021).

[8] The IHR came into force in June 2007 and were used for the first time during the H1N1 influenza epidemic in 2009. While the general view is that the IHR worked satisfactorily in this case, some experiences have shown that there are areas of opportunity as regards their implementation, like, for example, the extension of the WHO director-general’s powers to declare an international health emergency, international coordination, financing for the implementation of the IHR in developing countries, the relationship with other WHO prevention mechanisms, and the possibility of permitting States to take trade, travel and human rights measures that violate the IHR without incurring legal consequences or sanctions. *Vid.* Kumanan Wilson, John S. Brownstein y David P. Fidler, “Strengthening the International Health Regulations: lessons from the H1N1 pandemic”, in *Health Policy and Planning*, vol. 25, no. 6, November 2010, p. 506.



ensure States report possible health emergencies of international concern,⁹ 3. promote proactive, global cooperation for the assessment and management of risks and 4. implement the Event Management System (EMS).¹⁰

[9] China reported the appearance of SARS-CoV-2 31 on December 31st 2019 (various cases were already present in the province of Wuhan). WHO, "Pneumonia of Unknown Cause – China", January 5, 2020, at <https://www.who.int/csr/don/05-january-2020-pneumonia-of-unknown-cause-china/en/> (date of reference: January 18, 2021). Mexico reported influenza H1N1 on March 19, 2009. WHO, "Influenza-like illness in the United States and Mexico", April 24, 2009, at https://www.who.int/csr/don/2009_04_24/en/ (date of reference: January 18, 2021). The Democratic Republic of the Congo reported ebola on December 24, 2010. WHO, Ebola haemorrhagic fever in the Republic of the Congo - Update 6", 6 January, 2004, at https://www.who.int/csr/don/2004_01_06/en/ (date of reference: January 18, 2021).

[10] Diana Salcedo Novella Pardo Silva, *El sistema de gobernanza global en salud* [tesis of master], México, UNAM,

There are three scenarios in which countries are required to report an epidemiological event: 1. cases of SARS, smallpox, human influenza caused by a new subtype and polio, and any other highly contagious disease that has the potential to pose a serious public health threat, 2. any known disease that spreads beyond its natural endemic zone and that could lead to a health emergency of international concern and 3. any public health event with serious consequences for a community that has the potential to spread beyond its point of origin, such

2014, p. 200. To meet the proposed aims, Article 4 of the Regulations state that each State Party shall designate the authorities responsible for establishing communication with the WHO to consolidate global epidemiological surveillance strategies.

as cases of contamination whose source is suspected to be a food product.¹¹

Actors in the international health regime and the financing issue

Aside from comprehending its principles, a better understanding of the international global health regime requires identifying its most influential actors. The WHO tends to be the first international organization mentioned when it comes to health matters, due to its universality (it has 195 Member States) and broad powers. One way of analyzing it is to gauge its influence based on its financing model, this being a key factor in understanding the circumstances under which it operates in the context of the current pandemic.

The WHO obtains its funding from two main sources, one of which is assessed contributions (membership dues). Each Member State agrees to pay a fixed amount each biennium, which is calculated as a percentage of its GDP and population. These contributions are fixed and flexible, meaning the WHO can dispose of them without any restrictions whatsoever.¹² The second is voluntary contributions made by Member States and other U.N. agencies, inter-governmental organizations, philanthropic foundations and the private sector, among other sources. This second source accounts for approximately

80% of the WHO's budget and are classified into three types, depending on their flexibility of use:¹³

1. *Core voluntary contributions*: these are completely flexible, which means the WHO has full discretion as to how they are used to finance its programs. This category accounted for just 3.9% of all voluntary contributions made in 2019. The United Kingdom contributed the most in this category — US\$64.7 million — , followed by Sweden, Norway, Australia and the Netherlands.
2. *Strategic and themed contributions*: these are partially flexible, meaning the WHO has some room for maneuver in how they are used, provided it complies with reporting and accountability requirements. These contributions represent 6% of all voluntary aid. Germany, the European Commission and Japan were the main donors in this category in 2019, with contributions totaling US\$190 million.
3. *Voluntary specified contributions*: financing for specific areas of the program and geographic locations. The use of these funds is subject to a concrete timeframe. The WHO has no say over how they are used, as conditions are dictated by donors. These funds make up 90.1% of all voluntary contributions the WHO receives.

[11] *Ibid.*, p. 204.

[12] Gargeya Telakapalli, "AC/VC: The Shock of WHO Funding", in People's Health Movement, July 7, 2018, at <https://phmovement.org/ac-vc-the-shock-of-who-funding/> (date of reference: January 19, 2021). Paradoxically, less than 20% of the Organization's total budget is obtained from assessed contributions. "How WHO Is Funded", in World Health Organization, at <https://www.who.int/about/planning-finance-and-accountability/how-who-is-funded> (date of reference: January 19, 2021).

[13] *Idem.* The WHO itself is aware of the problem with its financing model, reason why, in its reports, it calls on members and contributors to increase their donations in flexible categories.

Since the 1980s,¹⁴ there has been an increase in non-state actors, who have rapidly inserted themselves into a scenario formerly dominated by public actors (States and international organizations).¹⁵ In 1983, the United States voted to freeze the Organization's assessed contributions,¹⁶ which led to an increase in voluntary financing and modified relations between the actors involved. In this process, the WHO's position as the international authority on health issues has undergone a transformation, as the emergence and growing presence of these new actors has diminished its scope for action.¹⁷ What implications does the proliferation and ever-stronger influence of non-state actors have



for global health and why is there such a huge disparity in their interactions?

According to the WHO Program budget, the resources it obtains from the aforementioned sources are spread over six categories: communicable diseases, non-communicable diseases, health promotion, health systems, corporate services (bureaucratic and operational matters) and health emergency programs (currently in use due to the COVID-19 pandemic). In the 2018-2019 biennium, just over 80% of funding in the communicable diseases category came from voluntary specified contributions.¹⁸ This illustrates that earmarked resources are restricted to one category, which the health regime considers to be more of a priority than the other five, in keeping with the individualist, biomedical logic mentioned previously. It should be noted that the Organization's main contributor was the United States, followed by the United Kingdom, the Bill & Melinda Gates

[14] In these years, a shortage of international health funding, exacerbated by the economic crisis at the turn of the decade and the changes countries introduced to their economies due to the structural adjustment programs decreed by international financial institutions (the International Monetary Fund and the World Bank) and the first signs of what was to become an international health emergency (the HIV/AIDS pandemic) were factors that fueled concern over resources and cooperation strategies in health and that decisively contributed to the trend toward cost-efficient interventions in health, once again favoring the biomedical, economic and security perspective that already permeated the health arena, and marking a clear move away from the "Health for All" social approach proclaimed in the Alma-Ata Declaration of 1978. Hani Kim, Uros Novakovic, Carles Muntaner and Michael T. Hawkes, "A Critical Assessment of the Ideological Underpinnings of Current Practice in Global Health and Their Historical Origins", in *Global Health Action*, vol. 12, no. 1, 2019, p. 7.

[15] Cfr. D. Salcedo Novella Pardo Silva, op. cit., p. 153.

[16] People's Health Movement, "People's Health Movement Condemns US Halt on Funding to WHO", April 20, 2020, <https://phmovement.org/wp-content/uploads/2020/04/PHM-Statement-in-Defence-of-WHO-20-4-20.pdf> (date of reference: January 19, 2021).

[17] Cfr. Theodore M. Brown, Marcos Cueto and Elizabeth Fee, "The World Health Organization and the Transition From 'International' to 'Global' Public Health", in *American Journal of Public Health*, vol. 96, no. 1, January 2006, 3.

[18] All the information on WHO financing figures through 2019 is available at WHO, *Results Report, Programme Budget 2018-2019: Driving Impact in Every Country*, Geneva, WHO, 2020, pp. 7-11, at https://www.who.int/about/finances-accountability/reports/results_report_18-19_high_res.pdf?ua=1 (date of reference: January 19, 2021).

Foundation,¹⁹ the GAVI Alliance and Germany. Of these five main contributors, three are WHO Member States and two are foundations and public-private initiatives funded with U.S. capital.

The conditioning of the budget allows these actors to openly influence the health agenda and financing trends²⁰ and channel funds toward a certain number of diseases (mainly communicable), which also receive priority treatment in terms of the actions the IHR indicate should be taken in the event a health emergency is declared. In short, based on the last revision of the IHR in 2005, the origin and flow of funds point to a strengthening of the same trends that have mapped out the course of the health regime for decades and that favor an economic perspective, a biomedical approach whereby care is concentrated on a certain number of diseases and patients with specific characteristics, and that ensures the continuity of globalization and its implications,

Having analyzed the foundations of the international public health regime and the actors that influence it, the next section aims to show that the individual actions of countries and multilateral initiatives have taken place within this regime, not in opposition to it.

The international response to COVID-19

The political component in the search for a vaccine

According to Richard N. Haass, the most difficult political aspect will most likely be access to the vaccine, given that responses to the pandemic have been mainly national in nature.²¹ International mass media has dubbed the search for a vaccine the “new space race”, a “health nationalism fever” and even “vaccine nationalism”.²² Private entities and public institutions have been conducting clinical trials in the last months,²³ some of which are collaborative research initiatives, while others have been performed by

[19] The Bill & Melinda Gates Foundation is one of the non-state actors that have acquired a stronger presence in the global health arena. Its donation of US\$455.3 million in 2019 was restricted only to the category of specified contributions. WHO Results Report, *op. cit.*, 10. The Bill & Melinda Gates Foundation is a private, non-profit organization founded in 1999 in Seattle, United States. It bears the names of Microsoft’s majority shareholders, who are also its directors, along with Warren Buffett, an investor in several multinationals and chairman and CEO of Berkshire Hathaway. As a result of Buffett’s donation of US\$31 billion in 2006, the Gates Foundation became a global philanthropic giant and has since established its presence in the international health regime. History”, in Bill & Melinda Gates Foundation, at <https://www.gates-foundation.org/Who-We-Are/General-Information/History> (date of reference: January 19, 2021).

[20] As well as enjoying a strong presence in the main public-private health initiatives, like the GAVI Alliance.

[21] Cfr. Richard N. Haass, Richard N. Haass, “The Politics of a COVID-19 Vaccine”, en Council on Foreign Relations, 14 de julio de 2020, en <https://www.cfr.org/article/politics-covid-19-vaccine> (date of reference: January 19, 2021).

[22] Vid. ONU México, “Necesitamos prevenir el nacionalismo de las vacunas”, August 18, 2020, at <https://coronavirus.onu.org.mx/necesitamos-prevenir-el-nacionalismo-de-las-vacunas> (date of reference: January 19, 2021); Rina Mussali, “COVID-19 y el maratón global por la vacuna”, in Expansión, September 2, 2020, at <https://expansion.mx/opinion/2020/09/01/covid-19-y-el-maraton-global-por-la-vacuna> (date of reference: January 19, 2021). Alberto Priego, “Geopolítica de las vacunas: la nueva ‘carrera espacial’”, in CincoDías, August 28, 2020, at https://cincodias.elpais.com/cincodias/2020/08/27/opinion/1598523779_185515.html (date of reference: January 19, 2021).

[23] WHO, “Draft Landscape of COVID-19 Candidate Vaccines”, January 15, 2021 at <https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines> (date of reference: January 19, 2021).



a single company, which largely explains why progress has been differentiated.

According to information gathered by the WHO and disseminated in the media, 20 clinical trials are currently at phase three.²⁴ Furthermore, the vaccine developed by Pfizer in collaboration with BioNTech, the vaccine developed by the University of Oxford in conjunction with the Swedish-British company AstraZeneca, and the vaccine developed by the U.S. pharmaceutical company Moderna and The National Institutes of Health (NIH) have been approved by diverse countries, and began its distribution and administration on December 2020 and January 2021.

[24] Carl Zimmer, Jonathan Corum and Sui-Lee, "Coronavirus Vaccine Tracker", *The New York Times*, January 19, 2021, at <https://www.nytimes.com/interactive/2020/science/coronavirus-vaccine-tracker.html> (date of reference: January 19, 2021). This means that the companies developing a vaccine have administered it to a sample population of thousands of volunteers and are now waiting for the results. It is at this phase in the process that it can be determined with greater certainty whether the vaccine is effective or not, and according to the *New York Times*, a positive result must be backed by a success rate of at least 50%.

At first sight, the race to find a vaccine would seem more akin to a competition with political overtones and specific economic ends than to a global governance mechanism. In this quest, those countries with stronger investment capabilities for research and development flex their scientific muscle, while entering into agreements with pharmaceutical companies and committing resources in exchange for millions of doses in an attempt to secure both the discovery and the supply of a vaccine.²⁵

[25] Just months after the outbreak of the pandemic and even though none of the candidate vaccines had completed their clinical trials, some countries with greater economic clout negotiated the purchase of at least 3.1 billion doses. The United States was one of these countries: The Trump administration signed contracts with six manufacturers guaranteeing at least 800 million doses for 330 million people, with deliveries beginning at the end of the year. Cecilia Barría, "Vacuna contra la covid-19, "Hay un juego político, económico y estratégico detrás de las vacunas que es una receta para el desastre", in *BBC News*, August 7, 2020, at <https://www.bbc.com/mundo/noticias-53618082> (date of reference: January 19, 2021); "Estados Unidos primero, la táctica de Trump con la vacuna", *El Universal*, September 2, 2020, at <https://www.eluniversal.com.mx/mundo/estados-unidos-primero-la-tactica-de-trump-con-la-vacuna> (date of reference: January 19, 2021).

However, in light of how rapidly the disease has spread worldwide, if there is one thing we have learned, it is that efforts to combat it will require global cooperation. This is why Mexico proposed before the U.N. General Assembly a resolution that was approved on April 20th, 2020 — resolution 74/274 —,²⁶ which aims to guarantee equal access to medicines, vaccines and medical equipment to address the pandemic. Aside from reaffirming the threat the pandemic poses to human health, safety and wellbeing, the resolution highlights the importance of international cooperation and multilateralism to ensuring such an objective for the benefit of every country — especially the less developed ones — to achieving adequate access to medical supplies and to avoiding stockpiling.

On September 25, 2020, Mexico joined the COVAX platform,²⁷ along with more than 170 other countries. COVAX is a financing instrument that fosters collaboration between international organizations and vaccine manufacturers.²⁸ This is an attempt to form a common

front against the risks the disease poses, so that when a safe, effective vaccine is developed,²⁹ it can be made available to all participants in the project as quickly as possible, regardless of their level of development.³⁰

Notwithstanding the above, certain actors keep specific economic interests due to the high financial stakes they hold in the global health arena. The United States, the country most affected by the disease, refused to participate in COVAX, arguing that it does not want to be bound by restrictions imposed by multilateral organizations like the WHO. This decision is in line with the one it took months previously to freeze its contributions to the Organization.³¹ This, compounded by the individual actions certain countries continue to take, has blocked the progress of mechanisms like COVAX. However, it is important to note that the position of the

[26] UN General Assembly, “International Cooperation to Ensure Global Access to Medicines, Vaccines and Medical Equipment to Face COVID-19”, A/RES/74/274, April 21, 2020, at <https://undocs.org/en/A/RES/74/274> (date of reference: January 19, 2021).

[27] “México se une a plataforma mundial de acceso a vacuna contra COVID-19”, in DW, September 25, 2020, at <https://www.dw.com/es/m%C3%A9xico-se-une-a-plataforma-mundial-de-acceso-a-vacuna-contra-covid-19/a-55059028> (date of reference: January 19, 2021).

[28] COVAX is co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), the Vaccine Alliance (GAVI) and the World Health Organization (WHO), in collaboration with vaccine manufacturers from all over the world. It is the only initiative that works with governments and manufacturers to guarantee the availability of COVID-19 vaccines worldwide, for both high- and low-income countries. WHO, “172 countries and multiple candidate vaccines engaged in COVID-19 vaccine Global Access Facility”, August 24, 2020, at [https://www.who.int/news/item/24-](https://www.who.int/news/item/24-08-2020-172-countries-and-multiple-candidate-vaccines-engaged-in-covid-19-vaccine-global-access-facility)

08-2020-172-countries-and-multiple-candidate-vaccines-engaged-in-covid-19-vaccine-global-access-facility (date of reference: January 19, 2021); “Creación del GAVI COVAX AMC”, in Spanish Association of Vaccinology, at <https://www.vacunas.org/creacion-del-gavi-covax-amc/> (date of reference: January 19, 2021).

[29] Editorial Board, “Trump’s Refusal to Join a Global Vaccine Effort Epitomizes an America that’s Isolated and Weak”, *The Washington Post*, September 2, 2020, at https://www.washingtonpost.com/opinions/trumps-refusal-to-join-a-global-vaccine-effort-epitomizes-an-america-thats-isolated-and-weak/2020/09/02/f64c23c6-ed44-11ea-99a1-71343d03bc29_story.html (date of reference: January 19, 2021).

[30] The purpose of COVAX is to ensure its 170-plus participating economies have access to the initiative’s portfolio of vaccines—provided these prove to be safe and effective—, under a funded or self-financing scheme, depending on each case. Subject to the availability of resources, funded countries will receive sufficient doses to vaccinate up to 20% of their populations in the long term. Seth Berkley, “COVAX Explained”, Gavi The Vaccine Alliance, September 3, 2020, at <https://www.gavi.org/vaccineswork/covax-explained> (date of reference: January 19, 2021).

[31] “Estados Unidos primero...”.

United States has shifted with the Biden Administration. The United States will join COVAX and will remain a member of the World Health Organization.

Furthermore, given that the search for a vaccine remains at the core of the health strategy, it could be argued that the measures taken to manage the disease (whether unilateral or multilateral) fall within the first principle of the existing public health global governance system, which favors the use of pharmaceutical tools accessible to the individual, like vaccines, to which universal access has yet to be guaranteed, even though the rapid spread of this modern pandemic can be attributed to global interactions and therefore poses a risk to us all.

Health decisions and their effect on economies

The COVID-19 outbreak has sparked off an economic crisis comparable to none other in recent history. The pandemic caused the world economy to plummet 4.4 % in 2020.³² Each country has been affected differently and response strategies have also varied due to domestic circumstances. A priority of the IHR is to take action in the event of health emergencies without affecting international trade, to the extent that this is possible.³³ The logic underpinning responses to

the health crises of recent years has been that economic activity cannot come to a halt. Our globalized world is an interdependent one that requires value chain flows be protected at all cost.

The above underlines the close relationship between international economic matters and a health emergency of global concern, shedding light on how responses to a crisis of this nature have been designed and have evolved based on the same premise. This has its roots in the second principle of the international health regime, which we discussed previously: the prioritization of economic rationality and a utilitarian approach to global health, based on cost and risk evaluations.

The current economic depression and the shared nature of the effects of the pandemic have surpassed the provisions of the IHR. So far, we have not been able to combat the virus without affecting national and international economies. In this context of grave uncertainty, there are three indicators that, taken together, suggest the path to recovery will be a long one:³⁴

1. *Exports.* Due to the closure of borders and sanitary blockades, global demand for goods fell, affecting economies that depend on the

[32] International Monetary Fund (IMF), *World Economic Outlook International Monetary Fund: A Long and Difficult Ascent*, Washington, D.C., IMF, October 2020, p. 8, at <https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020> (date of reference: January 19, 2021).

[33] The implementation of the IHR has evolved based on past experiences. The AH1N1 influenza epidemic in 2009 revealed an important area of opportunity for coordinating these regulations with the mechanisms of the World Trade Organization (WTO). While the IHR give the WHO direc-

tor-general ample faculties to issue recommendations in the event of a pandemic, the Organization does not have the power to either evaluate or control the unilateral trade actions taken by States, even when these go against its recommendations. In such cases, and where applicable, WTO mechanisms could be used to analyze and determine the reasonableness of such measures, taking into account health considerations.

[34] Carmen Reinhart and Vincent Reinhart, "The Pandemic Depression: The Global Economy Will Never Be the Same", in *Foreign Affairs*, vol. 99, no. 5, September/October 2020, at <https://www.foreignaffairs.com/articles/united-states/2020-08-06/coronavirus-depression-global-economy> (date of reference: January 19, 2021).



export sector, tourism and the oil market, among others.

2. *Unemployment.* Many people have lost their jobs as a result of closures and cutbacks at companies and other workplaces, while opportunities for professional development that would facilitate their reincorporation into the job market are now limited. At the same time, digitalization and the automation of processes has reduced the number of unskilled, low-paid jobs available in the service sector, where working from home is not an option, leading to an increase in precarious employment (part-time or on-call work or working for multiple employers³⁵ with no or inadequate social security benefits).

3. *The regressive nature of the pandemic.* The effects on consumer behavior could outlast mandatory closures, leading to a rapid decline in quality of life for people living in countries with incipient safety nets. To this we can add an increase in food prices, because the disease and blockades have interrupted global supply chains and labor migration patterns in the agricultural sector, exposing the world to a serious food crisis.

To address these and other economic consequences, in keeping with the second principle of the global health regime, the initial response of various governments was to shore up household income and the liquidity of companies by means of a series of tax incentives. As the crisis

[35] Laura D'Andrea Tyson, "Many Lost Jobs Will Never Return", in Joseph E Stiglitz, Robert Shiller, Gita Gopinath, Carmen Reinhart, Adam Posen, Eswar Prasad, Adam Tooze, Laura D. Tyson and Kishore Mahbubani, "How the Economy Will Look after the Coronavirus Pandemic", in Sydney Busi-

ness Insight, at <https://sbi.sydney.edu.au/how-the-economy-will-look-after-the-coronavirus-pandemic/> (date of reference: January 19, 2021).

has drawn out, many countries have expanded these initial incentives, and to the extent that blockades and other social distancing restrictions have been lifted, international organizations like the World Bank, the Organization for Economic Cooperation and Development (OECD) and the International Monetary Fund have urged governments to adopt expansive tax policy measures to aid economic recovery.³⁶ Government planning has been a key factor in determining how strategic sectors (industry, tourism, transport, health, energy) will adapt and interact in a world with more restrictive social rules and fewer financial resources.³⁷

The pandemic has shown that open borders are vulnerable and that trade and economic circuits are susceptible to interruptions in a

globalized world.³⁸ Although there has been no shortage of calls to rethink the current system of global interaction with a view to addressing the systemic causes of these and other problems (such as inequality and the destruction of the environment), in practice, the international community clearly continues to give priority to economic interests, given that the measures described in this paper have been taken based on the need to regain the public's trust and restore trade and growth to pre-pandemic levels.

Globalization and security in times of pandemic

The third and last pillar of the international health regime is the link between globalization and security. In the twentieth century, communicable diseases were deemed to be primarily an economic threat, because they affected productive activities and trade, although with the passing of time, other factors, such as the humanitarian implications of these phenomena, were also taken into consideration. From the 1990s on, we can see an explicit connection — albeit not a linear or consistent one — between global public health and security issues.³⁹ Concepts like “human security” have broadened the definition of security, which now goes beyond the survival of the State to encompass and focus on individuals and their wellbeing.

[36] *Op. cit.* Pascal Saint-Amans. The International Monetary Fund has warned that figures for the reactivation of the economy are not promising and that a much slower recovery than previously expected is projected for 2021. As countries reopen, the IMF has acknowledged that their return to activities will be uneven and has urged the international community to increase fiscal support (calculated at over US\$10 trillion) and drastically relax their monetary policy by reducing interest rates, injecting liquidity into the economy and purchasing assets. Several countries have already implemented these measures and have managed to protect livelihoods and ward off large-scale bankruptcies, but given the level of uncertainty that persists, these actions are not sufficient, reason why the IMF and other organizations recommend governments maintain the tax incentives they have introduced to date, while closely monitoring the evolution of their economies. *Vid.* Gita Gopinath, “Reopening from the Great Lockdown: Uneven and Uncertain Recovery”, in IMFblog, June 24, 2020, at <https://blogs.imf.org/2020/06/24/reopening-from-the-great-lockdown-uneven-and-uncertain-recovery/> (date of reference: January 19, 2021).

[37] OECD, “Building Resilience to the COVID-19 Pandemic: The Role of Centres of Government”, in OECD Tackling Coronavirus (COVID-19). Contributing to a Global Effort, September 2, 2020, at <http://www.oecd.org/coronavirus/policy-responses/building-resilience-to-the-covid-19-pandemic-the-role-of-centres-of-government-883d2961/> (fecha de consulta: 19 de enero de 2021).

[38] G. Gopinath, “The real risk is politicians exploiting our fears”, en J. E. Stiglitz *et al.*, *op. cit.*

[39] D. P. Fidler, “A Pathology of Public Health Securitism: Approaching Pandemics as Security Threats”, in Andrew F. Cooper, John J. Kirton and Ted Schrecker (eds.), *Governing Global Health: Challenge, Response, Innovation*, London, Routledge, 2016, p. 45.



Some of the actions taken during the pandemic can be put down to national and international security concerns. As regards the former, countries have opted for policies like closing their borders and surveilling their populations. Furthermore, because the disruption of supply chains, food insecurity and unemployment can all have a social impact, creating political unrest and leading to increased violence and conflicts, governments have adopted economic measures like the ones described.⁴⁰ This approach is tied in with the initial, uncoordinated responses of the first countries to be affected by COVID-19, which chose to look inside their borders and put their own economic and security interests

first, distancing themselves from the multilateral option and repositioning the Nation-State as the basic political and economic unit.⁴¹

As the virus has spread, the world has gradually tended to revert to cooperation initiatives, in the understanding that, in a globalized world, a country's security depends on that of the system itself. In other words, national actions are not sufficient to mitigate the risks of a global phenomenon like a pandemic. For this very reason, the Secretary-General of the United Nations and the Security Council have demanded a general and "immediate cessation of hostilities" the world over to combat the pandemic, which consists of a humanitarian pause for at least 90 days. Given the unparalleled scope of the health crisis, the resolution adopted by the Security Council states that violence and

[40] Robert Muggah, David Steven and Liv Tørrer, "We Urgently Need Major Cooperation on Global Security in the COVID-19 Era", in World Economic Forum, April 23, 2020, at <https://www.weforum.org/agenda/2020/04/we-need-major-cooperation-on-global-security-in-the-covid-19-era/> (date of reference: January 19, 2021).

[41] J. E. Stiglitz, "We Need a better Balance between Globalisation and Self-Reliance", in J. E. Stiglitz *et al.*, *op. cit.*

instability associated with situations of conflict have the potential to exacerbate the pandemic and, inversely, the pandemic has the potential to aggravate the negative humanitarian consequences of situations of conflict.⁴² It should be noted that while the Security Council recognizes that “the unprecedented extent of the COVID-19 pandemic is likely to endanger the maintenance of international peace and security”, it makes no explicit reference to the WHO.

The global health regime and the COVID-19 pandemic

To address the consequences of the pandemic, the United Nations has reiterated the need for multilateral initiatives and has suggested a comprehensive, three-point response:⁴³

1. *Strategic Preparedness and Response Plan.* Coordinated by the WHO, this plan acknowledges universal access to health as a critical global public good essential to recovery, and the importance of international cooperation and clinical research to finding a vaccine.
2. *Global Humanitarian Response Plan.* Designed to check the spread of the disease and reduce the impact on livelihoods, this plan focuses on vulnerable communities and recommends the adoption of tax incentives equivalent to

at least 10% of gross world product, a general debt moratorium, debt restructuring and greater support through international financial institutions.

3. *Framework for a development-oriented socio-economic response.* A transformative recovery process designed to rebuild economies and societies to be fairer, more inclusive, resilient and sustainable, and that addresses issues like climate crisis, inequalities and gaps in social protection systems.

This strategy indicates that the principles of the international regime remain in place. Firstly, its emphasis is on the biomedical method and finding a vaccine. Secondly, it acknowledges the humanitarian aspect of the pandemic. And thirdly, socio-economic measures are recommended.

The same can be seen in WHO resolution WHA73.1, ratified at the 73rd World Health Assembly (WHA) in May 2020,⁴⁴ where members stressed the need to guarantee the functioning of health systems to combat COVID-19, but also to treat other communicable and non-communicable diseases, and assure supplies of medicines. They also highlighted the importance of countering growing misinformation — exacerbated by

[42] UN Security Council, “Resolution 2532 (2020)”, S/RES/2532 (2020), July 1, 2020, at [http://undocs.org/es/S/RES/2532\(2020\)](http://undocs.org/es/S/RES/2532(2020)) (fecha de consulta: 19 de enero de 2021). (date of reference: January 19, 2021).

[43] UN, *United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better*, New York, UN, September 2020, p. 1-2, at https://www.un.org/sites/un2.un.org/files/un_comprehensive_response_to_covid-19_june_2020.pdf (date of reference: January 19, 2021).

[44] Vid. World Health Assembly, “COVID-19 Response”, WHA73.1, May 19, 2020, at https://apps.who.int/gb/eb-wha/pdf_files/WHA73/A73_R1-en.pdf (date of reference: January 19, 2021). The CII would like to thank Rodrigo López Tovar, who oversees Health Affairs for the Permanent Mission of Mexico to the UN, and other international organizations for providing information on the WHO’s activities. Given that the May meeting dealt exclusively with the COVID-19 issue, the Assembly will hold another semi-virtual meeting on November 9-14, 2020 to follow up on the 50 issues pending on its normal agenda.



digital media — which has undermined efforts to provide the public with clear, objective, scientifically-substantiated information and ensure the continuity of the joint endeavors of the United Nations Food and Agriculture Organization (FAO), the World Organisation for Animal Health (OIE) and several countries to identify the source of the virus and how it was transmitted to humans. Furthermore, other factors like climate change and economic and social inequalities, which have permeated the United Nations’ actions, especially following the adoption of the 2030 Agenda for Sustainable Development, are also taken into account.

These actions show that the WHO is willing to lend continuity to cooperation mechanisms and accept that measures taken to combat the pandemic can be improved upon. Aside from the WHA, the WHO has another decision-making body — the Executive Board — which is comprised of 34 members technically qualified in the health field. The Board’s main functions are to implement the decisions and policies of

the WHA, to which end it meets at least twice a year.⁴⁵ In 2020, in addition to meeting in February and again in May, a week after the WHA, the Board filed a request with the Organization’s director-general for an extraordinary meeting to follow up on the implementation of resolution WHA73.1. During the meeting, which took place on October 5 and 6⁴⁶, the office of the director-general provided updated information on the implementation of this resolution and the three panels set up to assess the international response to COVID-19:⁴⁷

[45] The Board’s main meeting usually takes place at the beginning of the year. It is here that the agenda for the next WHA is decided on and resolutions adopted for submission to the Assembly. The second, shorter meeting usually takes place in May, immediately after the WHA, to deal with affairs of a more administrative nature. Vid. WHO, “Governance”, at <https://www.who.int/governance> (date of reference: January 19, 2021); WHO, “Executive Board”, at <https://www.who.int/about/governance/executive-board/> (date of reference: January 19, 2021).

[46] For the first time in a hybrid or semi-virtual format.

[47] WHO Executive Board, “Update on Implementation of Resolution WHA73.1 (2020) on the COVID-19 Response.

1. The Independent Pandemic Preparedness and Response Group.
2. The Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response.
3. The Independent Oversight and Advisory Committee for the WHO Health Emergencies Program.

However, almost a year after the health emergency was declared, it is evident just how wide the gap is between words and actions: each pillar of the United Nations' three-pronged comprehensive response has received 59%, 20% and 5% of the required financing, respectively, meaning that, once again, the bulk of resources and attention are being channeled into the WHO response strategy, while the third pillar (which deals with the structural causes the Organization insists need to be tackled and that require long-term response and planning) had received just US\$49 million of the US\$1 billion needed for the first nine months of the pandemic as of June of this year.⁴⁸

If we look at the actions taken by States and multilateral organizations within the framework of the three pillars that support the global health governance system, it could be argued that changes have indeed occurred in their discourse and the problematization of their strategies, which now acknowledge systemic factors, the need to

address these and rethink mechanisms for action between and within countries. Notwithstanding, the funds the United Nations has raised to date for its strategy to combat COVID-19 clearly reflect the areas international actors have decided to give priority to.

Concluding remarks: the course of global health governance

The magnitude of the COVID-19 pandemic has forced the international public health regime to adapt in an attempt to offset the deficiencies it has shown during the health crisis, but so long as States continue to depend on this structure to coordinate their actions and interact both economically and socially, the regime the WHO represents will remain in force.

The biomedical public health model has endured as the paradigm of action during the pandemic and (barring a handful of exceptions that can be attributed to political circumstances) has not been criticized by WHO Member States (who favor the search for a vaccine, pharmaceutical remedies, medical preparation and unilateral contention measures over addressing the social and economic structural factors that cause the virus to spread faster and claim more human lives). The economic rationality of the health measures taken by the world's governments is self-evident, giving priority as they have to the lives of people of working age, the continuance of essential economic activities, the reactivation of secondary productive sectors, policies that ensure the globalization system remains operational and decisions whose benefits outweigh their costs. Likewise, security considerations — national and international — that seek to guarantee the stable functioning of the system have permeated discourse surrounding the

Interim Report by the Director-General", EBSS/5/2, September 23, 2020, at https://apps.who.int/gb/ebwha/pdf_files/EBSS5/EBSS5_2-en.pdf (date of reference: January 19, 2021); WHO Executive Board, "The Independent Panel for Pandemic Preparedness and Response. Report by the Co-Chairs", EBSS/5/3, September 21, 2020, at https://apps.who.int/gb/ebwha/pdf_files/EBSS5/EBSS5_3-en.pdf (date of reference: January 19, 2021).

[48] UN, *United Nations Comprehensive Response to COVID-19...*, p. 5.

pandemic and the logic behind the decisions made by the world's governments.

Due to the current uncertainty and the fact that the health emergency is far from being under control, it would be premature to predict what the future holds for the WHO and the global health governance system. Nonetheless, given that the trends observed in this and our first paper (published in the first semester of 2020) are gathering momentum, it could be argued that, while the WHO may yet deploy its scientific skills and epidemiological experience and assume a role of leadership, the Organization has essentially failed to exercise its authority to challenge governments politically and respond preemptively to the pandemic, even though mechanisms like the IHR empower it to do so.⁴⁹

The politicization of COVID-19 is an obstacle to international health cooperation. What happened this time around is just a taste of what the WHO will face in years to come, when it will have to deal with balances of power that will do their utmost to shape its future, as much as the recommendations of the experts who perform a postmortem on the pandemic. This is why the WHO would be well advised not to cave into the demands of the nations that have sought to multilaterally impose their respective sovereign interests that are far removed from those of global health.⁵⁰

Despite the COVID-19 pandemic is the worst threat we have come up against to date, it may not be the last or the worst crisis we ever

face. And although criticism of the global health regime is an inevitable part of the process, just as petitions to defund and dissolve the WHO (due to the prevailing political climate and analyses with a present bias)⁵¹ have been, it is clear the regime is solid enough to withstand this volatile environment. The ability to learn from the SARS-CoV-2 pandemic will depend the ability of WHO to adapt and address other adverse circumstances. In addition to all the challenges it faces, there is a lack of greater coordination with other international regimes, which have also had to react to the coronavirus and its consequences. Hence, the future of the WHO and the proper use of global governance mechanism depend on how it gets around the political discourse that has pervaded the pandemic.

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[49] David P. Fidler, "The World Health Organization and Pandemic Politics, the Good, the Bad, and an Ugly Future for Global Health", in *Think Global Health*, April 10, 2020, at <https://www.thinkglobalhealth.org/article/world-health-organization-and-pandemic-politics> (date of reference: January 19, 2021).

[50] *Idem*.

[51] A present bias is said to exist when more weight is given to recent events than the historic context of a given situation. Donald Lien and Joseph Kortsch, "The Future of the World Health Organization: China and the United States Square Off", in *The Hague Journal of Diplomacy*, vol. 15, no. 4, October 21, 2020, en https://brill.com/view/journals/hjd/15/4/article-p520_4.xml (date of reference: January 19, 2021).