A pandemic treaty for a fragmented global polity

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The COVID-19 pandemic is the most disruptive global political and economic crisis since World War 2, which gave birth to the UN, Bretton Woods institutions, and WHO. Although COVID-19 has prompted calls for equally ambitious reforms, the global polity is far more fragmented than the victor-dominated post-World War 2 era.

The president of the European Council called for a so-called pandemic treaty in December, 2020. This proposal has since been endorsed by 26 heads of state and by the director-general of WHO.[1] In *The Lancet Public Health*, Johnathan Duff and colleagues[2] outline an ambitious vision for such a treaty. At the core of their proposal is everything that global health advocates have wished for: a forceful WHO-like global entity with the capacity to coordinate recalcitrant governments, launch large-scale operations, enforce international rules by providing incentives and penalties, frankly assess the adequacy of national health systems, and provide technical advice free from the vagaries of scientific uncertainty.[2] The authors rightly recognise that such an entity would require substantial political autonomy from governments, and sustained and adequate funding. Perhaps such an improved and enhanced WHO could protect the world from the looming threat of future pandemics; however, these are powers beyond the reach of geopolitics today.

The pandemic has highlighted an enduring feature of the global system: the self-interested behaviour of sovereign states, and the challenge of ensuring that they comply with international rules when their perceived interests lie elsewhere.[3] The first and foremost challenge of a treaty is for governments to make binding commitments to each other. This treaty could include, but should not focus primarily on, WHO reform.

The scramble for access to COVID-19 vaccines illustrates the formidable challenge at hand. Governments have restricted exports of vaccines to meet domestic needs first. States without production facilities have used all the tools at their disposal—wealth, scientific and industrial capacity, diplomatic relationships, and the bodies of citizens as research subjects—to secure access to this strategic asset. The outcome has been predictably inequitable: the largest share of vaccine doses has gone to the countries with the greatest resources, and not necessarily to those with the greatest health needs.[4]

Countries in a position to share vaccines, or the technology to produce them, stand to gain politically from how they do so. The flow of vaccines, funding, and technology from the USA, EU, China, Russia, India, and other countries seems to reflect not only health objectives, but other political goals.[5] For example, Australia, India, Japan, and the USA announced in March, 2021, new financial and technological commitments to scale-up Indian vaccine production for global supply, a way to counterbalance China's influence in Asia.[6]

In a geopolitically fragmented world, countries have increasingly adopted so-called mini-lateral[7] or informal[8] approaches to cooperation as an alternative to the universal treaties of the past. Global health is no longer only about countries exerting so-called soft power, but a means to protect core political and economic interests.

This high-stakes, competitive context has three implications for a pandemic treaty. First, any treaty must meet the perceived self-interest of all involved countries. For governments to adhere to commitments, they must have confidence in the diffuse reciprocity that makes every country better off in the long term, especially when compliance imposes short-term costs.[9] Second, a treaty must be flexible enough to accommodate mini-lateral clubs with differing levels of ambition and willingness to share sovereignty. Not every country will accept a supercharged WHO. But many will see value in delegating stronger authority in some domains to WHO to make compliance by other states more probable. Finally, a pandemic treaty cannot rely on the tenuous normative power of international rules alone, but must also address the material conditions that can facilitate adherence. For example, countries might commit in advance to sharing vaccines with each other in a pandemic. But when crises strike, political pressure to retain supplies domestically will be formidable, as decisions by the EU, USA, and India to restrict vaccine and raw materials exports show.[10] If a treaty included not only commitments to share vaccines in emergencies, but also financing to boost vaccine production capacity in all regions in quieter times, this capacity would ease supply constraints and help countries to respect their obligations in the peak of a crisis. Governments precommitting flexible, adequate financing to WHO similarly strengthens the

organisation's ability to hold countries accountable for meeting their obligations.

Duff and colleagues[2] have painted an ambitious picture for what a pandemic treaty should achieve. Further attention is needed on how to get there. A treaty must intertwine self-interest and material factors within a flexible framework of shared principles and goals, if the world is to live up to this exceptional window of political opportunity to prevent future pandemics.

We declare no competing interests.

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1 Bainimarama JV, Chan-O-Cha P, da Costa ALS, et al. United action is needed for more robust international health architecture. March 30, 2021. https://emmanuelmacron.medium.com/united-action-is-needed-for-more-robust-international-health-architecture-c2b3b3aa8a37 (accessed April 19, 2021).

2 Duff JH, Liu A, Saavedra J, et al. A global public health convention for the 21st century. *Lancet Public Health* 2021; published online May 5. https://doi.org/10.1016/S2468-2667(21)00070-0.

3 Simmons BA. Compliance with international agreements. *Annu Rev Polit Sci* 1998; **1:** 75–93.

4 Duke Global Health Innovation Centre. Vaccine procurement: tracking COVID-19 vaccine purchases across the globe. https://launchandscalefaster.org/covid-19/vaccineprocurement (accessed April 10, 2021).

5 Bezruki A, Agarwal S, Chen Z, Alonso Ruiz A, Vieira M, Moon S. COVID-19 vaccine purchases and manufacturing agreements. Knowledge Portal for Innovation and Access to Medicines. https://www.knowledgeportalia.org/covid19-vaccine-arrangements (accessed April 19, 2021).

6 Bharadwaj S. Made-in-Hyderabad vaccine key weapon in Quad arsenal to counter China. The Times of India. March 14, 2021. https://timesofindia.indiatimes.com/city/hyderabad/made-in-hyd-vax-key-weapon-in-quad-arsenal-to-counter-china/articleshow/81488679.cms (accessed April 19, 2021).

7 Naim M. Minilateralism. *Foreign Policy* 2009; **173:** 136.

8 Pauwelyn J, Wessel RA, Wouters J. When structures become shackles: stagnation and dynamics in international lawmaking. *Eur J Int Law* 2014; **25:** 733–63.

9 Ruggie JG. Multilateralism: the anatomy of an institution. *Int Organ* 1992; **46:** 561–98.

10 The Economist. American export controls threaten to hinder global vaccine production. April 17, 2021. https://www.economist.com/science-and-technology/2021/04/17/american-export-controls-threaten-to-hinder-global-vaccine-production (accessed April 19, 2021).