JGPG (2020) 9: 97-116
DOI 10.14666/2194-7759-9-2-008

PAPER

The Construction and Reconstruction of Global Health Governance System under Public Health Emergencies

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Abstract A series of public health crisis disrupted throughout the 21st Century, bringing global health governance under spotlight and consequently challenging its existing structure. Analysing based on Zürn's three layers of the global political system that consist of normative principles, political institutions and the interactions between authorities, the article highlights that the current global health governance structure is under pressure for restructuring and reforming. The article argues that the key to enhancing international cooperation in combating public health crisis, is to reform the global health governance from its existing monopolist power structure to a multilateral governance model; and the normative principles should be adapted for regulating measures for combating public health emergencies, and their enforcement capacity should be enhanced. The article proposes that the World Health Organisation (WHO) is in need of reshaping the organisation by reducing its image as a political authority, while strengthening its role as a professional and independent global health authority, competent to lead in combating global public health crisis. Actors, such as non-government organisations and private corporations should also be given legitimate and institutionalised roles to the largest extent in the global health governance.

Keywords: Public health emergencies, Global health governance, Global governance, the World Health Organisation, Reconstruction.

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Introduction

A series of public health crisis disrupted throughout the 21st century has brought modern public health governance under global spotlight. The recent Coronavirus disease 2019 (COVID-19) pandemic spreading across every corner of the world poses unprecedented threats to human life, and further underlines the importance of global public health governance and the needs to reassess its existing structure.

Following the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak, amendments were made to the International Health Regulations (herein IHR) in 2005 as a remarkable first step to enhance the post-war global health structure, strengthen the role of the World Health Organisation (herein WHO) as the global health authority, and enhance measures to respond to public health emergencies. Despite these amendments, global health system continues to be dominated by a WHO-centred monopolist power structure, underprepared in face of the increasingly threatening global health crisis, such as influenza A virus subtype (H1N1), Zaire ebolavirus (Ebola) and COVID-19. The article therefore argues that the existing global health governance needs fundamental reforms and reconstruction to effectively respond to future global public health emergencies.

The article will first illustrate the history and setup of post-war global health system, and underline the systematic issues surrounding the WHO-centred monopolist power structure (section 1). Based on Zürn (2018)'s three layers of the global political system, the article will then evaluate the challenges brought by a series of significant public health emergencies to the existing global health governance structure (section 2). Through assessing the implementation of IHR from both international hard and soft law perspectives, the article will illuminate the key challenges to the governing legitimacy and authority of WHO (section 3). It will also analyse the limitations and complexities of WHO's interactions with other global entities including sovereign states, United Nations (UN) bodies, intergovernmental organisations and non-governmental actors (section 4), before eventually proposing to restructure the future global public health governance (section 5).

1. The Structure of Modern Public Health Governance

The modern global public health governance is constructed based on the Constitution of the World Health Organisation (herein the Constitution) in post-World War II (WWII). By integrating all pre-war international health institutions and unifying various public health normative principles into one, the global public health governance formed its present day WHO-centred monopolist power structure. While such a structure has improved the overall convenience and efficiency of global health governance, it led to a high degree of isolationism and bureaucracy limiting the system in its multilevel normative principles, governing authority and multilateral legitimacy in the decision-making process.

1.1 The Monopolist Structure of Global Public Health Governance

Zürn (2018) highlights three "distinct but interlinked layers" of the global governance system that inspires the analysis of this article. The first layer is a set of normative principles

that "provide justification for the exercise of authority in the global governance" (p.7). The normative principles in forms of international authority are established for the overall purpose of preventing anarchy through achieving global common goods and individual rights; this justifies states and non-states actors' actions to fulfil their international duties even when that may compromise their own interests (p. 8); the second layer encompasses a set of international and transnational institutions that "exercise a form of authority" in different spheres (p. 8). According to Zürn (2018), many inter-and transnational institutions are in the form of "epistemic authorities". Sovereign states delegate the competence to these institutions to gather and interpret information and are expected to follow the guidance and recommendations given by the institutions (p. 9); The third layer of global governance is the interactions between different state and non-state actors like inter-and transnational authorities. These interactions make up "the most important systematic features of global governance" (p.10), yet highlight the many systematic shortcomings and legitimation problems challenging the existing global governance arrangements (p.10). Building on this analytical framework of global governance, the article will evaluate the existing global public health governance system. The post-war global health governance is essentially dominated by a monopolist governance structure centred around WHO. Firstly, the core of such a global public health governance system is formed by a set of multi-level normative principles constituting a range of international soft and hard laws. The first level of the principles is defined in the Constitution as the primary law of global public health. The Constitution sets out the basic principles, duties, organisational structure, legislative power, budget and expenditures of WHO. It also defines the rights and obligations of Member States as well as WHO's relations with other organisations. The second level is constituted by the secondary laws, and among which, the IHR is the only international agreement on public health events recognised and accepted by nearly all Member States. It defines the roles and responsibilities of WHO and Member States as well as sets out procedural requirements for all parties to work together. The IHR is consequently the most significant international law for safeguarding global public health security. The third level is constituted by Resolutions, Guidance, Advice and Standards issued by the WHO, covering a range of topics including disease controls, medications and environmental health standards.

The WHO moreover operates and serves as the global public health governance authority. By integrating three major pre-WWII public health institutions, it is the only public health governance authority, forming the monopolist power structure of today's global health governance. According to the Constitution, WHO has legislative power in public health in forms of Treaties, Agreements and Regulations. The Director-General of WHO as stated in the IHR (2005) "shall make every effort" to settle a dispute.

Lastly, the global public health governance is characterised by a range of interactions among institutions and authorities. Formed around WHO as its core, the global health governance system is essentially dominated by sovereign states and supported by non-official actors such as NGOs and private foundations. The WHO collaborates with Member States through its six regional offices and 149 stations worldwide, providing necessary preventive measures, treatments, and health services

and advice.[1] The WHO's collaborations with non-official actors are only formally recognised and established through three procedures, that are setting up informal contacts, gaining permission and eventually being accepted to establish a formal relation with WHO.[2] Only through these procedures, non-states actors are given certain rights and responsibilities to legitimately work with the WHO.

1.2. The Shortcomings of the Monopolist Global Public Health Governance Structure Before 2005

Global public health security was significantly enhanced by the post-war public health governance, its structure had yet many underlying limitations. While the core of global public health governance was formed by a set of multilayer normative principles, each layer had failed to evolve and develop with the change of time. Firstly, as the primary law, the Constitution enabled the right to health as one of the basic constitutional rights. However safeguarding people's right to health was often in conflict with international free trade and with other basic human rights, including the rights to privacy and freedom of expression. This was particularly prevailing in face of disruptive public health emergencies. As the supreme law, the Constitution did not clarify ways to balance these rights in handling the emergencies. The second layer of the normative principles was made of several outdated secondary laws. Among all, the IHR (1969) had long been considered as "outdated, narrow, and ineffective" (Gong et al., 2011, p. 34). This was partially because the Regulations only focused on three traditional contagious diseases, namely cholera, plague and yellow fever. It failed to consider the potential danger of emerging or recurrent diseases spreading cross borders. The third layer was consisted of a set of soft laws, including Decisions, Advise, Guidance and Standards issued by WHO to guide the coordination of global public health affairs. The non-binding nature of these soft laws, however, allowed Member States to escape from their fulfilling duties and responsibilities, resulting in an ineffective global public health legal framework.

Secondly, as the sole global public health authority, WHO had but rarely exercised its legislative power as stated in the Constitution. The Organisation was disengaged in handling public health affairs that concern human rights and key global issues. Furthermore, although article 93 in IHR (1969) set out procedures for conflict resolutions, it did not legitimise the enforcement power of WHO's Director-General and its decision-making body to resolve these conflicts. Suspending the Member State's voting privileges and services it is entitled was the only measure WHO could take to punish a Member State failing to fulfil its financial obligations to the Organisation.[3] The Annual World Health Assembly possessed the authority to adopt

[1] WHO, *Cooperation with countries,* available at: https://www.who.int/country-cooperation/en/ (accessed 2 May 2020)

[2] WHO, *Criteria and principles for secondments from nongovernmental organizations, philanthropic foundations and academic institutions (*WHO, April 2020), available at: https://www.who.int/about/collaborations-and-partnerships/who-s-engagement-with-non-state-actors (accessed April 2020)

[3] Constitution of the World Health Organisation (adopted 22 July 1946, entered into force 7 April 1948) 14 UNTS 185. Chapter III, Article 7 p.189

health-related technical regulations and standards, but yet addressing the potentially conflicting demands for disease containment and commercial free trade principles.[4] Without a strong enforcement power to mediate and settle disputes, WHO's authority was severely challenged.

Thirdly, one of the main features of the global governance system is constituted by the interactions among institutions. According to Habermas, only when such interactions form a power cycle, can the stability of existing global health governance structure be sustained. Unfortunately, within the global public health governance system, WHO had multiple difficulties interacting with its Member States, particularly when handling public health emergencies. For instance, concerned with being imposed unfounded travel and trade restrictions by other countries, many Member States hesitated to report outbreaks to the WHO. Heavily dependent on official reporting from its Member States, WHO was unable to obtain timely information regarding potential public health emergencies and failed to efficiently set up procedures to contain diseases from spreading internationally.

Lastly, legitimised participation of multilateral actors in the governance system was largely restrained. WHO and Member States formed a relatively exclusive governance system that limited the legitimacy of other global actors participating in the decision-making process. One of the main theses of the normative principles is to legitimise multilateral actors' involvement in global health governance. However, legitimate participation of non-official bodies like NGOs and multinational corporations in the decision-making process of global health governance remained rather rare. Before being officially recognised as WHO's partners, non-official actors must have had a minimum two-year established working relation with the WHO, meanwhile implementing a three-year working plan with the WHO's technical department.[5] However, few non-governmental actors were able to achieve such formal working relations with WHO, and most were neither able to participate in WHO-hosted conferences nor access the Organisation's official documentations. Although many non-governmental actors contributed greatly to WHO's projects, they were disqualified from further entering the key decision-making stage ultimately dominated by Member States and a selective few non-governmental actor (Grigorescu,2020, p. 98-99).

1.3 The Challenges of Public Health Emergencies to Global Public Health Governance and its Response

In the 21st Century, major international health crisis like SARS, HIN1, Ebola, and COVID-19 pushed for reforms of the global public health governance system. In response to SARS 2003, the post-war health governance structure revealed its major underlying problems, and the IHR (1969) were insufficient in leading the global combat against emerging public health crisis. The amendments of IHR in 2005 led to reforms in global public health governance

[4] Ibid., See Chapter IV, Article 21 p192-193

[5] WHO, *Criteria and principles for secondments from nongovernmental organizations, philanthropic foundations and academic institutions,* available at: https://www.who.int/about/collaborations-and-partnerships/who-s-engagement-with-non-state-actors (accessed 30 March 2020)

addressing public emergencies. Despite improvements brought by these reforms, the recent Ebola and COVID-19 crisis further exposed the fragility and underdevelopment of the current public health governance in handling global health events.

An effective public health governance system is constituted of key factors including a set of multi-layered normative principles, governing authorities, and interactions among the institutions (Zürn 2018). In the following section, the article will engage with these key factors to explore the challenges brought by major global health emergencies to the existing public health governance, pressuring for its reconstruction.

2. The Multi-layered Normative Principles of Global Health Governance

Globalisation has led to an increasing demand for interdependent norms, principles, and regulations for cross-border interactions (Zürn, 2018). A set of widely acknowledged and up-to-date normative principles are at the core of an effective governance system. Following the SARS outbreak in 2003, IHR reformed its vague regulations and introduced "Public Health emergency of International Concerns" (PHEIC). On this basis, the IHR (2005) developed a set of international soft law and enhanced its multi-layered normative principle in solving acute public health risks. Despite the improvements brought by the reforms, the increasingly threatening public health crisis in recent years continues to challenge the IHR as the core normative principles of goal health governance as well as its ability in solving global crisis.

2.1 Reforming the IHR in 2005

The overall purpose of IHR remains 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, and which avoid unnecessary interference with international traffic and trade".[6] On this basis, the IHR (2005) have made several reforms. Firstly, the IHR (2005) aim to enhance its implementation effectiveness, through reforming its focus on infectious diseases and its vague theoretical narratives on measures to be taken by Member States and the WHO in handling an infectious disease. The term "International Infectious Diseases of International Concerns" was moreover contested and tabooed by Member States where outbreaks originated. To address the issue, a concept named Public Health Emergencies of International Concerns (PHEIC) was introduced in the IHR (2005). A PHEIC is defined as "an extraordinary event … to constitute a public health risk to other States through the international spread of disease; and to potentially require a coordinated international response".[7] The focus of PHEIC on public health emergencies in need of global attention and action does not imply political, trade and socio-economic consequences feared by Member States, which ultimately enhances the implementation effectiveness of the IHR.

Secondly, the IHR (2005) define the roles and responsibilities of WHO, Member States, and relevant participatory bodies in handling a PHEIC, detailing measures of

[6] IHR, supra note 8 at Article 2.

[7] Ibid., Article 1.

monitoring, information sharing, alerts issuance, and response. Each Member State establishes an IHR National Focal Point (NFP) and WHO sets up an internal IHR Contact Point. The NFP network and WHO's IHR Contact Point maintain close interactions: all NFP centres are accessible for IHR-related communications with WHO and relevant sectors, and should report truthfully to the WHO regarding any potential PHEIC. Furthermore, to reduce all potential global public health risks, IHR (2005) extend the NFPs' monitoring areas, covering both existing and newly discovered diseases, as well as emergencies caused by non-infectious diseases.

Thirdly, the IHR (2005) appoint WHO as the sole authority in determining a PHEIC with a set of strict standards and procedures. Only the Director-General has the right to establish and chair an IHR Emergency Committee, making the final determination of a PHEIC and delivering Temporary Recommendations to address the situation.[8] The decisions are made based on "advice from the Emergency Committee, information provided by the State Parties, scientific experts, and an assessment of risks to human health, risk of international spread of disease and of risk of interference with international travel".[9] In efforts to further strengthening WHO's role as a public health authority, the Regulations state that after receiving information for a potential PHEIC, WHO as an impartial organisation with advanced technical resources and knowledge, can establish an extensive network to evaluate information, provide guidance for actions and measures, and give necessary technical supports following the development of the events.

Fourthly, the IHR (2005) reconstruct the monopolist power structure by providing more opportunities for non-official actors to legitimately participate in the public health governing process. Being able obtain information from informal sources to evaluate and determine a PHEIC, WHO has become less dependent on formal reports from Member States and to a certain extent improved its long-term bureaucratic working structure.[10] Moreover, representatives of non-official actors with formal working relations with the WHO are allowed to attend meetings and conferences hosted by the Emergency Committee, delivering memos, making speeches, or providing relevant information to the Director-General on the long-term constructive proposals initiated by the WHO's Review Committee.

Lastly, the IHR (2005) enhance the stability of global public health governance by considering the public health capabilities of Member States into the decision-making process. For instance, for the first time ever the global emergency response system evaluates Member States' public health resources and their governing capabilities in monitoring and responding to public health events as key factors, and incorporates these factors into the decision-making process. The comprehensive evaluation consequently strengthens the overall stability of the governance structure.

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[8] Ibid., Article 12.

[9] WHO, *International Health Regulations and Emergency Committees* (June 2016), available at: http://origin.who.int/features/qa/emergency-committees/en/ (accessed May 2020)

[10] IHR, supra note 8. Article 9.1: "WHO may take into account reports from sources other than notifications or consultations and shall assess these reports according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring."

2.2 The Ineffective Implementation of the Global Health Emergency Response Measures

Based on the IHR (2005), WHO establishes a set of international soft laws including guidelines for prevention, controlling, and response to prevent outbreaks from spreading internationally. The guidelines comprise the Health Emergency and Disaster Risk Management, the Sendai Framework for Disaster Risk Reduction 2015-2030, and WHO's Health Emergencies Programme. They aim to reduce disaster risks and prevent loss of life, livelihood and health (WHO, 2019a), to define a framework for Member States' strategic response and responsibilities, and eventually to introduce ways for global communities and institutions to join efforts.[11]

Following the H1N1 crisis, WHO's Executive Board further reforms the IHR by establishing an IHR Review Committee to conduct independent evaluations and give feedback to the operational process of the Regulations. In May 2011, the Committee examined WHO's work in handling H1N1 and its implementation of the IHR (2005). It concludes that despite the efforts of the Regulations in strengthening the prevention and global response to public health emergencies, the international community is still ill equipped for combating similar or more severe PHEICs in the future.[12] This conclusion projects the underprepared global community in face of COVID-19.

Following such a notion, the underlying issues faced by the existing global governance structure are not essentially caused by the lack of rules and regulations, but rather by their implementation effectiveness. Many public health emergencies in the 21st century reveal the weak enforcement of the IHR as the biggest challenge to public health governance. Without sufficient enforcement mechanisms, the IHR have never fully managed to compel its 196 Member States to comply with the rules. Relying mostly on peer pressure and public recognition to isolate or damage the international image of a country, the WHO does not have legitimate law enforcement power to punish Member States that fail to act in accordance with the Regulations. The non-binding international soft law nature has consequently turned the IHR into "a tiger with no teeth", leaving the global community fragile in face of COVID-19.

Overall, despite the reforms brought by the IHR (2005) in reconstructing the global public health system with a focus on combating PHEIC, the non-binding nature of the Regulations fall short in face of the ever more severe and threatening public health crisis.

3. WHO as a Global Public Health Authority

Managing a public health emergency demands efforts from a united global force under an effective leadership. According to Zürn, "inter-and transnational authority comes not only in the form of political authority … but most frequently in the form

[11] The Sendai Framework for Disaster Risk Reduction 2015-2030 (adopted 18 March 2015), UNISDR/GE/2015

[12] WHO, *Strengthening Response to Pandemics and Other Public-Health Emergencies - Report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza (H1N1) 2009* (WHO 2009), available at: https://www.who.int/publications/i/item/strengthening-response-to-pandemics-and-other-public-health-emergencies (accessed March 2020)

of epistemic authorities …" (Zürn, 2018, p.8). In face of the different levels and kinds of challenges brought by major public health emergency outbreaks throughout the 21st century, the global community has expected WHO as an epistemic authority to play a vital role in all stages of handling a public health emergency, providing its advanced technical support and resources to predict, constrain, monitor and resolve the emergency, and eventually helping the society recover from the crisis; the global community further expects WHO as an international authority to safeguard people's rights to health without undermining other human rights and free trade. Unfortunately, in times of crisis, WHO fails to exhibit as a forceful epistemic authority, leaving the crisis management process to nations' "self-help" strategies. Constrained by its bureaucratic governance, limited legislative capacity, and inadequate coordinative power, WHO ultimately fails to act as an effective global public health authority.

3.1 WHO's Bureaucratic Structure

Following the long-term freeze on WHO's regular budget in the 1980s and a wave of criticism towards the Organisation's low efficiency in the 1990s, WHO had gradually lost its central position and influence over global public health governance in the late 20th Century. The health emergencies disrupted in the 21st century, however, compelled the WHO to rebuild and strengthen its role as a global authority in managing health events through providing technological support and public health resources. Following the outbreaks of SARS and Ebola, WHO established a wide range of expert communication networks to evaluate information and give advice. This has enabled the Organisation to give timely and adequate coordinative and technical support to manage a health crisis, and further enhanced its ability in handling public health emergencies. WHO has also acted swiftly in determining and alerting COVID-19 as a global emergency, sharing relevant information with the public and gathering scientists, sponsors, and medical providers to develop testing methods, vaccines, and medicines.

Nonetheless, despite WHO's efforts in rebuilding its role as an independent and professional public health authority, the Organisation's work has been largely undermined by its long-lasting bureaucratic structure. Due to its non-transparent and inefficient bureaucracy, WHO has had limited success in implementing the IHR (2005) to restructure and reform global public health governance. When Ebola was once considered the "emergency within emergency",[13] WHO was heavily criticised for its inefficient management and slow response to the crisis. The Emergency Committee had recognised the high risk of Ebola spreading regionally and its complexity and danger,[14] but only managed to determine Ebola as a PHEIC nine months later. Such a delay led to a widespread scepticism towards the transparency of the Committee's decision-making process (Eccleston-Turner & Kamradt-Scott, 2019) as well as towards

[13] WHO, *What this-the largest Ebola outbreak in history-tells the world*, (WHO May 2020), available at: https://www.who.int/csr/disease/ebola/ebola-6-months/lessons/en/ (accessed 25 May 2020)

[14] WHO, *IHR Emergency Committee on Ebola in the Democratic Republic of the Congo*, (WHO, 18 October 2019), available at: https://www.who.int/dg/speeches/detail/ihr-emergency-committee-on-ebola-in-the-democratic-republic-of-the-congo (accessed March 2020)

the list of selected Committee members published only after Ebola was determined as a PHEIC.[15] Many further question the Committee's unusual long working lengths. Following a range of revisions by the WHO Ebola Interim Assessment Panel, the conclusion indicates that organisational bureaucracy, information communication, and internal decision-making modules were among the main reasons contributing to the delay of its actions against Ebola (Ottersen et al., 2016).

3.2 WHO's Incapability in Balancing between Health Right, Human Rights and Economic Trade

The right to health was established as one of the basic rights when the Constitution was drafted (Sohn, 2012). Since then, the right to health remains a core value for global public health governance, but severely undermined under public health crisis. Measures to contain virus and safeguard people's right to health often come at a cost of slowing economic activities and limiting people's freedom of movement. Sometimes the measures could even imply to completely halt economic activities and breach other basic constitutional rights. When an outbreak happens in one country, Member States often overreact and take severe measures against this country, by imposing large-scale trade restrictions, installing excessive quarantine procedures, and using virus containment plans as an excuse for establishing inappropriate and unfair trade policies. The restrictions and policies installed during times of public health emergencies often lead to severe economic impact for countries and even the entire international community.

This means that public health emergencies impose risks to not only public health but also global travel and trade, violating the rights to privacy, freedom of movement, and other constitutional rights. One of the main mandates for global public health governance therefore is to protect people's right to health without harming global trade, economic development, and other constitutional rights. The IHR (2005) have given power to WHO and its Director-General to take on the task following the outbreak of SARS in 2003. The Regulations stipulate that when measures of isolation or quarantine limit personal freedom necessary to take place, States "shall treat travellers with respect for their dignity, human rights, and fundamental freedoms, and minimise any discomfort or distress associated with such measures",[16] and the fee of these measures should be charged according to relevant regulations. The IHR also state that countries implementing restrictions must inform WHO of the context, reasons, and evidence of restrictive measures within 48 hours, and prove that economic restrictions are reasonable.[17] Based on the actual situation, WHO and its Director-General evaluate the restrictive measures and their impact on international transportation, trade, and personal freedom, before determining these measures as reasonable to achieve an appropriate degree of health protection. On this basis, WHO and its Director announce

[15] M.C. Hardiman and World Health Organization Department of Global Capacities, Alert and Response, *World health organization perspective on implementation of International Health Regulations.* 18(7), Emerging infectious diseases (2012)

[16] IHR, supra note 8 at Article 32

[17] IHR, supra note 8 at Article 43

short- or long-term recommendations for travel and trade restrictions.[18]

In practice, however, the mediation power and rights given to the WHO and its Director-General are like a tiger's "fake teeth" in handling major public emergencies after SARS. During the outbreak of H1N1, many Member States had taken measures against international trades and none reported to WHO justifying their actions as demanded by the Regulations. Similarly, during the Ebola outbreak, more than 40 countries had taken measures resulting in disrupted international trades and traffic, and only a few reported to the WHO (Ottersen et al., 2016). In face of a potential global outbreak of COVID-19, WHO issued multiple alerts to Member States that restricting global movements is ineffective to contain the spread of the virus. Many countries around the world regardless issued travel and trade restrictions, without reporting and justifying their measures to WHO within the required 48 hours. With regrets, the WHO's Director-General concluded that "one of the biggest challenges the globe faces in combating the global epidemic is that too many countries affected by the disease failed to share data with the WHO" (Gebrekidan, 2020).

Measures such as imposing trade and transportation restrictions are often considered as a state's sovereign rights. Member States are unwilling to give up or transfer these rights to an international public health institution for collective actions. This ultimately limits the abilities of WHO Director-General and relevant bodies in effectively mediating disputes and conflicting interests. With the authority of WHO under attack, issues such as nationalism and diplomatic crisis begin to emerge as Member States take up their own response measures, leading to chaos in global public health governance.

3.3 WHO's Power Vacuum in Combating Global Health Emergencies

The UN Secretary-General Antonio Guterres declares that, "[COVID-19] is … a human crisis that calls for solidarity… Current responses at the country level will not address the global scale and complexity of the crisis".[19] The G20 also expresses that the damages of this pandemic can only be resolved through global cooperation.[20] With the increasing globalisation of public health management, traditional biomedical terminologies like hygiene and health have evolved into concepts concerning human rights, justice, gender, sustainable development, education, agriculture, and trades. WHO as the sole global public health authority is however in a state of power vacuum, failing to fulfil its responsibility in handling the unprecedented socio-economic complexities and consequences brought by a public health crisis like COVID-19. In other words, the existing WHO-oriented monopolist power structure of the global health system is in need of reconstruction to meet the global demands for a forceful

[18] Ibid.

[19] A. Guterres, *Secretary-General's opening remarks at virtual press encounter on COVID-19 Crisis*, (United Nations Secretary-General, 19 March 2020), available at: https://www.un.org/sg/en/content/sg/speeches/2020-03-19/remarks-virtual-press-encounter-covid-19-crisis (accessed March 2020)

[20] UN News, *G-20 Summit Provides Chance to Rally Strongly Against Coronavirus Threat: UN Chief*, (UN News, 20 March 2020), available at: https://news.un.org/en/story/2020/03/1060142, (accessed March 2020)

authority and procedures to mediate among Member States and global institutions in handling public health crisis.

4. The Interactions among Multilateral Institutions in Global Public Health Governance

One of the main compositions of global governance is the interactions among all institutions, including various global authorities and international regulation bodies (Zürn, 2018). Modern public health governance is essentially dominated by sovereign countries with support from intergovernmental organisations, multinational corporations, and other non-governmental actors. The overall governance structure is characterised by a high degree of exclusiveness with limited interactions among institutions. The disruptive public health crisis in recent years has to some extent forced open the system, by taking into considerations of the governing capabilities of Member States as one key factor in the decision-making process, and by giving non-governmental actors more opportunities to collaborate with WHO on a limited scale. As a double-edged sword, the sovereign-states-dominated global governance structure unfortunately does overall more harm than good to public health governance, continuously restricting non-state forces from joining the key decision-making process.

4.1 The Sovereign-State-Dominated Global Governance that does More Harm than Good

Sovereign states are a double-edged sword to the global governance system. On the one hand, sovereign states and especially the most powerful ones play an important role in global governance, promoting international collaborations and reaching agreements. On the other hand, states driven by self-interests are often in disputes with one another, which often jeopardises the global governance stability. Within the global public health system, for instance, sovereign states consented to the amendments of the IHR and the set of normative principles in global public health. But in face of emergencies, sovereign states prefer to act in their own interests, doing consequently more harm than good to overall health governance.

The IHR (2005) for instance define a range of detailed duties and responsibilities for WHO and Member States to handle a PHEIC at different stages. During major public health crisis, Member States are supposed to report the outbreak to the WHO; but "political incentives or fear of economic disruption means timely reporting does not always occur" (Jha, 2020). When a PHEIC concerns states' sovereignty, WHO is caught in the power struggles among Member States and unable to take forceful financial or legal actions to compel these states to fulfil their obligations (Ao & Sun, 2019, p. 150-160). As a result, although regional or local WHO offices can detect a government's non-transparent or failed actions in handling a health crisis, WHO has limited power in questioning the government and can hardly influence its public health policies (Kickbusch at al., 2020, p. 1336). The Organisation's public health governing ability is severely challenged by such limitations.

4.2 A Forest without Trees: The Global Health Governance on its Own

Prior to SARS, the global public health governance system did not take into consideration individual Member States' public health governance capacities, making the system "a forest without trees". After SARS, Member States' public health governance capacities were incorporated in the IHR (2005) and in the global health governance system as an important factor in the decision-making process. But due to the drastic fall in social expenditures on housing, health care, and education, national public health is often the least prioritised and most underfunded compared to a country's overall socio-economic development (Galway et al., 2012, p. 38). The global financial crisis in 2008 has led to the further reduction of governments' funding to public health, following a series of economic reforms and privatisation. Many researches indicate the disastrous impacts of these reforms on national public health, hitting particularly hard on the world's poorest (Ottersen, 2014, p. 630-667). The consequences of the weakened public health capacities among Member States leads to overall ineffectiveness of global public health governance in safeguarding people's right to health and protecting people from health emergencies.

4.3 The Limited Opportunities of NGOs, Foundations and Corporations

According to Habermas (1989), discourse creates a right of socialisation that depends on mutual recognition. Although such socialisation cannot replace bureaucracy in a system, they can indirectly insert pressure over the decision-making process. In global health governance, non-governmental forces such as NGOs, private foundations, and corporations act as a form of power to indirectly influence the global public health governing structure.

Research indicates that the power of global governance has been gradually taken over by non-sovereign governing bodies (Sending & Neumann, 2006, p. 651-672). This also applies to global public health governance, where non-governmental actors had rarely been legitimised to take part in. However, since the 1990s, non-governmental actors have gradually obtained their recognition, inserting influences over the WHO and the UN mainly through communication and information. This means that the more professional knowledge and information a non -governmental actor provides, the better chances the organisation can interact with policy makers and further influence the political outcome. In other words, the ability to obtain information has given some non-governmental actors a certain degree of influence.

When handling a public health emergency, NGOs and other non-governmental forces have created an even more powerful "siege" over the global health governance system. As Habermas (2003) writes, most operations in political systems are routine based. In incidents of conflicts, these routines will be trumped by another mode of operation. The non-governmental forces in times of public health emergencies, not only play a role as "risk capitals" in influencing the financing and implementation of international health programmes, but also challenge the monopolist global health governance through their strong multinational networks, resources, professional knowledge, and capacities to mobilise public opinion. Despite the increasing

influences of non-governmental actors, however, the legal procedures for these organisations to work with the WHO remain "non-official". During COVID-19, for instance, the foundation WHO established with non-governmental actors is rather an act of expediency than an effort to establish a formal institutionalised legal procedure for working with non-governmental actors.

4.4 The Isolated UN Entities in Face of a Global Crisis

The spread of COVID-19 has highlighted the limitations of modern global governance structure. According to Zürn (2018, p. 10), contemporary global governance is primarily constructed by functional systems that are sector-based: intergovernmental and multinational institutions are established based on specific areas and responsibilities, with limited dispute settlement mechanisms among each other. This consequently leads to the question of governing legitimacy when facing a global crisis.

Global public health governance also faces the same challenges. Prior to the IHR (2005), WHO was not legitimised to work with other UN bodies or intergovernmental organisations. After SARS 2003, the IHR (2005) incorporate provisions promoting cooperation among international organisations and creating legal channels for WHO to collaborate with other international entities.

Despite this effort, WHO and other UN bodies remain rather separated governing entities. This has become particularly obvious when all organisations needed to work together in face of a global public health crisis. During the early stage of COVID-19, different UN bodies including the International Monetary Fund (IMF) made statements and proposed solutions focusing on their own areas of concern, such as economy, agriculture, and labour, without addressing the pandemic as the root cause of all problems (Gostin, 2014, p. 134). With the growing impact of COVID-19 to global economy and society, UN entities gradually recognised the importance of collaborating with each other and issued rare joint statements. These collaborations however hardly depict the reality of overall global governance, where each international organisation focuses on the importance of its own area of work; and often the more powerful and resourceful ones would gain an upper hand in influencing the governing outcome. For instance, at a joint press conference with the WHO, IMF as a more resourceful organisation underlined the ultimate importance of saving livelihoods, despite WHO's emphasis on saving lives.[21]

5. A Rethinking on Global Public Health Governance Structure

Never in modern history has a public health crisis like COVID-19 brought as severe consequences on such a global scale. The pandemic urges us to rethink on the present-day global health governance, in order to gather and align full forces among Member States and UN bodies when handling the next potential crisis. To achieve this, the

[21] K. Georgieva, *Remarks by IMF Managing Director Kristalina Georgieva to G20 on Economic Impact of COVID-19,* (International Monetary Fund, 22 February 2020), available at: https://www.imf.org/en/News/Articles/2020/02/22/pr2061-remarks-by-kristalina-georgieva-to-g20-on-economic-impact-of-covid-19 (accessed March 2020)

WHO's monopolist power system should be reformed into a multilateral co-governance structure, and on which basis to improve the multilevel health emergency normative principles. A new international convention, namely the *Convention on Global Public Health Emergency Response* should be in place to reform global emergency measures and to strengthen WHO's enforcement power under the new structure. The WHO should further strengthen its role as an independent and professional global public health authority, leading the combat against global health crisis. Other actors such as NGOs and corporations should be allowed into the global public health governance given legitimacy and institutional power to a larger extent.

5.1 Global Public Health Emergency Measures and the Reconstruction of Global Public Emergency Response

Habermas (2003, p.442) points out that when a crisis occurs, people often first think of legal mediations, which entails a process of from emerging crisis awareness to growing public concern and eventually to searching for solutions. In other words, when a problem emerges … the public opinion pressures for an alternative way of problem solving, which is often likely to orient on legal mediations within the power cycles. When handling COVID-19, the IHR (2005) as legal measures in preventing and combating public health emergencies are not only weak in its enforcement mechanisms, but also too limited to take the lead in handling a public health emergency on such a global scale. While countries around the world declare and take measures against COVID-19 as a national emergency, the unprecedented public health crisis is also in need of an alternative overarching global solution. Therefore, as the world continues to reflect on lessons learnt from COVID-19, the *Convention on Global Public Health Emergency Response* with clearly defined regulations and collective responsibilities should be imminently established and adopted to protect the global community.

The primary goal of the *Convention on Global Public Health Emergency Response* as an alternative solution is to build an integrated platform for handling global public health emergencies. There has never been a common global health dialogue platform among International Organisations, sovereign states, and non-governmental actors (Gostin, 2014, p. 117); the UN and other multilateral organisations are inherently unprepared to respond to many interconnected challenges. As a result, the primary task for the *Convention on Global Public Health Emergency Response* is to build a platform for dialogues, which also serves as the basis for coordinated mediation measures. This will ultimately help resolve the governing chaos among UN bodies focusing only on their own areas of concerns. The WHO and other UN entities can further form alliances that will integrate all essential health equipment and public and private health resources to respond to the crisis, and eventually promote an aligned and unified global health governing body in action. Furthermore, in face of an international health crisis, especially when protecting the right to health conflicts with economic trades, WHO should overcome its usual submissiveness when working with "stronger" organisations like the WTO and IMF. Instead it should take a lead in enforcing measures handling global crisis caused by disruptive public health emergencies.

The secondary aim of the *Convention on Global Public Health Emergency Response* is to enhance the democratic representative system and accountability mechanism, which serves as a basis for reforming and strengthening the ability of the UN in handling large-scale global crisis. The UN Security Council (UNSC) is the only executive body with means of military intervention and economic sanctions in compelling states to comply with UN measures. The UNSC can take the most direct and important measures in declaring a health crisis as a threat to global peace and security. During the Ebola outbreak, the UNSC issued an alert with international legal effects. When facing a more severe global outbreak like COVID-19, UNSC should take further steps, authorising representatives from international organisations in forming a global emergency committee led by the WHO in coordinating necessary resources to respond to the emergency.

The third aim of the *Convention on Global Public Health Emergency Response i*s to provide a public health fundraising framework based on realising people's right to health. Member States are obliged to fulfil their international responsibilities in ensuring sustainable financing for global public health. Under such a framework, Member States should follow a Quota Subscription scheme to contribute to funds for global health affairs and in situations of responding to public health emergencies.

5.2 Reconstructing WHO as the Global Public Health Authority

During COVID-19, WHO as a global public health authority has faced unprecedented challenges to its professional ability in testing, issuing alerts, gathering information, and setting global standards. A core proposition for the future of global public health governance is to strengthen WHO's role as a professional and independent global health authority, through diminishing its bureaucratic nature to prevent influences from powerful sovereign states and to ultimately strengthen its independence and professionalism free from political interference.

Firstly, the WHO should enhance its data, technical support, and financing to strengthen its professionalism and independence. Data wise, the Organisation's work is often constrained by relying on sovereign states' reporting on an outbreak, which is often manipulated, delayed, or not reported at all. This to a certain extent limits the reliability of the data in depicting the reality and prevents WHO from issuing timely and credible alerts. During COVID-19, data provided from John Hopkins University was considered more trustworthy and widely shared than from the WHO. As a result, in response to a public health crisis, the WHO should work with various data providers to enhance the reliability and credibility of its statistics. The WHO should further set virus testing and detecting standards to systematically assist countries in improving their technical capacities. And lastly, the WHO should be able to provide financial support when a Member State experiences financing difficulties in response to a public health emergency.

Secondly, while WHO should enhance the transparency of its Emergency Committee's work in handling a public health emergency, a permanent Emergency Committee should be in place instead of its current temporary setup. Introducing a middle category between PHEIC and non-PHEIC can further help define a clearer coordination and escalation mechanism (Ottersen et al., 2016, p. 356-392).

Thirdly, the WHO should promote better interactions with its Member States to strengthen its mediation and enforcement ability in dispute settlement. Jha proposes the public health system to learn from the global financial sector that also engages with epidemiological terms such as "contagion or surveillance" (Jha, 2020). For example, the WHO can do as the IMF to establish a testing mechanism that uses the IHR to test if countries can give comprehensive, timely and transparent reporting related to an outbreak. Jha further proposes that the WHO can establish a system that provides an "epidemic insurance" to countries with open and comprehensive health data systems, in order to encourage truthful reporting to the WHO.[22]

Lastly, the WHO should upgrade its many "international soft laws" that have no legal binding power to "international hard laws". This will establish a strong enforcement mechanism in compelling its 196 member states to follow rules and regulations. When a Member State fails to comply, the WHO should not solely rely on "peer pressure" and "public recognition" to isolate the country or damage its international image. It should further emulate the WTO in establishing a strong and powerful Dispute Settlement Body, to reinforce its leadership in implementing case rulings concerning disputes between the right to health, economic trades, and other human rights.

5.3 Strengthening the Interactions within Global Public Health Governance

Zürn (2018, p. 6) argues that global governance should allow more legitimate participation of multinational corporations and institutions. Giving more legitimacy and easing the conditions for non-governmental actors to establish official working relations with the WHO will enable more actors to participate in the final decision making phase of global health governance (Gostin, 2014, p. 134). This will further allow the IHR to be better integrated with other emergency and humanitarian response frameworks and will ultimately widen financing means to WHO's core functions. Moreover, multinational corporations have benefited tremendously from globalisation. In return, these corporations should be taking up more humanitarian and social responsibilities to assist the WHO in tackling global challenges and contributing to enhancing global public health governance. Many NGOs and grassroots organisations can also help implement solutions to global health issues. Organisations, such as the Global Health Workforce Alliance, Vaccine Alliance, and Global Fund, are able to give community feedback and their implementation experiences to the governance system, which will potentially improve the overall implementation effectiveness of global public health governance. On the other hand, WHO should address public concerns towards the accountability of NGOs and quality of their work, through reforming its monitoring procedures towards both local and international NGOs. This will enable the Organisation's systematic evaluation and understanding of NGOs' impact. Among many large international institutions, the Global Fund established in 2002 has been one of the main donor institutions for NGOs. WHO can establish a comprehensive data base by monitoring the Global Fund's work and activities with NGOs worldwide (Galway, et al., 2012, p. 38).

[22] Ibid.

Conclusions

The current global health governance is characterised by the WHO-centred and sovereign states dominated monopolist power structure. One of the underlying issues of such a governance model has resulted in the unequal distribution of public health resources worldwide, profiting richer individuals and societies while leaving only 10% of public health research funds to resolve 90% of global diseases (Delisle, 2005, p. 3). The underlying cause is the unequal distribution of global power. Within the unequal system, global public health governance is under pressure to obtain adequate financial, technical and political support and resources, and unable to establish fair public health policies and to close the global health inequality gap (Kentikelenis & Rochford, 2019, p.70). The series of public health crisis in the 21st century has further worsened such inequalities; COVID-19 as an unprecedented public health crisis has led to chaos in global public health governance, and sent an alarming signal to the world that any seemingly insignificant public health events in one country can evolve into a global crisis deeply affecting our socio-economic life.

Firstly, it is important to strengthen the ability of the UN and other multilateral organisations in responding to global crisis, and to establish an overall multilateral global governance structure that promotes unified global health actions. This will provide opportunities to reform the existing global health governance structure characterised by self-interest-driven sovereign states and separated UN entities, and ultimately enhance global health protection.

Secondly, establishing sufficient legal reserves and enhancing multilevel normative principles are at the core of unifying global public health governance efforts. Therefore, a new international instrument, namely the *Convention on Global Public Health Emergency Response*, should be in place to protect human health in crisis and to provide as a foundation for global collaborations. When restructuring global public health emergency measures, the world needs a set of clear procedures strong and a forceful multilateral authority to mediate demands between health and economy and trade in face of a global crisis. WHO as the global health authority should establish and work towards the common goal of safeguarding public health without interference from sovereign states' political interests. And on this basis, the WHO can establish a strong dispute settlement mechanism and strengthen its authority in global health governance.

Lastly, the article argued that more multilateral actors should be allowed in the global health governance. With an enhanced evaluation and monitoring system for non-official actors and NGOs, an open and legitimised process enabling these actors in the health governance structure can help realise a true global governance.

Acknowledgement

This research is funded by the General Project of Art of the National Social Science Foundation of China, "Comparative Study of Cultural Policy and Law of the World". The grant number is 16BH138.

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