COVID-19 and the WHO's Political Moment

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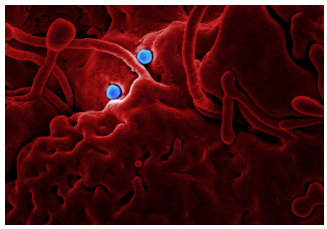
By Samantha Besson June 25, 2020



In its Preamble, the Constitution of the World Health Organization (WHO) states that "[t]he achievement of any State in the promotion and protection of health is *of value to all*. [….] The health of all peoples is […] dependent upon the *fullest co-operation of individuals and States*.". It would be difficult to find better terms to express the principle of solidarity most people are longing for in today's pandemic context, but also the corresponding proposition that health is a common concern and responsibility.

Those principles are not the only features that single out the WHO amidst the United Nations' specialised agencies. At the time of the organisation's creation in 1946, the World Health Assembly (WHA)'s law-making powers, to adopt both binding "regulations" (like the International Health Regulation [IHR]) and "treaties" (like the Framework Convention on Tobacco Control), were unprecedented in the multilateral institutional landscape. Furthermore, the WHO's Constitution was the first international law treaty to guarantee the human right to health and, more generally, the human right to enjoy the benefits of scientific progress.

In short, the organisation was clearly instituted to make a clean break from 19th Century international health diplomacy led by Western powers.

Questioning global health governance

Sadly, none of those principles and international law-making powers have really been put to practice. The WHO's "noble dream" quickly turned into a technocratic "nightmare". The reasons for this are well-known from other multilateral institutional settings, of course. It suffices here to mention two weaknesses of the so-called global (health) "governance" that particularly affect the WHO.

First of all, rule of expertise instead of rule of law. The WHO often favours governance by the recommendations of technoscientific experts (gathered in committees) over the government by international law (adopted by States in the WHA). This does not only affect the transparency and contestability of those decisions, but also more generally their representativeness and ability to be controlled by the peoples they apply to. Second, insufficient and unequal compulsory public funding. Funding by Member States only makes up 20% of the WHO's budget and is compensated by voluntary, mostly earmarked, public and private funding. This has led to undue, but also unequal influence by both public (e.g. rich States like the US) and private (e.g. major US non-governmental organisations [NGOs] or pharmaceutical groups) donors over the WHO's decisions and priorities.

In reaction to some of those weaknesses, the WHO has been the object of regular reform proposals. In fact, every pandemic has brought its own wave of inquiry commissions and reports. It has been the case with SARS and Ebola, and now again with COVID-19. Most of the recent reform proposals, however, repeat previous ones: e.g. increasing the transparency of WHO procedures, bolstering the independence of its organs, securing more public funding and streamlining private donations, and improving compliance with its recommendations.

It is crucial to understand that the current pandemic's specificity lies not only in the scale of the health threat and of its socio-economic consequences, but also in its political dimension. The 1990s and 2000s technocratic era in the international law of institutions seems to have come to an end. It is no longer enough, indeed, to invoke efficacy or even scientific authority to establish legitimacy. In fact, world politics are omnipresent in most of the recent discussions in and also about the WHO, as exemplified by the US-China opposition. Sovereignty has also become a regular concern of States therein lately. What we are facing at last, therefore, could be the WHO's political moment by analogy to what we know of States' "constitutional moments".

Seizing the political moment

Seizing that political moment implies leaving aside the last decades' quick fixes of global health "governance", be it through managerial reforms, indicators or "result-chains". It means aiming at complying, instead, with the requirements of "good government" since those requirements should also apply to health issues, be it on the national or the international plane.

Regrettably, anything "political" has a bad name in multilateral organisations like the WHO where it is equated with power play. The only way to rule power, however, is precisely to bring politics into the WHO and to address that latter's lack of political legitimacy openly. Most of its institutional weaknesses mentioned before are indeed but the symptoms of a deeper deficit in political representation. If we keep addressing each of those issues separately one by one, and through individualised reforms, as we have so far, we cannot hope to solve that problem at its root.

As long as its political legitimacy is not enhanced, the WHO will carry on producing soft law that does not bind States precisely because the authority it claims over them is not, and cannot be, justified. And those States will be right to invoke their sovereignty to fight back politically illegitimate (albeit scientifically, and especially medically correct in many cases) expert rulings. Of course, State sovereignty and the legitimacy of international law do not overlap entirely. However, the only way to disqualify invocations of State sovereignty by governments that do not represent their people is by taking their sovereignty seriously when they do. This is exactly what improving the political legitimacy of the WHO can achieve.

In a nutshell, political legitimacy refers to the questions of who has the right to rule and how such a right to rule should be exerted in order to generate obligations for those subject to such rule. Assuming here that the most plausible standard of political legitimacy is democratic, legitimacy should be assessed by reference to four abstract, and scalar, principles: ultimate effective popular control, political equality, deliberative contestability and human rights protection. The same principles of democratic legitimacy apply to the international law-making system. To the extent that creating a world health parliament and calling for a global election are not available options, we should explore other ways to ensure that peoples can exert ultimate control over international law-making.

Instituting multiple international representation

As José Luis Martí and I have argued elsewhere, international representation is best instituted as multiple. Indeed, none of the current institutions involved in international law-making, whether public (like States, but also intranational institutions, such as cities or regions, and international institutions, like international organisations [IOs]) or private (like NGOs or transnational corporations [TNC]), are sufficiently representative in themselves. They all suffer from democratic deficits of their own in terms of either popular control, equality, deliberative contestability or human rights protection. The only way to compensate for those deficits is to conceive of all those institutions as representing peoples together in a complex international representation system that can secure institutional continuity in the chain of democratic representation.

In turn, what this means for the WHO is that we should aim at revising its institutional system so as to ensure this kind of multiple representation of all peoples bound by its decisions. This implies, of course, making sure, through both domestic and international law means, that its Member States are democratic and that State representatives at the WHO are electorally accountable for their international health agenda to their peoples. We should also ensure, however, that other regional and universal IOs, but also cities, NGOs, TNCs and other institutions of the global civil society are all included, in a decisional (albeit complementary) capacity as opposed to a merely advisory one, within the WHO's institutional framework. Their inclusion can compensate for the many demographic and power imbalances, but also for the entrenchment of permanent minorities and the potentially self-interested vetoes induced by representation by States alone in multilateral settings. Importantly, those other (mostly non-elected) public and private representatives should themselves also comply, internally, with the four principles of democratic legitimacy presented before. The WHO's institutional design should be such, therefore, that all those institutions can compensate for each other's democratic deficits by representing the same peoples together in the organisation's various organs.

Unlike many other IOs currently in need of reform, the WHO is an organisation whose "constitution" already entails many of the principles, but also powers it takes for it to gain in political legitimacy. In many ways, therefore, the new world health "government" awaits to be kissed awake. The question is by whom. As we have come to realise, COVID-19 has the ability to reveal the weaknesses not only of physical bodies, but also of political ones. And it has revealed how much in international politics depends on us: it is not only a right, but a common responsibility of the WHO (States) peoples to constitute our world health government together.

Note: *An abridged version of this piece will be published, in French, in Ota de Leonardis et al. (eds),* Tour du monde du Covid-19*, Paris, Manucius, 2021.*