



# **BROADER, SMARTER, FAIRER**

**A more ambitious agenda for global health**

Andrea Renda, Chiara del Giovane, Clément Perarnaud, Hien Vu

**CEPS IN-DEPTH ANALYSIS**

January, 2023 - 03



# SUMMARY

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During the past few years, the global community has failed to promote better health for all. While the need to step up cooperation was widely acknowledged long before the Covid-19 pandemic, short-term solutions have generally prevailed over longer-term strategies to address global health governance's failures.

This CEPS In-Depth Analysis report takes stock of the reforms proposed for future global health governance since the outbreak of the Covid-19 pandemic and offers recommendations for both ongoing and possible new initiatives. After presenting a diagnosis of the policy problems that emerged before and during the pandemic, and identifying their underlying causes, we address current initiatives for enhanced political leadership, institutional reform, available financial support, and multistakeholder platforms for more effective delivery.

The report concludes by evaluating the effectiveness of proposed reforms, with a focus on the ongoing negotiations on the Pandemic Accord and the newly launched 'Pandemic Fund'. Observing that the emerging landscape for global health security governance provides for patchy solutions, the report supports the adoption of a more ambitious agenda, with ten areas for improvement identified.



Andrea Renda is a Senior Research Fellow and Head of Global Governance, Regulation, Innovation and the Digital Economy (GRID) at CEPS. Chiara Del Giovane is a Research Assistant, Clément Perarnaud is a Researcher and Hien Vu is an Associate Researcher in the Global Governance, Regulation, Innovation, and Digital Economy (GRID) unit at CEPS.

The report is prepared in the context of a grant from the Bill & Melinda Gates Foundation on future global health-security governance.

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## Abbreviations/Acronyms list

ACT-A	Access to Covid-19 Tools Accelerator
AI	Artificial Intelligence
AMR	Antimicrobial resistance
BARDA	Biomedical Advanced Research and Development Authority
CBDR	Common but differentiated responsibilities
CDC	Centre for Disease Control
CEPI	Coalition for Epidemic Preparedness Innovations
CFE	Contingency Fund for Emergencies
COP	Conference of the Parties
CSOs	Civil society organisations
DSSI	Debt Service Suspension Initiative
E-COP	Enlarged Conference of the Parties
<i>EGHRIN</i>	<i>European Global Health Research Institutes Network</i>
GHTB	Global Health Threats Board (proposed)
GHTSC	Global Health Threats Security Council (proposed)
GPMB	<i>Global Preparedness Monitoring Board</i>
GSN	Global South Nexus
HERA	European Health Emergency and Response Authority
FIF	Financial intermediary fund

GERM	Global Epidemic Response and Mobilization
GPAI	Global Partnership on AI
GPI	Global Public Investments
HLIP	High-Level Independent Panel
IFIs	International finance institutions
IHR	International Health Regulations
INB	Intergovernmental negotiating body
IOAC	Independent Oversight and Advisory Committee
IPPPR	Independent Panel for Pandemic Preparedness and Response
JFHTF	Joint Finance-Health Task Force
KDCA	Korean Disease Control and Prevention Agency
LMICs	Low- and middle-income countries
MDBs	Multilateral development banks
ODA	Official development assistance
PETs	Privacy-enhancing technologies
PHEIC	Public health emergency of international concern
PPE	Personal protective equipment
PPP	Pandemic Preparedness Partnership
PPR	Pandemic Prevention, Preparedness, and Response
SAGO	Scientific Advisory Group for the Origins of Novel Pathogens
SDRs	Special Drawing Rights
WHA	World Health Assembly
WGIHR	Working group on amendments to the International Health Regulations
WGPR	WHO working group on strengthening WHO preparedness and response to health emergencies
WGSF	WHO working group on Sustainable Financing

## EXECUTIVE SUMMARY

During the past years, and even more with the Covid-19 pandemic, the global community has failed to promote better health for all. While the need to step up cooperation to enhance global health security and resilience was widely acknowledged long before the Covid-19 pandemic, short-term solutions have generally prevailed over longer-term strategies to address global health governance's points of failures. Even now when problems appear on the policymakers' radar, solutions often ignore the underlying root causes, and thereby risk falling short of offering long-lasting remedies.

This report takes stock of the reforms proposed for future global health governance since the arrival of the Covid-19 pandemic, and offers recommendations for both ongoing and possible new initiatives. After presenting a comprehensive diagnosis of the policy problems that emerged before and during the pandemic and identifying their underlying causes, we discuss current initiatives for enhanced political leadership, institutional reform, available financial support, and multistakeholder platforms for more effective delivery. During 2022, we analysed key emerging proposals in each of these categories as part of a dedicated set of interviews to assess the support of stakeholders.

In the midst of a pandemic, proposed reforms must face the twofold challenge of bringing the current emergency to an end, as well as preventing new health emergencies from occurring. Thus the final section of the report evaluates the effectiveness of proposed reforms (with a focus on the ongoing negotiations on the pandemic accord and the newly launched 'Pandemic Fund') and reflects on existing gaps.

The emerging landscape for global health security governance analysed in this report appears to lack ambition and provide patchy solutions. On the one hand, measures such as the Pandemic Fund and the draft Pandemic Accord only partially address the root causes of the outstanding challenges and dysfunctions observed in the response to Covid-19. On the other hand, even if effective, these measures risk leaving national health systems underfunded, and the global community's ability to prevent future pandemics severely hampered.

The report thus supports the adoption of a more ambitious agenda – revolving around ten areas for improvement in current global health security governance, including: introducing health-oriented conditionalities in the international financing of LMICs; promoting 'pandemic clauses' for countries in financial distress; deepening multistakeholder partnerships by involving regional authorities and civil society; establishing an international task force for pandemic prevention and/or inspections on biosafety compliance; deepening research into social infrastructure to strengthen policy effectiveness; as well as supporting a 'maximin' principle inspired by adequate, global foresight.

## INTRODUCTION

The need to step up cooperation to enhance global health security and resilience was widely acknowledged long before the Covid-19 pandemic brought massive disruption to every corner of the world. Several actions had already been undertaken, under the belief that global health, or at least some of its aspects, constitutes a global public good, and as such requires global coordination and cooperation. Major initiatives of the past two decades include the adoption by the World Health Assembly of revised International Health Regulations (IHR) in 2005, as of today the only binding instrument in global health governance; the Global Health Security Initiative established in 2001 by eight States and the European Commission, with the WHO as an observer; the 2011 Pandemic Influenza Preparedness Framework, which brought together governments, industry, other stakeholders and the WHO to implement a global approach to pandemic influenza preparedness and response; the Global Health Security Agenda launched by the US in partnership with several other countries in 2014, which involves as many as seventy countries and several international organisations; the WHO Health Emergencies Programme and R&D Blueprint, the Contingency Fund for Emergencies, and the Commission on a Global Health Risk Framework for the Future, all established in 2016 following the Ebola epidemic<sup>1</sup>; the launch of the Coalition for Epidemic Preparedness Innovations (CEPI) in 2017; and the decision to create the Global Preparedness Monitoring Board in May 2018. As reported by the Independent Panel for Pandemic Preparedness, since the 2009 H1N1 influenza pandemic ‘at least 11 high-level panels and commissions have made specific recommendations in 16 reports to improve global pandemic preparedness’<sup>2</sup>.

None of this has worked. The global community has massively failed to promote better health for all. Recent pandemics and epidemics (including SARS, Zika and Ebola) have unveiled a general lack of preparedness and responsiveness of many communities, countries, and international governmental organisations in the face of unexpected (yet [foreseeable and foreseen](#)) emergencies. And with the emergence of the Covid-19 pandemic, the past three years has seen the world plunge into an inextricable quagmire due to the staggering lack of global coordination. The result is, at the time of writing, [more than 20 million excess deaths](#), the [loss of precious years](#) spent reducing health

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<sup>1</sup> The 2016 Commission on a Global Health Risk Framework for the Future argued that its proposed preparedness spending boost of USD 4.5 billion annually was a small investment compared with a scenario of the potential global cost of pandemics over the whole of the 21st century, which they assessed as being ‘in excess of USD 6 trillion’. Post-Ebola WHO reforms sparked the creation of a Health Emergencies Programme and the Contingency Fund for Emergencies (CFE), of which Germany, UK, Norway and Canada are top funders.

<sup>2</sup> Idem.

inequalities and eradicating poverty, a massive rise in the [indebtedness of many countries](#), and long-term consequences in terms of [mental health](#), [long COVID](#) and worsening patient conditions due to [co-morbidities](#) or the [foregone treatment of diseases](#). In this downward spiral, short-term solutions to protect the economy and society have often prevailed over longer-term strategies for resilience and sustainable development, placing a toll on the younger generation's right to a brighter future and fatally weakening the global community's commitment towards equally dramatic challenges posed by accelerating climate change and biodiversity loss.

### A LOST MONTH, A LOST YEAR, A LOST DECADE

The scientific and policy community today agrees that February 2020 was a '[lost month](#)' in the early phases of the response to the Covid-19 pandemic; that the entirety of 2021 was a '[lost year](#)' in the quest for more equitable access to knowledge and technology for more decentralised vaccine production; and that the world now faces a '[lost decade](#)' for development. And while at the end of October 2022 more than 12 billion Covid-19 vaccine doses had been administered around the world, in Africa no more than a quarter of the population had completed its primary vaccination series (the global average being 64 % and the year-end target being 70 %). The pace of vaccination even seems to be slowing down.

A recent [Lancet Commission report](#) identifies as many as ten distinct failures of international cooperation, resulting in thousands of avoidable deaths. These include a lack of timely notification of the initial outbreak in Wuhan, China; delays in acknowledging the airborne exposure pathway of SARS-CoV-2; lack of international coordination on suppression strategies; failure to examine evidence and adopt best practices for controlling the pandemic and managing socioeconomic spillovers from other countries; inefficient and insufficient global funding for low- and middle-income countries; failure to ensure adequate global supplies and equitable distribution of key commodities; a lack of timely, accurate, and systematic data collection and sharing; poor enforcement of biosafety regulations; ineffective measures to combat disinformation; and a lack of global and national safety nets to protect populations experiencing vulnerability.

### SOLUTIONS FOR THE LAST PANDEMIC?

For some of these problems, solutions are being sought, and the global community seems to have awoken to the urgency of more solid and effective coordination, as well as rapidly available funding. In forums such as the G7, the G20 and the WHO Global Health Summit, world leaders have set the aim of making Covid-19 '[the last pandemic](#)'. However, the proposed solutions seem more focused on the problems posed by the latest pandemic, rather than on ensuring that the next outbreak will be acted upon before it becomes a pandemic. The global community seems trapped into path-dependent behaviour, with



problems being found *post hoc* rather than anticipated; and a '[streetlight effect](#)', in which regulators look for solutions that fall under their immediate remit, rather than the ones that would prove most effective.

In reality, the list of problems to be addressed is likely to be much longer than the one proposed by the Lancet Commission. And even when problems appear on the policymakers' radar, solutions often ignore the underlying root causes, and thereby risk falling short of offering long-lasting remedies. Furthermore, while the global community struggles to agree swiftly on thorough reforms, new ancillary effects of the pandemic add to the pile of unresolved issues, creating the need for broader reform portfolios, and ultimately the definition of a revamped agenda for sustainable development.

This article takes stock of the reforms proposed for future global health governance since the arrival of the Covid-19 pandemic, and offers a number of recommendations. Section 1 presents a comprehensive diagnosis of the policy problems that emerged before and during the pandemic and identifies their underlying causes. Section 2 discusses current initiatives for enhanced political leadership, institutional reform, available financial support, and multistakeholder platforms for more effective delivery. Section 3 evaluates the effectiveness of proposed reforms (with a focus on the ongoing negotiations on the pandemic accord and the newly launched 'Pandemic Fund') and concludes by highlighting existing gaps. Two companion papers are dedicated to a deeper analysis of the role of the European Union in the emerging global health governance landscape, and an inquiry into the setting up and operation of the new European Health Emergency and Response Authority (HERA).

## 1. PANDEMIC PROBLEMS AND THEIR ROOT CAUSES

How did Covid-19 become the deadliest pandemic of the past century? Recent reports shed light on the problems that have emerged in the handling of the Covid-19 pandemic, by highlighting ‘what went wrong’ during the past three years. Other reports have taken a broader view by looking for the systemic failures of global health governance, which represent root causes of the dysfunctional responses observed around the globe. As will be mentioned in more detail below, solutions are being sought more clearly for the former set of problems than for the latter.

**Clearly not everything went wrong, and there are lessons to be learned by observing different impacts across countries and regions.** Overall, countries that handled the pandemic more effectively include those that had ramped up their investment in preparedness because of exposure to recent epidemics (e.g. South-East Asian countries with MERS and SARS); countries with relatively stronger and more skilled health systems (e.g. Scandinavian countries); and countries with overall propensity to follow government instructions, including not-fully-democratic ones. That said, the group of ‘good performers’ is rather small compared to the group of countries that have shown lack of preparedness, improvisation or even massive misconduct in managing the pandemic. This is relevant beyond pure cross-country comparison; given the public good nature of pandemic preparedness and response, a highly transmissible infection leaves the global community as strong as its weakest link. In the case of Covid-19, there was no shortage of weak links, in all continents.

Moreover, in several countries the performance of pandemic response has changed over time. Some countries that initially succeeded in containing the spread of the disease have later faced seasons of despair due to lack of immunity in the population, ‘lockdown fatigue’ or intervening problems with administering vaccines and protecting the economy. Likewise, other countries that initially performed very badly in responding to the spread of the contagion later learned the lesson. In this respect, the jury is still out as to which of the variants of zero-COVID, suppression or containment strategies adopted around the world should be seen as most effective from the broader perspective of well-being and sustainable development, also considering the substantial long-term socioeconomic and behavioural impacts that the ongoing pandemic will exert. And even when those effects have more clearly manifested themselves, the lessons to be learned will most likely suggest that there is no silver bullet strategy in the face of a pandemic. On the one hand, the most effective response depends on the specific features of the pathogenic agent; on the other hand, it also depends on the specific social, economic, and geographic features of the territory in which the response is implemented.

Against this backdrop, while focusing on the problems that emerged in the specific case of Covid-19, rather than on their underlying causes, can be misleading. An established

tenet of policy evaluation is that remedying past mistakes does not automatically lead to tackling their underlying root causes. Rather, in this case such an approach would be tantamount to ‘solving for the last pandemic’, rather than preparing for future emergencies.

Figure 1 shows the relationship between the problems that emerged in handling Covid-19 and their underlying causes. The first problems identified correspond to the ones highlighted by the [Lancet Commission report](#). An additional set of problems include challenges that emerged during the pandemic that had not been fully anticipated at the time of the first Covid-19 outbreak. For each of the problems, we identify a set of root causes, which will form the main subject of the remainder of this report.

First, the **lack of timely notification of the initial outbreak** can be related to several underlying problems, including insufficient enforcement of safety regulations and hygiene/security standards in scientific laboratories (if accepting the lab origin of Covid-19); lack of acceptance of the scientists’ advice in China and elsewhere; the poor state of international data-sharing arrangements when it comes to reporting and discussing early signs of a possible outbreak; the lack of specific powers and ad hoc human resources (for example, in the WHO) to independently and competently investigate early signs of an outbreak before it becomes a pandemic; and the lack of scenario planning, simulation and foresight on how to tackle outbreaks and epidemics.

Second, there were **delays in acknowledging the airborne exposure pathway of SARS-CoV-2**. Recent [research](#) has shed light on the historical reasons behind the lack of understanding of aerosols, which led to systematic errors in the interpretation of research evidence on transmission pathways. That said, authors (including in the Lancet report) have highlighted the WHO’s hesitancy to acknowledge emerging scientific agreement on the mode and extent of transmission of the virus, possibly leading to an overly conservative approach in declaring it a public health emergency of international concern. This, in turn, potentially calls into question the independence and authority of the WHO and its internal procedures and constraints when making decisions about future emergencies.

Third, the **lack of international coordination on suppression strategies** can be traced back to the inefficient implementation and enforcement of the IHR, the failure to establish functional decision-making structures during times of crisis, and the lack of support for the work of the WHO. Rather than cooperation, the global community reverted to inward-looking strategies, and even explicitly hostile behaviour (e.g. the ‘Chinese virus’ language, hoarding of supplies and medical countermeasures). However, for the reasons stated above, it would be a mistake to imagine that suppression strategies could be standardised across countries; and the evolving knowledge of the behaviour and transmission of SARS-COV-2 made it impossible to gather timely information on what

strategies could be coordinated across borders. The entire world became a gigantic experimental lab, with widely different strategies, and correspondingly diverging impacts and results. International coordination was also critically affected by the fragility of supply chains for essential medical counter-measures (or key inputs for their production), highlighting the need for more diversified and resilient value chains at the global level. The fragility of supply chains, in turn, called into [question](#) the pre-COVID economic model of globalisation and value chains, oriented towards cost reductions, just-in-time delivery and lean production, rather than towards resilience.

Fourth, experts have highlighted **failures in examining evidence and adopting best practices for controlling the pandemic and managing socioeconomic spillovers from other countries**. Such failures relate to the lack of an international framework for cooperation and policy learning, including joint foresight and simulation of cross-country effects; and the collective action problem that led most governments to hoard key assets such as oxygen, respirators and vaccines and introduce export controls (or bans), rather than helping other countries to successfully respond to the pandemic. This was an unforgivable mistake, also because international solidarity can at once strengthen the global response to the pandemic and reduce the probability of continuous circulation of the virus leading to new variants of concern.

Fifth, **lack of global funding for low- and middle-income countries** (LMICs) was not doomed to happen. On the contrary, the establishment of CEPI in 2016 and the launch of the Access to Covid-19 Tools Accelerator (ACT-A) promised an unprecedented level of global solidarity and equitable access to medical countermeasures. The reality, unfortunately, shows an enormous lack of commitment, and ultimately a persisting situation of flagrant discrimination, to the detriment of populations living in the Global South. Key episodes of this ongoing, rather shameful saga include the debate on the TRIPS waiver; the travel bans on affected countries (e.g. African countries when the Omicron variant was discovered); the export control measures put in place by countries with high-production capacity (e.g. the US, the UK and also the EU [vaccines export transparency and authorisation mechanism](#)); and the [persisting lack of contributions to the vaccine pillar COVAX](#), in particular for what concerned the humanitarian buffer and the LMICs channel. The race to hoard vaccines in developed countries was accompanied by equally detrimental phenomena such as stunning [price differentials across countries](#) that favoured richer economies, and an overall lack of transparency in the negotiations between governments and pharmaceutical companies on the supply of vaccines. Furthermore, experts had already [warned](#) in 2021 that the provision of aid to developing countries continued to be inspired by rather harsh, austerity-oriented conditionalities, which could have the effect of leading countries to further cut their expenditures in health systems. This approach [was](#) also [found](#) to remain fundamentally unchanged in the proposed '[rechannelling](#)' of SDRs proposed by the IMF.

Sixth, the observed **failure to ensure adequate global supplies and equitable distribution of key commodities** was caused, among other things, by the disruption of too-fragile supply chains; the absence of a pre-determined framework for distributing resources through a multistakeholder platform with global outreach, which was only partly remedied by the setting up of ACT-A; the lack of national and macro-regional institutions that would be able to participate in the planning of resource distributions; the rise of ‘strategic autonomy’ narratives, which led to countries to rethink supply chains to secure domestic availability of key resources; and the lack of production and distribution capacity for key medical countermeasures in developing countries. The latter can also be seen as a result of the insufficient implementation of the 2001 TRIPS agreement, which alongside compulsory licensing also aimed to promote knowledge and technology transfer to enable developing countries to gradually build local capacity.

Seventh, the world has experienced a **lack of timely, accurate, and systematic data collection and sharing**. Among the numerous root causes of this failure, it’s worth recalling the poor data collection and reporting systems’ quality in many LMICs (as testified by the systematic under-reporting of cases in many countries, particularly in Africa); the lack of adequately granular and interoperable data collection by institutes of statistics and health authorities around the world (including notably [in the EU](#), even more than in the UK and [the United States](#)); the dependency on data reporting by governments with strong incentives to under-report (e.g. Russia and China), coupled with limited data collection from less conventional sources; the relative immaturity (and sometimes, the [misuse](#)) of [new solutions](#) such as [machine learning for pandemic preparedness](#), monitoring and response; and the lack of regulatory frameworks for government access and the use of privately held data for public interest reasons, such as the proposed EU [Data Act](#) and proposed [European Health Data Space](#).

Eighth, the emergence of SARS-COV-2 could have been due to **poor enforcement of biosafety regulations**, which in turn is rooted in a tradition of loose governance of safety standards in laboratories. The [Preliminary Report](#) for the Scientific Advisory Group for the Origins of Novel Pathogens (SAGO) appointed by the WHO confirmed that one of the possible origins of the virus was a breach in biosafety and biosecurity measures through a laboratory incident. Reducing the risk of a future health emergency requires, among other things, adopting more stringent measures since most unintended pathogen exposures occur because of lack of training or lack of compliance with standard operating procedures. At the 2021 World Health Assembly, the US proposed the adoption of a global norm and international standard for biosafety and biosecurity. The WHO created a new Technical Advisory Group on biosafety, published a new edition of its Laboratory biosafety manual and adopted a new [life sciences framework](#) to help mitigate bio-risks and safely govern dual-use research. The framework, a very comprehensive and enlightening document, is, however, only a reference for health operators around the

world, with no binding commitment or enforcement mechanism. For example, the Lancet Commission's proposal to enable on-site inspections to ensure the respect of laboratory biosafety standards is not echoed by the WHO framework.

Ninth, the magnitude of the death toll paid by the global community during the first three years of the pandemic is also related to the **spread of disinformation and misinformation** on several aspects of Covid-19, including its origin and effects, as well as the impact and composition of remedies and vaccines. Disinformation was so widespread that international organisations such as WHO and UNESCO started referring to Covid-19 as an '[infodemic](#)' and a '[disinfodemic](#)' respectively, entailing practices such as emotive narrative constructs and memes, fabricated websites and authoritative identities, fraudulently altered, fabricated, or decontextualised images and videos, disinformation infiltrators and orchestrated campaigns. Alongside disinformation, misinformation can be traced back to conspiracy theories, but also a widespread lack of trust in science and in institutions; the emergence of populist narratives focused on showing political leaders' opposition to (needed) restrictions of personal freedoms; and lack of awareness in governments and among political leaders on the causes, scope and impacts of the virus. Even besides the obvious examples of US President Donald Trump and Brazilian President Jair Bolsonaro, in some cases political leaders themselves have spread false information, or created false hopes among their citizens, for example by erring on the side of 'techno-solutionism' (as in the case of contact-tracing apps, which after being hailed as the saviour of people's freedom to circulate, ended up mostly failing to provide a meaningful contribution to tracking-and-tracing activities). Besides structural lack of trust in science (among citizens and political leaders), failure to communicate science effectively to citizens, and bad or non-existent science advice to decision-makers, dis- and misinformation are also deeply rooted in the absence of a legislative framework that holds online intermediaries responsible for the moderation of content, and in particular the swift flagging, labelling or elimination of disinformation from their platforms (such as the provisions included in the newly adopted [EU Digital Services Act](#)). As a result, as people increasingly moved their social relationship and economic activities online, they found in the Web a patchwork of unstructured and often unreliable information sources, often intentionally packaged, which transformed the pandemic into an infodemic.

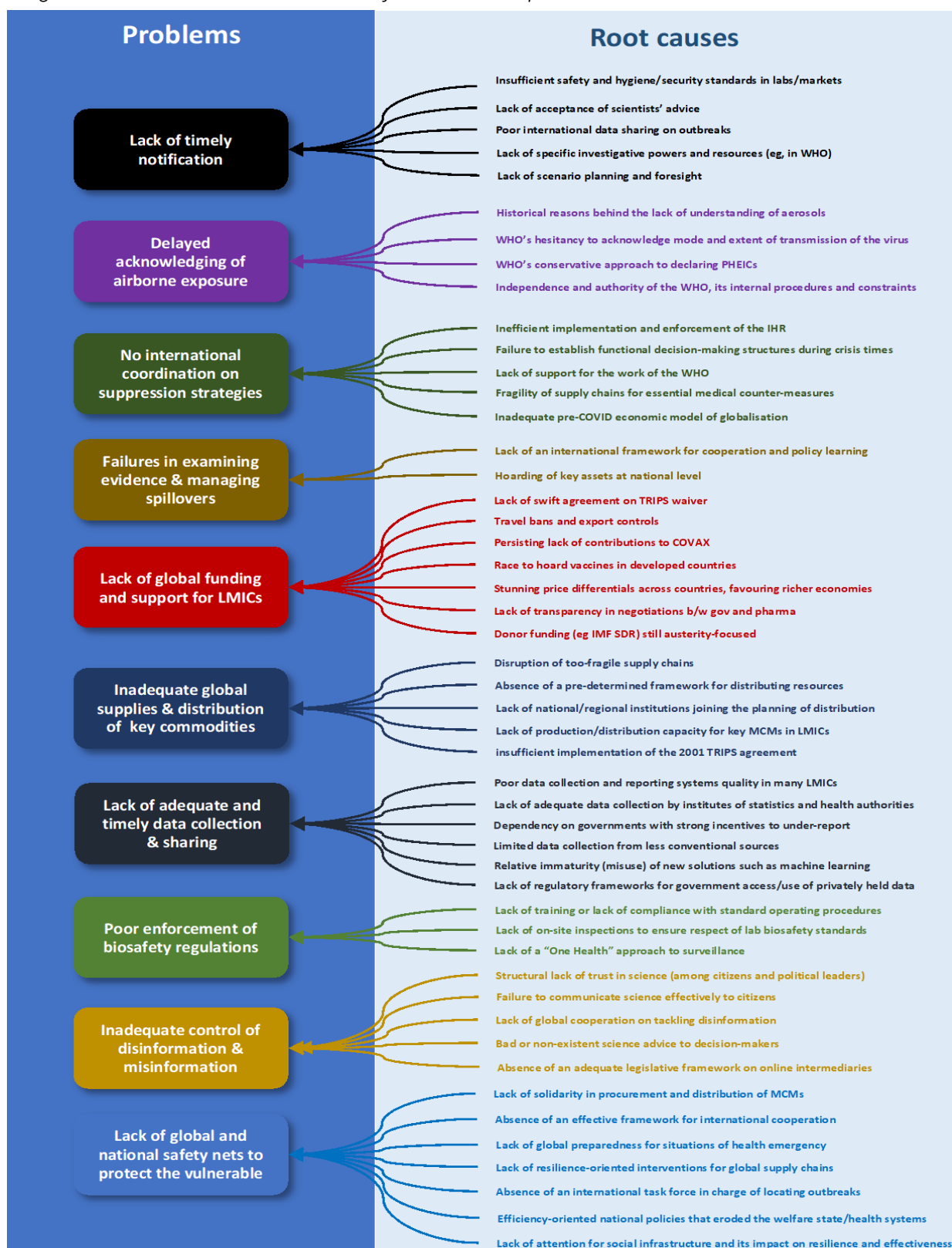
Tenth, the pandemic unveiled a generalised **lack of global and national safety nets to protect populations experiencing vulnerability**. For what concerns the global dimension, an astonishing lack of solidarity has emerged in the procurement and distribution of medical countermeasures, which in turn points to the absence of an effective framework for international cooperation; the use of travel bans and advance purchase agreements at favourable conditions has unveiled the stark divide between the Global North and the Global South when it comes to health. At the national level, similar problems have emerged, leading to widening inequalities in terms of income, gender, geography and

ethnicity. Among the many roots of this problem are legacies of past policymaking paradigms at the global, national and local level. At the global level, it is the lack of preparedness for situations of health emergency, coupled with the lack of resilience-oriented interventions for global supply chains, and the absence of an international task force in charge of locating outbreaks. At the national level, it is the adoption of austerity-based policies that have gradually eroded the welfare state and health systems in most countries (including developing countries, also as an effect of international lending, oriented as it often is towards austerity). At the local level, it is a lack of attention for local [social infrastructure](#) and its key impact on resilience and on the effectiveness of government policies in times of emergency.

As a result, all the 10 problems detected by the Lancet Commission can be traced back to a much broader array of dysfunctions in the global order, in the relationship between institutions and citizens, and in the way public policies have been designed and implemented for decades (and even more since the 2007-2008 financial crisis). Moreover, three years of pandemic have not only led to the exacerbation of pre-existing problems (inequality) and the loss of progress on other problems (i.e. poverty eradication), they have also created new challenges, which should be adequately taken into account in charting the path towards a brighter future. Among 'new' problems are the indirect impacts of the pandemic, for example on the treatment of other diseases, as well as on [mental health](#), and the dramatic increase in the indebtedness of LMICs both before and during the pandemic. Solutions for the latter problem have been sought by the international community, for example through the launch of the Debt Service Suspension Initiative ([DSSI](#)) by the G20 in May 2020, and later the '[Common Framework](#) for debt treatment' launched by the G20 and the Paris Club in November 2020; the already-mentioned reallocation of USD 650 billion in IMF SDRs; and instances of bilateral renegotiation of outstanding debts (e.g. between China and individual LMICs). However, despite initial hopes, the process for debt restructuring appears to be patchy, slow, not accessible to all countries in distress, and fraught with [many deficiencies](#). In particular, the Common Framework appears to be at the centre of geopolitical tensions between the Paris Club and new powerful creditor countries such as China and India, but also private creditors. Meanwhile, the Director of the United Nations Development Programme [denounced](#) how more than 50 countries are at risk of defaulting on their debt if no immediate assistance is provided by the global community. Figure 1 shows a graphical representation of the 10 problems identified by the Lancet Commission, and our analysis of the root causes.



Figure 1. Problems and root causes of the Covid-19 pandemic



Source: authors' composition.



## 2. WHICH SOLUTIONS ARE BEING SOUGHT?

The Covid-19 pandemic led to an unprecedented mobilisation of academics, practitioners, investors, and policymakers, and the flourishing of proposed solutions to outstanding and emerging problems. Key forums include the Global Preparedness Monitoring Board, a joint arm of the WHO and the World Bank; the Independent Oversight and Advisory Committee (IOAC) for the WHO Health Emergencies Programme; the Independent Review Panel on the Functioning of the IHR during the Covid-19 pandemic; the Independent Panel for Pandemic Preparedness and Response (IPPPR); the Report to the G7 by the Pandemic Preparedness Partnership: ‘100 Days Mission to Respond to Future Pandemic Threats’; the G20 High-Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response; the report on ‘A global public health convention for the 21st century’ (Duff et al., 2021); several publications of the Lancet Covid-19 Commission; and the pan-European Commission on Health and Sustainable Development.

In the context of the WHO, several countries have also issued ‘non-papers’ offering recommendations covering several aspects of future global health security. These include contributions from EU Member States on the possible structure of a pandemic prevention, preparedness and response accord; a contribution from Nordic Countries (Denmark, Finland, Iceland, Norway, Sweden) on ‘Global Health Security Financing & Governance’; and the US-Norwegian ‘100-Day Proposal for Reviewing, Designing and Launching the Establishment of a Financial Intermediary Fund for Global Health Security and Pandemic Preparedness’. The WHO has echoed these proposals, including in the 2022 [progress report](#) on the Global Action Plan for Healthy Lives and Well-being for All. The proposals were so numerous and far-reaching that the WHO decided to launch a dedicated portal with a [dashboard](#), which enables user-friendly navigation through the different texts. In addition, the Working group on strengthening WHO preparedness and response to health emergencies ([WGPR](#)) [Bureau](#) launched a survey on 6 December 2021 to seek the help of stakeholders in the prioritisation of specific recommendations. The survey covers 131 recommendations issued by the officially commissioned panels or committees: IOAC, IPPPR, IHR Review Committee, and the Global Preparedness Monitoring Board (GPMB).

Overall, emerging proposals can be organised into four different categories: (i) institutional reforms to reflect stronger political leadership and commitment; (ii) a stronger and more effective WHO; (iii) more efficient and effective financing facilities for future emergencies; and (iv) leveraging multistakeholder platforms for effective delivery. During 2022, we analysed proposals in each of these categories and tested the existing support of stakeholders in a dedicated set of interviews (see the Annex for a description of our methodology). The main findings of our analysis are summarised below.

## 2.1 STRENGTHENING POLITICAL LEADERSHIP AND COMMITMENT

There is no doubt that wavering political commitment has made things worse during the pandemic. While not being a sufficient condition for strong global health security, political salience and commitment is essential if the world is to avoid being trapped again in the vicious cycle of ‘panic and neglect’ that has characterised pandemics and epidemics so far. Creating a dedicated entity that groups heads of state and government around the issue of global health security may, to some extent, mitigate that risk, especially if such an entity is supported by concrete, binding and measurable commitments enshrined in an international agreement.

Several proposals have been presented on this specific aspect of future global health governance. They include:

- *A Global Health Threats Security Council (GHTSC)*. Proposed by the IPPPR in May 2021, the GHTSC would need endorsement by a United Nations General Assembly resolution. It would bring the issue of global health into the context of peace and security, recognising a link that has been widely acknowledged in the international debate<sup>3</sup>. By structurally bringing global health into the focus of the UN Secretary General, [this project](#) would aim to ensure that ‘high level political leadership and attention to pandemic prevention, preparedness and response are sustained over time in the service of a vision of a world without pandemics’. This development could be considered consistent with how the UN Security Council has gradually approached global health crises over the past decades in a number of public health contexts (e.g. SARS and Ebola).
- *A Global Health Threats Board (GHTB)*, an evolution of the GPMB, proposed by the IPPPR and supported by the Pan-European commission on health and sustainable development. The GHTB would be modelled on the Financial Stability Board, established by the G20 in the aftermath of the 2008 Global Financial Crisis and which has operated successfully as a collective to contain risks to the global financial system. According to the panel, it would complement the GHTSC (see above), and would have a permanent and independent secretariat composed of health and finance ministers from a ‘G20+ group of countries’ as well as heads of major regional organisations. It would provide financial oversight to ensure the ‘proper and timely resourcing of capacities to detect, prevent and rapidly respond to another pandemic, and to ensure the most effective use of funds’. The GHTB would also be accompanied by an independent scientific advisory panel and a Health Security Assessment Programme.

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<sup>3</sup> This proposal echoes a recent one by the PA International Foundation to the Independent Panel on Evidence Against Antimicrobial Resistance (AMR), established following the recommendations of the UN Interagency Coordination Group on Antimicrobial Resistance (UN IACG).

- *A new global health agency to face future threats and pandemics.* In the context of its presidency of the G20, Indonesia announced in Davos in 2022 that it would propose the creation of a new global health agency, which would partly supersede the WHO, to ensure a more resilient and responsive global health architecture to face future threats and pandemics. The key mission of the proposed agency would be to operate a global contingency fund for medical supplies, building capacity in developing countries to manufacture vaccines and to create global health protocols and standards<sup>4</sup>. The IMF and the G20 would be tasked to mobilise resources to revitalise the global health architecture and make it more efficient.

### 2.1.1 Views from stakeholders

During 2022, we interviewed several stakeholders to gauge the level of support for these proposals. Specifically, we found support for a new GHTSC to be very limited; this scenario had not been discussed by surveyed stakeholders within their own organisations, and no actor could specify their institutional position on the matter. In addition, only a few actors appeared sympathetic to the proposal; most respondents strongly rejected the idea of introducing such an entity at the UN Security Council level.

Interviewed WHO member states' representatives indicated that the UK had shown an interest in supporting the creation of a Health Council. It had been deemed 'an interesting idea'<sup>5</sup>, though with some initial scepticism as the added value was not clear and because of the limited appetite to create more institutions. Most actors indicated that it is rather the existing mechanisms and institutions that need to be improved. The potential added value of the UN Security Council to approach these complex and controversial processes was questioned on numerous occasions. A research participant from a civil society organisation signalled that 'in some ways, it is surprising to see that some still consider that the voice of the Security Council still matters'<sup>6</sup>. One of the arguments in favour of a global health threats council would be that it could hold world leaders to account. Yet one of the main drawbacks is that the new council would be New York-based, while most of global health governance is discussed in Geneva, as pointed out by one of the interviewees<sup>7</sup>.

As a result, respondents indicated that there was no particularly salient interest from Member States to push this proposal. As argued by a UK representative, 'there is no champion for it, despite some merits for it. As a result, it is not front and centre for the

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<sup>4</sup> <https://www.weforum.org/press/2022/01/indonesia-s-president-widodo-emphasizes-importance-of-g20-focus-on-resilient-health-systems-energy-transition-and-digital-transformation>

<sup>5</sup> Online interview 8, UK government, 2022.

<sup>6</sup> Online interview 5, People's Vaccine, 2022.

<sup>7</sup> Online interview 7, Health Poverty Action, 2022.

discussions’<sup>8</sup>. Yet the US had mentioned its support for this format during the 2021 Global Covid-19 Summit, through a declaration by the US Vice President Kamala Harris, who called ‘for greater political leadership and accountability, calling for the establishment of a Global Health Threats Council to monitor progress and sound the alarm to prevent future pandemics’<sup>9</sup>. Similarly, the South African President Matamela Cyril Ramaphosa also indicated his support for the idea. Overall, however, the support from global leaders appears limited. Instead, there has been a strong momentum for the organisation of a Special Session of the UN General Assembly (UNGA) in response to the pandemic, with the proactive support of South Africa and the US.

At the civil society level, the proposal of a new Global Health Threats Council received a lukewarm response from the beginning. One of the main challenges for civil society organisations (CSOs) is that many important questions remained unanswered in relation to this proposal, including who would be responsible, how members would be selected, and how would it relate to the WHO. Despite the initial interests of certain stakeholders, lack of clarity prevented any meaningful support from civil society<sup>10</sup>.

The proposed GHTB garnered mixed support from the interviewed stakeholders. In particular, the creation of the Board appeared to have strong support from the US government, whereas UK and EU representatives expressed mixed feelings regarding this proposal, albeit signalling their readiness to approve it if it became consensual<sup>11</sup>. China, however, voiced strong concerns, mostly to protect its own national sovereignty on the matter. Apart from the abovementioned, many respondents appeared unaware of the proposal and did not have an institutional position to share with the study team. Backing for this proposal remained limited among CSOs, although stronger than that shown for the GHTSC. Concerns were expressed about the extent to which the GHTB would be able to guarantee equity and inclusivity in its governance and decision-making process, in particular in adopting funding decisions. Support by CSOs would thus be conditional on there being sound, transparent and inclusive governance. Against this backdrop, the creation of a GHTB would also bear the risk of creating a ‘WHO-minus’, without providing remedies to eliminate the malaise that the WHO has been facing on financing and technical function.

Finally, our desk and field research results showed strong opposition from most stakeholders towards the possibility of replacing or partly superseding the WHO by creating a new agency. EU Member States and the UK, for example, were clearly unsupportive. As a result, a few weeks on from the Indonesian presidency’s initial

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<sup>8</sup> Online interview 8, UK government, 2022.

<sup>9</sup> See [Global Covid-19 Summit: Ending the Pandemic and Building Back Better | The White House](#).

<sup>10</sup> Online interview 10, GHTC, 2022.

<sup>11</sup> Online interview 8, UK government, 2022.

proposal, the idea of a new agency seems to have quickly lost momentum. Even on the side of Indonesia, diplomats quickly indicated that the proposal may have been the result of a misinterpreted communication<sup>12</sup>. Similarly, a civil society representative argued that creating a new organ to replace the WHO would create more fragmentation<sup>13</sup>. A representative of the European Global Health Research Institutes Network (EGHRIN) also stated that a new agency is the least desirable scenario among those presented on leadership and governance<sup>14</sup>.

All in all, the general view shared by most respondents is that if the WHO were replaced or complemented by other institutions, procedures and discussions would become even more cumbersome and challenging. In a nutshell, respondents made it clear that, given the already very complex architecture of global health governance, there is no need for yet another organisation: given that the WHO gathers very significant expertise, replacing it would not be desirable.

## 2.2 IMPROVING GOVERNANCE BY RELYING ON A STRONGER, MORE FINANCIALLY INDEPENDENT WHO

Rather than replacing it with a new agency, many expert reports have proposed strengthening the governance of the WHO, including its authority, financial independence and powers. As [Lee and Piper \(2020\)](#) vividly observed, as things stand the WHO features a ‘governance structure that upholds the primacy of Member States, a budget that makes the organization a hostage to fortune, and a constitution that bestows no enforcement powers’<sup>15</sup>. As was recently [recalled](#), four decades ago the WHO received 80 % of its resources in the form of ‘assessed contributions’, a predictable and unconstrained form of income, which left significant discretion to the WHO in allocating its budget. Today, this percentage has plummeted to 16 %, with the remainder provided as voluntary contributions from state and non-state actors, often with tight and sometimes restrictive conditions, and usually over two-year cycles. This makes the WHO extremely dependent on financial contributions that can be withdrawn almost overnight, as clearly demonstrated by the Trump administration during the Covid-19 pandemic. In addition, it leads to a structural underfunding of emergency preparedness and response. The main proposal being considered through a Member State-led working group process is to increase assessed contributions from the current levels of less than 20 % of the core budget to 50 %, and to allow all countries time to budget and prepare, and to do so incrementally, introducing the change in stages starting from 2028.

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<sup>12</sup> Online interview 9, UK government, 2022.

<sup>13</sup> Online interview 7, Health Poverty Action, 2022.

<sup>14</sup> Online interview 3, EGHRIN, 2022.

<sup>15</sup> WHO Member States established two new working groups in May 2021: one on Strengthening WHO Preparedness and Response to Health Emergencies (WGPR); and another on Sustainable Financing (WGSF).

WHO members are currently considering four main avenues to improve the WHO's future pandemic preparedness:

- *A Standing Committee on Health Emergency (Pandemic) Prevention, Preparedness and Response* to provide guidance and make recommendations to the Executive Board 'regarding ongoing work on policy proposals on pandemic and emergency preparedness and response'<sup>16</sup>. The standing committee, proposed by the Austrian government, would kick in automatically as soon as the WHO Director-General declared a health emergency, and it could facilitate the immediate transfer of information between the Secretariat and Member States.
- *A 'policy forum' within the WHO*. The recent World Health Summit in Berlin featured discussions about the need for a [committee C at the WHO](#), which had already been suggested in 2008 by authoritative commentators. The idea would be to set up an intermediate policy forum where other actors in global health would participate and interact with the formal governing body processes at the WHO. This would preserve the role of WHO member states as ultimate decision-makers but would provide other stakeholders with an opportunity to make their voice heard and influence the decisions taken by the WHO, thereby strengthening its accountability and transparency.
- *Modernising the International Health Regulations (IHR)*, last updated in 2005, which are the only legally binding rules in the health domain. The WGPR, chaired by the US and Indonesia, has been charged with overseeing the process of discussing targeted amendments to the IHR, mostly to address equity, technology governance and other gaps. Opposition to amendments that would somehow constrain national sovereignty came from Russia and China<sup>17</sup>. The IPPPR argued that the IHR are a 'conservative

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<sup>16</sup> The proposed standing committee, reporting to the board, would kick in automatically as soon as the Director-General declared a health emergency, and it could facilitate the immediate transfer of information between the Secretariat and member states, said Austria's Dr Clemens Martin Auer. Australia stressed that the standing committee 'should focus on governance for the health emergencies programme, allowing for in-depth discussion and reporting to the EB' and it 'should not encroach on the technical advisory and leadership roles of the Director-General and the IHR Emergency Committee'. Despite support from the WHO Director-General, a handful of countries indicated that they weren't yet ready to support the resolution, so it was stalled.

<sup>17</sup> Russia wants IHR amendments to address 'improving the priority infrastructure, developing regional and global networks, increasing cooperation between countries on implementing the rules and ensuring free movement of medical staff and technology to fight infections'. Russia also called for member states to 'work harder to fight the distribution of false and unreliable information because this prevents effective scientifically based measures being taken to fight epidemic outbreaks and it undermines international cooperation'. Ironically, Russia has been identified as a key source of Covid-19 misinformation aimed at undermining 'Western' vaccines.

instrument that constrain rather than facilitate rapid action’<sup>18</sup>, and proposed a more far-reaching series of actions, amounting to ‘a fundamental transformation designed to ensure commitment at the highest level to a new system that is coordinated, connected, fast-moving, accountable, just, and equitable — in other words, a complete pandemic preparedness and response system’<sup>19</sup>.

- *A pandemic prevention, preparedness and response accord.* The key discussions on a pandemic prevention, preparedness and response (PPR) accord are taking place in the intergovernmental negotiating body (INB), comprising all its 194 sovereign member countries. The INB would determine the form and content of the new accord, including its objectives, principle(s), priorities and scope for pandemic, preparedness and response to: 1) build resilience to pandemics; 2) support prevention, detection, and responses to outbreaks with pandemic potential; 3) ensure equitable access to pandemic countermeasures; and 4) support global coordination through a stronger and more accountable WHO. The new accord could complement other initiatives, including IHR reform. A more complete analysis of the ongoing negotiations is provided in Section 3.1 below.

### 2.2.1 Views from stakeholders

At the WHA special session in December 2021, proposals to strengthen the role of the WHO as the leading authority of the global health architecture were raised by Western Pacific region members, Southern African countries, Azerbaijan, Bulgaria, Chile, Cuba, Fiji, Haiti, India, Italy, Kenya, Lebanon, Madagascar, Maldives, Morocco, Niger, Portugal, Romania, Slovakia, Suriname, Syrian Arab Republic, Uruguay, Venezuela and the EU. The 75th World Health Assembly in May 2022 indeed allowed for some important progress in this respect. Regarding the financing of the WHO, member states agreed to increase assessed contributions, which currently make up approximately 16 % of the WHO base budget, and would increase to 50 % by 2030-2031<sup>20</sup>.

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<sup>18</sup> More from the same report: ‘The new IHR (2005) came into force in 2007 and imposed new requirements that must be met before the WHO Director-General could act on emergencies, rather than enabling WHO to act immediately and independently’.

<sup>19</sup> Since 2016, progress in the IHR core capacity periodical review has been made on two fronts: (1) the review system moved from exclusive self-evaluation to one that combines Mandatory States Parties Annual Reporting (SPAR), voluntary Joint External Evaluations (JEEs, conducted every five years), simulation exercises (SimEx), and After Action Reviews (AAR); and (2) in 2018, the WHO also digitised the SPAR system (e-SPAR) to allow states parties to make the annual report online. The JEE aims to provide an independent, impartial and transparent assessment of the current status of a country’s IHR core capacity. However, not many countries have adopted this tool. As of 2018, only 11 out of 53 member states in the WHO Europe regions have conducted or planned JEEs: Albania, Armenia, Belgium, Finland, Kyrgyzstan, Latvia, Lithuania, Serbia, Slovenia, Switzerland/Liechtenstein, and Turkmenistan.

<sup>20</sup> For more, see [World Health Assembly agrees historic decision to sustainably finance WHO](#).



Given that WHO member states had failed to agree on the same proposal in December 2021, this budget increase should be seen as a major breakthrough, particularly given the geopolitical context in which it took place. Still, it is slightly below what had been initially proposed by the IPPPR, which envisaged an increase of contributions to two-thirds of the budget for the WHO's base programme. This proposal faced significant opposition, including from the US, Russia, Brazil, Japan, Poland, Argentina and Mexico. During the spring of 2022, changes in the policy approach of the US, followed by Brazil and Japan, appear to have led to a new window of opportunity for increasing national contributions<sup>21</sup>. In December 2021, the Chair of the WHO's WGSF had [argued](#) in favour of ambitious reforms, observing that otherwise the role of the WHO would have gradually been dwarfed by rising investment by national governments and private players, with a consequent fragmentation in global health governance. Some developing countries, including Bangladesh, were opposed to increasing their contribution: 'for many developing countries, due to their resource and capacity constraints, it is not easy to affirm the [assessed contributions] increase. The COVID 19 pandemic has deepened their challenges. The strengthening of the WHO is required more than ever for optimum deliverables in the developing countries'<sup>22</sup>.

As underlined earlier, most Member States take the position that there is a need for a stronger and more independent WHO, and notably in relation to emergency preparedness and response. This was first highlighted in the proceedings of the WGPR; and later by the unanimous decision to establish a Standing Committee on Health Emergency (Pandemic) Prevention, Preparedness and Response by the WHA in May 2022. The Standing Committee is expected to improve the oversight of the WHO's work in emergencies, by regularly monitoring and assessing performance and helping ensure a more efficient response when a Public Health Emergency of International Concern is declared<sup>23</sup>. This decision, which was drawn from an earlier [proposal](#) made by Austria (and supported by the EU and Japan) in the first months of 2022, was initially contested by several countries, including many African states, Australia, Colombia, Malaysia, Norway and Paraguay, but also CSOs such as the Third World Network.

In addition, the WHA agreed on the creation of a 'Member States task group on strengthening WHO budgetary, programmatic and financing governance to analyse challenges in governance for transparency, efficiency, accountability and compliance, and come up with recommendations, which would report to the 76<sup>th</sup> WHA'<sup>24</sup>.

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<sup>21</sup> [Senior WHO Leadership Reshuffle Expected After Member States Agree On New Financing Formula For Global Health Agency - Health Policy Watch \(healthpolicy-watch.news\)](#)

<sup>22</sup> <https://apps.who.int/gb/statements/WHA75/PDF/Bangladesh-13.pdf>

<sup>23</sup> [Standing Committee on Health Emergency \(Pandemic\) Prevention, Preparedness and Response \(who.int\)](#)

<sup>24</sup> [Sustainable financing: report of the Working Group \(who.int\)](#)



Recent developments suggest a growing consensus towards strengthening the independence and financial resources of the WHO, although discussions on the final report of the WGPR were marked by growing tensions and demands, especially for what concerns equity and solidarity. In particular, developing countries including India, Paraguay, Argentina, China, Brazil and Bangladesh proposed to expand the scope of equity-related measures to all ‘health emergencies’, rather than only ‘pandemics’. The EU, supported by the US, took the [opposite stance](#).

On the idea of creating a ‘policy forum’, in the form of a committee C at the WHO, it was [reported](#) that many participants to the World Health Summit raised concerns over the prospective, predominant private sector representation, but also due to emerging attempts to bring the ‘policy forum’ outside of Geneva.

Several proposals concerning the amendment of the IHRs were [presented](#) during the 2022 WHA<sup>25</sup>. Among them, only one amendment (to Article 59), rather procedural in scope, has been agreed by consensus by the Assembly, despite the initial opposition of African countries, India and Iran. The US had initially envisioned proposing several substantive amendments relating to the deployment of expert teams to outbreak sites and a new compliance committee to monitor implementation of the rules but had to postpone this proposal to other negotiations due to the lack of sufficient support from other Member States. Several African countries were opposed to the initial proposal of fast-tracking the IHR amendments and concerned about the implications of this evolution for other policy streams (including the pandemic accord)<sup>26</sup>. Interestingly, China had voiced its support for the reform of the global health architecture in December 2021, including amending the IHR and, in principle, strengthening accountability.

One of the other dividing lines in relation to IHR amendments revolves around the interplay with the possible pandemic accord. Indeed, a number of stakeholders, for instance the People’s Health Movement, [stated](#) that ‘the new pandemic instrument and International Health Regulations 2005 must complement each other in response to public health emergencies and not lead to a fragmented approach. The principles of IHR 2005 should be used as foundation to create a new pandemic instrument that will strive to increase international cooperation, solidarity among countries and not the securitization of health’.

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<sup>25</sup> By Australia, Bosnia and Herzegovina, Colombia, the European Union and its Member States, Japan, Monaco, Republic of Korea, United Kingdom of Great Britain, Northern Ireland and United States.

<sup>26</sup> As an illustration, it was [reported](#) that South Africa cautioned against the ‘re-opening of the IHRs’, and rather favoured the adoption of a new legally binding instrument. Other countries had supported the US initiative: the UK, for example, repeatedly argued in favour of improving compliance with the IHR. One negotiator argued that: ‘IHR [...] is just an agreement. Few NGOs indeed promote implementation, but there is nothing with health [national] leaders promoting what they have done, with a positive pull-effect, like in other policy domains like [...]. None of that exists in IHR space’.

The IHR Review Committee regarding amendments to International Health Regulations (2005) [began its work](#) on [6 October 2022](#).<sup>27</sup> This committee will function in accordance with the WHO Regulations for Expert Advisory Panels and Committees, and will provide its report to the WHO Director-General by mid-January 2023. In accordance with Decision WHA75(9), the Working group on amendments to the International Health Regulations (WGIHR) will present its proposed amendments to the IHR for consideration by the Seventy-seventh World Health Assembly in 2024<sup>28</sup>. As a matter of fact, any IHR amendments during the next year will not enter into force before 2024, and thus intersect with the ongoing negotiations of the Accord.

The latter initially met with fierce criticism from several Member States and NGOs, but is being negotiated in a dedicated INB, established in December 2021<sup>29</sup>. After a first meeting on 24 February 2022, mostly dedicated to working methods and timeline, the INB carried out a round of public hearings in April 2022<sup>30</sup>. Interestingly, these were the first public hearings organised at the WHO in more than 20 years, as the last ones were launched during the adoption of the Framework Convention on Tobacco Control. In this context, the Civil Society Alliance for Human Rights in the Pandemic Treaty has [raised](#) substantial concerns about the nature and participatory range of the public consultations. The INB [met again](#) in July and December 2022 to discuss progress on a working draft (see Section 3.1 below). It is expected to deliver a progress report to the WHA in 2023, with the aim of adopting the instrument by 2024. The scope of the treaty or convention is still to be decided as proposals might include rules on vaccine-sharing, AMR, a temporary waiver for some Intellectual property rights (IPRs) and a proposed ban on wildlife markets.

Constant support for this initiative comes from the ‘Group of Friends of the Treaty’, which includes 27 countries<sup>31</sup>. However, the US, Brazil, China and Russia have shown more reluctance to engage in constructive discussion. It must be underlined that while China and India have not voiced opposition to the proposal, they have expressed a number of

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<sup>27</sup> Three persons were nominated to fill the roles of Chair, Vice-chair, and Rapporteur: Dr Patrick Mutuma Amoth, Kenya, Chair; Ambassador Juan Jose Gomez Comacho, Mexico, Vice-Chair; Dr Clare Wenham, United Kingdom of Great Britain and Northern Ireland, Rapporteur.

<sup>28</sup> As of 30 September 2022, the following 14 States Parties submitted proposals for amendments to the IHR, of which four States Parties submitted those proposals also on behalf of other States Parties – Armenia; Bangladesh; Brazil; Czech Republic on behalf of the Member States of the European Union; Eswantini on behalf the WHO African Region Member States; India; Indonesia; Japan; Namibia; New Zealand; Russian Federation on behalf of the Member States of the Eurasian Economic Union; Switzerland; United States of America; and Uruguay on behalf of MERCOSUR.

<sup>29</sup> The Bureau of the INB is composed of representatives from South Africa, Brazil, Egypt, the Netherlands, Thailand and Japan.

<sup>30</sup> For more, see: [Intergovernmental Negotiating Body \(who.int\)](https://www.who.int/news/item/20-04-2022-who-inb-public-hearings)

<sup>31</sup> Albania, Australia, Chile, Costa Rica, Croatia, Fiji, France, Germany, Greece, Indonesia, Italy, Kenya, Republic of Korea, the Netherlands, Norway, Portugal, Romania, Rwanda, Senegal, Serbia, South Africa, Spain, Thailand, Trinidad and Tobago, Tunisia, Ukraine, the UK.

reservations and argued in favour of focusing on other salient issues in relation to global health. China has stated on several occasions that IHRs must remain at the core of emergency response mechanisms. Russia also argued against an instrument that would challenge existing rules. Similarly, the US, backed by Brazil, Mexico, Monaco, and Jamaica attempted to delay discussions and prioritise the adoption of targeted amendments to the IHR. The fact that the pandemic treaty was not a discussion item during the 2022 WHA is indicative of a certain success for this strategy. On the contrary, the African bloc has been quite cohesive in supporting the pandemic treaty proposal. South Africa and Kenya are the African countries with the most salient preferences in this respect<sup>32</sup>. African countries appeared oriented towards formulating a common position and use negotiations around the pandemic treaty to push for more equity in global health governance<sup>33</sup>.

The approach of CSOs, as expressed during the interviews and the public hearings carried out by the INB, is far from crystal clear. Despite the support for an ambitious international instrument and the will to expand the scope of the instrument to key global health issues (such as AMR, or more broadly R&D), many expressed doubts regarding the feasibility of a treaty or accord. In addition, INB hearings have featured hectic discussions on the direct involvement of the private sector during the debate, while the legal nature of the text to be negotiated remains to be discussed, with actors referring alternatively to a treaty or to a framework convention<sup>34</sup>.

In July 2022, the INB [found consensus](#) on the legal basis of the potential pandemic accord, that is, the provision of the WHO Constitution under which the instrument should be adopted<sup>35</sup>. This significant development means that the new instrument would be granted a binding nature. On the basis of a new [working draft](#), the INB [hosted](#) lively discussions on the use of principles borrowed environmental treaties, such as common but differentiated responsibilities (CBDR). This approach was supported by Brazil and other developing countries, but was opposed by the US.

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<sup>32</sup> Online interview 8, UK government, 2022 and online interview 14, Gavi 2022.

<sup>33</sup> As [reported](#) by the Third World Network in October 2021, ‘countries like Indonesia, New Zealand, South Africa, Botswana, Algeria, Ghana, Kenya, Zambia and the rest of the Africa Group believe a new instrument should contain issues relating to equity, especially those relating to equitable access to diagnostics, treatments and vaccines, their local production and manufacturing capacity building, and the related technology transfer’.

<sup>34</sup> As suggested for instance by the health ministries of Tunisia, Oman and Somalia, which favoured the idea of a framework convention containing general obligations and envisioning subsequent instruments such as specialised protocols. For more, see [An international treaty for pandemic preparedness and response is an urgent necessity - The BMJ](#).

<sup>35</sup> The INB stated that ‘Article 19 of the WHO Constitution is the comprehensive provision under which the instrument should be adopted, without prejudice to also considering, as work progresses, the suitability of Article 21’.

A clear timeline has been [set](#) following the July INB meeting, which will guide the future intergovernmental discussions on a new international treaty. As reported by [Geneva Health Files](#), ‘just as the champions for a Pandemic Accord got comfortable with the reality of negotiating a new instrument under the aegis of the Intergovernmental Negotiating Body, it now appears the process towards amending the IHR has suddenly acquired critical mass’.

As many as four informal, focused consultations were scheduled by the INB in September and October 2022. Topics under discussion included legal matters (e.g. the relationship between the pandemic agreement and other instruments, such as the IHR, sovereignty and institutional arrangements); operationalising and achieving equity (e.g. access and benefit sharing, including genetic sequencing data and stronger health systems); intellectual property (IP) and the production and transfer of technology and know-how (e.g. R&D; the role of TRIPS, compulsory licensing and IP waivers; production capacity and supply chain considerations; and regulatory approvals during emergencies); One Health and AMR, climate change, and zoonoses (including integrated surveillance, monitoring and interoperable data-sharing systems).

The outcomes from these consultations, along with the outcomes from the public hearings, written input from Member States and relevant stakeholders on the working draft, input from the second meeting of the INB, and input from regional consultations, were utilised to develop a ‘conceptual zero draft’, which was discussed at the third meeting of the INB in December 2022 (see Section 3.1 below), and is now due for further discussion in February 2023.

While momentum is certainly growing for the accord, several important issues remain controversial. An example is the way in which equity-related provisions will be included in the accord, and whether binding measures will be introduced<sup>36</sup>; and in relation to this, IP, on which currently proposed provisions were found by commentators to be rather weak<sup>37</sup>. Furthermore, the overlap between negotiations on the IHRs and on the accord

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<sup>36</sup> As reported by [Health Policy Watch](#), ‘while there is unanimous agreement that equity is the essential ingredient in any future pandemic treaty ‘recipe’, World Health Organization (WHO) member states are unclear about how can it be incorporated practically’. One suggestion from the [African Vaccine Delivery Alliance](#) is that a ‘binding’ measure of the treaty should be to ensure manufacturing capacity across all regions.

<sup>37</sup> Dr Carlos Correa, executive director of the South Centre, [said](#) that the wording in the current draft of the pandemic treaty about tech transfer was ‘very weak’, and he suggested the INB follow the example of the UN Framework Convention on Climate Change, which contains ‘concrete words about an obligation to transfer technology’. Similarly, Padmashree Sampath, the chairperson of the technical advisory group of the Covid-19 Technology Access Pool (CTAP), [said](#) the lack of technology transfer during the Covid-19 pandemic had hindered the global response. Richard Hatchett, CEO of the Coalition for Epidemic Preparedness Innovations (CEPI), urged it to use the provisions CEPI has developed to create norms for countries where ‘equity is at the centre of all aspects of pandemic prevention, preparedness and response’.

are [reportedly](#) creating significant confusion, possibly hampering an orderly negotiation process.

Finally, on 5 January 2023 the WHO put forward [ten proposals](#) to strengthen health preparedness and response, including the creation of a Global Health Emergency Council and a committee on emergencies in the World Health Assembly; the strengthening of the health workforce; the standardisation of national preparedness plans; and stronger coordination between finance and health ministers. These will be discussed during 2023, and partly overlap with the reform of the IHRs and the negotiation on the Accord.

## 2.3 STRONGER FINANCING FACILITIES FOR FUTURE HEALTH EMERGENCIES

Several reports and international forums have highlighted the need for stronger financing mechanisms, mostly to be governed by financial institutions such as the IMF and the World Bank, or multilateral development banks (MDBs) in cooperation with large private donors. The need for ‘sustained investment’ was echoed by the GPMB, whose reports evoked the urgency of ‘establishing a collective financing mechanism for preparedness to ensure more sustainable, predictable, flexible, and scalable financing’. Four main proposals are currently on the table, as discussed below<sup>38</sup>.

- *An international pandemic financing facility overseen by the GHTSC.* The IPPPR suggested the creation of a facility able to mobilise long-term (10-15 year) contributions of approximately USD 5-10 billion annually from national governments to finance ongoing preparedness functions. In normal times, the annual budget would be devoted to preparedness activities, from building up global disease surveillance systems to funding country-led preparedness strategies in LMICs. But once the WHO declares a public health emergency of international concern (PHEIC), the facility would be empowered to issue USD 50-100 billion in bonds using the 10-year funding commitments as collateral. This ‘war chest’ would then be deployed to existing health organisations to fight the disease.
- *A G7-led PPR financing facility.* The UK-led Pandemic Preparedness Partnership (PPP) was launched to advise the UK G7 Presidency on how to meet the Prime Minister’s ambition to slash the time to develop and deploy high-quality vaccines for new diseases from 300 to 100 days, backed by additional funding to support CEPI’s work on global vaccine supply. The PPP called for the creation of a new financing facility along with a broad range of other reforms. The facility would be hosted at the World Bank and would focus primarily on emergency surge funding when a pandemic hits. National governments, starting with the G7 countries, would agree in advance to contribute a specified amount upon the declaration of a PHEIC, and then the fund would work through the vaccine alliance Gavi and the Global Fund to distribute

<sup>38</sup> [https://www.jcie.org/wp-content/uploads/2021/08/FGFJ\\_issue\\_brief\\_PPR.pdf](https://www.jcie.org/wp-content/uploads/2021/08/FGFJ_issue_brief_PPR.pdf)

billions of dollars in diagnostics, therapeutics, and vaccines to cover 30 % of the population of LMICs. Concessional loans from the World Bank or the IMF would also be available for countries to purchase additional supplies.

- *A Global Health Threats Fund.* The High-Level Independent Panel (HLIP) on Financing the Global Commons for Pandemic Preparedness and Response report argued that governments should collectively commit to increasing international financing for pandemic prevention and preparedness by at least USD 75 billion over the next five years, or USD 15 billion each year, with sustained investments in subsequent years. The estimate excludes other investments that contribute to resilience, such as containing AMR (an estimated USD 9 billion annually), and funds needed to build stronger and more inclusive national health and delivery systems<sup>39</sup>. This money should be understood as additional, not replacing, existing official development assistance (ODA). It requires, among other things, leveraging the resources of the international finance institutions (IFIs), such as the MDBs and the IMF, in support of global public goods and in particular pandemic preparedness. MDBs should build orchestration schemes together with large donors such as Gavi.
- *A new Financial Intermediary Fund managed by the World Bank.* This would be established in the World Bank as a financial intermediary fund (FIF) and used for key achievements such as: (i) building a transformed global network for surveillance of infectious disease threats; (ii) providing stronger grant financing to complement MDBs and global health intermediaries' support for country- and regional-level investments in global public goods; (iii) ensuring enhanced and reliable funding to enable public-private partnerships for global-scale supply of medical countermeasures; and (iv) supporting research and breakthrough innovations, complementing existing R&D funding mechanisms like CEPI. The idea of leveraging the World Bank was further explored during a finance and health working-group process under the G20 Italian Presidency in 2021, which led to the establishment of a G20 Joint Finance-Health Task Force (JFHTF). Following a two-week consultation process, the World Bank Board of Directors [approved](#) the establishment of a FIF for Pandemic Prevention, Preparedness and Response (renamed 'Pandemic Fund') at the end of June 2022, leading to its [official establishment](#) on 9 September by the FIF Governing Board. The remarkable acceleration of the creation of the FIF in mid-2022 was also accompanied by a significant expansion of the financial commitments

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<sup>39</sup> Such investments have sky-high value-for-money: they are expected to reduce the risk of events whose costs to government budgets alone are 700 times as large as the additional international investments per year proposed, and 300 times as large as the total additional investments, if one takes into account the domestic spending necessary.

(USD 1.4 billion as of mid-September 2022) and membership<sup>40</sup>. It must be highlighted, however, that the current amount of commitments only [equates](#) to slightly more than ‘one-tenth of the world’s annual PPR financing need’. Section 3.2 provides additional details on the scope and direction of the current FIF.

### 2.3.1 Views from stakeholders

Our interviews with relevant stakeholders revealed a lack of awareness or interest about the proposed international pandemic financing facility. This lack is possibly justified by the proliferation of initiatives in this domain, and by there being more prominent proposals, such as the debates about the upcoming FIF.

On the PPP, and its [100 Days Mission](#), USD 1.535 billion were pledged to the CEPI to support its [plan of action](#) in March 2022, in the context of the Global Pandemic Preparedness Summit. Qualitative interviews with government officials provided valuable insights on this proposal. One national diplomat stated: ‘In terms of financing, one of the main issues for the WHO is that there is currently not enough money. And when money comes in, it is with a lot of strings attached. The money is thus spent based on states’ contributions, and there is as a result less scope to actually design and implement public health responses’<sup>41</sup>. The 100 Days Mission proposal was revamped between 2021 and 2022, but with its initial ambition and magnitude lowered. This is partly because, as suggested by a research respondent, the PPP had not been ‘driving the discussions’<sup>42</sup>. As a result of this change, several CSOs argued that the focus of the 100 Days Mission, but also of CEPI, is not broad enough, as it only focuses on a few priority pathogens (instead of also including, for example, therapeutics). Respondents thus suggested the need to broaden the scope of action to make it a more efficient and timely proposal<sup>43</sup>. Neither was equity seen as a prominent feature of the initial proposal, although it admittedly became more visible over time, also as a way to obtain support from a broader group of stakeholders.

The US has been a [major proponent](#) of the establishment of the FIF. Other countries, such as the UK and [Norway](#), also expressed support for the proposal. Yet they were initially concerned by the issue of increased competition between funds. The UK had also [argued](#) that the FIF would be less likely to offer a ‘comparative advantage with regards to

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<sup>40</sup> Members include Australia, Canada, China, the European Commission, France, Germany, India, Indonesia, Italy, Japan, Republic of Korea, New Zealand, Norway, Singapore, South Africa, Spain, the United Arab Emirates, the UK, the US, the Bill & Melinda Gates Foundation, the Rockefeller Foundation, and the Wellcome Trust. Switzerland [announced](#) on November 4 that it would contribute to the FIF with EUR 2 million. More information about the state of play of the financial pledges can be found at <https://www.pandemicactionnetwork.org/news/closing-the-gap-global-pandemic-fund-tracker>.

<sup>41</sup> Online interview, Anonymous, 2022.

<sup>42</sup> Online interview 1, Wellcome Trust, 2022.

<sup>43</sup> Interview 7, Health Poverty Action, 2022.



pandemic response (where rapid surge financing is required), as distinct from preparedness'. Certain CSOs, such as the [Pandemic Action Network](#), supported this initiative early on. Others observed that the Fund's ambition to facilitate better and more equitable funding of R&D (indicated in a recent [white paper](#) of the World Bank) clashed with a rather limited endowment of resources.

The issue of how funding is to be allocated remains subject to debate. One of the worries expressed by respondents was also that the FIF could become a 'fund of funds', in other words, a fund that would transfer resources to 'global implementers' such as Gavi. The African Centre for Disease Control (CDC) [argued](#) in favour of 'direct allocations [that] would enable regional CDCs to promptly and efficiently respond to health threats'. This was echoed by the [Pandemic Action Network](#), which stated that 'funding projects and collaborative efforts at the regional level can solve for a lot of efficiency and for cross-border challenges'. NGOs such as Save the Children [argued](#) that this new mechanism should complement existing agencies as opposed to acting as an additional funding source to deliver on existing strategies. This position was also supported by the IPPPR, stating that the FIF should not be an [operating entity](#).

Moreover, many actors, including the [Global Preparedness Monitoring Board](#), argued that the current scale of funding is still far from sufficient, especially as it relies on voluntary contributions by donors rather than a burden-sharing mechanism. The WHO Council on the economics of Health for All [argued](#) that the FIF should meet the USD 10.5 billion per year gap to justify the creation of this mechanism and secure upfront multiannual funding contributions that enable it to focus on its mission rather than replenishment. Save The Children has [stated](#) that to incentivise countries' investments into the FIF, another model needs to be developed to balance each country's ability to pay with the need to catalyse domestic investments, as it could generate better uptake of the FIF and greater investments in PPR.

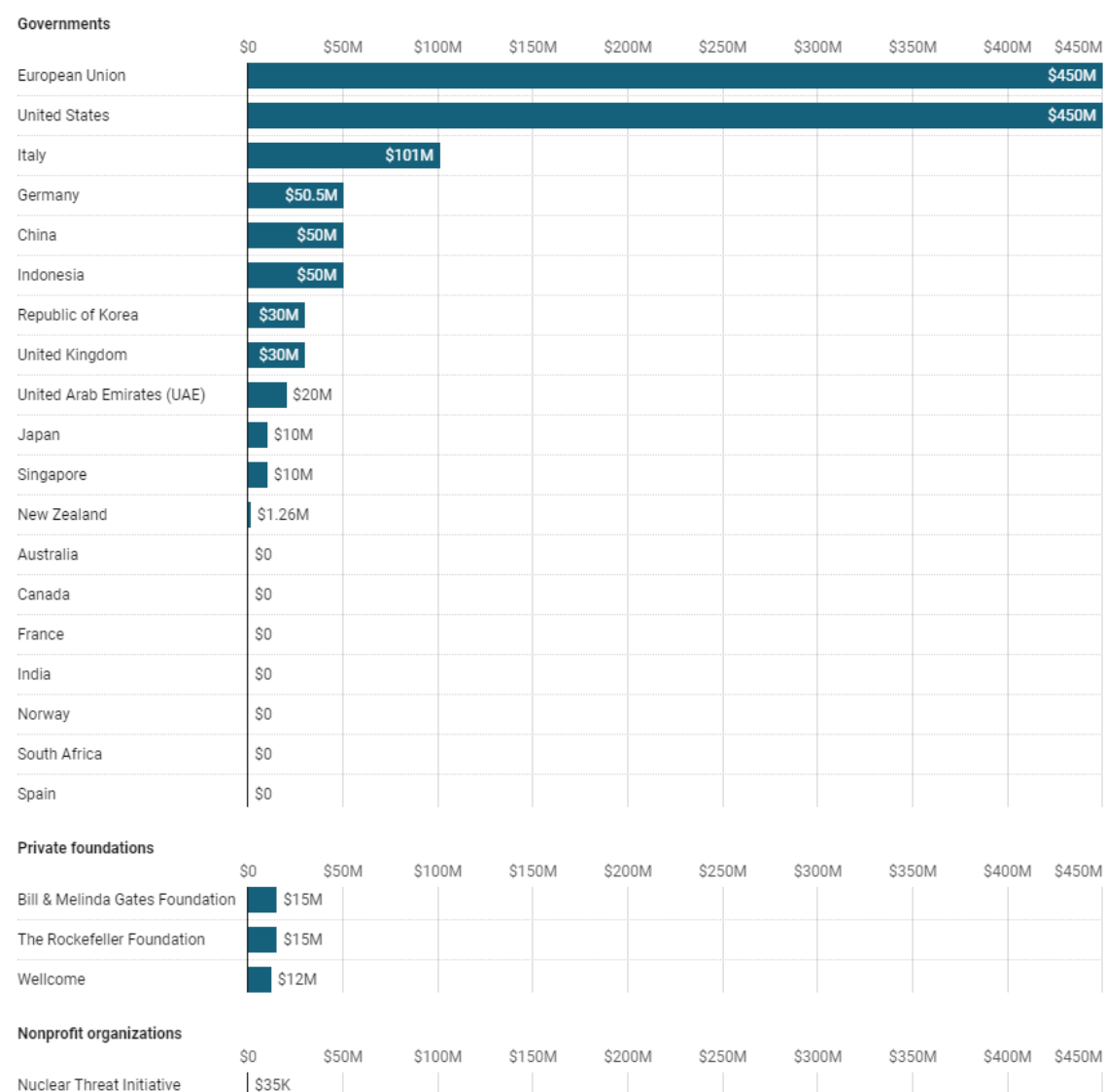
The [consultation process](#) conducted by the World Bank in June 2022, complemented by several [workshops](#) with CSOs in August 2022, underlined the relative divide of global health actors in relation to the governance, role and priority areas of the FIF. For instance, several [CSOs](#) have questioned the role given to the World Bank and MDBs, arguing the FIF could [replicate](#) 'mistakes from the past and leaving the most vulnerable groups behind'. Along the same lines, the Africa Civil Society Organizations Working Group on Preparedness and Response [suggested](#) that the FIF should not 'contribute to further indebtedness of African countries', while urging for the adoption of the [Global Public Investments](#) (GPI) approach that would grant more decision-making power to LMICs and CSOs. Others have [warned](#) against 'uncoordinated competition for diminishing donor funds among a growing number of organisations risks diluting and delaying their work'.

While the first calls for proposals for investments opened in November 2022, more technical and political discussions are expected in relation to the composition of the



Governing Board (notably on the representation of donors, governments and CSOs, and the overall work programme and notably in relation to strengthening PPR capabilities in low- and middle-income countries (see also Section 3.2 below).

Figure 2. Pledges to the FIF by donor



Australia, Canada, France, India, Norway, South Africa, and Spain have not announced a specific pledge amount yet. Last update: September 10, 2022.

Source: Pandemic Action Network, 2022.

In terms of composition and membership, experts have also highlighted that [founding donors](#) remain mostly ‘governments and philanthropies based in and representing the interests of high-income countries’, departing thus from the [constituency-based](#)

[approach](#) of other FIFs such as the CEPI, or the proposal from the IPPPR for a [focused but inclusive membership](#)<sup>44</sup>.

As for the upcoming workplan, the UK [pushes](#) for the FIF to ‘incentivize investment in commercially viable manufacturing capacity and R&D in therapeutics and vaccines’, by financially supporting multilateral development banks. Conversely, [Oxfam](#), among other CSOs, stated that the priority should be the ‘financing of public healthcare and the strengthening of public sector delivery of health services, as well as the funding of public and not-for-profit entities in LMICs, that are developing new or repurposed countermeasures for testing, treatment and vaccination’.

In terms of the next steps, the Governing Board is [expected](#) to appoint a technical advisory panel, chaired by the WHO, which will gather 20 leading experts to assess and make recommendations on the proposals for funding. The World Bank and the WHO are also working with the Governing Board in consultation with other stakeholders, to operationalise the fund and develop the FIF results framework and priorities.

Recent developments thus highlight the quick materialisation of this scenario since the end of 2021. Although its exact role, funding scale and action plan remain to be seen, the FIF is set to be an important new fund for global health governance, whose main priority should be to help complement gaps in existing arrangements. A key issue will thus be the actual interplay of the FIF with other schemes, and in particular with the Access to Covid-19 Tools Accelerator (ACT-A), as evidenced in the following section.

## 2.4 MORE EFFECTIVE DELIVERY THROUGH MULTISTAKEHOLDER PLATFORMS

Over the past two decades, the delivery of global public goods via public-private schemes has risen as a dominant governance form. In a growing number of cases, this has taken the form of ‘orchestration schemes’. These refer to governance models where an international organisation enlists and supports intermediary actors to address target actors in pursuit of its governance goals (Abbott et al., 2015).

Key examples of orchestration in the global health domain include Gavi, the Vaccine Alliance, founded in 2000 to pursue the goal of ‘immunisation for all’<sup>45</sup>, CEPI, launched in

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<sup>44</sup> According to Emily Bass and Asia Russel of [Think Global Health](#), ‘the United States government’s blistering pace for the fund’s launch is motivated more by the concern that U.S. commitments must be banked this fiscal year than by the urgent need to fund an ambitious, expansive pandemic-prevention agenda via a technically sound, transparent institution that is accountable to directly affected communities’. The authors also argue that ‘in lieu of a true participatory approach—and in light of the enormously high stakes of this effort if the first funding round doesn’t show impact and build trust—the fund itself will likely fail’.

<sup>45</sup> Gavi brings together developing country and donor governments, the WHO, UNICEF, the Bill & Melinda Gates Foundation, the World Bank, and others. Gavi acts as an orchestrator by leveraging the Global South Nexus (GSN) and its participants to help people in developing countries access life-saving vaccines at

Davos in 2017 in the aftermath of the West African Ebola epidemic, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, created in 2002 to raise, manage and invest money to combat these destructive diseases<sup>46</sup>. These three schemes became intimately connected as the Covid-19 pandemic hit the world, and the G20 countries announced the launch of a new public-private partnership, the Access to Covid-19 Tools Accelerator or ACT-A. ACT-A is in fact a large, complex cluster of public-private partnerships involving many actors in an ambitious, concerted effort to mobilise sufficient resources to put an end to the pandemic by distributing diagnostics, therapeutics, and vaccines<sup>47</sup>.

As of September 2022, ACT-A had [helped](#) 40 countries to begin their Covid-19 vaccination campaigns, delivering over 1.4 billion vaccine doses to 145 countries through COVAX, helping build the sequencing capacity in southern Africa where the Omicron variant was first detected, and negotiating deals with oxygen suppliers to increase access in more than 120 LMICs. Yet ACT-A has been strongly criticised for being unable to achieve equitable access to Covid-19 tools, and is currently faced with various challenges in relation to its financing structure, delivery scheme and role in the global health architecture. Echoing those concerns, the IPPPR strongly [criticised](#) the ‘way in which the ACT-A was conceptualized and calls for an independent evaluation to find out what went wrong with the initiative’.

Moon et al. (2022) found a rather siloed governance, unable to create and exploit synergies and featuring a rather patchy overall decision-making process. Commentators have observed that resources have been very unevenly allocated, and the role of governments appears to have gradually been ‘changing and receding’. Besides the governance of ACT-A, scholars and practitioners have focused in particular on its vaccine pillar, COVAX. This scheme ended up representing 80 % of the (few) vaccines delivered

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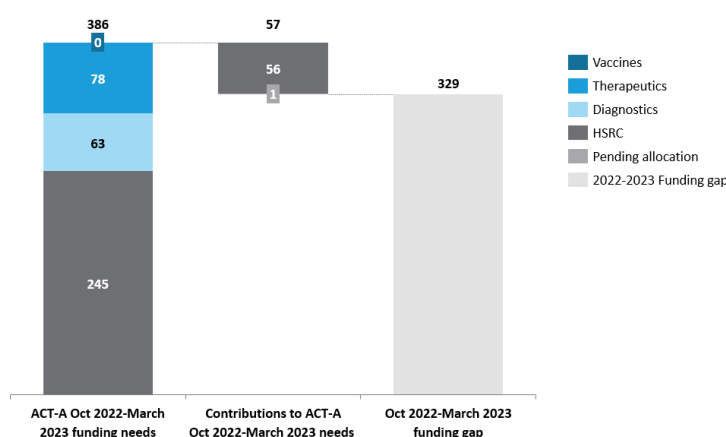
affordable prices, while also removing the commercial risks in serving these markets for the manufacturer. To date, Gavi has helped immunise over 760 million children globally, preventing over 13 million deaths worldwide (Ikilezi et al., 2020).

<sup>46</sup> Its partnership model is designed to promote inclusive solutions to global health challenges, and countries take the lead in determining where and how to best fight AIDS, TB and malaria. As of September 2021, the Global Fund had approved more than USD 62 billion in funding for its core HIV, TB, and malaria activities; and as of October 2021, awarded more than USD 4 billion in funding to respond to Covid-19. This funding has reached over 120 countries. Funding supports a wide range of prevention, treatment, and care activities and health systems development and strengthening. As of September 2021, pledged contributions to the Global Fund had come for 30 % from the US, 11 % from France, 10 % from the UK, and lower but significant contributions from Canada, Japan, Germany and the European Commission. Over 4.3 % of its funds were provided by the Bill & Melinda Gates Foundation <https://www.kff.org/global-health-policy/fact-sheet/the-u-s-the-global-fund-to-fight-aids-tuberculosis-and-malaria/>.

<sup>47</sup> It is so complex that even graphically rendering its governance is problematic: Moon et al. (2022) argue that its peculiar, very flexible governance arrangements warrant the use of a different term than PPP, such as ‘multistakeholder partnership’.

to LMICs, and as such established itself as the dominant channel for distribution<sup>48</sup>. As already mentioned, COVAX failed to achieve the target of 70 % Covid-19 vaccination coverage with the primary series in all countries by mid-2022. Experts and [journalists](#) have emphasised the lack of commitment, stop-and-go financing, rather murky governance and huge funding gaps as key problems faced by COVAX<sup>49</sup>. Recently, however, [top policymakers](#) have been more explicit in mentioning the ‘greed of the North’, and that of the pharmaceutical industry, as more important than governance aspects in causing COVAX’s failure.

Figure 3. ACT-A funding gap for the transition period (1 Oct 2022 to 31 Mar 2023) in US\$ million



Source: ACT-A, 2022

What can be done to ensure the lessons of the past three years are fully learned? Available options for future reform under this area include at least three scenarios: an improvement of the governance of ACT-A; its transformation into a fully end-to-end platform; or a more ambitious overhaul to bring more structure, a broader scope, and increased institutional density in the quest for delivering global health public goods on the ground.

<sup>48</sup> Gavi launched a ‘COVAX Facility’ through which self-financing economies and funded economies can participate; and a ‘COVAX Advance Market Commitment’, which supports access to Covid-19 vaccines for lower-income economies. Initially underfunded, COVAX was given a boost with the G7 meeting in February 2021, in which the US announced a USD 4 billion contribution, and the EU doubled its contribution from EUR 500 million to 1 billion. The orchestrated effort carried out under the umbrella of the COVAX scheme is attracting participation from several non-state actors; for example, global logistics company UPS recently partnered with COVAX to speed up vaccine delivery, aiming to bring 20 million Covid-19 vaccines to four continents.

<sup>49</sup> One of the major issues for ACT-A has been to raise the required budget for action areas other than its well-known vaccine component, COVAX. It is indeed [said to have raised only](#) ‘one-sixth of the required budget for its other three priorities — testing, treatment and health system initiatives such as equipping healthcare workers with personal protective equipment’. In June 2022, ACT-A had indeed a USD 11.2 billion [funding gap](#) for the 2022-2023 fiscal year for vaccines, diagnostics, treatments, and personal protective equipment (PPE). The scale of the funding gap has led to [pessimistic analyses](#) of the future of ACT-A, in particular as donors and countries recently prioritised the newly established FIF for PPR.

- *Improving the governance and effectiveness of ACT-A.* Short-term improvements to the governance of ACT-A have been proposed by commentators and experts, such as Moon et al. (2022). They would fall into four main areas: (i) clearer decision-making roles, responsibilities, and processes (i.e. strengthening accountability and legitimacy); (ii) adopting a common transparency policy across the multitude of operations and organisations that compose the ACT-A mosaic; (iii) consult stakeholders, globally and locally, on a regular basis; and (iv) carrying out a strategic review of individual pillars, in particular the vaccines one, to learn from past mistakes. The IPPPR, in proposing a more inclusive governance, proposed to transform ACT-A so that it carries out its many operations: (i) based on plans jointly developed by WHO, regional institutions, and the private sector; (ii) with commitments and processes for technology transfer, including to and among larger manufacturing hubs in each region; and (iii) supported financially by IFIs and regional development banks and other public and private financing organisations<sup>50</sup>.
- *Moving towards an end-to-end platform.* One of the proposals by the [Independent Panel for Pandemic Preparedness and Response](#) is that ACT-A could be transformed into a global end-to-end platform for vaccines, diagnostics, therapeutics, and essential supplies. This would be accompanied by a shift from a model where innovation is left to the market and conveyed through ACT-A to beneficiaries, to a model in which R&D, deployment and distribution are coordinated and carried out with stronger orientation towards the delivery of global public goods.
- *Global integration of ACT-A as a public-private multistakeholder ‘meta-partnership’.* This would entail increasing its orientation towards systemic health resilience, sharpening its vocation towards health and sustainable development, and increasing its institutional density in terms of multi-level governance representation. Stronger emphasis on resilience could lead ACT-A to focus on health systems and pursue a degree of decentralisation of priority-setting and production, rather than a prevalent focus on accelerating production and streamlining the time-to-delivery through better contracts. ACT-A would thus promote regional capacity-building for manufacturing, regulation, and procurement of tools for equitable and effective access to vaccines, therapeutics, diagnostics, and essential supplies, and for clinical trials. In this new context, the role of the WHO could be supported by national/regional institutions such as the US Biomedical Advanced Research and Development Authority (BARDA), the European Commission HERA (or crisis board),

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<sup>50</sup> Capitalise on the relative success of ACT-A (considering it did not exist before the pandemic) by building a more inclusive system, able ‘to coordinate decision-making globally; maintain effective relationships with vaccine and other product manufacturers from both the public and the private sector and from all regions; strengthen global and local manufacturing capacity, including long-term and sustained investment in technology transfer; and incorporate a financing mechanism that invests early in the development cycle in order to support rapid and equitable development, manufacturing, and access’.

the Korean Disease Control and Prevention Agency (KDCA) and homologous institutions in other continents. These institutions may be then joined by IFIs and private donors in a concerted, mission-oriented delivery on global public goods<sup>51</sup>.

#### 2.4.1 Views from stakeholders

In July 2022, the Act-A Facilitation Council co-chairs (Norway and South Africa) commissioned an independent, external evaluation of ACT-A and invited six other countries and four civil society representatives to join the ACT-A External Evaluation Reference Group to oversee the evaluation. In October 2022, the evaluation was [released](#) and indicated that the global scope of the vaccines pillar COVAX was too ambitious and that ACT-A's informal coordination model is insufficient for future pandemic response: a different design will be needed to address future pandemics. According to the evaluation report, one of the lessons learnt is also that 'future pandemic response must enable immediate access to initial funding for at-risk development and procurement. A pandemic Advance Commitment Facility – with access to a credit line, inclusive and accountable governance structure, and a targeted scope – should be established to enable a fast, equitable global response in a future pandemic'. However, in an [addendum to the external evaluation](#), stakeholders (including Gavi, the Global Fund, and Unitaidd) strongly criticised the approach and findings of the study.

Moreover, ACT-A also released its [plan on a transition](#) into the long-term control of Covid-19. In October 2022, ACT-A entered a 6-month transition period (to end in March 2023). This period has been presented as an opportunity to re-design ACT-A “from crisis mode to more sustainable operations and financing”. As a result, ACT-A's Facilitation Council was put on 'stand-by' and a Tracking & Monitoring Task Force was created to replace it during the transition. The next phase of ACT-A partners' work is to centre on three overarching areas: (i) focusing R&D and market-shaping activities to ensure a pipeline for new and enhanced Covid-19 tools; (ii) securing institutional arrangements for sustained access for all countries to Covid-19 vaccines, tests and treatments, including oxygen; and (iii) concentrating in-country work on new product introduction (e.g. new oral antivirals for those at highest risk) and protection of priority populations (e.g. full vaccination of healthcare workers and older populations), in support of national and international targets.

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<sup>51</sup> Traditionally, public goods for health include knowledge generated by R&D and communicable disease control. The Lancet Commission on Investing in Health, however, has broadened the definition of global public goods for health to include the management of negative cross-border externalities (such as controlling epidemics and pandemics, tracking AMR and curbing the spread of risk factors for noncommunicable diseases) and fostering global leadership or stewardship (cross-sectoral advocacy, global convening to develop consensus and global policies).

### 3. THE EMERGING LANDSCAPE OF GLOBAL HEALTH GOVERNANCE

In the midst of an ongoing pandemic, proposed reforms must face the twofold challenge of bringing the current emergency to an end, as well as preventing new health emergencies from occurring. At the time of writing, the Covid-19 pandemic is far from being under control, and social unrest is occurring in countries such as China, where the spread of the virus was contained through harsh zero-COVID policies. These policies eventually led to discontent and frustration among citizens in various provinces, and the subsequent relaxation of lockdown measures may cause a severe [death toll](#). Also in Europe, the emergence of new sub-variants of Omicron, such as ‘Cerberus’ and ‘Gryphon’, has led some countries to consider reinstating new non-pharmaceutical restrictions.

The coming months will see two major developments in the global health security landscape: the negotiations on the pandemic accord, which aim to arrive at a finalised text for the WHA in May 2024; and the entry into operation of the FIF, under the coordination of the World Bank. Below, we analyse these two developments in detail, and offer some recommendations for improvement and additional actions that would capture the whole range of the lessons learnt before and during the pandemic.

#### 3.1 THE DRAFT PANDEMIC ACCORD: BRIGHT AND DARK SIDES

The [Zero Draft of the pandemic accord](#) (the ‘WHO CA+’) circulated in November 2022 ticks many boxes. It contains, among other things, resounding statements on the need to prioritise equity and universal health coverage; a firm endorsement of the One Health approach (Article 17); the adoption of the CBDR principle adopted in climate policy since the 1992 Rio Summit; and the acknowledgment of the need for a ‘whole-of-government’ and ‘whole-of-society’ approach to strengthening national capacities for pandemic prevention, preparedness, response and health systems recovery. The reported objective of the WHO CA+ is ‘to save lives and protect livelihoods, through strengthening, proactively, the world’s capacities for preventing, preparing for and responding to, and recovery of health systems from pandemics’.

Obligations for member countries are far-reaching, at least in theory. On *global supply chains*, draft Article 6 calls on member countries to ensure a concerted and coordinated approach to the availability and distribution of, and equitable access to, pandemic response products. They will also have to find ways to prioritise and coordinate country requests for essential supplies, and keep updated national action plans for pandemic prevention, preparedness, response and recovery of health systems. They shall collectively enhance their national as well as regional logistical capacities to establish and

maintain strategic stockpiles of pandemic response products<sup>52</sup>. They shall also allocate supplies, raw materials and other necessary inputs for the sustainable production of pandemic response products.

The draft WHO CA+ also contains important provisions on *access to know-how and technology*, whereas Article 7 mandates that parties develop ad hoc multilateral mechanisms to promote and provide relevant transfer of technology and know-how to potential manufacturers to increase and strengthen regional and global manufacturing capacity. In addition, each country will have to take measures to strengthen local manufacturing and regulatory capacity.

When it comes to *research and innovation*, provisions *ex* Article 8 aim to foster international and regional cooperation, as well as information-sharing through open science. In addition, in the current version of the text, countries commit to developing strong, resilient national, regional and international clinical research ecosystems, provide enhanced transparency on public funding of research, and ‘recommend’ the disclosure of prices and contractual terms for public procurement in times of pandemics.

These provisions are complemented by rules on *access to pandemic response products*, where the CA+ (Article 9) calls on countries to promote ‘rapid and transparent sharing’ of relevant pathogens and genetic sequence data, as well as fair and equitable access to benefits arising from such sharing. Countries then individually commit to designing and implementing an ad hoc system for access and benefit sharing, including measures to promote open and safe data sharing and the respect of biosafety standards in laboratories.

Furthermore, important provisions are contained in the draft WHO CA+ for what concerns the *strengthening of national and local health systems*, one of the key lessons emerging from the pandemic. Proposed measures (Article 10) call on member countries to strengthen public health functions and infrastructures (including digital health), including authorities, laboratories, surveillance systems oriented towards One Health, and both prevention and response capacity. Part of this strengthening is also the commitment to establishing and (re)training a large and competent *health workforce* (Article 11).

As countries are asked to establish whole-of-government strategies and national pandemic prevention, preparedness, response and health system recovery strategies, the CA+ calls on them to ‘*drill*’ these plans on a regular basis; Article 12 also mandates

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<sup>52</sup> Article 6 also calls on countries to establish and operationalise international consolidation hubs, as well as regional staging areas, to ensure that transport of supplies is streamlined and uses the most appropriate means for the products concerned.



that countries establish peer review mechanisms to ensure the adequate monitoring of compliance with these obligations.

Most of these commitments are spelled out for the national level, and with full respect for the principle of sovereignty (on which, see below). Concerning coordination and collaboration at the international level, the proposed Article 13 calls on countries to ensure strong political commitment and leadership, promote science- and evidence-based decision-making, develop and support inclusive policies, and fully support the work of the WHO. Countries shall also put in place whole-of-government and whole-of-society policies and strategies, involving communities, civil society, academia, and the private sector in a joined-up endeavour to strengthen resilience. This includes, among other things, the promotion of health literacy, the fight against disinformation and misinformation and the study of behavioural factors that affect trust in public health measures (e.g. vaccine hesitancy). Even more prominently, member countries are urged to adopt a One Health approach by enhancing the surveillance and reporting of AMR; regularly assessing One Health capacities; strengthening synergies with policies and programmes on climate change, biodiversity loss, ecosystem degradation and increased risks at the animal–human–environment interface due to human activities; and bringing the One Health approach into science-based evidence, as well as evidence-based and risk-informed implementation of infection prevention and control.

Perhaps the most controversial provisions in the draft CA+, as confirmed by the recent meeting of the INB in early December 2022, are Chapter VI (on financing), and Chapter VII (on institutional arrangements). On *financing*, each member country is asked to support with adequate financial resources all the commitments included in the CA+ (Article 22). This implies, among other things, the use of ‘new or established international mechanisms’ for ensuring and enhancing equitable access to sustainable and predictable financing, in particular prioritising the mobilisation of adequate financial resources, including from international financing facilities, to affected countries (Article 18). These provisions were rather fiercely criticised, especially in light of the situations of distress many developing and least developed countries are currently in, as well as the insufficiency of the Pandemic Fund (see next Section), and the enduring austerity-orientation of the re-channelled IMF SDRs. Without more substantial support, and making the right to health and universal health coverage a priority over fiscal discipline constraints, LMICs would find themselves squeezed between a rock (the CA+ commitments to devote resources) and a hard place (the complementary contribution of the Pandemic Fund, conditioned on national resources).

On *institutional arrangements*, Chapter VII provides for the establishment of a Governing Body composed of a Conference of the Parties (COP), ‘borrowed’ from the experience of the WHO Framework Convention on Tobacco Control; an administrative organ with denominated Officers of the Parties; and an Enlarged Conference of the Parties (E-COP),

including relevant stakeholders, with the mandate to ‘provide broad input for the decision-making processes of the COP’. This latter body potentially re-proposes the original idea to create a multistakeholder ‘policy forum’, as detailed in Section 2.2. NGOs have raised concerns that the proposed E-COP does not come with provisions aimed at preventing large donors and foundations from strongly influencing the overall governance of the future accord, and given the limited resources of many CSOs and poorer countries to meaningfully participate in the collective decision-making process.

On 5 December 2022 the WHO secretariat circulated a [background information paper](#) on ‘certain legal and governance considerations’. The paper explores possible options for strengthening compliance monitoring and verification, mentioning existing procedures such as the Compliance Committees of both the Kyoto Protocol and of the Paris Agreement to the United Nations Framework Convention on Climate Change; and the non-compliance procedure of the Montreal Protocol on Substances that Deplete the Ozone Layer. It also recommended, albeit briefly, that the INB considers establishing instruments to assess and verify compliance with the instrument by its parties, ‘through means such as monitoring, fact-finding missions and inspection’. For the time being, however, no mention is made of possible resources or dedicated staff in charge of such activities.

The draft CA+, as already mentioned, apparently tackles many of the root causes of pandemic. However, there are reasons for concern, due to several [ongoing discussions on definitions](#), and to a governance scheme that is mostly reliant on individual country commitments, with a rather weak mechanism for peer review and overall coordination of measures at the regional and global level. First commentaries provided by academics and NGOs point to the lack of specific provisions on the set-up of adequate financial mechanisms, in particular when it comes to supporting LMICs in shouldering the burden of stronger health systems, as well as coping with the socioeconomic consequences of current and future pandemics. In this respect, the notion of ‘sovereignty’ reaffirmed by the CA+ was deemed to fall short of the need for LMICs to be shielded from unfair trade; and measures to protect human rights during health emergencies are [insufficient](#) in the current text, especially in light of the emphasis on a whole-of-government and whole-of-society approach contained in the draft CA+.

In summary, the draft WHO CA+, while endorsing a comprehensive and ambitious positioning of universal health coverage and One Health at the forefront of national public policies, falls short of creating the global solidarity and the credible, enforceable international commitments that are badly needed to remedy the root causes of the pandemic. Moreover, it potentially places LMICs in the rather awkward situation of having to commit to extremely ambitious plans with little certainty that global funding and support may eventually come to the rescue. Pending the possible reform of the IHRs, CA+ also seems timid in giving answers to one of the most evident fallacies of global

health governance both before and after the pandemic: the lack of true compliance with IHR commitments, despite their binding nature – a lack of compliance that was corroborated by a system grounded in self-reporting and subject to rather misleading indicators that consistently showed outstanding preparedness for countries that eventually succumbed to the dramatic evolution of Covid-19. Finally, the draft text misses the opportunity to create a global framework for the collection and reporting of granular and meaningful (official and non-conventional) data, and for their use in support of more effective, agile and proactive policies for health resilience.

### 3.2 THE ‘PANDEMIC FUND’: TOO SMALL, TOO DONOR-DOMINATED?

The launch of the FIF in November 2022 was accompanied by a mixture of hope and disappointment. The pandemic fund aims to reach significant yearly resources (USD 10.5 billion), to be distributed to recipient countries for a variety of investments, ranging from disease surveillance to the strengthening of health systems. However, the initial commitments to the fund did not go beyond USD 1.4 billion, and prospects for adequate replenishment in the coming months are gloomy, also because of the looming economic recession, and the current salience of old and new competing priorities, from climate and biodiversity to the war in Ukraine and the mounting food crisis. Contrast this situation with the conservatively estimated USD 31.1 billion needed annually to prevent, prepare for, and respond to future pandemics, a figure produced by the World Bank itself.

Moreover, [commentators](#) have raised concerns that the governance of the FIF, despite attempting to partly deviate from existing FIFs already established at the World Bank, may lead to severe shortcomings in terms of priority-setting, civil society involvement, and adequate tailoring of actions to the specific needs of recipient countries. A rather patchy and rushed procedure to choose the two seats (out of a total of 21) allocated to civil society in the Board of the Fund, leaving little space for less endowed CSOs to have a chance at securing sufficient ‘voice’. The FIF was also criticised since it will eventually keep the WHO at the margins, as a member of the technical advisory board panel and as ‘observer’ in the Board.

Critics of the Pandemic Fund mentioned the greater effectiveness and representativeness of the modus operandi of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and [invoke](#) the extension of the latter’s mandate as at least a complementary (if not substitutive altogether) move to strengthen global health financing for PPR. This would help alleviate [concerns](#) that the contributions to the Pandemic Fund, if eventually occurring, may come at the expense of investment in responding to equally pressing global diseases such as the ones addressed by the Global Fund. Not surprisingly, the Global Fund failed to meet its target for the seventh replenishment conference in September 2022, and even with the delayed pledges by the UK and Italy, it still struggles to secure sufficient support. One country, Namibia,

[reportedly](#) raised the need for a fund anchored to the WHO in the context of the CA+ negotiations in December 2022, but it is unclear whether this proposal will be considered given the launch of the Pandemic Fund.

Finally, concerns were expressed that relying on the FIF scheme may expose the Fund to the same problems [observed](#) by similar initiatives in the past years, including misalignment of aid and needs, lack of transparency and limited accountability. An authoritative commentator [observed](#) that ‘the model proposed by the World Bank seems to be inspired by organizational models from the last century’, and that in the FIF ‘only the Member States have a voice and a vote: the donors are at the top of the pyramid and the countries, which are called beneficiaries, are at the bottom’.

Table 1. Problems, root causes and current progress (authors' assessment as of December 2022)

Problem	Root cause	Addressed?	Comments
Lack of timely notification	Insufficient safety and hygiene/security standards in labs/markets	Partly	Mentioned in the current text of the CA+. In addition, the Pandemic Fund's Governing Board agreed to prioritise disease surveillance, national laboratory systems and human resources.
	Lack of acceptance of scientists' advice	Partly	Art. 13 CA+ calls on countries to promote health literacy, as well as evidence- and science-based policies. No concrete provision on stepping up science advice.
	Poor international data sharing on outbreaks	Partly	Art. 9 of the CA+ calls on countries to promote rapid and transparent sharing of relevant pathogens and genetic sequence data. But there seems to be, at the moment, no real binding commitment.
	Lack of specific investigative powers and resources (eg, in the WHO)	No	Originally proposed in the context of the IHR amendments, the creation of an ad hoc system never reached the advanced negotiation stage. Hopes are limited to the ongoing Universal Health Preparedness Reviews, piloted in four countries.
	Lack of scenario planning and foresight	Partly	The WHO Hub for Pandemic and Epidemic Intelligence will help to build collective capacities to predict, detect, assess and respond to health emergencies. However, it is not yet accompanied by adequate resources and a data collection/sharing infrastructure.
Delayed acknowledgment of airborne exposure	Historical reasons behind the lack of understanding of aerosols	No	Could be tackled by a stronger scientific advice and cooperation in support of the WHO.
	The WHO's hesitancy to acknowledge mode & extent of transmission of the virus	No	No specific provision on strengthening the scientific capacity of reviews. Possible improvements may come from the Universal Health and Preparedness Reviews, currently being piloted in four countries.
	The WHO's conservative approach to declaring PHEICs	Partly	Could be tackled by a stronger scientific advice and cooperation in support of the WHO; and by the creation of the Standing Committee on Pandemic Preparedness. Uncertainty persists on the upcoming negotiation of the IHRs, and on the definition of pandemic under the CA+.
	Independence and authority of the WHO, its internal procedures and constraints	Partly	Constraints may partly be eased by the increase in the percentage of assessed contributions on the total WHO budget. The Standing Committee on Pandemic Preparedness and the WHO CA+ appear to potentially strengthen the role of the WHO.
No international coordination of suppression strategies	Inefficient implementation and enforcement of the IHR	Partly	Unclear whether the amendments to the IHRs will be superseded by negotiations on the CA+, and will be ambitious enough in scope (currently, emphasis seems to be on procedural issues, e.g. Art. 59).
	Failure to establish functional decision-making structures during crisis times	Partly	The creation of the Standing Committee on Pandemic Preparedness is one step in this direction; the IHR amendments are at present unlikely to dig deeper into this issue.
	Lack of support for the work of the WHO	Yes	The CA+ and the amendment of the IHRs both reaffirm the centrality of the WHO, despite alternative proposals being initially tabled to complement or replace this institution. Also, there seems to be convergence on increasing assessed contributions up to 50 % of the total budget (even if this falls short of the initial proposal by the IPPPR).
	Fragility of supply chains for essential medical counter-measures	Yes	Art. 6 of the draft CA+ calls on countries to ensure a concerted and coordinated approach to the distribution of, and access to, pandemic response products, as well as to stockpiles. There are no specific provisions on international stress-testing of supply chains.
	Inadequate pre-COVID economic model of globalisation	No	No concrete measures on issues such as 'health in all policies'.
Failures in examining evidence and managing spillovers	Lack of an international framework for cooperation and policy learning	Partly	The pilots of the WHO Universal Health Preparedness reviews may provide an avenue for policy learning. The same could be said about the creation of an E-COP in the CA+.
	Hoarding of key assets at national level	Partly	Art. 6 of the draft CA+ calls on countries to ensure a concerted and coordinated approach to the distribution of, and access to, pandemic response products, as well as to stockpiles.

Lack of global funding and support for LMICs	Lack of swift agreement on TRIPS waiver	Partly	WTO adopted the controversial 'TRIPS waiver' proposal at the 12 <sup>th</sup> Ministerial Meeting in June 2022. The decision is much diluted compared to the original 'waiver proposal', but provides certainty and clarity in relation to compulsory licence authorisation vis-à-vis future pandemics.
	Persisting lack of contributions to COVAX	No	No concrete measures.
	Race to hoard vaccines in developed countries	Partly	Art. 6 of the draft CA+ calls on countries to ensure a concerted and coordinated approach to the distribution of, and access to, pandemic response products, as well as to stockpiles. But there is no concrete enforcement mechanism.
	Stunning price differentials across countries, favouring richer economies	No	Art. 6 CA+ calls for measures to promote and encourage transparency, but there are no provisions on containing price discrimination.
	Lack of transparency in negotiations b/w gov and pharma	Partly	Art. 6 CA+ calls for measures to promote and encourage transparency in cost and pricing of pandemic response products, including development, production and distribution costs.
	Donor funding (eg IMF SDR) still austerity-focused	No	Despite initial hopes and a variety of initiatives, the outlook for debt restructuring appears patchy, slow, not accessible to all countries, and fraught with many deficiencies. The Pandemic Fund is too small and not oriented towards remedying this problem.
Inadequate global supplies & distribution of key commodities	Disruption of too-fragile supply chains	Partly	Art. 6 of the draft CA+ calls on countries to ensure a concerted and coordinated approach to the distribution of, and access to, pandemic response products, as well as to stockpiles. There are no specific provisions on international stress-testing of supply chains.
	Absence of a pre-determined framework for distributing resources	Partly	The reform of ACT-A appears to move slowly, and it is unclear whether it will lead to a revamped, more effective and participated system for the delivery of pandemic products on the ground.
	Lack of national/regional institutions joining the planning of distribution	Partly	The role of regional authorities is mentioned in the CA+, but the creation of a more inclusive governance system (including the participation of regional authorities in the Pandemic Fund and in ACT-A) is far from a reality.
	Lack of production/distribution capacity in LMICs	Yes	Art. 7 and 8 of the proposed CA+ call for national and multilateral mechanisms to promote technology transfer and research cooperation, including through open science.
	Insufficient implementation of the 2001 TRIPS agreement	Partly	WTO adopted the controversial 'TRIPS waiver' proposal at the 12 <sup>th</sup> Ministerial Meeting in June 2022. The decision is much diluted compared to the original 'waiver proposal', but provides certainty and clarity in relation to compulsory licence authorisation vis-à-vis future pandemics.
Lack of adequate and timely data collection & sharing	Poor data collection and reporting systems quality in many LMICs	Partly	Art. 10 CA+ calls on countries to, among other things, building digital health and data science capacities.
	Lack of adequate data collection by institutes of statistics/health authorities	Partly	Art. 10 CA+ calls on countries to, among other things, building digital health and data science capacities.
	Dependency on governments with strong incentives to under-report	No	No concrete action.
	Limited data collection from less conventional sources	No	No concrete action.
	Relative immaturity (misuse) of new solutions such as machine learning	No	No concrete action.
	Lack of frameworks for government access/use of privately held data	No	No concrete action at the international level.

Poor enforcement of biosafety regulation	Lack of training or lack of compliance with standard operating procedures	Partly	The WHO Technical Advisory Group on biosafety published a new edition of its manual, and a new Life Science framework. These are, however, only guidance frameworks, with no binding commitment or enforcement mechanism. However, on 12 and 13 December 2022, the Pandemic Fund's Governing Board agreed that projects financed through the first round of funding in LMICs will prioritise disease surveillance, national laboratory systems and human resources.
	Lack of on-site inspections to ensure respect of lab biosafety standards	Partly	The CA+ calls on countries to strengthen respect for biosafety standards, and potentially established a peer review system. Enforcement is, however, lacking.
	Lack of a 'One Health' approach to surveillance	Yes	Both the proposed IHR amendments and the negotiation on the CA+ (Art. 10) emphasise the need for a One Health approach. Lack of clarity on the definition of One Health in the CA+.
Inadequate control of disinformation & misinformation	Lack of trust in science (among citizens and political leaders)	Partly	Art. 13 CA+ calls on countries to promote health literacy, as well as evidence- and science-based policies. This includes also tackling disinformation.
	Failure to communicate science effectively to citizens	Partly	Art. 13 CA+ calls on countries to promote health literacy.
	Lack of global cooperation on tackling disinformation	No	The most prominent initiatives are limited to soft law (global code of conduct).
	Bad or non-existent science advice to decision-makers	No	Art. 13 CA+ calls on countries to strengthen evidence-based and science-based decision-making, but the provision is still rather vague.
	Absence of an adequate legislative framework on online intermediaries	No	No concrete action on this front.
Lack of global and national safety nets to protect the vulnerable	Lack of solidarity in procurement and distribution of MCMs	Yes	The CA+ points to the need for solidarity and ensuring the distribution of pandemic products on the basis of need, to tackle situations of emergency. Art. 11 calls for adequate human, financial and other necessary resources for affected countries, based on public health need, to contain outbreaks and prevent escalation of small-scale spread to global proportions.
	Absence of an effective framework for international cooperation	Yes	Creation of the WHO Standing Committee on Health Emergency Prevention, Preparedness and Response; coordination measures in the CA+; possible strengthening of procedural rules in IHRs. Still unclear whether all the pieces of the puzzle will be there.
	Lack of global preparedness for situations of health emergency	Yes	Art. 12 of the CA+ calls on countries to develop preparedness plans, and drill them on a regular basis. Countries also have to establish peer review mechanisms.
	Lack of resilience-oriented interventions for global supply chains	No	No concrete provisions for the international stress-testing of supply chains. CA+ provisions may lead to enhanced coordination (e.g. Art. 6), but implementation is rather unclear at the moment.
	Absence of an international task force in charge of locating outbreaks	No	Originally proposed in the context of the IHR amendments, it never reached the advanced negotiation stage.
	Efficiency-oriented national policies that eroded the welfare state/health systems	Partly	Art. 10 of the draft CA+ deals with stronger health systems. But there is no significant funding for LMICs, and no concrete action item to ensure that the lessons from the pandemic are reflected in new guidance on national socioeconomic policies. Some countries in the Global South are responding by proposing 'pandemic clauses' and 'debt-to-health' conditionalities.
	Lack of attention for social infrastructure and its impact on resilience and effectiveness	No	Concerns are exacerbated by the limited involvement of civil society and local actors in the governance of the Pandemic Fund.

### 3.3 A MORE AMBITIOUS AGENDA: TEN AREAS FOR IMPROVEMENT IN CURRENT GLOBAL HEALTH SECURITY GOVERNANCE

The global community has tried to respond to the enduring pandemic with the launch of new instruments and new international agreements. At the same time, scientific evidence and advocacy by practitioners, academics and civil society has called for gradually shifting the focus of global and national action towards more comprehensive monitoring of the root causes of present and future pandemics ('One Health'); greater salience of health in government priorities ('Health in All Policies'); greater attention to the involvement of local communities; stronger focus on local social infrastructure to ensure the effectiveness and fitness-for-purpose of health policies; a broadening of the scope of government interventions to include better infrastructure, public-private schemes, training of (human and animal) health workers, focus on socioeconomic as well as behavioural aspects of epidemics and pandemics; and enhanced attention to the protection of human rights, including but not limited to the right to health and universal health coverage.

Against this background, the emerging landscape for global health governance analysed in this report appears to lack ambition, as well as creativity. On the one hand, measures such as the Pandemic Fund and the draft pandemic accord only partially address the root causes of the outstanding challenges and dysfunctions observed in the response to Covid-19 (as shown in Table 1). On the other hand, even if effective, these measures risk leaving national health systems underfunded, and the global community's ability to prevent future pandemics severely hampered. The magnitude of the challenge is so significant that a much greater degree of ambition and creativity will be needed to ensure that, as new crises plunge the multilateral order into a situation of poly-crisis (possibly becoming 'permacrisis'), the world's lack of health resilience becomes the victim of yet another episode of panic and neglect.

Future actions should look more carefully into the perverse incentives that have led to the disastrous impacts of Covid-19. These go far beyond the ten problems detected and highlighted by existing reports, and include: tackling the global public good nature of health, with its related collective action problems; the need to achieve resilience by empowering local communities, and at the same time strengthening global and regional coordination; and the urgency of revisiting the economic model that backs donor funding in LMICs, to include funding in exchange for universal health coverage, as well as a 'maximin' principle inspired by adequate, global foresight.

Below, we briefly outline a (non-exhaustive) list of possible future actions. As is self-evident, only a tiny portion of these initiatives can be achieved through incremental changes in current initiatives.



### 3.3.1 Introducing health-oriented conditionalities in the international financing of LMICs

One of the unaddressed causes of the Covid-19 pandemic is the insistence of the global community on an economic model of growth that disregarded the need for resilience, as opposed to purely cost-based economic efficiency. This was reflected in various domains of the global economy, from global value chains to domestic and international fiscal policies. And, as already mentioned, it is still largely reflected in the conditionalities imposed by international organisations and donors when providing aid to LMICs, as is prominently the case for the IMF SDRs.

Especially in the current context, which sees several countries close to, or already in, financial distress, the risk is that national health systems will be further weakened by governments in need of conditioned financial aid. This would in turn also lead countries to fail to respect the ambitious commitments included in the draft pandemic accord.

One of the possible ways to remedy this problem is the introduction of mandatory health- (or nature-) oriented conditionalities in international donor assistance. This would imply that rather than imposing drastic cuts in public expenditure, loans or grants would be offered to developing countries in exchange for meaningful investment in health systems and resilience. ‘Debt-to-health swaps’ resemble other forms of payment received by countries in exchange for contributing to global public goods, such as ‘payment for ecosystem services’ or ‘[debt-to-nature](#)’ schemes, and have been applied in various contexts, including by the Global Fund, over the past two decades.

Inevitably, debt-to-health swaps require adequate monitoring and reporting, and would need to be coupled with extensive data collection and sharing (see Section 4.6 below). This, in turn, could provide international organisations with key data sources to engage in more meaningful disease surveillance and monitoring.

### 3.3.2 Introducing ‘pandemic clauses’ for countries in (or close to) financial distress

The ongoing crisis of sovereign debts for several countries around the world will call for innovation and a degree of creativity in the way countries preserve their obligations and commitment towards guaranteeing health for all. This may require new financial schemes that attach conditionalities to the delayed repayment of debt. A good example is the ‘pandemic clause’ attached to the conversion of sovereign bonds completed by the government of Barbados in September 2022. As [described](#) by the WHO Council on the Economics of Health for All, the clause features conditionalities for the temporary deferral of interest payments on debt in the event of a new pandemic that meets certain predefined criteria. The scheme is similar to the one already implemented for natural disasters, starting with Grenada in 2015.

However, this instrument would differ from the ‘pandemic emergency funds’ (PEF) that were introduced by the World Bank in 2017. These instruments provide for principal reductions when an outbreak of one of the six identified viruses reaches a certain level of contagion and deaths, and is posted on publicly available WHO data. A pandemic clause would not provide fresh funding to countries experiencing a health crisis, but only a deferral of the repayment in exchange for expenditures on containing an established pandemic. The impact is also expected to be much larger: for example, [Jim-Ho and Fontana](#) report that PEF bonds paid out USD196 million in 2020, divided among 76 countries (USD2.9 million each); whereas Barbados alone managed to free up \$700 million from debt payments by triggering its pandemic clause.

Just as in the case of debt-to-health swaps, this provision requires significant reporting obligations and monitoring on the side of creditors, and could be usefully coupled with other recommendations offered in this section, such as the one related to data flows, and the one on the creation of a task force for pandemic prevention and inspections on biosafety compliance.

### 3.3.3 Deepening multistakeholder partnerships by involving regional authorities and civil society

One novel feature of global pandemic management post-COVID will be the existence of a much denser web of regional and local authorities in charge of both preparedness and response. Following the example of the US BARDA, the EU, Korea, the UK and other countries have created dedicated bodies to ensure a more effective performance of government functions such as foresight, R&D funding for pandemic preparedness, surveillance, the production, stockpiling and distribution of medical countermeasures, and the training of the health workforce. This was accompanied by regional coordination mechanisms, such as the African Vaccine Acquisition Trust.

Given the need to coordinate (as also mentioned in the draft WHO CA+) national strategies, stockpiling, surveillance and delivery of pandemic products at the regional level, it appears important to ensure that regional authorities are adequately included in the operation of multistakeholder schemes, such as ACT-A, going forward. The same could be said for what concerns the Pandemic Fund, currently mostly reliant on the operation of multilateral development banks and the likes of CEPI and COVAX. Empowering regional organisations would also be important when it comes to the exchange of good practices, as well as for the coordination of investments (e.g. in infrastructure and training), in the joint purchasing of key pandemic products and even in the negotiation of lending agreements such as debt-to-health swaps.

### 3.3.4 An international task force for pandemic prevention and/or inspections on biosafety compliance

The lack of a well-resourced monitoring and inspections body of experts is one of the currently criticised weaknesses of the draft pandemic treaty. Without the ability to quickly detect outbreaks and suggest courses of action to international and regional bodies, the world's ability to put pandemics behind us will be severely hampered. Accordingly, a task force could be created with the specific task to collect weak and strong signals of epidemics, and act on them in cooperation with scientists and public health institutions at the local, national, or regional level. The intervention of the task force could be triggered by national, or regional authorities in charge of surveillance; or be activated *ex officio* by the univocal decision of the task force, with which governments would have an obligation to cooperate.

Such a task force would be similar to the Global Health Emergency Taskforce contemplated by the WHO ahead of the WHA in May 2022, as well as by the Global Epidemic Response and Mobilization (GERM) team proposed by Bill Gates in a recent [book](#). The task force could be nested in the WHO and operate under the auspices of the WHO CA+. It would include experts with a mix of knowledge on data science, infectious diseases, vaccine development and health systems, and would be able to operate both in 'peace' and pandemic times, with both routine and emergency modes of operation. It would need to adopt a One Health approach, by including experts in environmental health and zoonotic diseases, and should implement guidance provided, among other things, by the WHO [One Health High-Level Expert Panel](#).

### 3.3.5 'Context matters': deepening research into social infrastructure to strengthen policy effectiveness

One important lesson of the first three years of the Covid-19 pandemic is that there is no one-size-fits-all policy mix, which enables a country to best manage a pandemic when it hits. Different social and economic conditions, different demographics and geographies, different starting points in terms of health infrastructure, workforce, skills, and overall different cultures and attitudes towards government can lead to completely diverging results when it comes to finding the optimal policy. In the words of [authoritative researchers](#) that have observed this phenomenon with first-hand experience, the 'social infrastructure' of a given territory and community may affect the overall compliance and effectiveness of policy measures, as well as the acceptance of government interventions.

As a result, it is difficult to imagine that the activities of the Pandemic Fund and the compliance with the pandemic accord (let alone conditionalities in international donor assistance) could be achieved in a top-down way, or at best with the involvement of MDBs. The involvement of local stakeholders and communities is essential to gauge the direction and scope of policy and spending measures, and this provides even stronger

backing for involving and empowering the CSOs that operate in the field in the governance of decision-making bodies at the local, regional and international level.

After all, the notion of resilience requires at once local empowerment and central coordination. Alone, the latter risks remaining the victim of lack of sufficient information on local conditions, whereas a disenfranchised and secluded community will not have the means to reorganise when a health emergency occurs.

### 3.3.6 Globally coordinated foresight, modelling and simulations

Covid-19 is not over, and uncertainty exists as regards possible future variants, which might prove more deadly, more transmissible, and more able to dodge existing vaccines than the ones currently spreading through the globe. An even greater degree of uncertainty exists as regards the possible causes of future pandemics: authoritative experts have warned that Covid-19 will not be the last, and possibly not the worst pandemic to hit the world in this century; and many believe that outbreaks of infectious disease will present themselves with great frequency over the coming years, with a rather broad phenomenology (including, among other things, zoonotic origin and AMR), calling for a portfolio strategy in R&D funding and adequate simulation exercises to stress-test the world's ability to react.

Since 2020, several foresight workshops and studies have been conducted, both on Covid-19 and on future infectious diseases. Among other things, the WHO has [intensified](#) its foresight activities, and published a detailed [guide](#) in 2022. That said, the current practice of foresight faces significant challenges when it comes to mainstreaming alternative futures thinking into concrete policy and spending priorities, and more generally, moving from the description of what 'may yet' happen towards concrete action, and salient actionable insights. This is also because foresight is still mostly carried out in qualitative ways, through rather small expert workshops and often patchy methodologies. Moreover, foresight exercises tend to be 'one-off' studies, and the methodologies followed to build future scenarios hardly lend themselves to the updating, scalability and replicability of results.

Against this backdrop, it is essential that the global research and policy community moves from treating foresight as a useful, sometimes fancy add-on, towards the use of advanced modelling of future diseases, their possible geographic sources, causes, mode of transmission and potential direct and indirect impacts. A model of this kind would need to incorporate both public and unofficial data, and include sources related to the whole One Health spectrum, and thus also from domains such as food, animal wealth, and climate. The overall aim of a project of this kind would be to generate a '[digital twin](#)' of global health emergency governance, and stress-test the current system by simulating a large variety of possible scenarios. These efforts would be usefully complemented by

similar projects being undertaken in the domain of climate ([Destination Earth](#)) and in modelling the [human immune system](#).

### 3.3.7 Leveraging data and Artificial Intelligence for prevention, preparedness and response

One of the most evident lessons from the pandemic is that without timely, trustworthy and sufficiently granular data, the world will always be too slow to predict, prevent and respond to possible future variants and new outbreaks. In addition, coordination between countries and non-state actors, as well as in the delivery of pandemic products, could be dramatically improved if data flows can be trusted. The same applies to the monitoring of the effectiveness of policy and spending measures, which critically depend on data availability. Once data are available, modern machine learning applications can provide enormous benefits in terms of predictive analytics, drug discovery, pattern detection, advanced epidemiological modelling and other use cases. And yet the response to the Covid-19 pandemic has been characterised at once by serious deficiencies in data availability, and by a lack of standards for both data and Artificial Intelligence (AI) quality and trustworthiness.

In the future, policies should be put in place to ensure that data are harvested, shared and leveraged by public and authorities and the private sector in the public interest. As mentioned in the previous section, the provisions related to data in the draft pandemic accord are far from sufficient to achieve this result. On the contrary, organisations such as the International Telecommunications Union and the Global Partnership on AI (GPAI), hosted by the OECD, have launched ad hoc working groups to promote the use of both public and non-official data and AI, mapping a myriad of possible use cases. The same can be said for private research-intensive corporations such as Deepmind, which developed solutions (such as AlphaFold) that are [enabling researchers](#) to study the coronavirus and predict possible future pandemics. Yet data still appear to be prey to asymmetries, which hamper their circulation, diffusion and use; and a number of market failures, such as lack of control over data reuse, and possible privacy violations.

Possible measures that would significantly improve data availability and leverage the potential of AI in the coming years include the following:

- *Enable access by researchers and international health institutions* to data in the possession of private entities for the purpose of pandemic surveillance, prevention, preparedness, mitigation and response. Such a measure could be inspired by the provisions included in the current text of the EU Data Act for Business-to-Government (B2G) data sharing. It could also envisage the creation of a public data trust for pandemic preparedness, prevention and response.

- *Create international data spaces and trusts for pandemic resilience.* This requires a multistakeholder debate on which data should be collected, and with what frequency, to enable swift detection and response in the future. A [call for action](#) by data scientists and experts for the creation of such an infrastructure has gathered numerous signatories, and warrants the attention of policymakers going forward.
- *Pilot privacy-enhancing technologies (PETs) in the domain of pandemic preparedness.* Recent initiatives include the UK-US innovation challenge for the use of PETs in public health emergencies; and the GPAI's recent announcement of a pilot project on PETs for pandemic resilience.
- *Pilot blockchain-enabled exchanges of relevant data.* Blockchain technologies have the potential to enable trusted data sharing, with immutable data that can enable contact tracing, investigations on the origins of a given disease, certifications of vaccine immunity and [much more](#). Blockchain can also potentially enable greater security and reliability in pandemic-relevant supply chains.

### 3.3.8 Global R&D cooperation: a moonshot on health resilience

Is it at all possible to make Covid-19 the last pandemic? The answer may be positive, but the path to this goal is certainly tortuous and uncertain. It would take a humongous effort by researchers with complementary expertise to put together data, research labs from all over the world, and AI experts with access to computational infrastructure. Moreover, it would require governance arrangements aimed at ensuring early detection, swift containment, and rapid production of countermeasures. This would be needed in any case, since even if the scientific community manages to make Covid-19 the last pandemic, it is impossible to imagine that it can put an end to outbreaks of infectious diseases or even more localised epidemics.

Most importantly, an endeavour such as making Covid-19 the last pandemic requires at once scale and scope: a scale that is global, and a scope that is broad enough to capture the various determinants of future infectious diseases (possibly including those that are man-made). A project of this kind is often described as a 'moonshot', echoing the project launched by President Kennedy in 1962 that led to the first man setting foot on the Moon in 1969. Such projects are chiefly based on a portfolio approach (encompassing various routes to the final goal), a large-scale collaborative approach, and a set of measurable targets.

In the health domain, a recent example is the [Apollo Program for Biodefense](#), launched in September 2021 by the Bipartisan Commission on Biodefense and named after the lunar Apollo Program that took humanity to the Moon. If the project succeeds in its aim to transform US capabilities to respond quickly and effectively to future biological threats, it could end the era of pandemic threats in effect by 2030. The technology priorities set

by the Apollo Program for Biodefense include: vaccine candidates for prototype pathogens; multi-pathogen therapeutic drugs in advance of outbreaks; flexible and scalable manufacturing of pharmaceuticals; needle-free methods of drug and vaccine administration; ubiquitous sequencing; minimally- and non-invasive infection detection; massively multiplexed detection capabilities; point-of-person diagnostics; digital pathogen surveillance; a national public health data system; an integrated national pathogen surveillance and forecasting centre; next-generation PPE; pathogen transmission suppression in the built environment; comprehensive laboratory biosafety; and technologies to deter and prevent bad actors.

The ‘high range’ [estimate](#) for the budget of the Apollo Program for Biodefense is USD 10 billion for 10 years, or a total of USD 100 billion. But a project of this size and ambition would probably achieve the most effective results if it were the subject of a global collaborative effort, as is the case for large-scale projects such as the International Space Station, or CERN. For example, the recent Joint Statement of the EU-US Trade and Technology Council mentions the two parties’ intention to work together intensively in the appropriate forums to facilitate the exchange of health information to support research, innovation and advancements in public health in compliance with applicable legal requirements governing the protection of data, including health data. If this could be translated into a multi-disciplinary, mission-oriented approach to ending pandemics, this target would appear less ambitious, and more likely to be shared with the rest of the world.

### 3.3.9 Taking the global infodemic seriously

One of the key lessons learnt during the current pandemic is that the spread of false or misleading information through online platforms and encrypted communication services can undermine even the most accurately designed strategies to contain infectious diseases. The ‘infodemic’ observed during the past three years was a result of several factors: lack of trust in science; lack of accountability of online intermediaries; lack of legislation on online harms at national and international level; lack of health literacy among the population, the health workforce and politicians; lack of clear, transparent and coordinated official communications; and undoubtedly also intentional, carefully designed disinformation campaigns. The latter can take various forms, not just ‘fake news’, but increasingly sophisticated techniques such as deepfakes, and more generally the use of AI to mislead end users and even move disinformation-based cyber-attacks vis à vis specific countries.

During the past three years, some legal systems (notably, the UK and the EU) have proposed rules that would reverse the established principle of non-liability of online intermediaries, which has characterised the Web since its early days. However, disinformation has reached a global and geopolitical scale, to the extent that single countries or regions cannot address it alone. In April 2022, the United Nations Security

Council adopted a resolution on disinformation, noting, ‘the increasing and far-reaching negative impact on the enjoyment and realization of human rights of the deliberate creation and dissemination of false or manipulated information intended to deceive and mislead audiences, either to cause harm or for personal, political or financial gain’.

The most appropriate forum to address this issue is the UN Global Digital Compact, currently under consultation and scheduled to be agreed at the Summit on the Future in September 2024. The Global Digital Compact was proposed in the [political declaration adopted at the occasion of the United Nations’ 75<sup>th</sup> anniversary](#) in September 2020, and presented in its overall content and scope with the release of the report ‘[Our Common Agenda](#)’ one year later. This report very clearly states that ‘the ability to cause large-scale disinformation and undermine scientifically established facts is an existential risk to humanity’; and states the need to ‘end the ‘infodemic’ plaguing our world by defending a common, empirically backed consensus around facts, science and knowledge’. Part of this call implies the creation of a global code of conduct that promotes integrity in public information. Likewise, the ‘Declaration on the Future of the Internet’, signed by at least 60 countries since April 2022, contains specific references to the need to fight disinformation.

However, in the future the global community will most likely have to go beyond a mere code of conduct to concretely reduce the risk of disinformation. The use of trust-enhancing technologies such as blockchain, PETs, or other means of verification of the information sources; and the implementation of innovative policy schemes, such as the provision of access to content moderation algorithms to ‘vetted researchers’ (as in the EU Digital Services Act) could potentially be proposed at a broader scale, in bilateral agreements (e.g. the EU-US Trade and Technology Council) or within multilateral organisations (UN, UNESCO). The global health community could join this process by offering specific verification of information related to infectious diseases and related medical countermeasures, in a way that potentially also reaches those parts of the population that are most exposed to possible online and offline mis- and disinformation.

### 3.3.10 A ‘maximin’ principle

Many of the possible actions explored above are complementary, rather than substitutes. In particular, the collection and processing of large-scale datasets for AI-enabled pandemic surveillance and predictive analytics will be a cornerstone of future foresight and horizon-scanning activities, and hence the mapping of potential threat scenarios. Once those scenarios are defined, policymakers and field experts would be able to stress-test their existing stockpiles, R&D capabilities, logistics and supply chains and ability to identify and implement new policy measures in a way that reduces the spread of the contagion, and thereby the emergence of new pandemics.



At the same time, the state of poly-crisis into which the world has fallen over the past years bears important consequences for our future understanding of risk. Assessing the consequences of massively damaging future scenarios, even when such scenarios are plausible but not probable, may trigger a series of cascading effects, leading to an enduring state of crisis and mutually amplifying risks (e.g. health, climate, food, migration, disinformation, social unrest, declining democracy, violations of human rights, and so on).

For this reason, foresight (and in general, decision-making on large-scale risks) may need to depart from a short-termist use of cost-benefit analysis, and embrace a longer-term, risk-mitigation use of multi-criteria analysis that sets clear priorities in terms of avoiding risk. In particular, once the worst-case scenario is defined, policies may want to prioritise measures that mitigate the consequences, or reduce the likelihood, of that scenario to occur. This ‘maximin’ principle, reminiscent of the lessons of the American philosopher John Rawls, was recently proposed by another authoritative scholar, [Cass Sunstein](#), as a way for policymakers to avert catastrophic events in the future. Its use in the prevention and preparedness phases, as well as in individual response measures, could become a new *modus operandi* for global, regional, national and local policymakers. At the same time, its concrete application must be appraised in light of the difficulty of communicating and obtaining acceptance of measures aimed at mitigating remote risks, especially in times of economic recession.

## ANNEX - METHODOLOGY FOR MAPPING STAKEHOLDER VIEWS

This working paper aims to provide a cartography of the positions of key stakeholders (as well as their salience) vis à vis alternative future scenarios for global health governance, collected through desk research and in-depth interviews.

### Data-collection methodology

This mapping exercise unpacks three main policy areas, previously identified as key in the context of the first stages of the project: leadership and governance, financing facilities, and delivery schemes.

The study draws on extensive fieldwork and desk research, which led to the creation of a dataset with systematic information on the preferences of actors and their salience level on the key issues identified. This dataset draws on spatial models of politics, by mapping the distance between actors' policy preferences on key controversial policy issues. Interviewing experts is the only viable method of collecting information on the policy positions of the key actors on controversial key areas, in particular when it comes to state actors. There are no publicly available records of the position of all stakeholders, which means that document-based data-collection strategies are unworkable.

In the context of qualitative interviews, representatives of key institutions identified the main controversial issues at stake and provided information on all actors' positions (including their own), as well as the levels of importance each actor attached to the issues (Thomson et al., 2012). The widespread use of this methodology in the field of public policy analysis and European studies demonstrates its relevance to uncover patterns in actors' policy positions, as shown by an established research tradition (Bueno de Mesquita & Stokman, 1994; Thomson et al., 2012; Arregui & Perarnaud, 2021).

The coding techniques used in this study build on the DEU codebook used regularly by political scientists. Scales between 0 and 100 were used to code the positions within the policy space of each controversial issue (0 and 100 were conceptualised as the opposite extreme positions). The same approach was followed to code actors' issue salience. The coded positions correspond to the current preferences of actors, but evolutions across time can also be taken into account. Every estimation provided by any expert had to be justified through evidence and/or substantive arguments.

### Interview protocol

At the beginning of the interviews, experts were asked to comment on the key areas identified by our project in relation to global governance of health preparedness and response. Subsequently experts had to locate the positions of actors along the policy scale. We first asked to identify actors with the most extreme policy positions. These alternatives were the end points of the issue continuum that represented each controversial issue (on a scale of 0 to 100). The main issues identified by policy experts had to (a) correspond to the main points of controversy that were discussed in each key area; (b) illustrate the content of the policy alternatives defended by actors; and (c) be

unidimensional (to be able to locate policy alternatives with a single-peaked preference function). Thus, issue specifications actually try to capture the major points of discussion.

In face-to-face interviews, interviewers assessed the expertise of interviewees and the amount of effort interviewees devoted to providing estimates. Throughout the semi-structured interviews, interviewers asked respondents to justify the information they gave. The guiding questions for these justifications were ‘why did each of the actors favour the alternatives they did?’ and ‘why did the actors prioritise the issues as they did?’ Respondents’ answers to these questions and the knowledge they displayed of the proposal in question were used to gauge their expertise and the credibility of their estimates.

When necessary, the author made a judgement about which sets of estimates to include based on respondents’ answers. For instance, one expert may have been uncertain about a particular Member State’s policy position on one of the controversial issues. If this was the case, other experts were consulted to confirm or provide this information. Obtaining information from experts was crucial for developing this dataset. Because of the need to test the validity of the data, we considered it necessary to contrast the results with the analysis of available public and confidential documents relative to these controversies<sup>53</sup>.

### Mapping framework

This working paper draws on results from the companion report on ‘Alternative scenarios for future global health security governance’, which identifies several alternative scenarios for the three key areas identified. In light of recent policy developments (the progressive adoption of the FIF, for instance) since January 2022, this framework has been updated to reflect the fast-evolving public policy agenda.

*Table A 1. Key areas and main policy options*

<b>AREA 1</b>	<b>Leadership and governance</b>
1.1	A Global Health Threats Security Council
1.2	A Global Health Threats Board
1.3	A Global Health Agency to (partly) replace the WHO
1.4	IHR amendments
1.5	A new pandemic treaty
<b>AREA 2</b>	<b>Stronger financing facilities for future emergencies</b>
2.1	An international financing facility by the UN Global Health Threats Council
2.2	G7-led PPR financing facility
2.3	A proposed Financial Intermediary Fund (FIF)
<b>AREA 3</b>	<b>Leveraging public-private schemes for effective delivery</b>
3.1	Improved ACT-A governance
3.2	A global end-to-end platform
3.3	An end-to-end platform with stronger multi-level governance

<sup>53</sup> For instance, the authors made use of existing databases compiling actors’ statements during previous sessions of the WHA: [WHASS2 | Statements \(who.int\)](#).

## Selection of the research participants

Drawing on the membership of the expert group launched in the context of this research project, interviews were conducted with key experts from the field, including academics, industry leaders, as well as NGOs, policymakers and key non-state actors. The list of interviewees can be found in the Annex.

## Mapping of the actors' incentives per scenario

area ref	issue ref	Policy scale
A	iA1	0: Full opposition to setting up a Global Health Threats Council - 40: GHTC 50: Neutral - WHO MS 60: UK, US, South Africa 100: Full support to setting up a Global Health Threats Council
A	iA2	0: Full opposition to setting up a Global Health Threats Board - China 50: Neutral 70: General support with minor reserves - UK, EU 100: Full support to setting up a Global Health Threats Board - US
A	iA3	0: Full opposition to replacing WHO by another global health agency - Western Pacific region members, Southern African countries, Azerbaijan, Bulgaria, Chile, Cuba, Fiji, Haiti, India, Italy, Kenya, Lebanon, Madagascar, Maldives, Morocco, Niger, Portugal, Romania, Slovakia, Suriname, Syrian Arab Republic, Uruguay, Venezuela and the EU. 20: Civil society organisations (EGHRIN, Health Poverty Action, GHTC, MSF) 50: Neutral 100: Full support to replacing WHO by another global health agency - (Indonesia)
A	iA4	0: Full opposition to the new proposal for amendments to the International Health Regulations: Iran 30: South Africa, India, African region 50: Neutral 60: China, Russia 80: European Union 100: Full support to the new proposal for amendments to the International Health Regulations - US, UK, Indonesia, Japan, Colombia, Thailand
A	iA5	0: Full opposition to the establishment of a new pandemic treaty 40: US, China, India, Mexico, Monaco, Jamaica 50: Neutral 90: UK, Brazil, African region, New Zealand 100: Full support to the establishment of a new pandemic treaty - Albania, Australia, Chile, Costa Rica, Croatia, EU, Fiji, France, Germany, Greece, Indonesia, Italy, Kenya, Republic of Korea, the Netherlands, Norway, Portugal, Romania, Rwanda, Senegal, Serbia, South Africa, Spain, Thailand, Trinidad and Tobago, Tunisia, Ukraine, UK
B	iB1	0: Full opposition to the International Financing Facility 50: Neutral 100: Full support to the new International Financing Facility
B	iB2	0: Full opposition to the G7-led PPP 50: Neutral 100: Full support to the G7-led PPR - UK
B	iB3	0: Full opposition to the FIF 40: France

		50: Neutral 80: Germany, European Commission 100: Full support to the FIF - US, UK, Denmark, Finland, Iceland, Norway, Sweden
C	iC1	0: New decision-making and governance for ACT-A - UK, GHTC 50: An end-to-end platform - Health Poverty Action 100: A meta-partnership

### List of research participants

Itw number	MS/Organisation	Position
1	Wellcome Trust	Advisor
2	KU Leuven	Professor
3	ECHRIN	Counsellor
4	University of Milan	Professor
5	People's Vaccine	Global South convenor
6	People's Vaccine	Advocacy officer
7	Health Poverty Action	Advisor
8	UK government	Health expert
9	UK government	Health expert
10	GHTC	Advocacy officer
11	DSW	Senior advocacy officer
12	Brazil government	Health expert
13	Mexico government	Health expert
14	Gavi	Public policy officer

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