COVID-19 and World Order

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Although the world has experienced pandemics before, including several in the last fifteen years, the COVID-19 pandemic has caused an unprecedented global public health crisis. The synergy among multiple factors—including the relative ease of transmission of SARS-CoV-2, the failure to identify and contain early outbreaks of COVID-19, and the at times fraught relationship between political and public health priorities—has fundamentally jolted the world order. What began as a local outbreak in Wuhan, China, rapidly expanded to impact private and public sectors throughout the world, including governments at every level, across a host of domains. The phrase “COVID-19 crisis” has evolved to become shorthand for challenges to health care systems, labor markets, supply chains, and even geopolitics.

In the coming months and years, as countries shift from the COVID-19 emergency response to the recovery process, the world must reconsider, and perhaps fundamentally shift, its approach to protecting and promoting the health of populations. Without such a change, global recovery from the COVID-19 crisis will remain tenuous, with fragile intra- and inter-country public health systems serving as the only shield against a future pandemic. The precise path forward may not be clear, but an immediate and intense focus on global public health policy is
imperative. With that lens, this essay considers two questions: (1) How should we understand the origins and consequences of the COVID-19 crisis? (2) What should be our vision to craft a better world order for the future?

This essay argues that, from the perspective of global public health policy, multiple factors converged and contributed to the rapid spread of the novel coronavirus. These include the traditionally less prominent role of public health within international affairs, the inconsistent patchwork of laws and policies that governs public health preparedness within and among countries, and structural limitations relative to pandemic preparedness and response experienced by the World Health Organization (WHO). After exploring these factors, the essay pivots to identifying opportunities to promote a more effective world order. From a global health policy standpoint, these include anticipating and avoiding societal complacency once the pandemic abates; promoting wide-ranging collaborations that span countries, sectors, and disciplines to protect the public’s health; and re-envisioning WHO based on lessons learned from current and prior pandemic responses.

**Origins of the COVID-19 Pandemic**

The origins of the COVID-19 pandemic are complex and multifaceted, with several key themes emerging. First, despite the primacy of public health to the survival of humankind, public health is often an invisible discipline within international affairs. Individuals typically become briefly aware of public health in times of crisis and tend to ignore it during periods of relative salubrity. As a result, public health systems are chronically underappreciated and underfunded. Second, the laws and policies that have been created within and among countries to secure public health are a sundry and inconsistent patchwork. This patchwork effect is exacerbated by an overlay of diverse emergency preparedness and response policies. As a result, intra- and inter-country public health emergency preparedness varies greatly. Finally, the primary body charged with protecting global public health, WHO, may deploy policy tools but has limited authority over their implementation and enforcement. In addition, WHO’s funding model is subject to political whims, often leaving this global body on precarious footing.

**Public Health Is a Largely Invisible Discipline**

Public health is a broad field focused on protecting and promoting the health of populations. The US Centers for Disease Control and Prevention defines public health as “the science of protecting and improving the health of people and their communities . . . by promoting healthy lifestyles, researching disease and in-
Epidemiology, the scientific discipline underlying public health, is the study of the distribution and determinants of health and related events within populations. This may include environmental exposures, outbreaks of foodborne illness or infectious diseases, violence in a community, incidence and prevalence of chronic conditions, and natural and human-made disasters. While public health is often conflated with health care, it is distinct. Public health practitioners and researchers consider population health at the local, regional, national, or global level. In contrast, the field of health care tends to involve individual-level encounters, typically between a health care provider and a patient.

For most people, the provision of health care has one or more faces associated with it: individuals may know their health care providers relatively well and value these relationships. Because public health work occurs at the population level, however, this type of personal relationship is absent. If asked who their public health provider is, people may mention, at most, their local health department. And even though a local health department’s purview may be quite broad—including chronic disease prevention, emergency preparedness and response, environmental health, infectious disease prevention, maternal and child health, mental and behavioral health, and violence prevention—the actual work feels abstract to the general public. As a result, during noncrisis periods, public health is a largely invisible discipline, particularly within international affairs.

The exception to public health’s invisibility within international affairs occurs during periods of emergency or disaster. When individuals’ lives and societal norms are disrupted, the cause of this disorder comes to the fore. For example, during and shortly after a major tropical cyclone, such as Hurricane Katrina in 2005 or Typhoon Haiyan in 2013, communities may experience displacement, lack of access to potable water, exacerbation of chronic health conditions, and infectious disease outbreaks. During a pandemic, such as H1N1 in 2009, Zika in 2016, or COVID-19 in 2020, societies across the globe become intensely focused on disease detection, treatment, containment, and mitigation. For some period of days, weeks, or even months, public health metrics, tools, and vocabulary populate the news cycle and daily conversations. In 2020, as countries throughout the world experienced the COVID-19 pandemic, terms familiar to any public health practitioner—terms such as social distancing, self-quarantine, and mortality rate—joined our shared lexicon.

During a widespread or high-profile emergency, when public health, emergency preparedness, and response command the focus of policy makers, the increase in
attention is often accompanied by an increase in funding. For example, in the United States, after the terrorist attacks of September 11, 2001, and the dissemination of anthrax via mail, the federal government appropriated nearly $1 billion for state and local public health preparedness efforts, which are typically tied to public health departments. Over nearly two decades, that funding decreased by 30%, leaving a chronically underfunded public health system in its wake. While this may be an extreme example, it is not unusual: as societies move out of a disaster’s response phase and begin the recovery process, public health’s visibility fades along with perceptions about its importance within the global policy agenda. Once a feeling of “return to normal” sets in—especially for those who did not experience the disaster’s most acute impacts—policy makers and the public turn their attention to quotidian concerns.

This may suggest a degree of societal resilience, but it fails to account for the life course of a public health disaster, which is cyclical and not linear. The highly visible response phase, when the public and private sectors may not be able to carry out their normal functions, is followed by the recovery phase. During recovery, a disaster may fade from public view, once, for example, hospitals are no longer overwhelmed with COVID-19 patients. Governments and communities rebuild systems, replace depleted resources, and attempt to implement lessons learned that may reduce vulnerability in the future. The recovery phase then transitions into the mitigation phase, which focuses on prevention or lessening the impacts of disasters. In this phase, researchers may develop new disease surveillance systems or strengthen efforts to limit disease transmission from animals to humans. Because new disasters are inevitable, mitigation transitions into the preparedness phase. At this point, preparation occurs for aspects of a disaster that cannot be mitigated, which includes planning and training for health care and public health responses to a future pandemic. The recovery, mitigation, and preparedness phases may be less visible, but they encompass critical public health activities that, ideally, lengthen the periods between disasters. These efforts are as important to protecting the public’s health as those that occur in the response phase.

Public Health Laws and Policies Are a Patchwork

One of the oldest roles of government, which remains a core function today, is protecting and promoting individuals’ health. The earliest known use of quarantine—the public health practice of breaking the chain of disease transmission by separating individuals exposed to a disease from those not exposed—can
be traced to 14th-century Venice. Ships that arrived in Venice from locations with known cases of plague were required to anchor in the port for forty days before making landfall.\(^9\) The Italian words that described this forty-day practice evolved over centuries into today’s *quarantine*. In addition to revealing the origin of a public health tool, this example demonstrates that implementation of public health laws and policies has traditionally rested with subnational jurisdictions.

In the United States, the foundational case for public health law concerns a local government’s attempt to keep its residents safe during a smallpox epidemic. In 1905, the US Supreme Court issued its opinion in *Jacobson v. Massachusetts*, which considered whether a local government could enact a compulsory vaccination law. In 1902, facing an outbreak of smallpox, Cambridge, Massachusetts, adopted a law requiring individuals over 21 years old to receive a smallpox vaccination. Henning Jacobson declined to be vaccinated, and he refused to pay the required fine. In essence, he argued that the Cambridge law compromised his autonomy in violation of several provisions of the US Constitution. In its decision the court found for the local government: “in every well ordered society charged with the duty of conserving the safety of its members the rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand.”\(^10\)

With this, the US Supreme Court established a balancing test that persists today, with reasonable governmental action to protect public health and safety on one side and respect for individuals’ liberty on the other. In practice, this has meant that, whenever possible, the least restrictive means of accomplishing a public health goal is preferable.\(^11\)

These two elements—the key role of subnational governments in the implementation of public health law and policy and efforts to balance government action with preservation of individuals’ rights—help explain the patchwork nature of public health law. Because public health challenges almost always originate locally, subnational jurisdictions traditionally serve as the front line for policy responses.\(^12\) And the response selected by one local, regional, state, or territorial government may differ from other subnational governments’ responses to the same public health issue. This variation may be attributed to multiple factors including the availability of resources, previous experiences with disasters, prioritization of government action over individuals’ autonomy or vice versa, actions of neighboring jurisdictions, and incentives or disincentives provided by a higher level of government.
The patchwork effect of public health law also appears within public health emergency preparedness and response policies. For example, in recognition of outmoded or absent subnational public health preparedness laws in the United States, the Centers for Disease Control and Prevention commissioned the Model State Emergency Health Powers Act (MSEHPA) shortly after the 9/11 terrorist attacks and anthrax scare.\textsuperscript{13} As a model law, MSEHPA carried no legal force on its own, but it provided a useful road map for subnational governments seeking language to update all or part of their public health preparedness laws and policies. More than two-thirds of US states ultimately adopted at least part of MSEHPA. However, because subnational governments selected which, if any, parts of MSEHPA to incorporate into their public health preparedness laws, the patchwork effect persisted. This, coupled with the ongoing funding challenges mentioned earlier, may impair the development of strong, cohesive public health and emergency response systems.

Today, intra- and inter-country public health preparedness and response laws and policies vary greatly. The Global Health Security Index, the first comprehensive assessment of health security capabilities in 195 countries, found vast differences across a host of categories, including disease detection and reporting, health system preparedness, and the ability to rapidly mitigate an epidemic.\textsuperscript{14} As witnessed by the range of responses to the COVID-19 pandemic, both within and among countries, variation in law and policy can impede a swift, coordinated, and effective response.

**WHO Has Limited Power to Protect the Public’s Health**

Among the United Nations agencies and public-private partnerships that interface with global public health, WHO is arguably the most prominent. Established in 1948, WHO is the United Nations agency responsible for “the attainment by all peoples of the highest possible level of health” and serves as the “co-ordinating authority on international health work.”\textsuperscript{15} Today, WHO’s seven thousand employees hail from over 150 countries and carry out WHO’s mission in country and regional offices as well as WHO’s headquarters in Geneva. WHO’s governing body is the World Health Assembly, with delegations from WHO’s member countries. The World Health Assembly determines WHO’s policies and approves the organization’s budget on an annual basis.

WHO describes itself as protecting the public’s health through several focus areas: (1) promoting universal health coverage through improved access to primary care, workforce training, and sustainable financing; (2) supporting populations’
health and well-being by fostering collaborations across sectors and championing a health-in-all-policies approach; and (3) preparing for and responding to public health emergencies through early detection of risks, development of outbreak response tools, and provision of essential health services in locations with fragile health care and public health systems. In each of these areas, WHO serves as a centralized body for collecting, developing, and disseminating information and for devising recommendations. For example, WHO produces the International Classification of Diseases, which gives countries a standardized approach for identifying and reporting diseases, health conditions, and related trends. WHO also works within countries to implement its recommendations and provide technical assistance. These efforts range from support for in-country vaccination programs to implementation of global health campaigns to reduce the prevalence of noncommunicable diseases. WHO’s work has secured global public health, perhaps most prominently through the Smallpox Eradication Program, which led to the first global eradication of a disease in 1980.

Given the breadth of its mission, the precarious nature of WHO’s funding structure may appear surprising. WHO is funded through contributions from its member countries as well as voluntary contributions. Member country dues, officially referred to as “assessed contributions,” are a percentage of a member country’s gross domestic product set by the United Nations General Assembly and approved by the World Health Assembly. Assessed contributions account for approximately 20% of WHO’s budget, and WHO can determine how to use these funds. The remaining 80% of WHO’s budget comes from voluntary contributions from member countries, philanthropic organizations, the private sector, and other entities. More than 90% of voluntary contributions are designated for particular uses: for instance, a particular programmatic area, geographic location, or time frame. During 2018–19, with assessed and voluntary contributions aggregated, WHO’s top three donors were the United States ($851.6 million), the United Kingdom ($463.4 million), and the Bill & Melinda Gates Foundation ($455.3 million).

As a result of its funding structure, WHO is often implementing work of greatest priority to its voluntary contributors, which does not necessarily align with the most objectively urgent global public health challenges. WHO has called for a more stable and flexible funding structure so that it can become increasingly nimble as it executes strategic priorities and pivots to address emerging health threats. Presently, WHO’s budget is divided among seven areas, with the largest percentages allocated to universal health coverage (23%), country support (19%),
emergency operations and appeals (17%), and health emergencies (15%). WHO typically cannot shift funds among these areas, although there is some flexibility with the emergency operations and appeals category, which can be critical during a pandemic response.

During a public health emergency, such as the COVID-19 pandemic, WHO has a key role in coordinating the global response. The International Health Regulations (IHRs) establish the framework for this coordination. Updated in 2005, the IHRs create binding obligations for WHO member countries regarding disease surveillance, information reporting, and emergency response, with an overall goal of preventing and mitigating pandemics while limiting “interference with international traffic and trade.” While WHO provides assistance and guidance, including dissemination of relevant information and data and updates to the IHRs and related documents, it ultimately depends on its member countries to implement the IHRs at the country level. This is a critical distinction—despite its broad mission, WHO lacks enforcement authority and, thus, does not have a legal means to require countries to act. Instead, it serves as a coordinating body to assist sovereign nations in implementing their own policy responses.

Given this dynamic, one of WHO’s greatest strengths is the ability to put the world on notice when an infectious disease outbreak—particularly involving a novel, or not previously known, disease—occurs. The IHRs delineate the process by which WHO may declare a Public Health Emergency of International Concern (PHEIC), defined as “an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response.” WHO’s director-general weighs various factors when deciding whether to issue a PHEIC declaration, including information provided by the country experiencing the outbreak, advice from a WHO-appointed Emergency Committee, scientific evidence, and an assessment of the risk of disease spread across countries and the risks to human health. Since the creation of PHEIC in a 2005 revision to the IHRs, WHO has made six declarations: H1N1 in 2009, polio in 2014, Ebola in 2014, Zika in 2016, Ebola in 2019, and COVID-19 in 2020.

A PHEIC declaration has several potential effects, including heightening global awareness of an emerging disease risk, putting countries on notice to initiate infectious disease response efforts, and potentially driving donations to WHO or other organizations focused on mitigating any outbreaks. Importantly, as noted above, WHO does not have the ability to enforce any aspect of a PHEIC declaration. This means that WHO must rely on its position as the coordinating body for
global public health to convey the severity of a threat and then wait for countries to act in accordance with its recommendations. WHO may use persuasion, data, and information to catalyze countries’ responses to a PHEIC declaration, but it does not have any formal enforcement tools.

Crafting a More Effective World Order

Several systemic changes are needed to secure global public health. First, societies must overcome the cycle of intense interest and commitment during a public health emergency that is followed by widespread complacency. Future pandemics are inevitable. Bold action must occur now—while the COVID-19 pandemic continues to rage—before the crisis fades from memory and is replaced with a feeling of returning to normal. Second, because jurisdictional boundaries are not recognized by infectious diseases, newly invigorated multinational coalitions should facilitate wide-ranging collaboration as the world moves into the recovery, planning, and preparedness phases of the disaster cycle. By capitalizing on the periods between disasters, governments can work together to establish systems that facilitate a more nimble response to future disasters. Finally, lessons learned from COVID-19 and prior pandemics can inform a re-envisioned WHO. The greatest chance of success for this institution, and for robust oversight of the global public health response, rests on an orientation that favors science over politics.

Anticipate Societal Complacency about Public Health Disasters

Individual and societal memories can be short. Everyone is naturally drawn in by events that impact them or their loved ones directly, and cataclysmic events—like the Indian Ocean tsunami of 2004 or the terrorist attacks of 9/11—capture the world’s attention for some period of time. This can be attributed to a variety of factors, including hyper-attentiveness by the news media, the vast and sometimes incomprehensible scope of a disaster, disruptions to everyday life, and fear that encompasses imminent and potential longer-term impacts. Over weeks or months, the period of intensity fades, and slowly a feeling of returning to normal seeps in. This typically coincides with a societal sigh of relief as individuals and policy makers determine that the disaster is over and they can move on to the next pressing thing. The impulse makes sense—within the individual, community, and policymaking spheres, there will always be something new and urgent to address.

As COVID-19 roars across the globe, reactions have been aligned with what one might expect during the response phase for a public health disaster of this
magnitude. The period of intense interest and fear has brought unprecedented policy responses with implementation of social distancing measures, closures of workplaces and schools, and allocation of government funds. While the response phase to COVID-19 will persist for the foreseeable future, governments are taking steps to reopen, and individuals are experiencing the fatigue that accompanies an enduring disaster response. Because future and potentially worse pandemics are inevitable, it would be irresponsible if governments were to fail to capitalize on the COVID-19 response to secure the long-term investment needed for the full disaster cycle of mitigation, preparedness, response, and recovery. While the pandemic continues and its impacts are felt on a daily basis, policy makers should use their political capital to establish a well-resourced infrastructure for the full public health disaster cycle. Many activities within this infrastructure—such as disease surveillance, innovation relative to personal protective equipment, and development of new therapeutics—will be largely invisible to the general public between disasters. Yet this type of work is critical to ensuring greater societal readiness and resilience for future pandemics.

The type of policy change described above is not inevitable. It would be naïve to assume that the magnitude of the COVID-19 pandemic and its rippling impacts will overcome the societal complacency likely to descend once the pandemic wanes. Incremental change characterizes public policy, with stasis being the norm. When viewed retrospectively, most disasters do not produce significant policy change, but some do. The political science theory of punctuated equilibrium offers helpful insights for understanding the factors that may coalesce to bring about meaningful departures from previous policy approaches. According to punctuated equilibrium theory, the greater societal context for policy making leads to one of two paths: reinforcement of current approaches or questioning of these approaches. When current approaches are reinforced—which happens most of the time, as the policy process ultimately tends to favor the status quo—only incremental change occurs because there is little motivation to consider alternatives. On the other hand, when a single issue dominates the political agenda and commands the attention of a broad cross-section of policy makers for a sustained period, change becomes possible.

The COVID-19 pandemic has caused a sustained impact that touches on all aspects of society, leaving no one apathetic to the disaster's consequences. This has brought the pandemic into clear focus for policy makers. While a public health disaster is traditionally viewed as touching health care and public health systems, the current pandemic has expanded well beyond that to disrupt the world econ-
conomics, leaving rampant unemployment and systemic uncertainty in its wake. These society-wide impacts have led to massive political pressure for change, making it difficult for governments not to respond. For example, the US Congress—often slowed by extreme partisan gridlock—has passed multiple pieces of legislation, including the Coronavirus Aid, Relief, and Economic Security Act. This includes direct payments to individuals and families, emergency loans for small businesses, expansion of unemployment benefits, and funds to support health care system infrastructure. The window for major policy change is open, but it will quickly close as COVID-19 fatigue sets in and attention shifts to other concerns. Before this happens, policy makers at every level of government should capitalize on this moment to strengthen public health infrastructure and secure funding to support public health preparedness, response, and recovery.

While the window for significant policy action may soon close, the opportunity to raise the profile of public health as a discipline will not. The exigency of a pandemic may have brought public health to the fore, but there are multiple opportunities to reimagine public health’s place in society. Prior to the COVID-19 pandemic, public health was often viewed as a domestic policy concern, meaning that it was tied to the stability of a country’s health care system and infrastructure. The pandemic has clearly demonstrated the fallacy of limiting public health domestically; instead, it should be framed as intimately tied to international affairs. COVID-19 has demonstrated that public health challenges, particularly bio-threats, can rapidly scale up. In other words, public health does not simply keep populations healthy—it also keeps them safe. It should thus receive the same respect, implementation support, and continuous investment given to other aspects of international affairs.

Finally, although local governments are on the front lines of public health policy and implementation, public health should not operate only within the purview of local government. Localities typically have a broad grant of authority to act in ways that protect and promote the public’s health, and their work is essential. However, local public health work inevitably impacts higher levels of government. For example, throughout the world, vaccinations are typically provided by a local public health workforce. The COVID-19 pandemic has already destabilized vaccination schedules in many parts of the world, raising the potential for outbreaks of diseases like measles and diphtheria. These secondary public health impacts of the pandemic are first experienced locally, but they can quickly transcend local borders to become regional, country-level, and even global health challenges. In developed and developing countries, societal complacency may be
overcome by elevating public health’s place beyond the local government and reimagining its role within both foreign and domestic planning and policy.

**Promote Wide-Ranging Collaboration to Protect Public Health**

Pandemics have long proven that infectious diseases do not respect jurisdictional boundaries, and the COVID-19 pandemic has reinforced this point. Over the course of several months, COVID-19 cases were reported on every continent except Antarctica and in virtually all of the world’s countries. On a daily basis, COVID-19 incidence and prevalence were tracked and communities watched with a combination of awe and horror as the disease progressively populated global maps. Importantly, while there may be some genomic variation among the strains of COVID-19 in circulation, the fundamental biology of the virus is not affected by geography. The traditional public health tools of isolation, quarantine, social distancing, testing, and surveillance are used consistently in efforts to mitigate COVID-19, regardless of the society in which it appears.

What does change, depending on the country in which the virus surfaces, are political responses and the activation of intra- and inter-country efforts to limit transmission and address the virus’s health effects. In addition to in-country variation, countries’ overall political environments do not necessarily remain predictable from one pandemic to the next. A change in leadership can dramatically alter a country’s priorities and its role relative to global public health. The United States provides an illustrative case study over several presidential administrations. In his 2003 State of the Union address, President George W. Bush, a Republican, announced plans to establish the President’s Emergency Plan for AIDS Relief, which received bipartisan support and has become the largest single-country funding commitment dedicated to one disease. During the Ebola pandemic of 2014, under President Barack Obama, a Democrat, the United States played a major role in coordinating a global response and sent thousands of health officials to West Africa to focus on disease containment. The administration viewed the Ebola response as both a public health and health security priority. In contrast, under President Donald J. Trump’s America First approach, the United States has retreated from global public health leadership during the COVID-19 pandemic, focusing instead on an isolationist response.

In an era when some leaders around the world have embraced nationalism and populism, the traditional ways of conceptualizing global public health security
may no longer apply. The global coordinating body for pandemic response, WHO, must account for donor-driven rather than public health priorities. The United States has backed away from a position of global leadership relative to public health, and many leaders have lost enthusiasm for inter-country efforts in general. While political whims may change, effective public health approaches will not: global public health challenges will continue to necessitate a collaborative approach that spans the developed and developing worlds. COVID-19 has temporarily slowed our increasingly interconnected world, but the same pathways that allowed COVID-19 to spread so quickly will eventually reemerge. And the pandemics of the last fifteen years, culminating in COVID-19, have repeatedly demonstrated that an isolationist stance does not yield positive public health outcomes.

While effective collaboration may arise spontaneously during a pandemic, the strongest collaborations will be built and nurtured during inter-pandemic periods, when governments, organizations, and individuals can focus on structure and goals, rather than the exigency of response. The recovery and mitigation phases of the disaster lifecycle—which are inherently less chaotic than the response phase—offer an ideal time to learn from the strengths and failures of collaborative responses to prior pandemics. As the global community shifts from the most acute COVID-19 response into longer-term planning for a lingering pandemic, lessons can be learned from responses to prior coronavirus pandemics, particularly SARS in 2002–4.

SARS was a coronavirus disease, but it differed from COVID-19 in important ways. COVID-19 is easier to transmit than SARS, but its case fatality rate is lower, meaning that it is less deadly for those who contract it. This means that COVID-19 is unlikely to fade away like SARS. Despite these differences, the SARS response offers important lessons about collaboration at individual and societal levels. In some countries that experienced SARS, especially those in eastern Asia, individuals implemented public health measures like mask wearing, handwashing, and social distancing to facilitate a collective response. Some have theorized that these societies retained their collective memory of population-level compliance from the SARS response, making them early adopters of public health practices during the COVID-19 pandemic. Importantly, this type of collective response may emerge more predictably in countries that tend toward centralized governance or more widely shared norms. In a country like the United States—with a long tradition of decentralized governance and local or regional norms—public health practices may be embraced inconsistently.
The SARS response also put the world on notice about the need for country-spanning collaborations to ensure timely disease surveillance and outbreak response. A National Academy of Sciences review of the SARS response noted that key collaborations related to linking laboratory research to epidemic response partners had been established years before SARS emerged. In addition, diagnosis, treatment, and mitigation were supported because SARS appeared primarily in countries with stronger health care and public health systems. This realization should have alerted the global community to the potentially devastating effects of a pandemic throughout the developing world, where containment or mitigation would depend on international assistance. As the COVID-19 response has shown, while the world made some strides to improve surveillance capabilities and strengthen global outbreak alert systems, countries did not fully internalize critical lessons from SARS.

The question then becomes, What might a future approach to global public health preparedness look like? It will depend on effective collaborations within and between countries, grounded in a shared recognition that jurisdictional boundaries are irrelevant to infectious diseases. Regardless of the patchwork effect in public health law and policy, governments at every level must embrace a shared, nonpartisan goal of protecting the health of their populations, with pandemics viewed as public health, health security, and existential threats. Because no country can mitigate a global threat on its own, public health systems should be viewed as interconnected entities, both within countries and across international borders. While these systems, of course, will vary greatly in terms of resources, technology, and longevity, the success of the whole—defined as effective mitigation, preparedness, response, and recovery from pandemics—depends on the functioning of each part.

Rather than challenge national sovereignty, this orientation seeks to ensure that populations continue to thrive under the leadership of their respective governments. But it also recognizes the fundamental limitation of stand-alone public health efforts in an interconnected world. Critically, effective global public health preparedness must recognize the essential role of nongovernmental or quasi-governmental institutions. For example, over two decades, Gavi, the Vaccine Alliance, has demonstrated the power of public-private partnerships to tackle seemingly intractable challenges such as global vaccine access. By bringing together diverse, multidisciplinary collaborators, these types of institutions can foster the innovation needed to supplement governments’ public health work and can fill global health policy gaps not addressed by WHO.
Apply Lessons Learned from the COVID-19 Response to WHO

During recent pandemics, two observations about WHO have gained traction: (1) the organization plays a key role in pandemic response, as the international coordinating body for this work; and (2) WHO’s effectiveness is curbed by structural limitations. To understand WHO’s strengths and weaknesses—and the potential for change moving forward—the timeline of its engagement relative to COVID-19 proves instructive. On December 31, 2019, WHO received a report of a cluster of pneumonia cases from the Wuhan Municipal Health Commission in China. On January 4, 2020, WHO shared this information with the world via a tweet and noted, “Investigations are underway to identify the cause of this illness.” The next day, WHO published information in its Disease Outbreak News about “cases of pneumonia of unknown etiology” in Wuhan, China, followed by technical guidance later that week. On January 12, WHO confirmed that China had shared the disease’s genetic sequence, and on January 14, a WHO official noted the possibility of human-to-human transmission. On January 20–21, a team of WHO officials visited Wuhan and, the next day, issued a statement confirming human-to-human transmission.

On January 22–23, Dr. Tedros Adhanom Ghebreyesus, WHO’s director-general, convened an Emergency Committee, in keeping with the process established by the IHRs. The committee, composed of independent experts from throughout the world, failed to reach a consensus about whether available information supported a PHEIC declaration. On January 28, Dr. Tedros led a WHO delegation to China to confer with Chinese leaders about their response to the novel coronavirus. Two days later, the Emergency Committee was reconvened, leading to a recommendation for a declaration of PHEIC. Dr. Tedros issued the official declaration on January 30. Significantly, WHO did not refer to the COVID-19 outbreak as a “pandemic” until March 11, 2020.

As these events demonstrate, WHO must rely on information provided by its member countries when making determinations about a disease outbreak. In the case of COVID-19, immense concerns have arisen about the timing and accuracy of information provided by the Chinese government. And, because the pandemic began in the Wuhan region of China, any delays, omissions, or flaws attributed to China had wide-ranging implications for the rest of the world. For example, while doctors in China raised concerns about human-to-human transmission of the novel coronavirus, the Chinese government hedged, and the mode of disease transmission was not confirmed for weeks by WHO. Even without a WHO
declaration of PHEIC, confirmation of human-to-human transmission would likely have led to much greater concern and swifter action by countries throughout the world. Instead, countries delayed their own responses—in many cases until late January or early February, after the PHEIC declaration. In addition, by not using the word *pandemic* until mid-March, WHO potentially gave a false sense of security to countries that had not yet identified COVID-19 cases within their borders.

In an ideal world, countries would report accurate, timely information to WHO, but varied reasons may constrain this. A country’s government may not want its own residents, let alone the entire world, to know that it failed to identify and contain a novel disease outbreak, especially if it arises at a politically inconvenient time. In China, Lunar New Year celebrations, in which individuals travel and spend time with family and friends, coincided with the emergence of the novel coronavirus. Countries may also fear that disclosing a novel disease outbreak may compromise their global standing, perpetuate stigma and stereotypes, or impact tourism and trade. This last concern resonates strongly with countries where tourism is a major economic driver. These concerns have been validated by prior pandemics, which is why the IHRs state that their purpose is “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.”

Yet, despite this, pandemics are routinely accompanied by country-specific decisions that do not reflect tenets of the IHRs. As a result, a country may have multifaceted reasons for withholding or limiting the information it shares with WHO while it attempts to contain a novel disease outbreak.

WHO’s COVID-19 response raises a second structural limitation, related to its funding mechanisms. Because approximately 80% of WHO’s funding comes from earmarked donor contributions, WHO must routinely view its member countries as both constituents and funders. Concern has arisen that this duality explains WHO’s actions during the initial weeks of the COVID-19 outbreak. China is among WHO’s largest contributors, which suggests that WHO is particularly attuned to that government’s preferences. This dynamic may have led WHO to resist declaring a PHEIC for a disease that had clearly originated in China, or at least postponed the declaration while it engaged with the Chinese government throughout the month of January.

If the timing of the PHEIC was a political decision, it certainly had public health consequences—countries throughout the world delayed their own responses, in-
including country-level emergency declarations, until WHO had acted. During these several weeks of wait-and-see, individuals carrying the novel coronavirus traveled and hastened its spread throughout the world. WHO’s actions may have also strengthened its ties to China: in the first half of 2020, China emerged as one of the leading donors to WHO’s COVID-19 response, with $50 million pledged. At the same time, WHO faces potentially catastrophic ramifications from recent US threats to withhold future funding; in addition to affecting the global response to the COVID-19 pandemic, other WHO efforts—to control infectious diseases, mitigate noncommunicable diseases, and prevent injuries—would suffer. Because the United States is WHO’s largest single funder, it remains unclear what country or organization might fill the void, raise its own profile in global health, and potentially reorient WHO’s donor-driven priorities. This suggests that, for WHO, politics and public health are inexorably intertwined. And, within the current funding model, advocates of good global health governance must enlist well-resourced partners to effectively compete for influence within the organization.

Despite this, it would be a mistake to forsake WHO and its critical coordinating role. No country can tackle a pandemic on its own, which means global health security depends on an entity that can facilitate inter-country mitigation, preparedness, response, and recovery. After SARS, the IHRs were revisited to strengthen WHO’s functions, and that will need to happen again to account for the lessons of COVID-19. As part of this process, member countries could consider the One Health perspective, to ensure that pandemic response is situated within the broader context of connections among people, animals, plants, and the environment.

WHO is unlikely to gain enforcement authority, given the geopolitical implications that would accompany such a shift, so WHO’s member countries must together develop processes that will yield compliance and timely, accurate information. Ultimately, all countries benefit from such an approach, as infectious diseases will continue to ignore jurisdictional boundaries and all populations remain susceptible to novel diseases that emerge. And these same member countries must determine their comfort level with a funding structure that forces WHO to constantly navigate the interface of politics and public health. A largely donor-driven agenda places global public health in peril if WHO is driven too heavily by politics rather than science. On the other hand, the door remains open for new funders to emerge—potentially even partnerships or funding consortiums that transcend country-level politics and span governments, civil society, and the private sector—to provide capital that allows WHO to address the world’s most pressing global public health priorities.
Conclusion

The COVID-19 pandemic will bring fundamental changes to the conceptualization of global health security, but it is much too early to understand any long-term impacts. After the world experienced SARS in the early 2000s, some believed that a new world order relative to public health was imminent. Populations became skilled at implementing public health practices, such as wearing face coverings and social distancing, and WHO’s IHRs were revised. While some global systems were strengthened, the COVID-19 pandemic has proven that the world’s reaction to SARS was not nearly strong enough. After SARS, governments failed to fully internalize the lesson that public health is not merely a domestic policy issue—it must join governments’ foreign policy agendas.

While society is in the midst of the current pandemic, heightened interest in public health preparedness and response must be channeled by policy makers. A window has opened in which leaders can address at least some of the factors that contributed to the origins of the COVID-19 pandemic, but this opportunity is fleeting. Leaders should use this period to look beyond the high-profile response and toward the next pandemic. Now is the time to ensure that all stages of the disaster cycle are accounted for, in terms of planning, resources, and infrastructure. Unless public health preparedness systems throughout the world are strengthened, any given country is at risk; infectious disease outbreaks require much more than lines on a map for containment.

As the world moves forward and envisions a post-COVID-19 era, science and politics will inevitably intermingle. Public health is inherently political for many reasons, including the frequent tension between government action to protect the health of a population and respect for the autonomy of individuals. It would be too simplistic to suggest that governments are now ready to view global public health through a purely technocratic lens. But it would also be incorrect to assume that politics alone will determine whether the world will be better prepared for the next pandemic. To surmount today’s geopolitical and ideological fractures, new collaborations, coalitions, and networks—perhaps some that cannot yet be fully imagined—will be needed. Such innovative partnerships may hold the key to spanning the political divide, fortifying WHO, and contributing to a world order that recognizes and responds effectively to infectious disease threats.
NOTES

45. World Health Organization, “WHO Timeline.”
47. World Health Organization, “WHO Timeline.”