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The main challenges in pandemic management: understanding global health security's current obstacles

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Abstract: The COVID-19's pandemic highlights the urgency of a global health security and infectious diseases agenda, as well as a need to effectively exercise the health governance mechanisms available or to be devised by the international community. This article seeks to identify and briefly discuss the main challenges pandemic's governance faces today, as to contribute to all efforts to address this need. They are four: the crisis of WHO as the main agent of global health governance; the limits of the international cooperation initiatives for development of national capacities in public health so far; international patent law and the obstacles to universal access to healthcare; and the restrictions to human mobility and the disrespect to human rights in times of health crisis. As an analysis method, extensive academic literature, official documents, and journalistic clippings are used in order to instruct the hypothesis proposed. Therefore, this paper is an analytical effort to bring the issue of global health security closer to the field of International Relations and Social Sciences, valuing the construction of a sustainable and comprehensive approach to global health and pandemic response.
Key Word: Global Health Security; Pandemic; International Health Governance.

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I. Introduction

The mathematician John Casti (2012) discusses the probability of extreme events that have the potential to transform the world as we conceive it. According to him, humanity currently has multifaceted systems and the occurrence of these so-called "X-events" is a real mathematical phenomenon intrinsic to their complexity. Among the examples provided is the emergence of lethal viruses that, specially driven by globalization, have the potential to gain unprecedented proportions[i] (Casti, 2012). In health studies, this narrative is recurrent and has motivated an important paradigm shift, responsible for moving the topic away from its domestic scope and building the field of global health and, especially, global health security[ii] (Kerouedan, 2016; Ventura *et. al*., 2020a).

Considering this context, Kerouedan (2016, p. 57) says that the risk of outbreaks and the need to standardize the management of Infectious Diseases (IDs) is at the "heart of the idea and emergency of global health's concept."[iii] Given the COVID-19[iv] pandemic, responsible for over 197.865 million cases and 4.219 million deaths (WHO, 2021), this urgency is evident. Once again, it's possible to see that "health is a social product, more than only the result of biological processes"[v] (Buss, Ferreira, 2010b, p. 115). Through a brutal manner, the current situation has shown the inevitable need to review the perspectives of global health security and public health policies at different levels (Ventura *et. al.*, 2020b).

The research exposed bellow aims to dialogue with this situation, asking what the shortcomings in pandemic's governance are today. Its goal is to conduct a situational analysis, based on bibliographic reviews, contained in academic articles, books, websites, and other various sources, physical and/or electronic. Thus, this paper identifies four obstacles to pandemic's management today: the crisis of the World Health Organization (WHO) as the main agent of global health governance; the limits of international cooperation initiatives for the development of national capacities in public health promoted so far; the international patent legislation and impediments to universal access to healthcare and supplies; and restrictions on human mobility and disrespect for human rights in times of health crises.

II. The World Health Organization Crisis

As the leading international organization for public health cooperation, WHO is the moral and technical authority for health globally (WHO, 1946). With 194 members, six regional offices, and over eight hundred collaborating institutions, it's possible to divide WHO's functions in global health management into three categories (Laude *et al.*, 2007 *apud* Ventura, Perez, 2014). The first is promote international cooperation around epidemiological surveillance and lead the fight against Emerging Infectious Diseases (EIDs),

synthesized in the creation and implementation of the International Health Regulations (IHR). The second is the responsibility for the development of international health standards, even if of a recommendatory nature – soft law[vi] – (Ventura, Perez, 2014). The third consists of organizing health interventions, defining and implementing programs to combat pathologies that present themselves as global challenges, whether new or old, as well as to support research and development.

Despite the prominent position that the WHO occupies in the governance of global health, many times its performance has been questioned and criticized by authorities, researchers and/or professionals from related areas. The first group of criticisms is related to its thematic amplitude (Albuquerque, 2020). Despite being created as an institution focused on technical support in the management of global health, WHO has tried to expand its field of interest, approaching issues such as global development and universal access to health. However, this movement was not well received by some of its member, especially by the United States[vii] and other industrialized nations, which pointed to the politicization of the Organization by pressure from developing countries (Chorev, 2012). In addition to this issue, some believe that by making this thematic expansion, the Organization fails to carry out both proposals effectively, mainly because the professional staff didn't follow this increase in complexity (Clift, 2014 *apud* Albuquerque, 2020).

Important criticisms are also made about WHO's structure, especially its lack of transparency in the appointment of representatives to the Executive Board and other committees – such as the Emergency Committee. The choice of consultants and the Director-General himself is subject to political negotiations and exchange of favors, to the detriment of a democratic process that prioritizes professional skills and possible conflicts of interest (Albuquerque, 2020). This criticism was already present during the first ESPII for the Influenza A H1N1 virus in 2009[viii]. Although the then Director-General, Margaret Chan, denies having been influenced in declaring the pandemic (Ventura, Perez, 2014), the consequence was an image, political and government crisis, which the Organization has sought to mitigate since then, increasing its presence on social media and conducting polls. However, the challenge of maintaining a good relationship with the international public, whether specialized or not, is a constant in the Organization.

The issues previously presented contribute to the third criticism to WHO, the erosion of its protagonism through the decentralized control over its own budget (Kerouedan, 2016; Albuquerque, 2020). Currently, the World Bank is the institution that exerts the greatest dispute for this protagonism, being the largest external financier of health programs and one of the largest in the fight against HIV/AIDS[ix] (Ruger, NG, 2010). In addition, since 1990, voluntary donations, known as "earmarked giving" (Ventura, Perez, 2014), have grown 54% relative to total funds, making up 80% of the Organization's budget in the 2016-2017 biennium (Ventura, Perez, 2014). In the 2017-2018 biennium, the Bill & Melinda Gates Foundation was the second largest contributor to WHO's budget ($228 million) providing about 10% of the total budget from voluntary donations ($2.29 billion), second only to the US ($281 million)[x] (WHO, 2019).

According to the WHO itself (2016), there is a lack of confidence in the Organization's ability to manage future outbreaks, which can be attributed to the cumulative effects of the Influenza A (H1N1) and Ebola ESPIIs. IA reform process began in 2011 in response to criticism pointing to the management of WHO by the interests of wealthy philanthropic organizations in the Global North (Ventura, Perez, 2014; Kerouedan, 2016). Its main goal was to strengthen WHO's leadership and increase its funding by restoring its reputation. The Framework of Engagement with Non-State Actors (FENSA) was created as a directive, a compilation of operational procedures that dictate the relationship with non-state actors at all levels of the Organization. It is also a legally binding international rule, as it stipulates sanctions (Ventura, Perez, 2014). However, the quest for the stabilization of WHO as the manager of global health persists and continues to influence its ability to respond to outbreaks.

According to Ventura and Perez (2014), FENSA can potentially assist in the process of regaining control by member states, but there are two important limitations of this mechanism: (1) it "does not enable independent auditors to control the collaboration with non-State actors" and "the provisions on access to information have restrictive interpretations" (Rached, Ventura, 2017, p. 6). As such, it seems to be closer to a technical vision of WHO than to the promotion of genuine reform. Therefore, several NGOs claim that the new framework has served to facilitate the influence of the private sector and philanthropic foundations in the WHO deliberative process, functioning as a "Trojan horse" (Rached, Ventura, 2017). In fact, partnerships with private entities go beyond the issue of funding, as in recent years they have begun to actively influence the decision-making process of the Organization (Kerouedan, 2016).

III. The Limits of the International Health Cooperation

To think about pandemic management, it's essential to recognize that, for peripheric countries, dealing with the unexpected in health is a bigger challenge (Buss, Ferreira, 2010b). Their populations often lack or have restricted access to the health system, which adds to the precarious conditions of other social, political, and economic structures, making the capabilities of these countries to face emergency health situations limited

(Santana, 2012; Ventura, Perez 2014). In addition, low-income countries tend to face the double burden of disease (Buss, Ferreira, 2010a), that is: chronic non-communicable diseases[xi] and neglected communicable, epidemic, emerging and re-emerging diseases[xii]. The reality is that the real pharmaceutical research and development needs of such diseases are not profitable enough and are often ignored by the Global North (Ruger, NG, 2010), at least until those become a threat to their own national interests (Kerouedan, 2016).

Moreover, the production of standards for surveillance and preparedness for global health emergencies and outbreaks does not consider the deficiencies of local peripheric health systems (Kerouedan, 2016). This creates the conditions for the process of implementing IHR's (2005) recommendations to always be in the background. Low-income countries, when they have resources to invest in public health, prefer to apply them in basic infrastructure or programs to combat most serious diseases, or those that affect their population immediately (Mcdougall *et al.*, 2008 *apud* Ventura, Perez, 2014). As of November 2014, eighty-one (41.33 %) of WHO member states have requested an increase in the timeframe for applying the recommendations on national surveillance capacities, and forty-eight (24.48%) of states parties have not reported on their progress (Ventura, 2016b).

In response, development cooperation initiatives began to take shape on the international scene. In 2014, the UN established the fifteen Sustainable Development Goals (SDGs) which, in the field of health, seek to "ensure healthy lives and promote well-being for all at all ages"[xiii] (Kickbusch, Buss, 2014, p.1). The WHO, in turn, advocated the Universal Health Coverage (UHC) as the health SDG (Kickbusch, Buss, 2014), according to the Organization's broader movement in discussing the social determinants of health[xiv] (Buss, Ferreira, 2010b). However, one criticism of this proposal is that the UHC's *raison d'etrê* is not a real change to the conditions of vulnerable populations, but rather mitigating the effects of health treatment spending (Kerouedan, 2016). Even the SDGs make restricted propositions and do not carry out practical proposals for their goals to be achieved, besides addressing health from an immediate perspective of medical and curative care (Kickbusch, Buss, 2014).

In short, Buss and Ferreira (2010a) argue that traditional aid attempts often do not foresee a dialogue, imposing priorities, objectives, and worldviews on recipient countries. The injection of resources by the international health cooperation system, known as Global Health Partnerships (GHP), is ineffective because it often does not offer technical support to facilitate its absorption by recipient countries, and often ignores pre-existing aid processes, overburdening domestic governments (Kerouedan, 2016). Therefore, as long as the allocation of resources occurs in a unilateral and uncoordinated way, any aid attempt will not be enough to promote real transformations in local health conditions (Buss, Ferreira, 2010a; Kerouedan, 2016).

The initiative of international South-South cooperation (SSC)[xv] in health begins as an attempt to address this issue, based on the notion that countries of the Global South share common interests and challenges (Santana, 2012). Cooperation initiatives among peripheric countries seek to review aspects of international cooperation that perpetuate North-South power dynamics and promote the implementation of programs and measures through joint efforts at all stages of its process, considering the countries involved previous experiences (Buss, Ferreira, 2010a). The Brics countries play an important role in this movement, since they promote cooperation initiatives among themselves and, individually, actively participate in their respective regional cooperation efforts (Ruger, NG, 2010)[xvi]. Brazil specially had developed its own health cooperation proposal, called "Structuring Cooperation in Health"[xvii], and sought to actively participate in building the health agenda in the two main regional cooperation forums, Mercosur and Unasur.

However, although South-South cooperation purpose is to be the solution to the limitations of traditional health cooperation, it is necessary to conduct a critical analysis of its practical performance. The main criticism presented is the unclarity of the power relations between donors and recipients of the aid (Ruger, NG, 2010) or that it can be understood as diplomatic and economic soft power[xviii] (Buss, Ferreira, 2010b). SSC also often fail to truly challenge the political and economic status quo of the development conjuncture imposed by the international system. Still, even if the example that emerging countries present for the development of health cooperation initiatives has both positive and negative perspectives, it serves as a model and a warning to the Global South in its quest for a quality health system (Ruger, NG, 2010).

IV. The Impediments to universal access to Health Supplies and Patent Law

In the context of global health, medical supplies such as antiretroviral drugs (ARVs), vaccines and tests are a necessity to fight against infectious diseases (T'Hoen, 2003; Castro, Westerhaus, 2007). In particular, the issue of patent legislation and Intellectual Property Rights (IPR) has a significant impact on the problem of access (T'Hoen, 2003), responsible for depriving populations around the world of better health conditions, and even of life itself. The dispute of interests of different agents on the subject has existed on the international scene for approximately two decades (T'Hoen, 2003). The central issue is the role and value of patents obtained for pharmaceutical products, as well as techniques and forms of distribution of health inputs (Castro,

Westerhaus, 2007). WHO[xix], UNAIDS, the World Bank, the G-77, regional entities and the UN, through the creation of the World Intellectual Property Organization (WIPO), have added their voices to this debate.

The main movement on the standardization of patent laws around the world was made, however, in the Uruguay Round (1986-1994) of GATT. It created the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), that became the main legal mechanism on patents at the international level, being monitored by both the WTO and WIPO, in achieving its goal of standardizing the international IPR legislations (Castro, Westerhaus, 2007). TRIPS works to essentially prohibit the production, export, and import of generic drugs that have a patent (Castro, Westerhaus, 2007). The only exception established is compulsory licensing, i.e., the "legal permission for the licensing of a patent regardless of the consent of its holder for another to produce a patented product or process" (Zucoloto *et al*., 2020, p.9, translated).

Currently, the Doha Round marked an important step in the discussion on DIPs and TRIPS limitations. In general, the Doha Declaration (2001), sought to affirm the priority of public health in patent law, recognizing the right of member states to take measures to protect public health and the compulsory licenses prerogative (T'Hoen, 2003). The declaration also agreed to remove the obligation to establish national patent and IPR legislation in least developed countries, facilitating their participation in and adherence to the TRIPS Agreement. Despite being viewed with optimism by low- and middle-income countries and global health activists, the Declaration was not well received by all member states, defining what became known as the "paragraph 6 problem" (Castro, Westerhaus, 2007). The United States and other developed countries argued that it was necessary to restrict the proposal to some specific diseases and raised opposition to the universal character of the measure[xx] (T'Hoen, 2003; Castro, Westerhaus, 2007).

According to T'Hoen (2003), the preparation of the peripheric countries guaranteed the achievements in the Doha Declaration. Still, the question of how to guarantee production in a country that has issued a compulsory license but has no national pharmaceutical infrastructure remains open[xxi] (T'Hoen, 2003). Moreover, although the TRIPS Agreement provides safeguards against the negative effects of patent laws, it's unclear how these are used in practice (T'Hoen, 2003). Therefore, it has been the focus of these countries promote debates on changes in international law and creating mechanisms that facilitate public health governance domestically. However, countries of the Global North and their pharmaceutical industries have made great opposition to revision proposals and flexibilization about IPRs (Castro, Westerhaus, 2007), insisting on the standardization of patent law according to TRIPS-plus[xxii] standards.

V. The Obstacles to human mobility during health crises

In a globalized world, an increasingly larger portion of the world's population is on the move, whether forced[xxiii] or voluntary, in search of better living conditions (Ventura, 2016a; Gushulak, *et al.*, 2010). However, according to Ventura (2015), this population has been constantly deprived of their rights to basic health conditions, whether in their home country, during the migration movement itself, or upon settling in a new country. In fact, globalization has been an important catalyst for intensified migration flows, and, consequently, a renewal of the racist and xenophobic characteristics of health securitization (Ventura, 2016a). Likewise, the increase in socioeconomic inequalities between rich and poor countries contributed to create the circumstances of this phenomenon (Carvallo, Mboup, 2005).

The topic already exists within the WHO, and the World Health Assembly asked in 2008 for the topic to receive more attention from the international community, but, especially in circumstances of epidemiological emergencies, policies to contain migration flows continue to deteriorate the health conditions of migrants and refugees (Ventura, 2015). Such policies are generally restrictive in nature, screening, quarantining, isolating people, and often preventing them from completing the migration movement (Carvallo, Mboup, 2005). The very topic of health security is usually associated with infectious diseases and the international transit of people, promoting the securitization not only of health, but of the migrant himself. However, it is known that, for the most part, those who manage to carry out the migration process are generally healthy, this phenomenon is known as the healthy migrant effect (Gushulak, *et al*., 2010; Ventura, 2015).

Moreover, this approach has proven ineffective, costly, and unsound in managing health and international migration flows, since increases in human mobility rarely stem from epidemics and pandemics, and when they do, they tend to be internal and temporary (Gushulak, *et al*., 2010). According to Ventura (2016a), this is one reason why the IHR gears its measures toward border control and shared surveillance, not on restricting people's movement. These restrictions also hamper the flow of humanitarian aid resources, whether personnel or medical supplies, to places facing epidemiological emergencies (Ventura, 2016a). Despite the mobilization around the issue[xxiv], the United Nations Convention on the protection of the rights of migrant workers and their families (UN/UNHCHR) is one of the agreements on human rights with the lowest adherence: forty-eight states, among them no developed countries.

Given this scenario, the Ebola[xxv] crisis was important to highlight that the containment of infectious diseases should include the reduction of social vulnerabilities (Chen, Takemi, 2015). During the two years that

ESPII was active, WHO's recommendations were to maintain human traffic, mainly to ensure access to humanitarian relief workers (Ventura, 2015). However, countries around the world modified their national migration legislation to prevent the entry of people from the affected regions and airlines – such as British Airways and Emirates Airlines – suspended their flights (Ventura, 2016a). In addition to contradicting WHO's recommendations and the IHR, these measures were taken without any plausible scientific or health justification (Ventura, 2015; Ventura, 2016a).

Important criticisms of the IHR have emerged from this example. As much as it mentions respect for human rights, the Regulation does not refer to any treaty or other international device on the subject and does not define international travelers and travelers when talking about the guarantee of their rights (Plotkin, 2007 *apud* Baptista, 2014). Moreover, it creates openings for possible human rights violations when it talks about the application of "biopolitical surveillance" strategies (Young, 2011 *apud* Baptista, 2014). It has become evident, as the conditions for epidemics and pandemics to occur multiply, that the free movement of people has not been a reality (Ventura, 2015), regardless of the promises made to date. On the contrary, migration and refuge have been managed as a national security problem (Ventura, 2015) and, along with them, solutions to health emergencies remain ineffective.

VI. Conclusion

Overall, the COVID-19 pandemic highlighted the persistence of pandemic governance challenges, as well as the limits of technical solutions in responding to health emergencies, posing the need for a sustainable health approach (Ventura, et al., 2020a). The crisis also presented the direct relationship between global public health, international relations, and political institutions, often contributing to increased inequality and securitization in health. According to Kerouedan (2016) the globalization of problems and solutions can disguise the real needs of each country and population in a selective manner, proportional to wealth and power. For this reality not to be perpetuated, a social and sustainable approach to health is proposed, which shifts the focus of health governance to a confrontation with the real causes of epidemics (Ventura, 2016a).

The current conjuncture has delimited the premises that urge the international community to think about global public health as a collective achievement. In a context of dismantling cooperation initiatives, academia, and science itself, promoting an analysis on health in its conditions of right and unique human welfare is an open door to the construction of the future (Ventura *et. al.*, 2020b). Moreover, the topic assumes an urgency that transcends the notion of global health as a secondary issue to International Relations and governmental interests. Health is a human right and as such must be present in academia and in national and international public policies, so that the answer to the question "are we prepared" for other health emergencies in the future is positive.

Notes

[i] The author mentions, for example, the Antonian Plague (165-180), the Plague of Justinian (541-750), the Black Death (14th, 15th centuries and later), and the Spanish Flu (1918-1919).

[ii] The concept of Global Health Security (GHS) is used by the WHO since the 1990s, under then WHO Director Gro Harlem Brundtland.

[iii] From the original "*O risco infeccioso e o risco pandêmico encontram-se no coração da ideia e da emergência do conceito de "saúde global*".

[iv] According to reports available so far, the SARS-CoV-2 virus, responsible for COVID-19, has emerged in Humbei, China. It was notified by the local government in December 2019 and the first cases outside China's boarders were reported by January 2020. The ESPII was declared later that same month and the pandemic was announced on March 11, 2021 (ALBUQUERQUE, 2020).

[v] From the original "(...) *a saúde é um produto social, mais do que apenas o resultado de processos biológicos.*"

[vi] According to Burci (2012 *in* Ventura, Perez, 2014), the concept of soft law stands for a normative production of rules with a recommendatory nature.

[vii] An example of this dissatisfaction was the reaction of the USA and some other institutions to the "Health for All" campaign, launching a policy of no real or nominal growth of the WHO budget for the 1980s and 1990s (Albuquerque, 2020). Therefore, to adapt to the demands of this neoliberal policies (CHOREV, 2012), the WHO set aside its leadership in health policies.

[viii] During this ESPII, allegations of conflicts of interest by WHO officials emerged (Ventura, Perez, 2014), over which the British Medical Journal conducted an in-depth investigation, together with The Bureau of Investigative Journalism, proving and formalizing the allegations and revealing that several consultants received financial rewards for their advocacy of the effectiveness of antivirals – such as Tamiflu, from Roche, or Relenza, from GlaxoSmithKline – or for advocating the need to purchase vaccines (Ventura, Perez, 2014).

[ix] Beginning in the 1980s, the Bank expanded its interpretation on the topic of health as part of a change in the concept of development it had adopted (Ventura, Perez, 2014).

[x] During this period, the US was WHO's largest voluntary donor, contributing 24% of total donations by nation states ($1.164 billion). Even so, private organizations contributed approximately twice as much ($1.243 billion) for the total voluntary budget (WHO, 2019).
[xi] Such as cardiovascular diseases, diabetes, and obesity.
[xii] Like HIV/AIDS, malaria, and tuberculosis, which Buss and Ferreira (2010a) call the "big three" in low-income countries.
[xiii] From the original "*assegurar vidas saudáveis e promover o bem-estar para todos em todas as idades*".
[xiv] At that moment, WHO created a series of initiatives to associate human development and health, such as the Commission on Social Determinants of Health (WHO, 2008) and the International Health Regulations (2005) itself, relying on the idea of Primary Health Care (PHC) (Buss, Ferreira, 2010).
[xv] South-South cooperation can be defined as "the process of economic, commercial, social, or other interaction that is (ideally) mutually beneficial between partners from developing countries, usually located in the southern hemisphere" (Buss, Ferreira, 2010b, p. 106, translated).
[xvi] India stands out for its efforts in vaccines development research, through the Policy Advocacy Initiative, which aims to raise awareness about the urgency of the issue of HIV/AIDS prevention; China, on the other hand, has made large investments in the African continent, proposing to build infrastructure and provide medicines, in addition to the exchange of health professionals (Ruger, NG, 2010).
[xvii] The Structural Cooperation and Health (*Cooperação Estrutural em Saúde*) approach aims to build development capacities according to the possibilities and resources of each country (Almeida *et al*., 2010). During the program's existence was in force in the national foreign policy, Latin America and Lusophone Africa were the main targets of Brazilian cooperation measures and it is estimated that, only in 2007, Brazil has invested about US$ 120 million in programs to fight HIV/AIDS and other areas of development in the African continent alone (Ruger, NG, 2010).
[xviii] According to Birn *et al.* (2017, p. 40, translated), soft power is "the ability to use persuasion or co-optation through lower priority areas, especially culture, to shape the ideologies, preferences, and behaviors of other states."
[xix] In 1998, the WHO created the Revised Medicines Strategy, which sought to monitor the impact of TRIPS and other trade agreements on access to medicines around the world. In addition, it also became an ad hoc observer at the WTO TRIPS Council (Castro, Westerhaus, 2007).
[xx] On the problem of the universality of the proposed measures, in 2007 a list of mostly developed countries was created, that voluntarily declared themselves illegible to the production of inputs by compulsory licensing (Zucoloto et al., 2020).
[xxi] In practice, the list of countries created prevents countries and their large markets from importing generic drugs produced based on this mechanism, which contributes to price increases (T'Hoen, 2003; Zucoloto *et al*., 2020).
[xxii] This mechanism follows the directive of the U.S. legislation (Castro, Westerhaus, 2007), extending the 20-year term for patents.
[xxiii] According to the UN Refugee Agency (UNHCR), by the end of 2019, 79.5 million people had been forced to move around the world; this number represents 1% of the global population.
[xxiv] In a joint statement in 2015, WHO, UNHCR and UNICEF, stated that "refugees and refugee seekers should benefit from equitable and non-discriminatory access to health, especially vaccination, regardless of their migration status" (Ventura, 2015, p.61, translated).
[xxv] The WHO declared, on August 8, 2014, the ESPII of the Ebola virus from West Africa. The disease was already known, but the escalation in the number of cases and deaths caught the attention of the international community, and in September of the same year, the UN Secretary-General created the Organization's first health mission, the United Nations Mission for Emergency Action Against Ebola (MINAUCE) (Ventura, 2016b).

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