The World Health Organization and the political embroilment of wounded multilateralism

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Abstract: *In the spring of 2020, the decision by the Trump administration to terminate its relationship with the WHO, in the midst of the more serious public health crisis in more than a century, shocked the international community. This controversial move shed a crude light on the global health watchdog's intrinsic vulnerabilities. The present article strives to map the apparition, the development and the challenges faced by the global health governance paradigm embodied by the World Health Organization. The working hypothesis of our paper rests upon the idea that the field of public health has been central to the fashioning of the liberal world order: as a result, it is important to understand the WHO' mandate goes beyond technocratic issues of disease prevention and containment. The organization is a spawn of a much wider liberal humanistic project, which now comes under intense fire. We will also strive to restore the diachronic dimension of the corrosive dynamics undercutting the global health governance infrastructure, from the North-South schism to the risk of public health "privatization" enacted though governmental disengagement and overreliance on private actors.*

Keywords: *global governance, public health governance, crisis management, globalization, Donald Trump, World Health Organization*

Introduction

In its July/August 2020 issue, the leading foreign policy magazine *Foreign Affairs* made an ominous premonition: "When future historians think of the moment that marked the end of the liberal world order, they may point to the spring of 2020[1]". The impasse of the liberal world order is mirrored in the crisis of its institutions. One in particular is now facing a predicament whose outcome will prove critical in determining the contours of the world we will inhabit in the next decades.

In the grip of a walloping pandemic outbreak that claimed more than 500.000 lives, wrecked economies and still continues unabated to sweep the world, the World Health Organization – the world's chief health watchdog – is now scrambling to come to terms with its own internal crisis, of an altogether different nature. At the root of the crisis lies not, this time around, an incontrollable pathogen or some microbial havoc-wreaking organism, but the world's reigning superpower, the United States, which also happens to be the organization's largest contributor. In mid-April, Donald Trump launched an attack on the WHO's handling of the pandemic, within the broader context of his escalating anti-China rhetoric. The president accused the UN agency of "failing its basic duty" and being complicit in China's initial downplay of the outbreak[2]. Quite significantly, the Trump administration's main line of argument was the WHO's collusion with China: "We fund it, and they

seem to be […] very China-centric, that's a nice way of saying it, they seem to err always on the side of China […]. They called it wrong and if you look back over the years, even, they are very much…everything seems to be very biased towards China. That's not right"[3]. The decision to halt funding, which was formally enacted a few days later, fits the anti-China narrative that Trump is championing since 2016, but also aligns with the current administration's wider wariness of abstract concepts such as "global governance" and "multilateralism"; it mirrored a worldview in which international transactions are governed by power play and zero-sum-games, entrapping actors into a binary, Cold-War-like side-taking logic. A month later, on the 19th of May, the USA issued a stern ultimatum demanding that the international body "commits to major substantive improvements" within the next 30 days, a stringently narrow time lapse for enacting such a comprehensive, yet vaguely define, imperative[4]. Despite that, the WHO declined any direct confrontation with the US. The World Health Assembly, the governing body of the organization, passed a resolution pledging "to initiate, at the earliest appropriate moment […] a stepwise process of impartial, independent and comprehensive evaluation" on the "actions of WHO and their timelines pertaining to the COVID-19 pandemic[5]". However, only 11 days after the pronouncement, the Trump administration announced it would be terminating its relationship with the WHO and cutting off definitely the institution from US cash, while not making it immediately clear if that meant legally withdrawing from the agency[6]. The announcement came alongside a salve of other measures targeting China and Chinese individuals or companies, in a clear bid to portray the WHO and Beijing as one inimical bloc[7]. In early July 2020, the US submitted its withdrawal notification to the United Nations and informed the Congress of the move[8].

It took less than three months between Trump's first expression of skepticism, in mid-April, and the format withdrawal notification in early July. In the newfound febrility of our pandemic-ridden world politics, it may seem like a lot. But, all things considered, the pace still feels rushed and impulsive, especially in view of what is at stake: a fruitful, half-century-old special relationship that presided over and oversaw the rise of global health governance concepts as we know it.

Donald Trump's controversial decision to defund and, ultimately, to withdraw from the WHO crudely exposed not only the worrying fragility of the global health governance system, but also the gaping chasms in the multilateral philosophy upon which is premised our international order. Let us not be naïve: multilateralism was, granted, more of an ideal or a moral conception than an effective institutional architecture – in practice, superpowers and nation states were still largely in charge of policing the world and there was always a lingering sense that the UN may just be a toothless tiger. Still, the ostentatious and much-publicized commitment to furthering international cooperation through common institutions and coordinated governance rather than brute force shouldn't be

dismissed as mere perfunctory lip service or opportunistic camouflage of imperialist agendas. It effectively permeated our geopolitical Zeitgeist and, even more importantly, our philosophical ethos, thus creating a dense web of constraints, and critical opprobrium that every country needed at least to consider before attempting to juggernaut through international norms. The hiatus between announced aims and actual behavior can only be so large before the public (and it would be absurd to contend that there is no public in international politics, and brutal *potestas* is the only law of the land – *auctoritas* and legitimacy are as much vital currencies in global politics as in national political struggles) notices the rift and penalizes the offender, which falls into a trap of its own making. In a cogent and striking essay, Albert O. Hirschman asked a pertinent question that sits uncomfortably with the realist strand of thought that often dominates international relationships: is ideology a mask or a Nessus shirt[9]? While, Hirschman contends, the traditional political vocabulary often chastised ideology as a "mask" under which cowers a darker agenda, the relationship between reality and "illusion" is far more complex and less univocal. The so-called mask ends up subverting reality instead of hiding and preserving it. It then becomes a Nessus tunic, burning and fusing into the flesh of he who dons it, until taking it off becomes impossible. This luminous metaphor can be extended to the field of international relations, where there is an inherent tension between the need for ruthless efficiency and the yearning for guiding mythologies and legitimizing grand narratives. However wildly optimistic that may sound, grand narrative *can* win the battle. Multilateralism is – or at least was, although it is too soon to pronounce it dead yet – such a grand narrative, a meaning-making mechanism that shaped how the international community viewed itself and provided an organizing principle for the US-led, post-Cold War world order. Though we remember more acutely its failings – the Crimean annexation, the grisly Syrian quagmire – one can wonder how many catastrophic military interventions have been quietly, without fanfare, stopped in their tracks in the last decades due to the culture of restraint it fostered.

The birth of the WHO and the liberal project in the XXth century

In the international governance ecosystem, the WHO played a symbolic role that extended far beyond mere technical management of disease and health. Its genesis was premised on a century of mounting salience of hygiene and sanitary issues. But previously the nation-state was the sole relevant arena of such concerns, despite plagues and pestilence exhibiting scant regard to notions such as border sovereignty. Furthermore, public health and hygiene concerns were often articulated in the language of nationalism: indeed, the crucial shift in the perception of citizens' bodies as assets to be preserved and protected came in the context of national industrial and military rivalries. The renewed interest in physical culture towards the end of the 19th century is best comprehended

as an element of the narrative of national rebirth, as the fortitude of the "social body" became a function of the ideology of nationalism. In many respects, the World Health Organization represented a radical departure from this paradigm. In disembedding such a crucial field of social existence from the national matrix and transferring it to the supranational level, the WHO had a powerful mandate to enact what was the cornerstone of a humanist liberal *Weltanschauung*: nurturing new "global commons" – such as health and well-being – which are beyond narrow national self-interests and demand collective, coordinated action. The WHO was construed as a testament to the universality of a new positive conception of human rights or, in more concrete, actionable terms, to the possibility of an authentically post-national governance framework. This liberal humanist political project intersected managerial concerns about better controlling risks in the context of increased fluxes of goods and people, and was propelled by the unprecedented development of medical technology which actually made possible such large-scale deployment of aid programs across the globe. Thus, understanding the political underpinnings of the WHO demands a better understanding of the complex historical processes that shaped this institution.

As Charles Rosenberg has astutely noted, "an epidemic has a dramaturgic form[10]". By this the distinguished historian of medicine meant that epidemics (and, more generally, disease) are essentially stories of resilience and survival, through which communities enact and reaffirm essential social values and modes of understanding. As a result, disease-fighting efforts are inherently ideological, and are often articulated within political processes. As we have previously highlighted, it was first nationalism which was successful in co-opting public health concerns and weaving them into its own unifying narrative. This process of medicalization occurs simultaneously on two distinct planes: symbolic and technocratic. On the symbolic plane, public health issues can be better understood and conceptualized within a "biopolitical" framework. Building on Michel Foucault[11] and Ruth A. Miller[12], we define biopolitics as a *political interest in the life of the body* and an attempt by political instances to achieve some sort of control over biological phenomena such as reproduction, disease or death. Starting with the 19th century, it becomes exceedingly obvious that such a biopolitical frame can be applied to analyze national citizenship, since in the modern Nation-State, the citizen is at least partially conceived as a biological category, organically connected to the "body of the nation" by a host of quasi-somatic interdependencies. The emergence of the physicality of the citizen's body in the public sphere – as opposed to the mere rationality and moral qualities of the abstract, ideal, almost ethereally "bodiless" citizen of the 1776 *United States Declaration of Independence* and the 1789 *Declaration of the Rights of Man and of the Citizen* – was a process that was intertwined with the emergence of national political spaces. With it grew new domains of knowledge (medicine, epidemiology, hygiene, but also demographics or, more

sinisterly, eugenics) over which the Nation-State quickly claimed ascendency. Individual bodies and their ills were seen as a metaphor for the well-being and vitality of the less tangible entity that was the nation. On a more pragmatic level, the key locus of elaboration of public health policy was also, unsurprisingly, the State. Indeed, rooting out epidemics and other scourges was such a consensual social project that it provided unparalleled narrative and practical opportunities for nation-building. A testament to this is the fact that the first drivers of the massification of health concerns, notably through compulsory vaccination programs, were two institutions organically tied to the Nation-State: the army and the school.

But, as early as the last decades of the 19th century, this paradigm was challenged and a new transnational institutional architecture grew in the interstices of what was still perceived as a sovereign prerogative. The emergence of a truly global health governance paradigm was, nonetheless, a slow and arduous process, driven by three interwoven overarching rationales: human rights, security and economics[13].

Historically, protecting trade and securing international routes drove early health governance efforts, especially in the context of the colossal wealth being extracted by Western powers from their colonial dominions – which, incidentally, were also hotbeds of tropical diseases which were always at risk of being unleashed onto the metropoles. According to Jeremy Youde, it was such commercial worries who inspired most of the impulses towards international health cooperation in the period between the late 19th century and the Second World War: governments worked together, and even agreed to cede some of their powers, because they did not want commerce grinding to a halt[14]. This shaped the morphology of the initial health governance response, orienting the system towards a heavy focus on the significant tropical diseases most likely to hamper the flows of goods; it also imparted a distinctive "defensive" character, with more quarantines and outbound disease "filters" than direct eradication programs targeting the underlying causes. Thus, the downside of this approach was that is sidelined local populations, especially if they were not directly involved into productive activities[15]. The first serious coordination effort at creating a system of international health governance was driven by the fight against the "big three" (cholera, plague and yellow fever), highly infectious diseases whose spread mirrored international trade routes. Six International Sanitary Conferences were held between 1851 and 1885, but without producing much in the way of actual coordinated action. The seventh such event, hold in 1892 in Venice, yielded however a more robust agreement (which was greatly helped by Robert Koch pioneering work on the pathology of the *Vibrio cholerae*). The International Sanitary Convention (ISC), signed by Germany, the Austro-Hungarian Empire, France, Great Britain, Belgium, Brazil, Spain, the United States, Greece, Italy, Luxembourg, Montenegro, the Netherlands, Persia, Portugal, Romania, Russia, Serbia, Switzerland

and Egypt, set up a series of mechanisms to limit the spread of disease, some of which are still in the arsenal of the WHO today. These included:

a) notification and communication to the other countries whenever there is a proven outbreak (art 1: "Each government shall immediately notify the other governments of the first appearance in its territory of authentic cases of plague or cholera.[16]");
b) signaling and quarantining infecting areas (art. 7: "when several unimported cases of plague have appeared or when the cholera cases become localized, the area shall be declared contaminated[17]") and vessels (with three thresholds: infected, suspicious and uninfected, as detailed in art. 20[18]);
c) harmonization/standardization of medical procedures and disinfection measures;
d) medical inspections for ships passing through the Suez Canal to and from Mecca for the annual hajj (thought to be potential vectors of disease, as in these regions infectious diseases were often endemic). It also created a network of sanitary establishments in the area for this purpose and enforced minimal hygiene standards for ships carrying pilgrims (art. 98: "In addition to the water-closets for the use of the crew, the vessel shall be provided with latrines […] in the proportion of at least one latrine for every 100 persons embarked[19]" and art. 109: "The competent authority shall not permit the departure of a pilgrim ship until he has ascertained that the vessel has been put in a state of perfect cleanliness and, if necessary, disinfected; and that the vessel is in a condition to undertake the voyage without danger, that it is properly equipped, arranged, and ventilated[20]").

Though the ISC had a very limited scope and failed to institute a formalized, permanent control body, it was a landmark achievement in many respects. It was the first to have actual enforcement mechanisms; it is equally noteworthy to mention that it was a truly global efforts, involving sovereign extra-European powers (such as Brazil, the US, Persia or Egypt) and not just the traditional "great powers". It is also important to highlight that the provisions of the ISC were *the most stringent allowable under international law*, as not to hamper trade excessively and unnecessarily[21]. It limited, as a result, the discretionary power of Nation-States in managing diseases, which was a paradigm-changing first step towards recognizing that there are potentially higher instances than the Nation-State in articulating the common good.

In the following years, the first two international health organizations appeared: in 1902 the International Sanitary Bureau (for the Americas) and in 1907 the Office International d'Hygiène Publique (for Europe). Both had the aim of enforcing the provisions of the ISC. Their budget was often minuscule and their mandate seriously restricted, but their creation still established a

milestone for health governance: it was the first time that national governments came together to create supranational, independent agencies for health-related purposes.

The First World War ushered in a new era in the history of globalization and of global governance. Created in 1919 with the aim of stopping all future wars in their tracks and further international cooperation, the League of Nations was an ambitious project which articulated an explicit liberal philosophy aimed at supplanting the Westphalian system. The League of Nations was set in motion in a world traumatized not only by four years of deadly military conflict, but also by the Spanish Flu pandemic which took off tens of millions of lives worldwide. As a result, health was since the very beginning embedded into the League of Nation's mission: in 1923 the League of Nations Health Organization (LNHO) was created. Its two agencies, one located in Singapore (dealing with tropical diseases) and the other Eastern Europe (where it tackled mainly the violent post-war outbreaks of typhus) were funded, contrary to other health and relief organizations, not by charitable funds but by national governments' budgets. These agencies provided expertise but also, crucially, material aid to local authorities in the form of soap, medicines, medical equipment, ambulances, etc. In parallel, the International Sanitary Convention framework was extended to include other diseases and a variety of new rules regarding mainly the transitional movement of people, such as pilgrims, migrants or seasonal workers.

However, the most important new development occurred in the postwar era. A paradigm-changing shift occurred with the emergence of the World Health Organization, which precipitated the fall of what David Fiddler called the "classical regime[22]". From the late 19th century to the late 1940s, the international health governance regime was mainly concerned with mitigating the spread of "exotic" diseases and organizing local responses in those peripheric disease-prone regions to lessen the burden on North America and Europe. Even if this concern proved fertile, it ensured only a patchwork coverage and didn't provide the robust, stable institutional infrastructure required for the task (for example the League of Nations' Epidemic Commission created to combat typhus in Eastern Europe lasted only a few years). A new model was needed.

As the World War II drew to a close, leaving behind an even bleaker picture of political, economic and, most importantly, moral wreckage, an emboldened sense of urgency prompted the victors – divided as they were – to set up a new architecture for the new world order. Among these were the United Nations, which, like its predecessor the League of Nations, integrated in its framework a specialized agency dedicated to nurturing global health: the World Health Organization. Created in 1948, the new World Health Organization was the product of the liberal project which was coming into focus into the post-war era. It comprised 55 member states (now 193) who all participated in the World Health Assembly; it even allowed a category of associated

membership open to territories "which are not responsible for the conduct of their international affairs" (i.e., colonial dominions); a new member could be approved by a simple majority of the existing Member States. This simplified membership application process– eschewing the unanimity or the two-third supermajorities rule prevalent in most international bodies – reflected a belief that health cooperation ought to be as inclusive as possible. The World Health Assembly elects the Executive Board made up of 32 officials designated by Member States but which cease once nominated to represent the interests of their respective government. The Secretariat tends to the everyday technical and administrative matters of the WHO, and is headed by a Director General who is appointed by the General Assembly on the nomination of the Board[23]. But the break with the classical model was not merely institutional: the focus and scope of intervention was significantly broadened to include, apart from infectious diseases, the altogether more diffuse and ideologically-laden notion of *well-being*. The preamble of the WHO Constitution put forth an inclusive definition of health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[24]". Most importantly, it articulated the "enjoyment of the highest attainable standard of health" as a fundamental human right and a responsibility of political authorities towards populations[25]. As such, this broadened conception of health allowed the WHO to engage in issues pertaining to "nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene[26]".

It would be myopic to consider the WHO as a purely technical biomedical agency. These goals echoed a wider paradigm change, visible in the network of cultural, humanitarian or human rights institutions (from the Food and Agriculture Organization to UNICEF) set up in the aftermath of the war years. The WHO was deeply embedded into the burgeoning liberal, multilateral project of these years. The broad conception of health it promoted acted as a flagship for a characteristically liberal concern for a unifying, consensual causes in the international arena. Improving health was not only an essential step in creating a prosperous, peaceful world: the WHO statute reads, in many respects, as a plea for a "global citizenship". This integrated view of health as a human right was, of course, congruent with political developments within nation-states (such as the Welfare States and, more broadly, the rise of the concept of social citizenship[27]), but the translation of such principle on the international stage – with the prospect of effectual cooperation through dedicated agencies and institutions – was a watershed moment in liberal philosophy. The WHO was among the new set of tools that the liberal world order had forged. In the following years, the WHO became an essential actor in the field known as *global governance*. It furthered not only pragmatic objectives – such as vaccine programs, international research initiatives or standardization of medical procedures – but also reiterated a message of unity and cooperation

infused with liberal optimism. The apex was reached in the early 1980, after a decade-long campaign achieved the worldwide eradication of one of the oldest and deadliest pathogens known to man, smallpox[28]. The 1970s saw large health education campaigns, the intensification of vaccination programs, the quasi-eradication of a number of the so-called tropical diseases that had tormented the last century and the creation of extensive medical databases (such as the essential medicine list); the WHO also participated in the political processes of the post-colonial world – stringently in need of medical technical assistance –, as an important conveyor belt between the developing world and industrialized Western powers.

A legitimacy crisis: failures of health governance from HIV to the Covid-19 epidemics

However, despite these resounding successes, the WHO was beset by new challenges which shed a much bleaker light on the failures and limitations of the liberal health governance paradigm. We will focus on two such global emergencies which saw the WHO become the focus of robust criticism and highlighted a series of dysfunctional reflexes at the heart of the global public health response. Even more worryingly, they questioned the triangular synergy that was the beating heart of the liberal governance project: between national governments, private actors (large pharmaceutical laboratories responsible for innovation and research) and transnational regulatory entities.

The AIDS epidemic ushered in the first global reckoning with the liberal health paradigm. Surfacing in the early 1980, the HIV virus was instantly political as it exposed and exacerbated fault lines, first *within* societies and ultimately – as it spread around the world and disproportionately hit developing countries – *between* societies, countries and even continents. AIDS fused into preexistent equations of inequality and prejudice, as it disproportionately ravaged invisibilized, marginalized communities[29]. Now that the race for a Covid-19 vaccine captivates all minds and reactivates the epic of science as humanity's salvation, it is sobering to hark back to the AIDS moral debacle and understand that, as *Foreign Affairs* put it in its April 2020 edition, finding a cure "is only the first step[30]". In the 1990s the world had a cure for AIDS, and that didn't prevent millions from succumbing to it. The world needs global governance – that is, political voluntarism and cooperation – to think and act beyond narrow domestic or private agendas. In the 1990s, by the time the Western pharmaceutical establishment had come up with efficient biomedical tools to counter the disease, the most stringent question was indeed how and to whom such vital resources will be delivered – and whether the economic logic of profit on a highly competitive market will ever be reconciled with the moral core of global solidarity embodied by the United Nations and WHO. Global trade rules in the 1990s required developing countries – who were bearing the brunt of the

AIDS infections and deaths – to begin offering patents on medicine for the first time. As a consequence, the antiretroviral drugs were only available from the original owner of the patent, and came with paralyzing prices, ranging to up to 15 000 dollars per patient per year. The results were catastrophic: in Africa, only one in a thousand people living with HIV in Africa had access to AIDS treatment[31]. While in the West, efficient medical solutions had stripped the disease of its terrifying lethal prognosis, in Africa it still carried a death sentence. Despite the WHO's steady – and immensely successful – action throughout the 1960s and 1970s, the rift between the medical haves and have-nots had never appeared greater. Harvard economist Jeffrey Sachs, a WHO advisor on macroeconomics and health, commented for *The Washington Post*: "To me, it's as though the Black Death were going on in Europe in the 14th century, and China were sitting on a cure and saying: Why should we help?[32]"And yet, the WHO appeared powerless to restore an equilibrium. Bound by the WTO's Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement, international public health agencies were uncapable to juggernaut through the dense web of economic interests, technical constraints and geopolitical reticence. The first worldwide conference on the access to AIDS drugs opened in 1991 in Geneva, under the patronage of the WHO. Its objective was measured and limited: allow "a certain flexibility in terms of pricing […] for developing countries" – according to the draft proposed by the WHO. It ended in 1993 in failure, and many suggested that it had been doomed the minute it began[33]. Throughout the decade, as the global death toll raised steadily, the patent quagmire descended into a geostrategic row pitting developing countries against large drug companies and some of the rich nations where these companies were based. Brazil and South Africa both denied patent rights and as a result were ceaselessly challenged by the United States at the WTO. Developing countries who took action faced lawsuits, sometimes dozens of them, for violations of intellectual property rights. The Office of the United States Trade Representative and the European Commission tried to pressure South Africa, who had then the largest HIV-infected population in the world, to backtrack on its Medicine Act, which allowed cheaper importations of medicine without the patent holders' consent. The US listed South Africa under its trade law for possible trade sanctions if it did not comply, and the situation escalated into a matter of serious diplomatic concern which saw personalities like US vice-president Al Gore or French president Jacques Chirac raising the issue in bilateral talks[34]. Eventually, in the early 2000s, a compromise was found with the WTO which made a series of adjustments to the TRIPS to allow for a more flexible global flow of essential medicine; fearing backlash, pharmaceutical companies agreed to budge too. The results were swift, with prices for AIDS drugs dropping steeply and constantly over the next decade, but the symbolic damage was done.

A second upheaval further dented the trust in the global health governance architecture as it had emerged after the WWII. It was linked to yet another epidemic outbreak, albeit of a less serious nature this time: the 2009 swine flu epidemic. But much like the AIDS crisis and the current coronavirus pandemic, it launched into the international community a torpedo of distrust, acrimony, conspiracy theories and (geo)political resentment. In the spring of 2009, an outbreak of influenza erupted in central Mexico and spread to the USA and worldwide. In June, the WHO declared it a pandemic, but in the following months the virus – which had a case fatality rate roughly similar to the typical influenza – progressively abated. But the response to the virus shed a bleak light on the deep geopolitical and cultural ramification of distrust: wealthy countries were quick to blame the developing world as a breeding ground for diseases and clamp down on immigration, while the global South trafficked heavily in tropes of evil imperialist plots and conspiracy theories. Indonesia, for example, saw a particular virulent backlash against the WHO and foreign research units on its soil, spearheaded by Siti Fadilah Supari, the country's Health Minister. The storm had been brewing for some time already: in 2007, the Indonesian government learned that the WHO had been transferring influenza samples provided by Indonesian authorities to pharmaceutical companies and that one particular company was using the samples to develop a vaccine against the particular strain of the virus circulating in the nation. It therefore decided to withheld sample from the WHO and negotiate directly with the pharmaceutical company Baxter International. According to Indonesian authorities, such action flowed from ethical concern that the WHO was infeudated to Big Pharma. Large drug companies, so the narrative went, were merely utilizing a submissive WHO to gain cheap and easy access to viral genomics. Rather, the country decided to reclaim its "biological sovereignty" and use the leverage offered by its possession of rare samples to strike a deal with the pharmaceutical giant – effectively *selling* the samples in return for cheaper access to the vaccine[35]. Supporters of the move sounded the theme of the "imperialistic" WHO exploiting developing countries and argued Western medical establishment saw the global South as little more than a large market outlet for its products[36]. Critics contended that strategically withholding pathogen samples and turning them into "bargaining chips" was a threat to global health and an act of medical egoism[37]. Indonesia was far from alone: it was backed vocally by other nations, all hailing from the "global South": Thailand, Brazil, India as well as the Third World Network. The fault line was reminiscent of the AIDS patents crisis in the previous decade, with a North-South (or even worse a West-"rest") bitterness hardening into a more entrenched dichotomy. In 2009, against this fraught context of mistrust, Indonesia doubled down on the narrative of a global struggle for (bio)power pitting on the one hand the WHO, wealthy Western powers and Big Pharma, and on the other, in the role of the underdog, emergent countries from the global South. Such narrative trafficked heavily in

conspiracy theories and paranoia: at the heart of this symbolic offensive, the United States Naval Medical Research Unit Two, in Jakarta, which could collect its own sample of local influenza. During the negotiations about the continued operations of the NAMRU 2, top health officials didn't hesitate to argue that the research center could at any time be used to manufacture and unleash biological weapons. In 2010, the NAMRU2 was closed and relocated to Pearl Harbor, Hawaii – the US thus losing an important public health "bridgehead" in Asia and a symbol of its global soft power reach. The WHO itself didn't emerged unscathed: the 2009 pandemic and the Indonesian row shed light on the alleged collusion between the WHO, rich industrialized countries and pharmaceutical companies. As swathes of the public opinion (both in developing countries and industrialized Western countries) saw in the 2009 outbreak a "hysteria" fanned up by Big Pharma, the WHO came under fire for declaring a pandemic to help boost the sales of antiviral drugs and vaccines. There were a host of narrative about the epidemic, ranging from a plot hatched by health authorities and business interests to an covert extermination enterprise. Then, a joint investigation by the BMJ and the Bureau of Investigative Journalism uncovered potential conflicts of interest within the WHO: it emerged that it had included into advisory boards experts who had declarable financial and research ties with pharmaceutical companies producing antivirals and influenza vaccines[38]. In the end, under mounting pressure, the WHO was compelled to create a review committee who, despite defending the agency's response, acknowledged the need for more transparency[39].

The uncertain future of global health governance

Crises often ignite questions of "Whom do we trust". The response we collectively offer under duress highlights not only pragmatic imperatives, but sheds light on the larger symbolic undertows at play. The evolution of the health governance creed and architecture is remarkably telling: the "first globalization" of the 19th century *fin-de-siècle* ushered in the first tentative of jointly managing the risk of incontrollable disease spread, especially along key trade routes. But the results illustrated the limitations and prejudices of the era. Such top-down, defensive strategy, with its almost exclusive focus on infectious exotic diseases, informed the resolutely "minimalistic" approach characteristic of the classical regime. But a new paradigm in health governance emerged in the post-WW II era, alongside a different outlook on international relationship and a political project to transcend the hitherto dominant Westphalian world order. In this respect, the WHO ought to be understand as a political initiative: albeit of a more focused and specialized nature than the United Nations or the European Economic Community, it is nevertheless an integral part of the same *élan*. The largely successful campaign of the 1960s and 1970s cemented the central position

of the public health agency in the global governance ecosystem. Not only did it proved to be one of the main forums for debate and an effective purveyor of technical assistance, it also articulated on the supranational level one of the driving ideological forces behind the reinvention of postwar liberal democracies: the necessity to redefine human rights in a more fleshed-out, positive way, that acknowledge not only Berlin's "negative liberties[40]" but also the material contingencies of life. Health and "well-being", with all their complex social determinants, were embedded into a global definition of citizenship. The doctrine of *development* was energetically championed by the United States, who saw it as a formidable weapon in the "battle for hearts and minds" of the Cold War. President Henry Truman regarded it as a quasi-messianic endeavor for the new superpower: "We must embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of underdeveloped areas. More than half the people of the world are living in conditions approaching misery. Their food is inadequate, they are victims of disease. Their economic life is primitive and stagnant. For the first time in history humanity possesses the knowledge and the skill to relieve the suffering of these people The United States is preeminent among nations in the development of industrial and scientific techniques. The material resources we can afford to use in the assistance of other people are limited. But our imponderable resources in technical knowledge are constantly growing and are inexhaustible[41]".

The results in the following decades were tangible, with the eradication or at least the containment of a number of scourges: smallpox was eradicated in 1979, plague outbreaks were virtually eliminated, and tropical diseases like malaria significantly receded. However, the 1990s and 2000s revealed the cracks in the liberal edifice – or, even more alarmingly, the exhaustion of the momentum of the liberal project in itself. The WHO and international aid organizations were for a decade powerless bystanders in the AIDS crisis in the developing world. In the mid-1990s, as the HIV virus decimated Africa, the hiatus between the geopolitical have and have-nots was wider than it had ever been in history. And while during earlier decades the WHO – with its ample vaccination campaigns in emergent countries – had been a powerful equalizer, this time it appeared tangled into the business interests of the large private laboratories who had become the main driver of medical innovation and on whose largesse public health governance came to depend. It suffered a series of legitimacy crises, which affected its outreach, especially in the global South – as the Indonesian spat proved it.

But the current crisis is unique, even if it builds on two decades of erosion of the global governance doctrine. The AIDS and the 2009 influenza crisis highlighted the schism between the "Western complex" – of which the World Health Organization, along other international regulatory

agencies, was as an integral part – and the emergent world. However, of these confrontations, no serious alternative visions of global governance emerged. On the contrary, such as during the AIDS crisis, the demand was for the WHO and other international organization to better uphold their founding liberal ideals. Nowadays, we witness the first decoupling of the WHO from its original political matrix: the Western democratic liberal world. More precisely, the Western world has split over the course of action to adopt. While the United States and the Trump administration decided to sever ties with the organization, European powers vehemently condemned the move and upheld their commitments to the WHO[42].

It is still unclear how the current crisis will unfold and whether it will resemble the previous ones. First of all, it is not a given that the US withdrawal will effectively take place and be a durable, consequential event – with candidate Joe Biden firmly pledging to reverse the decision "on day one" if elected in November[43]. Withdrawal is, both in the WHO statutes and in US law, a complex and intricate process on which, notwithstanding the presidential impetus, the US Congress and courts can have their bearing[44]. But if a new Trump administration presses ahead, then the fallout will likely be significant. The wrong question to ask is "Who needs whom more?" and frame the withdrawal as an arm-wrestle match. Both the US and the WHO will fare worse without each other. The World Health Organization stands to lose more than 15% of its budget[45]. Such recalibration of the financial means of the organization would seriously cripple many of the WHO's crucial global initiatives, such as polio eradication, child nutrition, vaccine distribution, and projects to combat HIV/AIDS, malaria, and tuberculosis. This loss of funds will also impact the Covid-19 response, especially in poorer areas that rely more on international aid to contain the outbreak. Furthermore, a robust international infrastructure and a public health agency with a truly global reach will be stringently needed once a vaccine is available: how will a crippled, financially-starved WHO be able to marshal what will undoubtedly be the largest, most ambitious vaccination campaign in recent history? But on the other hand, the US also needs this seat at the increasingly important table of global health governance, a seat it is thusly willingly giving up. It is possible, indeed, that the void left by the US will be filled by other contributors. China, for example, who is now contributing less than 1% of the organization's budget[46], has an ample margin to improve its role within the WHO, unchallenged by other major powers (the UK and Germany, the second and respectively third governmental contributors to the WHO, are no match for a more assertive China). Sensing rightly that the future of the agency has become an international battleground, China already pledged an additional 30 million dollars in April[47] and hinted at much larger prospects[48], all the while actively championing and defending the WHO's global mission. Chinese Foreign Ministry spokesman Geng Shuang praised the agency's response and declared that the WHO was

"actively fulfilling its duties and upholding an objective, scientific and impartial stance.[49]" China's state media stood staunchly and vocally by the WHO, reaffirming Beijing's commitment to the very values the US apparently abandoned[50]. This should be a serious cause of concern for the international community. China now positions itself as an ambassador of goodwill, but has its own burgeoning vision of public health and crisis management – one that echoes its wider social engineering project. The emphasis of the Chinese model falls heavily on surveillance and control (a concept Chinese authorities had baptized *fangkong*), through a highly technologized State apparatus. It already started exporting surveillance technology and, with it, its model of extensive monitoring of individuals, with little concern for data privacy or civil liberties[51]. The harsh logic of the *fangkong* is unsurprisingly at odds with the liberal heritage of the WHO and of the current health governance architecture. But if liberal democracies willfully renounce their leading role in health governance, liberalism – a political construct that does not exist in the ether of a geopolitical vacuum, but through actors that decide to actively defend it and invest in it – will soon be displaced by other ideological engines. In the process, Washington stands to lose large swathes of its soft power. Internally too, Trump is playing a dangerous game. Of course, shifting the blame towards an distant, technocratic international agency may play well into his populist narrative in the short run; but such move means ceding global leadership in health governance precisely at the moment when the American electorate considers infectious disease to be a greater threat than terrorism, nuclear weapons proliferation, immigration or the rise of China[52].

One common argument that is currently gaining traction is that, given how flawed and dysfunctional the WHO proved to be, the United States is better off rerouting resources towards alternatives, such as directly to countries, private charities or private-public partnerships (such as the GAVI Alliance or the Global Fund). But routing aid through bilateral agreements does not build a stable international governance system, it simply creates potentially patronal ties. Likewise, private initiatives, while necessary and laudable, should also not be the sole source of relief and the main well of research. Jeremy Konyndyk, Senior Research Fellow at the Center for Global Development, pertinently highlighted how an intergovernmental organization such as the WHO can reach further and deeper – through its formalized relations with top health official and national public health departments – than a private charity can ever dream of: "There are many, many countries in the world that lean on WHO as an extension of their own health ministries. WHO is inside the tent with the health ministry in a way that no NGO will ever be.[53]" The WHO, for all its transparency shortcomings, is also accountable in a way that most private endeavors are not. Private charities often lack formalized processes of verification and control, and don't have inbuilt democratic mechanisms that render decision-making transparent and predicable. The WHO statute

ensured a minimal level of equity by giving each member state a voice in the World Health Assembly. What is more, the fragmentation of the global health authority between the myriad funds, charities and NGO currently activating in the field of humanitarian relief would cripple a century-long effort to rationalize the collective response to disease. The privatization of global health is a worrying trend that is well underway. Already in 2011, *Foreign Affairs* purported that the stream of public funding for the WHO was running dry and private interests were "calling the shots in Geneva[54]". Such statements, however provocative they appeared, were based on simple financial arithmetic: in 1970, private contributions constituted a quarter of the agency's budget, while by 2010, they swelled up nearly 80 percent[55]. The withdrawing of the US will dramatically swing the pendulum even more in this direction, possibly so irremediably that the WHO will *de facto* cease to be an intergovernmental organization and will morph into a privately-funded international research consortium. As a testimony to that, the Bill and Melinda Gates Foundation stands to become the organization's biggest contributor, ahead of the UK, Germany or Japan[56]. There is a left-wing ideological bent to demonize private interests as inherently corrupt and scheming; it is important to shun such horse blinders and acknowledge the indispensable role that private charities, large companies and even concerned individuals play in the field of humanitarian aid and public health. But they should remain auxiliary forces, not the main drivers of the agenda. Private interests can be deeply dysfunctional if nothing can rein them in: memories of the AIDS crisis in the 1990s serve as a reminder of how difficult it is to coax drug companies – which until then were exemplary in their involvement against other diseases with less "commercial" potential such as plague or leprosy – into undermining their core business: capitalize on innovation to make profit.

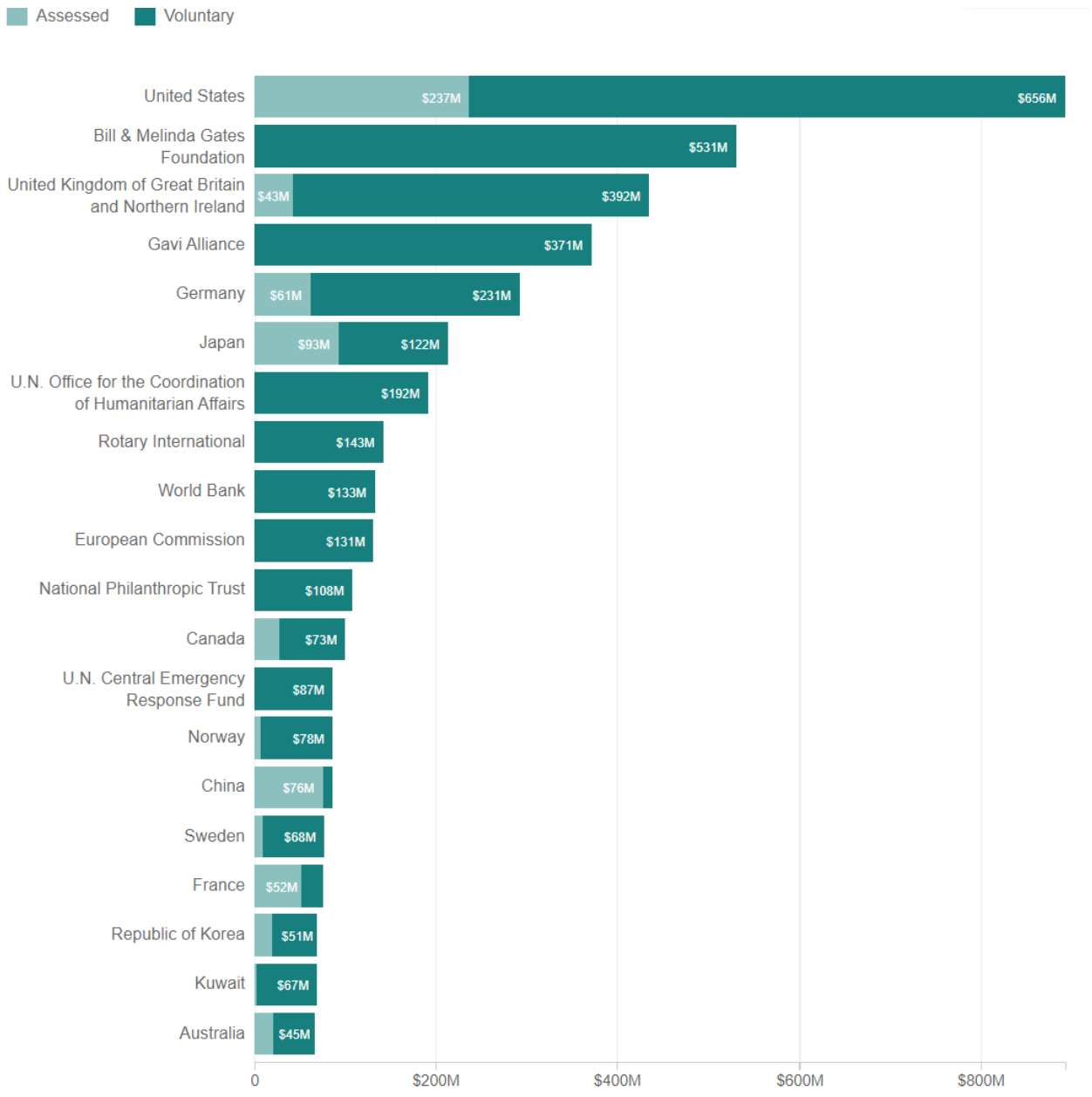

Fig. 1 – Contributors to the WHO, 2018-2019 biennium. Source: https://www.npr.org/sections/goatsandsoda/2020/06/05/869913174/how-will-the-u-s-and-who-fare-without-each-other?t=1594466461451

Conclusions

The termination of the relationship of the US with the WHO organization, a brusque and impulsive move in the midst of the worst health crisis in a century, appears as the culmination of a long-brewing crisis of global governance. The postwar governance architecture is showing glaring institutional and ethical vulnerabilities. Global collaboration failed to prevent a deadly pandemic, despite the repeated warnings of experts. Medical guidelines and basic safety precautions are neatly

being folded into acrimonious culture wars. Donald Trump has transformed support for the WHO and multilateral cooperation into another juicy morsel for the aforementioned culture warriors, after decades in which it constituted a relative bipartisan oasis of peace. On the international stage, the World Health Organization became a battleground between the two reigning heavyweights of global politics – China and the US. Of these two, one has ceded ground (whilst claiming a dubious victory) and the other is still planning the next move. Given the situation, it might the tempting to just let the WHO die, in hope a phoenix will rise of the ashes. But this will mean letting the liberal world order die. And what will rise of its ashes might be a beast no one wants to confront.

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[19] *Idem.*
[20] *Idem.*
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