COVID-19: INTERNATIONAL POWER STRUCTURES AND GLOBAL HEALTH POLICY. FOCUS ON WHO AND INTERNATIONAL SOLIDARITY[1]

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COVID-19: международные структуры власти и глобальная политика здравоохранения. В центре внимания ВОЗ и международная солидарность

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For decades, virtually all parties with political or medical responsibility for pandemic issues have stressed the need for more intensive inter-national cooperation. COVID-19 is only the latest epidemic for the time being to demonstrate the massive discrepancy between rhetoric and reality in this regard. A global health policy worthy of the name still does not exist. The WHO and its sub-organizations have neither the competencies nor the financial resources to live up to their claim pro-claimed by the community of states. Against the backdrop of the crisis created by the spread of SARS-CoV-2, this article asks what the pre-conditions and determinants of this failure are. First, it illuminates the ideological and political patterns that shape the strategic thinking and actions of those major powers that command global health policy and other aspects of global governance. The following section discusses the resulting (malfunctioning) structures for addressing epidemics and diseases, which are also barriers to the development of comprehensive health systems. Thirdly, the implications for the possibilities of addressing the COVID pandemic and also helping those countries and regions of the Global South that have neither the financial re-sources nor the tools of the rich North are discussed. In this context, we will take a look at the role of the EU and Germany and their pro-grams and practice of global health policy. Germany, after all, held the presidency of the Union in the second half of 2020 — amid the pandemic. The last part deals with the role and influence of an increasing «neoliberalization» of the health care system, especially since the 1990s, and the impacts for research and development, as well as with a pharmaceutical industry that primarily follows market laws and only secondarily health maxims. Under this aspect, the «vaccination race» between and within the EU and other actors is considered. Simultaneously, the question is raised whether and to what extent there are chances to steer the unsatisfactory state of affairs in a direction that enables better disease control on a regional and global scale through international cooperation and strengthened institution building.

Keywords: global health policy; COVID-19; solidarity; international cooperation; WHO; vaccination

На протяжении десятилетий практически все стороны, несущие политическую или медицинскую ответственность за проблемы пандемий, подчеркивали необходимость более интенсивного межнационального сотрудничества. COVID-19 на данный момент является лишь последней эпидемией, продемонстрировавшей огромное расхождение между риторикой и реальностью в этом отношении. Глобальной политики в области здравоохранения, достойной этого названия, до сих пор не существует. ВОЗ и ее структуры не обладают ни компетенцией, ни финансовыми ресурсами, чтобы соответствовать требованиям, провозглашенным сообществом государств. На фоне кризиса, вызванного распространением вируса SARS-CoV-2, в данной статье ставится вопрос о том, каковы предпосылки и детерминанты этого провала. Во-первых, в ней освещаются идеологические и политические модели, определяющие стратегическое мышление и действия тех крупных держав, которые определяют глобальную политику в области здравоохранения и другие аспекты глобального управления. В следующем разделе обсуждаются возникшие в результате (сбоя) структуры для борьбы с эпидемиями и болезнями, которые также являются барьерами на пути развития комплексных систем здравоохранения. В-третьих, обсуждаются последствия для возможностей борьбы с пандемией COVID, а также помощи тем странам и регионам Глобального Юга, которые не имеют ни финансовых ресурсов, ни инструментов богатого Севера. В этом контексте мы рассмотрим роль ЕС и Германии, их программы и практику глобальной политики в области здравоохранения. Германия, в конце концов, председательствовала в Союзе во второй половине 2020 года — на фоне пандемии. В последней части рассматривается роль и влияние растущей «неолиберализации» системы здравоохранения, особенно с 1990-х годов, и последствия для исследований и разработок, а также фармацевтической промышленности, которая в первую очередь следует законам рынка и лишь во вторую очередь — принципам здравоохранения. В этом аспекте рассматривается «гонка вакцинации» между ЕС и другими участниками, а также внутри них. Одновременно ставится вопрос о том, есть ли шансы и в какой степени, направить неудовлетворительное положение дел в русло, позволяющее улучшить контроль заболеваний в региональном и глобальном масштабе посредством международного сотрудничества и укрепления институционального строительства.

Ключевые слова: COVID-19; солидарность; международное сотрудничество; ВОЗ; глобальная политика в области здравоохранения; вакцинация

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I. «Crisis of the Century»?

For decades, the need for international cooperation on health issues has been undisputed. In a globalized world with its economic interdependencies and markets, cross-border traffic and migration, health issues — just like global warming — can no more be solved locally, nation-ally or regionally. This is stated in virtually every strategy paper on the subject. The same is true of the interrelationships between health, economic, social and political factors. Poverty and lack of education cause health deficits, and vice versa. Poor governance increases deficits in all sectors. Without linking relevant sectors and strengthening international coordination and international institutions, with the World Health Organization (WHO) at the forefront, the problems cannot be solved.

Discrepancy between rhetoric and implementation

However, the discrepancy between official analyses and declarations in this area and real-world realities and actions is monstrous, and has been for decades as well. Strategic rhetoric is inversely proportional to strategic action. What is lacking is not knowledge and correct conclusions, but the interest and willingness to implement them.

The main reason for this is the priority given to short-term economic and status interests over strategic objectives related to human security [1]. Unfortunately, funds for global health on a larger scale are at best held out when, for example, epidemics affect or threaten to massively affect one's own economic and political interests.

This kind of «global health policy» does not deserve its name. At best, it exists in rudimentary form. Even in the COVID-19 pandemic, de-scribed by many politicians as the «crisis of the century,» the WHO played a marginal role. The WHO, established in 1948 for the purpose of implementing global health policy, leads a shadowy existence in reality. Its budget corresponds to its competencies: Both are below the limit needed for an effective policy. Even after more than 70 years of existence, its competencies are largely limited to collecting data, writing reports, organizing conferences and formulating recommendations. Even for these tasks, it is highly dependent on the cooperation of its members.

The same applies to funding. The WHO has a budget of US$ 5 billion — for two years and under the assurance that governments and private financiers will transfer contributions and donations. As is well known, the U.S. withdrew from the WHO under US President Trump. This move not only reduced WHO's meager revenues, it also affected its already very limited functions. Overall, only 20 percent, or US$ 1 billion for two years, is acquired through contributions from the nearly 200 member states. The rest are voluntary donations, mainly from private foundations such as that of Bill and Melinda Gates, well-meaning countries such as China, Germany, the United Kingdom and Japan, and companies, especially from the pharmaceutical industry. The resulting dependence of the WHO on lobbies and individual interests has long been criticized. The behavior of the WHO and its partial failure in the fight against the pandemic is primarily associated with these conditions [2].

One can only wonder about this strategic myopia. Because it is associated with high political and economic costs, which indirectly and in the longer term also affect the rich countries. Poverty, a lack of education, the violation of human rights, environmental damage and bad governance in other parts of the world are associated with political tensions, wars and civil wars, refugee movements and the destruction of real or potential markets.

On the other hand, the deficits of global health policy also merely reflect failures that can be observed even in rich countries. Ignorance of health issues, lack of precautionary measures, and the bungling of health systems in many European countries have brought them to the brink of resilience and, in some cases, to collapse under the impact of the SARS-CoV-2 outbreak in 2020. The consequences, not only in terms of health but also in political and economic terms, are dramatic even in rich Europe.

Any signs of Change?

Of course, the conclusion cannot be resignation. But there is something mantra-like about repeating the same demands and conclusions that have been shared by more or less all actors for a long time: WHO must be strengthened in terms of competence as well as financially, its regional and country presence must be expanded, and organizationally it must become more independent. In view of the polarization of international health policy and the increasing formation of blocs, it is necessary to strengthen the health policy factor within the framework of development policy and trade, and to anchor the strengthening of health systems in respective treaties of the EU and its members. The goals and specifications declared with regard to global health policy must be demanded emphatically. This also includes human rights, environmental and health policy obligations that European companies have to comply with in third countries.

Average health has improved in many regions of the world in recent decades. This is shown, among other things, by the increase in life expectancy [3]. At the same time, however, the discrepancy has grown: between rich and poor countries and regions, and within many countries and regions. Most importantly, the gap be-tween, on the one hand, existing resources and hypothetically deployable means to improve health systems on a global scale, and, on the other hand, real expenditures and instruments mobilized for this purpose has not narrowed but widened. The COVID-19 pandemic only increases this disparity [4].

II. International Cooperation versus My Country First

A large part of the elites of most powerful states — USA, China, Russia — and those who consider themselves such — India, France, GB etc. — think strategically in terms of their own positioning in the international system, not strategically in terms of what is good for humanity. Real support for international institutions and mobilization of alliances, e.g. for global health policy, however, falls far short of what is needed and possible.

Global Governance at stake

After every crisis of the century — and in the 20th century these were, first and foremost, the First and Second World Wars with their consequences of immeasurable suffering and destruction — international cooperation and international organizations were strengthened. Attempts were made to establish mechanisms that would prevent the destructive competition and self-centered, sometimes egomaniacal antagonism that had provoked previous crises. International cooperation and the corresponding institutions were supposed to enable a balance of interests and the realization of shared objectives. The most visible expression of these efforts was the establishment of the League of Nations and its institutions after WW I and the founding of the United Nations and its sub-organizations — including the WHO — after WW II.

At the same time, and to some extent even before the collapse of the previous system and the establishment of new cooperative structures, another fundamental tendency came into effect, which is also inherent in every collapse of international systems. The same powers that advocated more international cooperation and its institutionalization gave a policy of power projection central importance in their foreign policy. They were eager to use the opportunities arising from the collapse of the old system to improve their own position in the international system. Whereby «improving one's own position» usually meant the traditional notion of military, political and economic strength or dominance compared to other actors. It was about expanding one's own sphere of influence, or at least about preventing a restriction of that influence. Status and prestige in the international system were defined in this way.

Reality-check

The WHO, its institutions, its financial base and its activities correspond to these realities. In terms of aspirations and requirements, the ideas about what WHO should represent and what tasks it should accaccomplish are far-reaching. It is to achieve «the highest possible level of health for all peoples» [5] It is to develop, standardize and enforce «guidelines, standards and methods in health-related areas» worldwide. Important fields of action in this context are, first, the worldwide coordination of national and international activities in the fight against communicable diseases such as AIDS, SARS or influenza; second, the initiation of global vaccination programs and programs against health risk factors such as smoking or obesity; third, the regular collection and analysis of global health and disease data; and fourth, support for the establishment of health systems in developing countries that are as effective and cost-effective as possible [6].

WHO has its headquarters in Geneva. It has six regional offices and more than 150 country offices. It employs more than 7000 people. The highest decision-making body is the World Health Assembly (WHA), consisting of all 194 member-states. This takes place once a year. In between, the Executive Board, composed of 34 government representatives, is responsible for steering the WHO.

Not for the first time, but also and especially in the SARS-CoV-2 pandemic 2020/21, the drastic discrepancy between claim and reality be-came apparent. Even the WHO homepage makes this clear. A «time-line» on the COVID-19 response lists WHO activities since the beginning of the pandemic (World Health Organization 2021b): collection of data, meetings, publications, recommendations for action, speeches, explanations by the Secretary-General, expert meetings, press conferences, organization of a solidarity concert, holding of the 73rd World Health Assembly, and efforts to analyze developments and processes.

These activities reflect the real competence of the WHO and the real weakness of international health policy: it is limited to coordination functions. However, these do not at all extend to the coordination of real activities to combat pandemics. At best, it is concerned with gaining an overview of the global pandemic situation by collecting data, systematizing this overview and making it available to its members as material, and making consensual recommendations on how to deal with the pandemic through expert meetings and conferences of country representatives. At the same time, it seeks to organize solidarity for those countries that cannot afford or do not want to implement recommendations.

The WHO's dependence on political influence and its funders in these functions was evident from the very beginning of the pandemic in Wuhan in December 2019: WHO leadership adapted to the wishes and information policy ideas of the Beijing leadership to the detriment of its own objectives and task definition [7].

III. WHO and EU in the Traditional System of International Relations

The results of its «coordination activities» during the pandemic were correspondingly modest. At the end of September 2020, for example, the WHO reported as a success that it had managed in a «global partnership» to make 120 million affordable COVID-19 rapid tests available to low- and middle-income countries. An «initial» US$ 50 million had been raised for

this purpose. That agreement, WHO said, was a «milestone.» The Africa Centres for Disease Control and Prevention (Africa CDC), the Bill & Melinda Gates Foundation, the Clinton Health Access Initiative (CHAI), the Foundation for Innovative New Diagnostics (FIND), the Global Fund and Unitaid were involved [8]. 20 countries in Africa could thus begin testing in October 2020 [9].

Unsuccessful Creation of COVAX

WHO sought to achieve the greatest success with the creation of CO-VAX (COVID-19 Vaccines Global Access). The initiative intended to accelerate the development and production of COVID-19 vaccines and ensure «fair and equal access» for all countries worldwide. CO-VAX was to be responsible for purchasing vaccine doses from manufacturers and allocating them to all countries that declared participation in COVAX. This plan was to be implemented through the involvement of two private-public vaccine alliances: Gavi (The Vaccine Alliance) and CEPI (Coalition for Epidemic Preparedness Innovations). As of January 2021, 98 wealthier countries and 92 low- and middle-income nations participated. Wealthier nations were to pay the full price negotiated by the COVAX Facility with vaccine manufacturers. Poorer countries were to be asked to contribute financially, but if they were unable to do so, they would be entitled to free supplies.

The campaign provides a good example of the described power-political, legal and financial context in which the WHO operates. The rich countries refrained from ordering the vaccines via COVAX from the outset, but negotiated supplies with the suppliers on their own. Germany and others nevertheless wanted to financially support the procurement of vaccines for the poorer countries via COVAX. The EU also entered into bilateral agreements with vaccine manufacturers [10] and saw COVAX only as a possible supplement. It decided to co-finance COVAX with a total contribution of 500 million euros [11].

The program should start in the first quarter of 2021, with at least two billion doses of quality-assured, needs-based vaccine available by the end of that year to end the acute phase of the pandemic. At least 1.3 billion of these should go to poorer countries. This would enable them to protect at least 20 percent of their populations in 2021. The idea behind this was, on the one hand, solidarity with the weak in these countries. On the other hand, the conviction, that in a closely interconnected world the pandemic can only be contained if all regions are adequately supplied. However, 20 percent was far below the 60–70 percent «vaccination coverage» planned in the EU. This proportion was estimated as the minimum needed to achieve herd immunity and contain the spread of the virus. These margins were obviously not assumed from the outset with regard to the countries of the Global South.

As of mid-January 2021, the initiative had about five billion US dollars. To provide the targeted two billion doses of vaccine, COVAX budget-ed an additional US$ 6.8 billion for 2021. 800 million was to be spent on research and development, US$ 4.6 billion on providing vaccines to poorer countries, and US$ 1.4 billion on delivery support. What be-came of this was seen as early as December 2020, when the first vaccines were licensed in various countries in the North and the race began to supply their own populations as quickly as possible. Governments, trying to outmaneuver others with high financial stakes and with dubious methods of exerting pressure on manufacturers, unrestrainedly undermined previously made arrangements and agreements. For COVAX and the WHO, what remained were mainly handouts and rhetorical expressions of solidarity.

IV. Global Health versus Status, Prestige, Capital

At the same time, in principle, the EU conclusions regarding a global, «comprehensive health policy» linking different sectors, institutions and decision-making levels remain just as correct for the period after the current pandemic [12]. It is about

- the «mainstreaming» of global health: health, development cooperation, trade and human rights are to be linked as policy fields. Health needs to be integrated into the sustainability chapters of trade agreements. In this context, the Global Health Policy Forum [13] has to be reactivated for exchange between the sectors;
- updating the 2010 Council Conclusions: they need to be aligned with the SDGs presented by the UN;
- the development of OECD health categories: To capture national and international health expenditures, a category system would have to be developed that depicts the dimensions of health systems strengthening in the first place, thus enabling alignment with the UN Sustainable Development Goals;
- the establishment of partnerships: The EU should enter into strategic partnerships, first and foremost with the African Union. The annual Human Rights Dialogue Forum can be used to discuss developmental health issues.

All of these are merely the basic prerequisites for the EU to enter into a global health policy. If these steps were incorporated into the global health concepts of important Member States, Brussels policy could also be pushed more strongly in this direction. The reality is, however, that under the impact of the pandemic developments in the course of 2020, the debate on a better coordinated and focused global health policy, which had just begun, was sidelined again. In addition, European development policy lost 12 percent of its previously available funds as a result of Brexit. In this way, it is foreseeable that the discrepancy between health development and health

systems in the rich North and the poorer South will continue to grow as a result of the pandemic.

The described conditions in international health policy are not only related to the mental setting of relevant actors in global politics and their status orientation, but also to capital interests. The way health policy is currently organized, these interests determine to a large extent what is researched and what drugs are developed. The use of resources ultimately depends on the market and on profit expectations.

To a limited extent, this process is influenced by states by providing money for developments that are politically desired but not served by the relevant companies due to cost reasons or lack of profit expectations. Many urgently needed developments are supported neither by status-oriented major powers nor by profit-oriented pharmaceutical companies, but by private foundations and NGOs, from the Bill & Melinda Gates Foundation to Rotary International (for example, with the goal of completely eradicating polio worldwide).

Many disasters and epidemics that have struck the world since the WHO was founded in 1948 have done little to change this state of affairs. And there is no real reason to see why this should change after dealing with the Corona pandemic. After all, contrary to many claims that COVID-19 is a «catastrophe of the century» that has the entire world «in its grip», the pandemic is not a particularly severe case. It has mainly taken hold of those countries and regions where the virus was not taken seriously [14]. Many Asian, African and even some European countries have reacted better. They are still affected by the problem, mainly because large parts of Europe, the USA and Latin America have become hotspots and first-rate danger spots for the rest of the world.

Vaccinate, Contain, Overcome — But at What Price?

In contrast, a large number of countries — whether dictatorial, semi-authoritarian or democratic — have shown that it is perfectly possible to contain and even overcome this epidemic. In those countries where the testing-tracing-treating strategy was consistently enforced and a few basic rules were strictly observed and controlled in everyday life, not even a lockdown was necessary or such measures had to be taken only for a short time. After that, normality returned to a large extent.

Even one year after the virus first appeared, Europe was still far from achieving this. The infection had gotten so out of control that the only hope left was to vaccinate the European population. However, as already mentioned, the given organization of the health care system al-so slowed down the attempts within Europe to put the vaccine strategy formulated in the fall of 2020 into practice.

Actually, the Commission and the Member States had already agreed on a centralized EU approach. Purchase guarantees were to be agreed with individual vaccine manufacturers on behalf of the Member States. Part of the manufacturers' upfront costs was to be financed from the related 2.7 billion euro «emergency instrument.» Additional support was to be provided by loans from the European Investment Bank. In return, the Commission was entitled to purchase «a certain number of doses of vaccine within a certain period at a certain price» from manufacturers [15]. Once approved, all Member States would be able to access them simultaneously. Distribution was planned on a per capita basis «in the interest of fairness.»

Apart from the lack of transparency of the agreements, which was soon criticized, the European reality consisted of national responses, as it had been in spring 2020 during the first attempts to ward off the virus. Many Member States sought to secure vaccine doses through independent agreements with producers. In this way, competition arose, with corresponding financial consequences. In addition, there were actors outside Europe. According to various estimates, the Israeli government paid two to three times as much for the vaccine doses supplied by those companies than had been agreed by the company managements with European customers, and whose production had been pre-financed not least by the EU. In this way, Israel was able to vaccinate a much higher proportion of its population within a few weeks of approval than was the case in Europe. The UK and the US were also supplied by domestic vaccine manufacturers more quickly than the EU — despite agreements and contracts to the contrary.

There was therefore no question of centralization, equitable distribution and price fairness. Private-sector organization and profit orientation in this area favored those who had sufficient financial resources and power. This was also true for the EU as a whole on an international scale. Poorer countries have to queue up [16].

Due to the structure of pharmaceutical production, the EU as well as other players had no choice but to negotiate and conclude agreements with various manufacturers working on the vaccine. It was not known at this point who would be quicker and more successful in bringing a vaccine to market. The European Union (as well as the Member States with their individual agreements) had no choice but to allocate their funds and orders among BioNTech-Pfizer, Moderna, AstraZeneca, Sanofi-ZSK, Johnson&Johnson, CureVac, Novavax and Velneva more or less on the basis of vague estimates of success.

Financing Global Goods — an Evidence-based Investigation

The vaccines of the first two companies were approved in the EU in December 2020 and thus vaccination campaigns began. Cooperation, data exchange, synergies between the companies and their scientists did not exist and do not exist. If this were the case, considerable funds could be saved and, above all, needed vaccines and drugs could be brought to market much faster. Normally, competition stimulates business. For the health care system, this type of organization and struc-

ture of research, development and production is counterproductive — not for the companies, which make gigantic profits if they are individually successful, but with great disadvantages for health care. Profits are also made possible by massive use of public funds. The fact that vaccines, which take an average of 10 years to develop, were developed in less than 12 months is due in no small part to public funding.

The same applies to research and development in areas such as universities and pharmacological research institutes. For pharmaceutical companies as well as for many areas of research, including in public institutions such as university hospitals, health and the development of drugs against diseases are virtually just the means by which prestige and money can be gained. Otherwise, they would collaborate with other researchers, facilities, institutions, international networks working in the same field and use everything that is being researched elsewhere and is accessible in terms of data.

The opposite happens. Every company, every university institution, every research group is anxious to keep everything secret until a new product can be brought onto market, at least initially, monopolistically with the highest chances of profit. Or/and a prestigious publication in a top journal and thus the prospect of further funding allocations and re-search money can be placed. Last but not least, the rights to a new development that may generate money must be secured.

This structure and characteristic endanger the elementary area of health, starting from the global corporations dominating the pharmaceutical market, down to the university institutes. From a medical and health point of view, it is both irrational and counterproductive, contradicting commitments to ethics in the field of health care and affirmations about the globality of scientific collaboration and knowledge (on sovereignty [17] and Powerhouses [18].

A necessary consequence of this and previous epidemics would be the expansion of the WHO into an institution where outstanding scientists and health policy makers from all over the world work together for the goals of «the best possible level of global health» defined by the world community, exchange findings, transfer them into programs for the development of «comprehensive health care» and have the corresponding production and distribution capacities — their own or in public-private partnerships — to come closer to the fundamental rights to physical integrity, health and human security. This would reduce humanity's dependence on primarily profit-oriented pharmaceutical corporations, status-oriented governments, and prestige-oriented competition among scientists.

It may be an illusion to be able to implement this together with Russia, China, the USA and others in the foreseeable future. The Corona epidemic and the varying degrees of success in dealing with it will strengthen rather than weaken the status orientation of the major powers and the interest of corporations in maintaining the present structure [19]. So, at least within the EU, would a reorientation to a more rational, efficient, and cost-saving sys-tem from a health promotion perspective be conceivable? Hypothetically, as a consequence of the pandemic, researchers and production sites could be organized that are committed to public health and not to other interests. This, however, would require an alternative offer for such scientists from Brussels or the Member States.

In practice, however, this option does not seem very promising. Despite all the negative side effects and consequences, the crisis is evidently not perceived by most of those in positions of responsibility as being so existential that fundamentally new ways would be thought of and organized. The mental setting of the political, economic, and scientific elites is so attached to a privately organized structure in this area as well that even hundreds of thousands of deaths in Europe (and millions of deaths globally) will hardly change anything. Research after the SARS-CoV-1 epidemic in 2003/2004 and the Mers epidemic in 2012 [20] was discontinued after the danger had subsided because it promised too little profit. Although there were clear indications and warnings that mutated viruses could trigger a new global pandemic.

Apart from the aforementioned needs for a different way of organizing the health sector in the West, and despite or precisely because of the problems and reservations that exist about international cooperation: It could take revenge not to explore and exploit the opportunities for cooperation that still exist — for example, at the level of the G20 — in order to create joint structures for solving global problems, starting with global governance in the health sector.

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