Institutional Change Through Crises
Will Ebola Spur Reform of the Global Health Architecture?

Tine Hanrieder and Christian Kreuder–Sonnen

Summary: Consecutive international health crises have shifted both the center of authority and the public attribution of success and failure in emergency governance to the international level, especially the WHO. Against the background of the current Ebola crisis, critics call for a further delegation of authority to international institutions. As the experience of the WHO's handling of the swine flu shows, however, it is also important to shield discretionary international authority from capture and thus to contain such powers constitutionally.

With already more than 10,000 deaths, a high number of unrecorded cases, and an initially almost unhindered proliferation of the disease in West Africa, the current Ebola epidemic has proven worse than all previous outbreaks of this disease which was first identified in 1976. This is even without counting the numerous "secondary deaths": collapsing health systems leave many to die of diseases such as malaria or diarrheal infections. The epidemic has devastated communities and health systems in the countries affected. But it also represents a crisis for global health institutions. The belated reaction of both the World Health Organization (WHO) and the affected countries, the lack of help from Western countries, and the lack of capacities for containing the epidemic have been criticized on all sides. As measures finally get under way to combat the crisis, blame has begun to be ascribed, setting off a debate on possible reforms.

The Ebola crisis has made it clear that responsibility for global health security is increasingly ascribed to international organizations. In the course of a series of health crises since the 2000s, authority has shifted strongly from the national to the international level. However, the institutional development of the WHO has shown that this crisis-induced authority accruing to international organizations also needs to be constrained in order to obviate abuse.

Until well into the 2000s, the WHO's competences in reacting to health crises had been relatively limited. The organization's key legal tool, the International Health Regulations (IHR), provided for measures that the WHO could only activate for a few diseases such as cholera and yellow fever. Moreover, it could do so only if states officially reported outbreaks to Geneva – which most states omitted to do because of concern for their trade and reputation. The WHO's crisis reaction was thus subject to the sovereign veto of the countries affected.

In the 1990s, this began to change in light of growing fears of bioterrorism and the emergence or recurrence of highly dangerous pathogens, which could spread rapidly in a globalized world. On the basis of new information and communication technologies, the WHO built up a monitoring and coordination center in Geneva, the so-called Global Outbreak Alert and Response Network (GOARN). Yet parallel negotiations on expanding the IHR made little progress over the years. The reformers managed neither to reach agreement on ex ante rules on how to recognize the next health crisis nor to provide for measures that were both effective and appropriate.

The SARS outbreak in 2002/3 relatively quickly put an end to this stagnation and brought a marked shift in authority to the WHO Secretariat. The hitherto unknown lung disease spread rapidly between Western centers such as Hong Kong and Canada through global air traffic. Not all the affected countries reported their cases in a timely manner. But unlike in earlier outbreaks, WHO headquarters now openly denounced the information policy of countries like China. WHO Director-General Gro Harlem Brundtland retrieved critical information from Internet sources and issued travel warnings for such countries as China and Canada on her own authority. This led to a de facto shift of the initiative for crisis reaction to the supranational level.

The fight against SARS is regarded as a success story in disease containment in which the failures of national governments were compensated by the intervention of the WHO. It therefore served as a model for the "new" IHR (in force since 2007). The new version relies no longer on an ex ante specification of possible crisis sources and appropriate measures but on the executive discretion of the supranational agency. The WHO Director-General is now empowered to declare any hazard to health, whether disease or chemical accident, to be a health emergency of international proportions. With the assistance of an emergency committee, she ultimately decides on her own responsibility what measures to recommend. At the same time, the new IHR lay down the respect of human rights standards, for instance putting a stop to unreasonable restrictions on travel or compulsory vaccination. Apart from this human rights component, however, the growth in supranational authority proved susceptible to abuse.

H1N1: exceeding powers and a lack of transparency

In the course of 2009, the so-called swine flu (H1N1) started to spread from Mexico, triggering the next international health crisis. From the beginning, attention focused primarily on Geneva, where the WHO Director-General for the first time declared a global health emergency and deployed her new emergency committee. Changes in the scale of the WHO pandemic alert system, for example, were closely watched. Many countries organized their efforts to control swine flu in accordance with the World Health Organization guidelines – in this case above all by buying vaccines and antiviral medicines.

However, this increase in political authority at the WHO level also increased the public monitoring of the organization's activities and thus the potential for criticism directed at the WHO.. The focus was primarily on aspects of procedural legitimacy which had arguably been sidelined in the WHO's crisis mode of governance. On the one hand it was criticized that the organization had abruptly dropped the aspect of a high mortality rate from the criteria for classifying a disease outbreak as a pandemic, thus allowing swine flu to be defined as such. On the other hand, not least the Parliamentary Assembly of the Council of Europe criticized the lack of transparency in appointments to and the decision-making of the emergency committee. The WHO had kept the names of all committee members secret until the health emergency had been declared over. Also, the committee did not meet in public session. Only later was it discovered that some members had close ties to the pharmaceutical industry.

Characteristically, the vehement criticism did not involve demands for a reversal of the transfer of competence to the WHO. This was never subject to renegotiation. Rather, objections to how the WHO had acted led to calls for procedural reform. For instance, the internal review body that evaluated WHO crisis intervention under the IHR recommended to install better precautions against conflicts of interests. These recommendations have already had an impact. WHO procedures in dealing with polio and Ebola have been far more open and accountable. The names of members of the emergency committee have been published from the outset and possible conflicts of interests disclosed.

Exacerbated by the war in Syria, the recent spread of polio induced the WHO to declare the second Public Health Emergency of International Concern in May 2014; but it hardly attracted public attention. This was different with the escalation of the Ebola outbreak in West Africa. Since the organization declared the outbreak to be a health emergency in August 2014 and the course of the epidemic reached disastrous proportions, Ebola is no longer merely seen as health threat, but increasingly even as a threat to security. And, indeed, there is no foreseeing what dimensions the epidemic will reach and what "costs" – human and economic – it will ultimately cause.

At any rate, Ebola has got out of control. It is less clear, however, who or what is responsible for this development. There are competing interpretations of what mistakes have been made, with the various actors blaming each other. In comparison with the SARS crisis, it is striking that the blame is now put far less on

Tine Hanrieder is senior research fellow in the Research Unit Global Governance. She investigates reform processes in international organizations and normative change in global health. *[Photo: Udo Borchert]*
tine.hanrieder@wzb.eu

Christian Kreuder-Sonnen is scholarship holder of the research unit Global Governance and doctoral student at the Berlin Graduate School for Transnational Studies (BTS). His doctoral project addresses emergency politics of international organizations and their containment. *[Photo: Udo Borchert]*
christian.kreuder-sonnen@wzb.eu

WHO Regional Director for Africa, Dr Matshidiso Rebecca Moeti, puts on protective gear during her visit to Monrovia, Liberia, in April 2015. Swift support for regions struck by the Ebola disease was needed, but it was also the debate on health governance that was once again sparked off by the Ebola crisis. *(Photo: EPA / Ahmed Jallanzo)*

the countries where the disease has broken out (Sierra Leone, for example, appears to have long kept infections there a secret and thus to have contributed to the spread of the disease). Since the WHO has become the central authority in fighting the epidemic, expectations now focus on the organization. Critics ranging from Médecins Sans Frontières (Doctors without Borders) to national politicians accuse the WHO of having failed. For its part, the WHO admits that it long underestimated Ebola, but sees member states and donors as bearing responsibility. On the one hand it points out that the organization lacks the requisite financial resources. On the other hand it claims that countries should react faster and more resolutely to its calls.

However, all contributors to the debate agree on one thing: they call for a more powerful international institution that can effectively combat global health risks. Yet greater international authority in the domain of public health can be achieved in various ways – with or without the WHO. Many see the solution in further and more fundamentally strengthening the World Health Organization. Not only should the fatal cutbacks in emergency resources of recent years be reversed; also the general financing structure of the WHO should be reformed so as to give the organization much greater autonomy in performing its core tasks. Moreover, representatives of Médecins Sans Frontières and others call for additional, centralized decision-making powers for the WHO which would provide greater capacity to act in future crises.

At the same time, the current weaknesses of the WHO give ground for considering other institutional solutions. For example, World Bank President Jim Yong Kim recently proposed an autonomous international health emergency fund, which, endowed with up to €20 billion, could be activated in the event of health crises. Other parallel structures are already developing in practice. The unchecked spread of the Ebola virus led, for the first time since AIDS, to the UN Security Council concerning itself with a disease and classifying it as an international security threat. UN Secretary General Ban Ki Moon also established the UN Mission for Ebola Emergency Response (UNMEER), the first UN health crisis intervention of this sort.

However obvious the call is for stronger international institutions to combat crises, it should not be forgotten that the transfer of decision-making competences to international organizations entails risks that ought to be recognized as early as possible. For past, current and future health crises are handled within the paradigm of international security, which primarily addresses political ne-

cessities and urgency rather than the rule of law and compliance with procedures. This logic of action does not stop at the gates of international organizations. On a small scale, this has already been demonstrated by how the WHO handled H1N1. The more authority shifts to international organizations, the more drastic will be their intervention in the affairs of states and individuals and thus the more important their constitutional containment becomes.

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