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State-Centric Governance in Global Health Crises: Ebola and COVID-19

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Abstract

Scholars have continually described global health as unique from other forms of governance due to its unstructured plurality (wherein non-state actors are as important as states). This article argues that this conceptualisation is becoming increasingly outdated. While non-state actors have agenda-setting influence, the implementation of their agendas is now predominately contingent on the nation state. This is particularly evident within global health crises. During crises, non-state actors typically have their authority undermined by states. Hegemonic states also tend to dictate governance within weaker states, and further undermine the authority of non-state actors. This article examines two recent health crises that have seen states become the most powerful actors within global health governance. The first crisis is the Ebola virus epidemic (2013-2016). The second crisis is the on-going COVID-19 (as officially used by WHO) pandemic (2019-).

Keywords: Global Health Governance; Ebola; COVID-19; Pandemic; Epidemic; Global Health Crises

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Scholars have claimed that global health governance has an unstructured plurality (wherein non-state actors are as important as states). This is not the case during global health crises. Certain non-state actors, such as the Bill and Melinda Gates Foundation (BMGF), can exert some influence over global health agendas. However, the operationalisation of their agendas is then contingent on both states and other non-state actors. This is problematic since authoritative non-state actors, including the World Health Organization (WHO), lack sufficient governance capacities. Their authority is typically eroded by most states once global health crises occur. Similarly, many poorer states lack the necessary domestic health infrastructures to enact international agendas. Implementing these agendas in poor states is now predominately dependent on support from hegemonic ones (including the US and China). These power imbalances further undermine the authority of non-state actors and illustrate that states are the most powerful actors in global health crises.

I develop my argument over three sections. The first section provides an overview of key concepts in global health governance. The second section examines the Ebola virus epidemic (2013-2015). The third section analyses the on-going COVID-19 pandemic (2019-). These cases have been selected as they are recent global health crises involving a plurality of state and non-state actors. This case selection will allow me to test whether non-state actors truly retain as much influence as states in global health crises.

Conceptual Overview

Global health governance is defined as the means used by various actors at "sub-national, national and international levels" to manage global health (Kay and Williams 2009: 1–2). Fidler goes further to argue that non-state actors rival the importance of the state in global health governance (2007: 2). Rather than functioning within a state-centric Westphalian system, Fidler thinks global health governance is now a post-Westphalian anarchy (2007: 2). In this post-Westphalian context, "both states and non-state actors shape responses to transnational health threats" (Fidler 2007: 2). Under post-Westphalian anarchy, state and non-state actors are both "resistant to governance reforms that would significantly restrict their freedom of action" (Fidler 2007: 2). Fidler characterises this diversity of state and non-state actors as an "unstructured plurality" (2007: 4). Unstructured plurality then distinguishes contemporary global health governance's post-Westphalian context from a state-centric, Westphalian anarchy (Fidler 2007: 4).

As a result of this post-Westphalian shift, Fidler thinks global health governance can no longer be adequately described with an "architecture" metaphor (2007: 2). Scholars have previously employed an architectural metaphor since "governance involves [the state] crafting ways to achieve political interests" in a manner similar to an architect (Fidler 2007: 3). Contemporary global health's unstructured plurality means, however, that it lacks the required architecture for governance to "take root in a sustainable manner" (Fidler 2007: 4). States and non-state actors alike instead participate in a post-Westphalian "open-source" anarchy where global health governance is equally accessible to all and is not treated as the proprietary of states (Fidler 2007: 7).

Fidler proposes then that an open "source code" is now a more appropriate metaphor for contemporary global health governance (2007: 9). Open-source software allows any actor to modify its source code. In much the same way, states and non-state actors equally modify global health agendas in accordance with their "normative policy reasons" (Fidler 2007: 9). Even authoritative actors, who would otherwise act as global health's sole architects (such as the WHO), both make their own modifications and adapt to outside modifications with respect to their source code (Fidler 2007: 10).

The plurality of actors that modify global health governance's source code means it reflects a variety of motivations. These motives range from "self-interests of states" to "universal ideals [of] health as a fundamental human right" (Fidler 2007: 11). The WHO sought to bridge this plurality of normative motivations with its 2005 International Health Regulations (IHR2005). Amongst other obligations, IHR2005 requires countries to: (i) report information to the WHO, and (ii) exercise health governance "while balancing human rights and international trade" (Gostin et al. 2014: 1095). By establishing the IHR2005, the WHO "strongly connected state interests in security and trade" with health as an "integrated human rights principle" (Fidler 2007: 11). This means that global health's post-Westphalian shift allowed for a normative, open-source code to be modified by state and non-state (the WHO) actors alike.

Finally, that "public health itself has emerged as an independent marker of good governance nationally, internationally, and globally" demonstrates that actors have beneficially modified global health governance's source code to reflect their normative beliefs (Fidler 2007: 9).

Yet, Fidler believes global health governance's open-source code also presents potential disadvantages (2007: 8). Since there is "anxiety related to unstructured plurality", state and non-state actors may be prone to exploit global health governing for their own security (Fidler 2007: 8). Exploitation of global health agendas results in "certain health problems becoming neglected" in favour of other problems (i.e., disease intervention is often prioritised over infrastructure development) (Fidler 2007: 8). Continuing the software metaphor, a further problem of an open-source code is that it "requires hardware on which to operate" (Fidler 2007: 13). For global health governance, this refers to operationalisation capacities of both non-state (including the WHO) and state actors (Fidler 2007: 13). These capacities are "simply not up to the task" of running global health's source code (Fidler 2007: 13).

In the case of providing HIV victims with anti-retrovirals, many sub-Saharan African states suffer from "hardware failures" (Fidler 2007: 13). These failures refer to "inadequate [infrastructure] capabilities to deliver drugs effectively to those in need" (Fidler 2007: 13). A post-Westphalian unstructured plurality thus entails competing "political attitudes that constrain building governance architecture" (or "hardware") to run global health's source code (Fidler 2007: 8). To determine whether Fidler remains correct regarding global health governance's unstructured plurality, I will now critically analyse two contemporary health crises.

The 2013-2016 Ebola Epidemic

The Western African Ebola epidemic lasted from December 2013-June 2016 (WHO 2020). The WHO declared the outbreak a "public health emergency of international concern" in August 2014 and triggered powers under IHR2005 (Gostin et al. 2014: 1095). Despite a plurality of global health actors, the WHO was perceived as the epidemic's authoritative governor. This authority referred to "expectations of the governor which, when they are not fulfilled, leads to potentially undermining [its] legitimacy" (McInnes 2015: 1301). Expectations of the WHO's authority "did not arise particularly from WHO member states" (who are the "traditional source of the WHO's authority") (McInnes 2015: 1302). As per Fidler's claimed post-Westphalian context, the WHO's expected authority instead "arose from civil society, NGOs, charities and the media" (McInnes 2015: 1302; Fidler 2007: 2).

Similarly, the WHO's capacity to act as an authoritative governor is tied to a plurality of state and non-state actors. The BMGF "provides the most voluntary contributions of any source to the WHO and is second only to the United States for total contributions to the institution" (Harman 2016: 355). During the Ebola epidemic's outset, insufficient health infrastructures in poorer African states impeded their ability to prevent the virus's spread (McInnes 2015: 1309).

These insufficient infrastructures (or in Fidler's terms, "hardware failures") are due partly to the BMGF's exploitative influence over the WHO's agenda-setting (including prioritising disease-specific interventions over domestic health infrastructure development) (2007: 13).

The WHO's response to Ebola was also significantly constrained by its operational limitations. The WHO has typically been treated as only as an advisory "expert authority" with limited operational capacities (McInnes 2015: 1301). This is in comparison to a "capacity-based authority with an ability to undertake effective [operational] action" (McInnes 2015: 1301). The WHO reaffirmed their position as only an expert authority by repeatedly declaring they were to offer "technical support rather than being operationally engaged" (McInnes 2015: 1305, summarising Chan 2015). Despite criticism "for its perceived lack of action" during the Ebola epidemic's outset, the WHO complied with its expected responsibilities as only an expert authority (McInnes 2015: 1305). These advisory responsibilities included declaring successively severe emergencies and coordinating responses in West Africa (Kamradt-Scott 2016: 414). The WHO presented "a narrative that it did act, by providing advice" and was "following established protocols" (McInnes 2015: 1309).

The WHO's operational limitations do illustrate Fidler's argument that inadequate governance architecture (or "hardware failures") prevent global health governance's normative source code from being realised (2007: 13). Growing discontent with the WHO's response led to proposals in January 2015 "to develop an operational capacity for major health crises" (McInnes 2015: 1310, referring to WHO 2015). At first glance, Ebola governance failure might appear solely the fault of non-state actors (the BMGF and the WHO) within Fidler's claimed unstructured plurality (2007: 2).

However, accrediting Ebola governance failures solely to non-state actors (either the BMGF or the WHO) overlooks the constraining influence of states. Leaked documents reveal that the WHO resisted calling a Public Health Emergency of International Concern (PHEIC) due to "risks of harming relations with the affected countries, not least because of the possible impact of any such declaration on their fragile economies" (McInnes 2015: 1307, referring to Associated Press 2015). The WHO's limited operational capacity during the Ebola epidemic are even due to constraints imposed by member states. States had previously condemned the WHO's overstepping as an authority during both the 2002-2004 SARS epidemic and the 2009-2010 Swine Flu pandemic (McInnes 2015: 1311). In the aftermath of the latter pandemic, states rejected "proposals from the WHO that it be given a more operational role in health emergencies" (McInnes 2015: 1311).

The above cases demonstrate that more than any other actors, states constrained the WHO's operational capacities throughout the Ebola epidemic. Harman shares this view, arguing that global health's source code functions "within a hierarchy" of state norms (2015: 12). States tend to prioritise global health norms "that come with financial assistance" over economically disadvantageous obligations (such as the WHO's IHR2005) (Harman 2015: 12).

Although the WHO's proposal for greater operational capacities were eventually approved in January 2015, this approval was again contingent on member states (McInnes 2015: 1313). Fidler himself claimed that state interests had little impact on the Ebola epidemic, since it was "geopolitically insignificant" (2020b: 242). Nevertheless, as I have shown in my analysis, state interests clearly took causal primacy in determining governance during the epidemic. Since states were the most influential actors, Fidler's claim of an unstructured plurality cannot accurately describe the Ebola epidemic (2007: 2). To further test the relevancy of Fidler's argument, I turn to a more recent health crisis.

The 2019- COVID-19 Pandemic

As with the Ebola epidemic, the WHO was the expected authority at the outset of the 2019 COVID-19 pandemic (Fidler 2020c: 211). The pandemic initially appears to fit Fidler's claimed post-Westphalian context: non-state actors (the WHO) should be as equally influential as states within global health governance (2007: 2). But a post-Westphalian framework fails to accurately describe subsequent developments in the pandemic. Member states quickly disavowed the WHO's authority in three notable ways:

(i) Multiple states accused the WHO director-general of "appeasing China by failing to exercise authorities that the IHR2005 provides" (including demanding "transparency of information sharing") (Fidler 2020c: 211).

(ii) While the IHR2005 requires that the director-general recommends "against implementing travel restrictions" after a PHEIC, over 100 states ignored these recommendations (Fidler 2020c: 211). States instead "imposed travel measures against China and other nations", and thereby undermined the IHR2005 (and the WHO's broader authority) (Fidler 2020c: 211). Further undermining its authority, the WHO then altered its advice and claimed that "early application of travel measures could provide public health benefit" (Fidler 2020c: 211).

(iii) As with other health crises, poorer states have engaged in "widespread non-compliance" with the IHR2005's "obligations on developing basic public health capacities" (Fidler 2020c: 211). Admittedly, this third point illustrates Fidler's argument that inadequate health infrastructures (or "hardware failures") inhibit the realisation of global health's source code (2007: 13). Nevertheless, the pandemic otherwise indicates that states hold greater influence over non-state actors (the WHO) than Fidler previously claimed (2007: 2). As with the Ebola epidemic, the primacy of states during the COVID-19 pandemic undermines Fidler's claim of a post-Westphalian unstructured plurality (2007: 2).

Despite not explicitly disavowing his earlier post-Westphalian claim, Fidler himself acknowledges that states have exerted "greater competitive influence" throughout the COVID-19 pandemic than prior health crises (2020b: 239). During the Cold War, hegemonic rivalry "never left a deep geopolitical imprint on international cooperation on health" (as evidenced by successful campaigns for smallpox eradication and HIV/AIDs alleviation) (Fidler 2020b: 240). Following the Cold War (and the international system's shift to a unipolarity), "political space opened" to allow an unstructured plurality of actors to "connect health with a new kind of high politics" (Fidler 2020b: 241). Fidler's unstructured plurality may have described the dynamics of the then US-led unipolar system (2007: 2).

In the contemporary multipolar system, however, unstructured plurality has instead been replaced by a state-centric global health governance. Multipolarity became evident by the late 2010s, with both the US and China treating the COVID-19 pandemic "as an event with geopolitical importance" (Fidler 2020b: 243). US commentary blamed the outbreak on China's political leaders and system (Mead 2020). China similarly utilised the pandemic to its geopolitical advantage: offering "assistance to countries in camera-friendly moments of health care diplomacy" (Lemmon, 2020). Contrary to Fidler's claim of unstructured plurality, the contemporary multipolarity has allowed hegemonic states to exploit global health governance to suit their power politics (2007: 2).

Hegemonic rivalry has now led to international polarisation over the WHO's authority throughout the COVID-19 pandemic. The Trump administration withdrew its membership from the WHO, and halted funding out of concern that the organisation had become too "China-

centric" (Fidler 2020b: 245, quoting New York Times 2020). In retaliation, China "condemned [the] WHO's critics and pledged to increase its support for the organization" (Fidler 2020b: 245). The successive Biden administration has since re-joined the WHO out of its support for liberal internationalism and multilateralism (Deudney and Ikenberry 2021: 1). The administration has, however, remained publicly critical of the WHO's competency, and further exacerbated international polarisation over the WHO's authority (Guarisco, Hunnicutt, and Nebehay 2020).

International polarisation has left the WHO with reduced support and potentially comprised "its ability to help [poorer] nations" (Fidler 2020a: 32). Smaller states are now increasingly dependent on aligning with either the US or China to receive funding for their local health governance. As part of its Belt and Road Initiative (BRI), China has introduced the Health Silk Road strategy (HSR). The HSR is a "full-fledged multilateral initiative for promoting global health cooperation" including establishing health policy research networks, improving coordination on disease monitoring and prevention, and providing medical and financial aid to BRI members (Jiahan 2020: 23). This final point is significant, as it illustrates that China can exert influence over the health governance within BRI countries (including agenda setting and levels of infrastructural development) (Jiahan 2020: 23).

One example of China's influence over governance in vulnerable states is the prevalence of invasive digital surveillance technology within Africa. This surveillance technology (including "track and trace" smartphone applications) was developed by private companies in response to the spread of COVID-19 (Harrisberg 2020: 2). This may appear to imply that non-state actors exert high health governance influence (as Fidler claims) (2007: 2). Yet, the adoption of digital surveillance technology by many African states was likely also due to China's influence. The technology had initial success in China in the early stages of the COVID -19 pandemic (Fidler 2020a: 44). It was then adopted by multiple African states in the context of "China's increased presence" in the region through the BRI (Fidler 2020a: 44).

Digital surveillance technology has also created international "concerns about the [human] right to privacy" (Fidler 2020a: 44). This means that China-advocated surveillance measures undermine the WHO's IHR2005 guidelines: dictating that health governance should not infringe upon human rights (WHO 2020). The COVID-19 pandemic has thus allowed China to increase its influence over domestic health governance in poorer states and weaken the WHO's authority.

China's extended influence over vulnerable states during the COVID-19 pandemic has also led to geopolitical backlash from the US. As a response to China's HSR, the US has promoted its US-ASEAN Health Futures initiative within South-East Asia (Jiahan 2020: 30). This initiative similarly advocates for "strengthening medical research, building health system capacity, and developing human capital" (Jiahan 2020: 30). But just as with the HSR, the US's Health Futures initiative also has geopolitical incentives. As states within South-East Asia have increasingly aligned with China over health security, the US has sought to regain influence in the region. In a similar manner, Middle Eastern states that have aligned with China through the HSR have received condemnation from the US (including limiting financial and medical assistance) (Jiahan 2020: 31). These geopolitical tensions have only exacerbated in the COVID-19 pandemic, with vulnerable states in all regions becoming increasingly reliant on external support from either the US or China (Jiahan 2020: 31).

Lastly, China's HSR also claims to support the WHO's role in global health governance (Jiahan 2020: 23). This is misleading, however, and again has geopolitical incentives. The HSR supports the WHO's "reform process", wherein the organisation is expected to alter its agenda priorities and diplomatic approaches in exchange for increased funding and support from

China (Jiahan 2020: 23). As an illustrative example, the WHO has not allowed Taiwan membership status, refused to recognise its status as a sovereign state, and has excluded Taiwan from the organisation's multilateral forums (Chen and Cohen 2020). From a health security perspective, this is particularly irresponsible as Taiwan has been amongst the most successful states in managing COVID-19 (Chen and Cohen 2020). While the WHO claims to be politically neutral, it can be inferred that the organisation's exclusion of Taiwan is due to geopolitical concerns of upsetting China (Chen and Cohen 2020). When Bruce Alyward (Senior Advisor to the WHO Director-General) was publicly interviewed regarding Taiwan's exclusion, Alyward ignored the question and then exited the interview (Wong 2020).

Just as with small states, non-state actors like the WHO have become increasingly dependent on siding with great powers. The COVID-19 pandemic allowed for this dependency to increase, as the US has repeatedly undermined the WHO's authority and forced it further towards China. In summary, hegemonic states have exerted greater influence than other actors throughout the COVID-19 pandemic. It is clear then that unstructured plurality cannot properly describe the state-centric governance evident in current health crises.

Conclusion

To conclude, I have argued that states are the most influential actors within global health crises. While scholars might claim that global health governance entails an unstructured plurality, this does not hold up when health crises occur. During crises, most states tend to reject the authority of non-state actors. Hegemonic states also exploit crises to shape domestic governance in poorer states (and in doing so, further undermine the authority of non-state actors).

I reached the above conclusion in three stages. First, I outlined concepts pertaining to global health governance and its supposed unstructured plurality. Second, I examined claims of an unstructured plurality in reference to the Ebola epidemic. While the BMGF had some agenda-setting influence, I concluded that Ebola governance failures were predominately due to constraints imposed by states. Second, I analysed this unstructured plurality thesis in the context of the COVID-19 pandemic. I concluded that hegemonic states exerted the most influence throughout the pandemic. Unstructured plurality might have described the prior US-led unipolar system. Yet, it now overlooks how hegemonic states (the US and China) dominate health governance in the contemporary multipolarity. Despite claims otherwise, states do function as the most powerful actors during global health crises. Global health scholars and policymakers alike must reconsider their conceptual frameworks to address this. Otherwise, these power imbalances will remain and constrain efficient governance.

Authors' Contributions
This article was written by Benjamin Smith, an International Relations MSc student at the London School of Economics and Political Science (LSE). It was peer-reviewed by the editorial board at the LSE International Development Review journal.

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