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Editorial

The proposed WHO Pandemic Agreement: Ambitious progress or business as usual?

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The World Health Organization (WHO)'s proposal for a Pandemic Agreement, released in April 2024, at first blush, seems laudable (WHO 2024a). The failure of governments to coordinate a response to COVID-19, as implored by the WHO and the United Nations (UN) at the beginning of the pandemic, underlines the urgent need for reform in the global governance of pandemics. This editorial considers: how has the Agreement progressed to date? And will it adequately prepare societies to tackle future pandemics?

The draft Agreement includes a list of proposals that seem largely unobjectionable. These include strengthening, implementing, periodically updating and reviewing 'multisectoral national pandemic prevention and public health surveillance plans'; recognising that 'environmental, climatic, social, anthropogenic and economic factors increase the risk of pandemics'; strengthening and maintaining resilient healthcare systems, including a multidisciplinary workforce 'to prevent, prepare for and respond to health emergencies closest to where they start'; sharing technology and know-how, particularly to developing countries; and 'multisectoral access and benefit-sharing for pathogens with pandemic potential', among others (WHO 2024a, p. 7-14).

In June 2024, the World Health Assembly (the decision-making body of WHO) agreed on *some* of the proposals in the draft Agreement, including introducing a definition of a pandemic emergency to help ensure more effective international collaboration; a commitment to solidarity and equity in relation to accessing medical products and financing; establishing a committee to facilitate the implementation of the amended regulations; and creating National International Health Regulation Authorities to help better coordinate the implementation of the Regulations among countries (WHO 2024b).

Yet, there remains *disagreement* on key proposals amid what have been reported as 'deep divisions between rich and poorer countries on issues like vaccine-sharing and preparedness' (Reuters 2024), which are certain to undermine the stated ambitions of international collaboration, solidarity and equity. The sticking points include incorporating the experience of countries of the Asia-Pacific that used an elimination strategy; that is, reducing transmission of cases to zero for a defined geographical area and time-period (Baker et al. 2023).

Given that the WHO comprises 194 members, including high-, low- and middle-income countries, developing consensus on a pandemic agreement was bound to be challenging. However, in public communications thus far, there has been no substantive discussion on whether a meaningful agreement is even possible considering the inequities that exist between countries that affect their capacities to prepare for and respond to a pandemic. As Didier Fassin and Marion Fourcade (2021) note, the COVID-19 pandemic laid bare the stark inequalities that already existed between countries and produced new ones. Western media coverage of the pandemic, they observe, ignored the plight of people living in countries such as Haiti, Yemen, Sudan, and those of the Middle East and Central Africa, who daily grapple with famine, conflicts, acute respiratory infections, political chaos, and a constant struggle for survival. One of the major characteristics of the COVID-19 pandemic, they argue, was the 'narrowing of the economy of attention' to an almost exclusive focus on case numbers and deaths and the tendency for individuals and economically rich countries to turn inward and to

largely disregard the situation of those in poorer countries (Fassin & Fourcade 2021, p. 3-5). This narrowing of attention and the inadequacy of agencies' responses during COVID-19 was also evident during the global outbreak of monkeypox in 2022, as discussed by Atuk and Cannon (2024) in this issue.

Systemic Failures Made Apparent by COVID-19

During the COVID-19 pandemic, interventions were often a reaction to *systemic failures*, caused by a combination of eroded public services following decades of neoliberal austerity measures and inadequate pandemic planning and preparedness. In the health sector, these failures include the lack of globally coordinated mechanisms for managing a public health emergency, including equitably distributing urgently needed vaccines. These failures were often compounded by poor leadership and political squabbling. In publicly available information on the Pandemic Agreement there is no meaningful reference to the 'lessons learnt' from responses to COVID-19 or other epidemics and pandemics, including reflection on these failures and why measures often did not achieve stated public health objectives in many countries but rather created or exacerbated social inequalities and divisions and produced many other harms. In the first and second years of COVID-19 an accumulating body of evidence made clear that pandemic measures had substantially increased inequalities and shown that the rich G20 group prioritised the interests of its own members over those of poorer countries (e.g., Sirleaf & Clark 2021, The Independent Panel for Pandemic Preparedness and Response 2021).

On 23rd March 2020, soon after WHO's declaration of the pandemic, the UN called on 'all actors, especially governments' to 'Strengthen international cooperation and take steps towards the provision of universal health care, collaborate in developing a vaccine and treatment for the pandemic, expedite trade and transfer essential medical supplies and equipment…to ensure that COVID-19 treatments are available and affordable to all'. Further, it called on countries to 'Take measures to alleviate the situation of vulnerable groups, including migrants and refugees, outside their country of origin…'. (UN 2020, p. 22).

We now know how things played out. There was an international 'race' among Big Pharma to develop vaccines and, when they did become available, high-income countries, including the UK, Germany, Canada, Singapore, Italy, France, and Chile, hoarded them for their own citizens (GT Staff Reporters 2022).

The Inherent Limitations and Contradictions of Current Supra-National Governance Structures

A series of reports published by a WHO-commissioned independent panel in 2021 drew attention to some of the key failures of COVID-19 preparedness and responses, including 'the slow flow of funding for response' after the public health emergency was declared, the different abilities or capacities of countries to manage the disease, and the inequities in access to vaccines and 'vaccine nationalism' which was described as 'one of today's pre-eminent global challenges' (The Independent Panel for Pandemic Preparedness and Response 2021, p. 12).

A second report, published six months later (in November 2021) again documented the issue of vaccine inequality, noting that 'More than 67% of the population of all high-income countries has been fully vaccinated against COVID-19, but in low-income countries fewer than 5% have received even one dose, and that figure hovers even lower in many'—a figure well below the WHO target of 40 percent of the population of each country to be fully vaccinated by the end of 2021 (Sirleaf & Clark 2021, p. 9) Moreover, the authors noted, the capacity of low- and middle-income countries to purchase vaccines had, problematically, been restricted by 'confidential high-cost deals between manufacturers and wealthy countries as they add booster doses to their immunization programmes, despite powerful arguments against this on equity grounds' (2021, p. 9). As the report emphasised, short-term national interests and the interests of Big Pharma, which put profit before the public's health and bought up patents and developed them worked to the detriment of lower- and middle-income countries.

Finally, and significantly, as the Independent Panel noted, the WHO has limited powers to address pandemic preparedness and responses and it is financially constrained. And herein lies the crux. As I have

argued elsewhere, the WHO is fundamentally constrained in its responses by its history, structure and modus operandi, as well as its assumptions about pandemics (Petersen 2024). For example, the WHO is constrained by the requirement to consider the views, needs and aspirations of its Member States and, as a 2011 report observed, its focus on 'relatively short, geographically focused events', of the type it confronts many times each year (WHO 2011, p. 11).

Given the WHO's history and the many constraints it faces, it is difficult to see how it can be reformed in the short-to-medium term, especially since, as the Independent Panel noted in its report, past recommendations for (even more modest) reform have been largely ignored (2021, p. 16). A critical first step in reforming the global governance of public health is to acknowledge the constraints on WHO in its ability to coordinate national responses and to develop strategies to assist nations to better prepare and respond to pandemics (see Petersen 2024, p. 114). However, the task of coordination is difficult in a period of increased nationalism which is occurring, paradoxically, in tandem with the decline of the power of the nation state.

Conclusion

In short, for various reasons, the proposed Pandemic Agreement will likely fall short of what is required for societies to tackle future pandemics, especially during a period of defined crisis when resource-rich countries will work to advance their own interests and those of Big Pharma. The Agreement itself, as currently framed, will do little to address entrenched problems with the WHO and the decline of the authority once bestowed on it and other supranational organisations in the current fractured global political order, which is marked by deeply polarised views on many issues and the social media-driven infodemic, which authorities struggled to control from the beginning of the COVID-19 pandemic. As this event showed, pandemic responses produce winners and losers with the priorities of wealthy nations and corporations tending to work against international solidarity (see, e.g. Shaw 2024). With growing nationalism and authoritarianism and the radical reshaping of the global order, modernist certainties that have underpinned efforts to support the public's health, including the power and influence of authorities such as WHO and UN, have been severely tested.

In this context, critical scholars have an important role to play in shifting debate and the research agenda on 'pandemic preparedness and planning', especially in highlighting the global inequalities that work against a coordinated response to pandemics—events that are expected to become more prevalent in the future.

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