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ARTICLE

Post-Pandemic Reform Discussions in International Health Law: The Reform of the International Health Regulations and the New WHO Pandemic Agreement Proposal

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Abstract

The COVID-19 pandemic has clearly demonstrated that international cooperation to combat pandemics is insufficient. The World Health Organization has, therefore, recently reformed the International Health Regulations based on the experience of the COVID 19-pandemic. The World Health Assembly also plans to adopt a new Pandemic Agreement to further strengthen international cooperation. However, negotiations have not yet been successful, and this year's World Health Assembly agreed to extend the negotiations for the Pandemic Agreement by one year. Reason enough to analyse and critically evaluate the reform efforts in detail, and to give an outlook on the future of international pandemic law.

Keywords: International health regulations; pandemic agreement; World Health Organization (WHO); international health law; pandemic emergency; public health emergency of international concern

I. Introduction

The COVID-19 pandemic has clearly shown how vulnerable the world is to infectious diseases. The World Health Organization (WHO) estimates that the pandemic has cost almost 15 million people their lives[1] and plunged the world into a global recession.[2] The Corona crisis has revealed that the existing international regulatory regime on global health suffers from considerable deficits, which have already occurred during the SARS crisis in 2003, that led to the revision of the International Health Regulations (IHR) 2005.[3]

[1] Estimated number of deaths associated directly or indirectly with the COVID-19 pandemic (referred to as "excess mortality") between 1 January 2020 and 31 December 2021, see WHO, *Press Release*, 5 May 2022 <https://www.who.int/news/item/05-05-2022-14.9-million-excess-deaths-were-associated-with-the-covid-19-pandemic-in-2020-and-2021> accessed 15 September 2024.

[2] World Bank Group, *World Development Report 2022. Finance for an Equitable Recovery* (2022), 49 et sqq.

[3] A Klafki, "International Health Regulations and Transmissible Diseases" (2018) 61 German Yearbook of International Law 73, 76 et sqq.; S Halabi, "Conceptual and Tangible Borders Under a Revised International Health Regulations or New International Pandemic Agreement" in Colleen M. Flood et al. (eds), *Pandemics, Public Health, and the Regulation of Borders, Lessons From Covid-19* (Routledge 2024) 388, 389; BM Meier, R Habibi and LO Gostin, "A Global Health Law Triology: Transformational Reforms to Strengthen Pandemic Prevention, Preparedness, and Response" (2022) 50 The Journal of Law, Medicine & Ethics 625.

However, the IHR 2005 failed to deliver the desired improvements, which became evident during the COVID-19 pandemic. The WHO's COVID-19 pandemic management was criticised early on.[4] In essence, the criticism focused on four aspects that had also been criticised in previous public health emergencies of international concern.[5] First, the WHO was blamed for its late response to the new pandemic.[6] While this was partly due to China's initial reluctance to report the newly emerged infectious disease outbreak to the WHO, it was also due to the WHO's hesitant approach, careful not to cause panic in view of the uncertainties with regard to the novel disease.[7] Second, although the WHO issued recommendations for moderate travel and cargo restrictions, most countries issued far more excessive travel and trade restrictions albeit without providing reasons.[8] Third, only one-third of the state parties had fulfilled their obligations to establish core capacities.[9] Fourth, the WHO failed to ensure adequate cooperation in the distribution of vaccines, medical treatment as well as protective health equipment, resulting in many avoidable deaths in middle- and low-income countries.[10]

Despite the existing obligations for all member states to cooperate under the IHR (2005), the handling of the COVID-19 pandemic was characterised by a distinct lack of solidarity with middle- and low-income countries.[11] Reasons for this shortcoming are that the global health system lacks accountability mechanisms and a coherent compliance machinery.[12] Overall, health law at the global level continues to be characterised by national egoism, which reduces the global effectiveness and efficiency

[4] See e.g. M Sohn et al., "The problems of International Health Regulations (IHR) in the process of responding to COVID-19 and improvement measures to improve its effectiveness" (2021) 3 Journal of Global Health Science 1 et sqq.

[5] See e.g. A Klafki, "International Health Regulations and Transmissible Diseases" (2018) 61 German Yearbook of International Law 73, 81 et sq.

[6] The Independent Panel for Pandemic Preparedness and Response, *COVID-19: Make it the Last Pandemic* (2021) 28.

[7] S Singh, C McNab, RM Olson et al., "How an outbreak became a pandemic: a chronological analysis of crucial junctures and international obligations in the early months of the COVID-19 pandemic" (2021) 398 The Lancet 2109, 2112; LO Gostin, EA Friedman and A Finch, "The Global Health Architecture: Governance and International Institutions to Advance Population Health Worldwide" (2023) 101 The Milbank Quarterly 734, 748. Also, cf. WHO, *Report of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response*, 5 May 2021, A74/9, p 32 et sqq.

[8] WHO, *Report of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response*, 5 May 2021, A74/9, p. 42 et sqq.; R Habibi, GL Burci et al, "Do not violate the International Health Regulations during the COVID-19 outbreak" (2020) 395 The Lancet 664 et sqq.; B von Tigerstrom B and K Wilson, "COVID-19 Travel Restrictions and the International Health Regulations (2005)" (2020) 5 BMJ Global Health 1 et sqq. See with regard to export restrictions of relevant health products such as face masks I Carreno, T Dolle, L Medina and M Brandenburger, "The Implications of the COVID-19 Pandemic on Trade" (2020) 11 European Journal of Risk Regulation 402–410.

[9] WHO, *Report of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response*, 5 May 2021, A74/9, p 24; The Independent Panel for Pandemic Preparedness and Response, *COVID-19: Make it the Last Pandemic* (2021) 17 et sqq.; LO Gostin, EA. Friedman and A Finch, "The Global Health Architecture: Governance and International Institutions to Advance Population Health Worldwide" (2023) 101 The Milbank Quarterly 734, 735.

[10] The Independent Panel for Pandemic Preparedness and Response, *COVID-19: Make it the Last Pandemic* (2021) 41 et sqq.; BM Meier, R Habibi and LO Gostin, "A Global Health Law Trilogy: Transformational Reforms to Strengthen Pandemic Prevention, Preparedness, and Response" (2022) 50 The Journal of Law, Medicine & Ethics 625; L Hallas, "COVID-19's New Cosmopolitanism? Structural Considerations for the Proposed Pandemic Treaty" (2023) 132 Yale Law Journal 2578, 2615 f.; PA Villarreal, "Lawmaking at the WHO: Amendments to the International Health Regulations and a New Pandemic Treaty after COVID-19" (2023) 4 SWP Comment 1, 5.

[11] LO Gostin, EA Friedman and A Finch, "The Global Health Architecture: Governance and International Institutions to Advance Population Health Worldwide" (2023) 101 The Milbank Quarterly 734, 749.

[12] See also WHO, *Report of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response*, 5 May 2021, A74/9, p. 10, 52 ff.

to fight pandemics.[13] The principles of equity and solidarity are therefore at the heart of current reform efforts.

In view of the recognised weaknesses of the global pandemic management under the IHR (2005), already at the end of the first year of the COVID-19 pandemic, the President of the European Council proposed an international treaty on pandemics within the framework of the World Health Organization during a Special Session of the UN General Assembly in response to COVID-19.[14] Following that proposal, the World Health Assembly (WHA) during a Special Session in December 2021[15] established an Intergovernmental Negotiating Body tasked to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response.[16] Furthermore, in 2022 the Executive Board of the WHO[17] and the WHA[18] decided to initiate a reform process of the core public health legal document, the directly binding IHR (2005). To this end, a Working Group on Amendments to the IHR (2005) was appointed and worked parallel to the Intergovernmental Negotiation Body. Both committees were expected to submit their proposals to the WHA for adoption in June 2024 .[19] Meanwhile, the Reform of the IHR (2005) has been endorsed,[20] whereas the proposed Pandemic Agreement has not yet received the necessary approval from the World Health Assembly. Therefore, the World Health Assembly decided to extend the mandate of the Intergovernmental Negotiating Body to finish its work as soon as possible and to submit its outcome for consideration by the next WHA in 2025, or earlier by a special session of the WHA.

II. Reform of the international health regulations

The IHR (2005) are the core legal document to ensure global health security.[21] They are based on Article 21 (a) of the WHO-Constitution. According to Article 22 WHO-Constitution, regulations adopted pursuant to Article 21 WHO-Constitution are legally binding for all members after due notice of their adoption has been given unless member states explicitly reject them or formulate reservations within a set time period.[22] In this respect, the WHO's legislative competence clearly exceeds that of other international

[13] L Gruszczynski and CH Wu, "Between the High Ideals and Reality: Managing COVID-19 Vaccine Nationalism" (2021) 12 European Journal of Risk Regulation 711, 713 et sqq.; TL Lee, "Why the WHO is failing and how to fix it," *EJIL:Talk!* 29 May 2020 <https://www.ejiltalk.org/why-the-who-is-failing-and-how-to-fix-it/> accessed 15 September 2024.

[14] See European Council, *Press Release*, 3 December 2020 <https://www.consilium.europa.eu/en/press/press-releases/2020/12/03/press-release-by-president-charles-michel-on-an-international-treaty-on-pandemics/> accessed 15 September 2024.

[15] For the appointment of the special session of the World Health Assembly see Decision WHA74(16).

[16] World Health Assembly Second Special Session, *The World Together: Establishment of an intergovernmental negotiating body to strengthen pandemic prevention, preparedness and response*, SSA2(5), at para 1 subpara (1).

[17] Executive Board Decision 150(3).

[18] World Health Organization, Strengthening WHO preparedness for and response to health emergencies, WHA75(9), 27 May 2022, at para (2).

[19] PA Villarreal, "Lawmaking at the WHO: Amendments to the International Health Regulations and a New Pandemic Treaty after COVID-19" (2023) 4 SWP Comment 1, 6.

[20] Decision of the World Health Assembly, *Strengthening preparedness for and response to public health emergencies through targeted amendments to the International Health Regulations (2005)*, WHA 77.12, 1 June 2024.

[21] LO Gostin and R Katz, "The International Health Regulations: The Governing Framework for Global Health Security" (2016) 94 The Milbank Quarterly 264 et sqq.; A Wilder-Smith and S Osman, "Public Health Emergencies of International Concern: A Historic Overview" (2020) *27* Journal of Travel Medicine 1; L Hallas, "COVID-19's New Cosmopolitanism? Structural Considerations for the Proposed Pandemic Treaty" (2023) 132 Yale Law Journal 2578, 2607.

[22] PA Villarreal, "Lawmaking at the WHO: Amendments to the International Health Regulations and a New Pandemic Treaty after COVID-19" (2023) 4 SWP Comment 1, 4.

organisations. The IHR (2005) are centred around the declaration of public health emergencies of international concern.[23] Article 12 in conjunction with Annex 2 of the IHR contains a specific decision-making scheme for determining whether an event constitutes a potential public health emergency of international concern which has to be reported to the WHO by national health authorities.[24] Since 2005, seven infectious disease outbreaks have been declared public health emergencies of international concern.[25] When such a public health emergency of international concern is declared, the Director-General may issue temporary or standing recommendations including public health measures to be implemented by the affected state parties as well as travel restrictions to be implemented by state parties which are not yet affected.[26] Although the recommendations are non-binding, if state parties impose more restrictive travel restrictions than recommended, they are required to provide justification to the WHO under Article 43 IHR.

Aside from the IHR (2005), the WHO's regulatory system includes a number of non-binding pandemic planning documents that relate to specific infectious diseases, such as influenza pandemics. These documents include a specific pandemic phase model which reflects the WHO's risk assessment of the global health situation with regard to the respective disease.[27] The declaration of a pandemic is an important trigger for implementing response measures at the national level.[28] Also, bilateral supply agreements for pandemic health products conducted under the Pandemic Influenza Preparedness Framework are often only applicable after a pandemic has been declared.[29] This is why during the outbreaks of the H1N1-influenza, Ebola and COVID-19, the WHO Director-General not only declared a public health emergency of international concern but also declared that these events constituted pandemics, despite the term not appearing in the IHR (2005).

The Revised IHR now include a legal definition of a "pandemic emergency." It constitutes a novel higher warning category within public emergencies of international concern. In addition to the requirements for a public emergency of international concern, the category of pandemic emergency requires that it results from a communicable disease and that it unfolds at least a high risk to spread geographically widely to and within multiple states, to exceed the health capacity of the affected states, to cause substantial social and/or economic disruption, and requires rapid, equitable and enhanced coordinated international action, with whole-of-government and whole-of-society approaches.[30] It should be noted, however, that the new category of pandemic emergency neither confers additional powers to the WHO nor specific obligations on the state parties. Rather, a pandemic emergency is treated in the same way as a regular public health emergency of international concern. In addition, this new warning category is meant to be legally independent from the disease specific-pandemic phase model in the WHO soft law

[23] A Klafki, "International Health Regulations and Transmissible Diseases" (2018) 61 German Yearbook of International Law 73, 77 et sqq.

[24] The EU has established a similar system to determine public health emergencies at Union level which leads to specific EU counter measures including the mobilisation of an EU Health Task Force. See for details Art 23 ff. of Regulation (EU) 2022/2371 of the European Parliament and of the Council of 23 November 2022 on serious cross-border threats to health and repealing Decision No 1082/2013/EU, [2022] OJ L314/26.

[25] A Wilder-Smith and S Osman, "Public Health Emergencies of International Concern: A Historic Overview" (2020) 27 Journal of Travel Medicine 1.

[26] Arts 15, 16 IHR (2005). See for details on temporary and standing recommendations C Nannini and GL Burci, "Standing Recommendations under the International Health Regulations (2005)" (2024) 28/4 ASIL Insights 1 et sqq.

[27] WHO, "Pandemic Influenza Risk Management. A WHO guide to inform & harmonize national & international pandemic preparedness and response," WHO/WHE/IHM/GIP/2017.1, 2017, 13 et sqq.

[28] WHO, *Report of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response*, 5 May 2021, A74/9, p 38.

[29] Ibid.

[30] Art 1 Revised IHR.

documents. The new term thus has political but no direct legal significance in the WHO's current regulatory system.[31]

Apart from that, the new amendments to IHR (2005) aim to strengthen the principles of equity and solidarity.[32] The WHO defines health equity as the absence of unfair, avoidable or remediable differences among groups of people. Health equity is achieved when everyone can attain their full potential for health and well-being.[33] Solidarity is not explicitly defined by the WHO. From the use of the term in WHO documents[34], however, it can be deduced that solidarity refers to international cooperation to achieve global health equity. Solidarity in international law is not limited to humanitarian assistance but is broadly understood in terms of sustainable international relations and the equitable sharing of benefits and burdens.[35] Nonetheless, it includes a particular focus on international assistance to low-income countries.[36]

To this end, a key element of the reform is the introduction of a Coordinating Financial Mechanism to strengthen financial cooperation among the state parties and to ensure that funds are used effectively to build the medical core capacities pursuant Article 5 of the Revised IHR in order to enable all states to implement the existing surveillance, information-sharing and control obligations.[37] The Coordinating Financing Mechanism aims to promote the provision of sustainable financing, particularly to support low-income countries. In addition, the WHO is mandated to support member states and to coordinate international response activities to public health emergencies of international concern, including pandemic emergencies.[38] The WHO shall especially facilitate equitable access to relevant health products by consultations, coordinative activities, through WHO networks, and by sharing relevant information.[39] Relevant health products are defined as health products needed to respond to public health emergencies of international concern. They may include medicines and vaccines as well as personal protective gear or gene-based technologies.[40] When interim or standing recommendations are issued in response to a public health emergency of international concern, available information on any WHO-coordinated mechanisms for access and distribution of relevant health products should be provided at the same time.[41] However, the amendments fall far short of the demands of middle- and low-income countries, which called for more binding benefit-sharing commitments from capable member states as part of the reform process.[42]

[31] See for a critical reflection on the new term also DP Fidler, "The Amendments to the International Health Regulations Are Not a Breakthrough," *Think Global Health*, 7 June 2024 <https://www.thinkglobalhealth.org/article/amendments-international-health-regulations-are-not-breakthrough> accessed 15 September 2024 ("Changes that make no changes").

[32] Art 3 (1) Revised IHR.

[33] See Glossary of Health Topics of the WHO <https://www.who.int/health-topics/health-equity#tab=tab_1> accessed 15 September 2024.

[34] See in particular WHO Director General, *Making the response to COVID-19 a public common good. Solidarity Call to Action. To realize equitable global access to COVID-19 health technologies through pooling of knowledge, intellectual property and data*, <https://www.who.int/publications/m/item/solidarity-call-to-action> accessed 15 September 2024.

[35] Human Rights Council Resolution A/HRC/RES/15/13, para 2; Human Rights Council Resolution A/HRC/RES/18/5, para 2.

[36] Human Rights Council Resolution A/HRC/RES/15/13, para 4; Human Rights Council Resolution A/HRC/RES/18/5, para 4.

[37] Art 44 (2bis-2quater), Art 44bis Revised IHR.

[38] Art 13 (7) Revised IHR.

[39] Art 13 (8) Revised IHR.

[40] Art 1 (1) Revised IHR.

[41] Art 15 (2bis), Art 16 (2) Revised IHR.

[42] Critically also DP Fidler, "The Amendments to the International Health Regulations Are Not a Breakthrough," *Think Global Health*, 7 June 2024 <https://www.thinkglobalhealth.org/article/amendments-international-health-regulations-are-not-breakthrough> accessed 15 September 2024.

Finally, the Revised IHR seek to strengthen the accountability of state parties in fulfilling their obligations. For this purpose, Member States are obliged to establish National IHR Authorities which are responsible for coordinating the implementation of the Revised IHR.[43] Also, the amendments install an Implementation Committee, which shall meet at least once in two years, to better track the regulations' implementation and enhance accountability.[44]

In addition, the decision-making scheme for the declaration of a public health emergency of international concern in Annex 2 of the revised IHR has been modified. In order to improve the detection and reporting of outbreaks of acute respiratory diseases, it is now specified that "clusters of cases of severe acute respiratory disease of unknown or novel cause" should lead to the application of the decision-making scheme (called "algorithm") for the national authorities to consider whether the event needs to be notified to the WHO. However, the demands for a more effective compliance mechanism were not implemented[45] nor were changes made to the non-binding nature of the Director-General's recommendations in case of a public health emergency of international concern. Therefore, it is to be feared that future outbreaks of infectious diseases will again lead to excessive travel restrictions, which in turn will reduce the willingness of affected countries to fulfil their reporting obligations.[46]

The reforms certainly point in the right direction. However, they do not solve existing problems. Ultimately, the reform process reflects a fundamental conflict of interest between poor and rich state parties. High-income countries, on the one hand, have a great interest in making capacity building and reporting obligations more binding to protect their own populations from future pandemics. Poorer member states, on the other hand, see themselves as victims. If they fulfil their reporting and virus sharing obligations, they suffer considerable financial losses as a result of excessive travel restrictions. This then makes them even more vulnerable to the disease outbreak and leads to them being financially unable to obtain vaccines and other health products that were produced on the basis of their virus sharing. They therefore demand more binding financial commitments for developing their core capacities, more binding regulations on benefit-sharing with regard to relevant healthcare products as well as higher accountability and greater binding force of the WHO's restrictions on travel and freight transport bans.[47]

III. Pending pandemic agreement

In view of these deficits of the IHR amendments, the Pandemic Agreement, which is still to be ratified, has far greater potential for improving future global pandemic management.[48]

[43] Art 1 (1), Art 4 (1bis) Revised IHR.

[44] Art 54bis Revised IHR.

[45] Critically C Forster, "Compliance and Accountability Mechanisms in the 2024 Revisions to the WHO International Health Regulations" (2005), *EJIL:Talk!*, 21 June 2024 <https://www.ejiltalk.org/compliance-and-accountability-mechanisms-in-the-2024-revisions-to-the-who-international-health-regulations-2005/> accessed 15 September 2024.

[46] Critically also DP Fidler, "The Amendments to the International Health Regulations Are Not a Breakthrough," *Think Global Health*, 7 June 2024 <https://www.thinkglobalhealth.org/article/amendments-international-health-regulations-are-not-breakthrough> accessed 15 September 2024.

[47] See e.g. the proposed amendments to the IHR 2005 submitted by Eswatini on behalf of the WHO Africa Region Member States, in WHO, Proposed Amendments to the International Health Regulations (2005) submitted in accordance with decision WHA75(9) (2022), pp 41 et sqq.

[48] See the joint statement by heads of states and WHO, "COVID-19 COVID-19 Shows Why United Action Is Needed for More Robust International Health Architecture" <https://www.who.int/news-room/commentaries/detail/op-ed—covid-19-shows-why-united-action-is-needed-for-more-robust-international-health-architecture> accessed 15 September 2024.

Further agreements are possible here, as the document is not directly binding on the member states. Rather, it constitutes an international agreement under Article 19 of the WHO Constitution, that – like other international treaties under Article 2 (1) (a) Vienna Convention – is only binding upon state parties that actively submitted their consent. Despite the legally binding nature of agreements in principle, the Intergovernmental Negotiating Body decided that the Pandemic Agreement should also include non-binding elements.[49] This combination of non-binding and binding elements within the framework of the Pandemic Agreement increases flexibility and can be used to attain more far-reaching agreements than would be possible with a fully binding international treaty.[50]

The central regulatory motive of the proposal of the Pandemic Agreement, which has not yet been adopted by the World Health Assembly, is to ensure equity in the prevention, preparedness and response to pandemics,[51] with solidarity as one of the guiding principles for achieving equity.[52] The agreement emphasises a collaborative approach to ensure that all countries, regardless of their development level, have the resources and capabilities to address pandemics. In order to translate the principle of equity into practice, the agreement stipulates collaboration with regard to resilient health systems,[53] collective research,[54] geographically diversified production of pandemic health products[55] as well as the transfer of technology, know-how and pandemic related health products.[56] Further elements of the pandemic agreement are the strengthening of pandemic preparedness through better surveillance systems, laboratory networks and public health infrastructure in all countries.[57] Also, a One Health[58] as well as a whole-of-government and whole-of-society approach is part of the agreement.[59] The key steering and monitoring body of the Pandemic Agreement is not the World Health Assembly but rather a Conference of the Parties[60] in which each state party of the Pandemic Agreement has one vote.[61]

At the heart of the negotiations, which are still unsettled, is the establishment of a system of pathogen access and benefit-sharing. It balances the interests of high-income countries in early warning and sharing of virus samples with the interests of low- and middle-income countries in equitable access to vaccines and medical treatment.[62] It should function as a specialised access and benefit-sharing system within the system established by Article 4 (4) of the Nagoya Protocol to the Convention on Biological Diversity.[63]

[49] Report of the Second Meeting of the INB, WHO Doc. A/INB/2/5 of 21 July 2022, para 4.

[50] Cf. HP Aust and F Schott, "To Bind or Not to Bind," *Verfassungsblog*, 4 April 2024 <https://verfassungsblog.de/to-bind-or-not-to-bind/> accessed 15 September 2024.

[51] Art 2 (1) Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10. See also AR Hampton, M Eccleston-Turner, M Rourke and S Switzer, "'Equity' in the Pandemic Treaty: The False Hope of 'Access and Benefit-Sharing'" (2023) 72 International and Comparative Law Quarterly 909, 917 ff.

[52] Art 3 (5) Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[53] Art 6 Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[54] Art 9 Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[55] Art 10 Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[56] Art 11 Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[57] Art 6 Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[58] The One Health approach overlaps with other norms of international law, see PA Villarreal, "Lawmaking at the WHO: Amendments to the International Health Regulations and a New Pandemic Treaty after COVID-19" (2023) 4 SWP Comment 1, 5.

[59] Art 5, 17 Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[60] Art 21 Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[61] Art 22 Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[62] Art 12 Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10. See AR Hampton, M Eccleston-Turner, M Rourke and S Switzer, "Equity" in the Pandemic Treaty: The False Hope of "Access and Benefit-Sharing'" (2023) 72 International and Comparative Law Quarterly 909, 923 et sqq.

[63] Art 12 (proposed new paragraph 1bis or 3bis) Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

The parties are expected to share pathogen samples through WHO-coordinated laboratory networks and databases.[64] In the event of a pandemic emergency, 20% of the real-time production of pandemic-related vaccines, therapeutics and diagnostics resulting from pathogen sharing should be made available to the WHO pathogen access and benefit-sharing system. The shared benefits should then be distributed – based on public health risk and need – by a newly set up Global Supply Chain and Logistics Network convened by the WHO in partnership with relevant stakeholders under the oversight of the Conference of the Parties.[65] In the event of a mere public health emergency of international concern that does not constitute a pandemic emergency, the share should only comprise 10–15% of the real-time production.[66] In addition, users of the benefit-sharing system must make annual monetary contributions to the WHO. Further details will be set out in a separate legally binding instrument to be adopted by the Conference of the Parties by 2026.

Although these concessions are considerable, 20% of the vaccines will hardly be sufficient to meet the global needs of middle- and low-income countries. Further efforts are therefore required to ensure equitable distribution of pandemic-related health products. After the disappointing experience with the global vaccine procurement initiative "COVAX,"[67] which aimed to act as a key purchasing agent for the world but turned out to be overly ambitious and unrealistic,[68] the current pandemic agreement draft now at least provides that parties should endeavour to publish relevant terms of purchase agreements with manufacturers of pandemic-related health products.[69] Also, parties should consider setting aside a portion of their purchase for countries in need.[70] However, the weak verbs "endeavour" and "consider" already indicate the non-binding nature of this part of the agreement.

If adopted in this or a similar form, the Pandemic Agreement will be a milestone in the history of international health law. It would be a major commitment to multilateralism at a time when right-wing populism and nationalism are on the rise. However, it is questionable whether the Pandemic Agreement is robust enough to significantly mitigate future pandemics. Many of the text parts on which initial agreements have been reached are of a non-binding nature. It is also questionable whether the system of access and benefit-sharing will lead to greater solidarity and equity in a situation where vaccines and medical treatments are scarce. It is foreseeable that the first priority of high-income countries will naturally be to protect their own populations. There are also loopholes in the pathogen access and benefit-sharing mechanism. For example, only "users" of the system are directly liable. However, if the user of the pathogen access and sharing system is an entity that is legally independent of the private vaccine manufacturers, the benefit-sharing obligation will not be enforceable.

IV. Prospects

Although the post-pandemic discussions on reforming international health law are bearing fruit and contributing to a better global health regime, the fundamental conflict between high-income countries, which demand compliance with regard to capacity

[64] Art 12 (4) (a) Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[65] Art 13 (1) Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[66] Art 12 (4) (b) Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[67] See for details L Gruszczynski and CH Wu, "Between the High Ideals and Reality: Managing COVID-19 Vaccine Nationalism" (2021) 12 European Journal of Risk Regulation 711, 716 et sqq.

[68] WHO, External Evaluation of the Access To COVID-19 Tools Accelerator (ACT-A), 2022, p 14; L Gruszczynski and CH Wu, "Between the High Ideals and Reality: Managing COVID-19 Vaccine Nationalism" (2021) 12 European Journal of Risk Regulation 711, 718 et sqq.

[69] Art 13 (1) Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

[70] Art 13 (3bis) Proposal for the WHO Pandemic Agreement, 24 May 2024, A77/10.

building and information sharing obligations, and middle- and low-income countries, which demand assistance and sharing of medical products, has not been resolved.

Equity and solidarity are guiding principles in the current reform debate. Not only the WHO, but also the EU declares its commitment to these principles. As part of its "European Health Union" it emphasises a One Health approach pointing at the advance of universal health coverage.[71] However, it is doubtful whether these principles, as noble as they may be, will ever prevail on the national level in the case of pandemics, which constitute existential disasters. If we look at international risk reduction and disaster law,[72] it is clear that the guiding principles are rather effectiveness and efficiency.[73] Therefore, I believe that the discussion on pandemic law needs to be reframed. It will take more than moral appeals to motivate high-income countries to share benefits and provide support in the face of an existential crisis. It is essential to demonstrate that pandemic preparedness, prevention and response is a global challenge that can only be met if all nations work together effectively and efficiently.[74] Only by building core health capacities in middle- and low-income countries can new infections be stopped before they become pandemics. Only if vaccines and medical treatments reach outbreak sites on time can the spread of a disease be prevented. And only if sufficient vaccine protection is achieved globally can the risk of new virus variants emerging and overcoming existing vaccine protection be reduced.

Strict compliance with the obligations of the Revised IHR and a fair distribution of resources is therefore not only a matter of equity and solidarity. Rather, it contributes directly to the health security of humanity in every country of the world. Only if this idea of global health as a common good[75] is internalised will there be a chance that the next pandemic will not be a matter of warm words, but of real collective action.

Competing interests. The author has no conflicts of interest to declare.

[71] See in particular EU Commission, *Communication to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, EU Global Health Strategy*, 2022, p 8.

[72] For a more integrated approach of international disaster law and international health law also P Dixit, "Synergising International Public Health Law and International Disaster Law" (2020) 13 European Journal of Risk Regulation 45–55.

[73] See the Guiding Principles of the Sendai Framework for Disaster Risk Reduction 2015–2030, adopted by the UN General Assembly Resolution A/Res/69/283; see also P Dixit, n 72, 45, 51.

[74] Cf. PA Villarreal, "Lawmaking at the WHO: Amendments to the International Health Regulations and a New Pandemic Treaty after COVID-19" (2023) 4 SWP Comment 1, 2.

[75] See in particular EU Commission, *Communication to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, EU Global Health Strategy*, 2022, p 4.

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