Letter to the Journal

To Fight a New Coronavirus: The COVID-19 Pandemic, Political Herd Immunity, and Global Health Jurisprudence

David P. Fidler*

I. Introduction

1. In global health, certain truths are held to be self-evident. Germs do not recognize borders, but, in a world where borders define the exercise of political power, international cooperation is critical to combatting pathogenic threats. Effective cooperation, including the use of international law, can produce political herd immunity—resistance within and between states to political behavior that disrupts measures needed to protect nations and individuals from infectious diseases.1 Outbreaks from cholera epidemics in the nineteenth century to Ebola crises in Africa in this century have reinforced, time and again, the necessity for countries to prioritize science and public health strategies in order to sustain political discipline within and across borders to prevail over common microbial threats. Unfortunately, history will not record the COVID-19 pandemic as a highwater moment for international cooperation and international law.

2. Lamentations abound that political actions across the international system have disrupted pandemic cooperation and damaged international law. The World Health Organization (WHO)—the center of gravity for international health cooperation—confronts political and health crises. Other venues for cooperation, including the UN Security Council and the Group of 7, have

* Adjunct Senior Fellow for Global Health and Cybersecurity, Council on Foreign Relations (dfidler@cfr.org). The essay was completed on 11 June 2020.

1 In public health, “herd immunity” happens when a large percentage of a population is immune to a disease, which makes the spread of the disease more difficult and protects the entire population.
not been productive. Controversies associated with COVID-19 have battered the main international agreement on infectious diseases, the International Health Regulations (2005) (IHR (2005)). Traditional global health leaders, such as the United States and the United Kingdom, proved unprepared for, and inept in responding to, the coronavirus. Nationalistic policies have complicated efforts to achieve equitable access to COVID-19 vaccines.

3. These problems are so comprehensive that probing the causes is important. The collapse of political herd immunity during COVID-19 has epidemiological, geopolitical, ideological, and legal sources. The international system encountered what experts most feared—a novel, dangerous respiratory virus transmissible among humans in a globalized world. However, the coronavirus emerged as balance-of-power politics returned to international relations. Ideological differences compounded geopolitical tensions and created divisiveness in domestic politics. In this turbulent context of power and ideas, international law proved vulnerable and inadequate to support robust pandemic cooperation.

II. A wicked pathogen

4. The coronavirus that causes COVID-19, SARS-CoV-2, transmits easily between humans primarily through airborne droplets and causes morbidity and mortality. People had no pre-existing immunity to the virus. This type of pathogen poses a serious threat, especially for persons living in densely populated cities and regions interconnected through air transportation. The lack of a vaccine or drugs requires health authorities to rely on early identification through surveillance and non-pharmaceutical interventions, such as testing, contact tracing, social distancing, quarantine, isolation, and clinical care.

5. These attributes of SARS-CoV-2 match the profile of pathogens that most concern health officials—new viruses efficiently spread through respiratory means that cause illness and death, especially in persons with compromised immune systems or underlying health problems. These types of germs spread at a speed and with a scope that threatens severe health, economic, social, and political consequences within countries. The danger increases the incentives for states to protect themselves by not being transparent about disease events in their territories, implementing trade or travel restrictions against countries suffering outbreaks, and taking steps to secure national needs for medical supplies, drugs, and vaccines. These incentives generate friction for mechanisms of cooperation, including international law, that emphasize information sharing, science-based decision-making, and equitable access to health resources.
III. The return of realpolitik

6. SARS-CoV-2’s emergence would have tested international cooperation in the best of times, but this coronavirus appeared in an international system experiencing the return of balance-of-power politics.\(^2\) After the Cold War, great-power competition did not characterize international relations for over two decades. During this period, geopolitics played no discernable role in global health. However, realpolitik re-emerged in the second decade of the twenty-first century, with the rivalry between the United States and China taking center stage.\(^3\) This rivalry has adversely affected the international politics of the COVID-19 pandemic.

7. The balance of power distorts how great powers perceive issues, including health. In the 1980s, for example, the United States and the Soviet Union analyzed the emergence of HIV/AIDS through their rivalry in Africa.\(^4\) The COVID-19 pandemic posed geopolitical challenges and opportunities for China and the United States. Both countries grasped the outbreak’s significance in their competition for power and influence. The United States argued that China violated the IHR (2005), was responsible for the damage that the coronavirus caused worldwide, and wielded such undue influence over WHO that the U.S. government threatened to leave the organization. China rejected the allegations, contrasted its control of COVID-19 with the American response, and moved to demonstrate global health leadership. The Sino-American tensions spilled into other contexts, including the Security Council, Group of 20, and Group of 7.

IV. Authoritarianism, liberalism, and nationalism

8. Cooperation also suffered because of ideological conflicts between nations and within countries that undermined effective strategies for pandemic control. U.S. criticisms of China’s handling of COVID-19 attacked the Communist Party, emphasized the authoritarian nature of the Chinese

\(^2\) Walter Russell Mead, The Return of Geopolitics: The Revenge of the Revisionist Powers, Foreign Affairs (May/June 2014), 69-79.

\(^3\) Elbridge A. Colby and A. Wess Mitchell, The Age of Great-Power Competition, Foreign Affairs (January/February 2020), 118-130.

\(^4\) Director of Central Intelligence, Sub-Saharan Africa: Implications of the AIDS Pandemic, Special National Intelligence Estimate 70/1-87 (2 June 1987); Douglas Selvage and Christopher Nehring, Operation Denver: KGB and Stasi Disinformation Regarding AIDS, Wilson Center, 22 July 2019.
government, and highlighted the nationalism stoked by China’s media and pandemic diplomacy. Advocates of liberal democracy expressed concerns that authoritarian governments and politicians around the world were exploiting the pandemic to increase their power at the expense of self-government and human rights. COVID-19 did not create the growing conflict between liberalism and authoritarianism, but the pandemic exacerbated the increasingly prominent ideological components of interstate relations.

9. The U.S. abandonment of global leadership during the pandemic owed much to hyper-partisan domestic politics. The Trump administration doubled down on its “America First” attitude by blaming China for the outbreak, deciding to withdraw from WHO, and not participating in efforts to achieve equitable vaccine access. President Trump continued to divide the American public by ignoring science, denigrating expertise, attacking opponents, and refusing to take responsibility for his administration’s response. Such divisiveness fueled disinformation that intensified the war of political ideas tearing at the nation’s fabric.

V. A reckoning for global health jurisprudence

10. The fraying of cooperation and the loss of political herd immunity contributed to problems that the international community encountered with international law during the pandemic. Controversies arose with the IHR (2005). The search for a vaccine exposed how states have not crafted an international legal framework for critical aspects of pandemic response—the sharing of pathogen samples and the need for equitable access to pharmaceutical interventions. The pandemic also created concerns for international human rights law.

11. WHO member states built the IHR (2005) to require countries to prepare for and respond to disease events in ways informed by science, public health strategies, and WHO guidance.Earlier outbreaks, such as the West African Ebola epidemic in 2014, revealed problems with the regulations. However, the COVID-19 pandemic has delivered the most serious blow to the IHR (2005) to date by generating disputes about fundamental aspects of the regulations.

5 Lawrence O. Gostin and Rebecca Katz, The International Health Regulations: The Governing Framework for Global Health Security, 54(2) Milbank Q (2016), 264-313.
12. Controversies flared over China’s compliance with the IHR (2005)’s provisions on disease-event notification and information sharing. The WHO director-general was accused of appeasing China by failing to exercise authorities that the IHR (2005) provides the director-general. These accusations focused on the director-general’s delayed declaration of a public health emergency of international concern (PHEIC), failure to challenge China over the transparency of its information sharing, and unqualified praise for the Chinese government.

13. As the IHR (2005) requires after a PHEIC declaration, the director-general issued temporary recommendations, including a recommendation against implementing travel restrictions. This recommendation produced acrimony. Over 100 countries ignored WHO and imposed travel measures against China and other nations, generating controversy about the IHR (2005)’s rules on additional health measures. Then, WHO changed its advice, indicating that early application of travel measures could provide public health benefits. This shift opened WHO for more criticism because it suggested that WHO exercised its authority to issue temporary recommendations in a way that was wrong at a critical moment in the COVID-19 outbreak. The relentless global spread of the coronavirus despite all the travel restrictions exacerbated this controversy over the IHR (2005)’s provisions on travel measures.

14. Past disease events have revealed widespread non-compliance by low-income countries with the IHR (2005)’s obligations on developing basic public health capacities. The impact of the coronavirus in high-income and high-capability countries revealed a shocking lack of preparedness in countries never questioned under the IHR (2005)’s core-capacity requirements and ranked highly on pandemic readiness. The spread of COVID-19 into low-income countries exposed, again, the lack of the public health capacities required by the IHR (2005). The pandemic left the IHR (2005)’s approach to public health capacities in shambles.

15. Although the IHR (2005) is the main international agreement on infectious diseases, the regulations do not govern every challenge that disease events create. The IHR (2005) does not address the sharing of pathogen samples, even though such sharing is important for surveillance and development of pharmaceutical countermeasures. The regulations do not have provisions on equitable access to drugs and vaccines despite the attention given to this

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6 Nuclear Threat Initiative, Global Health Security Index 2019: Building Collection Action and Accountability (2019).
objective. Nor have states developed international law that facilitates sample sharing and equitable access to pharmaceutical interventions. The closest states have come is a non-binding framework that aligns the sharing of pandemic strains of influenza with access to vaccines and other benefits.\textsuperscript{7}

16. The COVID-19 pandemic has again exposed the lack of international law on sample sharing and equitable access. The United States complained that China failed to share samples of SARS-CoV-2 for surveillance and countermeasure development. The global spread of the coronavirus and the availability of genetic sequencing data have prevented sample sharing from becoming a crisis, but the pandemic has underscored the lack of any legal obligation on states to share pathogen samples in response to a global health emergency.

17. Similarly, the quest for equitable access to COVID-19 diagnostics, drugs, and vaccines has proceeded without an international legal framework. Global collaboration on research and development, production, and equitable distribution is underway.\textsuperscript{8} However, the need to establish \textit{ad hoc} initiatives during one of the worst pandemics in a century illuminates the continued failure by states to address a glaring need in global health governance.

18. The pandemic has also highlighted challenges for international human rights law. Government responses have raised concerns about civil and political rights, including how quarantine and social-distancing mandates curtail freedom of movement and how digital technologies, such as smartphone apps for surveillance and contact-tracing, threaten privacy.\textsuperscript{9} The pandemic’s disproportionate impact on vulnerable and marginalized populations triggers worries about respect for economic, social, and cultural rights. COVID-19 also creates questions for the global movement for universal health coverage linked to the right to health because the pandemic hit many countries with universal health systems very hard.

19. The manner in which the pandemic exposed controversies and gaps in international law suggests that global health governance lacks an effective

\textsuperscript{7} Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits (2011).

\textsuperscript{8} Access to COVID-19 Tools (ACT) Accelerator—A Global Collaboration to Accelerate the Development, Production and Equitable Access to New COVID-19 Diagnostics, Therapeutics and Vaccines, 24 April 2020 (https://www.who.int/publications/m/item/access-to-covid-19-tools-(act)-accelerator).

\textsuperscript{9} Human Rights Watch, COVID-19: A Human Rights Checklist, 24 April 2020 (https://www.hrw.org/news/2020/04/14/covid-19-human-rights-checklist).
system of law. Over a decade ago, I argued that increased attention on law in public health was producing a jurisprudence for global health characterized by a coherent body of law supported by shared national interests and normative values. The fate of this jurisprudence would depend on “whether the political conditions in which the body of public health law and its supporting philosophy must operate are conducive to governance progress in the protection of population health.” Transformations concerning power and ideas would mean that “the convergence of interests and values cannot hold, and the divergence of interests returns with a vengeance.” In a world distorted by geopolitics and riven with ideological hostility, common interests and values are evaporating, leaving international law bereft of the political conditions needed for international cooperation to protect population health against dangerous pathogens.

VI. Conclusion

20. COVID-19 rages on, and the evaluation of the human carnage, economic calamity, legal wreckage, and political disaster has barely begun. Nevertheless, the painstaking work of re-building political herd immunity through international cooperation and international law must begin again. Proposals for improving pandemic preparedness, revising the IHR (2005), and reforming WHO will pour forth. However, such proposals will founder unless the United States and China forge détente on global health and support cooperation focused on what the pandemic makes painfully clear—in global health, certain truths remain self-evident.

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10 David P. Fidler, Global Health Jurisprudence: A Time of Reckoning, 96 Georgetown LJ (2008), 393-412.