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The constitutional economics of the World Health Organization

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Abstract

This paper brings a constitutional economics perspective to bear on the World Health Organization (WHO), the flagship United Nations intergovernmental health organisation, which is obligated by its Constitution to achieve 'the highest possible level of health' for the world's peoples. The WHO has in the seven decades of its existence used its formidable legislative powers only sparingly. It has been widely chided for being weak in regional coordination and unresponsive to transnational emergencies like the West African Ebola outbreak of 2014–2016. In 2020, it found itself at the centre of the COVID-19 pandemic and in the middle of the Sino-American geopolitical tug-of-war. This paper traces the discordance between the Constitution's stated purposes and the actual track record of the WHO not back to its organisational culture nor to weak leadership but to the design of the Constitution itself. It analytically distinguishes the Constitution's expressive from its instrumental halves, and shows that, whilst the former embodies a 'constitutional moment' of international health solidarity right after the Second World War, the latter embodies a reserved and limited delegation from member-states that are jealous of their sovereignty.

Key words: Constitutional economics; COVID-19; global health law; World Health Organization

1. Introduction

The World Health Organization (WHO) is the world's largest intergovernmental public health body, vested with wide-ranging constitutional authority to address global health problems (Taylor, 2002). It is also the United Nation's first specialised agency and remains one of its largest (Youde, 2018). At its signing by 61 states in 1946, the Constitution of the WHO was hailed by the United States Surgeon General to be 'a Magna Carta for world health', 'a great ideological victory' and 'an international declaration of the rights of man to health' (Parran and Boudreau, 1946: 1267). In bold terms, the Constitution erected the WHO as the 'premier global health leader' (Gostin, 2014: 104), and 'a normative institution with extraordinary powers' (Gostin *et al.*, 2015: 855), destined to fulfil a threefold purpose as normative leader, agreement facilitator and information disseminator (Youde, 2018). No other health organisation enjoys the WHO's international stature as the chosen vehicle for attaining 'the highest possible level of health', in the words of its Constitution. The WHO Constitution is undoubtedly an 'extraordinary and visionary' document in its long list of aspirations and principles (Kickbusch and Reddy, 2015: 838).

In stark contrast to the ideal portrait painted by its Constitution, the WHO's actual record in advancing global public health is at best mixed. On the one hand, it achieved a 'most dramatic success' in the eradication of smallpox (Gostin, 2014), and was instrumental in the adoption of the Framework Convention on Tobacco Control (FCTC) 2003, the first international treaty on the subject, and the 2005 revision and implementation of International Health Regulations

[IHR (2005)] following the severe acute respiratory syndrome (SARS) epidemic (Ruger, 2018). On the other hand, the operation of the WHO at the national level has often been weak (van de Pas and van Schaik, 2014), something explicable by the lack of 'a master global health plan and reliable compliance mechanisms' (Ruger, 2018: 247). The WHO's alarming weakness recur again and again in dealing with transnational health emergencies (Wibulpolprasert and Chowdhury, 2016). In 2014, it proved 'disastrously unprepared' for the Ebola pandemic (Ruger, 2018: 252), which claimed the lives of over 11,000 people and inflicted an economic loss of no less than $2.8 billion on West African countries (Wibulpolprasert and Chowdhury, 2016). Two years later its institutional competence was deeply challenged by the mosquito-borne Zika virus, which notoriously correlated with severe birth defects (Ruger, 2018). During the worldwide outbreak of the coronavirus disease 2019 (COVID-19) in 2020, the WHO found itself caught up in the middle of the political-economic tug-of-war between the United States and China (Jensen, 2020).

Despite being vested by its Constitution with sweeping legislative powers, the Organization has since its birth in 1948, 'produced significantly fewer norms than other [international] institutions' (Casini, 2016: 33). The World Health Assembly (WHA), its 'legislative body' (Garrett, 1995: 40), has issued a mere three treaties throughout its seven-decade history (Gostin *et al*., 2015). The Organization has been 'timid' in promoting health standards and of quality control of crisis responses (Francesco *et al*., 2016), making 'only marginal use' of its legislative competences provided by Chapter V of the Constitution (Toebes, 2018: 10). The WHO's inactivism results in a contemporary international health law that is 'remarkably thin' (Gostin, 2014: 110). Its steady decline since as early as the 1970s and 1980s has been accompanied by the emergence of new organisations that have made for an increasingly crowded transnational health architecture (Youde, 2012). The refusal of the WHO to take up the mantle of human rights champion, for instance, has opened up numberless opportunities for other actors to take up the challenge (Clinton and Sridhar, 2017).

This paper systematically examines the WHO Constitution from the perspective of constitutional economics, asking why the wide-ranging authority it created for the WHO has been used so scantly. It finds the Organization's legislative under-performance, among other problems, to be rooted in and fundamentally explicable by the design of its Constitution, the prestige of that document in the minds of many notwithstanding. The main problem of the WHO is not only that the political potential of its Constitution remains untapped (Kickbusch and Reddy, 2015). New light from the standpoint of constitutional economics is shed on the correlation between the Constitution, despite its ambitious language, and the real limits WHO faces. This brings an explanatory perspective to bear on understanding 'the choice of constitutional rules' (Buchanan, 1990: 2; Voigt, 2011: 246; Hamlin, 2013: 73). Constitutional economics distinguishes a constitution's design from sub-constitutional actions arising under it (Buchanan, 1991: 5). Constitutional economists theorise constitutional constraints as devices to overcome the transaction costs of collective action that might otherwise prevent the achievement of efficient exchanges. This implies that if no value can be extracted from cooperation, a constitution has no reason to exist (Trachtman, 2008; Ginsburg, 2017).

This paper is structured as follows. Section 2 shows that the Constitution of the WHO, like other constitutions, both international and national, has an 'expressive' and an 'instrumental' aspect (Brennan and Hamlin, 2002). Most constitutions embody the political agreements of their framers and their framers' constituencies, along with provisions implementing them (Elsig, 2009). Aspirational content is often written into a constitution for its own sake and to express the political sentiments of the original signatories. That a constitution offers mechanisms to effectively promote credible compliance with such aspirations cannot be assumed. This section, then, examines the paradoxical mismatch of deeply ambitious principles, internationally agreed-to as the purposes of the WHO Constitution, with weak mechanisms enforcing these goals under the same Constitution. Section 3 explores how the discordance between the

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WHO's official purposes and its constitutional competencies has played out since its inception. It identifies five major constitutional constraints that have effectively barred the Organization from asserting its legislative authority to produce a corpus of 'hard' international treaty law on public health (Gostin *et al*., 2015). Section 4 concludes with a discussion and summary of these findings.

2. Constitutional design

Constitutions, usually codified in constitutional documents, are primary institutions for organising political systems and have been core matter for comparative politics scholars since at least the time of Aristotle (Ginsburg, 2015). By contrast with national constitutions, those of international organisations, like the Charter of the United Nations and the Constitution of the World Health Organization, are much more recent and have emerged mostly in the 20th century, with the rise of multilateralism after the Second World War (Harrington, 2018). These documents are 'strange creatures', which are 'often said to occupy a special place in international law' (Klabbers, 2015: 70). On the one hand, they are ordinary international treaties made by nation-states which do not differ in principle from other treaties; on the other hand, they constitute the principles, powers and structures of international organisations and, as such, enjoy special treatment as being *sui generis* (Klabbers, 2015). Like their national counterparts, however, international constitutions establish institutions and mechanisms of governing, and distribute them to legislative, executive, sometimes even judicial authorities (Ginsburg, 2013; Trachtman, 2013).

Constitutional economics studies constitutions as devices that facilitate human cooperative interaction to achieve gains from political and other forms of transactions (Trachtman, 2009). National constitutions often spring from a convergent agreement by factions embroiled in a mixed game of conflict and cooperation, although each party may have an incentive to cooperate with each other to converge on an agreement, collectively they differ over how to distribute costs and benefits (Ginsburg, 2017). This insight of constitutional economics applies to global governance as well. States may have to undergo costly adjustments to meet unpredictable contingencies, or try to extract rents from other states by opportunistic practices (Aceves, 1996). Analogous to private persons assuming contractual obligations, states are involved in negotiating and implementing international treaties, including international organisational constitutions, which may take years of negotiations to conclude. Real-world negotiators do not enjoy the luxury of unlimited time and resources (Ginsburg, 2017). A standard solution to this scarcity and to other transaction costs of bargaining is to draft vaguely worded agreements that allow flexible adaptation over time as new information comes to light (Ginsburg, 2013). This state of affairs gives rise to the problem of incomplete contracting (Cooley and Spruyt, 2009): even if an international agreement can be concluded, member-states may have to face further transaction costs such as non-enforcement of the agreement (Dijkstra, 2013). States may resort to designing international organisations to solve coordination problems (Trachtman, 2017). These can reduce transaction costs by compiling information, utilising specialist expertise, setting binding norms, pooling resources, facilitating interstate collaboration, sometimes even monitoring state acts and settling interstate disputes (Tamanaha, 2017). An international organisation's existence is justified insofar as the value of cooperation is greater than the costs of its being thus organised (Trachtman, 2014). States resort to international organisations to further their own interests, and design the constitutions of these organisations accordingly (Koremenos *et al*., 2001).

The constitutions of international organisations can be impaired by a discordancy between the 'expressive' and the 'instrumental', between ends and means; this is most visible when momentous end-goals expressed as constituent principles of a community are disproportioned with weak enforcement mechanisms incompetent to actualise them (Brennan and Hamlin, 2000: 146). Constitutional economists have noted a phenomenon of 'expressive constitutionalism', analogous to the phenomenon of expressive voting in which voters, fully understanding that their votes cannot change electoral outcomes, may be motivated by concerns other than the outcome, such as

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expressing support for a political cause for its own sake (Hamlin and Jennings, 2011). Constitution-making is a rare event occurring 'under very special circumstances' (Voigt, 2011: 207). At 'constitutional moments' (Ackerman, 1993), expressive concerns for foundational values and principles like democracy and justice may be raised on par with more instrumental and consequentialist concerns (Brennan and Hamlin, 2002). The concept of constitutional moments has been modified to cover a significant moment in time that merits the memorialisation of constitutional principles respecting a certain issue (Giannini, 2018: 213). A constitutional moment may arise in the international arena as a consequence of an exogenous shock resulting in a shift in concerns or perceptions that disturbs the status quo (Trachtman, 2009). States can come together to express their sentiments in a high-political document under certain circumstances, as at the landmark adoption of the Universal Declaration of Human Rights in 1948, when 'so many delegations from so many different nations and cultural traditions' could converge on 'a universal moral code' with the horrors and destructions of the Second World War as the catalyst (Morsink, 1999: 36). There is a real risk that constitutions come to have 'more to do with their ability to raise a cheer than their ability to serve [consequential] interests' (Brennan and Hamlin, 2006: 341).

WHO's constitutional inaugural was on 22 July 1946, when representatives of 61 states, of which 51 were members of the newly established United Nations, signed the Constitution of the World Health Organization in New York at the concluding session of the International Health Conference (Calderone, 1947). Participants of this solidary Conference, assembled within a year of the end of the Second World War, apparently got along so well with each other that virtually no disagreement on the essentials occurred (Parran and Boudreau, 1946). That the Organization was established with international consent only in 1946 but not earlier was telling.. Serious attempts to establish an international health organisation had been made since the late 19th and early 20th century with the creation of the International Sanitary Bureau (later renamed the Pan-American Sanitary Bureau) in Washington, DC in 1902; the *Office international d'Hygiène publique* (OIHP) in Paris in 1907; and the League of Nations Health Organization (LNHO) in Geneva in 1920, all of which operated independent of each other (Birn *et al.*, 2018). The WHO's moment came precisely when there was a significant shift and realignment of state preferences and perceptions of pressures and interests concerning human rights and public health (Krajewska, 2015: 783; Trachtman, 2008). With so many parts of the world in ruins, socio-economic infrastructure destroyed, tens of millions of people killed in the War, and many more lacking basic housing, food and medicine, the delegates of the International Health Conference felt a strong urge to embody the global sentiment that public health should be given extraordinarily high priority in the nascent UN system (Lee, 2009). The delegates agreed that the LNHO and OIHP should be dissolved, their functions and personnel transferred to the new WHO, and the Pan American Sanitary Bureau incorporated into the WHO as one of its regional organisations (Youde, 2018). In less than a year, on 7 April 1948, the Constitution had earned the 26 ratifications needed for the document to enter into force.

The WHO Constitution was in some sense 'more ambitious than the UN Charter in terms of its goals' (Alvarez, 2017: 194). The Constitution's 'expressive' Preamble confidently redefines the concept of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', which is 'one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. It proceeds to declare, 'The health of all peoples' is 'fundamental to the attainment of peace and security', and is 'dependent upon the fullest co-operation of individuals'; and so to condemn '[u]nequal development in different countries in the promotion of health and control of disease, especially communicable disease' to be 'a common danger'. It moreover avers, 'Healthy development of the child' is of 'basic importance'; and the dissemination of 'medical, psychological and related knowledge' is 'essential to the fullest attainment of health'. It goes on to encourage 'the public' to offer '[i]nformed opinion and active co-operation' to 'the improvement of the health of the

people'; and obligates governments to provide 'adequate health and social measures' for the sake of 'the health of their peoples'.

As noted above, constitutional designers and their constituents may perceive the Constitution they are framing not principally as a manual for governing operations, but as a defining statement of the fundamental political beliefs of the time (Hamlin, 2011). The rump of the WHO's Constitution, that is, the 'instrumental' provisions, seen through the lens of constitutional economics, shows that the states parties were not prepared to delegate to the Organization formal enforcement mechanisms adequate for realising the lofty ideals codified in the Preamble. Indeed, as with the whole UN system, the states acting as principals resisted empowering any agent international organisation so that it might compromise the sovereignty of core states or displace the centrality of the state system in international affairs (Barkin, 2013). In short, the WHO was set up to operate within the parameters of 'Westphalianism' (Aginam, 2014: 559), under which sovereign nation-states remain 'the most important participants' in decision-making internationally (Chen, 2015: 25). The WHO does have a constitutional mandate to manage international cooperation: 'to act as the directing and co-ordinating authority on international health work' [article 1(a)]; as well as 'to establish and maintain effective collaboration with the United Nations' [article 1(b)].

The most ground-breaking constitutional function of the WHO is a wide-ranging legislative initiative competence 'to propose conventions, agreements and regulations, and make recommendations with respect to international health matters' [article 1(k)]. The actual power of institutions within the WHO to perform these functions, however, is sharply curtailed by the applicable provisions of the same Constitution, which establish a WHA *inter alia* to decide on the policies of the Organization [article 18(a)], as the collective principal of the Organization, in which each member-state is to have one vote (article 59), to make sure that as a formal matter, no state, regardless of its military or economic might, can dominate the Organization's agenda at the expense of the small and the developing countries (van der Rijt and Pang, 2015). The Assembly has no authority to adopt conventions or agreements without the consent of a two-thirds majority (article 19). Distinct from a simple majority, this super-majoritarian rule imposes considerable transaction costs on the WHO's legislative process. Any member-state that does not vote in favour of a WHO convention or agreement will not be bound by it under established principles of international law. The Constitution does provide for 'regulations' to be adopted by simple majority vote in the Assembly (article 21), and that such regulations bind all member-states by default unless they opt-out or make reservations within a period of expiry (article 2). Regulations are confined to the tightly defined domains of infectious diseases [article 21(a)]; medical nomenclature [article 21(b)]; diagnostic procedural standards [article 21(c)] and those covering 'the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce' [article 21(d)] and their 'advertising and labelling' [article 21(e)].

The framers of the Constitution entrenched a policy-maker/technocrat dichotomy in the Organization, by way of which the WHA serves as a collective political principal whereas the Executive Board and Secretariat serve as the administrative agents, staffed by apolitical technical experts holding no power or right in making political decisions (Kickbusch and Reddy, 2015). The Constitution designates the Executive Board as the 'executive organ of the Health Assembly' [article 28(b)], in charge of advising it [article 28(d)–(e)] and planning its session agendas. The WHA is enabled to delegate others of its own powers to the Board (article 29). It originally comprised 18 members, each of them 'technically qualified in the field of health', to be elected by the Health Assembly according to the principle of 'equitable geographical distribution' (article 24). Another technical corps, the Secretariat, is to consist of the Director-General and other administrative and technical staff (article 30). The Director-General, appointed by the WHA upon the Executive Board's nomination, was constitutionally defined to be merely 'the chief technical and administrative officer of the Organization' (article 31); not to exercise political leadership like the prime ministers of nation-states, but rather to serve as the '*ex officio* Secretary

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of the Health Assembly, of the Board, of all commissions and committees of the Organization and of conferences convened by it' (article 32). The Secretariat is enjoined to be impartial (article 37). The Constitution makes of each regional organisation 'an integral part of the Organization' (article 45), but paradoxically allows each of these to adopt its own rules of procedure (article 49), to formulate regional health policies and to supervise the regional office [article 50(b)], and effectively to veto the Executive Board's choice of Regional Director and staff (article 53).

The constitutions of international organisations, like other international agreements, may centralise mechanisms to enforce state obligations or stabilise the expectations of states about each other's behaviour, or both (Keohane, 1984). International organisations possess no inherent and general military power, the traditional *sine qua non* of international relations (Barkin, 2013). Outside of this, the most powerful formal mechanism that has ever existed is a judicial proceeding by which individuals can obtain substantial material redress against non-compliant states. Examples include the Court of Justice of the European Union in Luxembourg and the European Court of Human Rights in Strasbourg. A least powerful variant would be one that rewards cooperation or punishment on the tacit or explicit majoritarian consent of participating member-states. A conspicuous example is the three-tiered Dispute Settlement Body of the World Trade Organization (WTO), which has power to authorise complainant states to retaliate proportionately in the form of trade preferences contra a non-compliant state (Stephan, 2016). States that reckon the costs of enforcement by an international organisation greater than its benefits will prefer informal enforcement or avoid being bound in the first place. The WHO Constitution provides for no formal enforcement mechanism at all. Failure of a member-state 'to meet its financial obligations' to the WHO may, or may not, result in the mere suspension of that state's voting privileges and services by a high transaction costs body none other than the WHA (article 7) – a threat that is hardly credible. Neither the Constitution nor IHR (2005) confer on the Organization any enforcement powers to sanction state violations of international health law (Fidler, 1998). No world health tribunal exercising judicial power was ever established by the Constitution. Any question or dispute over the interpretation or application of the Constitution which is not settled by negotiation or by the WHA is to be referred to the International Court of Justice, unless the affected parties agree another mode of settlement (article 75). Consequently, there is no WHO legal system corresponding to the WTO legal system (Palmeter and Mavrodis, 1998), nor any WTO-style 'judicialized, rule-oriented approach to dispute resolution' (Matsushita *et al.*, 2015: 86), nor scholarship on 'WHO law' comparable to the sophisticated literature on WTO law.

It is safe to predict that the WHO as presently constituted will never manage to attain the manifold expressive ideals of its Preamble. First, the super-majoritarian rule governing WHA treaty making will inevitably trigger skyrocketing political transaction costs that will practically preclude this power from ever being invoked in the first place. Second, defining the domain of International Health Regulations narrowly circumscribes the Organization's ability to react to the mutating circumstances of global public health. Third, states parties' refusal to delegate formal enforcement powers to the Executive Board and the Secretariat means that states can violate WHO regulations with impunity; at most they would only be constrained by informal compliance mechanisms generally operative in international law, such as retaliation, reputation and reciprocity (Guzman, 2006). Fourth, to designate the Director-General a technical and administrative officer is to prevent the incumbent to function authoritatively as a coordinator in international health efforts. Fifth, the decentralisation of WHO regional organisations imposes prohibitive agency costs on the Executive Board and Secretariat in administering the Organization locally. As the next section demonstrates, these conclusions are broadly consistent with the WHO's developmental trajectory over its life, to such an extent that the Organization has been criticised as not 'fit for purpose' any more (Kickbusch and Reddy, 2015: 2839).

3. The Constitution-in-action

Constitutionally mandated transaction costs critically constrain the WHO's ability to legislate responsively. States very often disagree on everything from disease origins and travel advisories, to trade bans and border closings, to vaccine provision and the proper treatment of foreign nationals (Hoffman, 2015). One of the rationales for instituting an international organisation such as the Organization is to reduce transaction costs like bargaining costs, and information and coordination costs, to raise the efficiency of inter-state cooperation (Dijkstra, 2013). The world may look to the WHO as its coordinating health agency, but its Constitution imposes a two-thirds majority approval on many of its relations with other international actors (articles 69, 70 and 72). The Organization is paralysed by the unanimity required of any valid treaty of international applicability (Posner and Sykes, 2013). And as a member-driven multilateral organisation, the Organization is sensitive to the transition of global governance towards polycentrism (van de Pas and van Schaik, 2014). The rise of autonomous regions within nation-states and the proliferation of non-state actors have thwarted WHO's attempts to be an active, monopolising, international health legislator (Ruger, 2018). Non-state actors such as wealthy private foundations like the Bill & Melinda Gates Foundation (BMGF) and public–private partnerships such as Gavi, the Vaccine Alliance have gained immense influence over global public health in recent decades (Yeoh, 2015: 799). The BMGF, in particular, has funded virtually every major global health actor in ways that more or less bypassed the WHO and other public decisional processes (Birn *et al*., 2018: 183). Internal gridlock trammels the possibilities of ambitious external action. A perceived disconnect subsists between the priorities of the health ministries that govern the WHO through its Executive Board and the WHA, on the one hand, and on the other, those of the Ministries of Foreign Affairs and Departments of Development Assistance that give out the financing for global health through overseas development assistance (Lidén, 2014). The ambiguities of Chapter XII of the Constitution about the WHO's budget and expenses, as well as the difficulty in enforcing members' financial obligations according to that document are in all likelihood associated with the persistent underfunding and financial stress incurred by the Organization since the 1980s (see Reddy *et al*., 2018).

Against this institutional backdrop, it should surprise no one that the WHO rarely asserts its constitutional legislative authority by negotiating binding international health treaties (Gostin, 2014); so much so that the Executive Board and WHA have become 'dysfunctional' because of the agenda overload and the difficulty of achieving consensus (Kickbusch and Reddy, 2015: 2839). They have not even been a leader, let alone *the* leader, in the burgeoning health and human rights movement, leaving that to civil society and the UN Special Rapporteur on the Right to Health (Gostin *et al*., 2015). The WHA has adopted just three treaties in its history, two of which predate the WHO: the Nomenclature Regulations and the International Health Regulations (Gostin, 2014). In a similar vein, the WHO has rarely exercised its law-making powers to address such important problems as alcohol overconsumption and antimicrobial resistance (Clinton and Sridhar, 2017). It was woefully unprepared for events like the dramatic epidemic of tuberculosis in the former Soviet states that was rooted in larger political and economic developments (Lidén, 2014).

The legislative power of the WHA had never been meaningfully activated until the FCTC of 2003 (Cockerham, 2018). The FCTC is well known for how little time it took for member-states to converge on an ambitious text that was supposed to be implemented in dozens of countries around the world (Wipfli, 2015). As of 2015, as many as 70% of member-states have implemented its binding provisions (Wipfli, 2015: 181). Nonetheless, the success of the FCTC must not be overstated: it contains considerable ambiguities; provides no resources to developing countries to enforce its policies; and is inhibited by a militant tobacco industry, WTO cases against tobacco control measures in Australia and Uruguay (Gostin and Sridhar, 2014), and a United States-led campaign against the WHO for overstepping its mandate (Sekalala, 2017). The FCTC established

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no World Tobacco Organization, nor an international tobacco tribunal to arbitrate disputes arising from itself (Alvarez, 2017).

The FCTC is the outlier in the WHO's legislative history. There is, for instance, no comparable Framework Convention on Global Health or Framework Convention on Alcohol Regulation adopted in the same time frame (Wibulpolprasert and Chowdhury, 2016). Constitutionally originated transaction costs dampen the WHO's treaty-making initiative to such an extent that the WHO has been 'reticent to venture into norm-development', and 'rarely invokes the right to health' spoken of so highly in its Constitution (Clinton and Sridhar, 2017: 181). Even when it acts normatively, it has chosen soft law, in the form of guidelines, codes or recommendations, such as the International Code of Marketing of Breast-Milk Substitutes of 1981, and the Global Strategy for the Prevention and Control of HIV/AIDS of 1987, the Global Strategy on Diet and Physical Activity of 2004, and the Global Code of Practice on the International Recruitment of Health Personnel of 2010, rather than hard, binding international treaty law (Toebes, 2018). But even in relation to soft law, the WHO has rarely invoked its power under Article 23 of the Constitution to make recommendations, nor enforced its Article 62 power to require reporting (Gostin *et al*., 2015). And WHO is not the only originator of soft health law; other intergovernmental organisations (IGOs) that issue similar norms include the World Bank, the Global Fund, bilateral development agencies, private foundations and international health partnership programmes (Wibulpolprasert and Chowdhury, 2016).

The restraints on the scope of International Health Regulations (articles 21 and 22) trammel the Organization's responsiveness to new transnational health situations. In 1951, the WHA invoked its regulatory authority to substitute the International Sanitary Regulations for the International Sanitary Convention, and cover six 'quarantinable diseases' including smallpox. By 1981, these had been reduced to three only, namely, yellow fever, plague and cholera (Dover, 2014). Revision of the Regulations really gained momentum with the global outbreak of SARS in between 2002 and 2003, and the spread of both human (H3N2) and avian (H5N1) influenza barely a year later. If ever there was a situation that warranted immediate WHO action going beyond its treaty mandates and adopting recommendations for private companies and individuals, it was SARS (Casini, 2016), that 'distilled all of the fears about the weakness of the existing [International Health Regulations] into one single outbreak' (Youde, 2018: 66). These Regulations – IHR (2005) – formally vest in the WHO power to issue recommendations and alerts; which is seen as 'a very significant political step' for the Organization (Mack, 2006: 376). These powers imply no formal enforcement mechanism against non-compliance yet give teeth to the WHO as informal compliance levers, as witness how WHO-issued recommendations and travel advisories during the SARS epidemic devastated national economies and nudged 'wayward' states back into compliance with WHO demands (Mack, 2006), lest ignoring them detrimentally impacts a state's reputation and international standing indirectly, as a consequence of disease outbreaks, polio, cholera and plague (Davies *et al*., 2015). The new disease surveillance and reporting requirements of IHR (2005) were accompanied by no financial assistance to set them and keep them up; the upshot being that many states still lacked capacities to implement a broad, internationally liaised public health system (Youde, 2018). On six occasions since 2005, the WHO has declared a Public Health Emergency of International Concern (PHEIC), most recently on 30 January 2020, in response to the spread of COVID-19 from Wuhan, China. It received harsh criticism for its handling of the 2014–2016 Ebola epidemic in West Africa, which exposed the international community's unpreparedness for global health emergencies. Ebola took away more than 11,000 human lives, engendered an economic loss of more than $2.8 billion for West African countries, and most importantly for our purposes, revealed flaws in the IHR (2005), and in the WHO at a general level: the PHEIC declaration was not responsive enough, the domestic public health capacity was 'grossly inadequate', and the WHO 'suffered from a lack of clear leadership' (Gostin *et al*., 2015: 857).

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States' refusal to delegate formal enforcement powers to the Executive Board and the Secretariat has enabled them to violate WHO rules with impunity. The powers of the WHO to exercise jurisdiction in pursuit of its constitutional objectives are derived from the delegation and consent of its 194 members. This explains why neither the IHR (2005) nor the FCTC came with credible enforcement mechanisms (van de Pas and van Schaik, 2014). Global public health, the holy grail of all international health efforts, is a global public good (Cockerham and Cockerham, 2010), that is, one person consuming global public health does not diminish how much of it is left for others, and others are not deprived of it by the people currently consuming it (Moon *et al.*, 2017). Conversely, pandemics are a global public bad or evil: their harm is non-rival and, subject to costly quarantine measures, non-excludable (Trachtman, 2013). Notice that suppression of public evils is itself a public good, and all public goods are prone to be underprovided due to the free-rider problem. The provision of global public health thus exhibits the characteristics of a multilateral prisoners' dilemma in which all states in principle agree that some international cooperation is needed for the eradication of a global public evil, say, COVID-19, yet quarrel over how to go about that cooperation, notwithstanding their universal common interest in preventing pandemics (Guzman, 2008). Because so many states are involved, each has an incentive to shirk responsibility and just free-ride on the effort of others. National governments that are already free-riding are even likely to reckon on the benefits of free-riding when it comes to weighing up the costs and benefits of secrecy vs full disclosure, as seen in China's original approach towards the 2003 SARS outbreak (Davies, 2017), and the authorities' silencing of eight doctor-whistle-blowers during the initial phases of the COVID-19 outbreak 16 years later. Similarly, a small minority of states ignored WHO's bans on pork, importing live pigs, slaughtering livestock, international flights or quarantining persons from countries that reported cases of H1N1 influenza (Davies *et al.*, 2015). One reason states prefer to postpone till the last minute reporting an outbreak is to avoid as long as possible the loss of tourism and trade that a timelier report would cause (Trachtman, 2017). The consequence is a general failure to coordinate prudently, plunging all into a pessimal equilibrium (Eggleston *et al.*, 2010). Investment in global health by rational, self-interested utility-maximisers is bound to be small, given the lack of an effective framework of multilateral cooperation. Global public goods problems are best approached through a collective action lens, which shows classic diplomatic reciprocity to be less effective as an enforcement device (Guzman, 2008). It is, for instance, in all states' interest to be coordinated by a powerful global leader who can oversee health security, construct health systems and combat health inequalities. This will hardly materialise, however, if members are unwilling to fund it, vest adequate authority and discretion in it, and let it become an accountability holder (Gostin *et al.*, 2015).

In a multilateral prisoner's dilemma, defection is the dominant yet most inefficient strategy. The role of international law and international organisations is to modify these coordination payoffs until cooperation between the 'prisoners' becomes their dominant strategy. Ceding to an international organisation an enforcement mandate addresses the very second-order collective action problem that undermines enforcement (Trachtman, 2017). Such a mandate spares the costs of inefficient strategic behaviour by supplying and certifying information, filling in incomplete contracts; it changes the structure of retaliations and of payoffs from defection. A dispute settlement process can ameliorate information problems. But the WHO has no mechanism to compel states to divulge outbreaks at the optimal stage for issuing a general alert (Posner and Sykes, 2013), and having no enforcement authority from its member-state principals, it has been 'timid' as to promulgating health standards and keeping quality control of crisis responses (Francesco *et al.*, 2016: 3). By February 2020, over 60 countries including the United States had defied, in whole or in part, recommendations from Director-General Tedros Adhanom Ghebreyesus, elected in 2017 with Chinese support, that travel bans on China are unnecessary for combating COVID-19, in allusion to the IHR's (2005) discouragement of interferences with international traffic and trade. There is nothing in the WHO that is remotely comparable

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to the curia of supranational organisations which can use coercion on otherwise sovereign member-states to overcome prisoner's dilemmas, such as with the European Union institutions like the Commission and Court of Justice (Laursen, 1995; Scharpf, 2003). Without a 'World Health Tribunal' as a credible compliance mechanism, the WHO is frequently underestimated and ignored, if not dismissed by other international health actors. And new global health projects are emerging as alternatives to the WHO. But amending the WHO Constitution to entrench rigorous enforcement powers is highly unlikely; member-states harbour deep scepticism about assertive and coercive WHO management (Ruger, 2018).

The WHO in its early years was indeed dedicated to offering technical assistance to eradicate diseases in accord with the sanitary and quarantine rules agreed by member-states (Sekalala, 2017). Gradually, with the support of newly independent states from the developing world, the WHO began to coordinate international health efforts through resolutions to eradicate yaws, smallpox and malaria and by launching mass vaccination campaigns. Despite being the only institution with authority to develop and implement international health standards, the Organization's reputation has diminished (Ruger, 2018), in part because of the tight control that individual member-states exert over the Director-General and the Secretariat in overall planning and budgetary matters (Gostin *et al*., 2015). The same states in the teeth of their reiterated expressions of commitment to reform have blocked changes to the Organization's regional structure (Kickbusch and Reddy, 2015). Former Norwegian Prime Minister Gro Harlem Brundtland, who served as Director-General from 1998 to 2003, succeeded in restoring the WHO's primacy in setting world health priorities, especially in relation to tobacco control issues, but made little progress with the consistency of the WHO's work across nations, nor with overcoming active or passive resistance from directors of the regional organisations (Lidén, 2014). The Secretariat has been 'cautious and reluctant' to act independently on major global health policies, with the possible exception of the SARS epidemic (Cockerham, 2018). The explicit constitutional designation of the Director-General as a quasi-clerical technocrat has weakened the incumbent's stature to coordinate international health efforts as an authoritative world leader. Under extraordinary circumstances, this arrangement may even function as a convenient cover for powerful state and non-state agents to influence or even manipulate the Director-General for ulterior political ends.

Devolution is not necessarily a bad thing, for it has the potential of enabling the WHO to address the needs of particular localities more responsively. But the overt decentralism of the WHO regional organisations imposes high agency costs on the Executive Board and Secretariat in coordinating the Organization's transnational activities that transcended nations and continents. The predecessors of the regional organisations were Regional Sanitary Offices whose structure survived the 1946 founding of the WHO intact. Each of the six offices has its own governing structures, i.e. regional committees. Coordination and consistency with WHO headquarters have been a matter of concern, as fundraising and budget allocation do not always serve international strategic objectives. Africa's needs, for instance, are very different from other regions', and yet the current rigid structure is apt to be a 'key impediment' to the WHO's effectiveness (van de Pas and van Schaik, 2014: 197). WHO is too decentralised to credibly implement policy, with regional directors, for example, reporting to regional members instead of the Director-General (Gostin, 2014). This persistent incoordination of regional offices has time and again made it difficult for the WHO to reach unified goals (Youde, 2018). Halfdan Mahler, Director-General from 1973 to 1988, regretted devolving further administrative powers to the regional offices, which had failed to implement his Primary Health Care policy, and eventually became a 'major critic' of decentralisation in the WHO (Beigbeder, 2018: 24).

Much of the foregoing springs from the flaws in the constitutional design of the WHO. Ditching the super-majority rule would unleash the WHA's potential to legislate global health law responsively. Liberating the IHR (2005) from its straightjacket would allow the Organization to act timely on global health problems. Delegating formal enforcement powers to the Executive Board and Secretariat would raise the consequences of ignoring the

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Regulations. Broadening the Director-General's role from technician and administrator to policy-maker would revamp the office into an active coordinator of international health efforts. Integrating regional organisations into a cohesive structure under the leadership of the Executive Board and Secretariat would reduce the transaction costs of exploiting the WHO Constitution globally. None of the above is credibly achievable in the foreseeable future, since amending the Constitution requires a super-majority in the WHA [article 60(a)]. International bodies such as the Executive Board and Secretariat also suffer from a 'democratic deficit' (Tallberg *et al*., 2013: 257); empowering them could counter-productively trigger wider legitimacy crises. Above all, to empower WHO organs is to swim against the tide of international law and politics, which is still dominated by relatively weak international institutions and relatively strong sovereign states (Ip, 2010).

Through the Constitution and the WHA, member-states – including authoritarian ones unaccountable to their own citizens – are the only principals who hold the various organs of the WHO accountable (Distefano and Ruger, 2019). Constitutional delegation of power from states to international organisations occurs when its benefits, in the form of reduced transaction costs for bargaining efficient agreements and decisions, positive externalities and better division of labour, exceed the costs of resting content with no international organisation or putting up with a dysfunctional existing organisation (Okma *et al*., 2016). States have their reasons for wanting to resist international organisations becoming too autonomous, unleashing excessive agency costs (Nielson and Tierney, 2003; Klabbers, 2015). And a sovereign state can terminate its own membership of international organisations unilaterally, of course; but such an exit may be extremely costly; as witness the United Kingdom's messy exit from the European Union in January 2020 (Jarman *et al*., 2020). Most member-states therefore stay put most of the time. But this simply reinforces the *status quo*. There will be no world health governor with global authority and enforcement powers, as stakeholder states are unlikely to yield further sovereignty absent a major shock (Gostin *et al*., 2015). Thus, an effective global health policy requires an alternative governance structure to coordinate independent yet interdependent actors (Ruger, 2013).

Without a major shock, the WHO is unlikely ever to experience another 'constitutional moment'. There are signs that the ongoing COVID-19 pandemic, which has globally infected almost 16 million people, claimed the lives of at least 634,000, and inflicted massive economic costs on all inhabited continents as at 25 July 2020, may be culminating into just such a shock. But whether this shock would eventuate into a renewal or abandonment of the WHO Constitution remains to be seen. President Donald Trump condemned the WHO for being 'China-centric' and announced a suspension of voluntary contributions from the United States on 14 April 2020, in reaction to the Organization's repeated praises of China's transparency in handling the Wuhan outbreak despite evidence to the contrary (Gostin, 2020). Then on 29 May 2020, Trump claimed that the United States will terminate its relationship with the WHO. Other critics of the WHO's COVID-19 performance, such as Tom Tugendhat, chair of the United Kingdom Parliament's Foreign Affairs Committee, proposed the establishment of a parallel or even replacement body known as 'G20 for Public Health' to share health information (UK Parliament Foreign Affairs Committee, 2020). These sentiments may not be shared by most governments of the world, but an overhaul of the global health system, including the WHO, after this pandemic seems inevitable.

4. Discussion and conclusion

The Constitution of the World Health Organization established an IGO that brings states together from all over the world to discuss global health matters, and take necessary action for 'the attainment by all peoples of the highest possible level of health' (Lee and Pang, 2014: 121; van der Rijt and Pang, 2015). The historical trajectory of the WHO is characterised by a

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hardwired discord between the Constitution's declared purposes, embodying the post-War international enthusiasm for a new era of reconstruction and solidarity, and the same Constitution's instrumental design of the WHO's structure and powers, reflecting the Westphalian paradigm of sovereign state relations (Klabbers, 2015). Contrasting images of the WHO sprang from the Constitution, which envisions a flagship legislator of international health law on the one hand, and a limited livery of technical advisors who serve member-states not as a leader but as a showcase for policy shoppers seeking choices (Lee, 2009). The latter image has prevailed in practice. With the notable exceptions of the FCTC and the IHR (2005), the WHO generally prefers technical and scientific solutions over policy-driven rulemaking, and prefers to deploy guidelines and recommendations over 'hard' international treaty law (Gostin *et al.*, 2015).

It is sometimes argued that the WHO's problems stem predominantly from non-constitutional variables, like a lack of 'decisive leadership and visionary ideas to set a clear direction for the global health agenda and to lead the world towards it' (Lidén, 2014: 146). The recent failings of the Organization in addressing the Ebola outbreak of 2014–2016 have been attributed to 'a lack of leadership, sclerotic bureaucratisation and an ineffective politicised WHO Regional Office for Africa', or in the WHO's own view, 'lack of adequate funding' and 'a misunderstanding about WHO's role' as a 'full-fledged UN operational agency' (Beigbeder, 2018: xi). The allegation that the Organization 'rewards protocol over substance; caution over courage; hierarchy over competence; conservatism in estimating problems; and obfuscation of evidence that might challenge relations with governments or donors' has even been attributed to organisational 'culture' (Francesco *et al.*, 2016: 2). There is undoubtedly truth in these accusations; culturally embedded practices provide actors with powerful justifications for political behaviour. However, to attribute the cause of malpractice to an ambiguously defined 'culture' is arguably tautological (Ip, 2014: 180).

Constitutional economics, which directs analytical attention to 'the way groups collectively choose their institutional constraints' (Holcombe, 2016: 10), is not the only plausible way of interpreting the developmental history of the WHO. And it must be conceded that the constitutional economics perspective espoused here has clear limits. It cannot shed much light on sub-constitutional problems that cannot be conclusively addressed or resolved by the Constitution, such as the impacts of the WHO's current employment practices, funding models and the human agencies of specific Directors-General and other key personalities on its behaviour. Constitutions, important as they are, do not predetermine or micro-manage sub-constitutional outcomes (Shaw and Eichbaum, 2008: 38). This paper has demonstrated nonetheless that a constitutional economics perspective can clarify the constitutional origins and solutions of many of the problems that the WHO has perennially faced, which have resulted in the Organization being accused of 'inefficiency, lack of transparency, and irrelevance' (Cueto *et al.*, 2019: 1). This paper's core insight is that scholars and reformers of global health law and policy should dedicate more time to understanding the functioning of constitutional rules; it is sometimes easier to change the rules than change the mentalities of the actors (Buchanan, 2008). The failure of the WHO, despite the breadth of its mandate, to become as consequential as institutions like the WTO in international law is explicable by their constitutional differences. The WHO's shortcomings cannot be eliminated simply by unleashing the untapped potential of the current Constitution; rather, it is the Constitution that is part of the problem.

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