Feature Essay

International Pandemic Politics

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The tools for understanding the international political trials and tribulations of the current COVID-19 pandemic are quite similar to those we would use to try to understand the difficult politics of any global public good. All countries may have an overriding interest in protecting the environment and biodiversity, safeguarding financial stability, respecting neutral shipping – except when they don't, when other interests intervene. All countries may concur on the need for agreements, and perhaps institutions, to help ensure that these global public goods are provided – except when they don't, when they cannot agree on what is in the agreements and how the institutions function. Analyzing the dynamics of global public goods provision in the case of global public health sheds a great deal of light on what we have observed over the past year, and what we are likely to see in the future.

A classic global public good. Global public health, especially control of infectious diseases, is almost as pure an example of a global public good as can be found.[1] The eradication or control of an infectious disease benefits all countries, regardless of whether they contributed or not to the effort. In terms of the two typical features of a public good, these advances in global public health are typically non-excludable – no country can be kept from realizing the benefits -- and non-rival in consumption – one country's enjoyment of the benefits does not reduce another's.

Put another way, global public health is rife with externalities. Microbes do not respect borders, so it makes little sense to eradicate an infectious disease within your borders if neighboring countries do not – the infection will simply spread back to you. Countries that do not effectively control infectious diseases impose negative externalities on their neighbors. Conversely, each country's control of an infectious disease has benefits (positive externalities) for its neighbors. All of these considerations have been evident in the world's experience with COVID-19. China's initial inadequate response facilitated rapid spread to the rest of the world; once China got the virus under control, it ceased to be a significant vector of contamination and other countries with ineffective policies – such as the United States – became major sources of the disease. The global public good nature of global public health initiatives is so clear that over thirty years ago Richard Cooper used it as a paradigmatic example of how cooperation might be achieved in other areas, such as macroeconomic policy.[2]

Public goods, global and otherwise. Nonetheless, the analysis of global public goods is more complex than it is often portrayed. In the domestic arena, a public good is under-supplied because private economic actors do not have strong enough incentives to provide it: why supply something, like clean air, that you cannot realistically charge for? At the international level, the analysis needs to demonstrate that *governments* – not private actors – lack the incentive to supply the good. Governments respond to *political* incentives, which means that the public goods problem is only a problem if governments lack political incentives to supply them.

Why would a government not want to control an infectious disease? There are several possibilities;

If all other countries eradicate an infectious disease, the chances of it reaching my country are small. This is classic free riding.

If other countries contribute to the global cost of disease eradication, my contribution is unnecessary and will not be missed. This, too, is classic free riding.

Within my country, the political benefits of controlling the disease are small, for we are a poor country and have problems more pressing than, say, preparing for an epidemic that might or might not happen – like poverty.

These and other considerations do not affect the fact that the control of infectious diseases, and related global public health measures, are global public goods. But the disincentive to contribute to the supply of public health measures is different for national governments, internationally, than it is for private actors, domestically. It is worthwhile to remember the difference between national and global public goods: in one, the under-supply is due to insufficient *economic* incentives, while in the latter it is due to insufficient *political* incentives.

We have seen national politics at work in the differential responses to COVID-19: many governments have, largely for domestic political reasons, minimized the threat from the virus. Some regard a more aggressive response as electorally damaging: this would seem to be the Trump Administration's view. Others, especially in the developing world, regard the economic

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costs of such aggressive measures as "lockdowns" to be unacceptably high. It is interesting to note that countries whose political leadership is generally categorized as "populist" seem more likely to have downplayed the threat from COVID-19 and to have lagged in implementing effective measures of disease control.

Why supply a public good? The fact that global public health is a global public good, then, raises the question of why it is supplied at all. Domestically, *government* supplies public goods, inasmuch as no private agent has an incentive to do so. There is no global government with the political or other incentives to supply a global public good. Why do national governments collaborate on global public health in the absence of any authority that can force them to do so?

While governments may be sorely tempted to shirk responsibility for helping to control an infectious disease, they are also aware that an outbreak can be disastrous – as the current global pandemic illustrates. Public health, especially for infectious diseases, is inexpensive relative to the cost societies face from such diseases.[3] For this reason, there has long been inter-governmental cooperation on public health matters. The first of many International Sanitary Conferences was held in 1851, and over many decades oversaw international collaboration to combat such diseases as cholera and yellow fever.

Institutions and their discontents. These early efforts at international cooperation on public health led to the creation of some of the earliest international institutions, such as the Pan American Sanitary Bureau (now the Pan American Health Organization) founded in 1902. The League of Nations Health Organization was created in 1920, followed by continued efforts from the United Nations system, since 1948 under the auspices of the World Health Organization (WHO). The international public health institutions play a major role, like other international organizations, in providing reliable information and technical assistance, overseeing the fulfillment of member-country promises, and raising and distributing funds – lots of funds, in the case of the WHO (over $2 billion a year recently).

As is the case for most global public goods, the most important contributors are large and rich countries. The stakes in global public health are particularly high for rich countries, whose people regard (or used to regard) devastating plagues as things of the past. No government can relish the thought of presiding over a ruinous epidemic. And the largest and richest countries recognize that their contributions may be essential to disease control – or, conversely, that if they do not contribute the disease will likely not be controlled.

For these reasons, as in other areas of international politics, large and rich countries tend to account for outsized portions of the contributions to global public health. For example, the United States has paid 24% of the total assessed contributions to the WHO, while China has paid 12% and Japan 8%. Together these plus the four largest European nations paid nearly two-thirds of the WHO's assessed contributions.[4]

Inasmuch as the adequate provision of global public health activities depends on the contributions of the largest and richest countries, they can be expected to insist on an equally outsized influence on the direction of these efforts. What might a major contributor want to influence in an organization such as the WHO? It could be to limit the degree of scrutiny to which the WHO subjects the country's own policies or implementation; or to promote the extent to which the WHO favors the country's allies over its enemies; or to favor the national origin of a technology or medicine. The point is that the major countries may well differ in what they would like an organization like the WHO to do, even if they agree on the importance of its mission.

The pulling and hauling over the current pandemic – indeed, over global public health more generally – is an excellent example of the tension inherent in all cooperation. Collaboration for mutual gain is fine and dandy, but there are many different ways that collaboration can be carried out. In other words, even in the case of cooperation to provide a public good, there are differential distributional implications of how it is provided. Global public health cooperation, for example, may have differential benefits – helping poor countries more than rich. It can be financed by rich countries or by poor countries. It can favor one country's health standards over another. Virtually every decision made in global public health – as in all such global public goods – will have differential benefits and costs and will therefore be a source of potential conflict. The Trump Administration's drumbeat of criticism of the WHO, including the threat to leave the organization, appears to be a function of its belief that the institution shows too much favor to the views and interests of other countries – especially China – and too little to the United States.

Nationalist health care. Global public good or not, as we have found out in this pandemic, there is plenty of room for nationalistic policies even aside from disagreements over the WHO's direction and strategies. When equipment or medicine is scarce, countries can attempt to reserve as much as possible to themselves – even sequestering goods belonging to other countries. Bans on travel or trade may well be justified – or they may be excuses to punish enemies. And high-sounding phrases about

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cooperation can crumble under pressure from a country's public to do something about the epidemic – even at the expense of other countries, or the effectiveness of international efforts. We have seen instances of all this in the current pandemic, and it is no surprise that such conflicts will continue.

Conclusion. Global public health – and especially the control of infectious diseases – is about as close as the world comes to a pure global public good. In this, its political economy holds lessons for other global public goods, such as controlling climate change or safeguarding financial stability.[5] First, the analysis of global public goods – unlike those at the national level – requires careful attention to the *politics* of the demand for them and the supply of them. Global public goods are demanded by governments and must be supplied by governments, and the incentives to demand and supply them must of necessity run through the political system. Global public goods are difficult to police and enforce, so that international agreements and institutions almost always are needed to oversee them. Despite broad agreement on the desirability of the global public good in question, there are likely to be disagreements – even bitter conflict – over exactly how the public good is provided, and the distributional implications of its provision.

Global public goods are good by definition; but their provision is never easy. Control of a brutally efficient disease, as in the current pandemic, is in everyone's interest; but that does not mean that it is uncontroversial. Millions may die as the controversies play themselves out; we have both an academic and a human interest in understanding them and understanding how they can be most effectively addressed.

Notes

1 For the purposes of this essay, I focus on public health measures that can clearly be categorized as public goods, such as the control of infectious disease. There are other global and national public health measures – such as attempts to limit smoking or encourage healthy eating habits – that would not normally be thought of as global public goods. They may fit the definition domestically – limiting smoking and unhealthy eating may reduce national health-care costs – but they do not internationally.

2 Richard N. Cooper, "International cooperation in public health as a prologue to macroeconomic cooperation," in Richard N. Cooper, Barry Eichengreen, Gerald Holtham, Robert D. Putnam, and C. Randall Henning, *Can Nations Agree? Issues in International Economic Cooperation (*Washington: Brookings Institution, 1989).

3 To be sure, policymakers can under-invest in public health measures for a variety of reasons – perhaps most important, that such measures typically have a very long-term payoff while policymakers' time horizons are short. This indeed may be the reason so much of public health is delegated to independent agencies that can "force" policy to pay attention to the longer run.

4 Assessed contributions provide only a small portion of the WHO's budget, but they do speak to the structure of payments. If voluntary contributions are counted, the proportion paid by the United States is substantially larger.

5 On the latter, see Jeffry Frieden, "The Governance of International Finance," *Annual Review of Political Science* 19 (2016).