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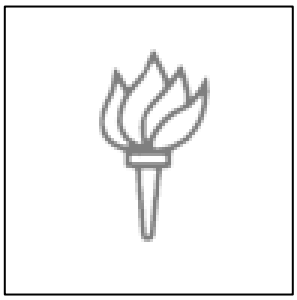

The WHO in the Age of the Coronavirus

Jose E. Alvarez

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The WHO in the Age of the Coronavirus (draft July 13, 2020) (all websites visited as of July 13, 2020)

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The actions of the WHO in the wake of COVID-19 reveal much about why such organizations, along with much of the post-WWII international legal order, are in crisis. This essay connects the frustrations generated by the global health regime's response to the current pandemic to broader criticisms of interstate organizations (IOs).

The realities of COVID-19 validate many of the premises of the WHO's Constitution, and particularly its visionary preamble. The current pandemic embodies the preamble's premise that global health is not a zero sum game, that the failure of one state to prevent its spread presents a "common danger" to all, and that, accordingly, all states benefit when each protects the health of its own inhabitants.[2] The many unknowns about the novel virus substantiates its emphasis on states' duty to cooperate since these uncertainties will only be answered by joint coordinated efforts by experts from around the world duly informed of each other's latest findings.[3] The complex consequences for those who fall sick from the virus – on their long term mental and not just physical health, their enjoyment of all human rights (and not only the right to health), and their communities – supports the WHO Constitution's comprehensive definition of 'health' as encompassing "physical, mental and social well-being."[4] The global health regime's current effects on other international regimes – from those dealing with trade in good to all 21 human rights treaty regimes – indicate why the WHO's "Magna Carta for Health" went far

[1] Board of Editors. The author acknowledges, with gratitude, comments received from Gian Luca Burci.
[2] WHO Constitution, Preamble, paras. 4 and 5.
[3] Id., para. 3.
[4] Id., paras. 1 and 7.

beyond efforts in the 19th century to harmonize infectious disease control measures at the border.[5] Now that a mere virus risks economic havoc everywhere, the WHO's preamble's claim that the provision of health is a public good of concern to governments inter-se looks like real politick. And the ever more obvious knock-on effects of the current pandemic – its effects on income inequality, structural racism, xenophobia, rates of chronic diseases left untreated, instances of spousal and child abuse, along with devastating impacts on vulnerable populations such as ethnic minorities, internal migrants, refugees, the institutionalized or incarcerated, the elderly, and the disabled – validates the WHO's Constitution's prescient assertion that a holistic conception of health is fundamental to human welfare.[6] Now that it is under serious threat, it is easy to accept the WHO Constitution's bold assertion (in 1948) that the right to health is a fundamental right that all governments have an obligation to fulfill.[7]

Coronavirus realities also appear to justify the approach taken by the WHO's International Health Regulations (IHR) as revised in 2005. Those regulations' emphasis on risk 'events' as determined by a risk assessment lessens the significance of conspiracy theories or unsubstantiated rumors that COVID-19 was created in a Wuhan lab or escaped from one. While the virus's origins are obviously important for purposes of prevention and treatment, the IHR affirm that state's duties to notify and respond to such risk events do not turn on whether the health threat was intentional or man-made.[8] At the same time, the dilatory and, it appears, purposely obfuscating actions taken by Chinese authorities with respect to reporting on the

[5] See, e.g., LAWRENCE O. GOSTIN, GLOBAL HEALTH LAW 91 (2014)(quoting Parran and Boudreau writing in 1946).
[6] WHO Constitution, preamble, paras. 3 and 4. See generally, Jan Hoffman and Ruth Maclean, *New Virus Hastens Spread of Old, Preventable Illness*, NY Times, June 15, 2020, at A1.
[7] WHO Constitution, preamble, paras. 2 and 9. Thereby anticipating by many decades the underlying premise of the 'Responsibility to Protect.'
[8] See, e.g., IHR, Annex 2.

virus's first appearance and the likelihood of human-to-human transmission, supports the decision by the drafters of the 2005 IHR to empower the organization to seek surveillance and other information from non-state sources and, if these are validated to request correction of any reports received from the original state within 24 hours.[9] The rapid diffusion of the virus within each country after a single occurrence supports the IHR requirement that states establish core capacities for surveillance and response *throughout* their territories and not only at places of entry.[10]

But comparing the virus on the ground to the law on the books yields a rosy picture at odds with the state of world. To many, the devastating impact of COVID-19 --- some 10 million infected and half a million dead as of this writing – demonstrates the global health regime's abject failure.

There is certainly enough blame to go around. States, especially our own, are responsible for failing to respect what the IHR demand, including failing to adhere to the WHO's policy advice. But the WHO needs to answer charges that it failed, despite its authority to seek information from other states and non-state sources, to challenge information initially received from the Chinese government and that it was overly deferential to the Chinese government's subsequent reports on and measures in response.[11] It also needs to respond to complaints that it was dilatory in declaring a Public Health Emergency of International Concern (PHEIC);

[9] IHR, Arts. 9.1 and 10.
[10] IHR, Annex 1.
[11] See, e.g., Gian Luca Burci, *The Legal Response to Pandemics*, J. Int'l Hum. L. Studies 1, at 8-9 (2020).

inflexible and contradictory with respect to its policy advice; insufficiently transparent; and unwilling to criticize major funder's failures to comply with the IHR.[12]

Misdiagnosing the Ills of the WHO

At the height of the COVID-19 crisis in the United States, the Wall Street Journal's editorial board opined that absent radical reform, the WHO needs to be replaced by a new leaner organization, comparable to Interpol, which would efficiently coordinate effective pandemic response.[13] According to that influential newspaper, the WHO had "lost its way" by taking seriously the "lofty rhetoric" of its first World Health Assembly (which had proclaimed that the organization should promote "the attainment by all peoples of the highest possible level of health"). It never should have engaged in "mission creep" by adopting the UN's "statist" agenda of "health for all" or involving itself in primary care for chronic diseases or the improvement of medical systems more generally.[14]

Although this was a deeply ahistorical misdiagnosis of the WHO and a fundamental misreading of the lessons of pandemics, the Journal's views found a receptive ear in the White House. By May 29, President Trump, who had praised the organization at the beginning of the COVID crisis, announced plans to cease funding and to withdraw from the organization.[15] Trump highlighted claims that the WHO had been overly deferential to China's misinformation

[12] See generally, Armin von Bogdandy and Pedro A. Villarreal, *International Law on Pandemic Response: A First Stocktaking in Light of the Coronavirus Crisis*, MPIL Research Paper Series, No. 2020-07 (available on SSRN). The WHO's inconsistent positions include its praise for the governments of China and Italy for their collective quarantines even while their standard recommendations anticipated only individual quarantines and isolation. Id., at 20.
[13] *How WHO Lost Its Way*, Wall Street Journal, May 16-17, 2020, at A14.
[14] Id.
[15] Allyn L. Taylor and Roojin Habibi, *The Collapse of Global Cooperation under the WHO International Health Regulations at the Outset of COVID-19*, 24 ASIL Insight 15 (June 5, 2020).

and overly critical of the U.S. travel ban on passengers arriving from China, thereby exacerbating the scale of the crisis in the United States and around the world.[16]

The "lofty" aspirations which the Wall Street Journal criticizes are not the latter day consequences of 'mission creep;' they were, as noted, part of the WHO's Constitution from the start. The organization was established precisely to ground pandemic response in the more holistic approach to health that such crises demand. In the wake of lessons drawn from SARS, the WHO restructured its IHR to require improvements in states' internal health systems, facilitate greater interstate cooperation with respect to improving primary health care, and enable surveillance to track and contain public health threats from whatever source (and not only specific diseases). Those who drafted the 2005 IHR drew the lesson that we are learning once again in the age of the coronavirus: global health threats require states to have core health capacities – whether or not government run -- to prevent, treat, and withstand the shock of a pandemic once it arrives. This requires readily available health care to all since chronic diseases make individuals more susceptible to new health threats and make these more deadly. The IHR also recognize that novel viruses demand forms of cooperation -- on clinical and research protocols and much else -- far more extensive than those needed to control border security.

If we did not know it before, COVID-19 makes it abundantly clear that no state can expect to go it alone when it comes to pandemics. Even states that have been relatively successful to date with respect to COVID-19, like New Zealand, continue to depend on other

[16] See, e.g., Secretary Alex M. Azar Plenary Remarks at World Health Assembly, May, 18, 2020, at https://www.hhs.gov/about/leadership/secretary/speeches/2020-speeches/secretary-azar-plenary-remarks-at-world-health-assembly.html.

states' success.[17] No state can expect to protect its population solely on the basis of measures at the border conducted with the assistance of an Interpol-styled organization.[18] Continued progress on controlling the spread of COVID-19 and optimal care for those who are sick depends on global comprehensive research now organized by the WHO.

Consider the WHO's R&D Blueprint strategy, a framework for cross-country, multi-disciplinary collaboration, launched after the West Africa Ebola outbreak, to rapidly expand scientific knowledge on emerging health threats as these develop.[19] That global effort is now focused on gathering all relevant information on the virus to provide sound advice on diagnostics, control measures, ameliorative treatments or drugs, and possible vaccines. Working under thematic work groups and shared data platforms that avoid duplication of effort and enable rapid response, experts in public health and relevant social sciences have released a series of studies on critical knowledge gaps,[20] research priorities, and the latest findings, along with specific recommendations for treating or controlling the virus.[21] These collaborations among the world's foremost authorities and institutions seek to ensure, in the face of strong political crosswinds, that science and research stays at the heart of the response. The WHO's Roadmap, which established eight immediate research tasks, has set the global agenda to control COVID-19 while establishing a sustainable baseline to address future outbreaks.[22] No other organization

[17] See, e.g., *PM Calls in Military after Coronavirus Returns to New Zealand*, Axios (June 18, 2020).
[18] See, e.g., Samantha Power, *We Can't Beat Covid by Ourselves*, NY Times, Apr. 9, 2020, at A27.
[19] WHO, R&D Blueprint and COVID-19, at https://www.who.int/teams/blueprint/covid-19.
[20] WHO, A Coordinated Global Research Roadmap: 2019 Novel Coronavirus, Mar. 2020, at 36 (henceforth Roadmap), 8 and 56, at https://www.who.int/blueprint/priority-diseases/key-action/Coronavirus_Roadmap_V9.pdf?ua=1.
[21] Roadmap, at 10 and 54.
[22] Roadmap, at 8.

has the equivalent capacity to achieve consensus on strategic directions, leverage the strengths of particular nations, respond to the needs of diverse stakeholders, or nurture scientific cooperation among rival institutions. To the extent the WHO Constitution seeks to build global solidarity on what needs to be done to conquer the coronavirus threat, it has a good claim to having done so.

The Wall Street Journal and the Trump Administration are not wrong that the WHO has had a checkered history with respect to the handling of pandemics (as does the United States itself).[23] But what ails the WHO is not its prescient vision of the multifaceted right to health, its recognition of the complexity of global health threats, or its fact-backed approach to pandemic response. It is that it and its members have fallen short on fulfilling that ambitious vision.

What ails the WHO might best be understood in terms of the top five reasons such IOs, along with the liberal international order, are in crisis.

(1) The WHO's inability to overcome its state-centered roots.

Although the WHO is no longer financially dependent solely on states, it continues to accord them the unique benefits of membership, including voting. Like other IOs, it uncomfortably straddles the need to coordinate the actions of states but also go beyond them for independent information and advice. Like other UN system organizations, it also has not come to terms with the 'participant revolution' that its own symbiotic relationships with NGOs have helped to produce. This state centric organization cannot directly involve non-state actors, like airlines, in its governance even when these can undermine or buttress the organization's public health recommendations. WHO officials, appointed by states and accountable to them, are

[23] See, e.g., JOSÉ E. ALVAREZ, THE IMPACT OF INTERNATIONAL ORGANIZATIONS ON INTERNATIONAL LAW 226-230 (2017).

reluctant to resort to the non-state sources of information that the revised IHR allow them to use, much less use that information to challenge what states report to the organization.

In the absence of other checks on what states report and the measures they take in response to pandemics (see challenge 2 below), changing the overly deferential stance of the organization to its most powerful members (including but not only China) will require hard work and the selection of WHO officials with backbone and principles. It may also require radical structural changes such as renewed attention to an old proposal to establish a 'Committee C' within the Health Assembly composed of diverse non-state actors to increase transparency, coordination, and engagement.[24]

(2) Overreliance on soft law techniques.

Like other technocratic UN specialized agencies such as ICAO, the WHO relies on its technocratic legitimacy and the self-interest of states to secure compliance. As with some of those organizations, many of its edicts are not formally binding, such as a welter of guidance instruments that accompany the formally binding IHR. On their face, the IHR most resemble ICAO's Standards and Recommended Practices (SARPs) which are also ambiguous in terms of legal effect.[25] But the comparison with aviation standards is misleading. There are

[24] See, e.g., IIona Kickbusch, Wolfgang Hein, and Gaudenz Silberschmidt, *Addressing Global Health Challenges Through a New Mechanism: The Proposal for a Committee C of the World Health Assembly*, 38 J. L. Med & Ethics 550 (2010).

[25] See, e.g., Gian Luca Burci, *The Outbreak of COVID-19 Coronavirus: Are the International Health Regulations fit for purpose?* EJIL:Talk!, Feb. 27, 2020, at https://www.ejiltalk.org/the-outbreak-of-covid-19-coronavirus-are-the-international-health-regulations-fit-for-purpose/ (noting that despite their formally binding nature, the IHR's lack of compliance monitoring has led critics to question their binding nature). ICAO members are only obligated to report deviations from SARPs. Convention on International Civil Aviation (Chicago Convention), Art. 38. As with the IHR, there is no formal mechanism for accountability in ICAO.

considerable market incentives that drive national aviation authorities (and airlines) to actually comply with SARPs that apply to a considerably lesser extent with respect to the IHR.[26]

The absence of 'name and shame' techniques, much less sanctions of any kind, for WHO members that ignore or openly defy their legal obligations under the IHR is a problem that needs fixing. Under the current regime it is hard to determine, on a real time basis, whether states are complying with their WHO obligations. Observers need to resort to media reports to identify potential violations of states' duties to establish a national focal point, to accurately report positive cases or deaths, or to pinpoint defiance of any WHO temporary recommendations issued in the wake of a PHEIC.

Thanks only to press and other reports we know, for example, that the Chinese quarantine of Wuhan beginning on Jan, 23, 2020 was the largest known quarantine in human history; that a number of governments detained for lengthy periods cruise ship passengers as the disease spread on board; that the U.S. failed to produce and follow the national plan foreseen by the IHR, delegated to its states critical decisions that generated races to the bottom on the acquisition of, for example, diagnostic tests and personal protective equipment, and has failed to date to take preventive measures (including widespread diagnostic testing) with respect to much of its population, including vulnerable persons in prisons or nursing homes; or that Singapore failed to implement timely preventive measures with respect to migrants working in its territory. While we suspect that all of these actions or inactions ran afoul of these states' WHO obligations, there is no institutionalized mechanism for accountability within the global health regime.[27] For these

[26] See, e.g., ALVAREZ, supra note 23, at 256.

[27] Challenges to some of these state measures are likely in human rights forums, including national courts, UN human rights treaty bodies, and regional human rights courts; they may also

reasons, knowledgeable global health experts, such as former WHO General Counsel Gian Luca Burci, have proposed additional reporting and assessment mechanisms.[28] These could include an ombudsperson comparable to the mechanism adopted as a 'check' on some Security Council 'smart sanctions,' expert committees like those in the ILO, or even a regularized practice of influential (even if not authoritative) interpretations issued by the WHO's lawyers in response to inquiries or complaints from members, public health professionals, or others. But this assumes that the organization is willing to discipline those it is trying to persuade. Of course, the WHO's commitment to managerial techniques for compliance would be more plausible if dedicated funding (apart from monies needed to operate the organization) were available to members that are persuaded to comply but cannot. At present, the IHR, particularly their requirement on states to build core health capacities, constitute unfunded mandates comparable to those imposed on states by other IOs.[29]

(3) Inflexible 'emergency' declarations.

'Emergency' proclamations issued by IOs have inspired a critical literature. Particularly when these are issued by select not necessarily representative bodies applying vague criteria and operating largely in secret – as by WHO Emergency Committees or by the UN Security Council under Chapter VII – such actions are bound to be controversial. While the WHO's powers to issue 'temporary recommendations' pursuant to a PHEIC are not comparable in scope or

arise before the WTO or in investor-state arbitrations. Such challenges may not address issues under global health law as such.

[28] Burci, supra note 25.

[29] See, e.g., ALVAREZ, supra note 23, 226-227 (discussing the low rates of compliance with the IHR's requirements for core capacities). See also Taylor and Habibi, supra note 15 (noting that the WHO's biennial budget for its regular budget (just below $5 billion) is approximately half of the annual budget of the US's Centers for Disease Control and Prevention).

authority to the sweeping Chapter VII powers of the Security Council pursuant to a finding of a 'threat to international peace,' the economic consequences on states can be just as grave and politically divisive. The organization's six proclamations of PHEICs have been generally subject to 'Goldilocks' criticisms. While the WHO's proclamation on COVID -19 was criticized for coming too late, in other cases PHEICs have been seen as premature or unjustified. PHEICs have also drawn complaints for lack of transparency and the harsh consequences that befall states on the receiving end of such actions. The dichotomous nature of such determinations makes it less likely that a state that detects a reportable health risk under the IHR will accurately report to the WHO.

The WHO's own reviews of prior PHEICs and their consequences have suggested that a less binary system of alerts – perhaps a traffic light system permitting a more gradual transition as the transnational transmission of a pathogen becomes more likely or severe – would more accurately reflect the risks while lowering the stakes to encourage states to provide more accurate information on the emergence of health threats.[30] This substantive reform might be paired with clearer criteria for particular alerts along with procedural changes that increase transparency and participation. All of these would help to dispel the mystery of why a public health emergency exists and increase public support for the WHO's policy advice.

(4) Absence of cross-regime institutionized mechanisms for collaboration.

Like many challenges facing UN system organizations, global health threats raise questions of the prioritization and/or harmonization of distinct parts of international law. State

[30] See, e.g., WHO, Report of the Ebola Interim Assessment Panel, at 6 (2015) (henceforth Panel Report), at https://www.who.int/csr/resources/publications/ebola/ebola-panel-report/en/; see also Burci, supra note 11, at 9-10.

and WHO responses to COVID have implications for international regimes dealing with peace and security, finance, trade, investment, international civil aviation, the law of the sea, regional and global human rights, international humanitarian law, and the environment.[31] But, as was acknowledged during the foremost effort to address the "fragmentation' of international law, questions of how best to handle cross-boundary regime issues remain a "legal black-hole."[32] Simply put: despite efforts to elevate the alleged principle of systemic integration in the VCT's Art. 31(3)(c) or other principles to assist efforts to 'harmonize' the law across regimes, black letter international legal doctrine is woefully underdeveloped when it comes to resolving when, for example, the individual or collective 'fundamental' right to health needs to give way to other human rights or needs to be given priority, along with the right to life.[33] At the moment, the IHR anticipate some of regime interactions (trade, human rights) but not others; in any case they leave it to states to accommodate their competing international obligations.[34] In the absence of adjudicatory or other forms of assessment within the global health regimes, conflicts among international legal regimes are left to be resolved in disparate forums, including interpreters of human rights. The result is that the WHO has little to say about the legality of even the world's largest collective quarantine or the dramatically disparate impact of COVID-19 on people of color in the United States – with predictably harsh consequences on its own legitimacy.

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[31] See, e.g., Bogdandy and Villarreal, supra note 12.
[32] ILC, Fragmentation of International Law: Difficulties Arising from the Diversification and Expansion of International Law, A/CN.4/L.682 (April 13, 2006), at 253.
[33] See generally, Mark Eccleston-Turner, Scarlett McArdle and Ross Upshur, *Inter-Institutional Relationships in Global Health: Regulating Coordination and Ensuring Accountability*, XII Global Health Governance 83 (Fall 2018).
[34] The IHR state that they are to be "interpreted so as to be compatible" with states' other international obligations and that they "shall not affect" those other rights and obligations. IHR, Art. 57 (1).

While it is possible that eventually general principles will evolve to resolve such cross-boundary issues (or, less likely, a new convention will emerge to address them)[35] international lawyers can in the interim devise mechanisms for greater inter-regime consultation and collaboration. These could include, for example, a requirement of prior consultation among the directors-generals of relevant IOs before a declaration of a PHEIC or the WHO's issuance of temporary recommendations. Regularized meetings of such leaders could lead to joint declarations among relevant IOs responding to serious quandaries about the desirability or legality of certain pandemic responses. Such inter-regime consultations may even redound to the benefit of other global or regional organizations that become involved in pandemic response.[36]

(5) The Hazards of expertise and other organizational pathologies.

The functionalist differentiation of UN specialized agencies yields many benefits. It is generally a good thing that economists run the World Bank, trade law specialists the WTO, and public health professionals the WHO. But as a growing body of critical literature indicates, when experts become bureaucrats, their organizations tend to develop blindspots.[37] While the WHO has largely escaped such criticism, it should not.

Although the WHO's Constitution affirms the multi-disciplinarity of the right to health, in practice the organization has been run by public health professionals resistant to, among

[35] See, e.g., Jaemin Lee, *IHR 2005 in the Coronavirus Pandemic: A Need for a New Instrument to Overcome Fragmentation?*, AJIL Insight (June 12, 2020).
[36] These might have anticipated and corrected the many flaws, for example, in the UN's Ebola response in West Africa (UNMEER). See, e.g., *Saving Lives: The Civil-Military Response to the 2014 Ebola Outbreak in West Africa*, University of Sydney (Oct. 2015), at https://www.researchgate.net/publication/283225441_Saving_Lives_The_Civil-Military_Response_to_the_2014_Ebola_outbreak_in_West_Africa_Final_Report.
[37] See, e.g., Galit A. Sarfaty, *Why Culture Matters in International Institutions: The Marginality of Human Rights at the World Bank*, 103 AJIL 647 (2009).

others, lawyers. That resistance has been reflected in the organization's rarely deployed powers to promulgate binding rules (the IHR as revised are the rare exception), engage in treaty-making (the Tobacco Framework Convention is the sole exception), or resort to ICJ or other forms of adjudication. At a time when some groups within the United States are urging lawsuits directed at the Chinese entities or at the WHO for their 'responsibility' for the spread of the 'China virus,'[38] the organization's resistance to adversarial (and distracting) responses to global health threats while such a threat is on-going may be a very good thing. At the same time, to the extent the public health culture of the WHO is responsible for the absence of assessment methods (see 2 above) and precludes *any* discussion of whether state or IO responsibility might be triggered by any actions taken in this space, the organization needs to get its head out of the sand.[39]

The global health regime is not self-enclosed. The IHR's concerns for trade and human rights concerns opens the door to other forms of expertise. The multiple dimensions of COVID-19 are clearly prompting the organization to reach outside its comfort zone. The WHO's impressive Roadmap with respect to the coronavirus, for example, usefully includes perspectives from multiple social science disciplines, including anthropology, psychology, social epidemiology, and political science.[40] But there is lagging concern that such other forms of expertise remain at the periphery. An organization in which human rights were more central, for example, would have had more to say about the state measures mentioned in (2) above. One

[38] See, e.g., Peter Tzeng, *Taking China to the International Court of Justice over COVID-19*, EJIL: Talk! (Apr. 2, 2020), at https://www.ejiltalk.org/taking-china-to-the-international-court-of-justice-over-covid-19/; Robert D. Williams and David Dollar, *Don't count on suing China for coronavirus compensation*, Brookings, Podcast, May 18, 2020, at https://www.brookings.edu/podcast-episode/dont-count-on-suing-china-for-coronavirus-compensation/.

[39] The era of absolute State and IO immunity is long since past. See, e.g. Jam v. International Financial Corp, 139 S. Ct. 759 (2019).

[40] Roadmap, supra note 20, at 61.

would hope that an organization sensitive to the multi-dimensions of health would have been more vocal about the reportedly harsh methods of confinement in Wuhan or the dire impacts of U.S. actions and inactions with respect to Mexican immigrants and guest workers during a pandemic.[41] From the opposite end, the WHO's singular reliance on public health professionals may cause it to be less nimble with respect to reasonable state measures that are not (yet) backed by rigorous testing or peer-reviewed studies but which are warranted by the precautionary principle.[42]

More fundamentally, there is an obvious gap for an organization which was the first to uphold (in its Constitution no less) the formal right to health as a human right: the organization has never had anything to say about the meaning of that right or its connection to other human rights. Indeed, the IHR's references to human rights all address limits on states' prophylaxis and other responsive measures, particularly with respect to (presumptively foreign) travelers. The IHR (like the organization as a whole) do not take seriously states' positive obligation to respect/ensure the right to health under its own Constitution or the ICESCR. Something has gone awry when the world's principal tool for upholding the right to health studiously avoids it.

The WHO's dependence on health professionals does not wholly explain its failure to adopt structural reforms noted above, including many that have been recommended years ago by its own experts in the wake of perceived failings with respect to Ebola.[43] The organization has failed to follow up on these recommendations not only because of the failure of leading members

[41] See, e.g., Patricia Mazzei, *Migrant Workers, Some Ill, Head North for Harvest*, NY Times, June 19, 2020, at A6.
[42] See, e.g., Apoorva Mandavilli, *WHO Says Particles May Linger in the air in Closed Indoor Spaces*, NY Times, July 12, 2020, at A10 (reporting criticisms of the WHO's delayed response to the risks of airborne spread).
[43] See Panel Report, supra note 30.

to push for them but because of Weberian pathologies endemic to all bureaucracies: dysfunctional behaviors such as capture, agency slack, bounded rationality, the flattening of diversity, along with path dependence and other forms of ritualized behavior. [44] Like those who work inside governments, even public health experts normally inclined to change with emerging facts may end up the side of a paralyzed status quo for fear of losing face or being perceived as 'taking sides.' Bureaucratic pathologies may explain small missteps that prove detrimental to organizational legitimacy. Aware of the relative progress on transparency shown by China with respect to COVID absent during SARs, WHO officials may double-down on praise where continued pressure for openness is demanded; path dependencies may make them hesitate to change course on the wisdom of travel bans even when the evidence suggests that the alternative – screening on arrival -- is dramatically less effective with respect to asymptomatic COVID than it was with respect to H1N1.[45]

One silver lining to bureaucratic resistance to change is that it is most likely to give way in response to serious crisis. COVID-19 is the kind of crisis that may ultimately drive organizational change.

[44] See, e.g., Michael N. Barnett and Martha Finnemore, *The Politics, Power and Pathologies of International Organizations*, 53 Int'l. Org. 699, at 715-725 (1999).

[45] Roadmap, supra note 20, at 30 (noting that while airport screenings were reasonably effective with respect to H1N1, they have detected only 46% of COVID-19 infected travelers who remain infectious). The WHO reluctantly modified, but only slightly, its recommendation against travel bans. See Updated WHO recommendations for international traffic in relation to COVID-19 outbreak (Feb. 29, 2020), at https://www.who.int/news-room/articles-detail/updated-who-recommendations-for-international-traffic-in-relation-to-covid-19-outbreak (reiterating prior advice that restricting the movement of people is "ineffective in most situations" but acknowledging that "in certain situations . . . [it] may prove to temporarily useful" and "may allow countries to gain time . . .").