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Achieving Global Health Security: The Implementation of International Health Regulations

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The 2014 Ebola outbreak in West Africa has again highlighted the critical need for countries to have strong health systems to respond to adverse health events when they arise.

In the absence of robust and adequately-funded domestic health systems, international assistance will always serve as a poor substitute. In May 2005, member states of the World Health Organization (WHO) adopted the revised International Health Regulations (IHR 2005), which is the only framework designed to prevent the spread of infectious diseases while minimising disruption to international traffic and trade. The framework then entered into force in June 2007.

Under the revised IHR 2005, the onus of responsibility has shifted from governments preventing the importation of disease to maintaining the ability to detect and manage disease outbreaks within their own territory, thereby preventing their spread. To that end, governments were given an initial five-year period to develop specific core capacities in disease surveillance and response. Where this was not possible, countries could apply for a two-year extension with a second two-year extension in cases of extreme hardship. By 2015 though, only 64 countries – or one-third of member states – had developed the core capacities required.

Added to this, in at least two public health emergencies of international concern (PHEIC) approximately 40 governments (20% of member states) ignored the WHO's recommendations and instituted measures such as trade embargoes that adversely affected international travel and trade. Such 'additional health measures' undermine both the spirit and purpose of the revised IHR 2005, but at the moment there is no mechanism to discourage this type of behaviour.

KEY POINTS

- The spread of infectious diseases and antimicrobial resistance remains one of the most challenging collective action problems confronted worldwide.
- Effective health security relies on each country doing their part in building and maintaining certain core capacities in disease surveillance and response. Most countries have not met their obligations and some apparently have no plan to.
- For some governments, the key challenge to meeting their International Health Regulations (IHR) obligations is resource scarcity while for others non-compliance is politically motivated. At the moment, there are insufficient penalties to dissuade countries from doing the wrong thing.
- New measures are needed to discourage non-compliance and encourage health system strengthening.

1 Building capacity for global health security

The IHR 2005 framework is, in many respects, an instrument to encourage governments to strengthen their respective health systems so they are capable of responding to adverse health events, whether they arise naturally or are intentionally-perpetrated. In so doing, the legal framework outlines the various roles and responsibilities that governments have when responding to these types of crises – how they are expected to behave, what they can do and, critically, what they should not do. It also places certain obligations on the WHO to help countries react appropriately and effectively to events that may spread internationally. The IHR 2005 is thus a collective action agreement for responding to a collective action problem (the international spread of disease) and harm minimisation.

According to the latest figures though, by 2015 only 64 of 196 member states had developed the necessary core capacities in disease surveillance and response. This means that two-thirds of the world's countries currently have not met their obligations, despite being given some nine years in which to do so. Of the non-compliant countries, 81 member states (41%) have requested further extensions. More disconcerting is that some 48 governments – almost one quarter – have not submitted any request for an extension or explained how they intend to meet their IHR commitments. The fact that so many countries have failed to meet their core capacity requirements, and that some appear to have no plan for doing so, undermines the IHR 2005 as a global health security instrument.

It is important to appreciate that when the IHR framework was being finalised in 2005, a number of countries indicated that they would find building the disease detection, verification and response capacities challenging, due to limited human and financial resources. Several governments stated that unless high-income countries were prepared to support their less-resourced counterparts, it would be unlikely that the targets for implementation of the IHR 2005 would be met. Regrettably, this is a prediction that has proved prescient; but the lack of penalties for non-compliant governments also means that there is very little incentive for member states to do everything they can to meet their commitments. This is an inherent weakness of the IHR 2005, and although formal reviews and commentators have called for changes to the legislative framework, given the length of time taken to gain agreement on the 2005 text it is unlikely that member states will be willing to revisit the negotiating table anytime soon.

Added to this, countries are only required to self-report their compliance. As sovereign entities, governments have traditionally resisted calls for the WHO or any other entity to evaluate their compliance with the IHR 2005 framework, preferring instead to undertake internal assessments only. While the WHO secretariat provided checklists that governments could use to evaluate their compliance, no independent verification was required. At the World Health Assembly in 2015 several member states advocated that perhaps it was time to consider establishing independent evaluation teams to conduct assessments on IHR core capacity compliance. At this stage, however, no consensus has emerged on whether governments should willingly subject themselves to external scrutiny.

Another problem for why so few countries have met their obligations is the view that implementation and compliance of the IHR 2005 rests exclusively with health ministries. This erroneous and short-sighted belief reflects a lack of insight on behalf of political leaders given the sometimes-catastrophic consequences to national economies, social cohesiveness, and even political stability, but it a belief that has proven difficult to shift. Responding to events such as disease outbreaks and the rise of antimicrobial resistance requires multi-sectoral collaboration, which is predicated upon political commitment and leadership across multiple sectors of society to tackling these challenges.

2 Notification and reporting health events

Governments have frequently gone to great lengths to avoid reporting disease outbreaks and other adverse health events for fear of other countries imposing trade embargoes and travel restrictions that harm national economies. To counter this recognised trend, the IHR 2005 framework codified a number of norms (expectations) around reporting disease-related events that may have the potential to spread internationally. In recognition, however, that not

all countries may be immediately persuaded to do the right thing by officially reporting these events, the IHR 2005 framework has also expanded the WHO's ability to draw upon non-government sources of information to identify public health risks. This new authority permits the WHO to approach member states with unofficial reports, even rumours, of a disease event. Governments then have 24 hours to verify the presence or absence of the health hazard. Where an incident is identified, the WHO is able to work with the affected countries to help contain the disease event. By contrast, when it is proven to be an unfounded rumour, the WHO can use its authority as the world's leading health agency to dispel the allegation, reducing the risk of other countries reacting negatively by applying trade and travel sanctions.

The IHR 2005 framework thereby seeks to incentivise rapid and transparent government-based reporting and verification of disease events by drawing on the organisation's normative influence to protect countries' reputations and economic interests, while simultaneously preventing unnecessary retaliatory action. Crucially, however, a government's ability to identify and verify whether a disease event is underway rests upon its surveillance and reporting infrastructure – core capacities that, as noted above, are currently inadequate across two-thirds of the world's countries. The lack of physical capacity to identify, verify and promptly report a disease event was partly to blame, for example, in why the 2014 Ebola outbreak in West Africa was not verified until three months after it had started.[1] Given this set of circumstances, it can be appreciated that even were countries able and willing to promptly report disease events, or even verify reports from unofficial sources, they are likely to still confront significant challenges in complying with the IHR 2005 for many years to come.

Having said this, history has also taught us that not all countries are willing to notify the WHO of disease-related incidents even when they have the capacity to detect and verify them. The Chinese government's initial attempts to hide the extent of the 2003 SARS outbreak provides a vivid example; but multiple countries have periodically attempted subterfuge to varying degrees of success since the IHR were first adopted in 1951. The WHO's new authority under the IHR 2005, combined with significant technological advances in information communication technology, greatly inhibits governments' attempts at deception. Even so, this is unlikely to prevent some countries from trying to avoid reporting and/or verifying disease-related events if it is perceived to be in their national interest. This is perhaps where the value of the IHR 2005 really comes to the fore, as it not only outlines the obligations and expectations of appropriate state behaviour, it also provides a framework that countries' behaviour can be publicly assessed against. Where governments circumvent their responsibilities, they can be exposed and criticised. This is intended to create a disincentive for governments avoiding their obligations under the IHR 2005.

3 Additional health measures

One of the perennial problems when diseases do spread internationally has been governments taking unnecessary actions that unduly harm the countries affected by a disease. These measures can often take a variety of forms, such as:

- imposing import trade barriers on all live pigs and pork products throughout the 2009 H1N1 influenza pandemic on the basis it was called 'Swine Flu';
- the Chinese government's decision in 2009 to quarantine all Mexican citizens within their territory irrespective of their risk of exposure to H1N1 influenza;
- the Egyptian government's decision to slaughter the entire country's porcine population on account the H1N1 influenza virus was originally detected in pigs;
- the cancellation of multiple commercial airline flights to and from West Africa following the 2014 outbreak of Ebola Virus Disease purportedly in an attempt to halt the virus spreading internationally; and
- the Australian government's decision to temporarily cancel its humanitarian visa program for persons emigrating from West Africa due to the potential risk they may have been exposed to Ebola.

1 In Guinea, the Ebola outbreak was initially misdiagnosed as Cholera and later on as Lassa Fever (before being corrected identified as Ebola); www.who.int/dg/speeches/2015/g7-ebola-lessons-learned/en/.

Such actions are described in the IHR 2005 as 'additional health measures', and are considered to be fundamentally at odds with both the spirit and purpose of the revised IHR as they discourage countries from promptly and openly reporting disease events.

Under the IHR 2005, the WHO has been given the authority to demand countries provide scientific rationales for any measures that are inconsistent with the organisation's own recommendations. Where such rationales are not forthcoming, or are assessed to be insufficient, the government will be asked to terminate the additional health measure(s). In the event that a government refuses, the WHO is authorised to publicly 'name and shame' the country, thereby damaging the country's international standing until such time as the government capitulates.

Critically, however, beyond inflicting reputational injury there are no punitive actions that the WHO is able to take against countries that flout the IHR 2005 framework. Nor do enforcement mechanisms exist to ensure compliance with WHO recommendations and advice. The absence of such powers was intentional, and an outcome of the IHR intergovernmental negotiations. As a result, in the two previous public health events of international concern (PHEICs) cited above, approximately 40 countries – or 20% of the 196 member states – implemented additional health measures that contravened the IHR 2005 framework. In the case of the 2009 influenza pandemic, some countries negatively affected by trade import bans did eventually manage to bring the trade bans before the World Trade Organization, but the cases were only heard long after the influenza pandemic had ended. Likewise, despite senior United Nations officials criticising commercial airlines' decision to cancel international flights to and from West Africa, companies declined to re-commence flights until after the outbreak had concluded.

Compounding the issue, in each PHEIC since the 2003 SARS outbreak the WHO has declined to 'name and shame' the countries that instituted additional health measures, despite having this authority enshrined within the IHR 2005. Such inaction by the WHO has served to undermine the revised framework, and will conceivably allow other countries greater scope in future to ignore their obligations, as they can do so without fear of reprisal. Strong leadership within the WHO and a willingness to utilise the full extent of its newfound authority is therefore needed in future PHEICs if the IHR 2005 is to be valued and global health security maintained.

4 Conclusion

The revised IHR 2005 were adopted in May 2005 to much acclaim, but it is clear from the above summary that there are still a number of hurdles to be overcome to attain and maintain global health security. More than a decade after their adoption, the majority of member states still lack sufficient disease surveillance and response capacities – the foundation to preventing diseases spreading internationally. A proportion of countries have also continued to ignore their obligations to promptly report and verify disease events, thereby creating greater potential for small local events to transform into international crises. In addition, in recent PHEICs a number of governments have intentionally decided to ignore their obligations under the IHR 2005 by imposing additional health measures that unjustifiably damage the trade and economic interests of disease-affected countries.

In such an environment, stronger incentives to encourage compliance are urgently needed if the IHR 2005 framework is to remain relevant. The international community would also arguably benefit from further strengthening the IHR so that countries that willingly ignore their obligations are penalised. While the political will to undertake further reforms of the IHR framework currently appear lacking, it is inevitable that in our highly interconnected, globalised world we will continue to see disease-related events and antimicrobial resistance spread internationally to cause widespread social and economic disruption.

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The GCSP Strategic Security Analysis series are short papers that address a current security issue. They provide background information about the theme, identify the main issues and challenges, and propose policy recommendations.

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