Chapter 13 Transnational Solidarity, International Law and the Distribution of Medical Goods during Pandemics

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1 Introduction

The current volume's conception of solidarity[1] and its role in crises is especially topical as the world enters an "endemic" phase of the COVID-19 pandemic.[2] Aside from the loss of life and health, the disease exposed rifts in how countries actually uphold any given principle of solidarity during a global crisis, characterized by a distributive dilemma featuring conditions of scarcity of goods and time pressure.[3] Against such a backdrop, a robust conception of solidarity would require public authorities of every state to cater not only to the well-being of their own population, but also of those in other countries.[4] Thus, transnational solidarity means persons in a country accept the costs of sharing their own (scarce) resources with those of other countries, through the recognition of something similar between both of

1 The introductory chapter puts forward a concept of solidarity as "an idea of order that manifests itself in mutual obligations and aims at tackling common challenges or realizing common goods… [solidarity] is mostly framed as an 'inner cement' holding together a political entity by compensating for inequalities and power asymmetries" Anuscheh Farahat, Marius Hildebrand and Teresa Violante, in this volume.

2 "Endemic" refers to a novel disease ceasing to be extraordinary and remain circulating seasonally within the population, Aris Katzourakis, 'COVID-19: Endemic Doesn't Mean Harmless' (2022) 601 Nature 485; Jeffrey V Lazarus and others, 'A Multinational Delphi Consensus to End the COVID-19 Public Health Threat' (2022) 611 Nature 341.

3 Katharina Kieslich and Barbara Prainsack, 'Solidarity in Times of a Pandemic: Everyday Practices and Prioritization Decisions in Light of the Solidarity Concept' in Andreas Reis, Martina Schmidhuber and Andreas Frewer (eds), *Pandemics and Ethics: Development – Problems – Solutions* (Springer 2023) 33.

4 The argument that states sovereignty could be a "trusteeship for humanity" by catering to the interests of persons in other territories is posited by Eyal Benvenisti, 'Sovereigns as Trustees of Humanity: On the
Accountability of States to Foreign Stakeholders' (2013) 107 American Journal of International Law 295–301.

them[5], which in this chapter means the need to protect against the global spread of a disease.

One of the most publicized displays of lack of solidarity during the COVID19 pandemic was so-called "vaccine nationalism".[6] Broadly speaking, this phenomenon occurred because effective vaccines against COVID-19 were initially scarce, and countries stockpiled doses at the expense of other countries. States competed against one another to procure as many doses as quickly as possible for their population. It represented an antagonistic setting in terms of a robust transnational solidarity between states.

During the COVID-19 pandemic, the World Health Organization (WHO), Gavi, the Vaccine Alliance – a public-private-partnership seated in Switzerland – the Coalition for Epidemic Preparedness Innovations – a Norwegian nongovernmental organization – the World Bank and the Bill & Melinda Gates Foundation, among others, launched the so-called Access to COVID-19 Tools Accelerator (ACT-Accelerator). The same partners launched the COVAX Initiative, the core operative component of the first pillar, whose goal was an equitable global distribution of vaccines against COVID-19. These were unprecedented mechanisms consisting of both procurement and donation of vaccine doses.

The innovative mechanisms of solidarity designed during the COVID-19 pandemic did not fulfil their purported goals. Only half of the promised doses were allocated in the expected timeframe, whereas most of these doses were through donations and not actual use of COVAX's procurement mechanism.[7] Such a scenario sheds light on the limits of transnational solidarity in the face of an acute global threat, like a pandemic. The debacle brought about by the global distribution of medical goods against COVID-19 generally, and vaccine nationalism in particular elicited calls for reforming the rules-based global health landscape. This has informed ongoing parallel negotiations for a new pandemic treaty and amendments to the International Health Regulations at the WHO in Geneva.

5 Taken *mutatis mutandis* from Barbara Prainsack and Alena Buyx, *Solidarity in Biomedicine and Beyond* (CUP 2017) 43.

6 Armin von Bogdandy and Pedro Villarreal, 'International Law's Role in Vaccinating Against COVID-19: Appraising the COVAX Initiative' (2021) 81 Heidelberg Journal of International Law 95–99.

7 Antoine de Bengy Puyvallée and Katerini Tagmatarchi Storeng, 'COVAX, Vaccine Donations and the Politics of Global Vaccine Inequity' (2022) 18 Globalization and Health 26.

In light of the above, the current chapter tackles the issue of solidarity in the distribution of medical goods – including vaccines – during pandemics. The structure is as follows: In the second section, the chapter examines existing conditions limiting solidarity during pandemics, with emphasis on the global distribution of medical goods. The ACT-Accelerator generally, and the COVAX Initiative particularly, have been core examples of attempts at countering nationalistic trends during the COVID-19 pandemic. While vaccines were the most notable display of limited solidarity, this certainly applies to other critical medical goods. The third section explains how multilateral mechanisms for fostering solidarity during pandemics are limited and, instead, the strongest structures of political representation and accountability are mostly national or, exceptionally in the case of the European Union,[8] regional. This landscape results in authorities prioritizing their own populations at the expense of those of other countries. Robert Putnam referred to these types of conundrums as a "two-level game", in which national authorities must navigate tensions between domestic prioritization and diplomatic, ie external considerations.[9] The current juncture of international negotiations on a pandemic treaty and amending the International Health Regulations at the WHO gives an example of Putnam's two-level game. The fourth section offers conclusions, arguing for a need to devise multilateral mechanisms that can pursue transnational solidarity as a realistic goal. Future initiatives to succeed the ACT-Accelerator and the COVAX Initiative should pay heed to the inherent limitations of transnational solidarity while remaining committed to changing the global distribution of scarce medical goods.

8 Alexia Katsanidou, Ann-Kathrin Reinl and Christina Eder, 'Together We Stand? Transnational Solidarity in the EU in Times of Crises' (2022) 23 European Union Politics 66–78.

9 Robert Putnam, 'Diplomacy and Domestic Politics: The Logic of Two-Level Games' (1988) 42 International Organization 434; for an application of the two-level game in the distribution of COVID-19 vaccines, see Matthew Kavanagh and Renu Singh, 'Vaccine Politics: Law and Inequality in the Pandemic Response to COVID-19' (2023) 14 Global Policy 239.

2 Legal Barriers and Catalysts for Transnational Solidarity in Pandemics

Law can play a role of both an inhibitor as well as a catalyst in entrenching transnational solidarity.[10] Whether the one or the other is the case will depend on how legal rights and obligations for different actors are framed. The following subsections address several dimensions of transnational solidarity in pandemics under international law, by referring to the past absence of mechanisms for the global distribution of medical goods, as well as some of the intricacies of the ACT-Accelerator.

2.1 Pre-COVID Distribution of Pandemic-Related Medical Goods

Pandemics caused by new and re-emerging diseases can trigger a global scramble to find medical goods offering protection and remedies against them. Which medical goods will be effective can vary from disease to disease. Key among these goods are safe and effective vaccines if and when they become available. In broad terms, these pharmaceutical goods allow persons to build an immune response to a disease before being directly exposed to it.[11] Vaccines are not the only medical goods required to treat communicable diseases. Other goods with prophylactic and therapeutic value, such as antiviral medicines, can contribute to protecting against communicable diseases.

Before COVID-19, the procurement of medical goods during pandemics was, with notable exceptions,[12] a mostly national affair. National authorities purchased medical goods both in "ordinary" and in emergency times

10 Alexandra Phelan, Mark Eccleston-Turner, Michelle Rourke, Allan Maleche and Chenguang Wang, 'Legal Agreements: Barriers and Enablers to Global Equitable COVID-19 Vaccine Access' (2020) 396 The Lancet 800–802.

11 Miquel Porta, 'Immunization' in *A Dictionary of Epidemiology* (6th ed, OUP 2016) available at: https://www.oxfordreference.com/display/10.1093/acref/9780199976720.001.0001/acref-9780199976720 all links accessed 12 January 2024.

12 The Revolving Fund from the Pan-American Health Organization (PAHO) was deployed during the H1N1 Influenza pandemic in 2009 to procured vaccines against influenza on behalf of Latin American and Caribbean countries. See Alba María Ropero-Álvarez, Álvaro Whittembury, Hanna Jane Kurtis, Thais dos Santos, M Carolina Danovaro-Holliday and Cuauhtémoc Ruiz-Matus, 'Pandemic influenza vaccination: Lessons learned from Latin America and the Caribbean' (2012) 30 Vaccine 916, 917.

through bilateral contracts with pharmaceutical companies.[13] The most immediate precedent to COVID-19 occurred during the H1N1 Influenza pandemic of 2009–2010.[14] During that event, there were no existing global mechanisms for the distribution of medical goods against the disease. Yet, when the H1N1 influenza pandemic officially concluded, the death toll was considerably low.[15] This fact likely explains why controversies regarding the H1N1 influenza pandemic were of a different, and therefore not comparable nature than those due to the COVID-19 pandemic: Whereas in the latter, vaccine nationalism has been decried due to the stockpiling of necessary medical goods;[16] in the former, the activation of dormant contracts for procuring those goods led to severe criticism and inquiries on potential conflicts of interest in the response to the pandemic.[17]

The post-pandemic reports concerning H1N1 influenza concluded by calling for more transparency in how public procurement procedures of medicines against pandemics are devised.[18] Studies pointed towards the absence of mechanisms fostering solidarity between countries in the distribution of medical goods during a pandemic.[19] Events occurring after the

13 Mark Turner, 'Vaccine procurement during an influenza pandemic and the role of Advance Purchase Agreements: Lessons from 2009-H1N1' (2015) 3 Global Public Health 322.

14 On 11 June 2009, the WHO Director-General declared the highest phase of pandemic alert, ie phase 6, due to the worldwide spread of H1N1 Influenza. The end of the pandemic phase was declared on 10 August, 2010. WHO, 'H1N1 in post-pandemic period. Director-General's opening statement at virtual press conference' (*WHO*, 10 August 2010) https://www.who.int/news/item/10-08-2010-h1n1-in-post-pandemic-period.

15 The higher-end estimates put the death toll worldwide due to H1N1 Influenza at around 200,000. Fatimah Dawood and others, 'Estimated global mortality associated with the first 12 months of 2009 pandemic influenza A H1N1 virus circulation: a modelling study' (2012) 12 The Lancet Infectious Diseases 687.

16 'WHO chief warns against 'catastrophic moral failure' in COVID-19 vaccine access', (*UN News*, 18 January 2021) https://news.un.org/en/story/2021/01/1082362.

17 Multiple institutional and journalistic reports pointed towards the use of millions of US dollars of taxpayer money in purchasing medical goods. For a critical perspective, see Sudeepa Abeysinghe, 'Pandemics, Science and Policy. H1N1 and the World Health Organization' (Palgrave MacMillan 2015).

18 See WHO, *Strengthening response to pandemics and other public health emergencies. Report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza (H1N1) 2009* (2011) available at: https://www.who.int/publications/i/item/strengthening-response-to-pandemics-and-other-public-health-emergencies.

19 Turner (n 13).

H1N1 influenza pandemic, such as the West African Ebola crisis of 2014, did not acquire a global dimension and hence did not raise a pressing sense of need. Public authorities may conclude contracts with private actors located either in the same country or in a foreign setting,[20] in order to procure goods or services lying in the public interest. In most instances, authorities undertake public procurement procedures for purchasing these goods or services *for the benefit of their own populations,* clearly including the healthcare sector.[21]

In the case of medical goods against COVID-19, private law actors provide the vast majority thereof.[22] In the exercise of their mandate, public authorities may secure agreements or contracts with providers under the best possible conditions. Under a rational choice theory,[23] procurers will look for available alternatives for a particular good in a competitive setting and choose the best one.[24] Nevertheless, the list of available providers of medical goods necessary against a pandemic can be quite a short one. In the case of medical goods, particularly technically elaborate ones, who can produce them depends on, first, having the required technical expertise to manufacture them; and, second, the existence or absence of intellectual property rights, mainly patents, granting innovators exclusive rights.[25] The combina-

20 For more on transnational contract-making, see Mathias Audit and Stephan Schill, 'Transnational Law of Public Contracts: An Introduction', in Matthias Audit and Stephan Schill (eds), *Transnational Law of Public Contracts* (Bruylant 2016) 3–20.

21 Asserted in World Trade Organization/World Intellectual Property Organization/WHO, *Promoting Access to Medical Technologies and Innovation: Intersections Between Public Health, Intellectual Property and Trade* (2nd edition, 2020) 103.

22 Philip Hanspach, 'Improving Health Resilience Through Better Procurement of Medical Supplies: Lessons from the Covid-19 Pandemic' [2021] STG Resilience Papers – European University Institute 1–2.

23 A theoretical model not without criticisms. See Juliane Mendelsohn, 'Competition, Concentration, and Inequality through the Lens of the Theory of Reflexive Modernisation', in Jan Broulík and Katalin Ceres (eds), *Competition Law and Economic Inequality* (Hart/Bloomsbury 2022) 55–72.

24 Robert D Anderson, William Kovacic and Antonella Salgueiro, 'Competition Policy in Relation to Public Procurement: An Essential Element of the Policy Framework for Addressing COVID-19' in Sue Arrowsmith, Luke Butler, Annamaria La Chimia and Christopher Yukins (eds), *Public Procurement Regulation in (a) Crisis? Global Lessons from the COVID-19 Pandemic* (Hart/Bloomsbury 2021) 199–200.

25 Holger Hestermeyer, *Human Rights and the WTO. The Case of Patents and Access to Medicines* (OUP 2007).

tion of both these elements often leads to a "sellers' market",[26] wherein competition may be stunted by both the limited amount of providers, as well as the urgent nature of the need to procure a specific good needed to counter a crisis.[27] Given how the procurement of medical goods mostly, though not exclusively,[28] follows a market logic, public authorities from a particular country capable of paying more can gain faster access to scarce medical goods than the authorities of others. In doing so, these procurers manage to attain those goods before other potential purchasers.[29]

Medical goods that are still in the earlier phases of research and development can be purchased through legal contracts celebrated between developers and procurers, known as Advance Purchase Agreements (APAs).[30] Through them, developers of new medical goods commit themselves to provide them if and when they become available.[31] These contracts can, and have led to stockpiling, as they can overload the supply chain and leave other potential purchasers behind. Thus, APAs risk worsening pre-existing global inequities, as the core determinant factor for distribution is the ability to pay.

When negotiating contracts with pharmaceutical companies and other private actors, procuring actors strive to attain the most advantageous terms possible for them, be they price, volume, delivery conditions, or other features. But this can lead to distortions in access to those goods. Studies have shown how even before the COVID-19 pandemic, middle-income countries have had to pay more expensive prices for vaccine doses than higher-income ones.[32] There are certainly other factors that may explain

26 On the definition of a sellers' market, Thomas Zorn and William Sackley, 'Buyers´ and Sellers´ Markets: A Simple Rational Expectations Search Model of the Housing Market' (1991) 4 Journal of Real Estate Finance and Economics 315, 315–316.

27 United Nations Office on Drugs and Crime, *COVID-19 Vaccines and Corruption Risks: Preventing Corruption in the Manufacture, Allocation and Distribution of Vaccines* (2020) 4.

28 Exceptions include the category of drugs for neglected diseases.

29 United Nations Conference on Trade and Development, *Impact of the COVID-19 Pandemic on Trade and Development. Lessons Learned* (2022) 33.

30 Phelan, Eccleston-Turner, Rourke, Maleche and Wang (n 10) 800.

31 Ian Thornton, Paul Wilson and Gian Gandhi, '"No Regrets" Purchasing in a Pandemic: Making the Most of Advance Purchase Agreements' (2022) 18 Globalization and Health 2.

32 A phenomenon predating the COVID-19 pandemic. See N Herlihy, R Hutubessy and M Jit, 'Current Global Pricing for Human Papillomavirus Vaccines Brings the Greatest Economic Benefits to Rich Countries' (2016) 35 Health Affairs (Millwood) 227–234; Jan Wouters and others, 'Challenges in Ensuring Global Access to COV-

this variation, such as whether purchasers pre-invested in a medical product by financing its research and development.[33] Nevertheless, the closed-door nature of contract negotiations by different parties with transnational pharmaceutical companies is a reason for this divergence.[34]

2.2 COVID-19 as a Stress Test of Transnational Solidarity

No country in the world escaped the impact of the COVID-19 pandemic. Little wonder, then, that issues of transnational solidarity took the global stage. One of the distinctive features of this crisis in comparison to, for example, the financial ones of the 2010 has been the lower degree of moral hazard, that is, a common threat that lies beyond any individual state's responsibility.[35] It is a scenario where transnational solidarity is not subject to other qualifying factors.

And yet, the global distribution of medical goods during the COVID-19 pandemic by states was hardly a display of unqualified transnational solidarity. Although some political leaders, like the President of the European Council, argued that their decisions during the COVID-19 pandemic were based on solidarity with other countries,[36] the prevailing disparities in the distribution of medical goods cast doubt upon such framings. Other authors have referred to the difficulties in realizing solidarity during pan-

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ID-19 Vaccines: Production, Affordability, Allocation, and Deployment' (2021) 397 The Lancet 1027.

33 Niall McCarthy, 'Which Companies Received The Most Covid-19 Vaccine R&D Funding?' *Forbes* (6 May 2021) https://www.forbes.com/siteWs/niallmccarthy/2021/05/06/which-companies-received-the-most-covid-19-vaccine-rd-funding-infographic/.

34 Ann Danaiya Usher, 'CEPI Criticised For Lack of Transparency' (2021) 397 The Lancet 265–266.

35 Michael Ioannidis, 'Between Responsibility and Solidarity: COVID-19 and the Future of the European Economic Order' (2020) 80 Heidelberg Journal of International Law 775–776. Beyond far-fetched accusations against the Chinese government on whether the event was intentional, the strongest condemnations focus on its lack of transparency and not on fault lines. 'Covid-19 pandemic: China "refused to give data" to WHO team' *BBC News* (14 February 2021) https://www.bbc.com/news/world-asia-china-56054468.

36 European Council, 'Remarks by President Charles Michel Following the First Session of the Video Conference of the Members of the European Council' (25 February 2021) available at: https://www.consilium.europa.eu/en/press/press-releases/2021/02/25/remarks-by-president-charles-michel-following-the-first-session-of-the-video-conference-of-the-members-of-the-european-council/.

demics, both interpersonally and at a societal- or group-level, arguing for institutions offering material conditions for realizing solidarity, and for a recognition in public discourse of a similar situation faced alongside "others".[37] These "others" may be transnational in nature, including other countries and their inhabitants.[38]

A case in point is the pricing of vaccine doses across different countries, which was not proportionate to purchasing power. In South Africa, according to an investigation by the Health Justice Initiative, prices per dose in some contracts were double than those for the EU.[39] Moreover, a lack of transnational solidarity did not only operate along North-South lines. A well-known spat emerged between the United Kingdom and the European Commission, in light of the perceived preference the company AstraZeneca gave the former when delivering COVID-19 vaccines to each.[40] Resultantly, the European Commission launched litigation procedures in Belgian Courts, which concluded by establishing AstraZeneca's liability for not upholding the agreed-upon vaccine delivery schedules.[41] This saga shows how challenges to transnational solidarity play out in North-North constellations as well.

Due to the developments presented above, medical goods against pandemics stand at the core of debates on how to entrench more robust transnational solidarity against future threats. When the first vaccines against COVID-19 were successfully developed in 2020, public authorities all over the world faced the dilemma of devising criteria for their global distribution, considering that countries with more resources were better positioned to acquire them more promptly. The conundrum of how to ensure global equity is further aggravated by how time is of the essence: the longer

37 Barbara Prainsack, 'Solidarity in Times of Pandemics' (2020) 7 Democratic Theory 132–133.

38 Katsanidou, Reinl and Eder (n 8) 68.

39 Health Justice Initiative and others,"*One-Sided". Vaccines Save Lives – Transparency Matters* (5 September 2023) available at: https://healthjusticeinitiative.org.za/pandemic-transparency/.

40 Armin von Bogdandy and Pedro A Villarreal, 'The EU´s and UK´s Self-Defeating Vaccine Nationalism', (*Verfassungsblog,* 30 January 2021) https://verfassungsblog.de/the-eus-and-uks-self-defeating-vaccine-nationalism/.

41 Eventually, the European Commission and AstraZeneca reached a settlement out of court. Pushkala Aripaka and Ludwig Burger, 'AstraZeneca reaches settlement with EU on COVID-19 vaccine delivery', *Reuters* (3 September 2021) https://www.reuters.com/world/europe/astrazeneca-eu-reach-settlement-delivery-covid-19-vaccine-doses-2021-09-03/.

it takes for a country to secure medical goods for its population, the higher the loss of life and overall adverse health outcomes will be. The HIV/AIDS pandemic is a key example, in so far as despite the availability of effective antiretroviral medicines against the disease since the 1990s, lower-income countries in Sub-Saharan Africa had access to them decades after they were first developed and distributed in higher-income countries.[42] It shows the longstanding nature of inequity during pandemics. Consequently, breaking the cycle of these distributive failures is a key normative challenge for international law.

2.3 ACT-Accelerator and COVAX: Between charity and solidarity

Previous to the COVID-19 pandemic, no global mechanisms for the distribution of medical goods comparable to the ACT-Accelerator existed.[43] A number of aid-based distribution mechanisms have been devised for a number of routine vaccines, both at the international level (through UNICEF) and regionally, such as the Pan-American Health Organization's Revolving Fund.[44] None of these, however, directly addressed a scenario of global scarcity of one or several medical goods in an emergency where all states had an urgent need to access them at the same time. Therefore, before the COVID-19 debacle, most of the schemes devised for distributing medical goods followed an idea of charity and not of solidarity. Assistance was given to countries mostly under circumstances where those providing aid were not under time pressure and were, generally speaking, already well-off themselves. Conversely, the idea of solidarity developed in this volume means to mitigate the impact of (economic) inequalities and power asymmetries during crises.[45] Under this robust idea of solidarity, states should have access to medical goods during a pandemic even while all

42 Sharifah Sekalala and John Harrington, 'Communicable Diseases, Health Security, and Human Rights: From AIDS to Ebola' in Lawrence Gostin and Benjamin Mason Meier (eds), *Foundations of Global Health & Human Rights* (OUP 2020) 221–242.
43 Turner (n 8).
44 Wouters and others (n 32).
45 Hildebrand, Farahat, and Violante (n 1).

others are being affected, and not wait until those with higher purchasing power have had their needs fully covered.

There are legal foundations available for a different idea of global distribution of medical goods, one based on a more robust conception of solidarity. Such a model would draw upon a human rights perspective, which pleads for the allocation of life-saving goods based on need and not ability to pay.[46] Major gaps still exist when attempting to determine which criteria of "need" apply between countries and not just within. From a medical point of view, criteria of nationality or residence do not play any role whatsoever in establishing necessity.[47] Beyond this dimension, however, criteria on need tend to be uncertain. Even after the lessons of the COVID-19 pandemic, and beyond frameworks such as the Fair Priority Model, insights from both epidemiology and medical ethics have yet to produce a definitive account of a solidarity-based distribution of scarce medical goods during emergencies that translates into political consensus.[48] Such a gap between scientific and political concepts is essential in any proposals for a future, more equitable global mechanism for the distribution of pandemic-related medical goods, including vaccines.

The ACT-Accelerator and its vaccines pillar, the COVAX Initiative, were an alternative to a pure market-logic background for the global distribution of medical goods during a pandemic.[49] At the moment of their inception, these were unprecedented mechanisms, set up by Gavi, the Vaccine Alliance, the WHO, the United Nations Children´s Fund (UNICEF), the Coalition for Epidemic Preparedness Innovations and other partners. They purported to be a multilateral alternative for the procurement and distribution of vaccines and other medical goods, through both commercial purchasing as well as through development aid.

The COVAX Initiative, and particularly its legal arm, the Facility, split the world in two. On the one hand, countries deemed to have sufficient econo-

46 Colleen Flood and Aeyal Gross, *The Right to Health at the Public/Private Divide. A Global Comparative Study* (CUP 2014).

47 Kyle Ferguson and Arthur Caplan, 'Love Thy Neighbour? Allocating Vaccines in a World of Competing Obligations' (2020) 47 Journal of Medical Ethics 1.

48 Though focusing on "fair and equitable distribution" rather than "solidarity", see on this point Ezekiel Emanuel, Ross Upshur and Maxwell Smith, 'What Covid Has Taught the World about Ethics' (2022) 387 The New England Journal of Medicine 1542–1543.

49 WHO, 'What is the ACT-Accelerator' https://www.who.int/initiatives/act-accelerator/about.

mic resources financed their own doses, resorting to COVAX as a "broker" for signing APAs with pharmaceutical companies able and willing to manufacture vaccines; on the other hand, countries with a lower capacity were financed through development aid.[50] It is worth underscoring, however, that self-financing countries would not be cross-subsidizing financed ones, meaning that the Facility's financial resources are not redistributed to cover financed countries.[51] This shows how there is an inherent limitation to solidarity between participating countries.

The concept of "sustainable solidarity" was coined elsewhere to highlight this version of solidarity, capable of accounting for the unavoidable nature of nationalistic self-interest.[52] Basically, the driving factors of vaccine nationalism are recognized and meant to coexist with, yet not be replaced by unrestrained global solidarity.[53] While some may question this self-restrained conception,[54] there are arguments supporting this modality. As explained in the following lines, the premises for this understanding of solidarity have been affirmed in empirical inquiries.

The COVAX Initiative did not meet its initial goal of distributing 2 billion doses of COVID-19 vaccines by the end of 2021, reaching only around 50 % of that amount.[55] Notably, most of the distribution of vaccines was undertaken through bilateral agreements between pharmaceutical companies and public authorities.[56] An external inquiry commissioned by the WHO published in October 2022[57] pinpointed what it considered to be one of the main reasons for the COVAX Initiative's limited success: its "overambitious" scope. Basically, it expected high-income countries to use

50 Bogdandy and Villarreal (n 6).

51 Felix Stein, 'Risky business: COVAX and the financialization of global vaccine equity' (2021) 17 Globalization and Health 5.

52 Bogdandy and Villarreal (n 6).

53 A more radical proposal was made by Goving Persad, Alan Wertheimer and Ezekiel Emanuel, 'Principles for allocation of scarce medical interventions' (2009) 373 The Lancet 423–431.

54 Mark Eccleston-Turner and Harry Upton, 'International Collaboration to Ensure Equitable Access to Vaccines for COVID-19: The ACT-Accelerator and the COVAX Facility'(2021) 99 The Milbank Quarterly 444–445.

55 WHO, 'COVAX Delivers its 1 Billionth COVID-19 Vaccine Dose' (16 January 2022) https://www.who.int/news/item/16-01-2022-covax-delivers-its-1-billionth-covid-19-vaccine-dose.

56 Eccleston-Turner and Upton (n 45).

57 Most recently, see Open Consultants, *External Evaluation of the Access to COVID-19 Tools Accelerator (ACT-A)* (10 October 2022). The report includes the COVAX Initiative as one of the scrutinized mechanisms.

the procurement mechanism therein, instead of their doing it individually. According to some accounts collected within said inquiry, it was an unrealistic goal because "that is not how the world works".[58] This supports the view that what is needed is a version of transnational solidarity that coexists with self-interests. Public authorities cannot be expected to act against their own constituencies when distributing scarce life-saving resources. If public authorities have the economic means to receive medical goods faster than others, they will have a legal reason for doing so. Otherwise, they risk being subjected to challenges of accountability nationally. Therefore, any expectation for national or regional authorities to put the population of other countries or regions on equal footing with their own remains wishful thinking. And expecting authorities to prioritize the population of other countries over their own in settings of scarcity and time pressure is, to put it bluntly, out of the question.

In its conclusions, the WHO-commissioned external inquiry on the performance of the ACT-Accelerator advocates more nuanced mechanisms for the procurement and distribution of medical goods in the future.[59] This effectively means creating initiatives meant to focus on supplying medical goods to countries unable to do so by themselves. High-income countries would retain their possibilities to procure medical goods based on their own economic capacities. A major question, then, lies in whether the competition between countries directly financing their own purchase medical goods could lead to some holdbacks.

3 Can International Law Strengthen Transnational Solidarity in Pandemics?

At the moment of writing, representatives of WHO Member States have embedded international solidarity in the distribution of medical goods during pandemics in the draft for a Convention on pandemic prevention, preparedness, and response. The draft published so far enshrines the principle of solidarity in health emergencies as aimed at "all people and countries… to achieve the common interest of a more equitable and better prepared world to prevent, respond to and recover from pandemics, recognizing

58 ibid 28.
59 ibid 73.

different levels of capacities and capabilities".[60] It is, therefore, a conception of solidarity that recognizes economic inequality between countries. An even stronger linkage is found in another core concept introduced in the draft for a pandemic agreement and the amendments to the International Health Regulations: equity. It is a concept closely linked to solidarity, as it refers to key normative arguments based on how global access to medical goods should not be contingent on the ability to pay for them.[61]

While equity has a distributive component, it is not a synonym for equality. Very broadly speaking, equity in the field of health refers to avoiding unequal outcomes that are both avoidable and unfair.[62] These two qualifiers lead us to assume that guaranteeing equality of outcomes in health is not possible, least of all in fields with multivariate problems such as public health. Instead, debates focus on how to remove "avoidable" obstacles preventing a more equitable global distribution of medical goods, whilst considering that full-blown equality cannot, and perhaps should not be the key objective. This falls in line with the Fair Priority Model developed during the COVID-19 pandemic by several scholars based on bioethical principles.[63] For instance, under the Fair Priority Model, countries with a higher need in view of epidemiological circumstances can be granted priority access to medical goods over others.[64]

In line with Putnam's two-level game explained in the introduction,[65] one major challenge present in the negotiations of a new pandemic agreement is to balance the domestic pull, on the one hand, and transnational solidarity in the distribution of pandemic-related medical goods, on the other hand. The domestic pull prevents negotiators, prima facie, from agreeing to positions that may put their populations at a disadvantage in future pandemic scenarios. Eventually, the populations of their countries may hold them accountable should they negotiate international obligations

60 At the moment of writing, the text used for reference is World Health Organization, *Proposal for the WHO Pandemic Agreement*, A77/10 (27 May 2024), available at: *https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_10-en.pdf*, see particularly Article 3.

61 Flood and Gross (n 46) 453.

62 Sara Willen, Michael Knipper, Cesar Abadia-Barrero and Nadav Davidovitch, 'Syndemic Vulnerability and the Right to Health' (2017) 389 The Lancet 966.

63 Ezekiel Emanuel and others, 'An Ethical Framework for Global Vaccine Allocation' (2020) 369 Science 1309–1312.

64 ibid. Authors, however, recognize that epidemiological circumstances can rapidly change, and global allocation mechanisms might hardly be able to keep up.

65 Putnam (n 9).

that do not cater to their interests.[66] Little wonder, then, that the envisaged provisions within a future pandemic treaty reflect a strong domestic focus as a basis for pandemic response.[67] Despite calls for reform,[68] national authorities' leeway in questions of public procurement is likely to remain unfazed, since states will retain the final say on how they will negotiate the purchasing of medical goods in the future. At the same time, unless consensus is achieved on alternative global distributive schemes of medical goods for future pandemics, the conditions undermining transnational solidarity during the COVID-19 pandemic will re-emerge.

In terms of a potential compromise, it is possible to devise multilateral mechanisms funded in parallel, with a focus on countries with fewer financial resources to secure medical goods more rapidly in the future. Some of the criteria for mitigating the nationalist pull have been included so far. For instance, the current pandemic agreement has obligations of transparency to know to what extent authorities are stockpiling pandemic-related medical goods.[69] After all, countering vaccine nationalism begins by attesting exactly how it is occurring. But, during the COVID-19 pandemic, most information related to the volume and prices in the procurement of vaccines was attained through secondary sources, ie in media reports and academic studies.[70] Enhanced transparency in disclosing the terms and conditions of pharmaceutical contracts – albeit with redacted clauses deemed to be commercially sensitive – would help diagnose the extent to which countries are procuring more doses than they actually need[71] while accounting for the difficulties in legally assessing such necessity. Exposing the obstacles to deeper transnational solidarity in the global distribution of medical goods is a needed endeavour. What remains, then, is to find a legal foundation for its success.

66 Joseph Brown and Johannes Urpelainen, 'Picking Treaties, Picking Winners: International Treaty Negotiations and the Strategic Mobilization of Domestic Interests' (2015) 59 Journal of Conflict Resolution 1069–1070.

67 The current negotiating text of the pandemic agreement includes sovereignty as one of the guiding principles for pandemic response. (n 60).

68 Ole Kristian Aars and Nina Schwalbe, 'Bold moves for vaccine manufacturing equity' (2023) 402 The Lancet 771–772.

69 (n 60), Articles 3 and 9. In favor of enhanced transparency in the disclosure of Advanced Purchase Agreements, Bogdandy and Villarreal (n 6).

70 See Wouters and others (n 32), Supplementary appendix 2.

71 Also argued in Katrina Perehudoff and others, 'A Pandemic Treaty for Equitable Global Access to Medical Countermeasures: Seven Recommendations for Sharing Intellectual Property, Know-How and Technology' (2022) 7 BMJ Global Health 4.

3.1 Human Rights Law: Legal Dimensions of (Constrained) International Solidarity

The strongest legal arguments for more solidarity between countries are found in human rights law. Considering the nature of pandemics, the right to health lies front and centre, as enshrined in Art. 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). It is certainly not the only human right at stake, because other human rights obligations are also relevant for shaping states' preparedness and response to pandemics.[72] But it is, ultimately, the clearest legal framing providing concrete, practical normative yardsticks for global health challenges. Under the right to health and existing authoritative interpretations such as those from the Committee on Economic, Social and Cultural Rights (CESCR), states must take active steps to protect their population against "epidemic diseases", including through "immunization".[73] Concrete actions to be taken will vary from disease to disease.

Human rights discussions abound on whether and to what extent governments ie states are obliged towards individuals located beyond their jurisdiction. While the ICESCR obliges states to cooperate towards economic development, this has been interpreted by the CESCR as referring to relationships between states,[74] and not between states and individuals. Furthermore, obligations to respect, protect and fulfill the right to health shed light on the precise manner in which persons' access to healthcare services and products ought to be guaranteed. Broadly speaking, human rights obligations to respect mandate authorities of a state not to act or incur in omission in a manner that impairs the enjoyment of human rights,[75] even of persons located outside their territory. This falls squarely with the no-harm principle, which also includes avoiding transboundary harm.[76] In

72 Among the different health-related human rights, the right to life enshrined in Article 6 of the International Covenant on Civil and Political Rights stands out. The Human Rights Committee has interpreted this provision as including an obligation by states to 'take appropriate measures to address… the prevalence of life-threatening diseases'. Human Rights Committee, *General Comment No. 36. Article 6: right to life*, para 26.

73 Committee on Economic, Social and Cultural Rights (CESCR) 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)' (11 August 2000) UN Doc EC/C.12/2000/4 para 16.

74 CESCR 'General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1 of the Covenant)' para 14.

75 CESCR (n 73) para. 33.

76 Jelena Bäumler, *Das Schädigungsverbot im Völkerrecht* (Springer 2017).

their dimension to protect, human rights require states to take active steps so that persons are not impaired by other factors in the enjoyment their rights. Lastly, human rights obligations to fulfill are perhaps the most onerous, considering how they compel states to take actions towards ensuring persons may achieve the "highest attainable standard of health".[77]

Under human rights law, it is uncontested that national authorities must take all means to fulfill the needs of the population under their effective control. Such a view, however, evolved in the course of time addressing situations where decisions by public authorities may have an impact on persons located outside their jurisdiction. This led to the development of the Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights.[78] These Principles, however, do not equate states' human rights between persons within their jurisdiction and persons outside of it.[79] In scholarship, some have posited such equivalence by stating that, practical implications notwithstanding, obligations to persons both within and beyond a state's jurisdiction stand at the same normative level.[80] Nevertheless, this point of view overlooks existing doctrine and institutional practice both at the multilateral and regional human rights systems. When States Parties fulfill their obligations under Arts. 16 and 17 ICESCR to report on the measures taken to observe their obligations,[81] both the CESCR and relevant non-state actors pose state representatives questions on how they upheld the human rights of persons within their jurisdiction.[82] At the most, as explained below, commitments

77 The obligation to fulfill is further structured in obligations to facilitate, provide and promote. CESCR (n 73), paras 3637.

78 Maastricht University/International Commission of Jurists, *Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights* (28 September 2011).

79 Olivier De Schutter, Asbjorn Eide, Ashfaq Khalfan, Marcos Orellana, Margot Salomon and Ian Seiderman, 'Commentary to the Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights' (2012) 34 Human Rights Quarterly 1146.

80 Elena Pribytkova, 'Are there Global Obligations to Assist in the Realization of Socio-Economic Rights?' (2022) 54 N.Y.U. Journal of International Law and Politics 451.

81 Most recently, see CESCR 'Report on the seventy-first and seventy-second sessions (14 February–4 March and 26 September–14 October 2022' (22 February 2023) UN Doc E/2023/22, paras 83–85.

82 See for instance, the Universal Periodic Reviews of the United Nations Human Rights Council, emphasizing their mandate as "reporting actions [taken by states] to improve the human rights situations *in their countries*" (emphasis added), United

to international assistance owed to other states are part and parcel of these obligations.

Obligations to fulfil ESC rights in general and the right to health, in particular, have not evolved to the extent that providing health services and goods – like immunization/vaccination of persons in territories beyond the jurisdiction of authorities – are inherent to states' human rights obligations. The United Nations General Assembly has set the goal for each country in terms of Official Development Assistance (ODA) as that of reaching 0.7 % of its Gross National Income.[83] The Committee on ESC Rights has linked the 0.7 % benchmark to Article 2(1) of the ICESCR, which enshrines states' obligations to "…take steps, individually and through international assistance and co-operation… to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means".[84] Such a decision, however, does not constitute a veritable transnational solidarity, rather a development aid at most.

By means of expanding the fulfillment of the right to health at the policy level, in 2015 all UN Members pledged in the Sustainable Development Goals

(SDGs) to "Ensure healthy lives and promote well-being for all at all ages".[85] Moreover, the SDGs also envisage a commitment to "Reduce inequality within and among countries", with the second dimension being based on official development assistance and financial flows.[86] While the

Nations Human Rights Council, *Universal Periodic Review*, available at: https://www.ohchr.org/en/hr-bodies/upr/upr-home.

83 The goal was first set in *International Development Strategy for the Second United Nations Development Decade,* United Nations General Assembly Resolution 2626 (XXV) (24 October 1970) UN Doc A/RES/25/2626.

84 Article 2(1), International Covenant on Economic, Social and Cultural Rights. There are trends at the Committee on ESC Rights to push for developed states' ODA commitments on the basis of this 0.7 %. CESCR 'Consideration of Reports by States Parties Under Articles 16 and 17 of the Covenant. Concluding observations of the Committee on Economic, Social and Cultural Rights: Spain' (6 June 2012) UN Doc E/C.12/ESP/CO/5, para. 10. See also Pribytkova (n 69) at 429.

85 SDG Goal 3, https://sdgs.un.org/goals/goal3.

86 SDG Goal 10.B, in particular, affirms a commitment to 'Encourage official development assistance and financial flows, including foreign direct investment, to States where the need is greatest…' https://www.un.org/sustainabledevelopment/inequality/.

SDGs are legally nonbinding, they can nevertheless be cited as normative references for assessing states' actions in a number of fields.[87]

3.2 A Prospective Legal Approach towards Transnational Solidarity in Pandemics

Picking up after the lessons learned from the limited success of the ACT-Accelerator and COVAX during the COVID-19 pandemic, the nationalist/regionalist pull should be worked around rather than rejected. Any future mechanism offering alternatives to the "every-country-for-itself" formula should not try to proscribe authorities' sovereign considerations to prioritize their own inhabitants. Such endeavour would be destined to fail. Heeding to arguments posited elsewhere, expecting high-income countries to "repair a broken system that works in their favour"[88] is hardly a compelling political case. High-income countries have little to no political incentive to restrain themselves in the procurement of pandemic-related goods in the future, particularly if that will mean relinquishing existing competitive advantages to the detriment of their constituents.

It is unclear to what extent the push for states to pay equal heed to distributive questions concerning the human rights of persons beyond those within their jurisdiction can be articulated. Not even the extraterritorial dimension of human rights law formulate normative standards applicable equally to the constituencies of different countries.[89] Indeed, when scrutinizing the actions of national authorities, quasi-judicial human rights bodies question them exclusively on the basis of what exactly they did to fulfill their obligations vis-à-vis their own populations.[90] There are exceptional instances in cases where the authorities of one country exercise effective

87 Heike Kuhn, 'Reducing Inequality Within and Among Countries: Realizing SDG 10. A Developmental Perspective', in Markus Kaltenborn, Markus Krajewski and Heike Kuhn (eds), *Sustainable Development Goals and Human Rights* (Springer 2020) 144–145.

88 Mark Eccleston-Turner, 'Future-Proofing Global Health Governance Through the Proposed Pandemic Treaty. Options and Challenges' (*Verfassungsblog*, 18 August 2022) https://verfassungsblog.de/future-proofing-global-health-governance-through-the-proposed-pandemic-treaty/.

89 Again, notwithstanding arguments in Pribytkova (ne 63).

90 As seen in the different United Nations Special Procedures and in the work of both the Human Rights Committee and the Human Rights Committee on Economic, Social and Cultural Rights.

control in territories beyond their own.[91] But there is no known instance in which national authorities are challenged on the basis of to what extent they actively *fulfill* the human rights of populations located beyond their jurisdiction. Moreover, the distribution of scarce goods during time constraints because of emergencies is a zero-sum game. Claims that vaccines, as such, are a "global public good" are normative and do not refer to their physical properties.[92]

That does not mean improvements are not conceivable. Instead, legal limits can be erected to constrain the domestic pull as much as possible.[93] A more robust version of transnational solidarity would need, first, to scrutinize exactly how inequities between countries played out during pandemics so far. The core drivers of vaccine nationalism will not recede in the foreseeable future. There is no point in devising mechanisms of distribution dependent on universal buy-ins, which may run counter to the interests of those meant to do so. Once there is consensus on that point, future mechanisms could offer middle-ground solutions that go beyond charity, whilst remaining a politically feasible option for stakeholders who need to accept such mechanisms.

Ongoing developments in international law on pandemic prevention, preparedness and response are paving the way for deeper discussions of what solidarity means at a transnational level. The current version of a pandemic treaty has devised a so-called Pathogen Access and Benefit-Sharing System (PABS).[94] It offers an operative dimension of solidarity through the concept of equity. In summarized terms, under the PABS model, states would be obliged to share samples of pathogens having pandemic potential with the WHO coordinating surveillance and lab network.[95] These pathogens can be crucial for developing future effective medical goods. In return, recipients of pathogen samples who attained them through PABS

91 Major examples are the United States' operations in Guantanamo prison and its occupation of Afghanistan, as well as the Russian Federation´s ongoing occupation of parts of the territory of Ukraine. For a related study, see Marko Milanovic, *Extraterritorial Application of Human Rights Treaties: Law, Principles, and Policy* (OUP 2011).

92 Jelena Bäumler and Julieta Sarno, 'The Immunisation against COVID-19 as a Global Public Good' (2022) 82 Heidelberg Journal of International Law 167–170.

93 Similar argument made by Benvenisti (n 3).

94 (n 60).

95 Namely, a global consortium of hundreds of laboratories that may handle pathogens with a pandemic potential, WHO, 'Coordinating Surveillance and Lab Network' https://www.who.int/europe/activities/coordinating-surveillance-and-lab-network.

must sign contracts – named Standard Material Transfer Agreements – that include a clause to provide the WHO with a 20 % of their "real-time production" if and when research using such samples leads to a pandemic-related product. This follows the logic of another existing non-binding mechanism, the Pandemic Influenza Preparedness Framework (PIP Framework).[96] The amount of 20 % doses is identical to the one found in the fair allocation mechanism in the COVAX Initiative, meant to ensure the protection of, first, critical personnel and, second, population groups at the highest risk in case of infection.[97]

The proposed PABS would represent a transnational form of solidarity, wherein states would commit to sharing pathogens with pandemic potential and the medical products resulting from the research and development using them. Such a model of solidarity, however, is not without criticism. The transactional approach of the PABS is, firstly, problematic in terms of the normative implications.[98] On the one hand, the proposed PABS does go beyond the PIP Framework's original bilateral framing, where only the state sharing the pathogen would have access to the benefit.[99] On the other hand, the PABS is based on the premise that sharing 20 % of real-time production is only justified after the sharing of a pathogen sample has occurred. This raises the question of why an unqualified international law obligation of sharing medical goods, which is not contingent upon a preceding pathogen-sharing, has not been considered.

96 WHO, *Pandemic influenza preparedness framework for the sharing of influenza viruses and access to vaccines and other benefits* (2nd edition, 2021) https://apps.who.int/iris/rest/bitstreams/1351857/retrieve. See also David Fidler and Lawrence Gostin, 'WHO's Pandemic Influenza Preparedness Framework: A Milestone in Global Governance for Health' (2011) 306 Journal of the American Medical Association 200.

97 Ezekiel Emanuel (n 63).

98 Mark Eccleston-Turner and Michelle Rourke, 'Arguments Against the Inequitable Distribution of Vaccines Using the Access and Benefit Sharing Transaction' (2021) 70 International and Comparative Law Quarterly 856, 858.

99 WHO, 'Standard Material Transfer Agreement 2' https://www.who.int/initiatives/pandemic-influenza-preparedness-framework/standard-material-transfer-agreement-2-(smta2).

4 Conclusions: Transnational Solidarity in Pandemics at a Crossroads

Like other crises, pandemics are in a relationship of tension with solidarity.[100] In a seminal article, Eyal Benvenisti argued that several of the normative principles of national-rooted sovereignty have evolved due to an increased interdependence between nations, where decisions taken by authorities in one state have an increased impact on stakeholders located beyond their jurisdiction.[101] The question, then, is what type of obligations derive from such interdependence. Considering the national anchors of political representation and accountability, a moral appeal to global ideas of solidarity does not suffice for shaping and construing international law obligations.[102]

Disagreements on how the global distribution of scarce medical goods should be undertaken during pandemics showcase the need to balance the interests of different stakeholders beyond those in a single country. Decisions on the procurement and, therefore, allocation of vaccines taken by public authorities have a direct impact on the populations of other countries. Vaccine nationalism is the direct offspring of pre-existing structures of political accountability, particularly in the public procurement of life-saving medicines. Studies have calculated around one million lives were unnecessarily lost to COVID-19 due to vaccine hoarding.[103] It can be said, then, that failures of transnational solidarity actually leads to a loss of life.

Despite the dramatic consequences of the unbridled self-interest of states, equality of consideration by authorities towards both their populations and those of other countries, while a subject of philosophical debate,[104] is not feasible in terms of international law arguments. Despite the expanding role of the WHO in the current pandemic treaty and amendments to the International Health Regulations, there is no intergovernmen-

100 Hildebrand, Farahat and Violante (n 1).

101 Benvenisti (n 3) 314–318.

102 Philipp Dann, 'Solidarity and the Law of Development Cooperation', in Rüdiger Wolfrum and Chie Kojima (eds), *Solidarity: A Structural Principle of International Law* (Springer 2010) 59–61.

103 Heidi Ledford, 'COVID vaccine hoarding might have cost more than a million lives', *Nature News* (2 November 2022) https://www.nature.com/articles/d41586-022-03529-3.

104 Notably, Thana de Campos-Rudinsky, 'Solidarity and Global Allocation of COVID-19 Vaccines. A Question of Equality?', in Tom Angier, Iain Benson and Mark Retter (eds), *The Cambridge Handbook of Natural Law and Human Rights* (CUP 2022) 465–482.

tal organization capable of representing the international community in the procurement of scarce medical goods. Instead, existing actors have either a private or a hybrid nature.[105] While these actors can exercise international public authority on the operative side of global health policies,[106] their lawmaking powers are still not equivalent to those of intergovernmental organizations. In view of this setting at the multilateral level, what is left is a set of competing normative priorities[107] towards national and foreign rights-holders, where existing legal structures allow the former to prevail over the latter.[108]

Ongoing developments regarding the lawmaking powers of the WHO have opened a path towards different visions of transnational solidarity. So far, treaty negotiations in Geneva have yet to entrench a stronger view of transnational solidarity in future pandemics. Nevertheless, proposals to mitigate the impact of nationalism on pandemic prevention, preparedness and response are still worth exploring. This chapter has posited that any transnational solidarity in pandemics can only be feasible by taking seriously the conceptual tenets of vaccine nationalism witnessed during the COVID-19 pandemic. Only then can solutions be devised to avoid a repeat of the distributive "moral catastrophe" experienced during the pandemic.[109] Future rules of international law will have higher chances of being effective if they work around, rather than aim to suppress the nationalist leanings involved in the public procurement of medical goods.

105 Whether and to what extent these actors exercise international public authority must be attested on a case by-case basis. This, in turn, differs from intergovernmental organization with a legal mandate provided at the outset by their Member States. For more on the theoretical framework of hybrid actors as ad hoc instances of international public authority, see Matthias Goldmann, 'Internationales Verwaltungsrecht', in Andreas Voßkuhle, Martin Eifert and Christoph Möllers (eds), *Grundlagen des Verwaltungsrechts* (3rd edn, CH Beck 2022) 351–352. More specifically on the role of public-private-partnerships in global health, see Markus Kaltenborn and Nina-Annette Reit-Born, 'Public-Private Partnerships als Akteure des Globalen Gesundheitrechts' (2019) 57 Archiv des Völkerrechts 53.

106 On how this was the case with the ACT-Accelerator, see Suerie Moon et al, 'Governing the Access to COVID-19 Tools Accelerator: Towards Greater Participation, Transparency, and Accountability' (2022) 399 The Lancet 492–493.

107 Ferguson and Caplan (n 47).

108 Ana Tanasoca and John Dryzek, 'Determining Vaccine Justice in the Time of COVID-19: A Democratic Perspective' (2022) 36 Ethics & International Affairs 336; (n 11).

109 (n 16).

Lastly, the reaffirmed principle of sovereignty in the current text of the pandemic treaty is not necessarily antagonistic to human rights considerations. Just like how decisions taken within ACT-Accelerator have "crucial implications" for numerous beneficiaries,[110] so does the procurement of medical goods by national and regional authorities. Consequently, even across national authorities, there is an emerging consensus on the need to devise better mechanisms for improving access to medical goods for stakeholders located outside of their jurisdiction. It is a recognition that they can, and should be held to a more stringent standard of transnational solidarity than they currently are. The legal framing of distributive issues during pandemics is a step in that direction, albeit not without hindrances. Whether more ambitious international law obligations for realizing transnational solidarity during pandemics politically stand any chance at prevailing remains an open question.

110 Moon and others (n 106) 491.