A Shared Responsibility Model

Sharon Bassan

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Piecemeal and fragmented policymaking during Covid-19 underscored the need for an equity-focused global health agenda. Several international health law mechanisms, such as The International Health Regulations (IHR) and "soft law" frameworks, try to bring together relevant stakeholders to the table, help ensure international sharing of medical information, and facilitate equitable distribution of the benefits of research in developing vaccines and therapeutics. Nevertheless, their application during COVID-19 did not result in an effective global governance. Most responses were nationally-focused, lacked global commitment and solidarity, failed to notify the WHO of novel outbreaks, and were non-compliant with its professional recommendations.

Many agree that the solution should be multileveled and structural—a result of the connection and cooperation between participants. The prism of the "shared responsibility model" provides an interesting opportunity to consider potential global health governance models for emergency actions. My refined version of the model is based on Iris Young and Christian Barry's suggested models, and includes two pairs of parameters, engaging and assigning. Engaging parameters locate the involved actors, and explain why they are assigned responsibilities. Assigning parameters address the type of duties each actor bears, and the site where they are expected to take action.

"Engaging parameters", *accountability* and *benefit*, redirect attention from those who experience injustice to those who contribute to or enjoy from the status quo. The *accountability* parameter looks who is accountable for an area where correction and prevention of ongoing structural injustice is required, rather than looking for actors who have contributed to bringing unjust situations about within their actions with the purpose to blame for mal-intent. Such actors could, for example, be those who advance the public's health in national and international contexts, rather than who has contributed to the breakout of COVID-19. The *benefit* parameter is based on the unjust gain, or relative privilege, contributors may get from the situation. Privileged actors have more power in the structure and are usually those who will have the capacity to change the structure in their favor. It is debatable if anyone gains from a pandemic, but some actors are more privileged than others, have better access to vaccines, medical equipment or relevant information, thus should play the substantial role.

The engaging parameters enable allocating responsibilities between different kinds of actors, with asymmetric powers, beyond governments. While the engagement of the UN, WHO, or governments is obvious, the accountability parameter may also engage other stakeholders to sit at the table. For example, domestically, representatives from the education systems responsible for student's health, employers' representative responsible for worker's health, or individuals whose accountabilities (to social distance, wear a mask, or get vaccinated) are required overcome the pandemic.

Globally, the benefit parameter should include privileged as well as less privileged countries to include a diverse perspective to needs and the feasibility of solutions in different contexts. The model could be adopted in different contexts, emergency or others, for different goals. Since it is forward-looking, it could focus on healing and minimizing general global health inequalities, beyond the pandemic, or on exacerbated inequalities due to the pandemic. However realistically, emergency goals provide more incentives to collaborate. Issues that are not unique to the pandemic may be addressed in a separate process. Inability of governments to address the pandemic in their border will not only result in greater health impact to their citizens, but will also inevitably affect other countries,

capable or not. Since the pandemic does not recognize national borders, the commitment of governments should extend beyond national interests. Affluent countries may be assigned duties towards less capable countries, for example to help them negotiate with pharmaceuticals to get vaccines before providing a third boost for their own citizens. Similarly, during pandemic, pharmaceuticals companies who may benefit if their product is used all over the world should be engaged due to their benefit from their product, for which they are accountable and show how they can reduce the spread of COVID-19. In a non-emergency situation they may have a different goal-specific duty, such as to contribute their share to a more extensive international assistance framework, especially where joint action is necessary. NGOs or human rights organizations could represent individuals' interests and strive to increase access to medical resources and minimize health inequalities in specific regions in accordance with specific needs.

"Assigning parameters," *connectedness* and *capacity,* address the content and the scope of the expected action, according to positions and authorities actors have within the specific context. The *connectedness* parameter looks into inter-relations between actors and the commitment they imply towards fellow actors. Connectedness does not mean how each actor is connected to the injustice (the connection to injustice is a preliminary engagement criterion rather than a parameter for assigning responsibilities). Rather, since each actor is differently positioned, not all stakeholders are connected to the goal of alleviating the burden of COVID-19, or reacting to public health crises in the same way. Responsibilities are different in nature and scope, according to the roles, the different values their positions entail, and specific interaction they may have with others. This implies different areas where action should be taken, even by the same actor. For example, based on their relationship, governments may have certain duties to their citizens, for example to allocate and provide vaccines. Governments may have different sort, albeit parallel, of duties to fellow governments with reduced capacities, for example humanitarian or political commitments. The *capacity* parameter requires all participants to take independent responsibility within their authority in accordance with each actor's level of powers and influence. This effective and practical parameter transfers many responsibilities to stronger, more capable actors who are better institutionally and materially situated in practices they are involved in. The duties assigned through the model are within the authorities those actors normally have, which may hold the potential to improve compliance, despite lack of governance which raises enforcement concerns regarding unmet duties.

Different goals will most likely engage different scope of actors and the bearers of duties may change according to specific contexts, for example, national and international. In a domestic policy-making, the grand majority of the responsibility lies with the state and its institutions. For example, national healthcare providers and public health professionals should be heard at the policy-making level in order to clarify the feasibility of different interventions. In the international sphere, some of the same responsibilities might be shared with international organizations (e.g. WHO) or with other global actors. The international role of states will obviously be different from their role within their sovereignty.

ABOUT THE AUTHOR

Sharon Bassan

Sharon Bassan is a legal scholar with expertise in (bio)ethics, health policy, innovation, and information technology law and ethics. She is currently the Jaharis Faculty Fellow in Health Law and Intellectual Property at the DePaul University College of Law.

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