A European Take on Global Public Health: Applying the Catholic Principle of Subsidiarity to Global Health Governance

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2019 COVID, 2016 ZIKA, 2014 EBOLA, and 2009 H1N1 outbreaks have repeatedly shown that global public health needs a better (more effective and more efficient) governance approach to tackle Public Health Emergencies of International Concern (PHEIC). The World Health Organization (WHO), perceived as the global public health leader *par excellence*, is typically accused of not doing enough.[1] A proper leader, so it is claimed, should centralize its authority and powers to reverse the spread of these PHEIC.[2] I call this "the centralization approach." I argue against it. Centralization is not always the most reasonable, effective, and efficient form of leadership in global governance. To explore and argue for the decentralization approach to global public health, I introduce a traditional idea of the European Union (EU) governance: the principle of subsidiarity.

As a principle of Catholic social teaching, subsidiarity has been emphasized as an effective governance tool over centuries by various papal encyclicals. It establishes that, where families, neighborhoods, and local communities can effectively address their own problems, they should do so. When they cannot, then governments and other higher-level structures of power and authority should intervene and provide aid (i.e., *subsidium*). The term "sub-sid-iary"—which literally

[1] See Lawrence O. Gostin, "Ebola: Towards an International Health Systems Fund," *Lancet* 384, no. 9951 (2014): doi.org/10.1016/S0140-6736(14)61345-3; Lawrence O. Gostin and Eric A. Friedman, "Ebola: A Crisis in Global Health Leadership," *Lancet* 384, no. 9951 (2014): doi.org/10.1016/S0140-6736(14)61791-8; Ilona Kickbusch and Krishna S. Reddy, "Global Health Governance: The Next Political Revolution," *Public Health* 129, no. 7 (2015): 838–842; Tim K. Mackey, "The Ebola Outbreak: Catalyzing a 'Shift' in Global Health Governance?," *BMC Infectious Diseases* 16 (2016): doi.org/10.1186/s12879-016-2016-y; Lawrence O. Gostin et al., "The Normative Authority of the World Health Organization," *Public Health* 129, no. 7 (2015): 854–863, at 857.

[2] See Mackey, "The Ebola Outbreak"; Gostin et al., "The Normative Authority," 857.

means to "seat" ("sid") an activity down ("sub") as close to the problem as possible[3]—recognizes the value of first trying to solve social problems locally and moving up to higher levels of governance only as necessary. This Catholic principle was adopted as part of the EU law in the 1992 Treaty of Maastricht in order to prevent excessive centralization within the European system of governance. Its legal requirements are most clearly defined in Article 5(3) of the 1992 Maastricht Treaty, which states that "in areas which do not fall within its exclusive competence, the Union shall act only if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States, either at central level or at regional and local level, but can rather, by reason of the scale or effects of the proposed action, be better achieved at Union level." In short, the 1992 Treaty of Maastricht embedded EU law with the principle of subsidiarity to prevent excessive centralization in Brussels, to recognize the value of a plurality of social groups, and to require "higher (larger) groups to aid lower (smaller) groups, rather than to obliterate or subsume them."[4]

The idea conveyed by the principle of subsidiarity, however, has not been applied to other structures of global governance beyond the EU, but subsidiarity and its decentralization approach could be a particularly promising principle for global health governance. In this chapter, I analyze some of main features of the centralization approach—the mainstream position among most global health governance scholars—according to which the WHO should centralize more power and authority to be able to exercise better leadership in global public health. To challenge this approach, I introduce the idea of subsidiarity as a structural principle of governance and discuss its application to global health governance. In doing so, I explain why subsidiarity proposes a better (i.e., more reasonable, effective, and efficient) alternative than centralization. I conclude by affirming that the principle of subsidiarity justifies certain limitations to the roles and functions of the WHO and of other higher-level global health authorities by including the participation of local communities and, thereby, strengthening the overall framework for preparedness and response to PHEIC.

THE CENTRALIZATION APPROACH

Global health governance is the worldwide institutional structure whose main purpose is to orchestrate a wide range of independent stakeholders, comprising state and non-state actors, with different

[3] See Robert K. Vicher, "Subsidiarity as a Principle of Governance: Beyond Devolution," *Indiana Law Review* 35 (2001): 103–142, at 103.
[4] Nicholas W. Barber and Richard Ekins, "Situating Subsidiarity," *American Journal of Jurisprudence* 61, no. 1 (2016): 5–12, at 5.

capacities and self-regulating mandates.[5] Examples of global health stakeholders include: the World Bank; United Nations agencies (such as the WHO and the International Monetary Fund); civil society organizations (like Global Fund, Médicins Sans Frontières, Red Cross, Bill and Melinda Gates Foundation, etc.); pharmaceutical transnational corporations; global health donors; governments in developed, developing, and underdeveloped countries; the local communities affected by the global public health problem under consideration; and the hospitals, healthcare professionals, medical researchers, and even the media reporting on global health threats. These stakeholders are independent because the laws, policies, and programs they enact typically address one singular aspect of a multi-faceted global health problem in a self-determining way.[6] Yet, they are willing to cooperate in addressing together global public health threats, like the recent PHEICs.

Although global health governance should serve the purpose of orchestrating this wide range of stakeholders towards an adequate global public health response that safeguards the global common good, lack of coordination among stakeholders is a fundamental defect of this governance structure. Lack of coordination leads to inadequate, delayed, and fragmented responses, as well as duplication of global public health services, waste, and unnecessary competition among stakeholders that could be working together in more efficient and complementary ways.[7]

While global health governance's lack of coordination among global health stakeholders leads to efficiency problems, its lack of inclusion and participation of local communities further leads to serious effectiveness problems.[8] Local communities, directly affected by the global public health problem under consideration, know better than outsiders what their specific health needs and most urgent concerns are. Not including affected communities in the decision-making process is therefore a sure way to respond less effectively to the problem. It is argued, however, that the chief cause of such exclusion is the donor-centered model of international development

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[5] See Sophie Harman, *Global Health Governance* (Abingdon, UK: Routledge, 2012).
[6] See Jennifer Prah Ruger, "Global Health Governance as Shared Health Governance," *Journal of Epidemiology and Community Health* 66, no. 7 (2012): 653–661, at 653.
[7] See Ruger, "Global Health Governance," 654; Mackey, "The Ebola Outbreak"; Lawrence O. Gostin and Emily A. Mok, "Innovative Solutions to Closing the Health Gap between Rich and Poor: A Special Symposium on Global Health Governance," *Journal of Law, Medicine & Ethics* 38, no. 3 (2010): 451–458, at 451 and 453; Gostin et al., "The Normative Authority," 854, 857; Gostin and Friedman, "Ebola: A Crisis in Global Health Leadership," 1323; Kickbusch, and Reddy, "Global Health Governance: The Next Political Revolution," 838.
[8] See Ruger, "Global Health Governance," 654.

assistance.[9] Since global health institutions providing assistance characteristically focus on complying first and foremost with the donors' expectations, rather than with the affected communities' specific health needs and most urgent concerns, local communities are habitually neglected and excluded from the decision-making processes.

The centralization of decision-making power and authority in the hands of the WHO has typically been advocated as the proper remedy to both lack of coordination and lack of inclusion of local communities.[10] In centralizing more power and authority, the WHO would take on new roles. These would include, first, the responsibility of ensuring that both global health institutions providing assistance and the local communities receiving such assistance pursue a common goal. The idea here is to foster coordination by uniting the efforts of all stakeholders involved in a more complementary and efficient way. This effort would be done under the coordination guidance and leadership of the WHO. This means that the WHO would have a more active role in helping to define and clarify stakeholders' goals (individual and shared goals alike). Second, the WHO would take on the responsibility of ensuring that the health needs and most urgent concerns of local communities are prioritized over and above donors' expectations. The idea here is to empower local communities by fostering their inclusion and participation in healthcare resource allocation decision-making processes. This would be done under the centralizing power and authority of the WHO. The WHO would have a more active role in administrating all global public health funds, more specifically by concentrating the power to set priorities and allocate these resources accordingly.

The strength of the centralization approach lies in the fact that it reclaims, rather than shrinking, WHO's responsibilities as the global public health leader *par excellence*. However, it is not clear how centralization would more efficiently create better coordination among global health stakeholders, and how it would more effectively give voice and include marginalized communities into complex decision-making processes, where judgements need to be made in haste as an immediate response to the characteristic time-constraints of outbreaks. Instead of fostering efficient coordination and effective participation of local communities, centralization with the WHO will, I argue, have the opposite effect. First, centralization will expand WHO's bureaucracy, management costs, and therefore its inefficiency. Second, in further expanding the level of administration and governance structure, centralization in the hands of the WHO will only increase the distance from the local communities. Surely, if there

[9] See Gostin and Mok, "Innovative Solutions," 452.
[10] See Gostin et al., "The Normative Authority," 857; Mackey, "The Ebola Outbreak."

is more separation, there is inevitably a less effective dialogue. Coordination and inclusion, therefore, are not made easier but rather become more challenging as the administration and governance structure expand.

THE DECENTRALIZATION APPROACH

If the centralization approach is not a reasonable solution to the defects of global health governance, can decentralization be a more suitable alternative? To argue for the decentralization approach to global health governance, I introduce the principle of subsidiarity, on which the decentralization approach is predicated.

Origins and Development of Subsidiarity

The origins of the idea of subsidiarity can be traced back to classical Greece, where Aristotle (384–322 BCE) discusses the city as the community of communities, and the family, home, and village as the communal structures conducive to human flourishing. Subsequently, in the medieval period, Aquinas (1225–1274) further developed the idea of subsidiarity. Building on Aristotle's discussion on community, Aquinas elaborates on the idea of subsidiarity by explaining the dynamics among diverse groups composing a community. Then, in the sixteenth and seventeenth centuries, the Calvinist scholar Johannes Althusius (1557–1638) mentions the idea of subsidiarity within his theory of the federal state and his idea of "spheres of sovereignty." A myriad of political theorists followed Althusius and further echoed the idea. These theorists included John Locke (1632–1704), Montesquieu (1689–1775), Alexis de Tocqueville (1805–1859), John Stuart Mill (1806–1873), Pierre-Joseph Proudhon (1809–1865), and Abraham Lincoln (1809–1865).[11]

Later, in the nineteenth century, when the world wrestled with the two extremes of laissez-faire capitalism and Marxist socialism, Catholic social theorists, in seeking a more balanced approach, found a principled alternative in the idea of subsidiarity. It was in this historical context of the nineteenth and twentieth centuries that Catholic social thought substantially developed the idea of subsidiarity.[12] In 1891, Pope Leo XIII's *Rerum Novarum* highlighted the idea of subsidiarity. Although this papal encyclical did not explicitly use the term subsidiarity, the idea was clearly embedded in

[11] See Paolo G. Carozza, "Subsidiarity as a Structural Principle of International Human Rights Law," *American Journal of International Law* 97, no. 38 (2003): 38–79, at 41; Michelle Evans, "The Principle of Subsidiarity as a Social and Political Principle in Catholic Social Teaching," *Solidarity: The Journal of Catholic Social Thought and Secular Ethics* 3, no. 1 (2013): 44–60, at 44.

[12] On subsidiarity and Catholic social teaching, see also Lisa Sowle Cahill's chapter in this volume.

the text by stressing that "the State must not absorb the individual or the family; both should be allowed free and untrammeled action so far as is consistent with the common good and the interest of others. Rulers should, nevertheless, anxiously safeguard the community and all its members" (no. 35).

Although *Rerum Novarum* stressed the need for the State not to obliterate the individuals, the families, and the various other forms of smaller communities within its jurisdiction, the encyclical also sought to respond more directly to unfettered capitalism, advocating for public assistance and for an adequate protection of civil society associations, such as workers unions. As Pope Leo XIII wrote,

> The consciousness of his own weakness urges man to call in aid from without. It is this natural impulse which binds men together in civil society; and it is likewise this which leads them to join together in associations which are, it is true, lesser and not independent societies, but, nevertheless, real societies (*Rerum Novarum*, no. 50).

In 1931, the dynamic relationship between the larger society and the lesser societies was revisited in Pope Pius XI's *Quadragesimo Anno*. In acknowledging the societal changes and historical situation of the time, the papal encyclical draws attention to the unchanging character of the principle of subsidiarity, in that it orders the relations between small/lower-level and large/higher-level associations towards the common good of all:

> As history abundantly proves, it is true that on account of changed conditions many things which were done by small associations in former times cannot be done now save by large associations. Still, that most weighty principle, which cannot be set aside or changed, remains fixed and unshaken in social philosophy: Just as it is gravely wrong to take from individuals what they can accomplish by their own initiative and industry and give it to the community, so also it is an injustice and at the same time a grave evil and disturbance of right order to assign to a greater and higher association what lesser and subordinate organizations can do. For every social activity ought of its very nature to furnish help to the members of the body social, and never destroy and absorb them (no. 79).

If *Quadragesimo Anno* more directly responds to unfettered socialism, by emphasizing the negative component of subsidiarity (i.e., the negative duty of large/higher-level communities to refrain from interfering in the business of small/lower-level communities),[13] in 1961 Pope John XXIII would reiterate the positive component—duty of large/higher-level communities to assist small/lower-level

[13] See Pius XI, *Quadragesimo Anno*, no. 80.

communities—in *Mater et Magistra*. This papal encyclical explains subsidiarity as a remedy against the excesses of both public and private forms of ownership of property (no. 53). While an excessive public ownership of property may lead to a complete destruction of private ownership of property (no. 117), an excess of the latter ought also to be contained by the "public authority [which] must encourage and assist private enterprise, entrusting to it, wherever possible, the continuation of economic development" (no. 152).

Pope Saint John Paul II puts forth a similarly balanced approach in *Centesimus Annus*. Acknowledging the creation of "a new type of State, the so-called 'Welfare State'" (no. 48) as an attempt to answer and react to "many needs and demands, [and] forms of poverty and deprivation unworthy of the human person" (no. 48), *Centesimus Annus* recalls the principle of subsidiarity for the pursuit of an ordered structure, where large/higher-level communities and small/lower-level communities respect each other's spheres of competence and work together towards the common good. As Pope St. John Paul II puts it: "Here again *the principle of subsidiarity* must be respected: a community of a higher order should not interfere in the internal life of a community of a lower order, depriving the latter of its functions, but rather should support it in case of need and help to coordinate its activity with the activities of the rest of society, always with a view to the common good" (*Centesimus Annus*, no. 48).

Most recently, in 2005, Pope Benedict XVI's *Deus Caritas Est*, further stresses subsidiarity as a principle of justice. For a "just social order," Pope Benedict XVI clarifies that "We do not need a State which regulates and controls everything, but a State which, in accordance with the principle of subsidiarity, generously acknowledges and supports initiatives arising from the different social forces and combines spontaneity with closeness to those in need" (no. 26).

Catholic social scholars have extensively studied, debated, and therefore developed the idea of subsidiarity over the past centuries. This Catholic idea was adopted in 1992 as part of the EU law in the Treaty of Maastricht, to avoid excessive centralization of power and authority within the European system of governance and the EU community.[14] This is because the principle of subsidiarity allocates

[14] See Article 5(3) of the 1992 Maastricht Treaty on the European Union for the legal requirements of the principle of subsidiarity. The 2007 Treaty of Lisbon (a.k.a., Reform Treaty) amends the Maastricht Treaty. For the principle of subsidiarity, see article 5 of the Treaty of Lisbon: "1. The limits of Union competences are governed by the principle of conferral. The use of Union competences is governed by the principles of subsidiarity and proportionality…. 3. Under the principle of subsidiarity, in areas which do not fall within its exclusive competence, the Union shall act only if and insofar as the objectives of the proposed action cannot be sufficiently achieved by the Member States, either at central level or at regional and local level, but can

power and authority in a principled manner amongst the various levels of competence that exist in a certain community. It serves the purpose of ordering the governance structure of a community, and it does so by calling the problems in such community to be addressed from the bottom up, rather than the top-down perspective. Alternatively put, the principle of subsidiarity establishes that, only when the lowest sphere of power and authority proves ineffective in solving a certain problem, should the higher spheres of power step in, interfere, and become involved in those local affairs. To be sure, although the principle of subsidiarity does call for the intervention of higher spheres of power and the assistance (or *subsidium*) of the lower-level community when necessary, it equally calls for the respect and protection of the legitimate freedom and self-determination of the lower-level/small communities which are directly facing the problem.[15]

One reason for the allocation of power and authority in such bottom-up manner is efficiency: the principle of subsidiarity optimally distributes power and authority in a way that seeks to minimize waste, delay, and duplication. However, the principle of subsidiarity goes beyond the utilitarian rationale of efficiency. By concomitantly requiring (a) the larger (i.e., higher level) community's intervention and assistance reliant on (b) respect and protection of the legitimate freedom and self-determination of the smaller (i.e., lower level) community in need of assistance, the principle of subsidiarity entails coordination and inclusion.

First, the principle of subsidiarity necessitates coordination between the provider and the recipient of the assistance in such a way that their interests are harmonized. The provision of *subsidium* is only adequate if the needs and most urgent concerns of the smaller (i.e., lower level) community are met. Subsidiarity therefore requires that the best interests (i.e., the good) of the smaller (i.e., lower level) community are safeguarded. However, it also requires that the best interests (i.e., the good) of the larger (i.e., higher level) community, of which the smaller (i.e., lower level) community is part, is safeguarded as well. In other words, the principle of subsidiarity requires the good as well as the common good of the parts involved. Their interests

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rather, by reason of the scale or effects of the proposed action, be better achieved at Union level. The institutions of the Union shall apply the principle of subsidiarity as laid down in the Protocol on the application of the principles of subsidiarity and proportionality. National Parliaments ensure compliance with the principle of subsidiarity in accordance with the procedure set out in that Protocol." European Parliament, "Treaty on the European Union/ Maastricht Treaty," www.europarl.europa.eu/about-parliament/en/in-the-past/the-parliament-and-the-treaties/maastricht-treaty.

[15] See Paolo G. Carozza, "The Problematic Applicability of Subsidiarity to International Law and Institutions," *American Journal of Jurisprudence* 61, no. 1 (2016): 51–67, at 51.

ought to be orchestrated, harmonized, and integrated into a coherent whole that upholds the flourishing of all (i.e., the common good).[16]

Second, the principle of subsidiarity is conditional upon the inclusion of the assisted community through their participation in the decisions pertaining to the assistance process. The provision of *subsidium* is only adequate if the legitimate freedom and self-determination of the smaller (i.e., lower level) community are respected, protected, and fulfilled. Subsidiarity therefore requires an appreciation for human agency, upon which all persons and communities need to act to realize and participate in their own good. Since human flourishing and the common good necessitate active participation of all persons and communities, rather than passive recipience of assistance, the principle of subsidiarity requires that the larger (i.e., higher level) community refrain from making decisions for the smaller (i.e., lower level) community. The smaller (i.e., lower level) community ought never to be treated as a mere passive recipient of material aid and ought to own her *subsidium*-related decisions, together with the larger (i.e., higher level) community.[17]

Subsidiarity and the Decentralization Approach to Global Health Governance

Both the centralization and the decentralization approaches share the goal of tackling global health governance's lack of coordination and inclusion. However, the means through which each approach proposes to achieve such common end differs substantially. On the one hand, the centralization approach advocates for a more powerful WHO, which concentrates more decision-making authority and therefore more responsibilities.[18] The decentralization approach, on the other hand, advocates for a more restrained WHO, which not only refrains from making decisions for the community in need of assistance—unless it is utterly incapable of doing so by itself—but also requires the assisted community to actively participate in all assistance-related decisions as a condition for the provision of aid. The decentralization approach may not be necessarily the fastest, as it gives the assisted community the time and space that it needs to make its own decisions and own its choices, which takes time and patience. Moreover, in PHEICs, since most decisions are often urgent, time is a particularly scarce and luxurious resource. The question of how much time the assisted community should be allowed to take is difficult and complex: for a prudent assessment, a number of factors (e.g., the spreadability of the PHEIC, its severity, resource-constraints, etc.) should be taken into consideration. However, the fact that this question

[16] See Carozza, "The Problematic Applicability," 53.
[17] See Carozza, "The Problematic Applicability," 54.
[18] See Mackey, "The Ebola Outbreak"; Gostin et al., "The Normative Authority," 857.

is difficult and complex does not mean that it is not ethically necessary. In dialogue with the community, it will be the task of global health policy makers to define a specific, prudent, and safe timeline.

Although the decentralization approach may not be the fastest and therefore the most efficient form of allocation of power and authority, the decentralization approach does minimize waste, delay, and duplication by requiring both coordination and inclusion. The interpretation of what coordination and inclusion mean within the centralization and the decentralization approaches varies. While the centralization approach understands "coordination" to mean that the WHO would have a more active role in helping define and clarify stakeholders' goals (individual and shared goals alike),[19] the decentralization approach invites the WHO to step back and leave the assisted communities to define their own goals as much as possible. The key idea behind the decentralization approach is that a good leader is a just leader. A just leader never steps in and interferes unnecessarily but rather respects the self-determination and protects the rhythm of development of those she assists with her leadership. In seeing the great leadership potential of the WHO, the decentralization approach would incentivize the WHO to lead by avoiding paternalistically imposing fixed goals or micromanaging the global health stakeholders under WHO coordination.

Likewise, while the centralization approach interprets "inclusion" to mean that the WHO would have a more active role in assuming the responsibility to administer all global public health funds—more specifically by concentrating the power to set priorities and allocate these resources accordingly[20]—the decentralization approach invites the WHO to assume less responsibilities. The key idea behind the decentralization approach is that a good leader is a wise and therefore humble leader who is not overcommitted and does not have overextended capacities. A good leader is prudently aware of her own limitations, weaknesses, and vulnerabilities and is ready to ask for assistance by delegating those tasks she will not be able to complete without aid. In recognizing the great leadership potential of the WHO, the decentralization approach would incentivize the WHO to lead by freeing itself from executing too many global health functions that could, instead, be executed by lower-level global health institutions, saving WHO's money, time, and energy, and allowing the WHO to exercise its core functions.

[19] See Mackey, "The Ebola Outbreak"; Gostin et al., "The Normative Authority," 857.
[20] See Tim K. Mackey and Bryan A. Liang, "A United Nations Global Health Panel for Global Health Governance," *Social Science and Medicine* 76, no. 1 (2013): 12–15, at 12–13.

CONCLUSION

It is commonly argued that the WHO should be reformed by way of centralizing more power and authority. Only then, so it is claimed, the WHO would be a good leader in global public health. I have challenged this mainstream view by arguing for a decentralized approach to global health governance, predicated on the EU law principle of subsidiarity. This principle justifies limitations to the roles and functions of higher-level structures of competence, such as the WHO. These limitations would free the WHO to focus on addressing the chief deficiencies of global health governance, namely lack of coordination and inclusion of local communities. The sort of coordination and inclusion proposed by the decentralization approach requires peculiar leadership skills—especially the ability to listen to those under one's leadership. This requires a leader with great disposition to be patient in hearing different voices, humble in learning by asking questions and including all under her leadership, and therefore wise in knowing when to assist or step back by respecting the persons and communities under her leadership.[21]

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[21] In this book, Alexandre Martins further stresses the importance of listening to the voices of those at the margins by fostering their engagement and by empowering them.