

Differentiated Institutionalization of Multilateral Rules under Distributional Conflict: Leadership and Modular Compromise in Negotiating the WHO Pandemic Agreement (2021–2025)

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Abstract. The COVID-19 pandemic revealed inequalities in response to direct health access. During the pandemic, states had engaged in manifesting a formally universal health system, but had had drastically varying access to vaccines, diagnostics, therapeutics, financing, and manufacturing capacity. The paper explores the institutionalisation of multilateral rules in the context of an ongoing distributional conflict within the negotiations of 2021–2025. It argues that agreement became possible through differentiated institutionalisation: negotiators combined binding framework obligations with flexible, capacity-sensitive implementation, deferred technical annexes, facilitative compliance, and issue-specific arrangements that permitted different levels and forms of commitment. Leadership was not just the (hegemonic) designation of powerful states, but it was a multi-layered affair of the WHO Secretariat, a regionally-balanced Bureau of the Intergovernmental Negotiating Body, the European Union, the African states, and even larger coalitions of developing countries. These actors illuminated incompatible preferences through modular compromises with regard to technology transfer, pathogen access and benefit sharing, financing, supply chain and implementation review. The resulting design reflected shared values of equity and had relatively few changes in its immediate impacts of redistribution, while maintaining national sovereignty. While widening the adoption coalition, the differentiation also pushed out thorny distributive dilemmas to future governance decisions, such as the Pathogen Access and Benefit-Sharing annex. The Agreement should therefore be better understood as an evolving framework rather than a one-off settlement.

Keywords: WHO Pandemic Agreement, Global health governance, Distributional conflict, Institutionalization, Multilateral negotiation

1. Introduction

The uneven distribution of resources necessary to tackle an infectious disease crisis has surfaced as a key tension in the governance of global health, tackling COVID-19. Current systems in place, such as the International Health Regulations (IHR), set provisions for reporting and cooperation, but

failed to have a similar commitment to access to vaccines, diagnostics, therapeutics, financial resources, or manufacturing facilities. During the pandemic situation, more medical countermeasures were secured in advance by high-income countries, whilst many low- and middle-income countries were faced with great delay, even after providing surveillance information and being part of international programs [1]. These differences shifted from a technical problem to a political problem with regard to equity, responsibility, and access.

To address these issues, the Intergovernmental Negotiating Body (INB) was established at the World Health Assembly in December 2021 to prepare an international instrument on pandemic prevention, preparedness and response [2]. After over three years of negotiation, the member states adopted the WHO Pandemic Agreement on 20 May 2025, under Article 19 of the WHO Constitution [3-5]. The Agreement is an important step in enhancing global pandemic governance and resolving some of the existing gaps identified during the COVID-19 outbreak. However, the importance of the Agreement extends beyond its legal status. The debate around things like sovereignty, intellectual property, funding, technology transfers and pathogen sharing was enormous. While states showed a consensus that international cooperation is needed, they were split on the distribution ground rules for costs and benefits of international cooperation [6]. Developing countries were interested in access to medical countermeasures and technology in an equitable fashion, while many developed countries were focused on surveillance, transparency and innovation protection [7]. These conflicting preferences led to the length of the negotiation game and the final institutional design being influenced by such distributional conflicts.

Based on this premise, this paper argues that the WHO Pandemic Agreement does not represent a legally uniform, but instead presents a model of differentiated institutionalisation. Differentiated institutionalisation is the development of a common framework with differentiated obligations, based on issue area, implementation requirements, and national capacities. These mechanisms enable divergent interests to engage in a single institutional structure with varying degrees and types of investment [8, 9]. Differentiation is what allowed negotiators to build a flexible compromise in the form of an agreement in the Pandemic Agreement, as it is a way to allow or facilitate continued cooperation by forging a common set of principles and providing mechanisms for flexibility in implementation.

This paper discusses the role distributional conflict played in shaping the institutional design of the Agreement, and the role of leadership and modular compromise in reaching a consensus. Flexibility, sequencing, and differentiated obligations are seen as a way to enable negotiators to have disagreements without losing the collaborative process. This strategy expanded the support base of the Agreement, although many difficult issues were postponed to potentially future negotiations. The Agreement should therefore be understood not as a one-off document, but must be viewed as a process that will depend, crucially, on effective implementation and political will on the part of the parties.

2. Drivers of differentiated institutionalization in the WHO Pandemic Agreement

2.1. Distributional conflict in global health governance

The main factor that helped drive the process of differentiated institutionalisation was distributional conflict present throughout the negotiation process. While states were united in support for greater international cooperation in the future in the event of a pandemic, they disagreed over the basis for distributing costs and benefits of cooperation [10]. The negotiations were thus no longer about

technical public health issues, but discussions on access to medical technologies, funding, and control in the global health governance system.

Equity emerged as the focal point of the political struggle during the negotiations as a result of the COVID-19 pandemic. During the crisis, sufficient vaccines and therapeutics were purchased upfront by wealthier countries well before a fair shot at many of the developing countries [11]. This result reinforced concerns about vaccine nationalism, as many developing countries experienced delayed access to vaccines despite contributing pathogen samples, thereby raising doubts about whether existing multilateral arrangements could ensure equitable distribution in future emergencies [12]. Whereas developed nations placed emphasis on monitoring, transparency and prompt information sharing, many developing nations questioned whether these commitments were feasible without ensuring equitable access to the benefits derived from the measures taken.

These differences were often expressed in discussions over pathogens sharing. Developed nations considered access to samples of pathogens and genomes necessary for research, surveillance and countermeasure development to be at a high rate [13]. In contrast, many developing countries highlighted the fact of past inequalities whereby research institutes developed products, which, within the developed world, benefited countries that would send them biological samples. Therefore, they proposed to make the association of pathogen sharing explicit with benefit-sharing arrangements with vaccine, therapeutic, diagnostic, technology transfer, and manufacturing support [14]. This debate will demonstrate the disparities in access to benefits created by cooperative access to global health.

Technology transfer constituted a second major area of conflict. According to Alakija [15], many low and middle-income countries have called for preparedness to be linked to increasing manufacturing capacity outside of the traditional production area. They thus called for stronger commitments of technology transfer and technical assistance. However, a few developed countries also pointed to the potential impact of compulsory licensing on IP rights and on innovation. Disagreements regarding technology transfer thus also symbolised conflicts between the equity and market-based incentive paradigms of innovation [16]. The divisions were similar for financing. While developing countries particularly highlighted the importance of predictable finance for the preparedness obligations, developed countries were reluctant to accept proposals that would result in an open-ended funding commitment. The differences in these discussions represent alternative thoughts on how to fund pandemic preparedness, either collectively or mostly at the national level.

2.2. Institutional preferences of developed and developing states

Distributional conflicts were further entrenched by the contrasting institutional preferences of the major negotiating coalitions. The European Union generally favoured a legally binding framework with stronger rules, monitoring, and international coordination, while also seeking to preserve intellectual property protection and implementation flexibility [17, 18]. The United States likewise supported enhanced international cooperation but remained more cautious about binding commitments on technology transfer and intellectual property, reflecting domestic political considerations and the influence of the pharmaceutical industry [19]. By contrast, the African Group consistently prioritised equitable access to pandemic products, regional manufacturing capacity, and benefit-sharing, arguing that preparedness should be accompanied by greater distributive fairness [20].

Similar positions were advanced by a broader coalition of low- and middle-income countries (LMICs), including members of the Group for Equity, which argued that surveillance and reporting obligations should be balanced by stronger commitments on technology transfer and financing [21].

Their preferred institutional design therefore sought to integrate public health cooperation with measures that strengthened domestic manufacturing capacity, reduced external dependence, and expanded participation in global production networks. As a result, the negotiations reflected competing visions of global health governance rather than disagreements over individual policy instruments [22]. One vision prioritised coordination, transparency, and information sharing, whereas the other emphasised redistribution, capacity-building, and structural equity. The final Agreement accommodated elements of both through differentiated institutionalisation rather than fully adopting either approach.

2.3. Emergence of differentiated institutionalization

The final form of the Pandemic Agreement illustrates how differentiated institutionalization emerged as a viable approach to these competing preferences. One of its primary form of differentiation is the incorporation of framework obligations with further operational development deferred to subsequent processes. The Pathogen Access and Benefit-Sharing (PABS) system provides the clearest example. States agreed in the main talks on broad principles, with detailed operational arrangements deferred to an additional annex, which remains unresolved and subject to future negotiation [23]. This deferral, rather than representing a shortcoming, is a deliberate institutional strategy. It enabled consensus on equity commitments while postponing contentious questions of benefit formulae, governance models, and implementation mechanisms. The annex is not yet operational, underscoring that differentiated institutionalization often entails sequencing agreement on principles while deferring distributive details to later governance arenas. Differentiation is also reflected in the way national capacities are being treated. A variety of obligations are stated with the sensitivity of various degrees of institutional capability and development [24]. The agreement does not call for identical measures from all the countries, but leaves room for implementation under differing national conditions. This flexibility was necessary to gain acceptance in the countries having different administrative, financial and technological capabilities.

In addition, the Agreement contains provisions for facilitative compliance mechanisms, instead of only punitive ones. Implementation provisions focus on cooperation, learning, support, and dialogue rather than primarily enforcement and sanctions [25]. Such arrangements reduce sovereignty costs and promote wider participation. Although some opponents have opined on the reduced accountability of more lax compliance measures, others have avowed their greater legitimacy and political viability in more varied international surroundings [26]. Differentiated institutionalization is thus an expression of a directed process of compromise between ambition and feasibility. Negotiators also judged that creating a massively centralized, uniform system would not be likely to generate enough support, and a completely voluntary design would be unable to do much more than complement existing arrangements. Through a common touch of principles and flexible application, the agreement found itself an institutional structure that could better embrace diversity while not completely losing its shared pledges.

3. Leadership and modular compromise in the negotiation process

3.1. Leadership by international organisations and key states

Leadership played an important role, as distributional issues would be insufficient to generate agreement. Continued negotiation in the face of repeated deadlocks required parties who could continue in dialogue, who could help bring about compromise and who could reassure in the

dialogue. The Pandemic Agreement provides an example of a more sophisticated version of collective and institutional leadership as opposed to powerful nation-states. The WHO Secretariat provided technical support, drafting, and procedural continuity in the negotiations and established an important agenda-setting role [27]. Its contribution was significant inasmuch as many conflicts required a depth of scientific, legal, and policy-based knowledge. The Secretariat helped clarify policy options and share them in order to turn political differences into institutional options open for negotiation.

The Intergovernmental Negotiating Body Bureau also exercised important leadership functions. Composed of representatives from all six WHO regions, with individual seats changing as national mandates evolved, its geographically balanced membership strengthened its claims to legitimacy and enabled it to bridge diverse viewpoints effectively [28]. A key focus of Bureau leadership involved finding common ground and drafting compromise language that would appeal to the broadest possible audience. This hands-on stewardship was crucial in sustaining momentum during moments of acute disagreement. The European Union played an important role throughout the process, consistently supporting the negotiations and promoting a comprehensive agreement [29]. Nevertheless, leadership was not confined to developed countries. African states and developing-country coalitions mounted strong advocacy, ensuring that equity issues remained central to the discussions. Their sustained efforts ensured that the final agreement extended beyond surveillance to include measures on manufacturing, technology access, and benefit-sharing.

3.2. Modular compromise as a negotiation strategy

The key process in which negotiators dealt with persistent distributional tensions and prevented institutional deadlocks was modular compromise. Rather than reaching a grand compromise, negotiators split up the rocky issues and settled on a handful of separate but related points [30]. This way, states were able to come to an agreement on general principles and put off the most salient details to future processes. As a result, modular compromise was both a negotiating technique and an institutional design concept, which maintained cooperation in spite of conflicting interests.

The best illustration of this is the Pathogen Access and Benefit-Sharing (PABS) system. As a negotiating strategy rather than a settled institutional design, the underlying dispute was not resolved but re-cast as a procedural question. Instead of agreeing on the substantive terms of pathogen sharing and benefit-sharing, negotiators agreed only on the principle that the two should be linked, and assigned the technical formulae to a dedicated Intergovernmental Working Group operating under its own mandate and timeline [31]. This sequencing made the deferral acceptable to both sides. Developed countries avoided locking in binding pathogen-sharing terms before knowing their practical scope, while developing countries secured a firm procedural commitment, rather than an open-ended promise, that the outstanding equity questions would be negotiated on a defined track instead of being shelved indefinitely [4]. In this way, PABS converted an intractable substantive disagreement into a manageable procedural one, buying time for trust-building without stalling adoption of the wider Agreement.

The same trend is seen with the technology transfer provisions. Most developing countries have demanded greater commitments from the sharing of technologies, skills and production capacities [32]. Several countries, however, voiced arguments that compulsory requirements would undermine IP rights and create an impetus against innovation. The final text therefore promotes cooperation, capacity-building, and voluntary technology transfer without imposing highly prescriptive requirements [12]. While it is a limitation for some, it actually enabled many more people to participate, as supporters say.

Modular compromise is also reflected in financing. Developing countries pushed for predictable, adequate funding to meet preparedness obligations, while developed countries resisted commitments that risked becoming open-ended [33]. Rather than resolving this tension through the creation of a new pandemic fund, the Agreement established a Coordinating Financial Mechanism under Article 20, intended to align and channel resources across existing financing instruments, such as the World Bank-housed Pandemic Fund and other health-financing bodies, alongside a possible pooled component fed by voluntary contributions and, in time, revenue linked to the PABS system. What was deferred, therefore, was not the existence of a financing arrangement but its scale, sourcing, and governance: the Agreement commits states to coordinate rather than specifying how much money would flow, from whom, or under whose oversight [4]. Likewise, the compliance requirements call for cooperation, communication, and assistance, rather than enforcement. The negotiators used a facilitative method, which minimised the issue of sovereignty but also boosted political acceptance.

Importantly, modular compromise should not be viewed solely as institutional weakness. Adaptability and participation can be improved by using flexible arrangements in complex governance situations with national capacities, uncertainty and technological change [34]. Nonetheless, there are also some risks to modularity. Unsolved decisions might remain unchanged, and future discussions can create inequalities again. Thus, the real questions to consider for the success of the Agreement will be to see if future discussions turn the procedural compromises into workable solutions concerning access to pandemic resources, resources for financing and benefit sharing globally.

4. Conclusion

The WHO Pandemic Agreement is one of the most significant advances in global health governance since the IHR were adopted. The negotiations emerged from the inequities that came to light during the COVID-19 experience and aimed to improve the prevention, preparedness, and response to pandemics while also addressing existing issues of equity and access. However, the negotiation process has shown that distributional conflict is at the very roots of pandemic governance. While a general consensus emerged on the need for international cooperation, there was a disparity on how the costs and benefits should be apportioned in the global system. This paper has argued that the Agreement became possible through two main strategies: differentiated obligations and modular compromise. Negotiators adopted a structure that builds on common principles with more room for flexibility in implementation, capacity-sensitive and tiered commitments, and staggered decision-making procedures. This allowed states to have a common framework of institutions without having to settle every distributive disagreement on the spot. The analysis also emphasised that leadership plays a vital role in maintaining the negotiations. The leadership provided by the WHO Secretariat, the INAB Bureau, the EU, African states, and other coalitions of developing countries were integral to building consensus and maintaining the legitimacy of the process. Although it has made progress, there is much about it that is uncertain. Several key issues have yet to be resolved, such as the operationalisation of the PABS system, funding structures and technology transfer conditions. Therefore, the Agreement is not a final agreement and should be seen as a process that is ongoing. The impact of its long-term may rely on the realisation of offering beneficial results for sharing, equitable use of medical countermeasures, and ongoing financial backing.

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