

## SYMPOSIUM ON GLOBAL HEALTH AT A CROSSROADS PART II

## SUBSIDIARITY AS A STRUCTURAL PRINCIPLE OF GLOBAL HEALTH LAW

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### Introduction

Subsidiarity, a principle of justice rooted in law and political philosophy, remains largely overlooked in contemporary debates in international law. Its central idea is that decisions should be made as close as possible to those affected, with higher authorities intervening only when necessary.<sup>1</sup> This approach balances local agency with supportive solidarity, promoting cooperation that is both participatory and responsive.<sup>2</sup>

Nowhere is this balance more urgently needed than in global health governance. Institutions such as the World Health Organization (WHO) have played indispensable roles in advancing collective health, yet they remain entangled in questions of legitimacy, representation, and accountability.<sup>3</sup> These tensions reveal a deeper structural challenge: how to pursue universal goals without silencing local voices or reproducing historical hierarchies.<sup>4</sup> Reframed through the lens of subsidiarity, international cooperation need not oppose the global to the local, but can instead cultivate a layered form of solidarity, one that honors diversity, empowers agency, and grounds justice in shared responsibility. Recent developments in international health law reinforce this understanding. As Lee and Villarreal show, the 2024 amendments to the International Health Regulations and the adoption of the WHO Pandemic Agreement reflect a shift away from discretionary charity and toward a resilience-based model of international cooperation grounded in rights, capacity building, and mutual reliance. These reforms partially operationalize states' duty to cooperate by linking preparedness, health-system strengthening, and equitable access to binding international commitments, thereby giving legal structure to what has long been treated as political discretion.

This essay argues that subsidiarity offers a pragmatic justice-oriented response to colonial legacies and systemic inequities. It embodies two commitments: first, that agency should rest with actors closest to a problem; second,

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<sup>1</sup> Robert K. Vischer, *Subsidiarity as a Principle of Governance: Beyond Devolution*, 35 IND. L.J. 103 (2001).

<sup>2</sup> Michael Da Silva & Daniel Wainstock, *Subsidiarity as a Normative Political Concept: Contemporary and Historical Reflections*, 56 J. SOC. PHIL. 363 (2025); John Finnis, *Subsidiarity's Roots and History: Some Observations*, 61 AM. J. JURIS. 133 (2016).

<sup>3</sup> Jennifer Prah Ruger, *International Institutional Legitimacy and the World Health Organization*, 68 J. EPIDEMIOLOGY & COMMUNITY HEALTH 697 (2014).

<sup>4</sup> Matiangai Sirleaf, *White Health as Global Health*, 117 AJIL UNBOUND 88 (2023).

that higher levels of governance retain a duty of support where local capacities are insufficient. Its most visible development has occurred in the Catholic Church and the European Union, institutions whose systemic flaws and limitations are well-documented.<sup>5</sup> Our use of subsidiarity does not idealize these traditions, but rather extracts from them a structural principle that can be reinterpreted and redeployed within international law, in general, and global health law, in particular.

Understood in this way, subsidiarity is not a rejection of cooperation but a framework for organizing it more equitably and intelligibly. It offers a means of communication across differences: a language already familiar to many legal and policy traditions in the West,<sup>6</sup> yet flexible enough to articulate the claims and priorities of diverse communities. By operationalizing both agency and non-abandonment, subsidiarity creates a meeting ground between local and global levels of governance, advancing equity while sustaining cooperation.<sup>7</sup>

### *The Conceptual Architecture of Subsidiarity*

Subsidiarity expresses the idea that governance should begin from the ground up: those directly impacted by an issue should have the main voice in addressing it, while broader institutions step in only to complement or strengthen local efforts. It promotes proximity in decision making and shared responsibility rather than centralized control.

This understanding is rooted in its historical development, emerging from Catholic social teaching in the late nineteenth and early twentieth centuries, where it was conceived as a moral guideline to ensure that higher authorities respect and support (rather than replace) the agency of smaller communities. Later absorbed into European Union law, particularly through Article 5(3) of the Maastricht Treaty, it evolved into a legal safeguard against excessive centralization. Across these traditions, subsidiarity empowers those closest to problems while fostering cooperation and mutual accountability among different levels of governance.<sup>8</sup>

Properly understood, subsidiarity is not merely a rule of allocation but a principle of justice: it unites agency with solidarity, locating authority near those affected while binding higher powers to support rather than supplant them. Far from opposing cross-border cooperation, it structures it to prevent domination, calling on global and regional institutions to complement rather than displace local capacities. In this sense, subsidiarity provides a framework for *structured interdependence*, a design that moves proximity to empowerment and interdependence to mutual responsibility.

In the European Union, it functions as a concrete test of legitimacy: supranational action must be justified as, both necessary, and more effective than local measures. This operational clarity renders subsidiarity especially relevant for global health governance, where justice requires that global interventions strengthen, rather than substitute for, local capacity, organizing cooperation through equity, responsiveness, and shared accountability.<sup>9</sup>

<sup>5</sup> Elisabetta Povoledo, *Vatican Panel Says Church Is Still Too Slow in Addressing Sexual Abuse*, N.Y. TIMES (Oct. 17, 2025); Iain Martin, *How Do We “Reset” with a Europe in Crisis?*, THE TIMES (Oct. 9, 2024).

<sup>6</sup> Andreas Follesdal shows how the practical wisdom contained in subsidiarity dialogues with concepts within a plurality of traditions: from Confucian, to Aristotelian, Islamic (in the idea of Zakat), African philosophy (including in the idea of Ubuntu), as well as Aztek and Māori. ANDREAS FOLLESDAL, *SUBSIDIARITY* 6–11 (2025).

<sup>7</sup> Thana C. de Campos-Rudinsky & Mariana Canales, *Global Health Governance and the Principle of Subsidiarity: In Defense of a Robust Decentralization Approach*, 20 INT’L J. CONST. L. 177 (2022).

<sup>8</sup> Paolo G. Carozza, *Subsidiarity as a Structural Principle of International Human Rights Law*, 97 AJIL 38 (2003).

<sup>9</sup> Paolo G. Carozza, *The Problematic Applicability of Subsidiarity to International Law and Institutions*, 61 AM. J. JURIS. 51 (2016).

### *Systemic Inequities and the Legacy of Centralized Global Health Governance*

Despite recurring calls for reform, global health governance continues to operate through a logic of centralization. Concentrating authority and resources in a handful of global institutions and donors has often reproduced structural inequities rather than resolved them. Decision-making power, financial flows, and priority-setting remain dominated by a small circle of international organizations, philanthropic foundations, and donor governments. While these actors have played indispensable roles in financing programs and coordinating emergencies, their dominance frequently sidelines local actors, who are treated as implementers of external agendas rather than equal partners. The results are weakened ownership and accountability, precisely where they matter most.

These patterns reflect the historical genealogy of global health. From colonial sanitary regulations to twentieth-century programs built on Northern expertise and Southern dependency, global health institutions have long reinforced hierarchies of knowledge and authority. The architecture of global health law thus bears the imprint of colonial power dynamics: privileging biomedical models developed in the North, marginalizing community-based approaches, and entrenching asymmetries in agenda-setting.<sup>10</sup>

The reliance of many health systems on external funding compounds these structural imbalances. Donor-driven programs often follow priorities defined elsewhere, producing fragmentation, short-termism, epistemic injustice, and the systematic devaluation of local knowledge and experience.<sup>11</sup> The paradox is that international investment expands, even as national and community capacities erode. The consequences were stark during COVID-19. Vaccine distribution mechanisms privileged wealthy states, while many low- and middle-income countries struggled to secure access. Local innovations (community tracing, grassroots care, and regionally adapted public health measures) were often overlooked or under-supported. Similar dynamics emerged in earlier outbreaks such as Ebola, where external interventions displaced trusted local actors, undermining both legitimacy and effectiveness. These failures did not stem from lack of cooperation but from misallocation: global actors overstepping where local ones were better placed, and withdrawing where support was most needed.<sup>12</sup> Recent reform initiatives, including a pandemic treaty and amendments to the International Health Regulations, recognize the need for inclusion but remain framed within the same centralized logic. Without a guiding structural principle to integrate global solidarity with local agency, reforms risk reproducing the very dependencies they seek to dismantle. Subsidiarity offers that missing framework, capable of reconciling universal commitments with local empowerment, resisting domination without retreating into isolation.<sup>13</sup>

### *Operationalizing Subsidiarity in Global Health Law*

Subsidiarity shifts the question from whether cooperation is necessary, to how it should be organized. Embedding subsidiarity into legal and institutional practice would reconfigure governance around three

<sup>10</sup> Tlaleng Mofokeng, Daniel Wainstock & Renzo Guinto, *Decolonizing the Pandemic Treaty Through Vaccine Equity*, BILL OF HEALTH (Oct. 29, 2021).

<sup>11</sup> Jennifer Prah Ruger, *Global Health Governance as a Shared Health Governance*, 66 CMTY. HEALTH 653 (2012); Lawrence O. Gostin & Emily A. Mok, *Innovative Solutions to Closing the Health Gap Between Rich and Poor: A Special Symposium on Global Health Governance*, 38 J. L. MED. & ETHICS 451 (2010).

<sup>12</sup> Gostin & Mok, *supra* note 11.

<sup>13</sup> Thana C. de Campos-Rudinsky et al., *Decolonising Global Health: Why the New Pandemic Agreement Should Have Included the Principle of Subsidiarity*, 12 LANCET GLOB. HEALTH e1200 (2024).

commitments: supporting local agency, reframing global responsibilities as shared rather than controlling, and designing models that are flexible and accountable to affected populations.<sup>14</sup>

### *Local Agency*

Subsidiarity recognizes local actors as protagonists: that is, as primary rights-holders, duty-bearers, and decision-makers. Legal standards should protect and empower communities, health workers, and national systems, affirming their authority to define priorities and strategies that best meet their specific needs. The presumption is that they lead by themselves unless higher-level intervention is justified by their request for assistance.

### *Shared Responsibilities of Global Actors*

International organizations, donors, and foundations remain indispensable for financing, logistical coordination, and technical support. Yet their role must be redefined as *service*, not control and domination. Subsidiarity shifts the operative question from “*what can global institutions deliver most efficiently?*” to “*what support enables local actors to deliver for themselves most effectively?*”

### *Reasonable Flexibility and Accountable Governance Models*

Governance must be reasonably accommodating of diverse contexts and oriented toward downward and horizontal accountability. Drawing on accountability as a reason-giving relationship, subsidiarity embeds answerability into governance, requiring decisions to be justified to those most directly affected rather than primarily to donors.

### *Case Illustration: COVAX and Its Collapse*

COVAX is a global risk-pooling and collective procurement platform, coordinated by Gavi, the World Health Organization (WHO), and the Coalition for Epidemic Preparedness Innovations (CEPI). Its core premise was that countries (particularly high-income states) would participate in a single pooled market rather than pursue bilateral contracts, in exchange for access to a diversified vaccine portfolio and reduced exposure to scientific, manufacturing, and supply-chain risk. In this sense, COVAX operationalized *shared responsibility* as co-ownership of a global vaccine market rather than as donor-recipient aid.

This design began to collapse early in the pandemic, during the 2020–2021 advance market commitment phase, when wealthy states exited the pool through large-scale bilateral advance purchase agreements, securing vaccine supplies far in excess of their populations. These contracts displaced COVAX in manufacturers’ production queues and converted it into a residual buyer dependent on surplus doses released by donor governments. As a result, what began as a system of collective risk-sharing and joint governance devolved into a donor-financed distribution mechanism in which low-income countries received what high-income countries chose to make available.<sup>15</sup>

The failure of COVAX was therefore not merely a shortage of vaccines but a dual failure operating at two distinct levels: (1) a breakdown of global procurement and allocation caused by the collapse of the pooled market;

<sup>14</sup> Maria Cahill, *Theorizing Subsidiarity: Towards an Ontology-Sensitive Approach*, 15 INT’L J. CONST. L. 201, 213 (2017).

<sup>15</sup> Ann Danaiya Usher, *A Beautiful Idea: How COVAX Has Fallen Short*, 397 LANCET 2322 (2021).

and (2) a failure of last-mile delivery resulting from the withdrawal of financial, logistical, and infrastructural support even as global actors continued to control supply chains, regulatory conditions, and eligibility rules.

Global actors retained control over vaccine supply chains, contractual terms, and allocation formulas, while withdrawing from the responsibilities that would have enabled effective local delivery, including financing cold-chain infrastructure, supporting community-based distribution systems, and enabling trusted communication and outreach. Even when doses were delivered, centralized eligibility rules and rigid delivery schedules limited the ability of national and subnational health systems to adapt vaccination strategies to local conditions. In contrast, low-income countries were left without sufficient supply or production capacity. Design decisions for global health supply chains are often based on “myopic operational objectives and metrics,” which leads to misalignment between global planning and local implementation, reducing effectiveness and creating inefficiencies at the point of delivery.<sup>16</sup> Vaccine inequity during COVID-19 revealed how global governance structures neglected their redistributive role while asserting control over decision-making and access logistics.<sup>17</sup>

The result is the exclusion of local actors from decision making and fragile implementation. A subsidiarity-guided approach would have recognized local systems and communities as authorities on needs, delivery, and messaging. COVAX exercised authority over allocation formulas, delivery schedules, regulatory conditions, and eligibility rules, but under-invested in the country-level systems required to turn doses into vaccinations, including cold-chain infrastructure, community health networks, and trusted last-mile delivery channels. This governance structure displaced local health authorities and community organizations from meaningful participation in prioritization, sequencing, and delivery strategies, while leaving them responsible for managing implementation failures that flowed from centrally imposed constraints. Global institutions would have enabled access (pooling procurement, underwriting financing, and supporting logistics) without dictating terms. Accountability would have flowed downward and horizontally as well as upward, requiring reason-giving to the populations whose trust was indispensable.

Yet applying subsidiarity in global health is not without challenges. One may worry that emphasizing local primacy may entrench fragile institutions, insulate governments that fail to meet basic obligations, or enable powerful states to offload responsibilities under the guise of “respecting local agency.” Others may fear that it could romanticize the local or obscure internal hierarchies that marginalize vulnerable groups. These concerns highlight real risks of misapplication—particularly in contexts marked by capacity constraints or political capture. Rather than weakening the case for subsidiarity, however, they underscore the need to articulate the principle in its full form: one that couples local agency with a robust duty of non-abandonment, requires justification for both intervention and restraint, and grounds authority in demonstrable responsiveness to affected populations. Properly understood, subsidiarity neither shields governments from accountability nor retreats from global solidarity; it structures collaboration so that support aligns with, rather than displaces, the competencies and priorities of those closest to the ground.

### *Conclusion: Subsidiarity as a Strategic Grammar of Justice*

Global health governance remains haunted by the logic of centralization. Even reforms inspired by COVID-19 often reproduce vertical authority rather than reconfigure the distribution of responsibility. Against this backdrop, subsidiarity can be advanced not only as a structural principle of law but also as a *strategic grammar of justice*, a way of speaking across asymmetrical terrains of power.

<sup>16</sup> Santiago Kraiselburd & Prashant Yadav, *Supply Chains and Global Health: An Imperative for Bringing Operations Management Scholarship into Action*, 22 PROD. & OPERATIONS MGMT. 377 (2013).

<sup>17</sup> Mofokeng, Wainstock & Guinto, *supra* note 10.

By grounding claims for equity in a language already familiar to Western legal traditions, subsidiarity provides a shared vocabulary through which the Global South can articulate demands for justice with a register the Global North can recognize. This is not a concession to dominant frameworks, but an ethical act of translational engagement: to speak within an inherited grammar while turning it toward postcolonial ends. Importantly, the evolving architecture of global health law now provides institutional footholds for this translation. As Lee and Villarreal show, the Pandemic Agreement and the revised IHR embed principles of equity, solidarity, health-system strengthening, and local production into binding instruments, creating legal space for states and communities to invoke cooperation as a matter of right rather than benevolence.

As both a structural principle and a critical language, subsidiarity reframes global health law not as a hierarchy of command but as a network of reason-giving relationships, where authority must be justified as service to those most affected. To adopt subsidiarity, then, is to envision global health governance not in the name of communities, but *with and through them*.