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Putting the ‘public’ back into global health, rights and development: Answering the complex challenges of governance in developmental transitions

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Introduction

This paper discusses the question of ‘good governance’ in relation to the current debates about global development and health. It explores the challenge of health governance in the face of interconnected complex developmental transitions. Global health is said to be undergoing its third ‘great transition’, the first two transitions being the clean water and sanitation transition in the nineteenth century and the vaccine research and mass vaccination programmes in the twentieth century. The third, twenty-first century, great global health transition is towards health system reform and universal health coverage (Rodin & Ferranti 2012). However, this momentous shift for global health is just one face of an interconnected, multifaceted ‘Rubik’s cube’ of concurrent developmental transitions. This discussion takes on this multiplicity of transitions and looks at ways to re-think global health within a new development consensus that integrates public goods and rights-based approaches:

- Major demographic and epidemiological transitions mean ageing populations and the rise of non-communicable diseases. However, infectious diseases persist and there is a worrying increase in anti-microbial drug resistance, threatening the gains made by massive, targeted programmes for infectious disease control.
- Macroeconomic trends of global economic growth, volatility and crisis have affected both ‘developed’ and ‘developing’ countries
- Marketization and the rapid privatization and commoditization of health and care
- Democratization, demanding formal and substantive democracy, with free participation by, and clear benefits to, the people. The ‘third global health transition’ to universal coverage and health system reform responds to social and political pressures for democratization and inclusion.

These transitions are complexifying governance, making it increasingly difficult to regulate and develop health systems and carry out effective stewardship of public health. ‘Health’ has become increasingly complex as authority and accountability become more multi-layered and multi-directional, while health interests have multiplied and diversified in ‘mixed health systems’ (Lagomarsino et al 2009).

‘Good governance’ and wicked problems

The discussion of ‘good governance’ is not helped by the fact that it is a selective and woolly concept. ‘Governance’ is a generic concept, meaning ‘the exercise of power to manage a nation’s affairs’, providing no intrinsic judgement as to what kinds of governance are ‘good’ or ‘bad’. The absence of objective standards leads to the criticism that ‘...[a]s there is no

consensus on the criteria for measuring good governance,...the term remains ambiguous and hence imprecision results' (Nanda 2006, 269;270). Indeed, the attractiveness of 'good governance' may lie in its capacity to make complex issues seem manageable, hide disagreement and provide a practical answer to disappointing development results, where leading policies have failed to deliver sufficient economic growth and development benefits (Demmers *et al* 2004,2). Thus the World Bank attributed '...the litany of Africa's development problems' to 'a crisis of governance' (World Bank, 1989), while the IMF blamed corruption, which it attributed to too much government regulation and intervention in the economy, trade and currency restrictions, complex tax laws, lax spending controls and government provision of goods, services and resources at below-market prices (IMF 2005). The selective definition and use of the 'good governance' concept led some countries to regard it as 'one more item on the list of aid conditionalities' (Mkandwire 2010, 265).

The term 'good governance' attempted to bring together a triad of different capacities (Fig. 1): 'developmental' capacities to maximise economic growth, induce structural change and use resources responsibly and sustainably; democratic capacities to include citizens and respect their rights, and social inclusion capacities to guarantee a decent standard of living and meaningful participation for citizens.

Triad of good governance

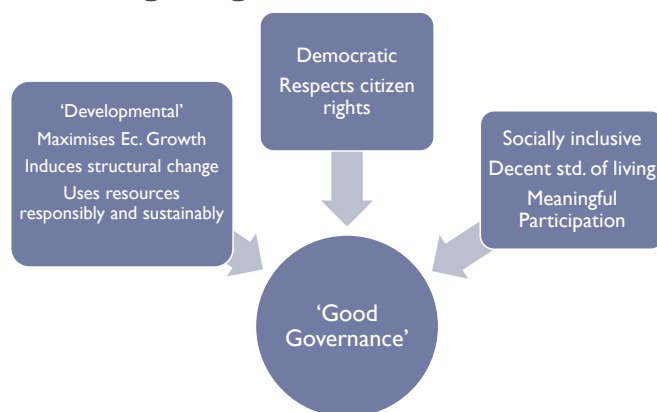


Fig. 1 'Good governance' as a triad of capacities

But what connects this triad of capacities? These could also be understood as three different interpretations of 'development', implying different roles and responsibilities and demanding different kinds of accountability (Fig.2).

Or three interpretations of ‘development’?

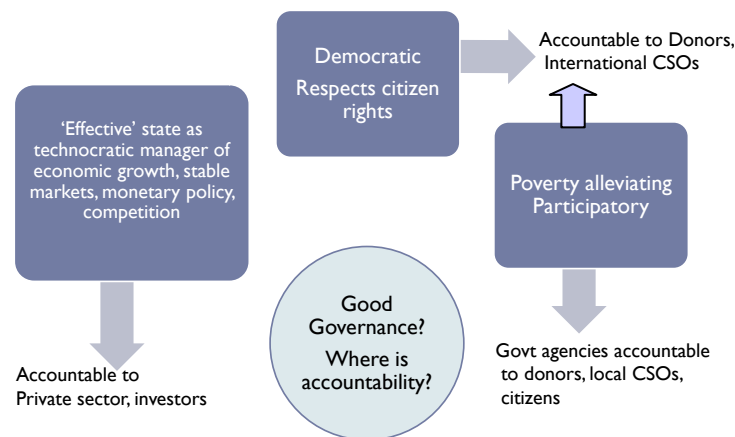


Fig. 2 Three interpretations of ‘development’ – where is accountability?

Like many topics in development, good governance can be understood as a ‘wicked problem’. A wicked problem is a problem that cannot be definitively solved because there are competing ideas about it, each facing towards a different solution (Rittel & Webber 1973; Conklin 2006). The development of an ‘effective’ state able to manage economic growth and markets reflects private sector and global investor interests, and sees accountability as facing in that direction. The development of democratic government reflects the interest in political democratization, with accountability facing towards donors and (largely) international civil society organizations (CSOs) which monitor and promote democratic institutions like elections and support civil and political freedoms. The agenda of social inclusion, spanning poverty alleviation, citizen participation and the broad range of economic, social and cultural entitlements, connects local CSOs and citizens with government agencies such as Ministries of Health, local health authorities and health service providers. These may also be upwardly accountable to donors, for example through the Poverty Reduction Strategy Paper (PRSP) processes or donor conditionality. Basic tensions arise for health governance, between international and national actors, between individual and collective health priorities, and between market-based and rights-based understandings of the problem (see O’Connell, 2007).

Locking down the problem: a rights-based perspective and the ‘publicness’ of health

A rights-based approach and a substantive focus on ‘publicness’ help to lock down the ‘wicked problem’ of health governance and provide the basis for coherent, shared understanding when approaching the hard questions of good governance, given the realities of mixed health systems and complex transitions. Coordination and consensus can be built around three main development goals: substantive health rights, democratic procedures and the protection and formation of public goods.

The recent UN Global Health Panel proposal for WHO reform (Mackey & Liang 2013a) shows a shift in perspective from technocratic to more participative understandings of health governance, aligning with new understandings of the ‘publicness’ of health. ‘Global health demands broader inclusion and forums for active engagement with various actors in shared

cooperation and coordination of promoting health'. At present, the legitimacy and decision-making authority or agency of global institutions '....remains woefully inadequate'. The disenfranchised suffer most and more inclusionary participation is needed, involving all stakeholders, especially under-represented groups (Mackey & Liang 2013b). London and Schneider (2012) see human rights as an essential counterbalance to disempowering forms of globalization that reduce governments' abilities to act in their population's interests. Human rights obligations require effective states that can implement their obligations by delivering health services as entitlements through capable and accountable health systems. Key contributions of the human rights approach include its focus on oversight and accountability and priority for the poor, vulnerable and disadvantaged. A rights-based approach improves the political leverage of the health sector, helping to access resources through parliamentary processes, while also creating spaces for civil society action to engage with the legislature and hold public officials accountable. The rights approach enables civil society mobilization and reinforces community agency to advance health rights for neglected and less well-resourced sectors. Experiences from Brazil's participatory health councils provide important insights, finding that health services are more pro-poor when marginalized and vulnerable people are truly represented (Coelho 2007; Cornwall *et al* 2008).

Global governance studies have pointed to the need to manage the globalization of health and disease using a global public goods approach. However, actual responses to global health challenges have been limited, partial or neglectful in their 'publicness' (Arhin-Tenkorang & Conceição 2003). A deeper look at the concept of 'public health' shows that the term encompasses a variety of connotations (Coggon 2012) and that it is not an apolitical concept. Public health is fundamentally political because it is a rationale for collective public action:

[w]hat we, as a society, do collectively to assure the conditions in which people can be healthy. This requires that continuing and emerging threats to the health of the public be successfully countered' (IOM, 1988)

Health is an inherently expansive concept and there is no clear agreement on what 'health' is or what makes it 'public'. This is why this paper argues for sound political reasoning, drawing upon recent innovations in public goods theory to help think through health governance and related issues of public policy, law and ethics. Global health governance can benefit from a fuller appreciation of global public goods theory, informed by substantive understandings of public health and health rights.

A new approach to public goods: putting the 'public' into global health

A new theory of global public goods brings together, and balances, three main faces of 'publicness':

- i) democratic publicness of decisionmaking,
- ii) equity, understood as rights-based, system-wide availability and accessibility without discrimination, and
- iii) publicness of benefits, guaranteeing safety, acceptability and quality of services, including educative, preventive and promotive strategies.

A 'new public goods' model of public health is summarised in Figure 3, drawing upon the work of Kaul and others on reflexive governance and global public goods (Kaul 2001; 2006), and combining this with public health and human rights approaches to health systems (Hunt & Backman 2008). The triangle of 'new public goods' represents three faces of the 'publicness' of public goods. A balance must be struck between participatory democracy, equity in enjoyment of health services and system-wide quality, cost and safety considerations. Crucially, the model tells us that 'more democracy' and 'participation' are not enough – this has to be balanced against the principle of societal equity, as well as prevailing scientific and medical consensus on the public interest in safety, quality, plus the need for educative, preventive and promotive efforts. For example, a group of citizens may democratically seek to withdraw their children from a vaccination programme, but their entitlement to do so needs to be balanced against the children's right to health and wider societal health equity and benefits, including the benefits of 'herd immunity' and disease eradication. It is relevant to consider what groups are advantaged or disadvantaged, and what the criteria are for attaining the highest attainable standard of health across a health system. Publicness of participation must be balanced against publicness of consumption and benefit and decisions should be informed by scientific evidence about risks and benefits across the entire health system (Hunt 2006a; 2006b, Hunt & Backman 2008).

The Publicness in Public Health

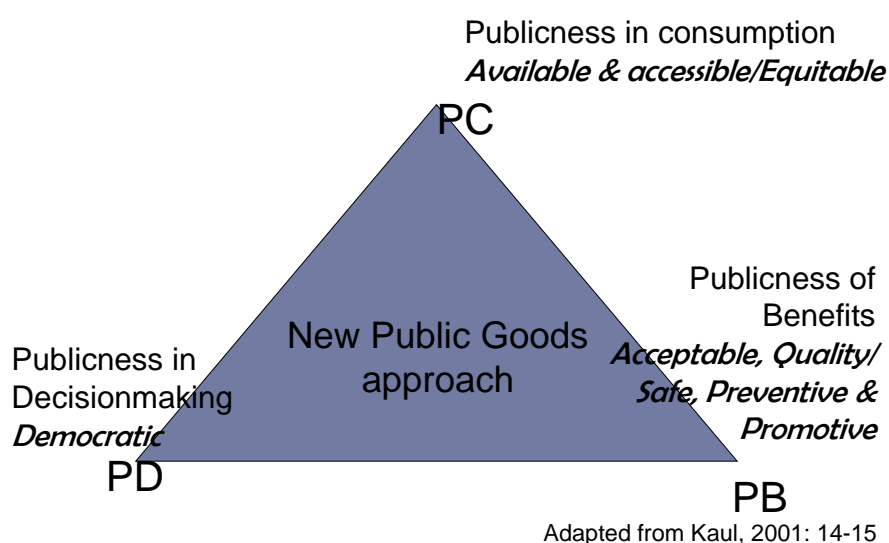


Fig 3. A New Public Goods Approach to the Publicness in Public Health

Current proposals for global health reform: towards universal coverage

This concluding section briefly discusses the debates and emerging consensus around a post-2015 agenda for global health governance and reform which integrate health into a wider development agenda. The new proposals place greater emphasis on health as a human right, health equity, and global coordination. There is a departure from the current strategy relying on several specific health-related MDGs, focusing instead on a single aim of

universal coverage comprising two elements: i) treatment, prevention, promotion and rehabilitative services and ii) financial risk protection (UN System Task Team 2012; WHO 2012). Many countries have already moved some way towards universal coverage and financing reforms (Ruger 2010; Tangcharoensathien *et al* 2010). Moving towards universal coverage means aiming for strong, efficient health systems capable of delivering quality services covering, *inter alia*, non-communicable disease, mental health, infectious diseases and reproductive health (Hunt 2006a; 2006b; Hunt & Bueno de Mesquita, 2010). The new consensus avoids unhelpful fragmentation and competition between different health interests, moving towards a more systematic approach underpinned by a new generation of development goals that conceptualize and measure progress across the economic, social and environmental pillars of sustainable development (WHO 2012). The new agenda embodies a *de facto* commitment to health equity and health rights, guaranteeing health services that are available, of good quality, and affordable, in line with the availability, accessibility, acceptability and quality criteria specified under the right to health (Hunt 2006a; Hunt & Backman 2008). The new approach is holistic, preventive and future oriented, adopting a multi-dimensional 'social determinants' approach to health and emphasising 'health in all policies'. This new emphasis on health systems, universal coverage and future public health is usefully supported by a model of public health goods that has democratic participation, equity and public benefit as common and non-competing concerns.

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