

Global Governance for Universal Health Coverage: Could a Framework Convention on Global Health Hold it Together?

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Since their development in 2000, the Millennium Development Goals have substantially influenced global health governance, their indicators now forming an accepted metric for the measurement of global and local progress towards health, and against poverty. With post-2015 development goals now being debated, the World Health Organization and key stakeholders have advocated for Universal Health Coverage (UHC) as the primary health goal, though support has been equivocal, in part due to a lack of consensus on its definition. Despite this, UHC does offer a necessary operative structure within which the ultimately selected post-2015 health goals could be operationalized. For this to occur, the meaning of UHC will need to be secured in a global health governance context. This paper argues that a Framework Convention on Global Health, acting as a “point de capiton”, may achieve this, stabilizing the discourse on UHC around which structures of global health governance may be organized.

INTRODUCTION

Proposed in 2007 by Professor Lawrence Gostin, a Framework Convention on Global Health (FCGH), with the right to health at its core, is garnering global attention.¹ In their June 2013 Introduction to the Special Issue on ‘Realizing the Right to Health Through a FCGH?’ in *Health and Human Rights: An International Journal*, Friedman et al. discuss three ways that a FCGH could surmount the key problems of standards, funding and governance mirroring global health today: First, by clearly setting out standards aimed at enabling health for all through equitable and effective health systems and socio-economic conditions required for good health; second, by establishing a financing framework to achieve predictable and sustainable funding for global health; and third, by entrenching good governance mechanisms to promote transparency, equity and accountability within and among states and other relevant actors.² The FCGH charts an ambitious agenda: promoting priority-setting and redressing health disparities experienced by marginalized populations. In seeking to overcome global health fragmentation, it offers a mechanism for bridging the formal structures of global governance and the complex network of information, discourses, and alliances that tether diverse global actors not bound by the United Nations (UN) system. While respecting our colleagues’ commitment to this ultimate claim, this paper argues for a more modest and incremental—though still substantial—initial role for a FCGH.³ We argue that the Framework Convention could demonstrate its utility by providing a structure through which global governance of Universal Health Coverage (UHC) might be achieved, binding donors and partner countries to ensure predictable, sustainable resourcing for health, ensuring consensus on outcomes, and preserving local diversity and ownership in the achievement of universal access and coverage of health systems.

Despite the apparent displacement of UHC from its anticipated primacy as the ‘umbrella’ health goal for the post-2015 development negotiations, there remains considerable support for UHC among Member States, the World Health Organization (WHO) and other key actors.⁴ Clearly, UHC will remain on the table.^{5,6,7,8,9,10} The still-to-be-decided post-2015 development goal(s) for health may provide an alternate focus for global attention, but will still require a health systems framing for implementation. The one health goal among the twelve illustrative goals in the High-Level Panel of Eminent Person’s post-2015 development agenda report (Goal 4 – Ensure Healthy Lives) embraces five targets.¹¹ These are essentially an iteration of the unfinished business of the health-related MDGs, adding Neglected Tropical Diseases and selected Non-Communicable Diseases. As in the previous goals, these are framed in a vertical, targeted approach; necessary but not sufficient to deal with the heterogeneity and complexity of issues in the unfolding global health landscape.¹² The filter of the sustainable development agenda—yet to be fully engaged by the global health community—adds a further layer of complexity. As WHO concedes: “while a new generation of goals offers a means of measuring progress across the economic, social and environmental pillars of sustainable development (and health is well suited to do this), institutional arrangements at a global level for ensuring such policy coherence remain weak.”¹³ The FCGH offers the most appropriate mechanism to bridge this global governance divide, as negotiating this daunting disease focus through the post-2015 goal process will require a health systems framing for delivery, which the provisions of an international treaty can explicitly sustain.

The challenge for the global health community is to now develop—and sell—a convincing framework that can rise to post-MDG health and development challenges (and meet fresh health agendas including non-communicable diseases, mental health, environmental health in a broader public health context, pandemic preparedness) while strategically accommodating the complexity of global governance for health that comprises the multiple stakeholders, agendas, budgets, networks and relationships that have evolved (and are evolving) in response to MDG health initiatives.^{12,14} The framework needs to be able to synchronize the increasing fragmentation of global health governance, but preserve its creative diversity and local autonomy. Ensuring that this new framework will have genuine political support for its compliance mechanisms, as well as civil society and private sector endorsement, will be key. This article will therefore explore the potential link between the FCGH and global governance for UHC, intersecting with the new health-related development goals. In doing so we recognize the imperative for UHC as the necessary structure within which any post-2015 health goals or targets will be operationalized. We argue that a FCGH may have the bold, transformative potential and positioning to provide a discourse for reforming global obligation around which structures of global health governance may be organized.

THE WORLD SINCE THE MILLENNIUM DECLARATION – CHANGES IN GLOBAL HEALTH GOVERNANCE

Since the MDGs were initiated in the early 2000s, the world has witnessed *profound* global change. This change has synergistically impacted—and been impacted by—dynamic changes in the global health landscape. Notably, “exceptionally rapid globalization” has transformed “the field of international health that had taken shape in

the mid-twentieth century into the field of global health that we encounter in the early twenty-first century.”¹⁵ The shift from international to global health also reflects the enormous growth in new actors, networks and mechanisms in health (and inter-related development sectors) that have crystalized in response to the MDG agenda.^{16,17} The unprecedented increase in stakeholder growth is further propelling global health funding: in under two decades, development assistance for health has seen a 400% increase (from US\$5.6 billion in 1990 to US\$21.8 billion in 2007).¹⁷

Powerful non-state actors, together with other international organizations, non-government organizations (NGOs), and a diverse array of individuals who are not government leaders (from Bono to Jeffrey Sachs) have brought new money (or new initiatives for raising money), new partnerships, and, significantly, new global health agendas. Juxtaposed with this is the recognition of newly emerging donor countries such as Brazil and China, with their own set of motivations, assumptions and discourses.¹⁸ Over 100 multi-stakeholder Global Health Initiatives (GHI), generally more disease focused in response to the health challenges prioritized in the MDGs, also vie for global health influence with considerable fiscal force.¹⁹ The United States President’s Emergency Plan for AIDS Relief (PEPFAR) has added a new dynamic to more traditional bilateral development assistance, and bilateral agencies such as the UK’s Department for International Development (DFID) and those of Scandinavian governments engage increasingly in networks and partnerships that extend their national influence in the new global governance for health.

The UN, meanwhile, sits uncomfortably at the global health governance juncture between the system of sovereign states from which it derives its legitimacy, and the complex of transnational networks and partnerships that effectively shape the global health agenda.²⁰ The UN itself is increasingly pluralized, with bodies such as WHO, UNICEF, UNFPA, and UNAIDS maintaining distinct and independent positions in health, and other supranational organizations, including the World Bank, World Trade Organization, and International Monetary Fund increasingly exercising engagement in health issues. New, inter-related forums have also been created, such as the Health 8 (H8), with UN health agencies combining with the World Bank, GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and the Bill and Melinda Gates Foundation to harness their combined public-private influence as a counterpoint to the G8.²¹

This century’s emerging global health governance has alternatively ensured that “calls for better *coordination* of aid are almost as common as calls for more aid,” with multiple -- and competing -- mechanisms emerging to manage the necessary coordination.²² The Paris Declaration on Aid Effectiveness in 2005 affirmed “the necessity for the donor community to march towards common goals” and represented “a crucial landmark on the path towards coherence.”¹⁸ Yet donor implementation of the Paris Declaration’s targets has been “highly uneven.”²³ The 4th High Level Forum on Aid in Busan, Korea, began to engage a more complex diaspora (including South-South assistance, Middle Eastern donors, and BRICS nations).²⁴ However, the recognition of this greater diversity simply exposes the anachronisms implicit in current mechanisms for coordination and their dependence on a Westphalian imagining of governance. The necessary instruments to engage this growing complexity will, in themselves, be incredibly diverse, creating a governance matrix that combines rules, norms, incentives

and agreements, information, discourses, networks and alliances that tenuously hold together disparate players in global health in a series of global forums.^{18, 25}

UNIVERSAL HEALTH COVERAGE: A NEW FRAMEWORK FOR GLOBAL HEALTH

Within this contemporary global health governance, the MDGs have played a significant role in managing this hybrid complexity, uniting UN structures with a range of other players—global public-private partnerships, private philanthropies, and elements of civil society—in the acceptance of the MDGs as mechanisms for setting global directions and as a metric for the measurement of global development.²⁶ For health, however, this has occurred in narrow ways—in child health, maternal health, HIV/AIDS, Tuberculosis (TB) and malaria: the MDGs were so specific as targets that they narrowed the extent of engagement available, even though they brought enormous resources and attention to the specific goals themselves. And the health goals, with their specific targeting of selected populations and diseases, simultaneously promoted an understanding that good health equates with provision of, and access to, targeted health care services for particular population groups—chiefly located in low- and middle-income countries—where the afflictions of child and maternal morbidity and mortality, HIV/AIDS, TB and malaria are more likely found.

The MDGs' presentation of health (namely in three discrete global goals) is in tension with the inclusive, yet broader global imagining of health that WHO has put forth for some time (especially under Margaret Chan's leadership) and has recently raised to stimulate post-MDG discussion.^{27,28} WHO recognizes, despite local and regional priorities, that, "there is a global desire to develop international strategies to improve healthcare" and achieve health for all (as opposed to the disease and population specific MDG health agenda).²⁹ It follows that for many global health players, the health-related development agenda post-2015 must be centered on UHC and its link to WHO's revitalization of Primary Health Care. While UHC does offer something more substantial in breadth than the MDG silos, it nevertheless has lacked fixed meaning. It has not been clear what health services UHC covers, and questions arise over whether UHC includes only services in the health sector or services and interventions outside the health sector (but still within sectors located inside the state).^{30, 31} Multiple meanings of UHC circulate: UHC as national service delivery; UHC as national service coverage; UHC as national health insurance coverage; and UHC as accessible, quality services. We agree with Fan, Glassman and Savedoff that "lack of consensus around the technical work" of UHC has served to "inflare rather than address ideological debates."³¹ Compounding this tension is that UHC is frequently described in public and global health circles as "utilization of health-care services" and "rights to health care financial protection" for citizens who reside within a state's borders; such state-centric positioning of UHC is increasingly confusing in light of the post-2015 global health debate in which WHO and others appear to be advocating for a 'globalist' rather than 'statist' definition of UHC.^{32,33} In other words, these traditional state-centric meanings and applications obscure the potential of a UHC redefined towards a more global (and indeed, literal) positioning.³² There is a risk that UHC may devolve from a global aspiration to a national, state-centric accounting, as has in part occurred with the MDGs.³⁴ Yet while global consensus needs to be preserved around our aspirations for health systems' values and health outcomes, local ownership and the necessary diversity

within health systems implementation in multiple social and cultural contexts also needs protection.

The real danger in the uncritical acceptance of UHC as the default position for health in the negotiations towards the post-2015 development goals is that it signifies divergent, but very specific meanings for its disparate advocates, ranging from the instrumental (universal health insurance) through to universal coverage of health services (with a range of service ‘packages’) to rights-based comprehensive entitlements. However, while UHC as currently debated may not be ideal in itself, we need a framework that adequately defines the concept, providing a workable consensus for UHC while stitching together the multiple understandings of UHC into one richer, more dynamic all-embracing cover. This may not be possible within the constrained format of the post-2015 development goals as the global debate is framing them. In fact, UHC reduced to a slogan, or to a composite (but one dimensional) metric, would be counterproductive. The UHC complex needs something that complements the goals process in order to ensure that the richness and dynamism of the concept, is preserved. This tension—between the stable and the adaptive—is what generates the momentum for an array of different stakeholders to engage, and re-engage with it as it evolves over time.

FRAMEWORK CONVENTION ON GLOBAL HEALTH: SECURING AN EXPANDED UNDERSTANDING OF UHC

One option offering the combination of global structure and flexibility necessary to support UHC is a FCGH. While the content of this potential treaty remains subject to debate, Gostin envisioned its terms would set “achievable goals for global health spending as a proportion of GNP; define areas of cost effective investment to meet basic survival needs; build sustainable health systems, including trained health care professionals, surveillance, and laboratories; and create incentives and systems for scientific innovation for affordable vaccines and essential medicines,” with the WHO “or a newly created institution...”³⁵ setting ongoing standards, monitoring progress, and mediating disputes. However, in this era of regime complexity mixed with post-2015 hyperbole, it remains unclear whether the international community of states would have either the energy or appetite for Gostin’s (undoubtedly time intensive and expensive) global health treaty.³⁶ Certainly even if there was interest, it remains to be seen whether states could come to consensus on the treaty’s terms, especially when a number of potentially contentious provisions are already being advocated for insertion and questions surround the Framework Convention’s justiciability.^{37,38,39,40,41}

Indeed, Hoffman and Rottingen, applying Kennedy’s exploration into the “dark side” of seemingly virtuosic and honorable international human rights law pursuits, warn of the proposed FCGH’s shadow.^{42,43} They point to its potential duplication of other human rights documents and governance mechanisms, arguable lack of feasibility in terms of both state negotiation and implementation, and questionable ability to effectively redress global health inequities. We recognize Hoffman and Rottingen’s (and others) concerns, but argue that if the first focus of the Framework Convention was initially directed towards UHC, which is “a practical expression of the concern of health equity and the right to health,” this incremental but still substantial approach could well generate a groundswell of state interest and challenge global sceptics.^{13,44,45}

Neither do we share Gostin's anxiety that an incremental process—the focus of UHC initially underpinning the Framework Convention—would stymie momentum and be a barrier to implementation.^{1,35,46,47} We argue this measured approach could, conversely, rally long-term state commitment to the FCGH and the development of subsequent protocols. This is particularly so, given that UN Member States (including, significantly, the United States) expressed widespread endorsement of UHC, supporting the UN Resolution on Global Health and Foreign Policy in December 2012, which urged governments to move toward providing affordable access to quality health-care services to all people by embracing UHC. The resolution, securing global prominence for UHC regardless of the post-2015 development agenda's reckoning on health on January 1, 2016, emphasized the intrinsic role health systems and universal coverage play in achieving the sustainable development goals, and consequent links to states' foreign policy agenda.⁴⁸

Furthermore, framing the FCGH around a recognized agenda such as UHC could go some way in mitigating Gostin's other (rightful) concern that “negotiation of a multilateral treaty involving resource distribution from rich to poor states would face political obstacles that limit its prospects of success”.⁴⁹ Rather, prospects of success could be enhanced as Member States have already supported the Global Health and Foreign Policy Resolution promoting linkage of UHC to “other foreign policy issues, such as the social dimension of globalization, inclusive and equitable growth and sustainable development”.⁴⁸ Therefore, the step to cementing this commitment in fiscal terms within a global health treaty may not be so much a giant leap for states as opposed to a hop. This brings us to our next point: the evolving intersection between universality and the post-2015 development goals (allowing states to negotiate differentiated, country-specific targets) may not be best placed to advance the pressing development needs of (and global attention on) lower income countries. This is particularly of concern in those states which have done least well in achieving the MDGs, and are most dependent on external support to maintain progress on their unfinished MDG business before addressing the post-2015 sustainable development agenda. In fact, if the post-2015 development goals are to follow the silo approach of the MDGs, crucial health systems strengthening and whole-of-government strategies to address the underlying determinants of health will be sidelined from both internal and external focus and resource in favor of addressing narrow, disease-specific targets. However, a FCGH with firm inter-governmental funding commitments for health and development encapsulated in a more tangible UHC could be better placed to meet the realities and interests of lower income countries—a far more attractive alternative in overcoming country inequities and realizing the human right to health (and interconnected rights) for all.

Smyth and Triponel argue that the “templates available under the umbrella framework could be devised using a mix-and-match approach that borrows liberally from different aspects of precedent initiatives that reflect best practices”.⁴¹ In our analysis for this proposal, the International Health Partnership Plus (IHP+), launched in 2007 to progress the 2005 Paris Declaration of Aid Effectiveness in the field of health, already offers a template for collaboration around health systems strengthening, and the Global Fund a precedent from which a model for sustainable financing might be extrapolated.^{50,51,52,53} The threat of duplication could be avoided by building on the premise of the IHP+ compacts and its existing 26 signatories, combining the

multilateral funding model of the Global Fund with the commitment of a Framework Convention to provide provisions for sustainable long-term financing, the key ingredient for impact feasibility not currently available to IHP+. Consistent with the IHP+'s focus, the Framework Convention would bring donors together by codifying a consensus aspiration to guarantee access to affordable, accessible quality care globally, yet flexible enough to allow country diversity and country ownership (while targeting those marginalized and most in need). This would enable the post-2015 sustainable development process to proceed while maintaining the focus on those countries least able to fund their systems and most vulnerable to the transition.

The proposed FCGH offers a mechanism for addressing this institutional weakness, at the same time bridging the formal structures of global governance and the network of information, discourses, and alliances that tether the burgeoning array of global actors not bound by the UN system. It offers the opportunity to hold together the layers of meaning implicit in the multiple definitions of UHC in a quilting stitch—what Lacan terms a “point de capiton” (the name suggests the buttons which hold together loose mattress stuffing)—that secures vital elements of the concept, while maintaining sufficient flexibility to allow an ongoing evolution within that frame of meaning that provokes the “desire” of stakeholders and their continuing engagement.^{54,55} The ambiguity that has surrounded UHC points to Lacan's contention that language at all levels is characteristically ambiguous, and that communication is only possible to the extent that the meaning of complex concepts is held together by an imagining of consensual understanding.⁵⁶ Clearly, within the current post-2015 debate, there are already numerous concepts in operation—maximizing healthy lives, finishing the MDG agenda, and leaving no one behind—each of which is capable of mobilizing support, advocacy, and the emotive “desire” that is produced through their discourse. UHC, without the stabilizing framework of a FCGH, risks only appearing to fix meaning while, in fact, introducing further ambiguity into the debate. Competing with the alternatives is not simply a matter of suggesting a more logical alternative: if the FCGH is to act as a “point de capiton” for UHC, and through UHC to “reimagine global governance for health,” it needs to mobilize a power beyond language in a way that captures and reshapes the global imagining of health.⁵⁷ That dynamic will need to be continued in order to preserve this function of holding the diverse elements of UHC together: and allowing the exploration of local solutions, adapted to local contexts while committing to global outcomes, may be sufficient to maintain ongoing drive.⁵⁶

We argue the Framework Convention's potential to achieve this arises for three reasons. Firstly, its grounding in the right to health definition provided by the Committee on Economic, Social and Cultural Rights in 2000 inherently underscores and aligns with both UHC and development agendas.

Secondly, a Framework Convention offers a solid framework, a mechanism, that has real potential to set priorities in global health and sustainable development, clarify national and international responsibility, ensure accountability, develop corresponding institutions (such as a Global Health Fund), and incorporate compliance mechanisms on treaty implementation (including sanctions and incentives).⁵⁷

Thirdly, we cannot locate any other proposed mechanism that has the comparable capability--and potential flexibility--to implement the various post-MDG desires of the global health community while also explicitly incorporating measures seeking to improve global health governance. It has the potential to act both as a binding

treaty and a flexible approach, “allowing states to agree to politically feasible obligations, saving contentious issues to later protocols.”⁵⁸

As Gostin himself imagined, “A FCGH would represent a historical shift in global health” by acting as the “innovative international mechanism” to bind States, and others, to collectively respond to ameliorate the enduring and complex problems of global health.³⁵

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