Putting the 'public' back into public health

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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. The third, twenty-first century, global health transition is towards health system reform and universal health coverage (Rodin and Ferranti, 2012). However, this momentous shift for global health is just one face of an interconnected, multifaceted 'Rubik's cube' of concurrent developmental transitions.

- Major demographic and epidemiological transitions mean ageing populations and the rise of non-communicable diseases (NCDs). 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.

- Macro-economic trends of global economic growth, volatility and crisis have affected both 'developed' and 'developing' countries.

- Marketisation and the rapid privatisation and commoditisation of health and care.

- The third 'global health transition' to universal coverage and health system reform responds to social and political pressures for democratisation 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).

'Into the public square': decision-making on mental health and well-being

Picture: Aniruddha Pal/Commonwealth Photographic Awards

'Good governance' and complex 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). 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). Thus the World Bank attributed 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).

The term 'good governance' attempted to bring together a triad of different capacities (see Figure 1):

- **'developmental state' 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.

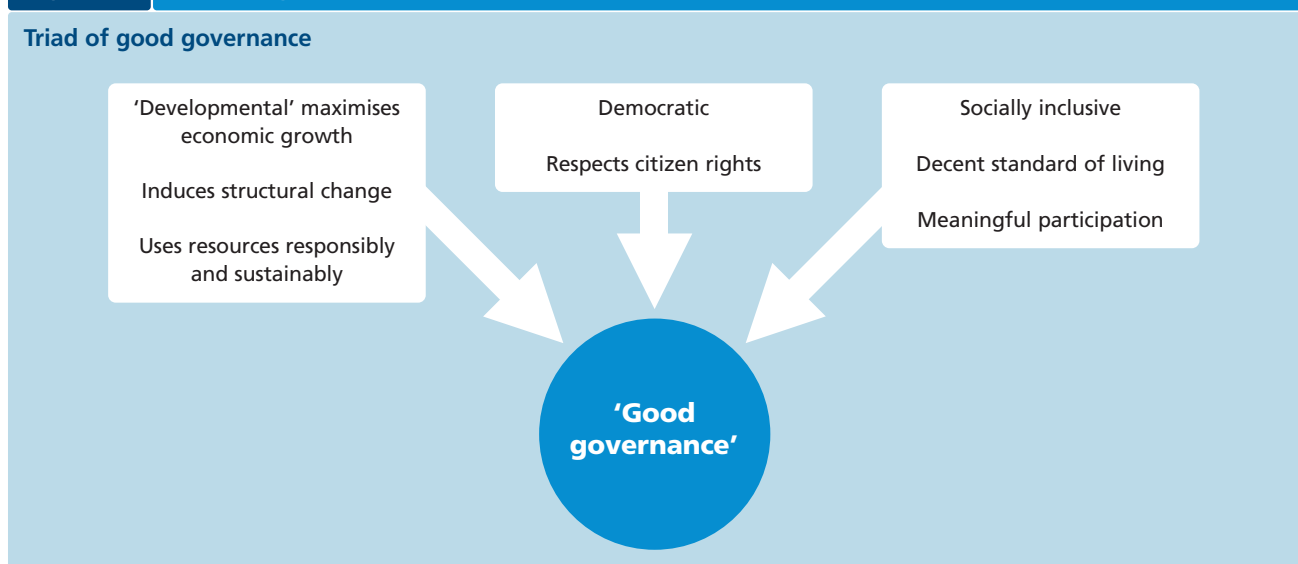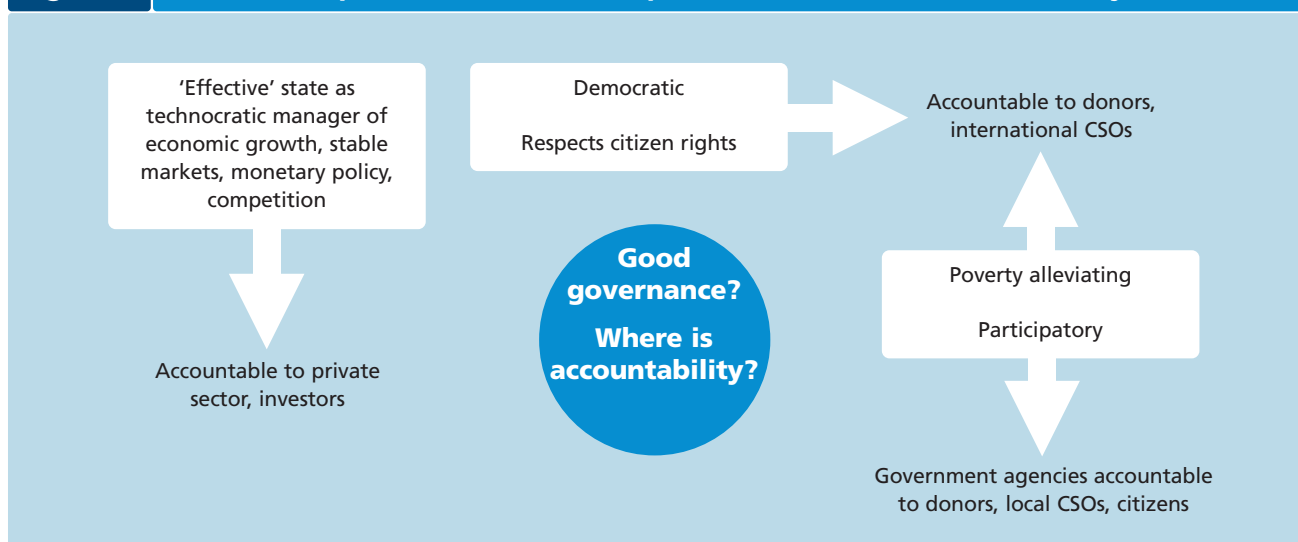**Figure 1**   **'Good governance' as a triad of capacities**

Figure 2   **Three interpretations of 'development' – where is accountability?**

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).

Like many topics in development, good governance can be understood as a 'complex problem'. This is one that cannot be definitively solved because there are competing ideas about it, each facing towards a different solution (Rittel and 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 democratisation, with accountability facing towards donors and (largely) international civil society organisations (CSOs) that 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' – i.e. of and for the people – help to lock down the 'complex 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. Co-ordination 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 World Health Organization (WHO) reform (Mackey and 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 co-operation and co-ordination 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 and Liang 2013b).

London and Schneider (2012) see human rights as an essential counterbalance to disempowering forms of globalisation 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 mobilisation 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 marginalised and vulnerable people are truly represented (Coelho, 2007; Cornwall et al., 2008).

Global governance studies have pointed to the need to manage the globalisation 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 and 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
> (Institute of Medicine, 1988)

Health is an inherently contested, expansive concept and, working definitions not withstanding, there may be no clear agreement on falls under 'public health'. 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':

1. democratic publicness of decision-making;

2. equity, understood as rights-based, system-wide availability and accessibility without discrimination; and

3. 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 and 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 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 and Backman, 2008).

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 that integrate health into a wider development agenda. The new proposals place greater emphasis on health as a human right, health equity and global co-ordination. There is a departure from the current strategy relying on several specific health-related Millennium Development Goals (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 made steps 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, NCDs, mental health, infectious diseases and reproductive health (Hunt, 2006a, 2006b; Hunt and 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 conceptualise 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 and Backman, 2008). The new approach is holistic, preventive and future oriented, adopting a multidimensional '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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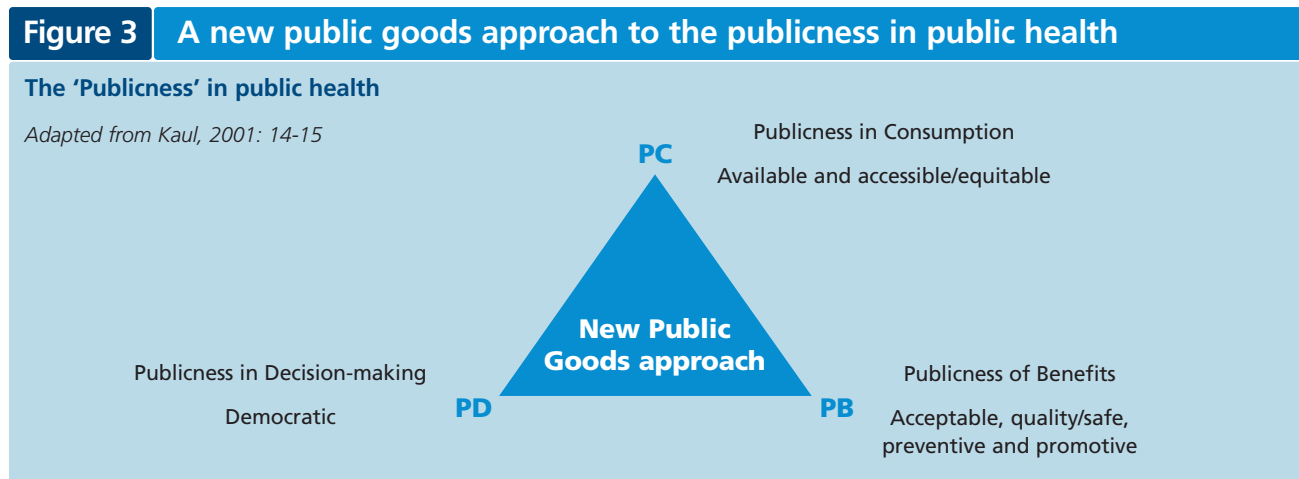
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Figure 3	A new public goods approach to the publicness in public health

The 'Publicness' in public health

Adapted from Kaul, 2001: 14-15

PC — Publicness in Consumption — Available and accessible/equitable

New Public Goods approach

PD — Publicness in Decision-making — Democratic

PB — Publicness of Benefits — Acceptable, quality/safe, preventive and promotive

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