



Health is Not Enough?

Competing Visions of Global Health Governance

Programme Report:
'The Transformation of Global Health Governance:
Competing World Views and Crises'
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Executive Summary and Key Policy Recommendations

If 'Health is Global', as the UK Government's 2008 White Paper claimed, then new forms of collective action are required to meet global health challenges. But progress towards achieving effective Global Health Governance (GHG) has been disappointingly slow and limited.

This programme of work addresses this problem through an examination of competing ideas about global health ('visions'), and the different ways in which health problems and solutions are presented ('frames'). Of particular interest are the ways in which these visions and frames influence global health policy and practice.

We have found that:

- There is no single underlying logic behind GHG. Rather, the space is characterised by a number of competing visions and frames, each with its own logic and preferred policy pathways.
- No frame is dominant across the entirety of GHG. Different frames have greater levels of policy purchase across different health issues, and for some issues a dominant frame can be identified.
- These competing frames and visions can be an important part of the explanation for a lack of progress in GHG.
- Framing health issues in particular ways allows them to be tied into other policy arenas (development, security, rights, economics). This multi-sectoral approach can be vital in advancing policy and developing governance frameworks. In many cases claims based on health grounds alone are less likely to succeed. Often, health is not enough.

Our key policy recommendations are that:

- Successful GHG must be grounded in an acceptance that it is an inherently political space, and one which is not limited to technical solutions based on 'best practice', cost effectiveness or evidence.
- Recognising that competition among frames exists, GHG should actively engage with the divergent problem definitions and policy solutions these frames imply rather than attempt to impose a single vision on global health.
- Smart advocacy can be developed where an issue can be strategically framed to appeal to different audiences within specific contexts and timeframes, in order to achieve desired policy outcomes.
- Policy can also be advanced through counter framing. This involves challenging the dominant vision of an issue by framing it in new ways. Examples here include the human rights frame being applied to access to medicines and the challenging of industry-led economic framing with economic arguments for regulating tobacco products.
- Framing can be used to speak to sectors outside health (including development, security and macro-economics) and therefore to develop a multi-sectoral approach to GHG, which can provide both opportunities and challenges.

Introduction

Globalisation is changing patterns of health and disease worldwide. This has created a challenge for societies to co-operate more closely, and across a wider range of issues, than ever before. This question, of how we should collectively protect and promote health in an increasingly globalised world, has opened up the policy space known as global health governance (GHG). However, although some progress has been made on GHG, for the most part this has been disappointingly slow and limited in scope. Why is this?

Rather than focussing on individual institutional actors, this programme of research conceptualises GHG in terms of different – and at times competing – ideas of the nature and causes of global health problems and the appropriate solutions to them.

The starting point for the programme is a recognition that these ideas are underpinned by certain normatively-based values and belief systems, thus diverging from many public health approaches which have traditionally been dominated by supposedly value-neutral, problem-solving approaches. In contrast, the project has sought to highlight how competing visions of global health issues emphasise and de-emphasise different agendas, concerns and policies; and how this can engage different actors, facilitate or inhibit effective governance, and shape the modalities through which GHG operates.

GHG is subsequently understood as a developing and contested landscape which is defined by the interrelationships of ideas – or ‘visions’ – about who or what health is for. Issues are presented, or ‘framed’, in such a way as to fit into one of these visions. Our research allowed us to identify five visions and accompanying frames which are dominant in GHG:

- Development
- Economics
- Evidence-based medicine
- Human rights
- Security

The operation of these was examined through four wide-ranging case studies - pandemic influenza, tobacco control, access to medicines and HIV/AIDS - carefully chosen because of their significance to GHG to date and their capacity to illustrate ideational contestation. Summary results from each of these case studies follow. The research includes over 300 key informant interviews who we would wish to formally thank. Initial conclusions were presented to an international group of academics and policy makers at the Royal Institute for International Affairs, Chatham House, and feedback from that meeting has been incorporated into this report.

Case Study 1: Pandemic Influenza

The governance arrangements surrounding pandemic influenza remain some of the most well-established technical cooperation mechanisms in global public health. In large part, this can be attributed to the impact of the 1918 Spanish Influenza pandemic that killed approximately 50 million people worldwide. Following the creation of the World Health Organization (WHO) in 1948, the WHO Global Influenza Programme was officially established in 1952. Under that programme, the WHO influenza surveillance network (now named the ‘Global Influenza Surveillance and Response System’) has subsequently grown to include some 138 National Influenza Centres worldwide, including six WHO Collaborating Centres.

Throughout this period, pandemic influenza has been primarily viewed as a biomedical issue that is best mitigated through the deployment of pharmaceutical measures (such as influenza vaccines and antiviral medications) and non-pharmaceutical measures (for example, handwashing, facemasks, quarantine and isolation). Over the past two decades however, a shift has occurred in how pandemic influenza is regarded due to the convergence of two frames – security and evidence-based medicine. Moreover, these two frames have become synergistic, significantly influencing the tenure and nature of public policy responses. The impacts of the 1997 H5N1 outbreak in Hong Kong, the emergence of the same strain in Asia and the Middle East from 2003 onwards, and the 2009 H1N1 outbreak have helped to reinforce both the perception of ‘threat’ and the need for verifiable, proven, and effective mitigation measures.

Since the 1950s, influenza vaccines have remained the cornerstone of pandemic influenza preparedness, backed up in more recent times by the rise of anti-virals as a ‘second tier’ of defence while vaccines are developed. Accordingly, particularly since 2005 the majority of effort (and indeed public expenditure) has been aimed towards improving access to influenza-related pharmaceutical measures through increasing global production capacity and supply, while the effectiveness of non-pharmaceutical measures (e.g. handwashing) has often been overlooked despite the fact that many low-income countries will still be unable to obtain access to pharmaceutical treatments in a pandemic. This suggests that the development frame has generally had little purchase, although the 2011 Pandemic Influenza Preparedness Framework that seeks to improve low-income countries’ access to influenza vaccines is a recent example of where development arguments have combined with security visions.

In contrast to other diseases such as HIV/AIDS, pandemic influenza has been rarely framed within the context of human rights, with the exception of limited discussion of civil liberties in relation to quarantine and isolation practices or compulsory vaccination. Similarly, the economic frame is arguably only implementable in the context of heightening security implications, such as the disruption to social and economic functioning.

The actors also differ – in the case of pandemic influenza these remain firmly grounded at the level of the state and state-based actors such as international organisations, with comparatively little civil society or community level organisational involvement. Within the context of state-based efforts, the medical community has played a particularly prominent role, often directly shaping the public policy responses. Within this context key individuals such as Robert Webster and David Nabarro (the UN System Coordinator for Avian and Human Influenza) have also played significant roles.

What are the implications of this for the global governance of pandemic influenza? Firstly, health system strengthening is necessary across the board, especially but not only in low-income countries. Secondly, as 85% of the world's population would not have early access to vaccines, building the 'evidence-base' for non-pharmaceutical measures has to be a priority. Thirdly, global vaccine production capacity needs to be increased alongside research into the feasibility and appropriateness and efficacy of other drug-based treatments (such as statins) in pandemic influenza outbreaks.

Case Study 2: Access to Medicines

WHO estimates that a third of the world's population lack access to essential medicines. The issue area is complex and the problems driven by low resource allocations for health, the imbalance of international drug markets toward Western consumers, the basic poverty of the majority of those who suffer or die from diseases for which they cannot afford the necessary treatments and by problems of quality and regulation. Governance of the issue area is equally problematic and defined by a contest between powerful framings which justify policy interventions. Research in this programme has identified how the economic frame used to justify global patent rules on drugs has been unsuccessfully challenged by human rights and development counter-frames; and how policies to promote access have been successfully adopted by working within the dominant economic frame.

Two international regimes have come to dominate the governance of this issue area. The first – the 'IPR/trade regime' – involves intellectual property rights (IPR) rules and patent laws (including TRIPS) which have strengthened private rights and temporary monopolies over medicines globally. The second regime relates to so-called new actors in health, including Global Health Partnerships (such as the Global Fund and GAVI), and philanthropic foundations (primarily the Gates, Clinton and Rockefeller Foundations). Ironically perhaps, this 'pro-access' regime has not typically been viewed as comprising actors that primarily work on access to medicines.

Both regimes have had enormous impacts on the access to medicines, and research has demonstrated that they have more commonality than would, on a superficial level, seem to be the case. Both regimes demonstrate an economic vision of health by intervening in a dysfunctional global pharmaceutical

market, albeit for different ends and purposes. The IPR/trade regime has at its core the objective of intervening in the market to incentivize innovation: if knowledge-intensive goods such as medicines are not protected from copying through patents, then there is very little incentive for further innovation and development. Yet patents have clearly impacted negatively on the price of medicines by blocking generic entry, and are also increasingly being understood as distorting patterns of innovation in the pharmaceutical sector. In contrast, the pro-access regime intervenes to correct market failure by investing in innovation for neglected diseases and by intervening on price by funding purchases or by negotiating lower prices.

Crucially, the basic function of market intervention is not present in the ideas of development, human rights and humanitarianism that are routinely used to describe and justify their actions. Rather they demonstrate the dominance of an often underlying yet very powerful economic vision of health. Therefore, whilst gains have been made in securing wider access to certain medicines, this has not been as a result of successful counter-framing, but by 'buying into' an economic logic (or vision) and correcting market failure.

Case Study 3: HIV/AIDS

It is now 30 years since HIV was first identified; soon after AIDS was recognised as a global problem requiring global-level solutions. As a result of this recognition a number of new international institutions were created: first the Global Programme on AIDS within the WHO, and later UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Governments have committed unprecedented resources to tackling AIDS, attempting to improve access to prevention, treatment and care services. The result of this massive level of effort and investment has been a mixed picture of success and failure. To take the example of access to treatment, there are now around 8 million people receiving antiretroviral therapies compared to 300,000 a decade ago. This is a remarkable achievement by any measure, but still only around half of people who need treatment are actually receiving it. AIDS thus remains a major challenge for GHG.

As in other areas of GHG, both resource limitations and the complicated institutional architecture have created problems. At the global level there has been competition between institutions for influence, leadership and finance. There have also been difficulties at the domestic level where, despite attempts to improve the harmonization of aid, recipient governments frequently find themselves having to deal with multiple donor agencies, each with their own priorities, funding rules and reporting requirements.

Competition between different visions has also, however, been abundantly evident in the case of AIDS. Indeed all of the visions examined in this project – evidence-based medicine, security, human rights, economics and development – have been apparent. At the 'macro-level', these different ideas have fundamentally shaped what kind of problem AIDS is considered to be, and also what should be done about it. Indeed to some extent it is possible to tell the story of the changing global AIDS response

through these ideas: from the biomedical approach in the 1980s where the emphasis was on understanding the HIV virus, improving epidemiological knowledge, and attempting to develop treatments; through a major focus on rights, and in particular attempts to address stigmatization and discrimination; on to the emergence of AIDS as a major international development problem in the 1990s; and the framing of AIDS as a security issue in the early 2000s. In reality, however, there is no clear linear narrative of one idea giving way to another. Rather, the extent to which these ideas have guided policy has varied across issues, over time, and between different contexts.

In order to better understand the relationship between these different ideas and how they have affected the global AIDS response, the research has included detailed examinations of some of the key policy debates around AIDS in order to see which ideas (or 'visions') have been apparent – and crucially how they have been used to forward particular positions, and with what degree of success – within those debates. The debates which have been examined as part of the project include those over travel restrictions on people living with HIV; compulsory HIV testing; the appropriate balance between prevention and treatment; and 'harm reduction' programmes (in addition to the project's case study on access to medicines which was closely linked with the AIDS case study).

These studies have led to a number of significant findings about the role of different visions of health in the global governance of AIDS, the ways in which these have been deployed (through the use of framing), and the effects they have had in these policy debates. These include: the fact that different visions have often been used deliberately and strategically in the pursuit of particular policy aims; that in many cases these different visions have been 'traded-off' against one another, although the ideas which have won out have varied between cases; that power relations – in particular who is forwarding an argument – matter, although power is not always decisive; and that there is evidence that even the most powerful states in the international system have on occasions changed their perceptions of their own interests (and as a result changed their policies) as a result of arguments based upon some of the ideas examined in this project.

Case Study 4: Tobacco control

Prior to the 1990s, although some tobacco control might be termed 'international', most was focused on national level regulation and was relatively weak in its development. It was not until 1998 that real progress was made in global tobacco control, with the election of Gro Harlem Brundtland as WHO Director-General. Brundtland's new cabinet recognised that tobacco control was a neglected issue with the potential for significant health gains globally. As a result, it became one of two cabinet priorities and the Tobacco-Free Initiative (TFI) was created, reporting back directly to the Director-General. However, TFI and WHO still faced an uphill battle. Not least, the tobacco industry attempted to cast doubt on the validity of the evidence on the links between smoking and health, couch restrictions on tobacco use in libertarian terms as an infringement of rights, and suggested that regulation was an economic rather than a health issue, and thus beyond WHO's remit.

It might be expected that tobacco control should have been most easily framed within the perspective of evidence-based medicine. WHO's Tobacco Free Initiative certainly focused on presenting the decades of scientific evidence of the links between tobacco and disease, but this had to be done in a different way to gain greater policy leverage. This was partly to counter the extensive undermining of the evidence base by industry, but also to overcome political apathy by presenting this evidence in new ways. A specific type of language began to emerge in the form of terminology reminiscent of infectious disease control (e.g. pandemic, vector), and measures quantifying the health impact of tobacco which had strategic value in appealing to donors such as Bloomberg and the Gates Foundation who were more willing to support 'evidence-based interventions'. In addition, tobacco control was specifically framed as an addiction rather than a personal lifestyle choice to counter-frame libertarian arguments about the right to choose. The rights of non-smokers worldwide, including women and children, not to be exposed to the dangers of secondhand smoke, was also emphasized.

The economic frame has been effectively used by the tobacco industry in claiming that tobacco creates net economic benefits to society; that smokers subsidise healthcare systems through tobacco taxes; and that the tobacco sector creates large scale employment from farmers to retailers. Public health advocates reframed these longstanding arguments by arguing that tobacco taxation actually increases government revenue while reducing demand especially among youth; that smokers use a disproportionate share of health care; and that overall tobacco is a net cost to societies..

The human rights frame has been prominent but largely used by the tobacco industry in the form of libertarian arguments to defend smoking as an individual choice. In recent years, the public health community has reframed the argument through advocating the rights of non-smokers not to be exposed to secondhand smoke; showing smoking to be an addiction rather than an individual lifestyle choice; and exposing the funding of smokers' rights groups by the tobacco industry.

In contrast to the previous three frames, the security frame has not been extensively used with the exception of the relationship of the illicit trade in tobacco to terrorism and organised crime. States Parties to the Framework Convention on Tobacco Control identified cigarette smuggling as the subject of the first (and only so far) protocol. WHO sought the involvement of law enforcement bodies and customs officials, recognizing that the security frame could help the protocol negotiation process. It is unclear how effective this framing has been deployed however given the time it has taken to agree this protocol (to be finally signed in 2012). Finally, there has also been tension between the tobacco industry and public health advocates in relation to the fifth and final frame – development. The industry has argued that tobacco is a legal product which generates important revenues for low-income countries; that tobacco farmers dependent on the industry for livelihoods; and that global tobacco control is a form of neo-colonialism whereby western countries are trying to tell the developing world what is in its best interests. All of these claims are disputed by tobacco control advocates who, along with the reframing of the alleged economic benefits of this non-productive sector, the true nature of the tobacco

industry is highlighted including the exploitation of tobacco farmers and their exposure to harmful working conditions (e.g. chemicals), and the use of child labour in many countries. Global tobacco control advocates also emphasise that collective action is needed to address the transnational nature of the problem, including the expansion of transnational tobacco companies into the developing world.

In short, global tobacco control has been a political battle against powerful vested interests that have framed tobacco production and consumption in particular ways. It has only been when public health advocates have framed and reframed key issues that weak national/international tobacco control has been transformed into global tobacco control governance. The effective use of framing has required a strategic approach that took into account prevailing public opinion, broader public policy debates and timing. Different frames worked at different times and not all have been equally effective.

Conclusion

This programme has underlined the influence of politics in the development of GHG. Politics has shaped the governance agenda, helping to identify which issues and ideas are considered important at any given time and what policy solutions are proposed to address them. While most analyses of the politics of GHG have focused on interests and power relations, this programme has also demonstrated that ideas are integral to the political process. Central to our findings is that no single coherent idea (or 'vision') has driven the development of GHG so far. Rather multiple visions can be identified and issues are framed in accordance with these. Although some health issues may be dominated by a single vision (such as economics in the case of access to medicines), other health issues demonstrate competition between visions and frames, or even (as is the case with tobacco control) competition within visions by competitive framings. Counterframings frequently appear but are not always successful, being dependent on a variety of factors including a permissive atmosphere.

If 'Health is Global', it is also multi-sectoral. The programme has demonstrated that this is the case not only with regard to determinants of health and interests influencing health policy, but also with regard to ideas shaping how we think about GHG. We think about health as an issue of trade, security, development and the environment, for example, and not simply of health as a discrete area of global life. The result of this is that progress on health cannot be guaranteed by reference solely to health outcomes, but securing the necessary resources and political will to address health crises often requires health to be linked to other perceived benefits: health is not enough. But equally the manner in which frames draw on other sectors allows health to mobilise a broader constituency of support for policies through smart advocacy. Integrating health into the governance of other sectors could serve to raise the profile of health alongside other global issues, and potentially also increases access to resources for health. The key however is to ensure that this is cooperative for mutual benefit, rather than one sector subordinating another for its own benefit.



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