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## EDITORIAL

### GOVERNANCE FOR GLOBAL AND NATIONAL HEALTH: A ROLE FOR FRAMEWORK CONVENTIONS?

*Timothy G. Evans*

In the last two decades, the mushrooming of global health partnerships, alliances, funds and initiatives accompanied by a shift in the resource psyche from millions to billions has been exciting but also bewildering. The landscape of global health is no longer defined primarily by multilateral institutions comprised of member states, but has been forced to expand to consider new types of international institutions with constituency representation from the private sector, civil society, academia, and philanthropy. Complex challenges like those related to pandemic flu, health worker migration, or HIV/AIDS are demanding intensive, intersectoral coordination and negotiation for which most institutions are ill-equipped to manage. From a governance perspective, it has challenged all institutions to rethink their roles and positions in a new global reality of health interdependence in which there is no single leader, issue, or comparative advantage that one institution can claim exclusively as their own. Not surprisingly, in the midst of such rapid change, which some have referred to as “open source anarchy” questions such as “who runs global health?” are leading to calls to reform multilateral institutions such as WHO and to rethink the global health architecture or governance.<sup>1-4</sup>

This global myriad of actors and partnerships is mirrored and magnified at the country level. The influx of external initiatives and projects in low-income countries has led to concerns about their duplicative, distorting, disrupting, and distracting impacts on overburdened national systems.<sup>11,12</sup> Yet the underlying reality of national health systems is much less a single coherent system and much more a plurality of actors spanning the public, non-governmental, informal and for-profit sectors with a host of endemic public and private sector failures referred to by some as “mixed health systems syndrome.”<sup>8</sup> Efforts in the global community to “align and harmonize” around a single health plan have struggled to embrace the complex plural character of national health systems.<sup>4,9,3,7</sup> Moreover, the growing recognition of the intersectoral, social and transnational character of health challenges—be it related to tobacco control, urban slums, healthy diets, medical tourism, or migration of health workers—is placing demands for flexible and innovative governance arrangements that traditionally structured Ministries of Health are largely unable to meet. The emergence of national strategies for global health and the new field of global health diplomacy are indicative of efforts to begin to

embrace the complex and interdependent realities of global health in the 21<sup>st</sup> century.<sup>10</sup>

It is in this context of rapid, complex change that the idea of a Framework Convention for Global Health (FCGH) must situate itself. The aim of the FCGH is to reduce inequities in health within and between countries by enshrining the right to health and mutual responsibility in a treaty-like instrument and thereby ensuring the three essential conditions for a healthy life: public health, health care and the social determinants of health. In the spirit of promoting reflection on this ambitious and exciting idea, this editorial raises three issues: i) the fit of the FCGH in the global health landscape; ii) the focus of the FCGH in relation to the governance instrument; and iii) the value of a broad platform to deliberate on health equity.

At the heart of the FCGH is the core value of equity in health. In many respects, an intolerance of inequities in health is a mobilizing value driving the global health agenda. In the area of child survival for example, from the establishment of the Global Task Force for Child Survival in the 1980s to the creation of the Global Alliance for Vaccines and Immunization (GAVI) in 1999 to the recent consensus to eliminate avoidable child mortality by 2030—there appears to be concerted global action and commitment to realizing this right over what will end up being a half century. The question, therefore, is what the FCGH can add to this already active agenda? Could it bring broader participation and voice of the disadvantaged? Could it bring more action on neglected social determinants of child survival? Could it ensure sustainability of financial commitments through its legally binding articles? Could it accelerate progress in attaining the goal of equity within and/or between countries?

As currently framed, the FCGH takes on a broad whole-of-global society approach through its focus on equity within and between countries, its engage-

ment of civil society and sovereign states, and its explicit model of determinants of health that stretches beyond medical care to the social determinants of health. This “framing” of the FCGH raises questions as to whether the instrument of a “treaty” is fit-for-purpose. Other precedents in global health for a treaty mechanism are focused more narrowly, as in the case of tobacco control, pandemic influenza, or trade agreements. Understanding the complexity and significant transaction costs associated with those more tightly focused undertakings raises questions as to whether a treaty for such a broad set of issues is feasible, or even the optimal global governance instrument. Might there be, for example, a “softer” instrument that accommodates the whole-of-society approach, such as multi-stakeholder forums on inequities in health? And from these forums, might more specific issues be targeted for “harder” or binding instruments, like a treaty?

The value of a menu of instruments from soft to hard allows the tailoring of responses that may better accommodate the divergent interests of the wide array of actors that typically are involved in complex global health challenges. This will be important in engaging partners who may view the FCGH as taking a blind view with respect, for example, to the for-profit private sector. The FCGH must establish early on that, a priori, health equity is not incompatible with market mechanisms; rather, it must be clear that failures in governance for health equity implicate all actors with a commensurate responsibility to examine ways of doing business differently.

While a more targeted use of the treaty mechanism might be considered more pragmatic, this should not mean necessarily that the FCGH should also narrow its scope. Indeed, its broad aim of creating a process for deliberation, commitment, and collective action towards the realization of the right to health and health equity might augur well to counter the risk that the global health justice agenda is set aside because a

single goal or small set of targets has been achieved. What form this process of deliberation would take deserves further reflection: is it a modification of the World Health Assembly, as some have suggested, through the introduction of a Committee C?<sup>5</sup> And might it have a national level expression as seen, for example, in the recent creation of the National Health Assembly in Thailand?

The aim of the FCGH to reach to the country level and redress within country inequities in health raises the critically important issues of national governance for health. As stated above, the governance challenges at country level are enormous and are ones that most states are struggling with, not simply because of challenges associated with global health interdependence. In this regard, the FCGH might help to bring overdue attention to these national challenges for governance and shed light on ways in which health justice can be stewarded more effectively in the national setting.

In this regard, further development of the FCGH can help to redefine and re-vitalize national and transnational governance mechanisms for health and thus contribute to a badly needed reservoir of ingenuity to address dynamic and rapidly changing health problems that threaten equity across and between countries.

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