Session 1: The emergence of UHC as a rights-based global health policy framework

Speaker of the first session was Jeremy Shiffman, Professor in the Department of Public Administration and Policy at the American University in Washington, DC. He started with the question Why and How (neglected) public health issues become a global political priority? Of all the possible priorities competing for scarce resources, which one will be addressed? Over the past 25 years there has been a proliferation of global health networks (linking individuals, NGOs, Foundations, governments, donors, academia, …), dealing with a shared concern, as e.g. the recent emergence of the UHC network. Here important question is: How important will a global network be for achieving national UHC? Some scholars see international involvement as crucial. Others see it as something that has to be emerging from national systems and dynamics. UHC is predominantly a national issue and a heavily political one, as it involves the transfer of resources from the rich to the poor. Prof. Shiffman focused on four challenges that global health networks face: problem definition, positioning, coalition building and governance. *Problem definition* is the process of generating consensus on what the problem is and how it should be addressed. Unfortunately in most global health networks there is no consensus, which leads to fragmentation and to less political power. *Positioning* is the way in which networks portray their issue to the public – e.g. to attract donors. Different framings appeal to different audiences and this framing the global and political attention to it. *Coalition building* refers to the way networks forge alliances. Most health networks are apolitical and insular, dominated by biomedical professionals who don't see the need to build political alliances. Additionally often the health sector at the national level is weak. Hence there is a need for broader political support and civil society pressure. *Governance* refers to the question of how institutions get established to facilitate collective action. This matters as it enables communities to steer effectively towards agreed-upon-goals. Prof. Shiffman then summarized the key concerns and applied them to UHC. Regarding *problem definition* UHC still faces some ongoing ambiguity concerning what 'UHC' refers to, which bears advantages and disadvantages. Regarding *positioning* UHC is a concept less resonant than disease specific goals yet more comprehensible than health system strengthening. *Coalition-building* is vital for UHC and actors recognize the political nature of it. With regards to *governance* and UHC, institutions are only beginning to be established (e.g. UHC 2030). All four challenges are linked and affect each other.

The first respondent to Prof. Shiffman was Prof. Jale Tosun from the Institute of Political Science, Heidelberg University. She first raised the question: as different networks exist, in which network are you interested in? Questions arise such as who is a member of a network and who not and there are competitions regarding who has influence on policy decisions. It is not only the *problem* that matters to policy makers and advocacy groups but also the story you tell about the problem, the image making. What story is told in the international debate on UHC? With relation to *positioning* she raised the following questions: Which actors should be brought in? Which actors should be excluded? How do you present something to attract attention or make sure that there is not too much attention paid for it? The concept of *coalition building* is linked to how the problem is defined. Prof. Tosun gave the example of babtists and bootleggers who formed a coalition during prohibition time in the US despite having nothing in common but the very end goal. Also UHC could unify different actors that strive for a common goal. Finally she mentioned different types of *governance*: hierarchy (also known as government), networks (the governance mode), markets (best practices to orient on). Her take away messages were: (1) challenges could be discussed in light of more nuanced theoretical perspec-

tives (2) challenges are interdependent and must be addressed jointly in theory and practice (3) challenges can also represent an opportunity since they force different actor groups to collaborate.

The second respondent to Prof. Shiffman was Kevin McCarthy from the European Commission, as the representative of a donor. He sees UHC as quite ambiguous, still being explored, it is addressed by many actors and organizations, it goes beyond health financing and includes the Agenda 2030, issues of transparency, alignment, ownership. UHC is linked to the human rights approach and elements feature in the discussion such as central services, policies at national level, social determinants of health, minimum core obligations, legal entitlements, regress, and regulation. UHC is for all citizens, regardless of income and reaching to vulnerable groups. Funding is a major concern, nationally and internationally, and the international donor community needs to engage – and does that in the context of UHC 2030. The process in which the consultation and participation is taking place is essential and one of the core elements of the EC regarding the way in which they disperse aid. There are many networks and initiatives, some are more effective than others. From a policy maker's side there are a number of questions: who are they? What is their agenda? Why now, why not before? Hence, do we need more research? Or to better understand what the findings are? And communicate them better to the ones that need them, such as e.g. policy makers? UHC for the EC resides firmly within the countries, the nation states. Understanding the country dynamics is a key to success. Stakeholders and actors are quite important as they have financial power. A more cautious question is how these networks impact? There is the possibility that they impact in a negative way and we need to be vigilant. Health is a social public good! It is not about one particular group or agenda of a group. There should be a benefit for all!

Third respondent was Prof. Seibert-Fohr from the faculty of law. She raised the question of how much human rights can contribute to UHC. There are a lot of nexuses, e.g. in the economic, social and cultural rights, but also in the right to nutrition, and water. There is the right to life and the prohibition of cruel and inhumane treatment, indigenous rights and the term of non-discrimination (.e.g UHC should be applied on a non-discriminatory basis). There is the concept of *vita digna*, a dignified life, not only meaning being not deprived of life but also to provide a minimal level of subsistence. Health coverage is not the only issue. By introducing the notion of human rights we should think more of prevention, not only of caring for the sick, but extend the *problem definition*. However, human rights can also render things more complex and difficult: how to deal with countries that have the death penalty and are executing people? This relates to the challenge of *positioning*. Also when talking about *governance*, there is a need for caution. There is the notion of progressive implementation but as long as there are no gross shortcuts there is hesitance of the international bodies to interfere with governments. Prof. Seibert-Fohr sees a limited role of the judiciary with regards to UHC. Human rights are very much state-centered, the state party is the primary addressee and this has impact on the governance. In conclusion, by introducing human rights there is a lot of potentials, but also caveats!