Doing ‘Upstream’ Priority-Setting for Global Health with Justice: Moving from Vision to Practice?

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The vision of global health with justice which Larry Gostin articulates in his book *Global Health Law* envisages a switch to ‘upstream’ priority-setting for expenditure on health, with a focus upon social determinants and a goal of redressing health inequalities. This article explores what is meant by this proposal and offers a critical evaluation of it. It is argued that difficulties arise in respect of the ethical and evidential bases for such an approach to the setting of priorities, while significant challenges may also arise in the necessary modification of structures of governance.

The picture of global health with justice which Larry Gostin delineates in *Global Health Law*, ‘a more ideal future for world health, with bold proposals to get there’ (Gostin, 2014: 413), is avowedly painted with a broad brush. As such, it does not seek to offer detail on the level of resources to be allocated to achieve particular goals, nor does it specify a process by which allocative decisions are to be made. Nevertheless, Gostin is not silent on the issue of setting priorities for expenditure of resources. In particular, he identifies the need for such priority-setting to assume an ‘upstream’ character, to ensure that priorities encompass protection and assure the conditions for health (Gostin, 2014: 439). This article seeks to present a critical analysis of that proposal. By way of introduction, it will explore the meaning and implications of a shift ‘upstream’, before moving to a discussion of the feasibility of giving practical effect to such an approach, through analysis of three criteria which are of central importance when priorities are being set.

What Is ‘Upstream’ Priority-Setting?

The ‘upstream/downstream’ terminology is of such common currency within the public health literature that it is easy to forget that it is, in fact, a metaphor which serves to elucidate the mission of public health: that of prevention, in contradistinction to that of medicine (whose primary objective is treatment). Perhaps the clearest exposition of the metaphor is that provided by McKinlay (1986: 489):

My friend, Irving Zola, relates the story of a physician trying to explain the dilemmas of the modern practice of medicine: ‘You know’, he said, ‘sometimes it feels like this. There I was standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So, I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, another cry for help, so back in the river again, reaching, pulling, applying, breathing and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in’.

This ‘parable’ thus emphasizes the importance of the role of public health in identifying the determinants of population health status and in developing policies to address these, which will thus serve to avert (or, at least, to inhibit), health problems before they eventuate. Additionally, it might be used to draw attention to the presence or absence of individual responsibility for states of health. Giving primacy to ‘downstream’ issues causes us to focus upon lifestyle choices (opting to go for a swim in the river), while a shift ‘upstream’ brings into view the social, political and economic factors which are causative of ill health, necessitating ‘basic social change to alter the conditions that facilitate people easily falling into the water’ (Dorfman and Wallack, 2007: S45).

Gostin’s call for priority-setting to move ‘upstream’ thus corresponds with his vision of what global health should look like: that efforts should be directed towards

assuring the conditions in which people can be healthy. He enumerates these conditions as provision of population-based health services and of universal health coverage, and ‘the assurance of socio-economic determinants that undergird healthy and productive lives’ (Gostin, 2014: 417). Compliance with these conditions would point to the pursuit of certain priorities for expenditure: for example, provision of sanitation or basic hygiene, amelioration of housing conditions or educational facilities, rather than funding of medical technologies to target specific diseases. Furthermore, even when the focus does properly lie upon diseases, Gostin’s framework would indicate that there should be a broadening of priorities beyond the familiar candidates such as AIDS and malaria, to more ‘unfashionable’ targets such as injuries, mental health conditions and non-communicable diseases which place significant burdens on both health and health systems (Gostin, 2014: 419).

However, it is important to note that Gostin seeks to move beyond increases in health outcomes, such as declining rates of infant mortality or greater life expectancy, to a scenario of global health *with justice*. Thus, he is concerned to reduce inequities in population health (especially between the well-off and the poor), arguing that this is not merely a matter of fairness but that it will also improve the health of the population overall, since more equitable societies tend to achieve better health outcomes (such as higher rates of life expectancy) (Gostin, 2014: 423–4). He also notes that prioritizing interventions for population health can itself enhance health equity since public goods such as sewage systems, safe roads or pollution control accrue to all those living within the same community.

The framework outlined by Gostin might appear somewhat idealized, yet it seeks to avoid naive utopianism (but cf Ashcroft, 2016). There is acknowledgment of the finite nature of resources and the consequent necessity of making trade-offs in pursuit of the goals of health with justice. It is clear, therefore, that the setting of priorities for expenditure of resources on global health is unavoidable. Gostin’s argument is, rather, that such priorities have, to date, been ‘skewed’ towards ‘downstream’ matters—in particular, that there has been excessive investment in ‘state-of-the-art medical interventions’—at the expense of population-level health strategies (Gostin, 2014:424). He concludes:

... the primary manifestations of justice in global health may look rather mundane. Justice in health is not primarily realised by delivering heroic medical interventions or through courtroom victories vindicating an individual’s right to some particular therapy. Rather, justice will

primarily be embedded in features of day-to-day life that are often taken for granted: the tap flowing clean water, the toilet that flushes, the neighbourhood market selling affordable nourishing food, public sanitation controlling the spread of disease, well-regulated industries, and so on (Gostin, 2014: 425).

One might plausibly surmise from this passage that ‘upstream’ priority-setting is eminently realizable. But the feasibility of operationalizing this form of decision-making does not rest simply upon the commonplace nature of the interventions it prescribes. As Gostin notes, appropriate modes of governance need also to be in place. This requirement can be understood, as Gostin himself does, primarily in terms of the *institutional structures and instruments* (such as his proposed Framework Convention on Global Health) which are best suited to enable pursuit of population-level health strategies. But additionally, one might wish to interrogate governance in respect of its *legitimacy*, a quality which necessitates consideration of whether the ‘output’ (in the form of choices as to priorities) rests upon appropriate and acceptable factual and ethical bases. This characteristic might be seen as especially significant in this context, as it has been famously claimed that priority-setting in health suffers from a ‘legitimacy problem’ (Daniels and Sabin, 2008).

The remainder of this article seeks to consider the achievability of shifting priority-setting ‘upstream’, with particular reference to the legitimacy and institutional dimensions of governance. Three aspects will be analysed: ethical values, evidence and modes of governance. The intention is not to offer an exhaustive account of the factors which may impact upon the viability of the ‘upstream’ shift, but rather to illustrate how substantial the impediments to giving Gostin’s vision practical effect are likely to prove.

Ethics

Although priority-setting in health is an activity with a significant technical dimension (and, moreover, this dimension has received particular emphasis over recent decades, as attempts have been made to imbue the process of priority-setting with rationality, especially through the application of the techniques of evidence-based medicine), it is widely acknowledged that employment of technical criteria alone as the basis for determining priorities is insufficient (Syrett, 2003; Rawlins and Culyer, 2004; Clark and Weale, 2012). Such decisions also engage deeply with social values

(NICE, 2008); indeed, at a still more fundamental level, decisions on priorities for expenditure on health speak to the question of the purpose(s) which health systems serve within a given society. Conversely, the choices on priorities which are made are likely to be accepted only if they are seen to contribute towards realization of those goals.

The distribution of resources for health is generally regarded as guided by two main aspirations (Hauck, Smith and Goddard, 2004; Daniels, 2006). The goal of *health maximization* is to achieve the highest health status for a population within available resources, while the aim of *health egalitarianism* is to minimize the differences in health status between individuals or (more usually) groups within society—that is, “levelling up”—bringing all those in less than full health to the status of the healthy’ (Daniels, 2006: 23). It is readily apparent that Gostin’s vision of global health with justice is more closely consonant with the second of these objectives than the first (although it should be noted that Gostin’s concern is not merely with inequalities in health, but also with other forms of inequality which are *causative* of inequalities in health).

This matters because, while it may be argued that the ultimate aim of the two approaches is the same—to ensure that people are healthy, for whatever reason we place value upon good health—the means of achieving that aim may well differ: that is, choosing between the two approaches ‘may lead to different policy recommendations’ (Norheim *et al.*, 2014). To take one example, if we seek to prioritize improvements in infant mortality rates, a health maximization approach might target educationally advantaged sectors of the population with ready access to health care facilities in urban areas so as to increase the aggregate health of the population. A health egalitarian approach might focus on those from educationally disadvantaged sectors with difficulty in comprehending health information, or the rural poor who have limited access to health care facilities and services. As Gostin contends (Gostin, 2014: 423–4), redressing inequalities in the latter case will also enhance overall population health, but it is likely to do so more slowly and, perhaps, haphazardly, than the former strategy and thus this is liable to be more attractive to priority-setting decision-makers who court political support.

Work of a quantitative character is ongoing to incorporate equity criteria into priority-setting with a view to pursuit of a combination of these two approaches. This may entail use of equity or distributive weights which enable priority to be accorded to the worst off (James *et al.*, 2005; Johri and Norheim,

2012), or application of multi-criteria decision analysis techniques (Tromp and Baltussen, 2012). Others have approached the task in a more qualitative manner; for example, Norheim *et al.* (2014) have developed a checklist of criteria related to the nature of the disease, the social characteristics of groups and the non-health values of interventions, which can be used in combination with data derived from cost-effectiveness analysis. However, as yet such criteria have not been widely operationalized within priority-setting frameworks, with the consequence that the health maximization approach—underpinned by the deployment of cost-effectiveness analysis—continues to dominate (Epstein *et al.*, 2009: 498; Norheim *et al.*, 2014), health egalitarianism playing, at best, a subordinate role.

Nonetheless, these avenues of research underline the importance attached to reducing health inequalities as a goal to be pursued when distributing resources and, ultimately, in deciding where to strike the balance between these two approaches, decision-makers will need to ‘carefully consider the criteria they find relevant to their health system and political context’ (Norheim *et al.*, 2014: 5). A further difficulty they face in undertaking this task, however, is that there is a ‘multiplicity of values and concepts discussed under the rubric of equity’ (Norheim *et al.*, 2014: 2). Given that resources are not sufficient to enable *all* determinants of health inequality to be addressed, those allocating resources are confronted with what Goldberg (2014: 1840) contends is ‘the most difficult priority-setting issue in all of public health ethics: which inequalities matter most?’.

One potential answer to this question is simply to prioritize interventions which are likely to have the greatest impact upon reducing inequalities, of whatever type. However, it is not clear that this is an *ethically* satisfactory response in Gostin’s terms since it appears to drift too close to a health maximization approach. That is, while inequalities would be reduced, the reduction would not necessarily occur in those forms of inequality which contributed most to poor and unequal states of population health, but rather in those which were the most susceptible to a ‘fix’. It would appear, therefore, that some criteria are needed to establish which forms of inequality have the highest *ethical* priority. But it is far from clear what these might be. To give one example, Powers and Faden (2006: 71–2) argue that ‘those inequalities that are most urgent to address . . . are ones that are a consequence of systematically related overlapping social determinants affecting multiple dimensions of wellbeing’. Yet, while their stance of ‘vigilance against systematic patterns of disadvantage’ (2006: 79) is undoubtedly consonant with Gostin’s vision of

health with justice, it offers little precision on the *forms of disadvantage which should be addressed first*. The difficulty is that the multifaceted and complex character of inequality (Temkin, 2001) gives ample scope 'for reasonable disagreements about which inequalities to give priority to reducing' (Daniels, 2006: 26).

In the absence of substantive consensus on the priority to be attached to differing dimensions of equity, decision-makers are likely to look to mechanisms of procedural justice to establish public legitimacy, both for the particular inequalities upon which they have chosen to focus and, more broadly, for the balance which they have chosen to strike between health maximization and health egalitarianism goals. One means of so doing is to ensure that their priority-setting decisions comply with the 'accountability for reasonableness' model developed by Daniels and Sabin (2008; Syrett, 2003) which requires decisions to be based upon criteria considered by the community to have relevance to the problem of allocating resources in situations of scarcity (even if particular members of that community might themselves have chosen different priorities), with mechanisms for revision and appeal, coupled with enforcement.

However, this in turn rests upon the assumption that the public regards the redress of inequalities, both in health and the determinants of health, as a relevant goal *at all* when allocative decisions are taken. Certainly, this objective does not appear to be considered *irrelevant*: empirical work which has been undertaken as to public perceptions of 'justice' in the allocation of health care resources to individuals tends to suggest that neither a health maximization nor a health egalitarianism approach is unequivocally favoured. Rather, the public appears to hold a plurality of preferences as to distribution (Cookson and Dolan, 2000), an outcome which is compatible with Gostin's ambition that priority-setting can serve both to improve health outcomes *and* to reduce inequalities.

However, it is notable that significant weight is accorded to the degree of immediate need (or, to put matters differently, the degree of ill health) of the individual. This is in accordance with the 'rule of rescue', which entails a preference for individual over statistical lives (McKie and Richardson, 2003). Since 'upstream' priority-setting emphasizes interventions for population, rather than individual, health, the value which the public appears to accord to immediate need as a relevant criterion for distribution is problematic in respect of the attainment of legitimacy. Moreover, this difficulty is likely to be exacerbated in respect of allocation of resources to redress health inequalities *globally* by the

argument, albeit contested, that proximity has normative significance (Nortvedt and Nordhaug, 2008).

Of course, it might be feasible to characterize 'immediate need' in such a manner that it pertained not to sick *individuals*, but rather to a certain *sector of society* whose health status was especially unequal to that of others—say, pregnant women in rural areas, or migrants—and to extend the meaning of need beyond purely clinical considerations, so that it embraces poverty, living conditions etc. But even if such a reframing were possible, there remains a concern that the public may favour prioritizing 'heroic medical interventions' and state-of-the-art technologies over 'mundane' matters such as taps, toilets or sanitation. Evidence exists—albeit derived from small-scale studies undertaken within particular localities in well-resourced health systems—that public preference is, indeed for expenditure to be focused upon acute care facilities and access to health care rather than upon the determinants of health (Yeo, Williams and Hooper, 1999; Robert *et al.*, 2008). Whether such preferences also apply to distribution of resources for health at a global level is, as yet, unclear. A survey of preferences of the public in 34 low-, middle-income and upper-middle income countries conducted in 2007 produced inconclusive results in this regard: clean water was ranked in the middle of a list of nine public health priorities in all regions; immunization was lowest or second lowest in all regions; while access to care fluctuated from highest to second lowest (Kaiser Family Foundation/Pew Global Attitudes Project, 2007: 4). Furthermore, this survey did not produce data on the preferences of those in higher income nations as to the public health priorities towards which they would wish their governments to be directing resources when providing overseas aid.

It is certainly not implausible that any difficulties or uncertainties in this particular regard can, in due course, be surmounted, perhaps through efforts to raise public awareness of the impact of social and economic determinants upon health (cf Robert *et al.*, 2008: 129–30). Nonetheless, it should be apparent from the preceding discussion that very considerable ethical ground requires clearing before an 'upstream' approach to priority-setting can be put into practice.

Evidence

As noted in the preceding section, those charged with priority-setting in health have made increasing use of evidence, especially of the clinical and cost-effectiveness of particular interventions, in recent years.

Epistemological advances in fields such as clinical epidemiology and health economics have generated relatively robust methodologies which can be applied to evaluate health services and treatments and to assist in determining which should be funded within a health system (and, in many instances, the price which is to be paid for them). Consistent with a ‘significant and growing international interest in facilitating and promoting the use of research in policy’ (Smith, 2013: 17), health technology assessment (HTA), a ‘policy-oriented research process aimed at informing decision-making’ (Battista and Lafortune, 2009: 227) has become a key feature of health systems in many countries worldwide. It has been endorsed by the World Health Assembly for use in low-income countries (WHA, 2014), and has been recommended for use in connection with global health funding initiatives such as the Global Fund (Teerawatananon *et al.*, 2013).

However, HTA has played a much more insignificant role in respect of interventions for population health, as distinct from those designed for individual clinical care. One significant important impediment is that such interventions are complex to evaluate (Holland, 2004). There are several, connected, reasons for this.

First, and importantly, assessment of the success or failure of interventions which seek to ameliorate population health can often only be undertaken after the lapse of considerable time. Holland (2004: 79) cites the example of measures to reduce smoking; modifications of smoking behaviour will only eventuate over the medium term, but observable changes in rates of morbidity and mortality will take even longer to emerge. By contrast, outcomes for clinical interventions, such as new drugs or diagnostic procedures, can be measured much more swiftly, for example, by observation of side effects or improvements in diagnosis. This distinction has important political consequences, which will be revisited in the next section. It should be noted that HTA is intended primarily to *inform and support* policy-makers in making choices on allocation of scarce resources, rather than in itself being determinative of such choices (Garrido *et al.*, 2008). Where HTA, or some other mechanism of evaluation, provides evidence that an ‘upstream’ intervention enhances the health of the population, funding will need to be maintained for a lengthy period—perhaps, a generation or more—if political capital is to be made of such improvement. Conversely, clinical interventions can be shown to produce results quickly. The choice between the two forms of intervention seems obvious for policy-makers driven by a short-term electoral cycle, as Gostin himself acknowledges in writing of the ‘domestic political

pressures . . . to show clear, measurable results’ (Gostin, 2014: 422).

Second, the choice of methodologies to gather evidence which might underpin priority-setting for population health is much less clear-cut than is the case for clinical technologies or diagnostic procedures. The ‘gold standard’ for evaluating effectiveness, the randomized controlled trial, has not been widely used beyond the clinical context, with some limited exceptions (Epstein *et al.*, 2009: 496). More broadly, the standard ‘hierarchy of evidence’, by means of which differing types of evidence are ranked in respect of their robustness in answering research questions on the effectiveness of interventions (especially, the presence or absence of bias), is unlikely to be of significant value in the context of population health, or to the social determinants which impact upon health. Indeed, in work carried out for the World Health Organization (WHO) Commission on the Social Determinants of Health, Kelly *et al.* (2007: 20) argue that an ‘evidence based approach to the social determinants of health categorically rejects the notion of a single hierarchy of evidence’. Rather, they take a much broader perspective upon the relevance of evidence, arguing that ‘the range of evidence that needs to be considered is extensive and the questions that the research [will seek] to answer are much broader than just those of clinical effectiveness’ (2007: 94). Nonetheless, they consider the development of appropriate hierarchies in this context to be an ‘urgent methodological priority’ (2007: 95), not least because of the value which evidence possesses as a catalyst for political action (2007: 7).

Following from this, and third, it should be recalled that while Gostin emphasizes the value of population-level health interventions over and above the provision of health care, he is concerned also to ensure that resources are prioritized to address the social determinants of that population health, such as education, housing or social inclusion. This presents further difficulties in respect of the gathering of evidence. The focus of the intervention is at least one step removed from the negative health state, raising questions of causality. However, establishing this is not easy, as Gostin himself concedes in noting that ‘socioeconomic factors influence health through a wide variety of causal pathways’ (Gostin, 2014: 417). There is extensive evidence of an *association* between social and economic determinants and poor states of health (Marmot and Wilkinson, 1999), but a lack of understanding of the precise causal relationship between them: as Epstein *et al.* (2009: 496) observe, socio-economic status may determine poor health, poor health may determine

socio-economic status, or both may be determined by a common third factor. To put matters differently, and by contrast again to clinical medicine, complex social interventions of the type which Gostin favours are problematic because causality is not successive (X produces Y), but rather generative (an intervention provides resources which would not otherwise have been available to enable subjects to act in accordance with the intervention's goals; however, whether they *do* act in such a way depends upon context, i.e. the characteristics of the subjects and of the locality in which the programme is introduced: Pawson, 2002). This is problematic if we accept that identification of causality is 'crucial in order to understand the problem and to design effective interventions' (Epstein *et al.*, 2009: 496).

It is, of course, perfectly possible to establish priorities for the allocation of resources in the absence of clear evidence of their likely effectiveness; policy-makers may have particular ideological or interest-driven reasons for so doing. Indeed, basing allocative decisions upon *evidence alone* runs the risk of generating a 'legitimacy problem' arising from a perceived preference for technocratically driven solutions over consideration of social values (Syrett, 2003). Provided that decision-makers demonstrate compliance with the conditions of procedural justice outlined in the preceding section—notably, that there is explanation of the priorities chosen and that these reflect criteria that the community is disposed to regard as relevant when allocating resources—such choices should be seen as legitimate irrespective of whether it is known whether they will be effective or not.

However, taking action without evidential support, or contrary to evidence, runs a clear risk of policy failure which will then engender further problems of legitimacy (not least, as questions are asked about resources being 'wasted'). Rather than risk failure upon interventions for population health for which there is little or no evidential basis, decision-makers are likely to prefer to base priorities upon the more clear-cut evidence available for specific health care services and interventions, especially in light of the tendency towards short-termism noted above. Thus, while evidence is not the sole driver of political action, it is an important impetus for it (Kelly *et al.*, 2007); in Marmot's terms (2014: 343), while seeking to address avoidable inequalities in health is in itself an ideological undertaking, 'the evidence must be a key part of the conversation', not least to dispel prejudice. Conversely, the absence or weakness of evidence on effectiveness and/or causal pathways in respect of population health interventions and the broader determinants of health can readily provide justification for

inaction, even if such inactivity may in fact be motivated by political considerations such as the contentious and costly character of redistributive policies.

Governance

An emphasis upon 'upstream' determinants carries distinct implications for the structuring of the governmental institutions within which priorities are set for the distribution of resources for health. Since the majority of these determinants fall outside the traditional remit of ministries of health, intersectoral activity is likely to be a prerequisite to any effective interventions in relation to them (Kelly *et al.*, 2007: 31). One means of realizing such intersectorality is to adopt a 'health in all policies' approach (Goldberg, 2014: 1841), defined by WHO (2013) as 'an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity'. It is notable that Gostin expresses strong support for the adoption of such an approach, arguing that it is a means of giving effect to 'a broadened understanding of the institutional actors responsible for promoting and protecting global health justice' (Gostin, 2014: 425).

The global commitment to an intersectoral approach to health— noted by Gostin (2014: 98) who cites the then Director-General of the WHO's labelling of the Declaration of Alma-Ata of 1978 as 'a holistic concept calling for efforts in agriculture, industry, education, housing and communications, just as much as in medicine and public health' (Mahler, 1981: 6)— has been matched by some activity at the regional level. For example, Article 152 of the EC Treaty (now Article 168 of the Treaty on the Functioning of the European Union) specifies that 'a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities'. Efforts have been made to give substance to this commitment through a thematic focus upon health in all policies during the Finnish presidency of the European Union (EU) in 2006 (Council of the European Union, 2006; Ståhl *et al.*, 2006) and through the adoption of health impact assessment as part of an integrated impact assessment process (Commission of the European Communities, 2002).

These developments raise the prospect of development of intersectoral working at these levels of governance to tackle 'the influence of multiple regimes on public health' (Gostin, 2014: xiv, arguing that this is

the ‘international analogue of health in all policies’). Given the role of multi-level governance in tackling global public health problems in the past, most notably in respect of tobacco control (Mamudu and Studlar, 2009), this is undoubtedly worthy of further exploration, but considerable obstacles are likely to remain. Thus, while Gostin’s call for a Framework Convention on Global Health envisages the WHO being ‘charged with engaging with and co-ordinating multiple sectors’ (Gostin, 2014: 438), with institutional commitment to intersectorality reflected in its leadership of an Intersectoral Consortium on Global Health (Gostin, 2014: 436), he acknowledges that its legitimacy is presently limited to convening, mediating and negotiating and that it lacks the ‘legal powers or political and economic clout to fully harmonise disparate activities’ (Gostin, 2014: 429). He notes also the ‘dogged pursuit by the World Trade Organization . . . of trade liberalization without sufficient concerns for health justice’, and the ‘siloe manner’ in which the two international bodies have traditionally worked (Gostin, 2014: 301). Similar difficulties are likely to be encountered at regional level. For example, there are deficiencies in the expertise, resources and capacity of EU institutions to deliver public health policies (McKee, Hervey and Gilmore, 2010: 231). Further, the EU’s integrated impact assessment process has frequently failed to take account of effects on human health, public health or health systems, instead reflecting the particular policy perspective of the Directorate General carrying out the assessment and often leading to prioritization of economic interests (Smith *et al.*, 2010; Ståhl, 2010).

At least in the short to medium term, therefore, Gostin’s ‘assumption . . . that national governments bear primary responsibility for health of their domestic populations’ (Gostin, 2014: 431) is likely to hold true. His proposed Framework Convention envisages *states* committing to a health in all policies approach (Gostin, 2014: 438), but how far is this realizable? While it would unduly extend this article to offer extensive analysis of the means by which this ‘modality’ might be brought about, or the obstacles to adoption of such an approach—and such issues have received detailed attention elsewhere (see e.g. Ståhl *et al.*, 2006; McQueen *et al.*, 2012)—a number of observations are germane to Gostin’s recommendation.

In a broad sense, strategies for ‘joined-up government’ seek to address cross-cutting problems which are resistant to traditional departmental action (Bogdanor, 2005: 6). Turning to the specific context of health, various structural, procedural, financial and/or regulatory mechanisms have been adopted to facilitate

intersectorality with a view to achieving health in all policies (St-Pierre, 2009). Within the first category are institutions for co-ordination of action on the determinants of population health, such as interdepartmental committees, networks of civil servants or ‘mega-ministries’. The most significant process mechanism is health impact assessment, which provides an evaluation of the potential population health impacts of policy proposals, and thus functions as ‘a governance tool, since it fosters interaction between public administration sectors. . . and therefore favours horizontal management within a government’ (St-Pierre, 2009: 11). Financial mechanisms include arrangements for joint budgeting, such as management of separate funds by a single individual to facilitate alignment between them, or allocation of resources to address specific population health problems rather than to governmental departments (McDaid, 2012). Finally, regulatory mechanisms might include legislative provisions which mandate an intersectoral approach, such as the Wellbeing of Future Generations (Wales) Act 2015, which requires public bodies to adopt integrated and collaborative strategies to secure the goal of a healthier Wales.

To date, we lack evidence as to the effectiveness of such mechanisms for achieving health in all policies (St-Pierre, 2009: 41; Lin *et al.*, 2012: 50). However, there are some sizable obstacles militating against success, which would appear to underlie the failure to turn this approach from rhetoric into action (Ollila, 2011).

Thus, in the context of priority-setting, a tendency for decision-making to remain located within particular departmental ‘silos’ is exacerbated by the desire of political actors to ‘own’, manage and increase their resources, consonant with a public choice budget maximization model (Niskanen, 1971). Relatedly, intersectorality also raises questions of competence: bureaucrats are required to become ‘boundary spanners’ (Hood and Lodge, 2006). This not only presents a challenge to their skills and expertise (and may thus necessitate ceding power to other actors, such as the ministerial ‘special advisers’ who have recently become a familiar feature in UK central government), but it is also likely to diminish the prospects of making a visible impact (since no single contribution to a cross-cutting initiative is likely to be decisive) and thus furthering their career ambitions. Additionally, a blurring of spheres of responsibility may further imperil job satisfaction, but can also undermine the usual pattern of vertical lines of constitutional accountability which depend upon clear attribution of responsibility for allocative decision-making. Conflicts of value—substantive disagreements upon objectives, or the means of achieving them—between the

various political actors who are engaged in priority-setting may also need to be addressed if intersectorality is to succeed (Davies, 2009). Similarly, deep-seated organizational cultures within particular areas of government—‘the way things have always been done’—may also have to be surmounted, not least because these are likely to inhibit the capacity to comprehend and address issues beyond the silo (Flinders, 2002: 56). Finally, and as noted in the preceding section, the brevity of the electoral cycle is problematic. Not only do the effects of intersectoral initiatives tend to manifest themselves mainly in the longer term, thus rendering them less attractive to politicians, but also key actors—notably ministers—are usually transient figures, regularly moved on for strategic political reasons, making co-ordination and the building of relationships challenging (Flinders, 2002: 66).

Conclusion

Taken on his own terms as a Rawlsian thought experiment as to what global health with justice would look like (Gostin, 2014: 420), Gostin provides his readers with a most helpful account of how prioritization of resources should be approached. But it is less clear that he succeeds in meeting another of the objectives which he sets for himself, namely, that ‘a meaningful vision for global health must specify the means as well as the ends’ (Gostin, 2014: 414). Of course, allocating resources to population health strategies rather than personal health care *is* a means to an end—but only in the very broadest of senses: more is needed by way of detail if we are fully to operationalize ‘upstream’ prioritization.

This article may be regarded as a means of embarking upon this process. As such, it has sought to identify some significant obstacles which stand in the way of success in this regard, although it has also noted areas—for example, with respect to incorporation of equity criteria into decision-making and experimentation with intersectoral mechanisms of governance—where relevant work is presently being undertaken. Even in those instances, however, much still remains to be done.

To the present author, the signal value of *Global Health Law* lies in its presentation of a clear-sighted and comprehensive articulation of an ideal—global health with justice—towards the achievement of which the international community should strive. In that regard, it will surely serve as an indispensable rallying cry to those who, ‘seizing the moment for global health’ (Gostin, 2014: 439), would seek to draw attention to the

multifarious current injustices in the distribution of resources for global health. But, while the vision which it presents is laudable, hard-headed pragmatism (and the allocation of scarce resources is an area where such pragmatism inevitably holds sway) is likely to give us significant pause for thought. Viewed from this perspective, the ‘more ideal future for global health’ which Gostin offers might seem discouragingly distant, more of an aspiration than a prescription for action.

Funding

The conference was funded by the Wellcome Trust.

Conflict of interest statement: None declared.

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