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THE POST-2015 DEVELOPMENT AGENDA: WHAT GOOD IS IT FOR HEALTH EQUITY?

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Introduction

This Beyond 2015 position paper for the thematic UN consultation on "Health in the Post-2015 Development Agenda"[1] was drafted by a broad team of health advocates from various backgrounds.[2] We have focused here on how to advance and value health equity, the right to health and sustainable health systems within the four core dimensions of global sustainable development proposed by the UN System Task Team[3]: inclusive social development; environmental sustainability; inclusive economic development; peace and security.

Achieving the right to health for everyone, everywhere, will depend on a huge effort, at all levels: political, intellectual and financial. Hence, our focus for the post-2015 process and outcome will not be on the health sector alone or solely on health related post-2015 goals, targets and indicators, but on the overall process, all the dimensions of sustainable development, and the multisectoral response needed to create and improve the environments that will facilitate improved health outcomes.

1 Lessons learnt from the health related Millennium Development Goals

Progress on the health related Millennium Development Goals (MDGs) has been made, and we have to build on those gains. Many of the problems associated with the MDGs lie within their design and a neglect of global governance issues. In order to advance health in a sustainable and equitable manner, we need to address these shortcomings in the development of a new framework.

We share the critical overall assessment of the strengths and weaknesses of the Millennium Development Goals (MDGs) provided by the UN System Task Team in its report to the UN Secretary General. The MDGs have been effective in increasing political commitment to key development issues and effective in generating new country and development partner resources. The concrete goals and clear, concise, measurable and time-bound targets appealed to the general public and were easy for policy makers to adopt. They created global public and political awareness of poverty-related injustices and their consequences.

The centrality of health to human development is evidenced by the substantial attention given to health in the MDG framework. Three out of the eight goals are directly focused on health. Consequently, these health goals have become a key objective of development cooperation and policies, resulting in substantial attention and donor resources to be directed toward achieving the goals, with clear improvement in global health outcome indicators. On a global scale, under five-mortality was reduced by 35% between 1990 and 2010. The reduction in maternal death has been significant, down from an estimated 543,000 in 1990 to 287,000 in 2010, although we should not forget that this is the MDG that is most off track. Neonatal mortality rates have declined from 32 per 1000 live births to 23 per 1000 live births over the same period – a 28% reduction. Access to antiretroviral therapy for people living with HIV has improved considerably; 16 times more people were treated in 2010 than in 2003.[4]

While global aggregate measures of the MDGs indicate progress in many countries, these aggregates do not account for national starting points at the inception of the MDGs, nor the widening national inequities that have emerged over the course of the last decade and hamper progress toward the achievement of all MDGs. While the specificity of the MDGs allowed for easily-understood global ambitions, one could argue that the goals were too specific and perhaps reductionist. Donors interpreted the MDGs as a veritable "shopping list" of development priorities, which has led to a skewed distribution of ODA for health that frequently fails to match the priorities of the recipient countries. This misalignment of aid is contrary to the principles of the Paris Declaration on Aid Effectiveness. Aid effectiveness in health is being improved, and lessons learned in this area must be considered in designing the future development framework. The specificity of the MDGs neglected critical global health issues and undervalued overall health and development dimensions.

Furthermore, the disproportional distribution of ODA for health has led to vertical disease-specific programmes in low- and middle- income countries (LMICs) and distorted health systems that focus on acute care and respond to the end stages of disease, rather than taking a more preventive and comprehensive approach to health. An equitable and sustainable approach to human health and development must be based on the principle that the health system should address the whole person and its (social and economic) environment, often with multiple conditions, and not compartmentalize

treatment by disease or stage in life. Moreover, as gaps in income level within and between countries persist and widen, the focus on inequities and their consequences for health needs to become sharper. [5,6] Because of how the MDGs were formulated, little attention was paid to how to address and improve equity. Inequalities in income and wealth as well as in health outcomes have, by and large, increased.

The MDGs have largely targeted refocusing development efforts within developing countries. However, issues beyond developing countries and development assistance have had a substantial effect on the well-being of people, including their health, such as macro-economic policies and the current austerity measures in many countries, the globalisation of trade, of services and of finances, demographic/population changes, climate change, food insecurity and energy policies. A high degree of policy coherence between these domains and the health sector objectives is required for lasting health improvement and equitable outcomes.

The MDGs have emphasized refocusing development efforts in developing countries. The MDG 8 – "Develop a Global Partnership for Development" – addresses what countries should do to fulfil ODA commitments through improved global development cooperation. Many of the commitments made under this goal remain unfulfilled. Target 8e within MDG 8 – provide access to affordable essential drugs in developing countries – is of utmost importance to a majority of health conditions. Yet this target has gone largely unnoticed, with a lack of progress attached to this neglect.

2 What are the health priorities in the coming decades?

In order to discuss what the further post-2015 process and outcome can contribute to the realization of the right to health we will ask what lessons we can learn from the past, and why the right to health for all has not been attained. We aim to establish a common understanding on how we define health and a strong health system, as well as on the underlying causes promoting or hindering real progress.

The "Realizing the Future We Want" report by the UN System Task Team states that "the central challenge of the post-2015 UN development agenda is to ensure that globalization becomes a positive force for all the world's peoples of present and future generations. Globalization offers great opportunities, but its benefits are at present very unevenly shared". The failure to adequately address global challenges such a as re-emerging and new infectious diseases, non-communicable diseases (NCDs), environmental and occupational health, climate change; population growth, sexual and reproductive health, social determinants of health; as well as the increasing inequalities between groups of different socio-economic, cultural and educational background, indicate that current global governance structures are not working for the benefit of all.

From Primary Health Care to Universal Health Coverage: Health as a human right and global common good

In a discussion paper on health in the post-2015 development agenda the World Health Organization states: "Health is central to development; it's a precondition for, as well as an indicator and outcome of progress in sustainable development". WHO suggests that "Universal Health Coverage" (UHC) is a way of accommodating the wide range of health concerns[7].

The current debate on UHC reminds us of Primary Health Care (PHC) in the WHO Alma Ata Declaration of 1978.[8] Over time the vocabulary, framing, demography and global context have changed considerably, but the essence remains the same:

- Health inequalities were an issue then and now, and they have grown over the last 35 years.
- A clear shift to new development pathways is required.
- Universal access to health care and the right to health are the key principles.
- The Alma Ata declaration recognizes health as a world-wide social goal, the realization of which requires the action of many other social and economic sectors in addition to the health sector. This is the inter-sectoral and governance for health approach envisaged nowadays[9].

The key question today is why, 35 years later, the *comprehensive Primary Health Care* vision has been implemented merely as *selective primary health care?* The same might happen to *Universal Health Coverage*; we can come up with a comprehensive definition and basis, but how can we prevent it from being implemented in *a selective manner?*

While ODA for health has increased and – slowly but steadily – aid effectiveness is being improved, we are still faced with the legacy of "market fundamentalism" that arose in the 1980's and 90's and in which macro-economic stability, trade liberalization and shrinking the public sector are seen as the route to economic growth and the end of poverty. This cost-effectiveness approach has proved to be a disaster for health, and one can conclude that it resulted in retrogression in realizing the right to health in many developing nations[10]. To reverse this trend, policies ought to be based on a human rights approach to health, as spelled out in general comment 14 by the UN committee on economic, social and cultural rights[11].

Health and sustainable development

Health is an essential element of the Rio+20 sustainable development outcome document, with its three dimensions of economic, social and environmental sustainability. It has three clear implications for health priorities beyond 2015: Firstly, sustainable development can only be achieved in the absence of a high prevalence of debilitating communicable and non-communicable diseases. Secondly, action on the social and environmental determinants of health is required to establish inclusive and healthy societies. This requires confronting the escalating threat to human health, even to human survival of climate change. Thirdly it acknowledges that the realisation of the right to health is a central element of sustainable development[12].

Many policies that tackle climate change, such as the reduction of private cars and inefficient cooking stoves have health co-benefits, e.g. a reduced burden of respiratory illness due to air pollution. Likewise, preventive health interventions such as the promotion of physical exercise and the reduction of animal meat in diets contribute to lower emission of greenhouse gasses[13]. Fulfilling the unfinished MDG target 5b, universal access to reproductive health, will increase women's access to family planning. This will contribute to child spacing, a reduction of infant and maternal mortality, and slow down population growth to a sustainable level that does not overextend the capacity of our planet.

From ODA to social justice and democratic global governance

The UN System Task Team report rightly notes that the global food, fuel and financial crises have "exposed systemic failures in the working of financial and commodity markets and major weaknesses in the mechanisms of global governance". However, none of the circulating proposals and documents from UN institutions challenge the prevailing paradigm of economic growth. The Commission on Social Determinants of Health stated rightly that "income redistribution, via taxes and transfers – the latter of which are key to social protection – are more efficient for poverty reduction than economic growth per se"[14].

The MDG framework, although enabling more international financing for health, has not sufficiently addressed the systemic aspects of health systems, and the need to strengthen them. The specific nature of the goals has led to fragmentation and disease-specific selective interventions. Furthermore, systemic improvements such as domestic financial resources for health, a well-equipped strong health workforce, and governance and accountability mechanisms have not been addressed sufficiently by implementing governmental and non-governmental institutions or by donor agencies. Under the International Health Partnership (IHP+), coordination between actors is being improved and it is critical that the new framework contributes to sustaining the gains made and further strengthens aid effectiveness, in line with the principles of the Paris Declaration. Solutions have been suggested for a more diagonal approach to health systems strengthening, in which disease specific programme funding is coupled with structural investments in the workforce and national health sector capacity.[15]. While not perfect, the IHP+ remains a relevant initiative to enhance coordination in global health actors for sustainable health systems strengthening. Its future is, however, uncertain for the time being due to financial austerity measures.[16]

Low-income country governments' resources are under severe pressure through the existence of tax havens, capital flight, and other international policies that contribute to tax avoidance and evasion.[17] Health goals cannot be seen separately from the need to establish a clear financing framework. We need to move beyond aid and the underlying charity concept to new innovative financing approaches, including financial transaction taxes, and fair and progressive taxation regimes, both at national and international level. A possible mechanism for this is a global Social Protection Floor (SPF). The SPF would commit states, via a rights-based approach, to agreed minimum levels of social protection tailored to their respective country. This mechanism could mitigate global tax competition and its related negative impact on public expenditure on health.[18] Mechanisms like this will enable a transformative and equitable redistribution of resources and power. Similarly, accountability and governance mechanisms at country

and multilateral levels have got to be much stronger to support an increase in tax-based financing for the implementation of health services.

Democratic Global Governance for Health

During the last decade we have witnessed the creation of a large number of organisations and partnerships for supporting the achievement of the MDGs. There is much fragmentation, duplication, competition, and a need for greater coordination and collaboration among global health actors and initiatives. The WHO is mandated via its constitution to take the lead in developing and improving a more coherent and accountable system of global health governance. It is taking up this role, in cooperation with the World Bank, in the IHP+. To maintain a strong input from the WHO in global health, WHO member states need to use the current reform of the WHO as a unique opportunity to strengthen it's leadership role.

Moreover, as health equity is to a large extent determined by policies outside the health sector, we must increasingly link institutions of global governance. This would involve areas of "thin" global governance (e.g. social polices, environment and human rights) receiving similar attention, priorities and institutional powers as current domains of "thick" governance (e.g. trade, investment, and finance), which requires a re-direction of our global priorities. For instance; why do we pay so much attention to the global financial crisis and much less to the ecological crisis? The principles for global governance for health and social policies can be summarised in three points (the three R's): Systemic resource *redistribution* between countries and within regions and countries to enable poorer countries to meet human needs; Effective supranational *regulation* to ensure that there is a social purpose in the global economy; enforceable social *rights* that enable citizens and residents to seek legal redress[19].

3 What good is the post-2015 development agenda for global health equity? And how does health fit in the post-2015 development agenda?

The lessons learned and the health priorities defined in the sections above allow conclusions about what is needed to make the process and outcome of developing a post-2015 agenda a strong contribution to health equity and to the achievement of the right to health for everybody, everywhere.

Health should remain an integral part of the new post-2015 Development Framework, and we must ensure that the unfinished business of the MDGs is not forgotten. On the other hand, the realities of the 21st century – shifting global trends and patterns of inequality, demography, migration, urbanization, consumption and production – have created new challenges that threaten to derail development. Hence, the post-2015 framework must by necessity take a broader view on both health priorities and the role of health within the larger framework.

The WHO, a number of UN Member States as well as civil society organizations are promoting Universal Health Coverage (UHC) as the central way to frame health, and encompass different health targets in the post-2015 framework. The definition of UHC is to "ensure that all people can use the promotive, preventive, curative and rehabilitative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."[20] In the World Health Report of 2010, WHO also highlights the importance of promoting equity in the implementation of UHC, but health equity is not explicitly included in the definition of UHC. While we appreciate the UHC concept, striving for 100% coverage and financial protection, we believe there are several points to be interrogated and properly addressed before UHC can be taken forward as a concept in the next development framework.

Departing from a right-based approach, we bring to the fore the following issues that we do not yet see sufficiently reflected in the UHC concept, and which in our view are essential ***benchmarks for the post-2015 health agenda:***

1. Health should be recognized as a right in and of itself as well as being clearly linked with other development sectors. The post-2015 framework must **address the root causes of poverty and the structural power imbalances**; it must, in general, have universal applicability and not only to low- and middle-income countries. This means setting goals and targets explicitly for high-income countries and other actors that have an impact on development issues, including in areas such as global accounting and

tax treaties, trade, migration and climate change, with the objective of redistributing wealth and achieving social justice, as well as addressing the democratic deficits in global governance.

2. **Reducing health inequities** must be an explicit and central outcome of the post-2015 health goal(s) – with special emphasis on disadvantaged populations. This requires policy interventions that Sir Michael Marmot has described as proportionate universalism: "Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage".[21] Thus, to improve the situation for disadvantaged groups, it does not suffice to only focus attention on these groups. Health inequities result from social inequities, and resolving them requires broad policy measures aimed at, e.g. giving every child the best start in life, and creating fair employment and good work for all.

3. **A comprehensive approach** is needed to move away from fragmented goals and targets, and incorporate the underlying determinants of health. Health in the post-2015 framework should extend beyond health care – from the perspective of the individual – to include public health interventions and underlying determinants of health, such as tobacco control policies, wider social protection schemes, healthy diets, access to clean water and environmental and occupational health interventions. The right to health framework as developed by the UN committee for economic, social and cultural rights is the starting point for determining the underlying determinants of health.[22] This work can take forward existing assessments of realizing the right to health at country level.[23]

A comprehensive approach also implies incorporating **health as an explicit outcome of other development goals.** Health and well-being are much determined by factors and policies outside the health sector, e.g. in the domain of macro-economic policies and trade. Policy coherence between these domains and the health sector is crucial, especially when it comes to improving health equity. Health must be considered in these policy domains. Extensive work on this has been conducted by WHO, leading to a framework called a Health in all Policies approach (HiAP)[24]. We are convinced that such a health and wellbeing approach is required to ensure that the right to health is respected and protected in other policy areas.

The HiAP approach, described above as national policy processes for societal well-being, has to be **translated to a global, supranational level**, enabling health to be more strongly represented in other policy domains. This is where new, strong global governance mechanisms are required that protect and enable health (and other social outcomes) in non-health international regimes. One could for instance think about health commissions that are mandated to provide recommendations during global and regional trade negotiations or the on-going climate change negotiations.

4. The post-2015 framework must ensure broad participation in its preparation and its monitoring of processes and outcomes by setting clear participation targets. Global goals must be translated to national level in accordance with the local context and through an inclusive process.

5. A new development agenda has little meaning without a **clear financing framework**. At the international level, we need to move beyond official development assistance (ODA) and address, on the one hand, the illicit outflow of resources from low-income countries through corruption, tax evasion and tax avoidance, and on the other hand set goals for the development of new financing mechanisms to overcome the problems of ODA.

At national level, experiences in the area of health care financing illustrate how some reforms, implemented with the aim of expanding coverage, can actually increase inequity if not guided by a comprehensive and rights-based approach. Essential elements for equitable financing of health services are a predominant reliance on compulsory contributions and public funding (general revenues are required in all systems to subsidize the contributions for the poor and most vulnerable), large-scale pooling arrangements that redistribute prepaid resources to individuals with the greatest health service needs, and strengthening strategic purchasing arrangements within a national health financing system.[25]

4 Measuring progress towards the World We Want: Using health indicators and targets?

In this chapter we suggest five concepts that are crucial to measuring progress on health as the post-2015 development goal.

1. In addition to defining health inputs and specific outcomes, we prefer to use an overarching aim of improving human wellbeing, defined in terms of overall outcome. The health goal could be a combination

of a reduction in the number of years lost due to ill-health, disability or death (DALY); complementarily it could revolve around gains in life-expectancy or healthy life years (HLY). This approach requires considerable investments in health information systems. It would in the development framework be extremely valuable to develop key health indicators, even in low-income countries, that include but extend beyond the disease mortality indicators currently used. A "hierarchy of health goals" framework can be used to further develop relevant health indicators.[26]

2. Both the framing of the health goal itself as well as related targets should explicitly require reductions in health inequities. These targets should address both coverage and health outcomes, as well as financial risk protection; a target could be minimizing disparity across health services between top and bottom income quintiles, gender, age groups, disability status, rural/urban location, ethnicity and minority population groups, etc.

3. Given the power of indicators to drive programming, the UN should strongly consider including health indicators across all dimensions of development, which would capture critical dimensions of health otherwise missed, establish health as a multisectoral issue with multisectoral solutions, and develop an understanding on how improvements in health impact upon poverty reduction, economic development, social development, and environmental sustainability.

4. Targets and indicators should incorporate policy measures, in addition to measures of health service coverage, and indicators related to the capacity and effectiveness of the state at enforcing policies. A key set of health indicators for use in other sectors will be very relevant to implementing the HiaP approach. Health impact assessments could be included as criteria in other sustainable development goals.

5. Strategies should be included to ensure accountability, at all levels, and measures that enable people to claim their rights. Building a strong accountability process is key, including independent monitoring by civil society and other third actors, including on human rights.

6. At global level, measurable indicators are essential to improving governance for global health, clarifying responsibilities of different actors, including for example access to essential medicines and to technological innovations, compliance with the WHO Global Code of Practice on the International Recruitment of Health Personnel, as well as human rights and health obligations under the International Covenant on Economic Social and Cultural rights.

5 How to ensure a process and outcome that is relevant to civil society?

We strongly believe that the consultation process needs to be more inclusive, and therefore should slow down to allow time for participative country consultations. The post-2015 agenda cannot be finalized without a wider consultation.

While preparing this paper, a call for organising civil society health consultation meetings has been issued. These consultations are to be organised on very short notice, so that it is not clear (1) how representative these can or will be and (2) how the different inputs will ultimately be collated and dealt with. Clarification is needed on how different processes and the inputs resulting from them will be brought together, both within the post-2015 process and between this process and other global consultations (such as Rio+20 follow-up and ICPD+)

We propose that a separate civil society committee – or multiple committees representing different regions – be formally involved in the UN negotiations. Their consent could be a prerequisite for UN adoption of the goals.

Furthermore, taking into consideration that communities and many smaller civil society organisations (CSOs) may be unable to participate in these consultation processes, we would like to stress the need for the adaptation of targets, timelines and indicators to national contexts, through an inclusive participatory process that includes marginalized populations. This would be a way to enable communities and local civil society to have input in and take ownership of post-2015 goals/targets and indicators.

The consultations should not be simply about extracting information to help define global goals. They should be used to put in place mechanisms of continuous community engagement, including a constant feedback loop that will enable people to effectively engage in the entire process and hold their governments to account for their promises. We call for community consultations, public hearings and public forums on sustainable development, not as a one-time information collection effort, but as a first step towards democratic global governance.

4900 words

Summary with key messages

The UN consultation on the post-2015 development agenda provides a crucial opportunity to reflect on the kind of future we want and how to get there. In this Beyond 2015 position paper, prepared by a drafting team of health advocates, we envision a future in which everyone enjoys the right to health.

While acknowledging the progress made on global health outcome indicators that are part of the current MDG framework, we highlight a number of weaknesses in this framework that need to be addressed in order to progress further and ensure that the benefits of globalisation are distributed equitably.

The heavy emphasis in the MDGs on development assistance and need for reforms in low-income countries should be balanced by equal attention to the need for high-income countries' reform in areas such as climate change, global trade and finance, to avoid the erosion of gains made in wellbeing. Secondly, the focus on a few measurable outcomes has led to the neglect of other important aspects of development, not all easily measured, such as participation and democratic governance. Thirdly, global targets were set that were not sufficiently aligned to local needs and not disaggregated for different population groups. As a consequence we have seen the fragmentation of health systems, an uneven allocation of Official Development Assistance (ODA) and increased inequity.

We call for a post-2015 framework, that:

- Addresses the root causes of poverty and structural power imbalances, has universal applicability and is not only applicable to low- and middle-income countries;
- Recognises health as a right in and of itself and seeks to reduce inequities in health and other aspects of development, including through the use of disaggregated data in the design, implementation, monitoring and evaluation of health programs;
- Ensures broad participation in its preparation, monitoring of processes and outcomes and includes systems of accountability and governance that strengthen the building blocks of health systems in a comprehensive way;
- Establishes a clear financing framework that moves beyond ODA, is based on social justice and addresses the illicit outflow of funds from developing countries;
- Takes due attention to the three R's (Regulation, Rights, and Redistribution) as principles for the global governance for health in policy domains within and beyond the health sector;
- Includes health and equity as outcome indicators in non-health development goals.

Beyond 2015

Beyond 2015 is a civil society campaign pushing for a strong and legitimate successor framework to the Millennium Development Goals. The campaign is built on a diverse, global base, brings together 577 organizations from 95 countries and ranges from small community based organizations to international NGOs, academics and trade unions. Whilst Beyond 2015 participating organizations have a range of views regarding the content of a post-2015 framework, the campaign is united in working to bring about the following outcome:

- A global overarching cross-thematic framework succeeds the Millennium Development Goals, reflecting Beyond 2015's policy positions.
- The process of developing this framework is participatory, inclusive and responsive to voices of those directly affected by poverty and injustice.

This paper is issued on behalf of the Beyond 2015 campaign. The drafting process coordinated by the Medicus Mundi International Network started with the collection of initial input received from Beyond 2015 members[27], a discussion on initial bullet points and with a first draft by lead authors Mariska Meurs and Remco van de Pas, Wemos. After an intensive drafting process within the broad drafting team[28] (written feedback, conference calls), a second draft was circulated to the Beyond 2015 campaign for review. In the final redrafting, it was possible to incorporate most of the inputs received.

In accordance with the Beyond 2015 protocol on forming policy positions, the final version was signed off unanimously by the Executive Committee of Beyond 2015. Thanks go to the drafting team and the coordinating organization for their great investment in this process.

www.beyond2015.org
www.bit.ly/mmi-beyond2015call

Notes and References

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Consultation website: www.worldwewant2015.org/health

2 Drafting process: See note "Beyond 2015" at the end of the document.

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