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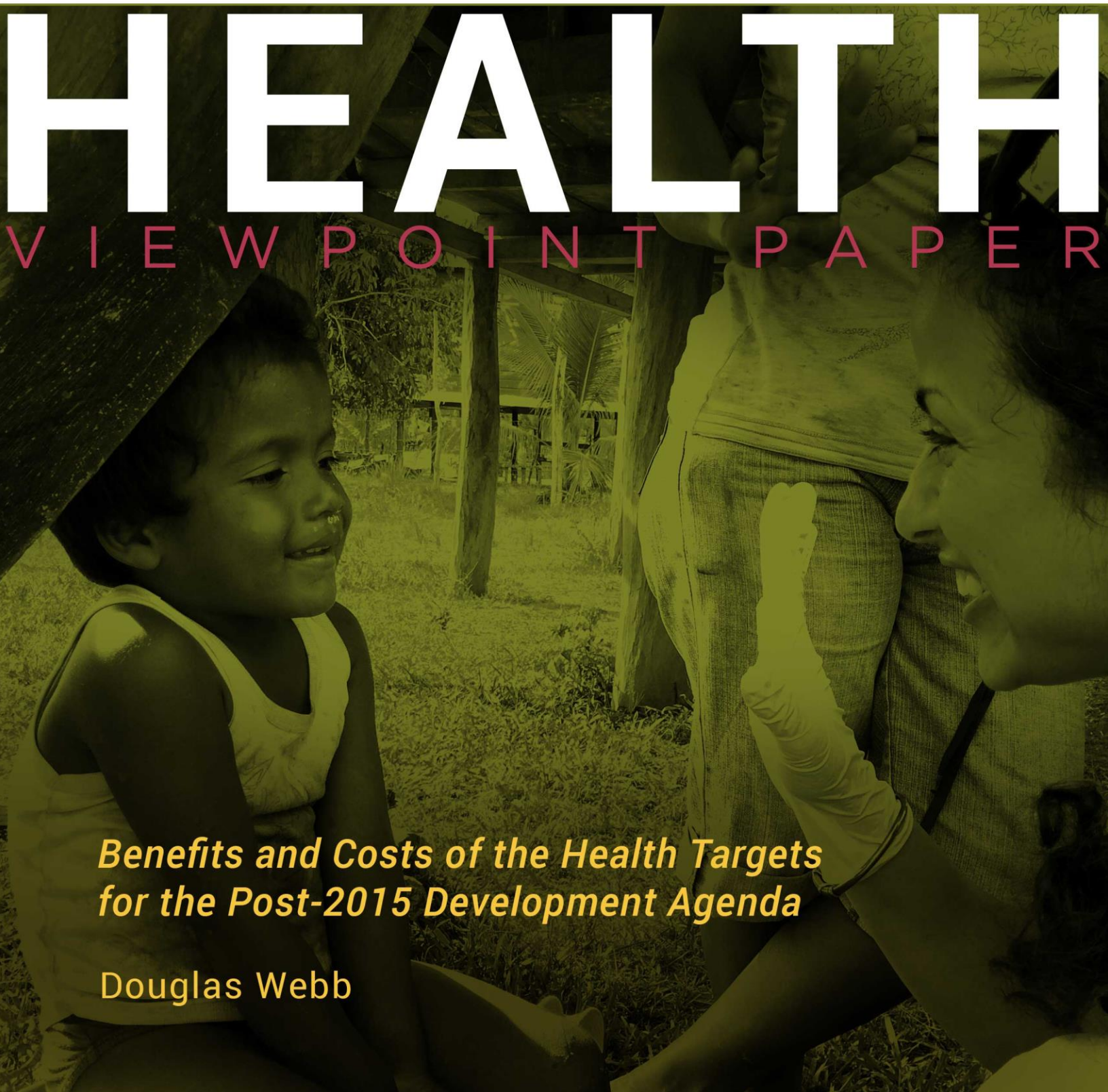
HEALTH

VIEWPOINT PAPER



Benefits and Costs of the Health Targets for the Post-2015 Development Agenda

Douglas Webb

POST-2015 CONSENSUS

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Working Paper as of 19 January, 2015

Introduction[1]

Critiquing the proposed Sustainable Development Goals (SDGs) is a desirable and no doubt essential exercise to ensure a set of ambitious yet realistic development human development aspirations for the global community for 2030. Their negotiation to date has been a mix of data and evidence analysis, combined with political trading, negotiation and compromise. Ultimately the development of the SDGs is a political process, within which the weight that is given to evidence, policy efficacy or any analytical tool such as benefit-to-cost ratio (BCR) calculation is contextual and not necessarily commensurate to the actual value, in objective terms, of the achievement of any one goal or target's impact on human development. While they are arguably closely connected to overall human and planetary well-being, because the achievement of the SDGs requires costs which are unevenly distributed, other considerations will inevitably distort the negotiations, hence the contested notion of 'shared responsibility'.

Revisiting the goal of 'Ensuring healthy lives and promoting well-being for all at all ages' at this stage is less important than refining the proposed targets themselves, which is where the emphasis on the remaining negotiations will be during 2015. All the goals are worded at the aspirational level and thus in and of themselves incontrovertible. Accountability thus lies at the target level and emphasis will be in the remaining negotiations in ensuring the targets are universally applicable and measurable. The proposition of a new health goal, here attempted by Hum et al.[2] and the use of the BCR analysis to assess the existing targets, exerts a useful and evidence-based pressure and analytical input into the target revision process that will extend from January through to the third quarter of 2015.

Viewpoint

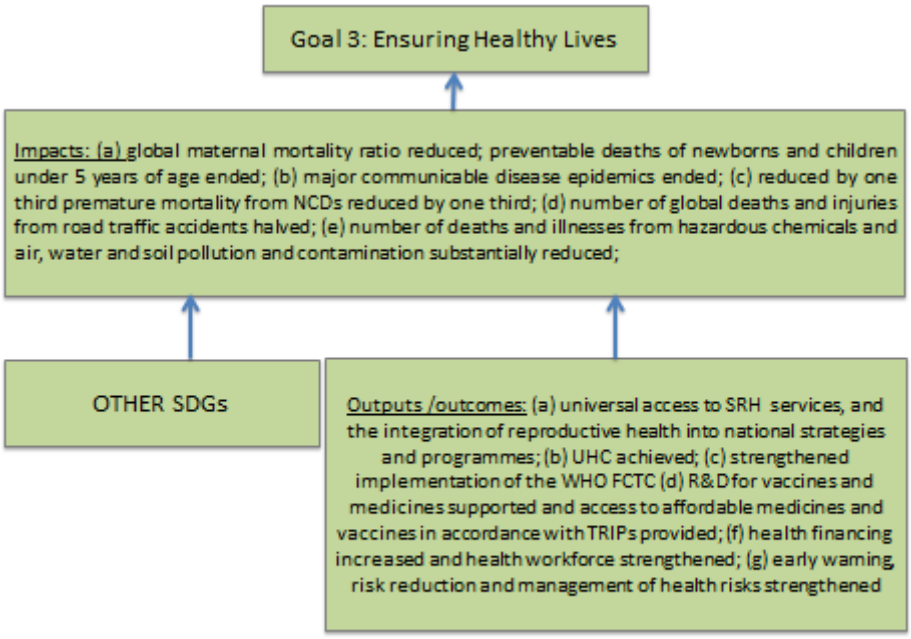
The benefit-to-cost ratio calculation exercise has some evident intrinsic limitations: linked to (1) the failure to recognize the qualitative differences but important complementarities between the health targets (2) the inability to capture the synergies between and across targets and goals and (3) the difficulty in assessing the value of human rights based approaches intrinsic to the targets.

Firstly, it is obvious that a BCR analysis cannot easily lend itself to a set of targets that combine programmatic objectives that themselves represent outputs or intermediate outcomes; for example 'strengthening capacity' (3.d), 'strengthen prevention..of substance abuse' (3.5) 'increase health financing' (3.c) with targets which describe outcome objectives 'reduce number of deaths' (3.2, 3.6, 3.9) or 'ending epidemics' (3.3). The targets themselves would be better arranged in a format where there is actually a hierarchy of objectives, consisting of outputs, intermediate outcomes, impacts and the goal itself, and expressed in results based language (Figure 1).

[1] The views expressed by the author are entirely his own, and do not necessarily reflect those of UNDP.

[2] This perspective is in response to Ryan Hum et al. (21 November, 2014) Health: Reducing Premature Mortality in the Post -2015 Consensus.

Figure 1. The proposed targets of Goal 3 arranged as a hierarchy



The second point is the inevitable interactivity and indeed interdependence between the proposed goals. Proposed Sustainable Development Goal 3 on ensuring healthy lives is itself an outcome of the achievement of many of the other proposed SDGs. The apparent synergies between the goals are much stronger than those between the MDGs. Proposed SDGs one on ending poverty and two on ending hunger for example, are themselves arguably the dominant determinants of overall health and well-being. While many of the social determinants of health reject econometric analysis as the BCR approach attests, this cannot diminish their value. Target 3.9 on reducing deaths from air pollution, which is the largest single cause of death globally, relies on achieving both goals 7 and 11 on sustainable energy supply and safe cities respectively. Similarly, within the proposed health goal, the targets are so interconnected that a systemic approach is unavoidable. Holding the disease or condition-specific outcome targets together is the central notion of achieving universal health coverage and reducing health inequities through the provision of affordable medicines and vaccines (targets 3.8 and 3.b).

As well as achieving the health targets through progress across the SDG spectrum, it is also true that investing in *social* spending will achieve many of the desired health outcomes. Investments in social protection, education, advancing gender equality, legal reform, improving employment practices, and improving the broader environment in which people live and work, all can have benefits and synergistic effects on health outcomes.

Action on social determinants can help investments *within* the health sector realise their potential and for disparities in health to be eliminated. For example, the randomized control trial in Malawi which showed that cash transfers can reduce HIV risk among girls

by 64% – a risk reduction that is greater than that seen with medical male circumcision.[3] The cash transfers also contributed to reduced teen pregnancy and increased school attendance – suggesting that multiple health and human development outcomes can be achieved through smart inter-sectoral initiatives. The growing interest in co-financing models increasingly delegitimizes a siloed approach to BCR where only costs elements within a single sector are factored in. Research that is unravelling complex behavioural pathways indicates that well targeted, modest but synergistic investments in education and social welfare have large returns regarding health outcomes. Investment framework modelling is taking this forward with great practical application potential in public policy.[4] [5] [6] Without explicit recognition, the targets within Goal 3 reflect this approach.

The most worrying assertion in Hum et al.'s review is that target 8 on achieving universal health coverage (UHC), including financial risk protection, "though an excellent goal, is rated "uncertain" due to the lack of cost effective data". The dangers of being restricted to data driven targets according to BCR calibrations at this stage become obvious. So important is UHC that for some time it warranted being the forerunner of the health goal itself and the preferred goal of the WHO, with Director General Margaret Chan insisting that Universal Health Coverage 'is the single most important concept that public health has to offer'.[7] UHC would be the core instrument to achieve the multiple impacts that the overarching goal encompasses. Its flexibility in definition and adaptation to local conditions is for the short term, inevitable, while the consensus on principle is secured.

Regarding UHC especially, synergies between goals again is evident. A UNDP issue brief on UHC captured a salient point: "UHC contributes to better health outcomes. Apart from being important in its own right, health is an indicator and driver of development. By expanding access to needed health services, UHC improves the well-being and productivity of people, households, communities and nations."[8] UHC as a driver of human development is itself however constrained by variations in access to health services determined by factors beyond the direct influence of the health sector: in the wider socio-cultural and economic environment. UHC may be necessary but in itself insufficient for healthy outcomes in contexts where stigma, discrimination, or any array of non-supply side inequities in access prevail.[9] In almost all cases these discriminations are highly gendered. Achieving Goal 3 will largely depend on progress against Goal 5 (achieving gender equality) and Goal 10 (reducing inequalities within and between countries). UHC is the epitome of

[3] Baird, Sarah, et al. (2012). Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial. *Lancet*, 379: 1320-29.
[4] UNDP (2014) Cash Transfers and HIV: Discussion Paper, New York.
[5] UNDP and UNAIDS (2012) Understanding and acting on critical enablers and development synergies for strategic investments, New York.
http://www.undp.org/content/dam/undp/library/hivaids/English/UNAIDS_UNDP_Enablers_and_Synergies_ENG.pdf
[6] Remme, Michelle, et al. (2014) Financing structural interventions: going beyond HIV-only value for money assessments, *AIDS*, 28: 425-434.
[7] Chan M. 2012. *The place of health on the post-2015 development agenda*. Opening remarks at an informal Member State consultation on health in the post -2015 development agenda;14 December 2012. *Available at:* http://www.who.int /dg/speeches /2012/mdgs_post 2015/en/index.html
[8] UNDP (2013) Universal Health Coverage in the Post 2015 Development Agenda, Issue Brief.
[9] Susana T Fried et al. (2013) Universal health coverage: necessary but not sufficient, Reproductive Health Matters 2013;21(42):50–60.

the social contract enacted in public health. Its rejection on data insufficiency grounds leads the reader to question what other *right to health* (or human rights based) principles and related targets, in Goal 3 and beyond, disconnect with the maturity of the available data sets that underpin the BCR analysis.

Finally, as the targets are refined during 2015, the degree of hyperbole will be curtailed. The term 'ending' (in the targets on preventable deaths in newborns and under-fives and in relation to communicable diseases) has already been defined otherwise. The notion of 'ending' is in the case of HIV and AIDS for example to be understood to be the reduction of HIV incidence and AIDS related deaths to levels that no longer represent a major health threat to any population or country, measured by the achievement of the three sub-targets which include: 90% reduction of HIV infections, 90% reduction of AIDS related deaths and 90% reduction of stigma and discrimination. Similar sentiments are expressed for tuberculosis and tobacco, wherein a country can be declared 'tobacco free' if prevalence of tobacco use falls below 5%. 'Ending an epidemic' is an appealing and politically motivating aspiration that will likely not survive the target-editing process,[10] in the same way it could not survive the BCR exercise.

Conclusion

Refinement of the targets is the job in hand and ensuring that they are universal, specific, measurable, and have a high 'value' is our collective task. But the retention of targets that do not lend themselves to econometric scrutiny is to my mind not in itself a problem. The interconnections between the targets and goals demand that the SDGs framework actually constitutes a giant lattice containing great shifts in public policy behaviours, especially toward inequity reduction. These need to be defined and agreed within the Goals in addition to their intended purposes. Human rights approaches are as much about processes as about outcomes.

[10] At least not for those specified by name.

This paper was written by Douglas Webb, Leader of the mainstreaming, gender and MDGs team, in the HIV, Health and Development Group, of UNDP's Bureau for Development Policy. The project brings together 60 teams of economists with NGOs, international agencies and businesses to identify the targets with the greatest benefit-to-cost ratio for the UN's post-2015 development goals.

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