Health in the Post-2015 Development Agenda

Call for papers

A position paper by the International Epidemiological Association

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The post-2015 global agenda is being intensely debated,(1-3) and institutions from all over the world are being invited to contribute to this debate (www.worldwewant.org). The International Epidemiological Association, made up by nearly 3,000 epidemiologists in about 100 countries, has an obligation to advise the global community on the scope, feasibility and measurement of international goals in the health field.

Should there be a health goal at all?

Three of the eight Millennium Development Goals were related to health (MDG 4 on child mortality, MDG 5 on maternal health and MDG 6 on HIV/AIDS, malaria and other infectious diseases). As a result, there has been some reluctance to include a specific health goal in the post-2015 global agenda, as made evident by virtual absence of health in the first draft of the Rio+20 conference report.(4) However, progress in terms of the health MDGs has been unsatisfactory. Of 75 countries that concentrate over 95% of maternal and child deaths, only 23 and 9 are on track to reach MDGs 4 and 5, respectively. (5) Regarding MDG 6, progress against HIV/AIDS, malaria and tuberculosis has been mixed in spite of substantial financial investments.(6) In particular, few countries in Sub-Saharan Africa will meet any of the health MDGs.

We believe that excluding a health goal would be a serious mistake. One should not drop a goal because it has proven difficult to achieve. There is a clear unfinished agenda on the health of mothers and children, and on the control of infectious diseases, which must be further pursued.(3) In addition, increasing awareness about the dominant burden of non-communicable diseases in most countries, (7-9) regardless of their level of economic development, indicates a need for health goals to be reinforced, rather than dropped from the international agenda.

“Integration” is a key word in the current round of discussions. A healthy population is an essential pre-requisite for inclusive social and economic development, and vice versa.(10) The

IEA therefore strongly supports the inclusion of at least one explicit health goal in the post-2015 agenda.

What should be the overarching health goal?

Achieving health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (http://www.who.int/about/definition/en/print.html) may be too ambitious, as well as difficult to operationalize. On the other hand, one must avoid defining goals that are too narrow in scope and which may lead to competition among implementing parties as may have been the case with the MDGs.(11) An overarching health goal, framed in terms of life expectancy at different ages, will highlight the need to simultaneously address communicable and non-communicable diseases, all age groups, both sexes, and a wide array of determinants of death and disease. Focusing on life expectancy not only avoids a narrow focus on specific actions but also stresses the need for broad cross-sectoral commitment and coordination.

Life expectancies at different ages are "hard" indicators that can be measured in all countries, with sufficient investment in demographic and epidemiological capacity. Moreover, the meaning, value and relevance of life expectancy are widely understood by the public in all countries.

Life expectancy is responsive to social and political forces that shape human development in both wealthy and poorer countries. It is affected by diverse factors such as obesity in the United States,(12) alcohol in Russia,(13) HIV/AIDS in Sub-Saharan Africa, (14) homicide in Latin America (15) and war in Afghanistan.(16)

The long term improvement of life expectancies over a period of two centuries in affluent countries shows that rapid progress is achievable.(17-19) This is supported by major recent advances in countries such as Brazil (20) or South Korea.(21)

Epidemiological research shows that mental health, dementia, and other disabilities– while often not affecting life expectancy as such – represent a major fraction of the total burden of ill-health in a community. However, there are major difficulties in measuring healthy life expectancy at country level, and before capacity is built for monitoring such a goal, it would be premature do adopt it as the primary health goal.

The IEA recommends that life expectancy should be the primary indicator for the health goal, with healthy life expectancy as a secondary indicator. Both indicators will require substantial investments in data collection and analysis at country level, an issue that we address below.

What indicators, targets and timelines should be set?

Much was learned from the MDG experience, including the fact that proper attention should be given to the measurability and timeliness of indicators being monitored. (22, 23)

The MDGs were adopted in 2000, but baseline values for the targets were set to 1990. This peculiar decision was presumably due to lack of real-time data to establish baseline values in

2000. Countries were therefore given 25 years (1990-2015) to reach a goal, but that 10 years had already elapsed at the time the goal was set up. Measurement of baseline values cannot be an afterthought. Research efforts must be intensified immediately to allow proper measurement of baseline levels in 2015.

Some MDG indicators proved impossible to measure directly in most countries. Maternal mortality ratios provide an excellent example. In the absence of functional and high-coverage birth and death registration, MDG estimates of maternal mortality are derived from regression models based on gross domestic product, female education, HIV prevalence, female mortality and in some cases coverage with skilled birth attendance.(24, 25) Modeled estimates may be better than nothing, but holding countries accountable for lack of progress when the actual outcome is impossible to measure should be avoided in the future. This is one of the reasons why life expectancy may be preferable to healthy life expectancy as the key indicator for a health goal.

A goal requires a target. Except for a couple of small, very rich countries, the highest national life expectancy at birth is about 84 years. Countries with the shortest life expectancies are close to 50 years.(26) Such differences in levels must be considered in target setting.

A life expectancy target may be expressed as an absolute increase (e.g. increase life expectancy by X years in all countries by 2030) or a relative increase (e.g. close the gap between 2015 life expectancy and say 85 years by one third by 2030). Both formulations have advantages and disadvantages, and these should be widely discussed and subjected to simulation exercises with actual data before they are adopted.

More than one indicator for life expectancy should be used. For example, life expectancy at birth is heavily driven by newborn and child deaths in poor countries, and would reflect efforts to control these conditions. Life expectancy at age 40 years, on the other hand, would be a valuable indicator of efforts to reduce non-communicable disease mortality. Both indicators should be monitored, as part of the life expectancy goal. Life disparity, a measure of within-population variability in ages at death, would be a useful additional indicator for expressing inequalities.(17)

A broad process for methodological discussion will be a major improvement relative to the rather arbitrary decisions behind the original MDGs. Targets should be ambitious, yet realistic. The fact that only 9 out of 75 countries are on track to reach the maternal mortality MDG (assuming that modeled estimates reflect actual trends) indicates that a more nuanced discussion should have preceded the setting of this target. Costly mistakes could have been avoided through broad consultation with professionals who are experts in population health. The international epidemiological community has had little if any involvement in the development of the original MDGs. Fortunately, these mistakes can be avoided through the ongoing consultation for the post-2015 goals (www.worldwewant.org/health).

Should second-level goals also be proposed?

The World Health Organization is pushing for a single, overarching health goal based on universal health coverage.(27) This goal has two components: coverage with needed health services (prevention, promotion, treatment and rehabilitation) and coverage with financial risk protection, to avoid catastrophic health spending.

Universal health coverage has an intrinsic equity dimension that was absent from the health MDGs.(11, 22) Even though a large number of equity analyses have been carried out in the process of monitoring the health MDGs,(5) these were originally framed in terms of general population measures, regardless of who may be left behind.(28) The concept of reaching every individual is therefore an advance relative to earlier goals and should be strongly supported. Equity-stratified monitoring is essential for keeping track of the progress in achieving the new round of goals.

WHO also endorses a life expectancy goal, but argues that "it is better seen as an overarching measure of all aspects of development including, but not limited to health." (27)

We disagree with this view. We argue that having an overarching health goal that also reflects other aspects of development – but underlies that health is one of the key drivers of development - is highly desirable, not only for those involved in public health but also for society as a whole.

Whereas we fully support universal health coverage as a second-level goal, we are concerned that placing coverage as the single health goal is misleading and inappropriate. However essential, coverage reflects preventive and curative actions delivered at individual level. The MDGs and of the post-2015 goals relate to improve the development of populations, for which health is an essential component. Relevant indicators, of necessity, have to be capable of measuring development at a population level.

Epidemiology and public health have taught us that population-level determinants of health are more important than individual-level secondary or tertiary prevention. Focusing on coverage as the overarching health goal even contradicts recent WHO initiatives such as the Commission on Social Determinants of Health.(29) With universal coverage as the health goal, population level interventions such as taxation of harmful products, legislation on nutritional content of foods or road safety, urban reform to promote physical activity or even more traditional water and sanitation interventions may be downplayed. It is possible to have universal coverage, while still having poor and declining population health because of these determinants which operate outside of the health services. Furthermore, health care is a means to an end - improved population health – and should not be treated as an end in itself.

Going for a health care goal misses the vital point that health care is an important but small contributor to disease incidence and survival prospects. For example, preventive interventions through taxation and legal action would be overlooked. In addition, upstream public health interventions tend to be more equitable (30) than downstream, health care interventions. (31)

The IEA strongly recommends a single health goal expressed in terms of life expectancy. We support the inclusion of second-level goals related to universal coverage and to one or more composite goals that reflect the implementation of population approaches to improve health.

How will the post-2015 goals be measured?

One of the many positive effects of the MDGs has been increased attention to the importance of population-based measures of health status. As a result of the central role of women and children's health in the MDGs, demographic and health surveys focused on these population groups became increasingly common in geographical scope and frequency.(http://www.measuredhs.com/; http://www.childinfo.org/mics4.html;(32)) Massive investments by donors ensured that we currently know more about maternal and child health than we ever did before. Better monitoring also means that partners at global and/or national level can be held accountable for failure to invest in health, or shortcomings in implementation of health interventions. (33)

Even so, major inequities persist when one considers the global picture. Just as Julian Tudor Hart postulated the "inverse care law" in the 1970s,(34) – stating that availability of quality health services is inversely related to their need - one could argue that we currently have an "inverse health data law". Timely information on births, deaths, disease episodes, services utilization, nutritional status and risk factors is inversely related to mortality rates, and as a consequence directly related to life expectancies. Countries with the greatest health needs and the highest mortality rates tend to have precarious health information and vital registration systems. Even availability of surveys still excludes some of the world's countries with highest mortality, due to armed conflict and lack of human resources for quality data collection.

The IEA believes that, whatever the shape that health and other development goals end up taking, there must be a massive effort in capacity building at national level of obtaining valid and timely health information. This will require more forethought and greater investments, than was the case during the MDG era. Incorporation of a social equity dimension in data collection and analyses is essential, and will entail important implications in terms of sample sizes and measurement of socioeconomic status, ethnicity and other stratification variables according to which trends in life expectancy would be monitored.

With our network of committed epidemiologists throughout the world, the IEA is willing to invest in full hearted collaborations with international, national and civil society organizations to improve capacity building in health measurement in order to monitor progress over time.

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