Health in the Post-2015 Development Agenda

Report of the Global Thematic Consultation on Health

Draft for public comment

1 February 2013

Note: This first draft of the report has been prepared by the Task Team of the Global Thematic Consultation on Health and is open for public comment from 1 to 19 February 2013. It is a technical report that summarizes the main themes and messages that have emerged thus far in the "global conversation" that is underway about how to frame health in the post-2015 development agenda and that will continue throughout 2013 and 2014. This report, however, will be completed by the end of March 2013 so that the UN High-Level Panel of Eminent Persons and the UN Secretary-General can consider it when they are drafting their reports on the overall post-2015 development agenda. Annex 1 captures in more detail the depth and breadth of the analyses and options presented in the more than 100 papers and meeting reports submitted to the health thematic consultation. All the inputs are available from www.worldwewant2015.org/health.

Contents

Executive Summary

To be written after the draft is finalized

1. Introduction

As the 2015 target date for achieving the Millennium Development Goals (MDGs) approaches, engaged debate continues on the content and form of the post-2015 development agenda. In January 2012, the UN Secretary-General established the UN System Task Team on the Post-2015 UN Development Agenda, co-chaired by the Department of Economic and Social Affairs and UNDP, to coordinate system-wide preparations for a new development framework in consultation with all stakeholders. Its first report — *Realizing the Future We Want for All* — delivered to the Secretary-General in June 2012, provides the main findings and recommendations based on the expertise of senior experts designated by the Principals of over 50 UN system entities and other international organizations. A "think piece" on health in the post-2015 development agenda, prepared by WHO, UNICEF, UNFPA, and UNAIDS, was used as an input.

In July 2012, the UN Secretary-General convened the High-level Panel of Eminent Persons on the Post-2015 Development Agenda to advise on the global development framework beyond 2015. The Panel is co-chaired by President Susilo Bambang Yudhoyono of Indonesia, President Ellen Johnson Sirleaf of Liberia, and Prime Minister David Cameron of the United Kingdom, and it includes leaders from civil society, the private sector, and government. *Realizing the Future We Want for All* is being used to help frame the work of the Panel, which will submit its report to the UN Secretary-General in the second quarter of 2013.

In addition, the UN Development Group is leading efforts to catalyze a "global conversation" on the post-2015 agenda through national consultations in around 100 low- and middle-income countries, six regional consultations, and 11 global thematic consultations. The aim of these consultations is to bring together a broad range of stakeholders to review progress on the MDGs and to discuss the options for a post-2015 framework. The 11 thematic consultations deal with topics that have been identified as being particularly important to the discussions: inequalities, governance, health, environmental sustainability, population dynamics, water, growth and development, conflict and fragility, food security and nutrition, education, and energy.

For each thematic area, selected UN organizations are leading the preparation and planning of the consultations in partnership with one or two governments in order to ensure Member State leadership and involvement as well as overall steering.

The Task Team for the Global Thematic Consultation on Health is co-led by WHO and UNICEF, in collaboration with the Governments of Botswana and Sweden, supported by a small secretariat and a UN interagency group that includes OHCHR, UNAIDS, UNDESA, UNDP, and UNFPA.

The objectives for the health thematic consultation are:

- to stimulate wide-ranging discussion at global, regional, and country levels on progress made and lessons learnt from the MDGs relating to health;

- to discuss and develop a shared understanding among Member States, UN agencies, civil society, and other stakeholders on the positioning of health in the post-2015 development framework;
- to propose health goals and related targets and indicators for the post-2015 development agenda, as well as approaches for implementation, measurement, and monitoring.

About this report

In line with these objectives, the purpose of this report is to present a summary of the main themes and messages that have emerged from the consultation and to make recommendations to inform the deliberations of the High-Level Panel of Eminent Persons and the UN Secretary-General's report to the General Assembly. Annex 1 captures in more detail the depth and breadth of the analyses and proposals in the more than 100 papers and meeting reports that were submitted to the consultation; all the inputs and a digest summarizing the papers are available from www.worldwewant2015.org/health.

Chapter 2 describes the consultation process, detailing the processes that were used to reach out to different constituencies. Chapters 3-5 explain why health should be at the centre of the post-2015 development agenda. Chapter 3 summarizes the inputs about the successes and shortcomings of the MDGs, many of which were unintended and only became apparent with the benefit of hindsight. Important lessons can be learned from this assessment. Chapter 4 describes the interdependent linkages between health and development. Chapter 5 considers some of the most significant changes that have happened (and in some cases continue to happen at an accelerated pace) since the MDGs were launched in 2000. Understanding how the world, global health and priority health needs have changed and what changes are likely in the next 15 years is critical to defining the health agenda for the coming years in terms of both what needs to be done (the content) and how (the approach).

Chapter 6 presents guiding principles for the post-2015 development agenda and the various options for health goals and indicators that were put forward during the consultation. Chapter 7 focuses on the importance of accountability, inclusive partnerships, innovation, and learning.

Chapter 8 includes the report's main recommendations on how to frame the future agenda for health. The contributors to this consultation are looking in the same general direction: all agree that the new development agenda needs strong and visible health goals supported by measurable indicators. The recommendations in this chapter are those that garnered the most support during the consultation. Chapter 9 concludes by suggesting concrete actions that could be taken between now and 2015 by those advocating for health to feature prominently in the next development agenda.

2. The consultation process

Note: This section can't be finished until closer to the end of the process so that it can say something more specific about website activity, the comments on this draft, and the Botswana meeting. The final version will be written in past tense.

A number of mechanisms and processes were set up to facilitate an effective, participatory consultation. The Task Team was committed to making the process as open and transparent as possible and to encouraging inputs from a range of different stakeholders.

Five guiding questions were used throughout the consultation:

- What lessons have been learned from the health-related MDGs?
- What is the priority health agenda for the 15 years after 2015?
- How does health fit into the post-2015 development agenda?
- What are the best indicators and targets for health?
- How can it be ensured that the process and outcome are relevant to the key stakeholders?

All the written inputs used in the drafting of this summary report are listed in Annex 1 and are available at www.worldwewant2015.org/health. This website, part of the online platform developed by the UN in collaboration with civil society, was launched in July 2012 to stimulate multi-stakeholder engagement in the post-2015 agenda. //Note: A sentence or two will be added about activity on the website with some stats on website traffic, such as number of visits, number of downloads, number of registered users, and so forth//

The written inputs came from three sources: background papers, papers submitted during the web-based consultation, and reports from the different stakeholder meetings and e-surveys.

In October 2012 all constituencies and stakeholders were invited to submit existing or new material as background papers to inform the discussions and contribute to the content of this summary document. These papers, subject to review by the Task Team, were published on the website.

The second source of inputs was a web-based consultation that ran from 1 October to 31 December 2012, which resulted in 107 papers being submitted by individuals, UN organizations, governments, research centres, civil society, and the private sector. Of these, 100 were considered directly relevant to the subject (that is, they responded to one or more of the five guiding questions) and thus uploaded to the consultation website.

A series of consultations focusing on different key stakeholder groups all led to reports that were also published on the website. Member State briefings were held in 2012, in Geneva in September and in New York in November, and an informal Member State consultation was held in December at WHO headquarters in Geneva, with the participation of UNICEF and other contributing UN agencies. During the 132nd session of the WHO Executive Board, a presentation about the consultation was given, including preliminary results. The discussions converged on the issues that this report raises.

Six civil society consultations took place in December 2012 and January 2013, selected by the Task Team from 106 responses to a call for proposals. Action for Global Health held a side event at the GAVI Alliance Partners' Forum in Dar es Salaam; and the Alliance of Southern Civil Societies in Global Health hosted an online survey with civil society organizations in Africa and other regions. The STOP AIDS Alliance, International Civil Society Support, and the International Council of AIDS Service Organizations hosted an online survey, a series of webinars, and a meeting in Amsterdam for HIV,

tuberculosis, and malaria advocates. The People's Health Movement hosted a side meeting during the Prince Mahidol Award conference in Bangkok; and the ASTRA Central and Eastern European Women's Network for Sexual and Reproductive Rights and Health held a consultation in Moscow.

Finally, an e-consultation on HIV and health with three moderated debates was held over 10 days in late January 2013.

Other face-to-face consultations included: a day session on health in the post-2015 agenda at the International Conference on Population and Development Beyond 2014 Global Youth Forum in Bali, with more than 600 participants; a private sector consultation in Amsterdam, hosted by GBCHealth; a cross sectoral consultation on health, food security, and population in the post-2015 development agenda in Washington hosted by the Aspen Institute, involving representatives from the private sector; and a series of events at the Second Global Symposium on Health Systems Research in Beijing, including a plenary session and two lunchtime sessions.

To ensure that the many inputs from the consultation process were well represented in this report, the Task Team built up the content through a three-step process.

- The first step was to meet with representatives from the key stakeholder groups in Geneva on 17 January 2013 to consider the inputs and discuss the report's structure and content.
- The next step was to post the first draft on the website for comments and feedback. This review ran from 1-19 February 2013. //Note: a sentence or two will be added on the number of responses etc//.
- The third and final step was to discuss the revised draft (which was uploaded to the consultation website on 1 March 2013) at a high-level meeting in Botswana on 5-6 March. The meeting was hosted by the Government of Botswana; the XX participants included ministers of health and finance, members of the High-Level Panel of Eminent Persons, leaders of international health institutions, representatives from civil society and the private sector, academics, and public health experts.

After the meeting the report was finalized, submitted to the High-Level Panel and UN Secretary-General, and published on the website, marking the end point of this stage of the global thematic consultation on health. However, as described in Chapter 9 it is just the beginning of the work required to secure health's place in the post-2015 development agenda.

The Task Team recognizes that health has featured prominently in several if not all of the other ten thematic consultations (because all have profound effects on health and well-being, and vice-versa). This report includes some discussion of the cross-cutting nature of many of the world's most pressing health challenges and the need for effective multi-sectoral responses, but these ideas will need to be further developed when all the outputs have been published. In addition, health will feature highly in many of the 100 country consultations that have been planned for 2013. By February, approximately 25 of these national consultations will have been completed, and inputs that are available by March 2013 will be incorporated into this report.

3. Lessons from the health MDGs

The United Nations Millennium Declaration, signed in September 2000, commits world leaders to combating poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. The eight MDGs that all 191 UN Member States agreed to achieve by the year 2015 provide for the practical implementation of this Declaration, and all have specific targets and indicators. There are three specific health goals; targets under several other goals also relate to some of the more significant underlying determinants of health (see Table 1).

Table 1. Health and the MDGs: goals and targets

MDG 1: eradicate extreme poverty and hunger
Target 1C. Halve, between 1990 and 2015, the proportion of people who suffer from hunger
MDG 4: reduce child mortality
Target 4A. Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
MDG 5: improve maternal health
Target 5A. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
Target 5B. Achieve, by 2015, universal access to reproductive health
MDG 6: combat HIV/AIDS, malaria and other diseases
Target 6A. Have halted, by 2015, and begun to reverse the spread of HIV/AIDS
Target 6B. Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it
Target 6C. Have halted, by 2015, and begun to reverse the incidence of malaria and other major diseases
MDG 7: ensure environmental sustainability
Target 7C. Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation
MDG 8: develop a global partnership for development
Target 8E. In cooperation with pharmaceutical companies, provide access to affordable essential medicines in developing countries

While some countries have made impressive gains in achieving health-related targets, others are falling behind. Often the countries making the least progress are those affected by high levels of HIV/AIDS, economic hardship, or conflict. Box 1 summarizes progress to date.

Box 1. Progress report on the health-related MDGs

MDG 1: In low- and middle-income countries, the percentage of underweight children under five years old dropped from 28% in 1990 to 17% in 2011. The MDG target may be met, but improvements have been unevenly distributed between and within different regions and countries.

MDG 4: Globally, the number of deaths of children under five years of age fell from 12 million in 1990 to 6.9 million in 2011. The global rate of decline has accelerated in recent years: from 1.8% per annum during 1990-2000 to 3.2% during 2000-2011. Despite this improvement, the world is unlikely to achieve the MDG 4A target by 2015.

MDG 5: While the proportion of births attended by a skilled health worker has increased globally, fewer than 50% of births are attended in the WHO African Region. Despite a significant reduction in the number of maternal deaths – from an estimated 543,000 in 1990 to 287,000 in 2010 – the rate of decline is just over half that needed to achieve the MDG 5A target by 2015. In 2008, 63% of women aged 15–49 years who were married or in a consensual union were using some form of contraception, while 11% wanted to stop or postpone childbearing but were not using contraception.

MDG 6: Globally, new HIV infections declined by 24% between 2001 and 2011. In 2011, an estimated 2.5 million people were newly infected with HIV, of whom 70% live in sub-Saharan Africa. More people are living with HIV: an estimated 34 million people in 2011. A little over 8 million people in low- and middle-income countries received antiretroviral therapy in 2011, but there is still a long way to go to achieve universal access. Several malaria endemic countries have reported a more than 50% reduction in either confirmed malaria cases or malaria admissions and deaths. Use of insecticide-treated nets and indoor residual spraying has greatly increased, and will need to be sustained in order to prevent the resurgence of disease and deaths caused by malaria. There were an estimated 8.7 million new cases of tuberculosis in 2011, of which about 13% involved people with HIV. Globally mortality due to tuberculosis has fallen 41% since 1990 and should reach 50% by 2015. Treatment success rates have been sustained at high levels, at or above the target of 85%, for the past four years.

MDG 7: The world has met the MDG target on access to safe drinking water, but much more needs to be done to achieve the sanitation target.

MDG 8: Most of the targets are not on track, including 8E. Effective treatments exist for the majority of conditions causing the global chronic disease burden, yet universal access remains out of reach. Many people in low-income countries continue to face a scarcity of medicines in the public sector, forcing them into the private sector where prices can be substantially higher. Patient prices of lowest priced generics in the private sector averaged five times international reference prices, ranging up to about 14 times higher in some countries. Even the lowest-priced generics can put common treatments beyond the reach of the poor. Source: WHO

In addition to monitoring progress towards achieving the specific MDG targets by 2015, various reports, academic journals and other fora have devoted considerable attention to analysing the MDGs' strengths and shortcomings for health and development more broadly. What have they achieved and why? What were the unintended consequences? What could have been done differently to have made the MDGs even more successful? What lessons can be learned about designing goals to have maximum impact on improving health and well-being? Many of the inputs to this consultation offered answers to these questions, often reiterating points that have been widely expressed in the published literature. There is broad agreement around some of the strengths, and several widely shared concerns. Some aspects of the MDGs appear to be open to different interpretations: what some inputs note as strengths are viewed by others as shortcomings. Some of the more common themes are highlighted below.

Beyond targets: strengths and achievements of the health MDGs

There is broad agreement that having three of the eight goals directly related to improving health outcomes has raised the profile of global health to the highest political level, increased development assistance for health, and improved health outcomes in low- and middle-income countries. The overall perception from the contributions is that the MDGs have been: 1) instrumental to global and national development policies; 2) a major contributor to the global acceptance today of the centrality of health to human development; 3) important in setting an agenda for health; and 4) a catalyst in focusing attention on the need for results, resources and greater accountability.

Since 2000 there has been significant progress on the MDG health indicators. Although the extent to which these health improvements are a direct result of the MDGs is debateable (no one can say what would have happened without the MDGs) the response to the MDGs has shown that progress can be achieved on an ambitious agenda.

One lesson noted in several of the inputs is the importance of having goals. The three health goals have had far greater traction than the health targets attached to other goals. The three health MDGs have considerably strengthened resources, action, and results on women's and children's health, HIV/AIDS, and malaria, tuberculosis, and other infectious diseases. However, the health-related targets included in other MDGs (such as nutrition, water, sanitation and hygiene, and access to essential medicines) have been nowhere near as successful in galvanizing popular and political support.

One of the most frequently recognized strengths of the health MDGs is that that they are easy to understand and communicate. They have a clear vision, well-defined goals, concise objectives, measureable targets for improving specific health outcomes, and well-specified indicators. These attributes are widely regarded as the reasons why they have: been embraced by heads of state, policy-makers, and the public; engaged civil society and research communities; stimulated monitoring and evaluation; and catalysed new institutions and new global technical and development partners.

Another important achievement noted during the consultation is that the MDGs have led to a much more nuanced view of what is needed for global health and development. The MDGs have been used both politically and technically at national and global levels, bringing greater policy consistency and exerting pressure for greater action from national governments and development partners.

Room for improvement

One concern frequently raised in the inputs is that the MDGs do not capture the broader dynamic of development enshrined in the Millennium Declaration, including human rights, equity, democracy, and governance. The lack of attention to equity is widely regarded as one of the most significant shortcomings of the health MDGs. Although equity is an important part of the Millennium Declaration, it is not a central feature in monitoring the MDGs. Because the goals focus on aggregate national targets, they fail to measure and thus disregard outcomes for vulnerable and marginalized groups. The focus on improving national averages encourages utilitarian rather than universal approaches, often exacerbating inequities even as progress is made in absolute average levels of indicators.

Several inputs are critical of the process that led to the MDGs: the selection of the MDGs emerged from a technocratic closed-door process that was poorly specified, influenced by special interests, and lacked a coherent conceptual design or rigorous statistical parameters. Others note that the process was only faulty in retrospect. At the time it was expedient and it was not clear how much traction the MDGs would get. It is impressive how much influence they have had (and continue to have) given their imperfect genesis. Other related criticisms are that the MDGs did not have enough input from low- and middle-income countries and that there was almost no input from the people and communities that were intended to benefit the most from the MDGs. For example, the MDG framework lacks a youth analysis and perspective, even though young people are disproportionately affected by many of the development issues addressed by the goals. Some inputs are also critical of the process that set up performance targets for low- and middle-income countries to be paid for by development partners.

Another area of concern is the "vertical" nature of the goals. It is a widely shared view that this has created competing interests and encouraged sector-specific responses and accountability rather than facilitating intersectoral co-operation and the "health in all policies" approach required to address the majority of health challenges, nationally, regionally, and globally. By not articulating the synergies between the individual goals, opportunities for coordination and efficiency were missed.

Similarly, while the specificity of the MDGs is widely seen as a strength, the selection of a few indicators for health also contributed to fragmentation within national health sectors.

The MDGs give limited attention to the specific needs of countries facing particular challenges: these include the least-developed countries, and those affected by current or past conflict which have few institutions and services and in which the state is functioning poorly or not at all. Fragile states have failed to achieve the MDG, and the MDGs will not be achieved globally until progress is made in these countries.

Some inputs point out that at least some of the shortcomings in the initial design of the MDGs were subsequently addressed. For example, the MDGs did not address the need to build sufficient country information systems to measure goals, and comprehensive mechanisms for accountability were not implemented at the outset of the MDG process. However, the Commission on Information and Accountability for Women's and Children's Health was set up to address these gaps and the 75 countries with the highest burden of maternal and child mortality are in the process of implementing its 10 recommendations.

Differing views on the same issue

The limited number of clear health goals in the MDGs is widely considered as a critical success factor; at the same time the omission of other major health challenges from the MDGs is commonly cited as a major weakness. Some inputs argue that the exclusion of many health priorities from the MDGs, including non-communicable diseases (NCDs), comprehensive sexual and reproductive health and rights, mental health, violence and injuries, has hindered progress on the goals themselves and equitable progress in overall health outcomes. Clearly, given the framework, the MDGs could not have done both.

Some inputs argue that the focus on particular diseases and target groups has led to the neglect of overarching issues, such as health system strengthening, access to quality health care and financial protection, health promotion and disease prevention, and the underlying determinants of health. Others counter that the health MDGs have helped to focus attention on these issues because the goals cannot be reached without paying attention to them. For example, it is claimed that the response to HIV/AIDS has contributed towards broader system strengthening that can be leveraged to tackle other, non-HIV, health areas. Country ownership, managing for and achieving results, and shared accountability and transparency in the response to HIV can readily translate to other health priorities, including NCDs.

Another dimension of the focus on specific health outcomes is that it overshadows the root causes of poor health and health inequity; structural issues that impact upon health, such as punitive legal environments, absence of social protection measures, inadequate investment in health, gender equality, and social justice, and unfavourable terms of trade and international debt have been sidelined. Others say this is not the fault of the health MDGs per se, but arises because the partnership goal of MDG 8, which is meant to address these issues, has less precise indicators compared with the clearly defined targets and indicators for most of the other MDGs.

In summary, there is a broad consensus about some of the strengths and shortcomings of the health MDGs, as well as some diverging views. As the next chapter shows, global health encompasses far more than the health MDGs. Going forward, the post-2015 agenda process should systematically identify and assess the critical gaps in the MDGs and make practical evidence-based recommendations on how they should be addressed.

4. How health is linked to development

As shown in Table 1 above, the MDGs recognize health as central to development and to improving human development outcomes. This has also been a key message from the consultations. The MDGs are interdependent: they all influence health, and health in turn influences and contributes to all the MDGs. For example:

- better health (MDGs 4-6) enables children to learn (MDGs 2-3);
- gender equality (MDG 3) is essential to the achievement of better health (MDGs 4-6);
- reducing poverty and hunger (MDG 1) and environmental degradation (MDG 7) positively influences, but also depends on, better health (MDG 4-6);
- HIV and AIDS (MDG 6) impact on MDGs 1-7 and vice versa;
- MDGs 3-6 are directly dependent, and MDGs 1, 2, 7, and 8 indirectly dependent, on the sexual and reproductive health and rights of women and girls;
- primary education (MDG 2) and even more so secondary education have a strong impact on young people (especially girls) in terms of development (economically due to later marriage, fewer children, etc.) and in lowering under-5 mortality (MDGs 4 and 5).

However, a strong message emerging from many inputs to this consultation is that the linkages between health and development should be made much clearer and more visible in the post-2015 development agenda than they are in the MDGs. Several contributions call for the new agenda to clearly articulate and support the synergies between health and other sectors, and increase policy coherence, interdependence, and shared solutions to drive people-centred, inclusive, and sustainable development.

In its report titled *Realizing the Future We Want for All* the UN System Task Team defines four dimensions of development: inclusive human development, environmental sustainability, inclusive economic development, and peace and human security; and states that its vision for the future rests on the core values of human rights, equality, and sustainability. Some inputs elaborate on the links between health and these dimensions and core values of development.

Other inputs describe the links between health and development using the three dimensions of sustainable development as set out in the 2012 UN Conference on Sustainable Development (Rio+20) outcome document: economic development, environmental sustainability, and social inclusion. This document notes that: “Health is a precondition for, an outcome of, and an indicator of all three dimensions of sustainable development” and that sustainable development “can only be achieved in the absence of a high prevalence of debilitating communicable and non-communicable diseases”. This was further reinforced in a new United Nations General Assembly resolution on Global Health and Foreign Policy in December 2012.

Many inputs focus on “determinants of health”, whether referred to as “social determinants”, “social, cultural, environmental, economic, and/or political determinants”, or “underlying determinants”. Others build the narrative around a human rights-based approach to health.

Although the framing differs across the inputs the key message is the same: most aspects of development encompass the same underlying factors that determine population health. Health is a beneficiary of development, a contributor to development, and a key indicator of what people-centred, rights-based, and equitable development seeks to achieve.

Health as a beneficiary of and a contributor to development

Ill health is both a consequence and a cause of poverty. Every year 100 million people are either pushed into poverty by health-related costs, including out-of-pocket expenses for health care, or unable to afford essential health services so that pre-existing sickness is aggravated. Poor peoples' ability to work and/or study is determined by their health. As such, poor health limits productivity and school attendance, thereby preventing many poor people from escaping poverty. Moreover, structural (and poverty-related) disadvantages fuel the spread and hinder the prevention of diseases. Countless people, particularly those with social disadvantages, face insurmountable economic, environmental, and social barriers to healthy living on a daily basis.

It is widely acknowledged, including during this consultation, that health is both a driver and a beneficiary of economic growth and development. It has long been known that people in the higher income quintiles are more likely to enjoy good health and have longer life expectancies. However, a growing body of evidence shows the inverse causal link between health outcomes and long-term economic development: healthier means wealthier. Health is likely to affect a country's economic output through: labour productivity, education, increased savings and investment, and a demographic transition. The following points elaborate further.

- A healthier workforce is more productive as workers tend to have more energy and better mental health, and there is less absenteeism.
- Better education is directly linked to income growth, and health affects education by enhancing children's physical ability to attend school and by increasing children's cognitive ability to absorb knowledge.
- Healthy populations live longer and therefore have increased incentives to save for their future financial needs. An increase in national savings leads to a larger supply of capital, leading to further domestic investment, additional physical and human capital, and technological progress: all of which are classic drivers of economic growth. In addition, a country with a healthy workforce is likely to attract more foreign direct investment.
- Better health also triggers a set of demographic changes that can ultimately boost economic growth. It typically begins when improvements in health – for example, through better access to water and sanitation and increased use of vaccines and antibiotics – trigger a decline in infant and child mortality rates. As parents begin to realize that the risk of mortality is reduced, fertility declines and population growth gradually slows.

As some of the inputs note, health can be an effective way of measuring progress across the economic, social, and environmental dimensions of sustainable development. For example, measuring the impact of sustainable development on health can generate public and political interest in a way that builds popular support for policies that have more diffuse or deferred outcomes (such as reducing CO_2 emissions).

More concrete examples are provided in Box 2, which shows how health is linked to the other 10 thematic consultations.

Box 2: Links between health and the other post-2015 UN development themes

Water: A range of ill-health outcomes result from determinants dominated by water, including: diarrhoeal diseases and malnutrition related to lack of access to safe drinking water and sanitation; the harm to public health and livelihoods associated with wastewater management (in particular re-use in agriculture); and water-related vector-borne diseases linked to irrigation schemes, dams, and other water resource development.

Inequalities: Inequitable health outcomes are both a result of financial and social inequality and a contributor to inequity, since the poor cannot protect themselves against catastrophic health risks. Gender equity is also an important issue. People living with illnesses such as mental illness, as well as some infectious diseases such as HIV/AIDS are often subjected to stigma, gross violations of human rights, and inhuman treatment. Discrimination against women and girls, including gender-based violence, economic discrimination, reproductive health inequities, and harmful traditional practices, remains one of the most pervasive forms of inequalities and one of the most important underlying causes of poor health outcomes for women and children.

Governance: According to WHO estimates, as much as 20-40% of health expenditures are wasted, often through inefficiencies, and therefore any governance agenda must address the issue of value for money in health spending. Improvements in health data are crucial for better policy-making and strengthened accountability for resources and results. Including the most marginalized groups in decision-making will help ensure that laws, policies, and resources are used to create enabling, equitable, health-promoting environments for those most vulnerable to health risks.

Environmental sustainability: Climate change and environmental degradation are increasing the risk of extreme weather events, compromising food and water security, and affecting both communicable and non-communicable diseases. Related effects of unsustainable development, notably outdoor and indoor air pollution, are now major causes of global ill health. The greatest burdens fall on the poorest populations, women, and children.

Population: Population dynamics both affect and are driven by health outcomes. Population size and mobility, including rapid urbanization and migration fuelled by poverty, unemployment, and displacement, can outpace the requirements of investments in health services and other basic amenities for the population, thus undermining economic prosperity and poverty reduction. Rapid changes in population structure, with increasingly ageing populations in some countries and a youth bulge in Africa, alter the nature of the health coverage that needs to be provided. Family size is a key component of population policy-making, particularly with natural resources already under stress to meet basic needs. Providing women with contraceptive choices is therefore crucial. Population policies also need to mainstream gender considerations to ensure that responses to phenomena such as migration and urbanization take into account the specific needs of women and children.

Economic growth and employment: Healthy individuals are more productive, earn more, save more, invest more, and work longer. One extra year's increase in average life expectancy can raise GDP by 4%. For economic growth and employment to be sustainable, it must also be equitable. The conditions under which people work have a direct impact on their health. Inequalities derived from employment and working conditions are closely linked with increased health inequalities in injuries, chronic diseases, ill health, and mortality. Fair employment relations and decent work, including reasonable employment and working conditions and reasonable wages contributing to income security, are key determinants of workers' health.

Conflict and fragility: The populations of fragile and conflict-affected countries are significantly worse off, in terms of many key health outcomes and determinants of health, than their counterparts living in other countries at comparable stages of development. Very often, health interventions in fragile and conflict-affected areas are limited to humanitarian relief, which does not advance health system development. Also, information is rarely available on the nature and extent of health inequities. There is an urgent need to address weaknesses in policy, leadership, management capacity, human resources for health, supplies, service delivery, and data collection and evaluation.

Food and nutrition security: Low birth weight and early childhood malnutrition have long-term, irreversible effects on brain development, adult health, and productivity, which in turn can create a cycle of intergenerational poverty and ill health. Chronic nutrition-related anaemia during pregnancy substantially raises the risk of death by postpartum haemorrhage. Food availability and food access are major problems, especially in low- and middle-income countries. Climate change and other global environmental factors could further exacerbate food and nutritional insecurity. A sanitary environment, access to safe water and to health services and care, and adequate food storage and preparation are all important aspects of food and nutrition security. The double burden of undernutrition and overweight/obesity constitutes a major challenge to development. Action should be directed to healthy diets and consumption patterns and to appropriate care practices.

Education: Education is a determinant of health, with a critical role in improving health. Early childhood experiences have a long-lasting impact on the mental and physical health of individuals, and affect their scholastic performance. Improving access to nutrition and health care for children from lower socioeconomic strata improves their attendance in school, and their scholastic performance. Education of girls and women is a crucial building block for improving women's and children's health and choices of family size. Equally, women who are empowered through education, good health and other means, generally choose to have fewer children and are able to invest more in the health and education of their children, thereby creating a positive cycle for growth and development.

Energy: Access to clean energy in homes is crucial for reducing child and maternal mortality. Nearly half of deaths globally from pneumonia among children under 5 and about one-third of deaths from chronic obstructive pulmonary disease are due to inefficient use of energy in the home for cooking. Lack of access to clean reliable energy in healthcare facilities is a hidden barrier to universal health coverage. In some sub-Saharan African countries over 50% of healthcare facilities lack any access to electricity, which limits critical care and emergency response at night, storage of vaccines and blood, waste management, and water access. Energy efficient transport systems can prevent millions of deaths from traffic injuries and air pollution, while renewable sources of electricity have a major role in reducing air pollution and heavy metal exposure from coal-fired power plants.

Health as a critical pathway to human rights and equality

Health has a strong relationship with the core values that should be at the heart of a visionary new development framework: human rights, poverty eradication, equality, and sustainability.

Health is a human right, provided for by the International Covenant on Economic, Social and Cultural Rights, which recognizes the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health", as well as the WHO's Constitution, which states that "the enjoyment of the highest standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

Health is critical to achieving equity. Equitable access to quality health care underpins equitable access to employment, engagement with economic activity, and quality of life. Poor health and poor health outcomes, as well as disease-related stigma and discrimination, can marginalize entire groups of people. Contentious health issues need to be faced head-on, including the rights of people living with disability, sexual and reproductive health rights, the rights of people living with and affected by HIV and AIDS and other diseases, and the rights of people whose access to health is obstructed by unjust laws and policies. The elimination of financial exclusion and of gender discrimination are priorities.

The following example illustrates the multiple benefits that universal access to reproductive health services and protection of reproductive rights would bring. People's, and especially women's, right to decide the number of children they wish to have (and are able to afford) is a basic human right. Countries that have fully supported this right tend to have a lower total fertility rate. Smaller families benefit women's and children's health and make it easier for health systems in low resource contexts to serve their populations. Among other things, having fewer children empowers women to participate in society, complete their education, and access formal employment, giving them an independent income. It also contributes to human development by reducing household poverty. Smaller families slow population growth, which in turn reduces demand for water, food, and energy; alleviate pressures on education and the environment; diminish social conflict and state fragility; and reduce climate change and mitigate its impact.

In summary, this chapter has focused on the interconnections and interdependence between health and development, and the mutual benefits of maximizing synergies and policy coherence across multiple sectors. Acting on these linkages is crucial: this necessitates operational research on these synergies and potential efficiency gains, and their representation in public financing. Such evidence-based action will accelerate the attainment of the MDGs, help to address the many other emerging priority health needs briefly described in the next chapter, and bring benefits for the economic, social, and environmental dimensions of sustainable development.

5. Health priorities post 2015: opportunities and challenges

Considerable convergence around some of the health priorities to be addressed in the post-2015 development agenda has emerged from the consultation process. The different options that have been proposed for how these priorities can best be addressed are presented in Chapter 6. This chapter briefly notes how the world has changed since 2000, highlights the need for the health MDGs to remain priorities after 2015, and describes a host of other priority health challenges and a changed health landscape, all of which need to be reflected in a new development framework.

The world has undergone fundamental changes since the MDGs were adopted in 2000, bringing both opportunities and challenges for global health and development. While the MDGs were focused on low-income countries, the development landscape is now dominated by common global challenges. As affirmed at Rio+20, the focus is now on universal and sustainable development and a more comprehensive understanding of how the different dimensions of development interact.

There is a rapidly escalating amount of accessible research evidence, knowledge, and innovation that can be harnessed and used by policy-makers, researchers, communities, and other stakeholders to accelerate efforts to improve population health and well-being. Low- and middle-income countries have an opportunity to lower infant, child, and maternal mortality in a far shorter time than it took high-income countries to achieve. Low- and middle-income countries can also learn from other country experiences about how to strengthen health systems and, equally importantly, devote more resources to addressing risk factors and creating the conditions that promote good health.

People want more engagement, inclusivity, transparency, and mutual accountability. Groups of people with a shared interest can mobilize more quickly than ever before. Everyone and everything is increasingly interconnected. Mobile phones, the internet, and social networking have transformed how information is accessed and shared.

Global trends in demography, epidemiology, globalization, migration, urbanization, consumption, and production have improved well-being for many populations but have also created new challenges such as rising income inequalities, environmental degradation, and the rising burden of NCDs that are undermining development.

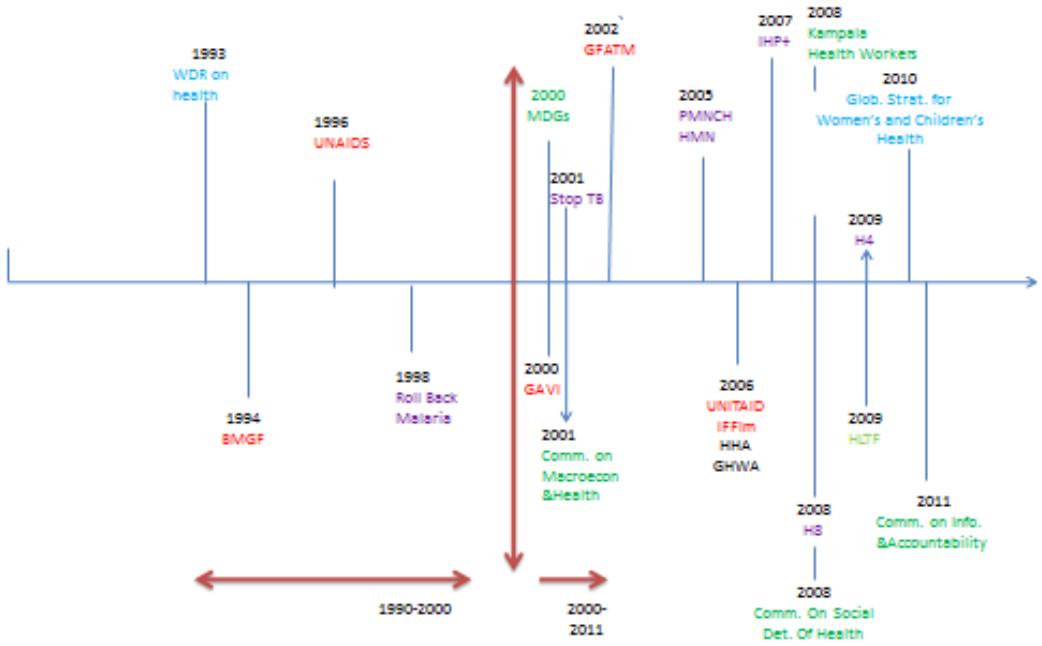
At the same time the development landscape has grown in organizational diversity, bringing both unprecedented opportunities and challenges. Changes include: the shift from the Paris Declaration on Aid Effectiveness to the Busan Partnership for Development Cooperation which focuses on shared but differentiated responsibility; South-South and triangular cooperation; the rise of Brazil, Russia, India, China, and South Africa (the BRICS) as a political power bloc; new development partners from emerging economies that do not use OECD DAC policies; the proliferation of funds, and of bilateral and multilateral agencies; and the growth of civil society and the private sector in development.

Like the broader global development landscape, the health landscape has also experienced a dramatic transformation since 2000, and now bears little resemblance to how it looked then. Some of most significant milestones are shown in Figure 1. These changes in the overall development and global health landscapes must be taken into account in order to make the post-2015 agenda and its goals relevant to all countries. At the same time, global efforts to redress global inequalities will remain critical in the post-2015 world, and therefore the new agenda should address resource issues. Several inputs say it will be important to strike the right balance between being comprehensive and adequately reflecting the linkages between health and other sectors in the

development agenda, while articulating an agenda that can be made appropriately specific to different settings.

Figure 1. Global health milestones, 1990-2012

Note: The next draft will include a figure similar to the one below but with more milestone added including the political declarations on HIV, NCDs, SDH as well as UNGA resolutions, 2012 FP 2020, A promise renewed, Commodities for MNCH Commission, TRIPs, FCTC and IHR.



The present health MDGs will still be priorities after 2015

As was often emphasized throughout this consultation, the health MDGs will still be priorities after 2015. Data from the Global Burden of Disease Study (add ref) show that in 2010 women's and children's health, AIDS, and other infectious diseases were the dominant health priorities in sub-Saharan Africa, in many fragile states, and among the poor in many low- and middle-income countries. None of the inputs said they expected this to change in the near future. Box 3 includes examples of the numbers involved.

Box 3: The "unfinished business" of the health MDGs

MDG 1: In 2011, 1 in 6 children (100 million) were estimated to be underweight in developing countries. Underweight prevalence is very high in South-central Asia (30%).

MDG 4: About 19,000 children under the age of five die every day (2011). Nearly 30% of these child deaths are due to pneumonia and diarrhoeal diseases which are preventable by vaccines.

MDG 5: Every day approximately 800 women die from preventable causes related to pregnancy and childbirth (2010). An estimated 222 million women worldwide do not have access to modern contraception and sexual and reproductive health services.

MDG 6: Every day around 7000 people are newly infected with HIV, including 1000 children; 46% of people in need of HIV treatment are still unable to access it (in low- and middle-income countries);

there were an estimated 219 million cases of malaria and 660,000 deaths in 2010; in 2011 there were an estimated 8.7 million new cases of tuberculosis and 1.4 million people died from the disease.

To maintain and secure progress made under the MDG agenda, and to continue efforts to reach and then surpass the targets in all countries, MDGs 4, 5 and 6 must remain part of the post-2015 agenda. Although targets will need to be redefined to reflect the different era that this period represents, it will not be the role of this Task Team or consultative process to define these.

Importantly, the unfinished business of the MDGs also includes those targets under other goals that relate to the underlying determinants of health. For example, malnutrition, unsafe water, lack of sanitation, and leaving school too soon are important underlying determinants of ill health, so achieving the related MDG targets should be a priority in all countries that have not already done so. Lack of progress on MDG 8 is also hampering efforts to improve health outcomes.

Emerging health priorities

The world's health challenges have grown in both size and complexity since 2000. Changes in epidemiology, demographics and risk factors are redefining priority health needs. Globally, the proportion of deaths or years of life lost has shifted away from communicable, maternal, neonatal and nutritional causes, and towards NCDs, mental illness, and injuries (add ref). As a result people are living longer but more people are living with disability. Unsustainable patterns of production, consumption, and growth underpin the rapid rise in NCDs, which now account for over 60% of global deaths, 80% of which are in low- and middle- income countries; and approximately 25% of the global disease burden is due to modifiable environmental factors. In the UN Political Declaration on NCDs in 2011, Member States unanimously affirmed that the scale and threat of NCDs is one of the foremost challenges to social, economic, and sustainable development in the 21st century. It is not surprising that the prevention and control of NCDs was noted as a priority in many of the inputs.

Increasing population size, a substantial increase in the average age in most regions, and falling death rates are among the main demographic changes. In the coming decades, changes in population growth rates, age structures, and distribution — particularly in the context of persistent inequalities — will have a major influence on development processes and on inclusive and balanced growth and outcomes, and will challenge the capacity of countries to achieve broad-based development goals, including health. Most population growth in the coming decades will take place in low- and middle-income countries, where it is likely to increase pressure on the economy, basic health and social services, and the environment. In many low-income countries, high fertility, unacceptably high rates of morbidity and mortality, and low life expectancies hinder development. By contrast, higher income countries are experiencing low fertility, shrinking working-age populations, and rapid population ageing.

Both youth and ageing are significant from a health perspective. For example, although people aged 10-24 years old are generally in good health, they face threats to health such as mental illness, injuries, and risk behaviours such as tobacco use, alcohol abuse, unsafe sexual behaviours, and inadequate diet and physical activity. Actions to empower and build resilience among young people through, for example, access to health information (including on sexual and reproductive health), education, and jobs, can help them avoid such risks. On the other hand, ageing populations are associated with a shift in the patterns of disease away from infectious diseases towards non-communicable conditions such as cancer, heart disease, and mental illness. These chronic conditions impose substantial economic burdens on individuals and societies. Actions are needed to promote healthy ageing and economic well-being in old age, and to provide supportive environments where older persons are treated as assets rather than burdens.

Another major global transition is the shift from risks related to poverty to lifestyle risks: tobacco smoking, alcohol use, poor diet, over eating, and lack of exercise.

The rising prevalence of NCDs, demographic changes, and risk factors are interconnected. For example, the causes of NCDs are rooted in complex global patterns of urbanization, globalization, and economic development, which increase exposure to the leading risk factors: tobacco and alcohol consumption, unhealthy diets and physical inactivity. Addressing these risk factors requires a greater emphasis on public health, health promotion, behaviour change, and disease prevention, which are underfunded in most national health policies and development assistance allocations. Tackling risk factors will also require actions beyond the health system, for example, road transport, ambient air pollution, and agricultural and food policies.

To reduce the growing burden of NCDs and their associated burden of premature mortality, disability, and health-care costs, some inputs to the consultation say the scaling up of evidence-based interventions to reduce the consumption of alcohol and tobacco should be included in strategies for the post-2015 agenda. Others note that addressing the harmful use of alcohol would not only help in combating NCDs but could also help with setting the policy agenda in other priority areas, given the links between alcohol and violence, gender-based violence, injuries, HIV and STI transmission, drug use, and so forth. It will also be important to avoid the trap of pitting NCDs against communicable diseases when raising the profile of NCDs in the development agenda, when in fact there are many linkages that require a balanced and “non-competitive” approach; hence the value of looking at these from the perspective of addressing the determinants of health, as many inputs have suggested.

Another priority area mentioned in several inputs is the need for action to strengthen the building blocks of national health systems, including robust and sustainable financing mechanisms, infrastructure (including surgical capacity), health information systems, health workforce (including management), and health research capacity.

As shown in Figure 1 above, since 2000 several global commissions and task forces have been set up to address particular health priorities, often those not mentioned in the MDGs. Topics include macroeconomics and health, innovative international financing for health systems, the social determinants of health, information and accountability, NCDs, and universal health coverage (UHC).

Perhaps because of the increased attention to health issues at the highest political level, several inputs advocated that other priorities should also be recognized in the post-2015 agenda, arguing that they warrant the same high-level attention that the health MDGs, NCDs, and UHC have received. While no one is advocating a long unwieldy list of health goals addressing all major health concerns, there is widespread (though not universal) support for broader, more holistic health goals in the new development agenda.

To address the long list of health challenges, many inputs argue that the post-2015 framework needs to ensure that people are the priority in global health, not disease. A two-pronged approach is needed: tackling the underlying determinants that cause or contribute to ill health, and creating health systems that are proactive, preventive, and can provide continuing care and on-going management for all health issues. Health goals and indicators in the next development agenda should encourage countries to do both by measuring both health outcomes and the creation of conditions that promote good health. Setting the post-2015 development agenda offers a unique opportunity to focus attention on NCDs alongside the MDGs and to harness new resources needed to address all health challenges.

6. Health in the post-2015 development agenda: guiding principles, goals, indicators and targets

The previous three chapters highlighted key contextual factors and set out the reasons why health should be prominent in the post-2015 development agenda. Health is a basic human right; health is necessary for development; and development is necessary for health. The MDGs, despite their shortcomings, have shown that big global "headline" health goals have the power to galvanize action to improve specific health outcomes. However, the world is facing enormous challenges and threats to health and well-being that require an even more ambitious agenda than the MDGs. Can a new set of goals that puts people at the centre rather than a specific disease or target group be effective and deliver results? What would be the best indicators, and how should targets be set? On these issues the inputs are divided broadly into three groups: one group wants overarching, aspirational health goals, one group wants to stick with focused, targeted MDG-like goals, and one group supports a tiered approach with a hierarchy of health goals and sub-goals. This chapter summarizes some of the options proposed, starting with a set of guiding principles.

Guiding principles for the new development framework

The following principles were proposed during the health thematic consultation. The first list relates to the post-2015 framework overall; the second relates specifically to health within that framework.

1. The principles of the Millennium Declaration — human dignity, equality, and equity at the global level — should be re-endorsed and made more explicit.
2. The approach should be rights-based, with attention to sustainability, equity, including gender equality, good governance, and policy coherence for development.
3. The framework should aim to accelerate progress towards the MDG targets that have not yet been achieved.
4. Like the MDGs, the post-2015 goals need to be limited in number, convincing, clear, and easy to communicate to politicians and the public, measurable, time-bound, and achievable.
5. The goals and indicators should have universal relevance; they should pay particular attention to the most vulnerable, marginalized, stigmatized, and hard to reach populations in all countries, regardless of level of income.
6. Goals should facilitate action between and across sectors where necessary.
7. Accountability, transparency, partnership, and inclusivity should be prominent.
8. The concept of "shared and differentiated responsibility" should be clarified and more clearly allocated.
9. The importance of country context should be acknowledged and countries given greater flexibility to tailor targets to national and sub-national realities. Countries should centre targets on what they can achieve in their own settings and with the resources available to them intrinsically, rather than solely through development assistance.
10. Progress at the global level should be reviewed every five years to strengthen accountability and allow the goals to be adjusted.

In addition, there are calls for the health goals to:

1. be framed so as to accelerate efforts to achieve the health MDGs and, at the same time, incorporate other priority health and development issues;
2. clearly state that health is a human right that comes with entitlements and duty bearers;
3. commit to ensuring that all people have access to affordable, quality health-care services that include public health, health promotion, and disease prevention as well as diagnostic and curative care;

4. encourage the implementation of evidence-based measures to tackle risk factors and address the social, cultural, economic, environmental, and political determinants of health;
5. hold governments, international agencies, and development partners accountable for all the health commitments they have already made;
6. pay due attention to means and intermediate processes, with relevant indicators and targets.

Potential goals for health

Among the various health goals proposed during the consultation for inclusion in the post-2015 framework, three appear to have the most support: maximizing healthy life expectancy; universal health coverage (UHC); and a set of MDG-like health goals.

The first two options had already been proposed when the health thematic consultation began in October 2012. The UN Task Team report *Realizing the Future We Want for All* recommends that an overarching health goal be framed so as to reinforce health as a global concern for all countries, to stimulate political leadership and still be measurable: that is, a goal that measures healthy life expectancy. A position paper from WHO set out the case for UHC as a health goal.

Interestingly, it seems that most supporters of these two goals want a combination of both: there is very little support for either of them alone. Many inputs support UHC (several with caveats, such as avoiding a focus on finance alone, an emphasis on service access, appropriateness, coverage, and quality, as well as health promotion and disease prevention) as long as it is not the only health goal, on the ground that it does not address the determinants of health, which they deem at least as important as UHC. Many proponents of a UHC goal see it as one aspect of a broader healthy life expectancy goal; they therefore argue that the two goals do not carry the same weight.

Some inputs call for more specific goals that resemble the MDGs. One of the main arguments given is that the post-2015 development agenda should maintain the priorities of the MDG framework and not be designed to encapsulate everything that development seeks to achieve. The MDG framework generated resonance and buy-in because of the focus on clear, targeted, measurable outcomes that were meaningful to both the general public and policy-makers.

It is important to note that some (not all) inputs promoting one or more focused MDG-like goals also support these two broader goals.

Several papers caution against any weakening in the HIV response. Despite considerable progress since the MDGs were formulated, much remains to be done, in particular to tackle inequities in access to prevention, treatment, and care for marginalized and hard-to-reach population groups. When efforts to tackle infectious diseases falter, there is often a resurgence of the disease in more virulent forms. Some of the inputs that focused on HIV/AIDS argue that, although the MDG approach has worked well, consolidating and building upon gains already made will require approaches that place human rights and equity at the centre. Also required is a move away from the top-down thinking that characterized the MDGs, building instead upon community involvement. Community groups and civil society organizations are not only key providers of promotive, preventive, care, and support interventions; they can also play a key role in advocating for gender equality and human rights, and increasing the demand for effective health interventions. UHC should include universal access to HIV prevention, treatment, care and support, and access to sexual and reproductive health services via a rights-based approach.

Below are the goals that have been proposed.

Healthy life expectancy
Many inputs propose healthy life expectancy as an overarching goal, because it addresses the need for action on the determinants of health and on the root causes of ill-health, preventable disability, and premature death. Another reason is that it could be a way to combine the post-2015 agenda and the Sustainable Development Goals (SDGs) proposed in the Rio+20 outcome document. No inputs into this consultation support two separate frameworks. As described in Chapter 4, many of the underlying determinants of health are related to social, cultural, economic, environmental, and political factors that have little to do with the health sector: efforts to improve health and well-being need to go further than ensuring access to high-quality health services. Any meaningful effort to prevent avoidable death and improve health and well-being, especially of the disadvantaged and most vulnerable, and to reduce health inequities, requires engagement with all the sectors that impact on health.

Healthy life expectancy is a goal that can be used as a benchmark for progress in other fields of development. It should stimulate a more pro-active "health-in-all-policies" holistic approach because it requires going beyond the health sector and looking at other fields to ensure policy coherence and maximize synergies between the different goals. It puts human rights, including the rights to health, equity, sustainability, and empowerment, at the centre of all policies. This will require a broader view of development, a more democratic and participatory regime of global and national governance, and a configuration of economic relations that supports equity, decent living conditions, and ecological sustainability.

Healthy life expectancy, with disaggregated data to address the equity dimension, is considered a particularly attractive outcome goal because it takes mortality, morbidity, and disability into account. More consideration needs to be given to how it could be measured, but it would allow for a qualitative quality of life assessment, in addition to quantitative data. Other options for an overarching development goal focused on a health outcome include life expectancy at birth and at 40 years or all-cause mortality, lives saved or diseases averted, or the number of years lost due to ill-health, disability or early death (disability-adjusted life years, or DALYs). However, none of these options are likely to have the same traction with politicians or the public as a non-technical term that is easy to understand and communicate: one of the things most people want for everyone (including themselves and their loved ones) is to live a longer and healthier life.

Some argue against it as a goal because life expectancy is slow to change, and because it is a summative indicator of progress across multiple sectors and thus fails to capture the impact of direct healthcare interventions. Many counter that this is equally true of other indicators, including child and maternal mortality, and that a search for goals and indicators that can be neatly ascribed to defined sectoral interventions is likely to prove futile.

A health goal with a focus on healthy or productive life expectancy has broad support partly because it is relevant for high-, middle-, and low-income countries alike. This is consistent with one of the widely held views emerging from this consultation: that future goals must reach beyond traditional development thinking to become sustainable "one-world" goals, and that to do this the global community should move beyond the "meeting basic human needs" approach and adopt a more dynamic, inclusive, and sustainable approach to development.

Universal health coverage
Supporters of UHC as a health goal point to its recognition that the provision of and access to quality health services is a vital component of efforts to improve healthy life expectancy. It addresses many

of the shortcomings of the MDGs (see Chapter 3) and it could accommodate several of the health priorities noted in Chapter 5.

UHC has two inter-related components: coverage with needed health services (prevention, promotion, treatment, and rehabilitation) and coverage with financial risk protection, for everyone. Achieving the goal of UHC is a dynamic process that requires action on several fronts: the range of services available to people; the proportion of the costs of those services that are covered; and the proportion of the population that is covered. Few countries reach the ideal, but all can make progress. It thus has the potential to be a universal goal.

Moving towards UHC requires a strong, efficient health system that can deliver quality services on a broad range of country health priorities. This requires sufficiently funded health financing systems, experienced health managers, accurate and timely health information, procurement, supply chain management and logistics, access to essential medicines, supplies and equipment, and a well-trained, motivated workforce.

Access to needed services (primary, secondary, and tertiary including surgical care) improves or maintains health, allowing people to earn incomes and children to learn, thus providing them with a means to escape from poverty. At the same time, financial risk protection prevents people from being pushed into poverty by out-of-pocket payments for health. UHC is therefore a critical component of sustainable development and poverty reduction.

Supporters of UHC as a health goal say it provides a vehicle for sustaining gains and protecting investments in the health MDGs, and for maintaining the visibility of other internationally agreed health goals relating to specific diseases as sub-goals. Similarly, UHC offers a way of accommodating other health priorities while avoiding unhelpful competition between them. UHC means that people have access to all the health services they need and as such it promotes a more integrated approach within the health sector.

One paper suggested a UHC goal be worded thus: all persons, irrespective of age, gender, disability, ethnic descent, and social status, should benefit from equal access to quality health care services for treatment, rehabilitation, and disease prevention, including health education and immunization.

Not all are convinced of the merits of UHC as the overall health goal. The major concern, noted above, is that UHC does not address determinants of health, and therefore its use as a health goal addresses only a proportion of the factors that create or impair health. A further argument is that it is difficult and complicated to measure and to compare across countries. Another is that it is only a means to an end (i.e. better health) and therefore not a goal. However, the counterargument is that UHC is a right in and of itself, and a practical expression of the concern for health equity.

More MDG-like goals

Some submissions suggested the retention of the health MDGs or new goals like the MDGs either as headline health goals or as subsidiary targets. In many cases there was a desire to see the current MDGs updated with revised targets, reflecting progress that has occurred since 2000, but also the fact that many countries will not achieve the current targets by 2015.

One specific MDG-related goal suggested is to **end preventable child and maternal deaths**. This goal would build on the vital unmet commitments to improving maternal, newborn, and child health within the current MDGs. A goal for ending preventable child deaths would also build on the *A Promise Renewed* commitment that already exists (by which countries have pledged to intensify efforts to reduce under-5 mortality, with an overall target of decreasing it to less than 20

deaths/1000 live births in all countries by 2035). It recognizes the significant progress made in pursuit of the targets expressed in the MDGs but refocuses the efforts of all stakeholders on the people who have been missed to date: the poorest and hardest to reach children and mothers. Specific targets and indicators can reflect the action that is needed outside the health sector. Another similar proposal adds "**and provide health care for all**" to this goal.

The **fully immunized child** is another MDG-like goal that has been proposed. This would aim for the universal provision of all 11 antigens recommended for infants everywhere in the world.

A goal to **reduce child stunting** is framed like an MDG and would ensure stronger links between health and nutrition: this goal could only be achieved by cooperation across sectors.

A specific NCD goal for 2025 already exists: to **reduce the probability of dying from the four main NCDs for people aged 30–70 years**. It is framed like an MDG with a time-bound global target (25% reduction by 2025) and it has nine sub-targets and 25 indicators, such as 30% reduction in tobacco use by 2025.

Universal access to sexual and reproductive health and protection of reproductive rights: Several inputs support this goal on the ground that access to reproductive health and the protection of reproductive rights are critical for achieving dignifying human development and well-being for all. While population dynamics, including changing population structures and distributions, have tremendous bearing on macro social and economic development processes and outcomes, and can be construed as cross-cutting enabling factors for post-2015 development goals, access to quality reproductive health services and protection of reproductive rights should be included in and monitored through clear development goal and target frameworks. Some inputs place this goal within a broader health goal like UHC (some also add "family planning" to the goal) but one argues that it should be the key health goal. The indicators for monitoring progress should include: universal access to a full range of affordable family planning commodities and services; universal sex and relationships education, including family planning; and access to legal and safe abortion on demand.

Other proposed health goals

- G**ood health for the best possible physical, mental, and social well-being**: one overarching health goal is designed to encompass the three disease-specific health goals of the original MDGs and better address emerging patterns of mortality and morbidity, particularly in relation to NCDs. This goal is part of a set of **11 "one-world" goals** that aims to collectively foster individual potential, promote and protect human capital, and enable the effective provision of global public goods.
- A health goal that focuses on **improving health for the most vulnerable people: women, children, and persons with disabilities**.
- A goal on **early childhood development**, which would help reduce health inequalities in adulthood.
- A separate **gender goal** to ensure gender equity and the meaningful involvement of women of all ages in decisions affecting health.
- A goal on **child protection and care**. The addition of such a goal would help ensure well-resourced national child protection systems, with mutual benefits for those striving to improve children's protection and care, and those working to enhance rights to health and survival.
- A **health promotion goal** could offer a complementary strategy, through its explicit focus on the upstream distal determinants of health, and its use of bottom-up empowerment strategies such as community engagement and participation.

- A **healthy public policies** goal could be meaningfully integrated within a Framework Convention on Global Health and/or global health governance.
- A goal aimed at **strengthening human resources for health**. It is argued that only by overcoming structural deficiencies of health systems, particularly in human resources, will it be possible to achieve global goals related to individual diseases or population sub-groups. An adequate health workforce is a precondition of delivering essential health services and improving health outcomes. An adequately staffed, properly trained and motivated health workforce is in itself a hallmark of development, besides being a prerequisite for achieving other health-related goals. It is also essential in achieving the wider goal of universal health care.
- A goal that sets targets for **financing for health** (total health expenditure per capita and proportions of domestic government budget expenditure on health). In addition, the new development framework should provide the political space for new innovative financing mechanisms, such as a financial transaction tax.
- A goal to **accelerate global health research particularly on addressing the health needs of the poor.**
- A goal to **apply universal standards in data collection, quality, and dissemination.**

Indicators and monitoring progress

As stated in the previous section, health should be at the core of the next global development framework, as an overarching development goal, as its own goal, and as a cross-cutting issue. While everyone can agree to goals that aim to improve health and around which efforts and resources can be mobilized, aspirational statements are of little value without metrics that enable the formulation and monitoring of targets.

To move beyond the MDGs towards a multi-dimensional approach to improved health and well-being that focuses on its interrelated and core economic, social, and environmental root causes, many indicators and targets in the post-2015 framework will need to be cross-cutting. For example, in the case of sexual and reproductive health and rights, youth-friendly services, sexuality education, access to a range of modern contraceptives, and postnatal and antenatal care all require, not only indicators relating to the health system (number of skilled workers, sufficient and effective drugs, among others), but also elements linked to the education system, access to nutrition and water, possibly even stigmatization and discrimination, and so forth. Another example is the interconnection between health and financing mechanisms to avoid high out-of-pocket costs, for example by introducing social protection systems to make progress towards universal health coverage.

At the same time the new agenda should not lose a strong advantage of the MDGs: specificity. Overall goals related to improved health are supported by a set of specific indicators and targets many of which relate to the effective and equitable implementation of proven interventions. These include specified reductions in, for example, maternal mortality, child mortality, cause-specific mortality, morbidity and disability, and risk factors such as tobacco use. They also include specified improvements in intervention coverage such as immunization.

It is widely acknowledged that overarching health impact indicators tend to be slow to change and hard to measure. When it comes to monitoring change, more responsive, simpler indicators will also be needed. These should reflect health status and the performance of the healthcare system in terms of access to and use of health care services, the financial costs of doing so, quality of care, and the availability of healthcare professionals and managers, among others. Several inputs call for indicators and targets to focus in particular on the need for disaggregation by gender, sexual

orientation, age, ethnicity, income, and vulnerability, but as yet there are few concrete suggestions of how these could be worded. Some propose a single all-encompassing outcome indicator such as excess mortality or stunting (height for age). Others recommend a single summary indicator of health system performance such as universal health coverage

General comments on indicators in the post-2015 framework

- They should be able to be monitored effectively and reliably.
- They should be scientifically sound, easy to interpret and convey, and measureable with attainable resources.
- They should be both summative (reflecting multiple elements) and diagnostic (able to identify critical weaknesses that policy and programmes must address).
- They should be tailored and adapted to national and regional contexts and existing conditions to reflect national health needs and priorities. A global set of indicators could also be "rolled up" from countries' indicators.
- Indicators should be chosen that have already been agreed so as to not add to the reporting burden.
- They need to be disaggregated so that progress can be measured, not just at the aggregate, national level, but by various factors including age, income, gender, geography, ethnicity, and education, to make inequities visible and allow better prioritization and targeting of vulnerable groups.
- They need to be supported by indicators that measure health promoting environments and should be integrated across development issues such as: food and nutrition; jobs, employment, trade, and economic growth; gender and inequalities; and environmental sustainability.

Comments on health targets and indicators

- Healthy life expectancy and UHC indicators should include both qualitative and quantitative measures, especially for assessments of quality of life and quality of health services.
- Indicators for UHC should address both health coverage and improved health outcomes.
- Disease specific indicators are an effective and important means of driving progress on priority issues, but integration of health planning, funding, and service delivery at the national level will be crucial to achieving improvements in health status.
- Indicators for health could be framed as a combination of health status and health enablers (such as access to medicines, universal health coverage, and health systems strengthening) to ensure the post-2015 framework both improves health outcomes and provides guidance on the means to do so.
- Coverage indicators with an ultimate target of 100% are not problematic for UHC, which assumes that the whole population should have equal access. However, milestones for the achievement of the target are difficult to set.
- For the measurement of financial hardship associated with seeking healthcare, indicators relating to financial impoverishment of households as a result of using health services have particular intuitive appeal. Impoverishment indicators can be measured using internationally comparable absolute or relative poverty lines, and generated through household surveys.

Improving measurement capacities

The intuitive attractiveness of the concepts of health life expectancy and UHC disguises the inherent challenges of measuring them over time and across different settings. Yet in many ways these are no more of a challenge than monitoring gross domestic product or the rate of inflation, concepts that are widely used in the economic domain and which bring together multiple variables into a single construct.

Health information systems including vital registration systems are a precondition for monitoring progress on targets and indicators. More resources should be devoted to improving national civil registration (births, deaths, and cause of death) and timely, accurate data collection for reporting progress towards the health goals.

Investing in data is a critical step to improving understanding of factors influencing health processes and outcomes among different population groups. Important development goals, such as addressing disparities and inequalities, need disaggregated population data, as well as appropriate analyses to design and implement effective development strategies and monitor programme performance and impact.

The post-2015 agenda should be driven by what can be achieved, and not by what can be measured at the present time. Goals need to be chosen that are feasible to measure and monitor, but must also be ambitious, driving the future development of data availability.

7. Implementation: mutual accountability and shared responsibility

The importance of outlining steps towards implementation of the framework and concrete mechanisms for ensuring transparency, accountability, and an enabling environment for sustainable development were highlighted in several of the contributions. There is widespread support for the post-2015 development framework to be flexible in implementation and for national policies to be based on international standards for human rights, decent work and social protection. Because many of the contributions support a more comprehensive view of health that requires action not only within the health sector but also within and across many other sectors, many of the comments relate to overall development processes, and are not specifically about implementing the health goals.

This chapter summarizes inputs to the consultation that relate to what needs to be done once the agenda and goals are agreed to have the best chance of achieving them in all countries in the post-2015 period. The inputs are grouped into four areas:

- comprehensive health poverty reduction policies and mechanisms
- adequate and sustainable financing
- accountability and transparency
- cooperation and coordination.

Comprehensive poverty reduction policies and mechanisms

Orchestrating a coherent response across government and society that result in better health outcomes remains one of the most prominent challenges in global health. The Rio Political Declaration on Social Determinants of Health (add ref) called for action in several areas to address the interconnectedness of social policies and health in several areas:

- adopt improved governance for health and development
- promote participation in policy-making and implementation
- further reorient the care delivery system towards promoting health and reducing health inequities
- strengthen global governance and collaboration
- monitor progress and increase accountability.

Some inputs note that the new development agenda requires global action to change rules, incentives and power structures aimed at achieving social justice and more democratic global governance.

Some inputs draw attention to the Guiding Principles on Human Rights and Extreme Poverty, which call on States “individually and jointly, to create an international enabling environment conducive to poverty reduction, including in matters relating to bilateral and multilateral trade, investment, taxation, finance, environmental protection and development cooperation." (add ref) Others quote the Commission on Social Determinants of Health: “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” (add ref).

All countries should find means to include relevant stakeholders in national consultation processes about how to implement the new development goals. National parliaments should be included in consultation processes and public discussions in order to gain their support for allocating more financial resources to health, social security and the underlying determinants of health.

Some inputs emphasize the need to foster governance arrangements that empower people (especially women) and support communities to choose and enact their own pathways to better health and sustainable development. Holistic approaches to poverty reduction are just as important at community level as they are at national and global levels. In marginalized communities, problems like food insecurity, maternal and child mortality, and resource scarcity are inextricably linked. Where these linkages are strongest, community-based, integrated approaches can create positive synergies by addressing multiple needs at once. Models of cost-effective, integrated programs that outperform single-sector approaches can be found in communities around the world.

Financial resources and mechanisms

Long-term, predicable and sustainable financing for health and development — mostly domestic resources but also international resources (ODA) — will be required to achieve the post-2015 development goals. Some contributions want the necessary finance mechanisms articulated as part of a post-2015 framework.

Note: The next draft will have a paragraph on financing for health and development — domestic financing for health is 80-90% of total health expenditure in most countries and the growth in ODA until 2011 and the stagnation since as a result of the financial crisis. A figure may also be included.

Some inputs want to see mechanisms incorporated to hold all countries to account for their financial responsibilities in building a shared future, articulating (for example) required national spending commitments, aid and development cooperation efforts, and funds committed to multilateral institutions. The suggestion is that this may build upon existing pledges made, for example, the Abuja Declaration for African governments to spend 15% of their budget on health, and OECD countries' commitment to spend 0.7% of their gross national income on development assistance.

Some inputs call for more efforts to address corporate tax avoidance, unfair taxation, rules of trade and finance, and sovereign debt relief arrangements.

Other contributions call for innovative sources of financing that provide incentives for progress, have a redistributive capacity and support strategy implementation, particularly Financial Transactions Taxes (FTTs) and transportation fuel taxes and levies for the airline and shipping industries. Some inputs mention the importance of encouraging more foreign direct investment.

Note: A paragraph to be added on stimulating the private sector to invest in development through subsidies and incentives. And another paragraph will be added related to efficient and effective use of resources.

Accountability and transparency

Several inputs stress that accountability and transparency — at all levels and by all actors — are essential for any new commitments and objectives in the post-2015 development framework (as stated in the proposed guiding principles). Some recommend a standalone goal on accountability; others want to make "access to information" a goal in its own right."

Some call for global legal mechanisms to further define these responsibilities and ensure accountability. Improving the availability and quality of data would be a prerequisite for monitoring and measuring gradual progress.

Recent efforts to improve accountability include the UN Commission on Information and Accountability for Women's and Children's Health (add ref). Convened in 2011 to develop a process to improve national and global reporting, oversight and accountability for women's and children's health, the Commission delivered a report outlining ten ambitious recommendations to fast track urgent action needed to meet MDGs 4 and 5. These recommendations cover three broad categories; better information for better results, better tracking of resources; and better oversight of results and resources nationally and globally.

Although efforts to implement the detailed recommendations of the Commission have initially been seen as critical to accelerating progress towards MDGs 4 and 5 there is also a long-term foundation being developed for greater accountability for health that can be of significant benefit for the post-2015 development framework. For example, the report includes an inclusive, participatory monitor-review-act framework that could be used to review progress towards the achievement of new health goals at the local, national and global levels. Another example: improvements to vital registration and health information systems in low-income countries with high child and maternal mortality will be of critical importance to the measurement of any new health goal, but will require further attention and investment beyond the timeframe of the current MDGs.

Cooperation and coordination

Several inputs referred to the need to make more progress on MDG 8 —to develop a global partnership for development — because in their view it is the necessary precondition for the achievement of the other goals and the least specific and therefore least successful MDG.

While recognizing that some countries will need official development assistance (financial and technical) well into the post-2015 era, a new paradigm is needed to replace the outdated donor-recipient model of development assistance. The Paris, Accra, and Busan declarations have established a clear framework for development effectiveness which needs to be robustly implemented, particularly with regards to development assistance for health. To create effective working relations in global health and development, the five principles within the Paris Declaration – ownership, alignment, harmonization, results and mutual accountability – should be adhered to by countries and development partners alike.

Since 2000 global health has had considerable success in multi-stakeholder engagement, innovative financing, public-private partnerships, and civil society engagement. The health sector has already put in place platforms such as the International Health Partnership (IHP), an inclusive and participatory process used to improve alignment and harmonization and mutual accountability could be expanded to include sectors others than health. Another example is the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization) which brings together all the key players, including the vaccine industry, research and technical agencies, and civil society. The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) brings together at the country level a wide diversity of implementing government bodies, international development partners, national civil society organizations (including local media, professional associations, and faith-based institutions), the private sector, and communities living with or affected by the diseases.

There was considerable support in this consultation for clearly delineated roles and responsibilities (alongside appropriate safeguards) for all parties in the design, implementation and evaluation on the post-2015 framework. Harnessing the resources and expertise of the private sector and academia has been crucial to progress in global health issues from HIV/AIDS to maternal, newborn and child health. //Note: a paragraph will be added to expand on this further and include some practical suggestion//

The commitment, experience, and mobilizing capacity of civil society and NGOs plays a key role in global health and development, including through advocacy and awareness; technical and scientific support; policy setting, implementation and monitoring; delivering vital resources and services to vulnerable populations; and acting as a watchdog for progress. A clear role for civil society will be crucial for supporting country achievement of global goals and targets.

Innovative, multi-sector partnerships that align and coordinate efforts will be the cornerstone of action in future global health. //Note: This will be expanded on and be forward looking. e.g. the potential transformative power of such partnerships. Also a paragraph will be added on research and harnessing potentially game-changing technologies and the opportunities for the next generation of development goals to leverage them to advance radical improvements in human well-being. //

Several inputs were of the view that the institutional architecture in global health requires major reform because the impact of the MDG era in creating disease-specific programmes, funds and agencies has created both an insufficient and duplicative use of resources. These inputs claim success in global health will require comprehensive governance reform to break down the vertical barriers between diseases and health issues. Some contributions say that the world is becoming increasingly complex and the key is to manage this complexity. Some inputs suggest that WHO – as the only multilateral agency able to set norms, standards and surveillance for health – retain a stewardship role and provide strategic direction for multiple stakeholders with a robust framework for interaction.

In summary, many inputs into the consultation agree that the post-2015 development era should be open and inclusive, and should ensure the participation and engagement of all nations and stakeholders. There should be efforts to take account of the perspectives of marginalized groups. At country level this means involving civil society, indigenous peoples and cultural minorities in political processes so that marginalized communities have the opportunity to articulate their own concerns and priorities to governments. Especially vulnerable groups as women, children, people with disabilities and the elderly should be included in planning, monitoring and evaluating efforts to achieve the post-2015 health goals at local, national and global levels. In addition, global governance for health should be underpinned by a shared vision, an overarching goal to improve health status, and mutual accountability for results.

8. Framing the future agenda for health

//Note: The Task Team has been asked to make recommendations to the High-Level Panel and the UN Secretary-General; that is the purpose of this chapter. Like the rest of the report the text below is based on inputs to date and is still in development. The final recommendations will depend on the comments received from 1-19 February and on the discussion at the meeting in Botswana on 5-6 March.//

> "Human development as an approach, deals with what I consider the basic development idea: namely, increasing the richness of human life rather than the wealth of the economy in which human beings live, which is only a part of life itself." —Amartya Sen, Nobel Prize winner for economics in 1998

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." —WHO Constitution

Health as a key dimension of the post-2015 development agenda

Health is a beneficiary of development, a contributor to development across a broad spectrum of sectors and priorities, and a key indicator of what people-centred, rights-based, equitable, and sustainable development seeks to achieve.

There is a call for a new vision and approach to development that goes beyond measuring progress in economic growth and gross national product, and instead measures development in terms of well-being, health, security, and quality of life. This will require, among other things, addressing the social, cultural, economic, environmental, and political determinants of health, tackling risk factors, building health promoting environments, and strengthening health systems.

Placing health at the heart of the post-2015 development agenda will not only save lives and advance economic development, it will also protect environmental sustainability, and advance well-being, equity and social justice.

Health goals for a changed world: equitable, holistic, and people-centred

The post-2015 development agenda should be relevant for all people in all countries, and direct explicit attention to reducing health inequities between and within all countries, especially when considering the needs of the poor, marginalized, and those whom the efforts of the MDGs have not reached. The MDGs have shown that aspirational global health goals can be a powerful force for change. The right to health means that governments must generate conditions in which everyone can be as healthy as possible. The new goals and indicators need to take into consideration knowledge about the health needs and priorities for the next 15-20 years.

A hierarchy of goals is needed to capture the increasing complexity of priority health challenges and the reality that efforts to prevent disease and disability and improve health and well-being require policies and actions both within the health sector and across many other sectors.

Indicators need to measure impact (mortality, burden of disease, and risk factors), coverage of health services (promotion, prevention, care, and rehabilitation), and health systems (service delivery, health workforce, information, medicines, financing, governance, and management capacity). Indicators also need to be disaggregated within countries to go beyond averages and

measure progress on health inequities, focusing on the main groups who experience disadvantage according to each country context. Some qualitative indicators may be needed to measure quality of life and well-being, while assessing quality of health services may require qualitative as well as quantitative indicators.

The MDG targets and indicators as well as those in other internationally agreed agendas should be revised for the post-2015 era and included under the relevant goals.

Countries could add other sub-goals and indicators based on their priority health needs and develop targets relative to their own baselines. However, a common set of tracer indicators is necessary because a global measure of progress can only be synthesized from country data and because comparisons between countries can be a powerful stimulus for progress. All countries will have to include this information, and measure these indicators on a regular basis using global measurement standards, allowing a "roll-up" of country data into global monitoring.

An overarching goal to increase healthy life expectancy could be connected to several next-tier goals addressing the broad range of factors that affect mortality and morbidity, and these goals could have explicit health-related targets and indicators (including revised targets of those in the MDGs).

Maximizing healthy life expectancy

The overall goal should be to ensure that people have the possibility not only to survive and live longer lives but also to stay healthy. This goal could potentially be measured with three sets of indicators, all focusing on impact.

1. ***Improved survival***: increased life expectancy, reduced under-5 child mortality and maternal mortality (MDGs 4 and 5).
2. ***Reduced burden of disease***: build on MDG 4, 5 & 6 (Child morbidity, AIDS, tuberculosis, malaria, etc.) plus NCDs.
3. ***Lower levels of risk factors***: % of population smoking, % of population without access to water and sanitation, etc.

Universal health coverage (UHC) could be one of the means by which the overarching goal of healthier life expectancy is achieved. UHC would bring equity and fairness as well as the need for an integrated approach in the provision of health services.

UHC recognizes that the provision of and access to quality health services (health promotion, disease prevention, care, and rehabilitation) are vital components of efforts to improve healthy life expectancy.

Universal health coverage

The objective should be to ensure that people have as equal as possible access to the best possible health services and financial protection. UHC could be measured with three sets of indicators focusing on coverage and protection.

1. ***Increased coverage of essential services***: build on the present MDGs (immunization coverage, reproductive health services, insecticide-treated bed nets, essential medicines, etc.) plus NCDs and preventive services.
2. ***Increased equity and financial protection***: reduced gap between the first and fifth quintiles, reduced levels of out-of-pocket expenditure, etc.

3. ***Strengthening health systems:*** indicators on workforce, management and leadership capacity, information systems, governance, infrastructure, and quality.

Where possible, other goals related to health determinants should incorporate a health approach; at the very least, they must not undermine the right to health. Health indicators should be used to measure goals that impact on health (such as migration, education, water and sanitation, gender equality, youth empowerment and employment, environmental sustainability, population dynamics, and good governance). Examples that could lead to improved healthy life expectancy include: increased access to water and sanitation, better nutrition, less indoor air pollution, and better traffic safety.

//Note: paragraphs will be added that discusses implementation and measurement issues: the importance of health systems capacity, management, accountability, inclusive and effective partnerships, sustainable and predictable financing etc. //

9. The road to 2015

The Global Thematic Consultation on Health has been fortunate to receive numerous inputs from Member States, civil society, the private sector, academia, foundations, national and global health leaders, and UN agencies, through written submissions and face-to-face meetings. The high level of participation reflects the great interest in the post-2015 agenda and the strong desire to ensure that health maintains its central position in national and global priorities for development.

Following the public consultation on this synthesis report, and the High-Level Dialogue in Botswana in March 2013, the final report of the consultation will be submitted to the UN Secretary-General and High-Level Panel of Eminent Persons on the Post-2015 Development Agenda. The High-Level Panel will consider this input as it finalizes its own final report to the UN Secretary-General, to be finalized in June 2013. The UN Secretary-General will also consider the consultation's report as he prepares his own report to the planned special session of the UN General Assembly on the Post-2015 Agenda in September 2013.

However, for those who are keen to ensure that health features prominently in the post-2015 agenda, and that the right goals and indicators are set for health, the conclusion of the Global Thematic Consultation on Health is merely the "end of the beginning". Between now and 2015, the debate will continue. Even the UN General Assembly Special Session, although a key milestone, will still represent only an early part of the process.

The consultation received a number of submissions concerning the key priorities for ensuring that health is well considered in the final post-2015 agenda. First, the timeline for the MDGs is not complete. Significant progress on unrealized MDG targets can still be achieved between now and the end of 2015. The process of defining the post-2015 agenda must not detract from continuing efforts to reach the MDG targets by 2015, or indeed the continued building on the strong foundation established by the goals, as shown by the gains made in women's and children's health as well as the control of HIV/AIDS, tuberculosis, and malaria. Efforts should be accelerated in all countries to optimize achievement of the MDG targets, particularly in those countries that are off track. This will be an important preparatory step to implementation of the post 2015 agenda

Second, the consultation has yielded a rich collection of papers and viewpoints, not only on the role of health in the post-2015 agenda, but also on key challenges and opportunities for health in the second decade of the 21st century. This knowledge can be fed, not only into the High-Level Panel of Eminent Persons, but also into other processes which are considering the post-2015 era, such as the national consultations which remain to be held, the Sustainable Development Solutions Network (which also has a thematic working group on health), and the Open Working Group on Sustainable Development Goals, which convenes Member States.

Third, most inputs into the consultation called for the processes relating to the Sustainable Development Goals and the post-2015 development agenda to be integrated as soon as possible. It is, however, still not certain that this will occur. Consideration needs to be given to the importance of health in both processes, and how they might be integrated.

Fourth, the consultation, to date, while being a global process, has aimed to be as inclusive as possible. It is important that further work on defining the place of health in the post-2015 agenda continues to be open and inclusive, including reaching out to communities that have so far been absent or under-represented. In particular, it is crucial that young people and older people be actively engaged.

Finally, the balance between making the case for the importance of health in the post-2015 agenda, and identifying which specific health targets or interests should be highlighted, must be carefully managed. Following on from this consultation, the health community should build internal consensus and propose strategies for articulating the ways in which health is a key contributor, consequence, and indicator of each of the dimensions of sustainable development. Negotiations within health should not overshadow understanding the central importance of health to people's lives and aspirations.

The Task Team and supporting UN Agencies of the Global Thematic Consultation on Health would like to express their sincere appreciation for the considered efforts of all who have contributed to this process so far, and look forward to their continued engagement to ensure that the right goals and indicators for health are set for the post-2015 agenda, through all processes leading up to the UN General Assembly special session in September 2013 and beyond.

References

Acronyms

Acknowledgements

Annexes

Annex 1: digests of submitted papers