

Overview

The Commonwealth health and development agenda: Beyond 2015

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In the Commonwealth and wider world, considerable progress has been made in the pursuit of the MDG targets. Profound reductions have been recorded in under-five deaths worldwide, falling from more than 12 million in 1990 to around 6.6 million in 2012. Maternal deaths have dropped by 47 per cent over this period. Around 9.7 million people living with HIV/AIDS now have access to anti-retroviral treatments and more than seven billion treatments for neglected tropical diseases have been disbursed since 2005. The spread of tuberculosis is on target to be reversed by 2015 and the global incidence of malaria has fallen by 17 per cent since 2000. The global target of halving the proportion of people without access to safe, clean water has been met. Despite these achievements, much remains to be done.

As we move towards the conclusion of the Millennium Development Goals (MDGs) process, the Rio+20 Summit (2012) also resolved to put an end to extreme poverty and hunger by placing poverty reduction in the broader context of sustainable development. That summit called for new Sustainable Development Goals (SDGs) to be adopted by the United Nations (UN) post-2015. While continuing the key commitments of the MDGs, the SDGs will provide a framework for integrating actions across multiple sectors to enable human development to proceed in a manner that optimises the equitable use of planetary resources whilst minimising threats to sustainability. Unlike the MDGs, which were principally directed at the low- and middle-income countries (LMICs), the SDGs will be universal, encompassing the health concerns of all countries in an era of rapid epidemiological transition and positioning health as a shared global commitment within the broad framework of sustainable development.

As the articles in this volume show, epidemiological and demographic transitions, accompanied by changing exposures to risk factors, have brought forth non-communicable diseases (NCDs) – for these purposes including mental ill-health) as major global contributors to preventable death and disability. The UN political resolution on NCDs (2011) and the World Health Assembly resolution (2013) call for an urgent global response to this threat, which is the major public health challenge of this century. At the same time, health inequities have persisted within populations despite improvement in aggregate national health indicators. There is also a concern that segmentation into specific age or risk groups, such as childhood and pregnancy, misses critical periods of life like adolescence, a vital link in the life course that lays the foundation for adult health. Similarly, the health needs of the elderly must also be addressed.

By prioritising sustainable development, societies commit to progress across four dimensions: economic development, including the eradication of extreme poverty; social inclusion; environmental sustainability; and good governance. Each of these dimensions contributes to the others, and progress across all four is required for individual and societal well-being. Health has both intrinsic and instrumental value. It is inherently important as a human right, but is also critical to achieving these four pillars.

In November 2013 Commonwealth Heads of Government discussed the theme of *inclusive* growth. While recognising that national aspirations for economic growth cannot be achieved without a healthy and productive population, bridging global and national health inequalities was acknowledged as a critical development imperative. While health benefits from economic growth, its value as a critical catalyst for development led to health-related goals being centrally positioned in the MDGs. Child and maternal mortality became a measure of a nation's overall development, along with poverty eradication, the empowerment of women and environmental sustainability. At the same time, combating the spread of HIV/AIDS, and reducing the burden of tuberculosis and malaria is critical to human progress, as these communicable diseases greatly impact the development potential of many member countries.

Further evidence of the importance of health to sustainable development are the growing numbers of reports, such as the World Health Organization (WHO) Commission on Macroeconomics and Health (1999), emphasising the need for greater investments in health through increased public financing. These reports have highlighted the multiplier effects of investment in health and the 'cost of neglect' from preventable death and disability. The recent report of *The Lancet* Commission on Investing in Health, for example, estimates that increased investments in health, to achieve 'grand convergence' in key MDG health indicators by 2035, will yield benefits that will exceed costs by a factor of nine in low-income countries and a factor of 20 in lower-middle-income countries. In the case of NCDs, a counterfactual estimate of the 'cost of neglect' is provided by the Harvard – World Economic Forum Report, which warns that the world will lose US\$47 trillion between 2011 and 2030 if urgent action is not taken. The WHO Commission on Social Determinants of Health has called for concerted action on the 'causes of the causes', which lie in sectors regarded as outside of health but have a profound impact on health. The articles here, by Professor Sir Michael Marmot and others, address this socio-economic foundation to the health landscape.

Strengthening national policies and systems

National and regional disparities remain the most formidable challenge. Many countries making progress have done so only in certain populations, increasing inequalities across socio-economic gradients, ethnicity, gender and geographically marginalised subgroups. The SDG on health has to ensure that progress on MDGs is accelerated and health inequities are reduced within and across populations.

The importance of strengthening health systems has become increasingly clear over the last decade. The health systems of many countries remain unduly fragmented – vertical or over-centralised programmes, in part a result of institutional and professional aid, and other dynamics, represent an opportunity cost in other areas of public health. Vertical programmes resulting from the MDGs, however well intended, have neglected some disease burdens and risks. Furthermore, they have not enjoyed an easy fit with existing systems or sufficiently addressed system strengthening. The SDG on health must have the effect of building efficient and equitable health systems rather than fragmenting them. At the same time, the focus on attainable targets, which energises action within the health system and generates political will, must be retained.

These efforts require increased financial allocations to health as well as improved efficiencies in the utilisation of health resources. The impetus for review and reform of national and global health financing mechanisms has also come from the high burden of health care-related impoverishment in many countries. The call for universal health coverage (UHC) has grown stronger over the past decade. Dr Margaret Chan, the Director-General of WHO, has called UHC the ‘the single most powerful concept that public health has to offer’¹. Dr Jim Yong Kim, the President of the World Bank, has called for the global achievement of UHC ‘within this generation’². The post-2015 SDGs on health and poverty reduction must incorporate this vision of UHC.

The lessons learned from the MDGs, which need to be translated into the framing of the health SDGs, are that the goals: need to be universal, engaging all countries; need to address major causes of mortality and morbidity at all stages of life (life course approach); have to be delivered through a well-resourced, efficient, equitable and accountable health system that can integrate multiple programmes while reaching specific targets; and have to catalyse pro-health policies in all other sectors which impact on health.

Towards a Commonwealth understanding of UHC

In the past three years, several consultations have deliberated on the opportunities and challenges provided by the existing MDGs, and the call for a new health goal which resonates with contemporary issues and concerns. These issues have ranged from universalism versus targeting, inclusion, equity, concerns regarding financial protection and differences in interpretation, among others. While several candidate goals have been proposed by different groups, two major themes have emerged through this process, both with the potential for becoming the health SDG. One is UHC and the other is maximising healthy life expectancy. These are not mutually exclusive; indeed, they reflect and reinforce each

other. Importantly, they help to create a broad platform for integrating diverse health concerns and agendas.

As debates concerning the post-2015 development agenda intensify, many governments, development agencies and civil society organisations are calling for prioritisation of UHC as either the specific health goal or the stated means to achieve any health goal. This can be attributed to a growing recognition that increasing health coverage, coupled with financial protection, delivers substantial developmental benefits – both in terms of better health indicators and improved economic performance, both of which lead to poverty reduction. Furthermore, political leaders are realising that moving towards UHC is popular with people across the world. By improving the health and economic welfare of all people, governments can foster social harmony, enhance the legitimacy of the state and secure considerable political support.

However, there needs to be clarity on what UHC means. While health financing is a critical component, the broad mandate of any health system has to be stated in terms of the services that are assured to the whole population through UHC. These include promotive, preventive, curative, palliative and rehabilitative services, as well as other health-enabling public services such as water, sanitation and environment. Pro-health policies in other sectors, addressing the broad social determinants of health, also need to be coupled with UHC.

UHC clearly has appeal as an SDG because of the following features:

- **Inclusion:** UHC addresses a wide range of health problems across all age groups and through the life course
- **Equity:** If designed well, UHC has the potential for reducing health disparities
- **Financial protection:** UHC reduces Out Of Pocket Spending (OOPS) and catastrophic health expenditure, thereby decreasing the risk of poverty from health care spending by individuals
- **Livelihood generation:** By emphasising ‘people-centred primary health care’, UHC provides the stimulus to create a multi-layered health workforce for delivering primary health care services. The employment of both physician and non-physician health care providers is encouraged, with major opportunities for young persons, especially women, to enter the labour market. Both the health sector and the overall economy benefit through such job creation
- **Common global vision:** UHC is applicable to both high-income countries and LMICs, and can be implemented based on contextual priorities
- **Unifying global rallying point:** UHC has been strongly endorsed by WHO, the World Bank, civil society organisations, many governments and private sector confederations through reports, declarations, resolutions and statements issued in the past three years (WHO and World Bank, 2013)

However, there are also concerns to be noted:

- **Diverse definitions and models:** Diverse definitions and conceptual models offer varying designs for implementation of delivery, thereby introducing difficulties in agreeing on a common goal or target for comparative assessment of progress



ACCREDITATION OF HEALTH PROFESSIONS PROGRAMMES IN THE CARIBBEAN

Accreditation is an objective peer review process designed to attest to the educational quality of new, developing and established educational programmes. It serves two main purposes:

- to determine if a programme is in substantial compliance with accreditation standards
- to promote institutional improvement and renewal.

The Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP) is the only one of its kind in the Caribbean with a remit to accredit the education programmes of medicine, dentistry, veterinary medicine, nursing and other

health professions offered at the degree level in institutions in CARICOM member states. This body functions to accredit and monitor programme quality, manage the accreditation cycle, provide information to governments and the public, provide guidance and advice to schools and to train surveyors for programme review.

CAAM-HP's achievements to date demonstrate that this authority has resolved the issues that led to its establishment in 2004, namely, filling the gap left by the General Medical Council's (GMC) discontinuation of the accreditation of overseas programmes, monitoring the growth and development of new and established for-profit, offshore medical schools and assuring the quality of the programmes offered by these institutions.





Above: Site visit team along with senior faculty of the Xavier University School of Medicine in Aruba

SUCCESSSES

CAAM-HP was granted international recognition in June 2012 by the recognition committee of the World Federation for Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER) which found CAAM-HP to be 'credible in its standards and procedures to assure the quality of medical education in the programmes and medical schools that it accredits'.

MORE SCHOOLS COMING ON BOARD

Since then, CAAM-HP has seen an increase in the number of schools seeking accreditation. Five schools were visited between February and July 2013, including two from the Dutch islands of Aruba and Curacao and one new dental school in Jamaica.

UPCOMING SITE VISITS

In addition to annual monitoring visits, CAAM-HP has seen a record number of requests and as a result, 2014 is expected to be very busy with six medical schools and one dental school on schedule for full site visits.

Far Left: The 21st Caucus of CARICOM Ministers Responsible for Health where representatives of CAMC and CAAM-HP were in attendance

Left: Mrs Lorna Parkins, Executive Director

PROFESSIONAL MEMBERSHIP

CAAM-HP has become a member of the USA's Council for Higher Education Accreditation (CHEA) International Quality Group, a new international forum established in September 2012 to address accreditation and quality assurance. Membership of this new body includes over a hundred institutions and organisations from 37 countries. CAAM-HP has also become a member of the International Association of Medical Regulatory Authorities (IAMRA).

REGIONAL COLLABORATION

The Caribbean Association of Medical Councils (CAMC) is a regional organisation consisting of representatives from national medical councils whose remit is the registration and monitoring of doctors. CAMC is represented on the Authority.

WHAT'S NEXT FOR CAAM-HP

As CAAM-HP approaches the 10th anniversary of its establishment, consideration is being given to a tenth anniversary conference to, *inter alia*, evaluate its achievements and carefully examine areas for improvement as it continues to secure the confidence of the peoples of the region in its work through its role in assuring the quality of medical and other health professions training offered in the region.

WWW.CAAM-HP.ORG

CAAM-HP was established in 2003 under the aegis of the Caribbean Community (CARICOM) and launched in 2004.

The purpose of CAAM-HP is to accredit the education programmes of medicine, dentistry, veterinary medicine, nursing and other health professions offered at the degree level in institutions in CARICOM member states.

- **Measured by diverse metrics:** Adoption of specific metrics for measuring national and global progress towards UHC is a challenge. The indicators jointly developed by WHO and the World Bank merit consideration in this regard (WHO and World Bank, 2013)
- **Potential for narrow interpretation:** There is an apprehension that UHC may be understood narrowly as provision of health care and many exclude action on the social determinants of health, which have a profound influence on the health of populations and individuals. Such a restricted interpretation would overemphasise the biomedical model of clinical care without substantial impact on population health outcomes
- **Recognition of priority equity needs:** An apprehension that a 'universal' programme may dilute the priority accorded to the needs of the poor and may permit the non-poor to benefit in a disproportionate manner through better access and negotiating power. To address this concern, UHC has to be designed to meet the requirements of both horizontal and vertical equity

While recognising the importance of UHC, some groups have proposed to overcome these concerns by recommending a goal linked to healthy life expectancy (HLE). This would require UHC to be a pathway but would also explicitly call for action on the social determinants of health. It would also highlight a life course approach to health. A quantitative target for increasing HLE would have to vary across different countries, which have widely varying baseline life expectancies at present. Therefore, the proposed goal is more generic in its formulation: 'Maximizing Healthy Life Expectancy'.

Attempting to bridge these different proposals, the Sustainable Development Solutions Network (SDSN) has suggested the adoption of a more encompassing goal, which incorporates action on MDGs, NCDs and UHC but brings in the concepts of the life course approach to health, a strong health system delivering a wide range of health services and pro-health policies in other sectors to address the social determinants of health.

Linking health with other development goals

Health and other development sectors, which will feature in the SDGs, are closely interlinked through mostly bi-directional relationships. It is universally recognised that several critical determinants of health and illness lie outside the health sector. At the level of household economics, poor health impoverishes families through costs of care, lost wages and even permanent loss of employment. Long periods of illness lead to stress and domestic strife within households.

Health is also influenced by policies and programmes in other development domains, such as poverty reduction, agriculture, education, climate change, gender, women's empowerment and urban development. Several of the actions needed to prevent NCDs have co-benefits for the environment, while climate change will adversely affect the spread of infectious diseases and undermine human nutrition. It is essential that the post-2015 development agenda and resulting policies recognise these linkages. When designing policies to achieve future development goals, impacts across multiple sectors should be taken into account to increase

synergistic effects and reduce detrimental effects. It is here that the Commonwealth's multi-sectoral remits and partnerships can add value to the debate.

A compelling example of the need for 'Health in All Policies' is the case of global tobacco control. According to the World Health Organization, 100 million persons died due to tobacco-related diseases in the 20th century. WHO also estimates that the death toll due to tobacco will be one billion human lives in the 21st century. But tobacco is not only a health hazard. It is a threat to the environment through deforestation, extensive pesticide use, and high levels of water and soil depletion. It is unacceptable that around four million hectares of arable land are wasted on a killer crop instead of growing nutrient crops. As the article by Barraclough, de Silva and Hayes indicates (see page 95), there is a range of policy solutions available to Commonwealth governments – including using the Commonwealth network itself.

Conclusion

Responding to the challenges of global health transition and recognising the close links between health and other development sectors, the SDGs must collectively position health centrally in the framework of sustainable development. The health SDG should extend action on MDGs, expand the agenda to NCDs and other major disorders, adopt a life course approach, call for UHC and enable the strengthening of health systems. Since the determinants of health extend across multiple sectors, the post-2015 development agenda must also promote synergies and partnerships that align actions for better health, linking several stakeholders. Finally, migration, a long-standing concern for the Commonwealth, deserves close focus as a factor both in social determinants and in sustainable human resourcing for health.

Alongside the 2014 Health Ministers Meeting, *Commonwealth Health Partnerships 2014* looks at these issues in detail and from various perspectives, as a contribution to the debate.

Adapted from a background paper prepared for Commonwealth Health Ministers Meeting (Geneva, May 2014).

Endnotes

- 1 Chan, M., 2012. Speech to the World Health Assembly, 23 May 2012.
- 2 World Bank, 2013. President of the World Bank speech to the World Health Assembly, 21 May 2013. Available at: www.worldbank.org/en/news/speech/2013/05/21/world-bank-group-president-jim-yong-kim-speech-at-world-health-assembly [Accessed 11 April 2014].

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Current Projects

- Cecilia Makiwane Hospital, Mdantsane, South Africa
- Lilitha Nursing College, Mdantsane, South Africa
- Frere Hospital New Oncology and ICU, East London, South Africa
- Sipetu District Hospital, Eastern Cape, South Africa
- Avenues Clinic Maternity Hospital, Harare, Zimbabwe
- Selborne Hospital, Bulawayo, Zimbabwe
- La Clinique Mauricienne Oncology, Port Louis, Mauritius
- Nampula General Hospital, Nampula, Mozambique



After six years of successfully executing health infrastructure development Sakhiwo has been branching out into other spheres of public sector infrastructure development.



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