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EDITORIALS

The 2030 sustainable development goal for health

Must balance bold aspiration with technical feasibility

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In the year 2000, 193 countries adopted the millennium development goals (MDGs), a milestone in global development. The eight goals were simple to grasp, measurable, and time bound, ending in 2015. Goals 4, 5, and 6 focused on reducing child, maternal, and infectious disease mortality, respectively, raising health to the top of the global agenda and mobilising new health financing.[1] Although the three health related goals are unlikely to be met, there has been substantial progress towards their achievement, particularly for infectious diseases.[2]

As the MDGs come to an end, a new set of sustainable development goals (SDGs) will be debated during the UN General Assembly that starts on 24 September 2014. These goals will have a 2030 end date. They could catalyse further transformations in global health.

An intergovernmental open working group is writing the new goals and has just published its first draft.[3] Whereas the MDGs were "'top-down goals' formulated by policy elites,"[4] the working group deserves credit for drafting the new goals using a bottom-up approach, based on wide ranging consultations. There is much to like in the draft: a strong focus on women, climate change, and the importance of technological innovation for human development. But in trying to please everyone, it reads as a long wish list. Fortunately, the first draft is not the last word and will be revised over the next year. We urge the working group to address important weaknesses.

Firstly, the draft tries to do too much. It has 17 goals and 164 targets; the single health goal (SDG3), to "ensure healthy lives and promote well-being for all at all ages," itself has 13 targets. Though we favour ambition, this first draft is overly expansive and lacks focus, making the overarching purpose of the goals unclear. They should be winnowed down to no more than 10 goals.

Furthermore, several targets are aspirational, unachievable, or inappropriate. Take target 3.2, to "end preventable deaths of newborns and under-five children," or target 3.3, to "end the epidemics of AIDS, tuberculosis, malaria." We know of no research showing that we can "end" these health crises within just 15 years. And for malaria, the WHO's focus for 2015-2030 will be on reducing deaths and cases and eliminating the disease from an additional 30 countries, not on ending malaria epidemics.[5]

Instead of setting unattainable zero targets, a more valid approach is to model the trajectory of mortality to 2030 under different degrees of health sector investment. For example, the Commission on Investing in Health modelled the effect of aggressively scaling-up existing and new tools for HIV, tuberculosis, malaria, maternal and child health, and neglected tropical diseases on mortality.[6] It found that scale-up could lead to a "grand convergence" by 2030—death rates from these conditions in poor countries could fall to rates seen today in high performing middle income countries. Early prioritisation of family planning, antiretroviral therapy, and vaccination would bring particularly large pay-offs. Yet even with these enhanced investments, by 2030 child mortality would still be about 27/1000 live births in low income countries. And though the mortality burden of AIDS, tuberculosis, and malaria would be greatly reduced, it would not be zero.

A third problem is that too many of the goals and targets are vague and unmeasurable. Consider SDG3—how will we measure progress towards "wellbeing for all"? We are strong supporters of publicly financed universal coverage of medical and surgical services in all countries, but target 3.8—"achieve universal health coverage"—is meaningless unless the package of services and the metric for measuring its coverage are clearly articulated.[7]

Another concern is that health plays second fiddle to other development goals, relegated to a single goal with no links to the other sixteen goals. Health is integral to sustainable development—better health boosts educational and economic outcomes[6]—and should be more explicitly linked with economic and social development.

Finally, substantial new financing will be needed to finish the "unfinished health MDGs agenda" and curb non-communicable diseases and injuries, yet the draft says little on where the money will come from. As low income countries become middle income, they will increasingly be able to fund health

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programmes themselves through economic growth. But they will still have large populations living in poverty: 70% of the world's poor are in middle income countries.[8] They will need to find new domestic sources of health financing, such as taxing tobacco and diverting fossil fuel subsidies to the health sector,[9 10] and may require transitional donor support to target their subnational "pockets" of poverty. Other countries, especially fragile states, will remain low income and reliant on aid through to 2030. Innovations in mobilising aid, such as "solidarity taxes" on airline tickets,[11] will be required to overcome the aid stagnation that has occurred since the global financial crisis.[12]

Could the SDGs be as influential as the MDGs? Yes—if the first draft can be transformed from utopian "fairy tales"[13] into a prioritised list of measurable goals, targets, and interim milestones that all countries can achieve, with a central role for health and new approaches to development finance.

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