

SDG 3

Ensure healthy lives and promote well-being for all at all ages

The “Health SDG”: Some progress, but critical concerns remain

BY DEVELOPMENT ALTERNATIVES WITH WOMEN FOR A NEW ERA (DAWN)

The final decisions on SDG 3, the “Health SDG”, occurred after intense, multi-cornered contestation among UN member states, the for-profit sector, civil society, and private foundations. Each of these groupings did not represent a single interest and there were many differences and schisms among them.

In the end these differences of ideology and interest were covered over, and the multiple MDGs on health were brought together under the single umbrella of SDG 3. SDG 3 has thus been claimed by champions of “universal health coverage” (UHC) to be a victory for an approach focused on strengthening public health systems. This is an important advance over the MDGs which treated health related goals separately, thereby operating to undermine a systemic approach. But the schisms are deep, and it is not clear whether they have genuinely been overcome, or merely papered over.

Among the major challenges bedeviling global health at present, the following are likely to be crucial in determining whether or not the SDG 3 targets are met, particularly Targets 3.7 and 3.8.

Funding

Funding for health, national and global, has been restricted ever since the 1980s – the early years of the neoliberal policy regime, with its cuts in national health budgets, its push towards privatization, and liberalization of regulatory structures. The years since then have witnessed a plethora of alternative

funding mechanisms that have led to disease-focused silos, however well-intentioned, at the expense of strengthening the health system overall, and also at the cost of insufficient attention to primary health care.

National funding restrictions have been matched in the last decade by a severe squeeze by key member states on core funding for the World Health Organization (WHO), perhaps because it is viewed as insufficiently open to private for-profit interests. The WHO is a bureaucracy with typical bureaucratic limitations and rigidities, all too easy to blame for inadequate responsiveness (as in the case of the recent Ebola crisis), but it must be remembered that its core funding has been under severe stress for too long, its morale undermined, and its role in setting norms and standards for global health under attack.¹

Private foundations have stepped into the breach, with the Bill and Melinda Gates Foundation (BMGF) becoming one of the largest health funders both within and outside WHO. While such funding has been welcomed by many in the climate of inadequate funding by UN Member States there is a severe accountability deficit as private funders are not accountable to anyone outside themselves.²

¹ Cf. Adams / Martens (2015).

² Cf. Martens / Seitz (2015).

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The tension between BMGF’s belief in technology-driven, disease-focused approaches focused on targeted ‘quick wins’, versus a comprehensive universal health care approach is embodied in SDG 3’s substantive targets, the majority of which seem to follow the former, while only Target 3.8 specifically talks about UHC. It may be argued that the implementation targets (especially Targets 3.b, 3.c and 3.d) complement the UHC target. The devil, however, is in the details. While Targets 3.1 – 3.4, and 3.6 are numerically specified, this is not true for the UHC-linked targets that are not quantitative but use vaguer verbs such as “strengthen”, “support”, and “substantially increase”. Round 1 seems to have gone against health systems strengthening.

Growing corporate influence

Corporate, for-profit influence in shaping global health agendas has been growing considerably in recent years, after being on the defensive during the intensive anti-corporate drive against breast milk substitutes and tobacco. Four large industries – big pharma, tobacco, alcohol and sugar (including soft drinks) – are deeply interested in how global and national health norms are determined. The tobacco industry’s fingerprints are already present in Target 3.a where the call to “strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries” has been qualified by the words “as appropriate”, which in UN language implies a significant watering down.

The “morphing” of for-profit interests from within the health sector into non-profit and philanthropic guises, raises many unresolved questions about accountability and where the lines lie between profit-making and non-profit benevolence. BMGF’s role and influence on health agendas has already raised many questions, but its own funding largely comes from outside the health sector. Not so in the case of Merck for Mothers, a 10-year, US\$ 500 million initiative focused on improving maternal health, that is an offshoot of one of the world’s largest pharmaceutical companies.³

3 Cf. <http://merckformothers.com>.

Starting in 2011, and made more urgent after the Ebola crisis, the WHO embarked on an effort to develop a Framework of Engagement with Non-State Actors (FENSA). Adopted by the 69th World Health Assembly (WHA) in May 2016, FENSA is meant to guide WHO’s interaction with both for-profit and non-profit organizations. It includes a general framework of engagement and separate policies for NGOs, the private sector, academic institutions and philanthropies, which cover participation, resources, advocacy, evidence, and technical collaboration. Early analysis suggests key weaknesses among which para 27bis may be the most problematic because it appears to water down due diligence and risk assessment. The suggestion of a pooled fund to avoid undue influence by individual donors was also dropped in the final agreement.⁴

Public-private partnerships (PPPs), including the proliferating number of global multi-stakeholder partnerships operating in the health sphere, are among the most under-regulated, unaccountable and poorly analysed of institutional mechanisms, not only in relation to large physical infrastructure projects, but also in the health sector. While PPPs may have differing objectives, their chief aims include improved efficiency and the provision of needed health products or services where these may not already exist. International product development partnerships in health have proliferated.⁵ While they may bring needed resources to the table when tackling major diseases, uneasy questions remain about conflicts of interest in the role of industry partners, donations in kind that require high national inputs, and take-over of national policy space.⁶

The European Commission’s Expert Panel on Effective Ways of Investing in Health adopted an opinion in 2014, based on a review of 15 PPP cases in European countries by an independent consultant, that

4 Cf. Gopakumar (2016).

5 Examples, some of which date back to the 1990s, include Roll Back Malaria, the PATH Malaria Vaccine, the Drugs for Neglected Diseases Initiative, Gavi, the Vaccine Alliance (the former Global Alliance for Vaccines and Immunization), the Global Fund to Fight AIDS, TB and Malaria, to name only a few.

6 Cf. www.who.int/trade/glossary/story077/en/.

“public disclosure of data and analyses behind PPP investments is very poor, inconsistent and not standardized. (...) The Expert Panel has not found scientific evidence that PPPs are cost-effective compared with traditional forms of public financed and managed provision of health care.”⁷ The above challenges may engender policy incoherence among the agreed targets of SDG 3, especially between the push for UHC (including for access to medicines as agreed in the Doha Declaration on the TRIPS Agreement of the WTO) on the one side and the growing influence of the private sector in relation to the first six targets, on the other. But this is not all.

The challenge of equity and equality

Target 3.8 seeks to achieve universal health care but (understandably perhaps) says relatively little about the pathways by which this should happen. Yet, there is growing concern that those pathways may be critical to determining whether those responsible for implementing the UHC approach, nationally and globally, limit themselves in the foreseeable future to picking low-hanging fruit, or tackles the more difficult challenges that confront the health of those at the very bottom of social and economic hierarchies.⁸ The UHC approach has traditionally been concerned with economic inequality and whether or not the health system protects and promotes the health of the poor. But, at the bottom of most socio-economic ladders, inequality is not only economic but is reinforced by such factors as gender, caste, race, ethnicity, disability, gender identity or sexual orientation to name some. This kind of intersectional inequality is often impervious to universalizing approaches, and requires specific targeted approaches. A complementary mix of the two types of approaches may be essential if the UHC pathways are not to bypass those at the very bottom.

Such complementarity would require more serious delving into the ways in which different root causes of inequality interact with each other, resulting in fun-

damental differences in the ways in which different groups interact with health systems. For instance, how families negotiate health insurance and who benefits the most from them is relatively under-researched. Issues such as violence or the threat of violence from intimate partners or in domestic settings may have many physical and psychological implications for children and women, but in most countries is rarely recognized as a public health concern, at least until recently. Those at the very bottom of caste or ethnic hierarchies may be especially at risk of disrespectful or abusive health care, but this is only weakly integrated, if at all, into the training of health providers. Suicide has become one of the main killers of adolescents but its roots in gender or other social systems of power are rarely viewed as concerns for UHC.

Inequality is one of the most important of the social determinants of health, but it is all too often wider than SDG 3 seems to recognize. An illustrative example is the case of adolescent girls. In 2010, six United Nations organizations – UNICEF, WHO, UNFPA, UNIFEM, ILO, and UNESCO – put out an unusual Joint Statement on *Accelerating Efforts to Advance the Rights of Adolescent Girls*.⁹ The six organizations were members of the UN Adolescent Girls Task Force, set up to fill a major gap in global policy direction. They recognized that “many of the 600 million adolescent girls living in developing countries remain invisible in national policies and programmes (...), live in poverty, are burdened by gender discrimination and inequality, and are subject to multiple forms of violence, abuse, and exploitation (...).”¹⁰

The statement identified five strategic priorities: education, health, freedom from violence, building leadership capacities, and strengthening the evidence base through better data collection, analysis and use. What was special about the Joint Statement was that it was the first of its kind on the subject. It brought together the heads of the UN agencies responsible for child survival, health, sexual and reproductive health and rights, gender equality, labour rights, and education and culture – all key to the survival

7 European Commission Expert Panel on Effective Ways of Investing in Health (2014), p. 36 and 39.

8 Cf. Sen/Govender (2015).

9 Cf. <http://unesdoc.unesco.org/images/0018/001871/187124e.pdf>.

10 Ibid.

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and well-being of adolescent girls. It also prioritized the needs of younger adolescents aged 10–14 years, who along with the pre-adolescent group (5–9 years), often slip through policy and programme cracks. Civil society organizations, and especially women’s organizations in many countries and globally,

had been highlighting the plight of adolescent girls for many years before the UN Joint Statement. But serious and concerted attention at the policy level is a recent phenomenon. Nor is this attention very consistent or sustained as yet. For instance, despite the attempt by UNFPA and others to push for a goal on

Targets for SDG 3

- 3.1** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- 3.2** By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
- 3.3** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- 3.4** By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- 3.5** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- 3.6** By 2020, halve the number of global deaths and injuries from road traffic accidents
- 3.7** By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- 3.8** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- 3.9** By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
- 3.a** Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
- 3.b** Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
- 3.c** Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
- 3.d** Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

adolescents as part of the SDGs, this did not come to fruition. Nor is the health of adolescents specifically mentioned in the targets of SDG 3.

Women's and girls' health and human rights

Target 3.7 of SDG 3, although not fully part of the UHC approach, marks a significant breakthrough for the many who have attempted to integrate the sexual and reproductive health and rights agenda into a larger health and rights agenda. To be included in the health goal instead of being segregated is indeed an advance. But achieving this target was no mean feat, against the concerted opposition of conservative religious forces.

The past three years have witnessed not only the intense discussions about the 2030 Agenda, but also the 20th year reviews of the International Conference on Population and Development (Cairo), and of the Fourth World Conference on Women (Beijing). The latter two were the site of continuing opposition by religious conservatives to women's human rights and especially to sexual and reproductive health and rights. In these battles women's and young people's groups formed strong alliances that included multiple and intersecting forms of discrimination in their key concerns, but very few of the health groups concerned mainly with economic inequality made common cause with them. Achieving Target 3.7 as part of the broader UHC agenda will be difficult in the face of conservative opposition unless broader alliances and coalitions are made.

Which way forward?

Among the key challenges to achieving SDG 3, we have identified four critical concerns: the problem of health funding in terms of both amounts and patterns; the poorly regulated and growing role of private parties taking multiple forms; the intersectional nature of inequality and the limitations of many current approaches to UHC focusing only or largely on economic inequality; and the challenge of the conservative religious opposition to women's human rights, and to sexual and reproductive health and rights generally.

SDG 3 represents some forward movement, but these four challenges must be tackled if “healthy lives and (...) well-being for all at all ages” are indeed to be achieved. Yet, health may be on the back-foot yet again if the failed efforts to make the FENSA agreement stronger with regard to relationships with non-UN partners, particularly in the corporate sector is anything to go by.

Much will depend in this somewhat gloomy scenario on the way in which civil society can mobilize to use the positive advances contained in some of the SDG 3 targets, and to push for policy coherence of other health actions and actors with these targets. Much will also depend on the ability of health groups with different antecedents and interests to make common cause to truly work towards “health for all”.

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