Health post-2015: evidence and power

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For **Global Burden of Disease Study 2010** see http://www.thelancet.com/themed/global-burden-of-disease

On Sept 25, 2013, the UN General Assembly held a special session devoted to progress on the Millennium Development Goals (MDGs) and the post-2015 development agenda. Building on more than a year of consultation, advocacy, and lobbying, the debate provides an opportunity to take stock of health-related proposals. Described as a generational opportunity, to what extent is evidence of the burden of ill health and early death setting the agenda?

The Global Burden of Disease Study 2010 (GBD 2010) arguably presents the best comparable estimates on the causes of death and disability and their underlying risk factors.[1] Non-communicable diseases (NCDs) accounted for two of every three deaths globally in 2010,[1] and projections indicate that by 2030 NCDs will be the most common cause of death in Africa.[2] Do the priorities and targets currently under discussion reflect the most rational use of this evidence?

For the health goals, a multistakeholder consultation in Gaborone, Botswana, in March, 2013, was complemented by the commissioned involvement of civil society, academia, and a global online consultation. The resulting evidence-informed, health thematic report proposed a framework for accelerating the MDG agenda, ensuring universal health coverage and access, and reducing the burden of NCDs.[3] This report was submitted to the UN Secretary-General's High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (HLP), which produced its own report.[4] As *The Lancet* noted, the HLP's proposed health goal—ensuring healthy lives—had a "weak" commitment to NCDs.[5] For example, GBD 2010[6] and other data[7] highlight the burden attributable to tobacco smoking, alcohol use, and poor diet. Yet these risks warrant no more than a cursory mention in the HLP report under a catch-all and vague target to "reduce the burden of NCDs".[4]

In July, 2013, the UN Secretary-General published *A Life of Dignity for All*[8] to inform discussions in the General Assembly debate. This report drew on a range of inputs including the HLP, the Sustainable Development Solutions Network, and the UN Global Compact and emphasised the importance of dealing with the unfinished MDG agenda. The burden of NCDs is briefly mentioned, with a particular focus on mental illness and road accidents, while the report's call to "promote healthy behaviours" did not include any NCD-related specifics, such as promoting healthy diets and moderating alcohol consumption.[8] The Secretary-General's report will have far-reaching implications for the post-2015 development agenda and it is therefore vital that the priorities are reflective of both current and future health needs. Yet the proposals do not seem to fully address what is needed to reduce major disease burdens.

How did this happen? We believe Steven Lukes' classic analysis of the "three faces of power" might be at play.[9] First, power as decision making suggests that those at the table compete to ensure their interests and concerns are reflected in an agenda. A review of the institutions involved in the health thematic consultation reveals the institutional path dependency within the global health community: institutions funded to push specific, often MDG-related, health issues. For example, of the 99 submitted papers reviewed for the health thematic report,[3] 15 were from civil society organisations that promote sexual and reproductive health and rights and five were from NCD-focused civil society groups.

Second, power as non-decision-making focuses on how certain issues are kept off the agenda by resourceful interest groups. The absence of any overt mention in the HLP's report of some leading global health risk factors—tobacco, alcohol, and poor diet—are an example of Lukes' second dimension of power. Global health has witnessed this aspect of power in relation to NCDs in the past. An independent committee of experts convened by WHO found that the tobacco industry deployed elaborate and secretive tactics over many years to divert the focus of WHO from NCDs.[10] Recent publications reveal that the tobacco and food industries share common strategies and tactics to influence health policy.[11]

Lukes identified "thought control" as the third and most insidious face of power. Here the existing order of things is accepted, even when it is not in people's interests. This face reveals itself less in the goal architecture (the *what*) of the post-2015 agenda but rather in the lack of concern with the proposed means (the *how*) to realise ambitious health outcomes in the

next 15 years. Although welcome attention is given to equity and human rights, the frames seem apolitical to date.

Addressing the global burden of disease, and promoting healthy lives, cannot be a function of the health system alone; it requires concerted cross-sectoral action supported by a range of global functions and global public goods. Legal and structural changes are required to reduce unhealthy exposure (eg, to tobacco) and maximise opportunities for healthy lifestyle choices. Holding countries to account for outcomes (eg, disease prevalence) is important, but the means of doing so are equally if not more so. For example, the Sustainable Development Solutions Network devotes one of three health-related indicators to NCDs, but it focuses exclusively on personal behaviour change as opposed to structural interventions.[12]

The HIV response has much to offer in relation to "the how".[13] People living with and affected by HIV took centre stage: they organised mass social movements that linked demands for change at national and global levels, they dismantled structural and social barriers, they articulated norms and standards in human rights terms and thereby removed the "discretionary" from development, and provided a framework of accountability which included monitoring of legal and policy environments. The movement also demanded that everyone enjoy the right to health, including the most marginalised and vulnerable populations, making it hard to claim "progress" by reference to national averages.

The international community faces a historic opportunity to ensure that health priorities truly reflect the health needs of current and future generations. If it is going to have any chance of success, it needs to pay more attention to the voices of those affected, to evidence-driven priorities, and to the politics of change.

Kent Buse, Sarah Hawkes
Political Affairs and Strategy, UNAIDS, 1211 Geneva 27, Switzerland (KB); and University College London, London, UK (SH)
BuseK@unaids.org

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