

SUSTAINABLE DEVELOPMENT GOALS

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SDG 3: Ensure healthy lives and promote well-being for all at all ages

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Health and Development

The WHO (World Health Organization) was founded in 1948 as a result of the first World Health Assembly, instigated by the then newly formed UN (United Nations). Since then, WHO's definition of health has remained unchanged. In defining health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", WHO took a holistic view of health that has seen remarkably little argument in over seventy years. WHO's charter frames health as a basic human right, a government responsibility, and as fundamental to peace and security, both within nations and globally. The WHO goal of *Health for All* was introduced in the Alma Ata declaration in 1978. In 2006 the concept of *Health in All Policies* (HiAP) was articulated, and in 2018 WHO recommitted to focussed action on *Health For All* in the promotion of global universal health coverage.

Until relatively recently, concepts of development rested on assumptions of capacity in so-called "first world countries", or the Global North, and deficit in so-called "third-world countries", or the Global South. Up until 2008 the focus of WHO was primarily in infectious diseases, tropical diseases, maternal and child health, and reproductive health. These were seen as performance indicators of a country's development progress, and improvement in these areas was linked to economic wellbeing and economic growth. These foci were also linked to global security, as infectious diseases and overpopulation in the Global South were understood to present security risks to the Global North. Critiques of the singling out of AIDS, malaria and tuberculosis in the MDGs (Millennium Development Goals 2000-2015) led to attention also being paid to what are referred to as the NTDs (Neglected Tropical Diseases). Health goals in the MDGs were framed within a deficit model, aimed at improvement in health systems and delivery in impoverished countries. From 2008, WHO World Health Statistics started to register a global shift in focus to include non-communicable diseases (NCDs) along with infectious diseases, leading to goals set in 2012 focussed on so-called 'life-style diseases' such as cardiovascular disease, diabetes, cancer and other non-infectious diseases that are major causes of death in the Global North. Within the SDGs (Sustainable Development Goals 2015-2030), SDG 3 incorporates health targets relevant to all countries, including the Global North as well as the Global South.

Health and Economics

Critics of activities of International Development agencies often cite harm to health as a negative outcome of economic strategies promoted by the World Bank and the International Monetary Fund (IMF). In many early economic development models, health spending was seen as a cost rather than an investment. This approach intensified in the 1970s and 80s under the influence of neoliberal economic policies. The austerity approach of

Structural Adjustment Programs (SAPs), where large loans were offered for economic development, frequently came with caveats that included slashing government spending in health, education and social services. According to many commentators, the slashing of existing services and crippling debt burdens imposed on developing countries through SAPs created unnecessary harms. Former World Bank economist Susan George published a number of scathing books highlighting damage caused by SAPs, including *How the Other Half Dies* (1974) and *A Fate Worse than Debt* (1988). More than three decades on, the similarity of the arguments made in Shrecker and Bamba's *How Politics Makes Us Sick: Neoliberal Epidemics* (2015) raise questions as to the extent to which global agencies have chosen to learn from their mistakes. Economist Jeffrey Sach's argument that health is a prerequisite to economic growth was incorporated into the MDGs. In the development of the SDGs/2030 agenda, Sach's point was inverted - without evidence - to suggest that economic growth is a prerequisite for health. This assumption is now embedded in the SDGs, contributing to what Brown labels the "oxymoron of sustainable development" (2015).

Along with a critique of the impact of neoliberal economic models on health, development health is critiqued for the ethnocentrism of the models of health promoted. Wedded firmly to biomedical approaches, development health is framed within individualised constructions of personhood that downplay the role of communities and often fail to address sociopolitical causes of ill health (Farmer 2005). Metric based indicators offer reductionist and often inaccurate understandings of health complexities. While the benefits that western medicine can bring to communities are undeniable, local health beliefs and practices, and localised knowledges, are often poorly incorporated into international health development projects, and cultural safety is often not a consideration in health project framing (Long et al 2017).

Global Health

While the MDGs focused on improving health in poorer nations, the SDGs incorporate all nations' health as part of sustainable development. In addition to this, the SDGs recognise health in the context of globalisation, and go at least part of the way to recognising the extent to which health statuses and outcomes of the Global North and Global South are intimately intertwined. Trade in commodities such as tobacco and sugar have had severe negative impacts on the health of both grower and recipient countries, as has the incursion of monocultural industrialised farming practices that sequester land previously used for subsistence food growing in poorer communities (often causing or exacerbating hunger and poverty-related diseases) in order to produce highly processed foods that contribute to life-style related disease in wealthier communities. Impoverished peoples in the Global South have long been used as test subjects in clinical trials for drugs that disproportionately benefit wealthier communities in the Global North. Global markets intersect with health in a multitude of ways, including: trade agreements and pharmaceutical availability; health workforce movement; internationalisation of reproductive technology services; medical tourism; food supply and control of arable land; water availability; and the disproportionate impact of climate change on those who have done the least to contribute to it.

SDG#3: Health

The 13 targets that underpin SDG3 aim to, by 2030:

- end* preventable deaths of newborns and children under 5 (SDG 3.2); AIDS, TB, malaria and neglected tropical diseases (3.3)
- reduce* global maternal mortality rate (3.1); premature mortality from non-communicable diseases (3.4); deaths and injury from road traffic accidents (3.6); deaths and illness from hazardous chemicals and pollution (3.9)
- combat* hepatitis, water-borne diseases and other communicable diseases (3.3)
- promote* mental health and well-being (3.4)
- support* research & development and accessibility of vaccines and medicines for communicable and non-communicable diseases (3.B); increase health funding and health workforce capacity (3.C)
- strengthen* prevention and treatment of substance abuse (3.5); implementation of tobacco Control Framework (3.A) and early warning, risk reduction and management systems (3.D)
- ensure* universal access to sexual and reproductive health programs (3.7)
- achieve* universal health coverage (3.8)

The targets that aim to end or reduce particular indicators are expressed in metrics (e.g. reduce maternal mortality to less than 70 deaths per 100,000 live births, or reduce non communicable disease mortality by one third). Most of the other targets are also tied to indicators expressed in metrics (e.g. for SDG 3.A.1: prevalence of tobacco use, is used as an indicator for SDG 3.A strengthening adherence to the tobacco framework), while some have indicators that are either more qualitative, or rely on more complex correlations (SDG 3.8.1: coverage of essential health services, is provided as an indicator for SDG 3.8: achieve universal health care).

Embedding of Health into all SDGs

While SDG3 focusses primarily on health interventions, health systems and health care delivery, WHO's HiAP (Health in All Policies) platform aims to ensure that health considerations are incorporated into all the SDGs. "The SDGs challenge us to move towards whole-of-government and whole-of-society approaches that leave no one behind" (SA Gov & WHO 2017). A key strategy within the UN's health agenda and HiAP rests on the social determinants of health, which are defined as "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries" (WHO 2008). While the social determinants approach has been widely heralded in public health circles, there is disquiet among social scientists about a set of principles that was developed in Europe being declared universal and then rolled out globally, with questions being raised about the neo-colonial nature of principles designed for industrialised societies being applied to non-industrialised and industrialising communities (Long et al 2017).

Gaps

The SDGs developed from the MDGs, aiming to continue the work begun by the MDGs, and to fill gaps identified in evaluations of the MDGs. While the SDGs are the most comprehensive and holistic set of development goals the international community has ever committed to, further gaps will inevitably be identified as the SDGs roll out. Gaps identified thus far include: the politics of food supply as crucial to health; the sparse attention paid to mental health; lack of conflict-related health issues in SDG3, including enormous challenges in health of displaced people; insufficient attention paid to nonbinary gender constructions; risk reduction strategies still heavily focussed on infectious disease, with insufficient attention to other threats including nuclear weapons and technologies; and the fact that climate change related health risks are not explicitly included in the health SDG. Furthermore, with only four of 230 SDG indicators specifically mentioning indigenous peoples, there is inadequate acknowledgement of the unique health challenges faced by descendants of colonised and dispossessed peoples.

Fundamental Flaw

As many commentators have noted, the fundamental flaw in the SDGs lies in the internal contradiction between the promotion of both economic growth and sustainability (Brown 2015, Spaiser et al 2017). The Brundtland Report *Our Common Future* (1987) defined sustainable development as "development that meets the needs of the present without compromising the ability of future generations to meet their own needs." According to the EU-funded Sustainable Development Advocacy Toolkit, "the report highlighted three fundamental components to sustainable development: environmental protection, economic growth and social equity. The concept of sustainable development focused attention on finding strategies to promote economic and social advancement in ways that avoid environmental degradation, over-exploitation or pollution." The Brundtland Report argued that development could be sustainable as long as the finite nature of resources was acknowledged. Key to finite-resource development is that rather than the Global South aiming for similar consumption levels to the Global North, the Global North must address overconsumption (SDG12 *Responsible Consumption and Production*). This strategy, whilst having some space within the SDGs, is embedded inconsistently. Particularly problematic are SDGs 8 & 9 (*Decent Work and Economic Growth* and *Industry, Innovation and Infrastructure*). While the term "sustainable" is used in these goals, some strategies advocated are underpinned by an assumption of abundant if not infinite resources, whereas sustainability is predicated on the assumption of finite resources. Economists attached to the growth model of development argue that science will solve resource shortages as they arise, however evidence suggests that this at best unevenly reliable and at worst wildly inaccurate.

The interaction of this internal contradiction with the Health SDG is as complex as it is with other aspects of the SDG development agenda. Unless strategies are shown to be sustainable, intergenerational health will be compromised. While many of the SDG Health targets are highly ambitious, and require significant levels of funding, unsustainable economic strategies directly and indirectly threaten health and health systems.

Early Achievements

Annual reporting from the first three years of the SDG implementation show continuing improvements in key indicators, including decreasing rates of maternal, child and infant mortality; adolescent births; AIDS/HIV, TB, NTDs (Neglected Tropical Diseases) and under-five Hepatitis B. There has been an increase in reported cases of malaria globally. Major continuing health risks flagged in the annual reports include unsafe drinking water, sanitation and hygiene; cardiovascular disease, cancer, diabetes and chronic respiratory disease; household and outdoor air pollution; healthcare costs; health workforce shortages; mental health and suicide; road traffic accidents; and addiction, including alcohol and tobacco.

One of the most significant achievements of the SDGs in terms of global health is the understanding that health is intimately intertwined with all aspects of development. The SDGs are “by design ... an integrated set of global priorities and objectives that are fundamentally interdependent” (ICS 2017). By challenging disciplinary silos, the SDGs have paved the way for two significant changes in ways development health is approached by the international community. Firstly, adoption of the SDGs means that health concerns can no longer be ignored in the interests of economic growth. Health impacts in areas as diverse as work practices, human trafficking, industrialised agribusiness, urban infrastructure, manufacturing and extractive mining cannot, under the SDG framework, be ignored. Secondly, while design and implementation of health policy and practice remains substantially within the realms of biomedical gatekeepers, rather than being a truly multidisciplinary endeavour, the imperative to understand broader interconnections between social and environmental impacts on health at a systems level is starting to be heard. For example, the recent publication in the *Lancet* - a bastion of biomedical empiricism - of a major commissioned piece of research into sustainable food systems (Willett et al 2019) could be the tip of the iceberg of a major paradigm shift that the SDGs have the potential to deliver within the global health community.

References

- Brown, James H., 2015. "The Oxymoron of Sustainable Development." *Bioscience* 65(10):1027–9.
- Brundtland Commission, 1987. *Our Common Future. The World Commission on Environment and Development* Oxford: Oxford University Press.
- Costanza, R., Fioramonti, L. and Kubiszewski, I., 2016. "The UN Sustainable Development Goals and the Dynamics of Well-Being." *Frontiers in Ecology and the Environment*, 14(2): 59.
- CSDH (Commission on Social Determinants of Health), 2008. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Geneva: WHO.
- DeLuca, Danielle, 2017. "What do the Sustainable Development Goals mean for indigenous peoples?" *Cultural Survival Quarterly Magazine* (December).
- Farmer, Paul, 2005. *Pathologies of Power*. Berkeley: University of California Press.
- Fukuda-Parr, Sylvia, 2016. "From the Millennium Development Goals to the Sustainable Development Goals: Shifts in Purpose, Concept, and the Politics of Global Goal Setting for Development," *Gender & Development* 4(1):43–62.
- Hawkes, Corinna and Barry M. Popkin, 2015. "Can the Sustainable Development Goals Reduce the Burden of Nutrition-Related Non-Communicable Diseases without Truly Addressing Major Food System Reforms?" *BMC Medicine* 13(143).
- ICS (International Council for Science), 2017. *A Guide to SDG Interactions: from Science to Implementation*. Paris: International Council for Science.
- George, Susan, 1974. *How the Other Half Dies: The Real Reasons for World Hunger*. London: Penguin.
- George, Susan, 1988. *A Fate Worse than Debt: The World Financial Crisis and the Poor*. London: Penguin.
- Long, Debbi, Paul Komesaroff & Elizabeth Kath, 2017. "Global Health and Development Practice," *International Development: A Global Perspective on Theory and Practice* Paul Battersby & Ravi Roy (eds) London: Sage.
- Meadows, Donella H, Dennis L Meadows, Jørgen Randers & William W Behrens III, 1972. *The Limits to Growth: A Report for the Club of Rome's Project on the Predicament of Mankind*. New York: Universe Books.
- Marmot, Michael, 2005. "Social Determinants of Health Inequalities," *Lancet* 365:1099–104.
- Marmot, Michael, 2015. *The Health Gap: The Challenge of an Unequal World*. London: Bloomsbury.
- Murray, Christopher, 2015. "Shifting to Sustainable Development Goals - Implications for Global Health," *New England Journal of Medicine* 375(15):1390–2.
- Ramcilovic-Suominen, Sabaheta & Helga Pulzl, 2018. "Sustainable Development – A 'selling point' of the emerging EU bioeconomy policy framework?" *Journal of Cleaner Production* 172:4179-4180.
- SA Gov & WHO (Government of South Australia & World Health Organization), 2017. *Key Messages: Progressing the Sustainable Development Goals through Health in All Policies: Case studies from around the world*. Adelaide: Government of South Australia.
- Sachs, Jeffrey D., 2015. *The Age of Sustainable Development* New York: University of Columbia Press.
- Schrecker Ted & Clare Bamba, 2015. *How Politics Makes Us Sick: Neoliberal Epidemics*. Basingstoke: Palgrave Macmillan.
- Spaiser, Viktoria, Shyam Ranganathan, Ranjula Bali Swain & David J.T. Sumpter, 2017. "The Sustainable Development Oxymoron: Quantifying and Modelling the Incompatibility of Sustainable Development Goals," *International Journal of Sustainable Development & World Ecology* 24(6):457-470.
- Wanner, Thomas, 2015. "The New "Passive Revolution" of the Green Economy and Growth Discourse: Maintaining the "Sustainable Development" of Neoliberal Capitalism," *New Political Economy*, 20(1): 21–41.
- WHO (World Health Organization), 1948. *Preamble to the Constitution of WHO* as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948. Geneva: WHO.
- WHO, 2006. *Constitution of the World Health Organization* (including 1977, 1984, 1994 and 2005 amendments). Geneva: WHO
- WHO, 2008. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva: WHO.
- WHO, 2013. *Helsinki Statement on Health in All Policies*. 8th Global Conference on Health Promotion, Helsinki, 10-14 June 2013. Geneva: WHO.
- Wilkinson, Richard and Michael Marmot (eds), 2003. *Social Determinants of Health: The Solid Facts* (2nd edn). Geneva: WHO.
- Willett, Walter, Johan Rockström, Brent Loken et al, 2019. "Food in the Anthropocene: the EAT–Lancet Commission on healthy diets from sustainable food systems," *Lancet* 393:447-492.