

Investing in health: why, what, and three reflections



When Dean Jamison proposed in 2012 that he and Lawrence Summers should reprise their work on investing in health—their 1993 World Development Report (WDR)¹ remains the only World Bank annual publication dedicated to health—it seemed a huge and daunting task. WDR 1993, as it came to be known, is surrounded in global health mythology. For some, it was a milestone in making the case for health to heads of state and finance ministers. For others, it opened the door to private sector colonisation of health care, a door that, once opened, could never be closed again. Whatever one's view, it is uncontroversial to say that WDR 1993 was a landmark document in health. Its 20-year anniversary deserves reflection.

But the reason we embraced the idea of a *Lancet* Commission on Investing in Health² was not merely to celebrate an anniversary. The landscape of global health today is utterly different from what it was 20 years ago. In 1993, there were no Millennium Development Goals (MDGs). The Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance did not exist. Bill Gates was still focused on putting a personal computer on every desk and in every home. And development assistance for health stood, in 2010 currency values, at US\$6.7 billion (in 2011 it was US\$28.4 billion). This steady growth in global health investments is now in a phase of uncertainty, a critical transition from the MDG era to a new epoch of sustainable development. The global health community has worked hard to make the case for health as a post-2015 development goal. But the case has not yet been finally won, and there is an urgent need to deliver more convincing arguments to Presidents and Prime Ministers about why they should continue to invest in health as a development priority.

Although the MDGs have been a successful means to achieve health advancements since 2000, many countries have been excluded from those successes. Take mortality in children younger than 5 years. Spectacular improvements in child survival have taken place since 1990: under-5 deaths have fallen from 12.6 million in 1990 to 6.6 million in 2012. But almost half of that improvement comes from just two countries—India and China. 38 countries have seen either increases or no change in absolute numbers of under-5 or newborn deaths. The time seems right to step back and take an

impartial look at the larger case for continuing to take health seriously as a global political priority.

Two questions may be worth asking as one contemplates the future for human development. First, why should a head of state invest in health? Second, what specifically should that head of state invest in?

For those of us in the health community, health matters because it addresses the burden of preventable disease in our populations. It meets the goal of a person's right to the highest attainable standard of health. And achieving health equity is an important dimension of social justice. But these arguments are often insufficient to convince finance ministers, who might have many competing and important demands on their budgets. Other arguments need to be marshalled. They can be summarised in this way. Besides improving health, investing in health is also an investment in prosperity, social and financial protection, and national security. What our Commission also underlines, in an original and compelling way, is that investing in health means investing in a quality human beings value deeply, but which we do not capture well in our usual measures of development, such as gross domestic product. A fuller accounting of health, as the Commission shows, reveals its broader significance, which we each hold true.

Let us assume that we have won the argument that health matters. What should a head of state now choose to invest in? Without doubt, there is an

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unfinished MDG agenda to pursue—at a minimum, maternal, newborn, and child health; nutrition; and HIV/AIDS, tuberculosis, and malaria. One must add to this manifesto the emerging epidemic of non-communicable diseases. And the global health community has now enthusiastically adopted universal health coverage as an additional (perhaps the) ideal goal that combines health-system strengthening, the right to health, and the social determinants of health into a single global health objective. But although there is much consensus on these investment choices, there is wide disagreement about their implementation. The multiple vertical initiatives that define global health today frequently cause huge frustration in countries. Moreover, there are now many global health actors—the private sector, non-governmental organisations, and new global health institutions—all of whom continue to apply their different strategies and processes to countries, and who unfortunately also change their plans to suit donor requirements. What a country wants is not a series of new donor-driven initiatives. It wants development partners to invest in a plan that has been devised by the country itself, one that meets the country's unique needs. Too many partners pay only lip service to the wishes of countries, launching initiatives that do not put countries and their peoples at the centre of each stage of discussion and planning.

Perhaps worse still, the global health community has not persuaded decision makers that universal health coverage is the best investment opportunity post-2015.

An influential group in the development community see universal health coverage as too complex and nebulous to be a sustainable development goal. That criticism is fair. We in the health community have so far failed to identify attractive indicators for universal health coverage, indicators that are politically meaningful, easy to communicate, understandable to non-health experts, and for which reliable data can be found. Until we meet these expectations, universal health coverage will stumble.

There are three further issues to consider as we reflect on the findings and recommendations of our Commission on Investing in Health.

When the UK Government this year had £1 billion to spend on development aid, what did it choose to invest in? The health of women and children? No. Non-communicable diseases? No. Universal health coverage? No. The UK chose the Global Fund. Why? Because the Global Fund is a trusted, effective, and efficient vehicle for disbursing valuable development investments. This fact raises a neglected question across the entire spectrum of global health. What institutions are necessary, globally and nationally, to ensure that investments in health are used to their maximum effect? The global health community has paid far too little attention to these institutional questions. The first challenge, therefore, is a clear statement about the necessary institutional functions that must be fulfilled to ensure investments work for those they are intended to benefit. Without that institutional analysis, the investment case for health will be incompletely realised.

We see at least six institutional functions that must be satisfied. First, institutions for information. These informational functions range from adequate health information systems to knowledge generation and transfer institutions, such as schools and universities. Second, institutions of deliberation—parliaments, the media, civil society, and even the judiciary. These deliberative mechanisms enable countries to create participatory and transparent means to debate national priorities. Third, institutions of finance for the efficient allocation of investments in health. Fourth, institutions of stewardship: the organisational structures that ensure adequate leadership and management of the health system and non-health sectors that contribute to health. Fifth, normative institutions that set standards, produce guidelines, ensure best practices,

and strengthen the quality and cost-effectiveness of preventive and treatment services offered by the health system. And finally, institutions of independent accountability—monitoring, reviewing, and remedying deficiencies in the health system. These institutional functions deserve our greater attention, which would allow space for the proper discussion of a broader set of political determinants of health.

A second contextual issue is the notion of sustainable development itself. The global community has yet to comprehend fully what sustainable development means. It is an entirely different concept from poverty reduction, the overriding objective of the MDG era. Sustainable development is about all of us, not some of us. It is about taking the health of future generations as seriously as we take our own. And it is about rethinking the economic models on which our present highly consumptive societies depend. The kind of economy one needs to deliver sustainable and inclusive development is likely to be very different from the economy of today.

The third and final contextual issue is the meaning of health itself. We believe we need to move beyond the concept of global health towards the broader idea of planetary health. Planetary health includes global health, but it adds two further dimensions. One is the health of

the physical planetary systems our species depends upon for life. Another is the health of the human civilisations we have created (and which, as history attests, can so easily collapse). The “health” of these two systems can be summed up in a single word—resilience. Investing in health means investing in resilience. Health without resilience is unsustainable. Resilience without health fails to satisfy one of the most important human qualities we value—which our Commission on Investing in Health at last makes so abundantly clear.²

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- 1 The World Bank. World development report 1993: investing in health. Washington, DC: World Bank and Oxford University Press, 1993.
- 2 Jamison DT, Summers LH, Alleyne G, et al. Global health 2035: a world converging within a generation. *Lancet* 2013; published online Dec 3. [http://dx.doi.org/10.1016/S0140-6736\(13\)62105-4](http://dx.doi.org/10.1016/S0140-6736(13)62105-4).

Reinvesting in health post-2015

During the past few years we have jointly forged a strong case for health and its links to sustainable development in the post-2015 agenda, with an overarching goal that seeks to maximise health at all stages of life, and with universal health coverage and access as the key means to its achievement. We have acknowledged the need to accelerate progress on the current Millennium Development Goals; to broaden the agenda to encompass non-communicable diseases; and to give more prominence to sexual and reproductive health, with particular emphasis on the health of adolescents.

The review of, and lessons learned, in the past 20 years since the launch of the World Bank's 1993 World Development Report, *Investing in Health*,¹ is strategically important and timely. Since the early 1990s, health gains and economic progress have been extraordinary.

The number of people living in low-income countries has fallen from 3.1 billion people (57.8% of the world's population) in 1990 to 820 million (11.7%) in 2011, and much of the world's poor population now lives in middle-income countries. For the first time in history most countries see their citizens living longer, and fewer of their babies and infants dying unnecessarily. Life expectancy in such countries as China, Ethiopia, Mexico, and India has almost doubled. These are transformational shifts.

So clearly we are on the right path. The results of both the *Lancet* Commission on Investing in Health² and the Global Investment Framework for Women's and Children's Health³ make a powerful case that the full impact of health investments goes beyond gross domestic product (GDP) to the value of being alive and well, the most basic human right of all: when



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