

Setting goals for health in a time of prosperity

Millennium Development Goals for the world's poorest nations need to be matched by Health Priority Goals for prosperous nations, to relieve the burden of wealth-related disease

We have a set of clear and challenging goals — the Millennium Development Goals, adopted by the United Nations in 2000 — to improve the health of the poorest 760 million people on earth,¹ but none for health development for the rest of us, and it is time that we did.

Twelve per cent of the world's population, inhabiting 50 countries, live on US\$3 a day or less.² Four and a half billion people live in less impoverished circumstances in Asia (excluding Japan), Latin South America, the Caribbean and some of Africa.¹ Their countries have built the economic, legal and political infrastructure to attract investment, and they have achieved prosperity through the commercial, industrial and financial processes of global market participation. Birth rates and infant mortality have fallen, life expectancy has risen, and infectious diseases have been brought more or less under control. A further 1.2 billion people live long and prosperous lives in economically sound nations. Let us call these three groups Worlds A, B and C.

The health needs of World A are those of people caught in desperate poverty, where infant and maternal mortality is high, infectious disease is out of control, and essential medical care for readily cured life-threatening illness is hard or impossible to obtain. HIV, malaria, respiratory and gastrointestinal infections and tuberculosis are the warlords that molest and kill.

In 2000, the UN adopted the Millennium Development Goals to help World A gain its feet. The Millennium Development Goals called for global assistance through debt relief, direct aid, and scaling up of critical infrastructure, to cut in half the prevalence of abject poverty by 2015.³

The Millennium Development Goals correctly and appropriately concentrate on infant and maternal deaths, HIV and other diseases, but there are things that should be done now to prevent future chronic disease epidemics, for example, in tobacco control. For US\$70 billion a year, less than the cost to the United States of the Iraq war, it would be possible to put in place a graded program of infrastructure development and community strengthening as a springboard for health gain and development. Part of poverty entrapment is health entrapment, and it may be easier to tackle this than try regime change as a means of social uplift.

Although World A struggles desperately, it is now on the global radar. International aid agencies commit most of their resources to its relief. The Group of Eight (G8) summit recently agreed to a doubling of aid for Africa by US\$25 billion a year by 2010, as part of an overall increase of US\$50 billion for all developing countries. The G8 partners also cancelled 100% of the multilateral debts of the Highly Indebted Poor Countries.⁴ No one who understands the Millennium Development Goals claims that money is the whole answer, but while not sufficient, it is necessary.

World B, meanwhile, is coming to terms with the impact of diseases that stem from the urbanisation, changing diet, tobacco, and transport changes that characterise their growing

prosperity. Birth rates and infant mortality have fallen, and life expectancy is converging on that of World C, so that the global average life expectancy today is 65 years.¹ Cardiovascular disease is now *the* truly global disease, evenly spread through Worlds A, B and C.

World C has succeeded in pushing cardiovascular disease (both its death toll and much of its morbidity) into people's late 70s and beyond. Not so in World B, where a third of deaths and suffering from cardiovascular disease occur among men and women, of working age.⁵

While the needs of World A are now on aid agendas, those of World B receive scant attention. Heart disease and stroke top the list of causes of disease burden worldwide. While the World Health Organization, the World Bank and the International Monetary Fund (to a lesser extent) have been steadily producing regional and national reports on the continuing and serious illnesses afflicting World B, no global commitment equivalent to the Millennium Development Goals has yet been proposed. As a result, efforts to control these problems are poorly directed and effective interventions all too rarely applied.

A different set of goals — Health Prosperity Goals — is needed for World B. These goals should specify cuts in the toll of chronic disease, which is rising in developing countries. Specifically, smoking should be reduced by 20% in 10 years, and death from cardiovascular disease among people aged under 65 should be reduced by 15%. These goals could be discussed with town planners, food producers and retailers, insurers, employers (whose workforces cardiovascular disease adversely affects), unions (whose members suffer from cardiovascular disease), doctors and nurses, ministries of finance, educators, and the other people who must help us define the problem and solve it.

Four benefits would follow from articulating a set of Health Prosperity Goals that would clearly define our intentions and bring to global attention the need to act on these conditions.

First, Health Prosperity Goals would redirect us from repeatedly describing the size of our current health problems to concentrating thought on how to relieve them. To take cardiovascular disease again, we do not need to prove repeatedly that it is a serious problem. More to the point, we know we can achieve much through programs that manage people at elevated risk medically, combined with efforts to modulate the social and economic forces that promote those risks. Let us therefore aim for a 15% reduction in death from heart disease in people aged less than 65 by 2015 throughout Worlds B and C.

Second, Health Prosperity Goals would establish accountability. Those who manage health programs then have an aim for which the community can hold them accountable.

Third, we might frame the Health Prosperity Goals so that they specify broad strategies, based on evidence of effectiveness, but leave the details to individual nations to determine.

Fourth, by concentrating on intervention, we will see how crucial it is that those involved in producing prosperity and its

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untoward side-effects contribute ideas and support to preventing and relieving those side effects. Discussion with city planners, developers, insurers, employers, union representatives, and non-government organisations may lead to a redefinition of health problems such as cardiovascular disease and proposals for their solution that introverted public health professionals, meeting in closed seminar rooms, might not think of in a decade.

Stephen R Leeder

Professor of Public Health and Community Medicine; and
Director, Australian Health Policy Institute
University of Sydney, Sydney, NSW
steve@med.usyd.edu.au

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- 4 G8 Gleneagles 2005. Tony Blair makes statement to Parliament on the G8 summit. Available at: <http://www.g8.gov.uk> (accessed Jul 2005).
- 5 Leeder S, Raymond S, Greenberg H, et al. A race against time: the challenge of cardiovascular disease in developing economies. New York: The Center for Global Health and Economic Development, 2004. □