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The United Nations Sustainable Development Goals: Achieving the Vision of Global Health with Justice

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“We are resolved to free the human race from the tyranny of poverty and want and to heal and secure our planet” (UN General Assembly, 2015, September 25, preamble). So pronounced the 2030 Agenda, the United Nations declaration on the Sustainable Development Goals (SDGs), adopted on September 25, 2015, succeeding the Millennium Development Goals (MDGs). If achieved, the SDGs will secure an improved level of health, development, and global justice. However, if the international community fails to live up to its commitments, an untold number of people will likely perish prematurely, people’s opportunities to thrive will be cut off, social dynamics will continue to leave people behind, and unsustainable environmental pathways will create risks to the health and well-being of generations to come.

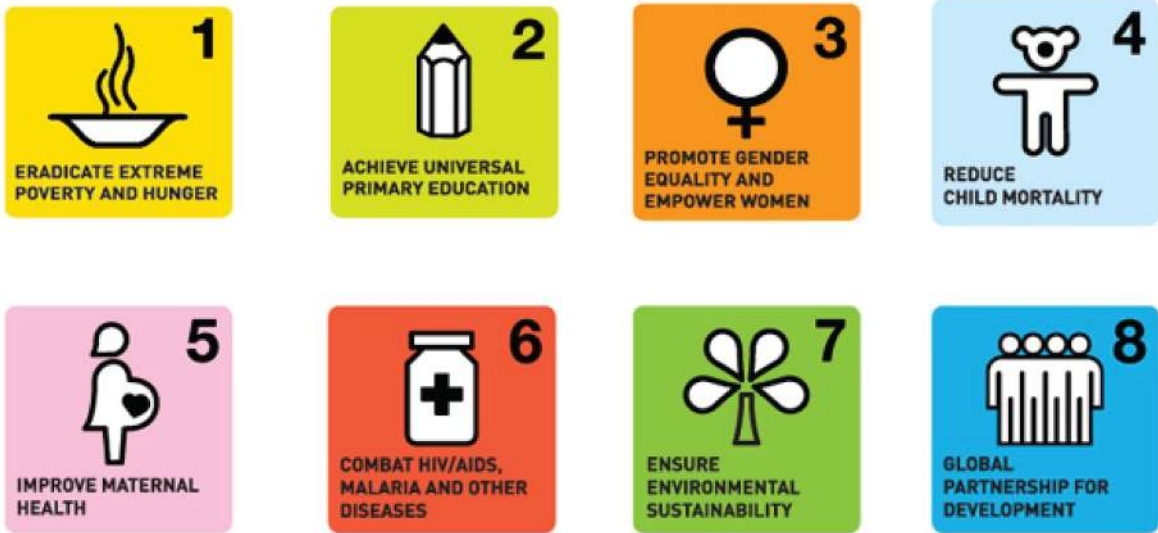
Here, we systematically review the MDGs—specifically, their formation, achievements, and shortcomings. Next, we review the transition to the SDGs—how they differ from the MDGs, some of the critical challenges they present, and suggestions for a response to these challenges, using a human rights-based approach. Finally, we will offer early markers to assess whether states are sincere in their commitment to longer, healthier lives for all, and offer a next step to ensure that commitment: a global health treaty based on the right to health—embodying the vision of global health with justice.

From the MDGs...

The MDGs were built on a series of UN conferences in the 1990s. With the Cold War over, the international community sought to establish a shared global agenda on human progress in such critical spheres as children’s health, education, and women’s rights.

The UN Millennium Declaration of 2000 captured the commitments of the preceding decade, but came at a time of declining international aid. The United Nations feared that those commitments could “slip into oblivion” (Rippin, 2013, p. 7). To prevent this, the United Nations, World Bank, International Monetary Fund, and the Organization for Economic Co-operation and Development convened an inter-agency group to develop motivating targets, which would become the MDGs. Captured in a September 2001 report by UN Secretary-General Kofi Annan, the MDGs were not endorsed by the UN General Assembly until 2005, and continued to evolve until a final framework was agreed upon in 2008, with 8 goals, 21 targets, and 60 indicators (Rippin, 2013).

Millenium Development Goals (MDGs)



The MDGs focused on social development, including reducing poverty and hunger (halving the proportion of people, between 1990 and 2015, who live in extreme poverty and who suffer from hunger), expanding education (achieving universal access to primary The Georgetown Public Policy Review

education), promoting gender equity (e.g., eliminate gender disparities in primary and secondary education), protecting the environment (e.g., significantly reducing the rate of biodiversity loss by 2010), developing global partnerships (e.g., providing affordable access to essential drugs in developing countries, and developing an open, rules-based, predictable, non-discriminatory trade and financial system), and most of all, improving health (e.g., reducing maternal mortality by three-quarters between 1990 and 2015, halting and beginning to reduce the spread of HIV/AIDS, halving the proportion of people without sustainable access to safe drinking water and basic sanitation). Targets were adopted using the arguably dishonest baseline year of 1990, allowing for a head start in assessing progress given the advances already made by the time the goals were set. The targets typically represented what would be achieved by 2015 if trends of the 1970s and 1980s continued. In that respect, the targets required only business as usual, a low ambition. Still, progress slowed during the 1990s, so achieving the goals nonetheless required unanticipated accelerated progress.

By contrast, a human rights-based approach would have linked goals to what countries could achieve if they devoted their maximum available resources towards securing rights for their people, as required by the International Covenant on Economic, Social and Cultural Rights. Further, a human rights-based approach, which would be based in the legally binding human rights obligations associated with the MDGs (the right to health, the right to education, and so forth) and in line with established human rights principles, could have brought to the goals missing dimensions of equity, people's participation in decisions that affect their health and other rights, and greater accountability (World Health Organization, n.d.[b]), as well as the view of development assistance as an obligation, not simply an act of goodwill. More than they were, the MDGs might have been not a technical developmental challenge, but a means of empowering people to claim their rights.

The MDGs captured the global imagination – particularly that of the global health development community. Official Development Assistance (ODA) increased from 0.23% of gross national income (GNI) in 1999 to 0.32% in 2010 for Development Assistance Committee members of the Organization of Economic Co-operation and Development (Rippin, 2013), though slipped afterwards (Organization of Economic Co-operation and Development, Development Co-operation Directorate, 2015), and never approached the United Nations' 0.7% target. Global health assistance (from all sources) tripled from \$12 billion in 2001 to \$36 billion in 2013 before falling in 2014. Increased HIV/AIDS funding,

enabling tremendous progress, helped drive the overall increase, though other vital investments, such as maternal health and health system strengthening, lagged, increasing at lower rates (Dieleman, et al., 2015). Domestic health financing in low-income countries also tripled (World Health Organization, 2015b, p. 134-135).

With new money came new funding mechanisms focused on MDG goals, prominently the GAVI Alliance (vaccinations), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and a new Global Financing Facility in July 2015 to finance women's, children's, and adolescents' health. The increased funding also led to formal efforts to change the approach to development financing, specifically the Monterrey Consensus of 2002 and the Paris Declaration on Aid Effectiveness (2005) and their successors. These agreements contained principles of country ownership, alignment, and mutual accountability, representing steps towards transforming the traditional donor-recipient relationship into a partnership for development. The MDGs also brought greater focus on achieving measurable health outcomes.

“The Millennium Development Goals captured the global imagination, but may have achieved more with greater resources, a rights-based approach, and greater attention to equity.”

These efforts accelerated progress globally, demonstrating that the MDGs helped mobilize greater political will and resources. However, this was not a universal phenomenon. Progress varied considerably by country and MDG target. Improvements accelerated most in sub-Saharan Africa, a region where external development assistance is particularly important, suggesting that accelerated progress may have reflected more the MDGs' effect on development partner priorities than on national agendas (Rippin, 2013).

While several of the most prominent MDG targets were achieved, including halving the proportion of people living in extreme poverty and without access to clean water, others saw significant progress that still fell well short of the targets, such as cutting child and maternal mortality, expanding AIDS treatment coverage, and access to primary education. From a decline in the under-five mortality rate by more than half (though short of the two-third reduction target) to a 40 percent decline in new HIV infections from 2000 to 2013, the MDGs likely helped save millions of lives (UN Secretariat, 2015).

Yet more might have been achieved with more funding and greater political will – along with the social empowerment that a human rights-based approach could have facilitated. Progress in certain areas lagged, including in gender equity, the environment, and access to improved sanitation. More granular goals, rather than aggregate targets, could have helped close vast domestic inequalities. Glaring health gaps between the rich and the poor within and among countries have persisted (Garay, 2015). A 2010 UNICEF analysis found that in a majority of 26 developing countries with decreasing child mortality, differences in child mortality rates between the richest and poorest households had increased (UNICEF, 2010, p. 23). Also absent from the MDGs was a process “of accountability for meeting goals in an equitable, transparent and participatory manner that promotes sustained institutional change” (Yamin, A., & Fukuda-Parr, 2011).

The MDGs had demonstrated their value, galvanizing resources and political will towards shared global development goals, and beginning to shift the development dynamic away from one of an asymmetric donor-recipient dynamic to one of partnership and mutual accountability. Still, they might have achieved more with greater resources, attention to neglected areas within the MDG agenda (such as a fairer trading system) and those not included (like corruption and governance), a rights-based approach, and greater attention to equity.

...to the SDGs...

The relative success of the MDGs led to an early global understanding that post-2015 goals would be needed, reflecting an expanded agenda and lessons learned from MDG weaknesses (Williams, 2011). The SDGs differed from the MDGs in a number of significant ways.

First, the SDGs were developed not by a group of experts but by an unprecedented global priority-setting process, engaging more than a million people around the world through global surveys, reports, and consultations in nearly 100 countries (UN Development Group, 2013). While an Open Working Group on Sustainable Development was government-led, it also included input from thousands of organizations (UN Sustainable Development Knowledge Platform, n.d.). The broad-based process contributed to a more expansive agenda, reflecting a broader scope of people’s priorities, and has created the potential for a broader sense of global ownership of the

MDGs, with the potential to increase commitments of governments and the engagement of people in pressing for government accountability.

Second, while the MDGs sought to lift health and development primarily in low- and middle-income states, the SDGs aim to transform health, development, and environmental standards for every country—rich or poor.

Third, and closely related to the first two changes, the SDGs' expanded scope and more open process of developing them, led to an increase in the number of goals and targets from 8 and 21 to 17 and 169, respectively. The SDGs encompass three dimensions: social, such as ending poverty, improving health and education, and achieving gender equality; environmental, such as action on climate change and protecting terrestrial and marine environments; and economic, such as economic growth, full employment, and resilient infrastructures. Several goals encompass multiple dimensions, including reducing inequality and building more peaceful, just, and inclusive societies.

“Ironically for a document framed around leaving no one behind, some goals risk inadequate focus on the most vulnerable.”

Fourth, the SDGs' goals and targets for health are both fewer and more expansive than the MDGs. Unlike the MDGs, which had three express health goals, SDG 3 (ensuring healthy lives and promoting the well-being for all at all ages) is the only explicit health goal. However, other goals address underlying determinants of health, including food, water, sanitation, housing, and sexual and reproductive rights. The MDGs focused mainly on discrete health concerns often subject to vertical interventions, such as AIDS, tuberculosis, malaria, and maternal and child health. The SDGs not only incorporate many of the same disease-specific targets, but also cover complex multifactorial diseases and health determinants, such as mental illness, non-communicable diseases, pollution, road safety, and more. Other targets address the Framework Convention on Tobacco Control, health financing and the health workforce, research and development, and managing national and global health risks. The health targets vary in precision. Some are numeric targets; others offer little more than issues on which states should make progress. Several have end-state goals (ending AIDS and other epidemics, ending preventable child deaths); others do not. Another health target, universal health coverage, is a critical means towards achieving other SDG 3 targets.

Health MDGs



4

REDUCE CHILD MORTALITY

A: Reduce the under-five mortality rate by two-thirds



5

IMPROVE MATERNAL HEALTH

A: Reduce the maternal mortality ratio by three-quarters
B: Achieve universal access to reproductive health



6

COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

A: Halt and reverse the spread of HIV/AIDS
B: Achieve universal access to treatment for HIV/AIDS
C: Halt and reverse the incidence of malaria and other major diseases

Direct Health SDG



3

GOOD HEALTH AND WELL-BEING

A: Reduce the global maternal mortality ratio
B: End preventable deaths of newborns and children under 5 years of age
C: End current epidemics and combat communicable diseases
D: Reduce premature mortality from non-communicable diseases
E: Strengthen the prevention and treatment of substance abuse
F: Halve the number of global deaths and injuries from road traffic accidents
G: Ensure universal access to sexual and reproductive health-care services
H: Achieve universal health coverage
I: Reduce deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

And fifth, the SDG agenda includes commitments to accountability at national, regional, and global levels. Standards include respect for human rights, inclusive decision-making, participatory engagement, and transparency, with a focus on populations furthest behind in terms of health and well-being. States must periodically review progress, identifying gaps, recommending solutions, and mobilizing partnerships. Globally, a High-Level Political Forum on Sustainable Development will review progress annually through ministerial level meetings, and every four years through heads of state meetings. However, the SDG agenda includes repeated caveats that its follow-up and review processes are voluntary, and the process fails to require independent monitoring of progress and failures.

For all the goals' breadth, several gaps stand out. Ironically for a document framed around leaving no one behind, some goals risk inadequate focus on the most vulnerable. To their credit, the SDGs include far more on equity than their predecessors, with a goal on reducing inequality and several targets specifically focused on the most disadvantaged. Yet many targets lack this direction, including the health targets, creating the risk that pathways towards universal health coverage and progress on particular health challenges will leave the poorest behind.

Indirect Health SDGs



Meanwhile, no target specifically addresses one of today's most urgent challenges, which shows no signs of abating: the mass of refugees and internally displaced populations. As migrants face enormous risks to their health and their personal and economic security, mass migrations are inherently connected to the aims of the SDGs. For example, about one in five people in humanitarian crises suffer from mental illness, having experienced war or other trauma and the multitude of stresses of life as a refugee, yet they often lack access to treatment (Halawi, 2016). A worldwide study of tuberculosis in migrants found that forced migrants were 50% more likely to be infected than economic migrants, likely due to refugees' poorer overall health and nutritional status, along with the poor living conditions and other circumstances of refugees (International Organization for Migration, n.d.).

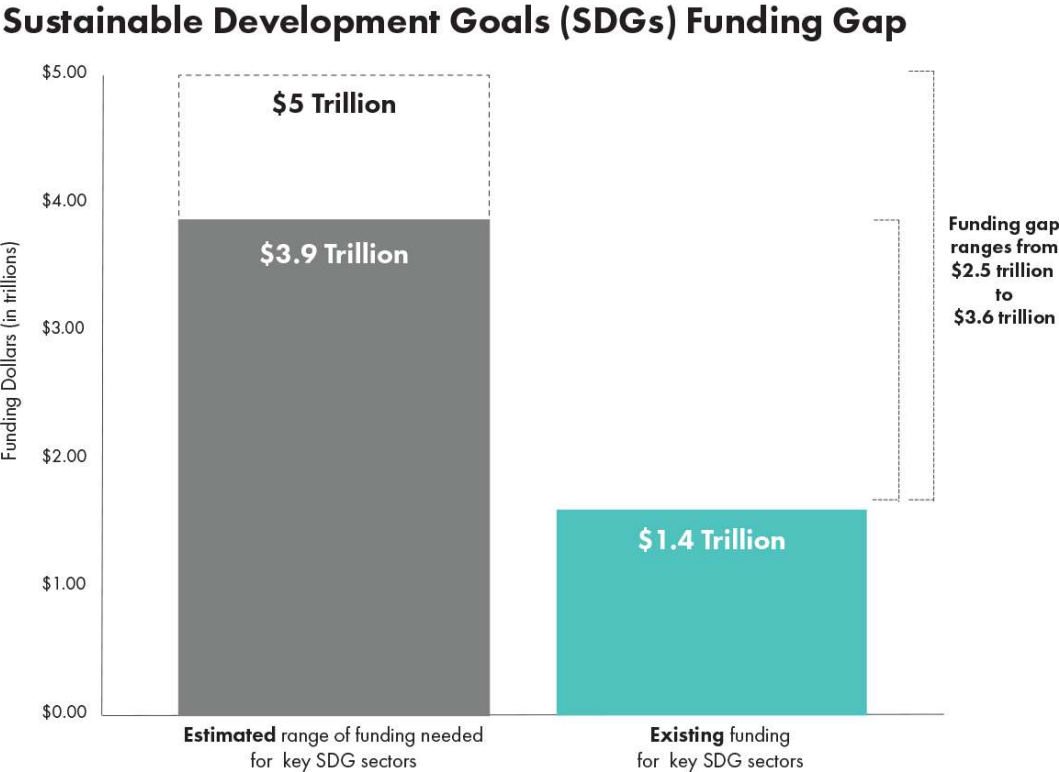
Further, while its principles emphasize respect for human rights, the SDG agenda missed an opportunity to more fully ground the SDGs and their accountability mechanisms in human rights. More thoroughly incorporating equity throughout the goals and targets, insisting upon inclusive participation in the budgeting and policymaking processes, and

calling for mechanisms to enhance accountability to human rights, including linking to existing human rights accountability structures, would have strengthened the SDGs.

Challenges and Pathways

Achieving the SDGs’ bold vision would be historic. Yet the challenges remain immense (Gostin & Friedman, 2015).

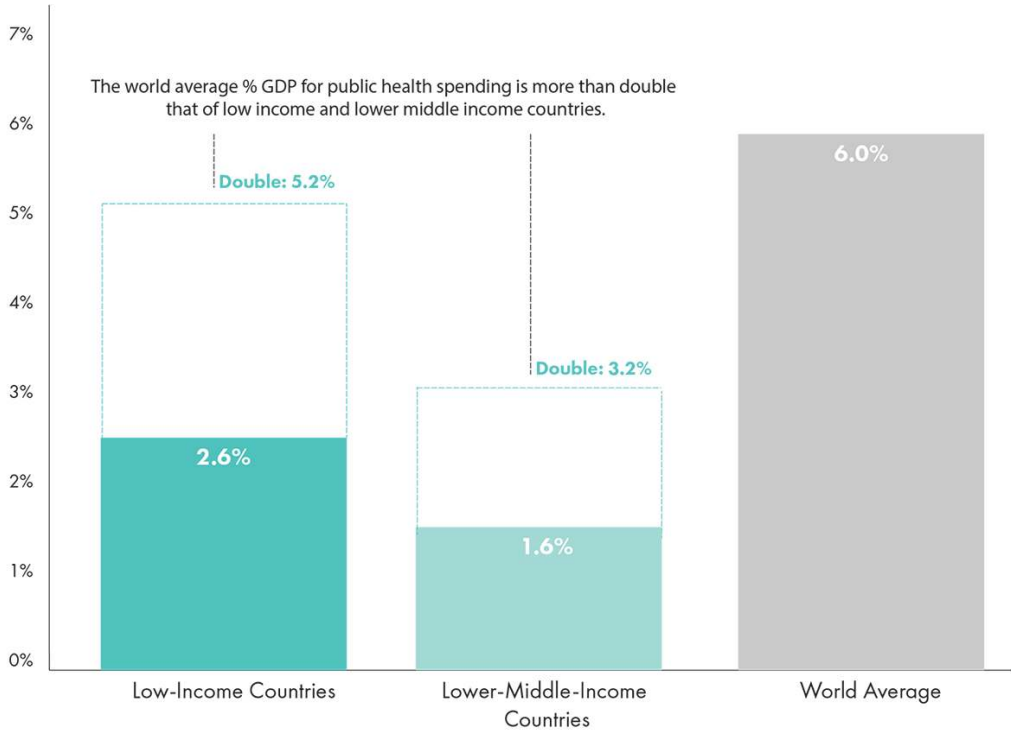
Cost: Enormous investments are needed to achieve the SDGs, with an estimated \$4-5 trillion needed annually for infrastructure, such as water and sanitation, agriculture, clean energy, transportation, and telecommunications, and tens of billions each for such areas as health, food security, and education (UN Intergovernmental Committee of Experts on Sustainable Development Financing, 2015). By one measure, a \$2.5 trillion funding gap now exists for key SDG sectors (UN Conference on Trade and Development, 2014). The United Nations expects that much of the funding will need to come from the private sector (UN Conference on Trade and Development, 2014). Yet with the private sector’s need to turn a profit and its primary allegiance to stockholders, its role in financing risks undermining a commitment to the poorest, with the least ability to pay.



Source: United Nations Conference on Trade and Development, June 23, 2014

A series of financing measures could secure considerable new funding for health, such as African leaders adhering to their Abuja Declaration pledge to devote 15 percent of their budgets to the health sector, with governments elsewhere acting similarly. New and increased taxes on tobacco, alcohol, and unhealthy foods and drinks (e.g., sugary beverages) could bring added resources—for example, Mexico collected \$1.3 billion from the first year of its sugary tax (2014) (Barclay, 2015)—while governments may consider dedicated taxes earmarked for health systems, as in Ghana (for its health insurance program) (Center for Health Market Innovations, n.d.) and Zimbabwe (for its HIV/AIDS program) (“Zimbabwe,” 2012). More effective tax systems, better collecting what is owed and increasing rates for those most able to pay, would further mobilize domestic resources. In addition, preventing companies from taking advantage of tax havens, where they pay little or no taxes, would also ensure against a race to the bottom. If these actions could raise low- and lower-middle-income country public health spending to the global averages (as a percentage of gross domestic product), their health spending would more than double (World Bank, n.d.[b]).

Disparities in Public Health Spending (% of GDP)



Source: World Bank. Health expenditure, public (% of GDP).

Some lower-income countries would still have financing gaps. Wealthy countries would have to step up development assistance, including for health, in line with their long-standing international commitments. For example, the Commission on Macroeconomics and Health (Commission on Macroeconomics and Health, 2001, p. 12), and more recently the Sustainable Development Solutions Network, calculated that affluent states would need to devote approximately 0.1% of GNI to international development assistance for health care, with another group's estimate somewhat higher (World Health Organization, 2015, p. 17). Even the 0.1% would approximately double present official development assistance for health (Institute for Health Metrics and Evaluation, 2015; World Bank, n.d.[a]). Additional resources would be required for the underlying determinants of health. Non-traditional donors, such as wealthy Middle East economies, could contribute, as could rapidly developing BRICS governments.¹ Evidence suggests that expanding innovative forms of taxation, such as financial transaction and airline levies, could raise significant additional international funding.

Many priorities: The breadth of the SDGs, while inspiring, risks watering down expectations. If everything is a priority, nothing is a priority (“Development,” 2015). The SDGs offer no explicit guidance as to the key areas in which states should invest, no global strategy to implement the many goals and targets, while simultaneously prioritizing among them (Hill, 2015).

While the agenda is expansive for good reason, as all areas are important to sustainable development, a central aim of good health—life itself—is a basic prerequisite for people to benefit from all other goals. Furthermore, health contributes enormously to people's well-being and to economic growth (Jamison, et al., 2013), while unsustainable environmental practices (e.g., burning coal) contribute significantly to ill health. Countries should thus maintain a high priority on health. Moreover, ensuring good health services for all is a basic expectation people hold of their governments, and (as with some but not all goals) a human right.

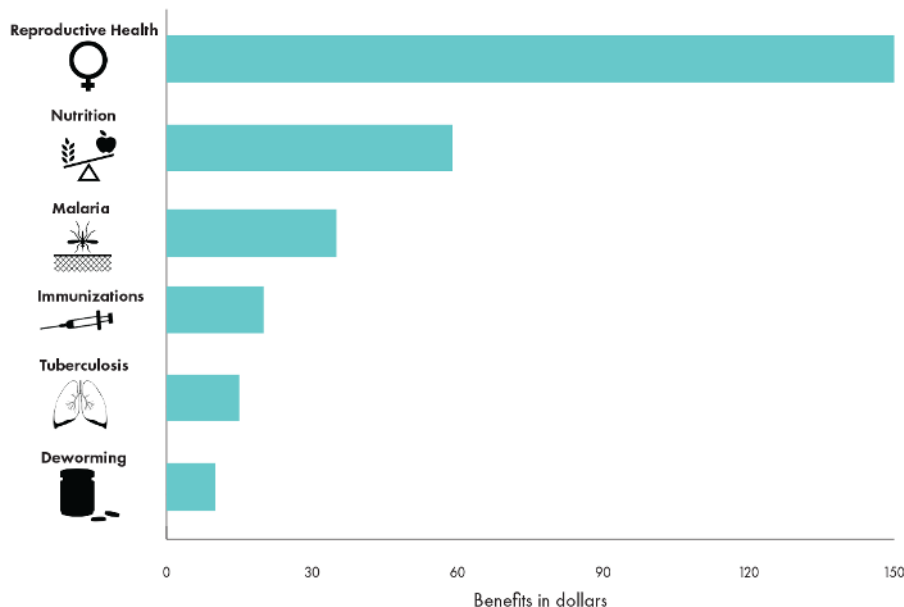
Concerns about priority-setting are real. Surely the target on ending modern slavery (SDG 8.7) is more important than other targets under the work goal, such as expanding

¹ The BRICS countries are Brazil, Russia, India, China, and South Africa.

access to financial services (SDG 8.10) or creating sustainable tourism (SDG 8.9). It would be tragic if policymakers focused scarce funds on the latter two at the expense of the first. Will countries focus funding on tertiary care—disproportionately accessed by the wealthy—while neglecting basic public health needs, like water and sanitation, that save lives without making headlines? Universal health coverage in lower-income countries, central to improving health, needs sustained external financing. Yet with such an array of funding needs in the SDGs, will wealthier countries commit to this funding? International development assistance for health under the MDGs mirrored each of the health goals, leaving health systems grossly under-funded. The SDGs do not solve this problem and may exacerbate it given the multiplicity of targets.

Cost-effectiveness could be one guide to prioritizing, with many health-related investments faring particularly well. One prominent exercise proposed that the five development investments that could do the most good in the world for each dollar spent on them were all related to health: nutritional supplements to combat malnutrition, childhood immunizations, and combating malaria, intestinal worms, and tuberculosis (Ridley, 2014). Another such list includes three health investments, including universal sexual and reproductive health, with benefits as high as \$150 for each dollar spent (Ridley, 2014). Cost-effectiveness captures what is surely a widely shared desire to do the greatest good across the SDGs for a given level of political will and resources.

Cost-Effectiveness of Health Investments (per dollar)



Source: Matt Ridley, "Smart Aid for the World's Poor," *Wall Street Journal*, July 26, 2014

Yet priorities cannot be left to cost-effectiveness algorithms alone (Friedman & Gostin, 2016). There is a basic question of what to value, requiring subjective choices (Healthy life expectancy? Reductions in carbon emissions? Multi-factor measures of well-being?). Some interventions are difficult to put a cost to (e.g., changing discriminatory laws), possibly risking their neglect. Moreover, a single-minded focus on cost-effectiveness would suffer other deficits. It would sidestep the possibilities of and priority needed on expanding the resource envelope (domestically and through global financing), focus on discrete interventions rather than systems to ensure them, risk leaving behind highly marginalized populations (e.g., people living in remote areas, who may be costlier to reach with services), and devalue people's own agency and dignity by minimizing the importance of their own views of their priorities and how to achieve them. Indeed, nominally cost-effective interventions may prove ineffective in practice if they fail to secure the population's support. In food-insecure villages along Lake Tanganyika in East Africa, community members often use insecticide-treated malaria nets—an inexpensive, effective tool against malaria—as fishing nets (Gettleman, 2015). And it is people's direct engagement in implementing the SDGs that has the greatest chance of mobilizing the political will and resources to make the greatest possible progress.

“If everything is a priority, nothing is a priority.”

States could do better by developing comprehensive national strategies, with broad participation, including marginalized populations, and subject to external comment and peer review. This would ensure that individuals' collective priorities are national priorities. Within and beyond health, these strategies could be informed—but not solely guided—by considerations of cost-effectiveness. And they can be tied to state obligations to spend their maximum available resources towards meeting their people's human rights, closely tied to many of the SDGs (UN General Assembly, 1966, art. 2). Targets and timelines could be driven by these resources (including through global support) and institutional and other practical realities (e.g., the time it may take to hire and train new health workers, utilize democratic, participatory processes to reform laws and regulations, and develop and scale-up technologies), even as states look to innovative approaches to overcome perceived constraints.

Contradictions: Prioritization links to another challenge: inherent or potential contradictions. The 2030 Agenda emphasizes economic growth to fund the SDGs, but with this comes questions on how to achieve this growth. Will government investments justified by the need for economic growth displace domestic public funds for health and education? Or, in a quest for economic growth, will governments reduce corporate tax rates and adopt other policies that constrain the public purse, or austerity measures that harm employment? Will actions to implement the target on increasing exports from least developed countries (17.11) lead to unsustainable natural resource exploitation, increased pollution that harms health, or lax safety standards that cause injuries? Further, will any of the targets condone state behavior in ways that interfere with the overall purpose of the SDGs? The SDGs commit countries to ending the illicit flow of arms (SDG 16.4), yet legally traded arms steal public funds from social development and contribute to violence (Perry, et al., 2015).

“Implementing the SDGs will thus require advocates to challenge entrenched political, economic, and social power structures.”

Likewise, aspects of the SDG agenda are fiercely at odds with many governments’ policies. The SDGs calls for eliminating discriminatory laws and policies and for promoting inclusion, even as governments intensify laws against homosexuality and pass legislation impeding civil society organizations. A commitment to affordable medicines for all comes amid the growth of bilateral and regional trade agreements with heightened patent protections that threaten access to medicines. ODA has stagnated, having hovered around \$135 billion (in constant dollars) over the past five years, as the proportion of assistance to the poorest countries falls, dropping 16% from 2013 to 2014 (Organization of Economic Co-operation and Development, Development Co-operation Directorate, 2015). Implementing the SDGs will thus require advocates to challenge entrenched political, economic, and social power structures (Dearden, 2015).

To guard against these threats, annual SDG reviews, with input from civil society, could identify contradictions, both within the SDG agenda itself and between government policies and the SDGs. The annual reviews could, for example, propose rights-based resolutions to existing tensions, such as prioritizing health and protecting the environment, expanding resources for realizing rights, anti-discrimination laws, civil society engagement, and right to health impact assessments. Assessing progress toward

realizing rights could be incorporated into the SDG review processes, with indicators developed to ensure routine monitoring and ongoing attention.

Accountability: Accountability is vital. The SDG declaration envisions participatory accountability processes, but will all countries develop such approaches, with meaningful participation? The United Nations could foster greater accountability through independent monitoring, conducted by people who exercise their own judgment, and including key indicators in annual reviews, such as on transparency, participation, anti-corruption, and accountability mechanisms. Accountability for achieving greater equity (“no one will be left behind” [UN General Assembly, 2015, September 25, para. 4]) will require high-quality, disaggregated data, now largely absent. An SDG target (17.18) calls for capacity-building for increased disaggregated data by 2020. Every country should establish and fund five-year plans to upgrade health information systems, with international support. Unless national health statistics reveal inequities among disadvantaged populations, (e.g., ethnic, racial, religious, gender, geography) governments can claim overall success while leaving the disadvantaged behind.

“Achieving the SDGs’ bold vision would be historic. Yet the challenges remain immense.”

Even with engaged populations and good data, how is it possible to hold countries accountable to indeterminate commitments? What qualifies as meeting a commitment to “substantially reduce” deaths from pollution, or to “upgrade slums”? Indicators may clarify how to measure these targets, but will not establish endpoints. National processes to create ambitious benchmarks will be critical, such as linking the SDG target to “promote mental health and well-being” (SDG 3.4) to the WHO Comprehensive Mental Health Action Plan 2013-2020, and using the targets in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020. International health standards from WHO and other agencies and scientific bodies could become the launching point towards achieving the SDG target of reducing premature mortality from non-communicable diseases by one-third by 2030 (SDG 3.4).

Early markers of health progress

In light of these significant challenges, we offer five health-focused early indicators of whether the SDGs are succeeding, or whether significant course corrections and new approaches are urgently needed (Gostin & Friedman, 2015). The SDGs represent an

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ambitious agenda. States will need to prioritize actions and resources, and this is far from an exhaustive list of priorities. Yet state failure to act quickly in the following areas would raise serious questions about commitment to the necessary level of ambition and the pledge to leave no one behind.

- 1) **Universal targets and equity-driven policies:** Achieving universal health coverage (UHC) will often require significant policy reforms and resource re-allocation to reduce immense health inequities. Dismantling barriers to access and focusing on social determinants would achieve greater parity in services. Accordingly, governments should remove all legal and other (e.g., linguistic) barriers to equal health coverage for all populations, including documented and undocumented immigrants. Further, governments should identify populations with the lowest life expectancies and prioritize services and access for those groups.

Massively inequitable distribution of infrastructure and human and financial resources are inconsistent with UHC. Some remote districts in Liberia, for example, spend \$0.76 per capita on health, compared to the national average of \$44 (Panjabi, 2015). Inhabitants of capital cities gain the lion's share of health resources, leaving rural inhabitants with little. Health professionals cluster in urban areas, or migrate to high-income countries, limiting rural populations' access to health care. Governments need to redirect health spending to ensure that it is equitable, and implement comprehensive policies to attract and retain health workers in rural and other underserved areas.

The speed with which governments make these reforms will indicate the level of commitment to universal health coverage, as will the extent to which national government spending and international assistance are directed to rural and other underserved and marginalized populations.

- 2) **Refocus UHC to give greater attention to public health:** There are reasons to believe that UHC directs countries toward increased spending on medical services, with diminished attention to the conditions and systems in which people can be healthy, such as surveillance, laboratories, tobacco control, and effective health agencies (Schmidt, et al., 2015). The UHC target virtually excludes public health services, expressly comprising only “financial risk protection, ... health-care services, and ... essential medicines and vaccines” (UN General Assembly, 2015,

September 25). This narrow focus risks country expansion of curative clinical services at the expense of population-level disease prevention and health promotion. Expanded health care services with less funding for public health could result in worse health outcomes, with less equitably distributed benefits (Schmidt, et al., 2015). Health care should be delivered as part of a comprehensive, integrated, and universal health system.

- 3) **Funding for life's necessities:** The SDGs commit to universal access for life necessities, such as potable water, hygiene, sanitation, and nutritious food. Yet international funding in these areas has taken a back seat to high-profile disease-specific programs, such as for AIDS, TB, and malaria, with easily measurable results. The financing gap for water and sanitation in developing countries has been estimated at \$39 billion annually, yet wealthy countries provided only an average of \$6.6 billion per year from 2011 to 2013 (WaterAid, 2015, p. 18). Combatting infectious diseases remains vital, but healthy life conditions such as food, water, and sanitation are indispensable prerequisites for health, requiring rapid and sustained funding increases. WHO, for example, had estimated that by reducing diarrheal infections and other benefits, achieving the MDG target on water and sanitation would have saved 470,000 lives per year (World Health Organization, n.d.[a]).

- 4) **Clean water in health facilities:** For all the breadth of the SDGs, there are telling gaps. Revealing the extent of health system deficits, a mere 42% of health facilities in 38 countries in Africa have access to safe water (Garrett, 2015). SDG 3 is silent on ensuring basic standards for health infrastructure, while SDG 6, on water and sanitation, includes a target (SDG 6.1) on safe drinking water for all, but is silent on adequate water and sanitation for social infrastructure like health facilities and schools. Can quality universal health care be realized when most health facilities do not even have safe water? Can we say that the world has achieved universal access to clean water and adequate sanitation when health facilities and schools are without these basics? Swiftly increasing the number of health facilities in Africa with access to safe water is critical for its own sake, but also as an indication that countries will be looking for comprehensive, cross-cutting, coherent approaches to implementing the SDGs, here linking SDGs 3 and 6 to help fulfill the promise of both.

5) **Health and security for refugees:** The commitment to universal access to health services and other necessities stands in sharp contrast with the failure to provide the funding today to meet essential needs of some of the world's most vulnerable populations, particularly approximately 60 million refugees and internally displaced persons, from the Syrian refugees in today's headlines to the victims of conflicts not in the global spotlight (such as internally displaced persons in South Sudan or Somali refugees in Kenya). Yet the 2015 UN humanitarian aid needs were only 55% funded (as of April 2016), more than \$8 billion short (UN Office for the Coordination of Humanitarian Affairs, 2016). A genuine commitment to universality entails fully meeting UN humanitarian appeals.

“Even with engaged populations and good data, how is it possible to hold countries accountable to indeterminate commitments?”

Leaving No One Behind: The SDGs Through the Right to Health

The SDGs could be transformative, but transformation is far from assured. A powerful next step towards helping the SDGs realize their promises would be negotiating and adopting a Framework Convention on Global Health (FCGH). The proposed global treaty would be based on the right to health and aimed at national and global health equity (Platform for a Framework Convention on Global Health, n.d.; Friedman, 2016). The FCGH would establish national and global governance for health to fill critical gaps in the SDG agenda on accountability, with binding obligations, capacity building, and creative incentives and sanctions. Towards greater equity, it would establish precise obligations regarding non-discrimination, strategies tailored to marginalized populations, and ensured participation of those long excluded. To augment funding, the treaty would develop a financing framework for comprehensive universal health coverage, including public health measures. And to address the health effects of non-health sectors, the FCGH would require right to health impact assessments and respect for the right to health by all actors, in all sectors and international regimes.

From fully meeting humanitarian and health needs now to adopting and faithfully implementing the FCGH in the years ahead, the universal right to health offers a clear path ahead towards the health-related SDGs. That path would be truly transformative.

Indeed, looking towards the SDGs as a whole, human rights point the way forward. Along with the addition of the FCGH itself, the human rights path towards the SDGs would see the infrastructure to implement and enhance accountability to the SDGs evolve in the years ahead, much as the MDGs evolved, with their new funding mechanisms and principles of development cooperation, and even new MDG targets. The SDG follow-up and review processes could add an independent review (Hunt, 2015), while human rights treaty bodies—which cover such rights as health, education, food and nutrition, women’s rights, and others rights that SDG targets implicate—could incorporate the SDGs into their periodic reviews (Office of the UN High Commissioner for Human Rights, n.d.). Countries could agree on new international taxes with the specific purpose of funding the SDGs, including for health, breathing life into the human rights imperative of international cooperation towards the universal achievement of these rights (UN General Assembly, 1966, art. 2), while countries share lessons on mobilizing domestic resources and stopping tax evasion and capital flight. The SDG targets (part of SDG 16) on accountable institutions and inclusive, participatory decision-making could frame countries’ overarching approach to SDG implementation, establishing the processes to resolve questions of prioritization in ways that respect the priorities of the people, particularly those who are most marginalized. Global support for civil society, from increased funding to eliminating constraints on civil society advocacy (such as by restricting foreign funding or requiring “official” recognition of civil society organizations), would better enable civil society organizations everywhere to hold governments accountable to the SDG promises.

Perhaps, then, the best blueprint for the SDGs agreed to in 2015 was adopted in 1948—the Universal Declaration of Human Rights (UN General Assembly, 1948), along with the treaties that followed. The universal promise of the SDGs—health care and nutrition, clean water and sanitation, housing and electricity, education and equal access to justice for all—will require states to give full weight to their obligation to ensure human rights for all

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References:

1. Barclay, E. (2015, June 19). Mexico's sugary drink tax makes a dent in consumption, study claims," NPR. The salt. Retrieved from <http://www.npr.org/sections/thesalt/2015/06/19/415741354/mexicos-sugary-drink-tax-makes-a-dent-in-consumption-study-claims>.
2. Center for Health Market Innovations. (n.d.). Ghana national health insurance scheme. Retrieved from <http://healthmarketinnovations.org/program/ghana-national-health-insurance-scheme>.
3. Commission on Macroeconomics and Health. (2001, December 20). Macroeconomics and health: Investing in health for economic development. Geneva: WHO. Retrieved from <http://www.cid.harvard.edu/archive/cmh/cmhreport.pdf>.
4. Dearden, N. (2015, September 25). The U.N. development goals miss the point—it's all about power. Common Dreams. Retrieved from <http://www.commondreams.org/views/2015/09/25/un-development-goals-miss-point-its-all-about-power>.
5. Development: the 169 commandments. (2015, May 28). Economist. Retrieved from <http://www.economist.com/news/leaders/21647286-proposed-sustainable-development-goals-would-be-worse-useless-169-commandments>.
6. Dieleman, J., Murray, C. J. L., Haakenstad, A., Graves, C., Johnson, E., Templin, T., et al. (2015). Financing global health 2014: shifts in funding as the MDG era closes. Seattle, WA: Institute for Health Metrics and Evaluation. Retrieved from <http://www.healthdata.org/policy-report/financing-global-health-2014-shifts-funding-mdg-era-closes>.
7. Friedman, E.A. (2016, January 20). An independent review and accountability mechanism for the Sustainable Development Goals: The possibilities of a Framework Convention on Global Health. Health and Human Rights 18(1). Retrieved from <http://www.hhrjournal.org/2016/01/an-independent-review-and-accountability-mechanism-for-the-sustainable-development-goals-the-possibilities-of-a-framework-convention-on-global-health/>.
8. Friedman, E. A., & Gostin, L. O. (2016, February 4). Beyond cost-effectiveness: Why we need a human rights approach to universal health coverage. O'Neill Institute blog. [Web blog post]. <http://www.oneillinstituteblog.org/beyond-cost-effectiveness-why-we-need-a-human-rights-approach-to-universal-health-coverage/>.

9. Garay, J. (2015). Health equity: The key for transformational change. San José, Costa Rica: Editorial Nacional de Salud y Seguridad Social. Retrieved from <https://www.dropbox.com/s/bd0k0ey7u95koka/Dualbook%20EQUIDAD%20EN%20SALUD%20CCSS%20Ingl%C3%A9s%20WEB.pdf?dl=0>.
10. Garrett, L. (2015, November 16). Garrett on global health. Council on Foreign Relations Newsletter. Retrieved from <http://www.cfr.org/about/newsletters/archive/newsletter/n3325>.
11. Gettleman, J. (2015, January 25). Meant to keep mosquitos out, nets are used to haul fish in. New York Times, p. A1. Retrieved from <http://www.nytimes.com/2015/01/25/world/africa/mosquito-nets-for-malaria-spawn-new-epidemic-overfishing.html>.
12. Gostin, L. O., & Friedman, E. A. (2015, December 22/29). The Sustainable Development Goals: One-health in the world's development agenda. JAMA 314(24), 2621-2622. doi:10.1001/jama.2015.1628. Retrieved from <http://jama.jamanetwork.com/article.aspx?articleid=2475848>.
13. Halawi, D. (2016, February 29). Lebanon struggles to help Syrian refugees with mental health problems. Reuters. Retrieved from <http://www.reuters.com/article/us-mideast-crisis-syria-health-idUSKCN0W32YI>.
14. Hill, P. (2015, September 22). More is less? Health in the Sustainable Development Goals. The Conversation. [Web blog post]. Retrieved from <https://theconversation.com/more-is-less-health-in-the-sustainable-development-goals-47627>.
15. Hunt, P. (2015, September 1). SDGs and the importance of formal independent review: An opportunity for health to lead the way. Health and Human Rights SDG Series Blog. [Web blog post]. Retrieved from <http://www.hhrjournal.org/2015/09/sdg-series-sdgs-and-the-importance-of-formal-independent-review-an-opportunity-for-health-to-lead-the-way/>.
16. Institute for Health Metrics and Evaluation. (2015). Financing global health 2014: Shifts in funding as the MDG era closes. Retrieved from <http://www.healthdata.org/policy-report/financing-global-health-2014-shifts-funding-mdg-era-closes>.
17. International Organization for Migration. (n.d.). Migrant inclusion: Post-2015 agenda. Retrieved March 18, 2016, from <http://health.iom.int/tb>.
18. Jamison, D. T., Summers, L. H., Alleyne, G., Arrow, J. K., Berkley, S., Binagwaho, A., et al., (2013, December 7). Global health 2035: A world converging within a generation. Lancet 382(1908), 1898-1955. <http://dx.doi.org/10.1016/S0140->

- [6736\(13\)62105-4](http://www.globalhealth2035.org/sites/default/files/report/global-health-2035.pdf). Retrieved from <http://www.globalhealth2035.org/sites/default/files/report/global-health-2035.pdf>.
19. Office of the UN High Commissioner for Human Rights. (n.d.). Monitoring the core international human rights treaties. Retrieved March 21, 2016, from <http://www.ohchr.org/EN/HRBodies/Pages/TreatyBodies.aspx>.
 20. Organization of Economic Co-operation and Development, Development Co-operation Directorate. (2015, April 8). Development aid stable in 2014 but flows to poorest countries still falling. Retrieved from <http://www.oecd.org/dac/stats/development-aid-stable-in-2014-but-flows-to-poorest-countries-still-falling.htm>.
 21. Panjabi, R. (2015, October 16). Ethics and human rights in pandemics: Lessons from the West Africa Ebola epidemic. Presentation at the meeting of the National Academy of Medicine, Interest Group 15: Human Rights, Professional Ethics, and the Values of Medicine, Washington, DC.
 22. Platform for a Framework Convention on Global Health. (n.d.). Retrieved October 1, 2015, from <http://www.globalhealthtreaty.org/>.
 23. Perry, D., Guillermet Fernández, C., & Fernández Puyana, D. (2015, September 15). Transforming our world: Reflections on the Sustainable Development Goal for peace. Health and Human Rights: SDGs series blog. [Web blog post]. Retrieved from <http://www.hhrjournal.org/2015/09/15/sdg-series-transforming-our-world-reflections-on-the-sustainable-development-goal-for-peace/>.
 24. Ridley, R. (2014, July 26). Smart aid for the world's poor. Wall Street Journal, p. C1.
 25. Rippin, N. (2013, May). Progress, prospects and lessons from the MDGs: Background research paper for the report of the High Level Panel on the Post-2015 Development Agenda. Retrieved from http://www.post2015hlp.org/wp-content/uploads/2013/05/Rippin_Progress-Prospects-and-Lessons-from-the-MDGs.pdf.
 26. Schmidt, H., Gostin, L. O., & Emanuel, E. J. (2015, August 29). Public health, universal health coverage, and Sustainable Development Goals: Can they coexist? *Lancet* 386(9996), 928-930. [http://dx.doi.org/10.1016/S0140-6736\(15\)60244-6](http://dx.doi.org/10.1016/S0140-6736(15)60244-6). Retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2625208.
 27. UN Conference on Trade and Development. (2014). World investment report 2014: Investing in the SDGs: An action plan. New York, NY and Geneva: United Nations. Retrieved from http://unctad.org/en/PublicationsLibrary/wir2014_en.pdf.

28. UN Conference on Trade and Development. (2014, June 23). Developing countries face \$2.5 trillion annual investment gap in key sustainable development sectors, UNCTAD report estimates. Retrieved from <http://unctad.org/en/pages/PressRelease.aspx?OriginalVersionID=194>.
29. UN Development Group. (2013, September). A million voices: The world we want: A sustainable future with dignity for all. New York, NY: United Nations. Retrieved from <https://www.worldwewant2015.org/bitcache/cb02253d47a0f7d4318f41a4d11c330229991089?vid=422422&disposition=inline&op=view>.
30. UN General Assembly. (1948). Universal Declaration of Human Rights. UN G.A. Res. 217A (III). Retrieved from <http://www1.umn.edu/humanrts/instreet/b1udhr.htm>.
31. UN General Assembly. (1966). International Covenant on Economic, Social and Cultural Rights. UN G.A. Res. 2200A (XXI). Retrieved from <http://www1.umn.edu/humanrts/instreet/b2esc.htm>.
32. UN General Assembly. (2015, September 25). Transforming our world: The 2030 agenda for sustainable development. UN G.A. Res. A/RES/70/1. Retrieved from http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/1.
33. UN Intergovernmental Committee of Experts on Sustainable Development Financing. (2015, August 15). Report of the Intergovernmental Committee of Experts on Sustainable Development Financing. UN Doc. A/69/315*. Retrieved from http://www.un.org/ga/search/view_doc.asp?symbol=A/69/315&Lang=E.
34. UN Office for the Coordination of Humanitarian Affairs. (2016, April 12). Humanitarian response plans(s) 2015: Summary of requirements and funding as of 12-April-2016. Retrieved from [https://fts.unocha.org/reports/daily/ocha_R21_Y2015_asof_12_April_2016_\(11_40\).pdf](https://fts.unocha.org/reports/daily/ocha_R21_Y2015_asof_12_April_2016_(11_40).pdf).
35. UN Secretariat. (2015). The Millennium Development Goals report 2015. New York, NY: United Nations. Retrieved from [http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20\(July%201\).pdf](http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf).
36. UN Sustainable Development Knowledge Platform. (n.d.). Registry of major group organizations. Retrieved August 30, 2015, from <https://sustainabledevelopment.un.org//index.php?menu=1562>.
37. UNICEF. (2010). Progress for children: Achieving the MDGs with equity, no. 9. New York: UNICEF. Retrieved

from http://www.unicef.org/publications/files/Progress_for_Children-No.9_EN_081710.pdf.

38. WaterAid. (2015, July). Essential element: Why international aid for water, sanitation and hygiene is still a critical source of finance for many countries. Retrieved from <http://www.wateraid.org/what-we-do/our-approach/research-and-publications/view-publication?id=0cad195c-1701-4466-959c-7cc7907732d1>.
39. Williams, L. (2011, June 17). What comes after the MDGs? Guardian (UK) Poverty Matters blog [Web blog post]. Retrieved from <http://www.theguardian.com/global-development/poverty-matters/2011/jun/17/millennium-development-goals-beyond-2015>.
40. World Bank. (n.d.)a. Gross national income 2014, atlas method. Retrieved March 18, 2016, from <http://databank.worldbank.org/data/download/GNI.pdf>.
41. World Bank. (n.d.)b. Health expenditure, public (% of GDP). Retrieved October 17, 2015, from <http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS/countries/1W-XM-XN?display=graph>.
42. World Health Organization. (2015a). Anchoring universal health coverage in the right to health: What difference would it make? Geneva: WHO. Retrieved from http://apps.who.int/iris/bitstream/10665/199548/1/9789241509770_eng.pdf.
43. World Health Organization. (2015b). World health statistics 2015. Geneva: WHO. Retrieved from http://who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf.
44. World Health Organization. (n.d.)a. Health through safe drinking water and basic sanitation. Retrieved March 18, 2016, from http://www.who.int/water_sanitation_health/mdg1/en/.
45. World Health Organization. (n.d.)b. Human rights-based approach to health. Retrieved March 17, 2016, from <http://www.who.int/trade/glossary/story054/en/>.
46. Yamin, A., & Fukuda-Parr, S. (2011, August 30). Learning the lessons of the MDGs: Second time round, let's get it right. Guardian: Poverty Matters blog [Web log post]. Retrieved from <http://www.theguardian.com/global-development/poverty-matters/2011/aug/30/millennium-development-goals-after-2015>.
47. Zimbabwe: Improved AIDS levy collections fill part of funding gap. (2012, February 3). IRIN. Retrieved from <http://www.irinnews.org/report/94786/zimbabwe-improved-aids-levy-collections-fill-part-of-funding-gap>.