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A section of *The Lancet* Commission on Investing in Health[1] that will no doubt be of particular interest to Ministries of Finance and Treasuries the world over is the one entitled "Avoiding unproductive cost escalation". A comprehensive review of the evidence is summarised and an important range of policy options are provided with a particular emphasis on using hard budget constraints, reducing fee-for-service payments, and the use of reference pricing.[1] The report also discusses the role of single payer systems, health technology assessment, strategic purchasing, gatekeeping, preventing chronic disease, and, with some caveats, cost-sharing schemes for patients with high incomes. However one area that gets little mention, despite a growing body of evidence, is the role of health information in both improving quality of services and keeping costs down. All countries need to understand and measure three key domains of health—the determinants of health, health status, and the health system.[2] Investing in health information is essential for containing costs for three reasons. Providing sound epidemiological and health system performance knowledge can lead to cost savings by making the right health investments. Up to date information about the performance of health services can lead to greater efficiency and data driven continuous quality improvement techniques are well established in high-income countries and of growing importance in low-income settings.[3] Lastly, health information technology itself leads to considerable savings in the health sector. Again this is well established in high-income settings, where health information technology brings efficiency through increasing adherence to evidence-based guidelines, improving surveillance and monitoring, and reducing prescribing errors.[4] Similar evidence is also now growing in low-income and middle-income settings.[5] The difficulties in scaling up such systems are well known, with calls for incentives that reward the sharing of data,[6] for less reliance on commercial marketing, and for more use of evaluations. However, despite these problems of scaling up, the message that investment in and use of good health information can help reduce costs as well as improve individual care is an important one. With the new emphasis on the need for a "data revolution" in the post-2015 agenda, commissioners should not miss this opportunity to promote investment in health information to help a more efficient delivery of the "grand convergence" in health by 2035.

For **data revolution** see http://post2015.org/tag/data-revolution/

I declare that I have no competing interests. I thank Ties Boerma (WHO, Geneva, Switzerland) for providing comments on a first draft.

Robert Fryatt
bobfryatt@gmail.com
175 East 96th, New York, NY 10128, USA

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Authors' reply

The publication of *The Lancet* Commission[1] sparked intense discussion and debate at country, regional, and international levels. This extraordinary response is perhaps not surprising, given that the report lays out an extremely ambitious global health investment framework and claims that investing in this framework would achieve very dramatic health gains within a generation. Our claims are bold, but we are confident that they are based on rigorous and replicable analyses.

We argue that with the right investments, the world's starkest inequity—the appalling rates of avertable child and infectious deaths in low-income and middle-income countries—could end within a generation. With aggressive scale-up of current and new measures, the under-5 mortality rate in almost all low-income and lower-middle-income countries could be reduced to levels seen today in the best-performing middle-income countries, achieving a grand convergence in health. The returns on investment would be enormous. As *The Lancet* Editors recently noted in their Editorial,[2] "The economic rigour of the work that underpins grand convergence, together with the economic calculus that measures the value of health to individuals and societies, can give decision makers confidence that the claims being made for the next 15–20 years are neither special pleading by the health community nor overoptimistic advocacy."[2]

A grand convergence cannot be achieved without health systems strengthening, which should certainly include improving health information systems. It also cannot be achieved without universal health coverage (UHC). Global Health 2035 lays out two progressive pathways towards UHC—progressive universalism—that are publicly financed and that ensure that the poor get equal treatment from day one. We make no apologies for promoting policies that protect the poor. We argue forcefully for a major increase in prepayment and pooling of funds to extend publicly financed insurance. We also argue for zero

fee-for-service charges at the point of care for the poor and we explicitly reject the notion that UHC can be achieved through private insurance or user fees.

Lastly, our report also lays out a set of common sense, low-cost policies that could dramatically curb deaths from non-communicable diseases and injuries, while at the same time raising substantial revenue for investing in health. We particularly favour aggressive taxation of cigarettes, alcohol, and sugar, and removal of fossil fuel subsidies. While the health benefits would extend to everyone, we see it as a major advantage that the poor would benefit the most.

The possibility of a grand convergence is now within our reach, we have evidence-based policies at our disposal for curbing non-communicable diseases and injuries, and progressive universalism offers an efficient means to achieving health and financial protection.

We declare that we have no competing interests other than those stated in the original paper.[1]

*Gavin Yamey, Dean T Jamison, Lawrence H Summers
yameyg@globalhealth.ucsf.edu

Evidence to Policy Initiative, Global Health Group, University of California San Francisco, San Francisco, CA 94105, USA (GY, DTJ); and Harvard University, Cambridge, MA, USA (LHS)

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What does UHC mean?

In their Viewpoint on universal health coverage (UHC), Thomas O'Connell and colleagues (Jan 18, p 277)[1] discuss the lack of clarity in the global discourse on what UHC means. Despite this apparent confusion at the global level, countries are anyhow implementing UHC-related reforms on their own terms. Is this confusion? Or is it the local reality of a global aspiration?

In Chinese, several definitions of UHC coexist, the most recent *Quanmin Jiankang Fugai* (health coverage for all) followed the publication of the new World Health Report 2013 in Chinese. Earlier, officials used to claim that *Quanmin Yibao* (medical insurance or medical protection for all) had been achieved. In Portuguese, *Cobertura universal em saúde* has strongly influenced the Brazilian health system for the last 25 years and is about narrowing health inequalities. In Filipino, *Kalusugan Pangkalahatan* (health for all, rather than UHC) comes with reforms focused on improving access to services for the poor. In French, *Couverture Maladie Universelle* (universal disease coverage), highlights the substantial burden of diseases (such as HIV, tuberculosis, and malaria) in Africa and what preoccupies policy makers; many look at disease control as an important step towards UHC.

UHC is powerful as an idea because it can resonate with many. Countries are embracing UHC because it aligns with their broader efforts—although there are challenges and lessons to be learnt from countries' experiences.[2–4]

A clear description of what UHC entails is lacking, but a global dogma on UHC could well be equally perilous.

We declare that we have no competing interests.

*Raoul A Bermejo, Jin Xu, Daniel E Henao, Beverly Lorraine Ho, Isidore Sieleunou
rbermejo@itg.be

Institute of Tropical Medicine, 2000 Antwerp, Belgium (RAB); Peking University China Center for Health Development Studies, Beijing, China (JX); Grupo de Investigación en Salud y Comunidad, Fundación Universitaria Autónoma de las Américas, Pereira, Colombia (DEH); Alliance for the Improvement of Health Outcomes, Manila, Philippines (BLH); and AEDES, Yaounde, Cameroon (IS)

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On global health: stick to sovereignty


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Discussing the concept of global health, Julio Frenk and colleagues (Jan 4, p 94)[1] oppose sovereignty and solidarity arguing that a global society might be a substitute for state sovereignty.[1] We are not, however, living in a global village but in a world where the distribution of economic, political, and military power is extremely inequitable. The WHO Commission on Social Determinants of Health famously stated that "inequities are killing people on a grand scale."[2]

Frenk and colleagues advocate states to share sovereignty at the global level and weaken their sovereign power. Yet many substantial improvements in public health resulted from power rearrangements between social movements and elites within a state framework. Rights-based approaches to health equity therefore emphasise the state's responsibility for people's health.[3] International solidarity, by contrast, is an ethical concept failing to provide a regulatory framework to address power imbalances. Without an effective regulatory framework, the right to health is rendered virtually meaningless.

Especially in low-income countries, the state's ability to protect and promote the right to health is eroded more by power imbalances with transnational corporations than by increased interdependence. With trade and investment treaties curtailing governments' policy space, undermining the latter's sovereignty will probably benefit transnational corporations more than it will benefit public health.[4] Unsurprisingly, global