and strong governance, even well-intentioned health policies, such as the Unified Health System, could struggle to deliver lasting improvements in public health outcomes across diverse regions. Health outcomes reflect a region's socioeconomic and political realities, and without strong local governance, global targets will be hard to achieve. For example, life expectancy in Brazil was 75·5 years in 2022,[4] a decline compared with previous years, illustrating the influence of these factors.

The Global Health 2050 report rightly calls for intersectoral policies to achieve its 50 by 50 goal.[1] Brazil's example suggests that these policies must be grounded in local realities to be effective. Only by addressing regional inequalities can we expect to see meaningful progress towards the global targets set for 2050.

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The *Lancet* Commission on Investing in Health's Global Health 2050 report[1] offers valuable insights into the health conditions responsible for most premature deaths globally. However, the report suffers from a methodological and ontological bias: it focuses on direct causes of premature death and proposes mostly biomedical or technological solutions. Despite claiming they are not advocating for the proposed priority modules to be vertical programmes in the usual sense of the term,[1] the authors ignore that their effectiveness depends on health system capacities and downgrades health-system strengthening to a side-effect of specific interventions. Such a worldview also totally overlooks the importance of socioeconomic, political, and commercial determinants of health, and obliterates the role of more cost-effective non-health sector interventions in improving health. For instance, in the USA, clinical care has been shown to account for only 16% of health outcome variability, whereas socioeconomic factors and health behaviours account for 47% and 34%, respectively.[2] In low-income countries, socioeconomic determinants such as water and sanitation[3] and economic downturns[4] play a large role in mortality, particularly in children—yet the Commission neglects these in favour of commodity-based approaches.

Moreover, the report's focus on condition-specific interventions is inadequate for addressing complex problems induced by the root causes (eg, inflammation) behind multimorbidity.[5] WHO has long pleaded for a shift away from disease-specific approaches towards a more holistic primary health-care approach.[6] To that end, health systems should be redesigned and medical research approaches reframed to move away from a reductionist, linear causality approach, and adopt a complex, systems thinking approach, so as to improve health in a sustainable way.

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The *Lancet* Commission on Investing in Health's Global Health 2050 report concludes that by 2050, "countries that choose to do so could reduce by 50% the probability of premature death in their populations".[1] The same Commission concluded in their Global Health 2035 report that countries that chose to do so could achieve a "grand convergence" in health, whereby mortality rates from infectious diseases and maternal conditions would be reduced to those of the best-performing middle-income countries.[2] Has the concept of the grand convergence been abandoned with more than a decade to run until 2035? In 2024, 11 years and exactly mid-way between 2013 and 2035, instead of a mid-point assessment, we have a new target and new extended timeline—an additional 15 years until 2050. These shifts are not clearly explained let alone justified and set a worrying precedent for moving the goalposts if or when it appears we are off track.

Some of the few reasons the authors cite as motivation for this new report are the recent challenges of "rising geopolitical tensions, the increasingly manifest effects of climate change, growth in nationalistic populism, dwindling concern for global health, slowed progress towards UHC [universal health coverage], and, most significantly, the COVID-19 pandemic".[1] They claim that this report is part of a "practical pathway" and is "more realistic" about public spending on health.[1] And yet, to achieve 50 by 50, the authors estimate that government health spending would need to at least double compared with today's spending. How is that practical and realistic when data from the past two decades (2000–19) show almost half of low-income and lower-middle income countries are trending in the opposite direction?[3] It seems the authors recognise these challenges but do not effectively incorporate the implications into their recommendations.

We are also struck by a depressing sense of déjà vu; the report notes that they depart from mainstream thinking on universal health coverage by "stressing the need for selectivity in the interventions initially included in health benefit packages".[1] More than 40 years after Alma Ata,[4] this is a step backwards. Communities the world over deserve holistic, people-centred health care. We appreciate the need to be evidence-informed and indeed to prioritise. But people-centred health is more than care for 15 conditions, and a focus that takes us back to dealing with specific diseases is unlikely to advance such an approach. The real world is messy and complex. Yet, the Commission's report adopts an orderly and overly technocratic approach, in which failure is assigned to countries if they do not "choose" to prioritise health. This technocratic approach ultimately fails the people who depend on these health systems.

Let us assume, however, that a country wants to pursue the 50 by 50 goal; the report is silent on how countries should go about adopting this goal and adapting their general intervention recommendations. For the Commission, the right decisions are clear and obvious, underscored by data and analytics. In reality, how do we support understaffed and overworked Ministry of Health staff, District Health Management Teams, and front-line health-care workers to make the right choices and implement them?

This brings us to our final point. Who is this report seeking to influence? It is easy to state that 50 by 50 can be achieved if you double public spending and make the right choices. In fact, why stop there? How much more could countries achieve if countries choose to triple spending on health? Or quadruple spending? But these are the wrong questions. The question is not what combination of interventions will achieve 50 by 50, but why aren't countries—despite all these reports making a compelling case for health—choosing to prioritise health?

In *The Lancet*'s accompanying Comment to the Global Health 2035 report, Horton and Lo asked us to "assume that we have won the argument that health matters" and moved swiftly onto asking "What should a head of state now choose to invest in?" [5] Worryingly, we continue to make this assumption and fail to accept that countries have not prioritised health when given compelling evidence for the need to make further investments. Failure to address why countries are not prioritising health means we risk continuing to make the case for health to ourselves, and we do not see the increases in spending and improved decision making needed to actually change the lives of the communities we have all committed to serve.

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We, the World Obesity Federation, on behalf of the global obesity community, are writing to express serious concern about the omission of obesity as a priority in the *Lancet* Commission on Investing in Health's Global Health 2050 report.[1] Given the Commission's aim of identifying priorities towards halving premature mortality by 2050, it is incomprehensible that obesity is absent aside from an indirect reference within the topic of health taxes. We believe that this is yet another example of systemic stigma.

For more on the **World Obesity Federation** see https://www.worldobesity.org/

The exclusion of obesity makes even less sense with respect to investment. The World Obesity Federation's work on the global cost of inaction on obesity showed that obesity is already costing economies 2–3% of gross domestic product; by 2035, nine of the ten countries with the highest numbers of people living with obesity will be low-income and middle-income countries.[2] Obesity is a costly challenge for health systems and economies; its effect—in terms of health and economic impacts—is greater in low-income and middle-income countries, where health systems are least prepared and where its cost to economies affects development.[3]

Our work with other allies in the cardiometabolic space suggests that a focus on overweight and obesity in their own right can bring together multiple disease and risk factor groups, resulting in greater coordination and impact. Still, expert publication after expert publication revert to the simplistic and de-legitimatised