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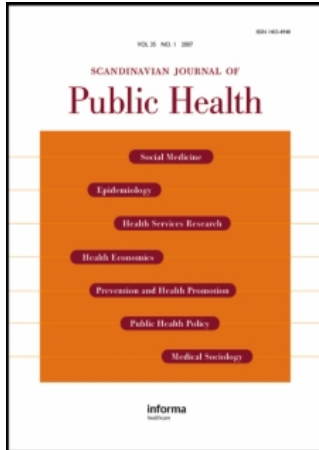
On: 20 April 2007

Access Details: [subscription number 731910130]

Publisher: Informa Healthcare

Informa Ltd Registered in England and Wales Registered Number: 1072954

Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Scandinavian Journal of Public Health

Publication details, including instructions for authors and subscription information:
<http://www.informaworld.com/smpp/title-content=t713684341>

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To cite this Article: , 'Health inequalities across the globe demand new global policies', Scandinavian Journal of Public Health, 35:2, 113 - 115

To link to this article: DOI: 10.1080/14034940701217679

URL: <http://dx.doi.org/10.1080/14034940701217679>

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EDITORIAL

Health inequalities across the globe demand new global policies

DENNY VÅGERÖ*

CHESS, Center for Health Equity Studies, Stockholm University/Karolinska Institutet, Sweden

The appointment of Dr Margaret Chan as new Director General of WHO provides a good opportunity to consider afresh the most burning global health problems. For someone writing in the Scandinavian Journal of Public Health it may also be allowed to discuss these from a Scandinavian perspective. It is certainly a relevant perspective when one considers the enormous change in population health that has taken place here in the last 100 years or so. In Stockholm, towards the end of the nineteenth century infant mortality was nearly 200 per 1,000 births, about as high as in the Kibera slum in Nairobi today. The last 100 years in Sweden have seen a most dramatic improvement in infant health, child health, and adult health and survival; this is so particularly for girls and women [1]. The driving force behind this development has been a dynamic social development, influenced (I would guess) in about equal measure by new knowledge and by the shared benefits of social and economic progress. The sharing of economic and social progress across the globe and of new scientific knowledge – including new knowledge about the social determinants of health – may also be the key to solving the most burning global health problems.

However, public discussion regarding globalization often ignores health. A people's health situation is an expression of its social and economic development and of the circumstances in which people work and live. This is why life expectancy is a component of the Human Development Index and why it serves as an alternative or a supplement to more economic measures of successful development. It is probably a

better measure than indices of happiness, which are heavily influenced by expectations, traditions, and norms concerning what one could reasonably expect from life.

Between 1950 and 2000, average life expectancy among the Earth's inhabitants increased by about 20 years, while at the same time the global population doubled. To a great extent, this improvement was due to falling rates of infant mortality all over the world. A giant step forward, certainly! Today, global average life expectancy is 68 years and increasing (although at a slower pace than previously). Further, the increase in global average life expectancy has been accompanied by a levelling out of differences between countries during most of the last half-century.

This, however, is not so any more. Rather, the differences between countries in life expectancy have in fact been widening since around 1990, as shown by Kath Moser et al. [2]. It is not simply that some countries have progressed more rapidly than others. Twenty-four countries actually experienced a decline in average life expectancy in the 1990s. This was the case in 16 (out of 41) countries in sub-Saharan Africa, in six (out of 14) countries in the former Soviet Union, including the largest of them all, Russia, and in Iraq and North Korea.

Thus global economic growth is helping to improve global health, yet in important parts of the world this is presently not the case.

Tony Blair's Commission for Africa predicted that the number of poor people there would increase by 80 million over the next two decades [3]. Hunger, malnourishment, and the burden of disease are

*Member of the WHO's Commission on Social Determinants of Health.

Correspondence: Denny Vågerö, Centre for Health Equity Studies Stockholm universitet/Karolinska Institutet, SE-106 91 Stockholm, Sweden. E-mail: denny.vagero@chess.su.se

interrelated problems that together constitute a highly effective obstacle to social and economic development. The implementation of the Millennium Development Goals concerning health and poverty in Africa risks total failure, according to a UNDP report prepared for the UN World Summit in September 2005 [4]. Reflecting this insight, the new Director General of the WHO, Margaret Chan, declared in her acceptance speech in November 2006 that [5]: “the health of the people of Africa must be the key indicator of the performance of WHO”.

The former Soviet Union is the other major world region where poverty increased and public health deteriorated in the 1990s. Despite the radical systemic shift that has taken place there, Russia has not yet managed to end four decades of stagnation in public health. On the contrary, the problems worsened in the 1990s. Tamara Men et al. estimate that in the period 1992–2001, between 2.5 and 3 million more deaths occurred among adult Russians than would have been expected on the basis of the 1991 mortality rate [6].

Russian life expectancy today (2004 data) is lower than in 1965, for both women and men. Russian men can expect to die 15 years earlier than men in Chile. Economic growth has been under way again in Russia since 1998, but so far this has not led to any improvement in health. The most likely explanation for this is that economic growth in Russia has not yielded benefits for the majority of the people. Health trends in the former communist world were discussed at length at an international seminar in Kiev, Ukraine in October 2006. The conclusion was that most of the transition countries are now moving out of, or have already left behind, their public health crises, but Russia and Ukraine are not. And Russia is performing worse than Ukraine.

Almost everywhere, the seriousness of the public health crises in the former Soviet Union has been underestimated. The Millennium Development Goals relating to health are not geared to the types of problem found in this part of the world, as while infant mortality is falling, mortality among the adult population has risen, due primarily to vascular disease, alcohol-related deaths, and violent deaths. The chronic disease burden in this and other middle-income countries was one of the reasons why Richard Horton, editor of the *Lancet*, suggested an addition to the millennium goals: the reduction of chronic disease mortality by 2% annually up to the year 2015 [7].

Global processes are generating global, regional, and national inequalities. We might describe this as a “globalization of inequality”. The question is, what impact is the new global order having on the obvious inequalities that exist between people born in

different parts of the globe? It seems clear that the global increase in trade in the 1990s was fully compatible with a situation in which large sections of the global population, sometimes entire countries, were either left standing or forced into retreat.

The WHO Commission on Social Determinants of Health (CSDH) visited slum areas and poor communities in Kenya, India, Brazil, Iran, and Chile during 2005–2006. The general level of health and development differs markedly between these countries but within each of them there is evidence of strong inequalities in health. Each one of them is also feeling the pressure from global economic and political forces.

In Ahmedabad, India we saw how a large segment of the poor and castless women have organized themselves in the Self-employed Women’s Association (SEWA). Their many activities, including their bank for microcredits, can be described as a realistic effort “to make poverty history”, working from below rather than from the top. We visited the Kibera in Nairobi, where 500,000 people live their lives in the largest slum in Africa. Experience from “slum upgrading” in India suggests that to give each household clean water, underground sewerage, street lights and paved roads would probably cost less than US\$50 million [8]. Such a change would of course have an immense impact on the health of the people living there. It would be most likely to come about by a combination of pressure from below and an enlightened response from those in power, as in the case of Chilean social and health reforms. This is the essence of the idea that social change is the key to health development. WHO could do a lot to help achieve this by providing new knowledge and forceful arguments regarding the social determinants of health, for instance when speaking to national governments or to those providing international aid.

While the solution to the problems in these countries must largely come from within, various global actors and institutions are playing a crucial (and sometimes highly counter-productive) part. Blair’s Commission for Africa wrote that the International Monetary Fund (IMF) and the World Bank “took little account of how [their economic] policies would potentially impact on poor people in Africa” [3]. Joseph Stiglitz, the Nobel Economics Prizewinner, wrote of the developing countries that “all too often the policies forced upon them by the IMF have aggravated the problems they were trying to remedy” [9]. Stiglitz was particularly scathing in his criticism of various Western advisers in Russia.

A whole network of international organizations and actors is engaged in monitoring global trends, global problems, and global crises, based on the assumption that problems must be solved by joint action and with

the participation of all. The UN system is a key part of this, and needs to be strengthened and reformed. The same is true of the World Health Organization. Indeed, the launch of the Commission on Social Determinants of Health by the late Dr Lee, former head of WHO, was designed to make the WHO more active in the social sphere. One of the members of the Commission, former president Llagos of Chile, declared at its inaugural meeting in Santiago in March 2005 that “good public health springs from a good society” – a claim that would also seem to be justified in light of experience in the Nordic countries.

The earlier WHO Commission on Macroeconomics and Health, led by economist Jeffrey Sachs, concluded that investment in health is necessary for economic development [10]. Rightly so. But the Commission on Social Determinants of Health is not a mere complement to the Macroeconomics Commission, as some have suggested or feared [11]. It is based on the conviction that poverty reduction is not enough. Health inequalities, between and within countries, span the entire global population. Most people in the world probably feel that the enormous global inequities in health and wealth found in the world today are unjust, unacceptable, and intolerable.

They would perhaps become less intolerable if we had reason to believe that the most powerful global actors are doing their best to reduce them. Is this the case? This is a relevant question to put to governments, UN agencies, and the world’s multinational corporations.

I believe that the academic community has an important role in this. Not only to pose the question above, but also to work out the evidence base for new and more radical policies (radical in the meaning “going to the root of the problem”). WHO has reached out to the academic community in all countries but the initial response to its call in 2004 to form “knowledge networks” on social determinants of health was poor, reflecting two subcultures that sometimes ignore each other. Within the WHO knowledge concerning social determinants of health is of course less than knowledge concerning disease transmission via viral or bacterial agents. But as Stephen Lewis, UN envoy for AIDS in Africa and member of CSDH, demonstrates so convincingly in a recent book [12], it is the social and political contexts, and the way they force (or admit) peoples’ lives and work to change, that are the key determinants of whether the HIV pandemic is growing or diminishing. The same is true when one looks at other global health problems, such as the epidemic of violence and cardiovascular disease in Russia and Ukraine or mental illness in disadvantaged communities around the world.

We need an international academic effort to permanently monitor health differences between countries in the world, as well as national and international systems to monitor change within countries. This would give us benchmarks for measuring progress. In her acceptance speech Dr Margaret Chan noted that:

Progress in medicine races ahead, yet resources for public health grow more slowly. This leads to further imbalances across the globe – some people leading ever longer and healthier lives, others dying prematurely from preventable causes. This is not a healthy situation – for populations or world security.

Rectifying this imbalance should also be a target for the WHO. And the family of organizations that make up the UN (including national governments) should be measured by whether or not they allow health “imbalances” across the globe to continue to grow. To give all children in the world a fair chance to develop and live a healthy and long life is a truly formidable task. But how else should one understand the old WHO slogan of “Health for All”?

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