Reducing global health inequalities. Part 1

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Summary

This paper summarizes four UK reviews of socially stratified health inequalities that were undertaken during the past five decades. It describes the background of misplaced optimism and false hopes which characterized the UK's own record of health inequalities; the broken promises on debt cancellations which was the experience of developing countries. It describes why the UK's past leadership record in international health provides grounds for optimism for the future and for benefits for both developed and developing countries through the adoption of more collaborative approaches to global health than have characterized international relationships in the past. It recalls the enthusiasm generated in the UK, and internationally, by the establishment of the Global Commission on the Social Determinants of Health. It promotes the perception of health both as a global public good and as a developmental issue and why a focus on poverty is essential to the address of global health issues. It sees the designing of appropriate strategies and partnerships towards the achievement of the Millennium Development Goals as an important first step for achieving successful address to global public health issues.

Introduction and statement of issues

Belief in health as a societal right was affirmed by Aristotle more than 2000 years ago: 'If we believe that men have any personal rights at all as human beings, they have an absolute right to such measure of good health as society, and society alone, is able to give to them'.[1] It is an emphasis that was also implicit in the 1988 report by the United States Institute of Medicine, which defined the mission of public health as 'ensuring the conditions in which people can be healthy'.

It also features in the American Declaration on the Rights and Duties of Man (article XI): 'Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources'. Amartya Sen has pointed out that 'there is a long tradition of thinking of rights in terms of social ethics: what a good society must have. Indeed, when the American Declaration of Independence invoked "certain inalienable rights" that everyone had, the idea of human rights served not as a "child of law" but more as a "parent of law" in guiding legislation. In seeing health as a human right, there is a call to action now to advance people's health in the same way that the 18th-century activists fought for freedom and liberty.'[2]

The year 1948 witnessed the founding of the World Health Organization with its remit for the attainment by all peoples of the highest possible

level of health. Another key event of the same year was the Universal Declaration of Human Rights. That document referred, in article 25, to societal responsibility for health: 'every one has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services…'

In spite of this long historical, and now growing global, concern about health as a human right, gross examples of its infringement are to be found everywhere. That it is an issue calling for social justice is almost universally acknowledged. It is an issue on which a global consensus is required, that needs to be illuminated by principles of human rights, world citizenship and a global contract.

Global health rights would be a meaningless term if international agreement on acceptable standards and safeguards for ensuring them could not be reached and if such standards and safeguards could be ignored, overridden or capriciously re-defined to conform with whatever might be existing local, national or regional situations. Michael Marmot has argued that: 'Inequalities in health between and within countries are avoidable; there is no necessary biological reason why life expectancy should be 48 years longer in Japan than in Sierra Leone or 20 years shorter in Australian Aboriginal and Torres Strait Islander People than in other Australians. The reduction of social inequalities in health, and thus meeting human needs, is an issue of social justice.'[3]

The enterprise of setting common international standards and their acceptance by countries of widely varying cultural diversity carries with it shared notions of human dignity, equity and social justice – notions that should contribute to an international 'lingua franca' of public health.

Reviews of socially stratified health inequalities in Britain

In Britain there have been four major reports on the subject of socially stratified inequalities in health during the past 30 years. The first, Sir Douglas Black's seminal report in 1980, drew attention to marked differences in morbidity and mortality rates between individuals in the top and bottom social groups.[4]

The second, the Acheson inquiry nearly 20 years later, in 1998, showed that, although these rates had fallen among both men and women across the social groups, the differences in rates between those at the top and bottom of the social scale had increased.[5] It made several recommendations for measures for their correction. The overarching one was that 'all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities'.

The third was from the UK Department of Health in September 2005, *Tackling Health Inequalities: A Programme for Action*. It confirmed that, 'Despite improvements, the gap in health outcomes between those at the top and bottom ends of the social scale remains large and in some areas continues to widen'. In his foreword to this report Prime Minister Blair said: 'Our society remains scarred by inequalities. Whole communities remain cut off from the greater wealth and opportunities that others take for granted … behind these figures are thousands of individual stories of pain, wasted talent and potential. The costs to individuals, communities and the nation are huge. Social justice demands action.' This appeal confirms how ineffective UK's response to the past disclosures of its levels of health inequalities had been.

The fourth, the 2010 Marmot Review, *Fair Society, Healthy Lives* identified social inequalities as root causes of health inequalities; it pointed to the 'social gradient' as the target on which action should be focused: 'These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, all these influences are reflected by the socio-political cultural and social context in which they sit.'

The Marmot Review sets out six key policy objectives that should underpin initiatives for countering these adverse social influences, the rationale for them and guidelines for their achievement were:

- Give every child the best start in life;
- Enable all children, young people and adults to maximize their capabilities and have control over their lives;
- Create fair employment and food and work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities;
- Strengthen the role and impact of ill-health prevention.

The spotlight it places on the association of health problems with social inequalities, and more recently with social status, has catalyzed a new international health public strategy. It has produced in the health field what Barbara Ward has termed 'a change of our fundamental angle of vision'. She said: 'The most important change that people can make is to change their way of looking at the world. We can change studies, jobs, and still remain much as we always were. But change our fundamental angle of vision and everything changes – our priorities, our values, our judgments, our pursuits.'[6] Many of the most intractable health problems that confront our world today are neither technical nor scientific, but are social, ethical, behavioural or moral.

The more the gap widens between rich and poor – communities and countries alike – the greater the numbers of people who are being left stranded in back-waters of progress; and with this come conflicts, human rights infringements, and other problems rooted in poverty and inequality. It has been observed that, although dying before your time must be the ultimate form of exclusion from society, there are several other less dramatic ways in which social disadvantage and exclusion are manifested. Stress, lack of hopes and prospects, inadequate education, limited behavioural choices and, perhaps more importantly, the health inequalities and the other infringements of human rights, with which they are associated, are major causes of social unrest and can threaten both national and international security. These and their partner, poverty, foment insecurity and unrest; destroy the social capital that is essential for stable societies. It is almost impossible for people confronted with the disabilities and disadvantages which stem from them to take part meaningfully in normal social intercourse, in the formal democratic process.

Health as a global public good

The concept of health as global citizenship is an important element in the address to poverty and health inequalities. It calls for a worldwide focus on health, education, economic growth, a safe social environment and a set of people freedoms that embrace such things as human security, social contentment and what Prime Minister Blair had termed 'respect'. Amartya Sen has stated that the understanding of health as an end (the right of citizenship) is as important as the utilitarian principle of health as a means.

In the Millennium Poll health emerged as the thing that people valued most. And yet, in spite of these and similar perceptions, and although all governments pay lip service to the promotion of health, it still cannot yet be said that countries, developed or developing, place any great priority on activities and policies concerned primarily with the social wellbeing of societies as compared, for instance, with the economy. Nor, at the global level, are there any genuinely comparable international social counterparts for the International Monetary Fund or the World Bank. Layard argues that 'Public policy should be judged by how it increases human happiness and decreases human misery'.[7]

Focus on poverty

Poverty is clearly a major determinant of health differentials everywhere. Poor countries have worse health indicators than rich ones and the poor within a country have worse indicators than the rich. That health is an important condition for poverty reduction and economic development of nations was one of the conclusions of the report of the 2001 WHO Commission on 'Macroeconomics and Health: Investing in Health for Economic Development'.

Forty years ago (1970) the Pearson Commission on International Development began its report with the recognition that 'The widening gap between the developed and developing countries has become the crucial problem of our times'. Over the past three decades the income gap

between the one-fifth of people living in the world's richest countries and the one-fifth of people living in the poorest has widened markedly. It was 74:1 in 1997, up from 60:1 in 1990 and 30:1 in 1960. Siglitz also observed in his *Globalization and its Discontents* that 'Over the last decade of the twentieth century the actual number of people living in poverty has actually increased by almost 100 million. This has occurred at the same time that total world income has actually increased by an average of 2.5 per cent annually.'[8]

The individual Millennium Development goals – extensive poverty and hunger, universal primary education, promotion of gender equality and improvement of women, reduction of child mortality, reduction of maternal mortality, combating AIDS, malaria and other diseases, ensuring environmental accountability, development of a global partnership for development – are said to be not a set of independent development targets, but to represent a shared image of development. Each addresses elements of poverty elimination, human and social development. The UNDP 2003 Human Development Report termed them 'a compact among nations to end poverty'. They are claimed to be 'the first global political endorsement with a clear focus on, and means to engage directly with the world's poor people'.[9] And there can be no question that the current deepening world economic crisis will contribute to the number of the world's health inequalities and the difficulties of addressing them.

An important and optimistic image of the shared benefits that collaboration in global health can bring to rich and poor countries alike has been set out in a recent paper by Donaldson and Banatvala.[10] It stresses the need for greater international cooperation in biomedical research that is relevant to developing countries. It places a special emphasis on the contribution of health to sustainable development, to health as a global public-health good and as a human right. It draws attention to the UK's past leadership role in several issues calling for wide global responses – debt cancellation, the global fund for fighting AIDS, tuberculosis and malaria, the Global Alliance for Vaccines and Immunization, the World Alliance for Patient Safety, the WHO Commission on Social Determinants of Health and other international initiatives. It sets out guidelines towards one of the main targets of this series – greater recognition of the importance of the creation of coalitions between civil societies, professional groups and cross-governmental sectors nationally and internationally for successful collaboration in the promotion of global health.

This approach has also been reflected in a recent *Lancet* report which confirmed that at the inaugural World Health Summit in 2009 'the M8 alliance of Academic Health Centers and Medical Universities was formed to lead intensified international debate about research and education on global health challenges. The idea was to create an international forum that seeks discussions with governmental representatives, policymakers, non-governmental organizations, civil society and the health-related industry to initiate cross-sectoral solutions for the most pressing global challenges.'[11] Its success has yet to be evaluated.

Roles of the World Bank and International Monetary Fund

The motto of the World Bank – 'Our dream is a world without poverty' – was indicative of the expectations of its founders at Bretton Woods in 1944. Its proper name – The International Bank for Reconstruction and Development – reflects its original mission. Its main role was to have been not so much to provide funds to poor countries at times of crisis but to enable countries to develop and grow. The International Monetary Fund (IMF) was founded at the same time, on the belief that there was need for collective action at the global level for economic stability, just as the United Nations had been formed on the belief that there was need for collective action at the global level for political stability.

Development, a shared objective of both the Bank and the Fund, is about more than money. It is about transforming societies, strengthening infrastructures, improving the lives of the poor, enabling them to have a chance at success, to have access to health and education, to play contributory and dignified roles in their communities. Social cohesion, self-confidence in making their own decisions, respect for themselves and for the rights of others are both manifestations of and conditions for it. Neither the Bank nor the Fund has placed any special emphasis on these

aspects of their roles. Many of their policies and prescriptions, their often harmful 'structural adjustment programmes', their flawed conditionalities – flawed both in how they were arrived at and the one-size-fits-all manner in which they have been applied – have been, on the contrary, socially and economically disruptive for many of the countries on which they have been imposed.

Accountable as they have been to their founders in developed countries, and with their policies influenced more by the Washington Consensus than by the particular needs of individual poor countries it is not surprising that the successes of both the Bank and the Fund have been limited. The countries and people whose lives they so profoundly influence have no seats at the table around which their policies and actions have been to date determined. The poverty, the retarded development, the social and economic instability, the civic unrest they were intended to ameliorate, far from diminishing, have increased worldwide during the six decades of their existence.

There are lessons to be learnt from the Commission for Africa and from earlier and later initiatives of rich countries to identify and address the causes of poverty in Africa and elsewhere. These initiatives commonly take the form of meetings of representatives of rich countries whenever a new statistic or outrage triggers international concern. The 2005 Gleneagles meeting of the G8 countries was characteristic of previous ones. Optimism was high that this meeting could in fact herald in the process of making poverty history.

There were several reasons for this optimism: As the report of the Commission stated, '2005 offers a real opportunity for a major change. The UK holds the presidencies of both the G8 and the EU, and the Prime Minister will present the Commission's findings to these bodies.' Prime Minister Blair had acclaimed that the year 2005 offered 'a unique set of opportunities'.[12] He termed Gleneagles 'a partnership' between G8 and Africa.[13] Gordon Brown had described 2005 as 'a make or break year for development'.[14] He called specifically upon the richest countries of the world to enact a comprehensive financing programme to help poor countries to advance further towards meeting the Millennium Development Goals.

In spite of all these reasons for optimism all that emerged from Gleneagles was a series of promises – termed decisions:

- To double aid to all developing countries by around US$50 billion per year, with at least US$25 billion extra per year for Africa;
- To take forward, via a working group, discussion of innovative financing mechanisms to generate more aid, including the International Financing Facility (IFF) promoted for the past two years by Brown;
- To cancel all the debts (estimated to amount to more than US$40 billion) owed by eligible heavily indebted poor countries to the International Development Association of the World Bank, the International Development Fund and the African Development Bank;
- To boost investment in health and education in Africa, and to take action to combat HIV/AIDS, malaria, tuberculosis and other killer diseases.

The Roman poet Juvenal's satirical line comes to mind: 'Parturiunt montes: nascitur ridiculus mus': 'Mountains are in labour: a ridiculous little mouse is born'. What emerged from Gleneagles was definitely not a plan to make poverty history, to put delivery of the MDGs safely back on track. The concept and processes of development were hardly ever examined or defined. In his post-Gleneagles press conference Blair had stated that the meeting was 'a beginning, not an end'. Siglitz quipped later that it was 'the end of the beginning of ending poverty'.[14] The highly indebted poor countries are still supplicants at the high table. There was not even a timetable for the promised cancellation of their debts. They remain as closely supervised as before by the IMF and the World Bank with their unpopular and often damaging conditionalities.

Promises from the UK

In his foreword to DIFID's July 2009 White Paper Britain's Prime Minister Brown said: 'Aid increases and debt cancellation have helped to get some 40 million more children into school. Securing global justice remains one of my top priorities, and the publication of this White Paper comes at a critical juncture in the fight to eliminate poverty. We do not under-estimate the challenges. But we will continue to act with confidence and

determination to protect the world's poorest and to deliver real global justice.'

In his October 2010 budget Spending Review Chancellor Osborne gave assurance that, in spite of current financial constraints, expenditure on international aid would not only be protected, it would be increased. 'It will cut deaths from preventable diseases in the developing world… I can also confirm that this coalition government will be the first British Government in history, and the first major country in the world, to honour the United Nations commitment on international aid. (The funding increase) will halve the numbers of deaths caused by malaria; it will save the lives of 50,000 women in pregnancy and 250,000 newborn babies.'

The UK's meeting of these commitments would be important not only for its own credibility but also for its assistance to the developing world to meet its Millennium Development Goals. Evidence has also been presented of the value of north–south partnerships for the promotion of international health along the lines proposed in this paper – not only for international health itself, but for the partners in the partnership as well.

Summary and conclusions

This paper has reviewed historical and social perspectives on health. Health has been a subject of concern as a societal right since the days of Aristotle. The enterprise of setting optimal achievable standards as a goal and the acceptance of this principle by countries of widely varying cultural diversity carries with it shared notions of human dignity, equity and social justice. This is why we propose that the reduction of global health inequalities should be a shared international aspiration.

We have reviewed measurements of socially stratified inequalities in the UK during the past five decades. These reviews have revealed the wide range of issues and factors that contribute to them – social exclusion, unhealthy living habits, poverty and other societal stressors. These are issues that permeate all levels of society, all countries and whose address call for solutions from all social classes, all professions, all governments and all sectors of governments.

A common contributory social factor to health inequalities everywhere is poverty on which we have placed a special focus – its causes, consequences and approaches to its amelioration. We have examined the roles of the IMF, the World Bank, cancellation of debts, cancellation of debts, the place for inter- and intra-national collaboration. We have noted that health is both a cause and a consequence of development. We have concluded that we need to create broad national and international coalitions of collaborators; that there will always be need for teams. We have shown the importance of whole-of-government and wide intra- and inter-national consultation in dealing with major national or international health issues. This is a theme to which we will return, from differing introductions, throughout this series.

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