PART 1: Setting the scene for a global approach to health equity
CHAPTER 1
A new global agenda – the Commission on Social Determinants of Health

Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; in India, 63 years; and in one of several African countries, fewer than 50 years. Within countries, the differences in life chances are dramatic and are seen in all countries – even the richest. The balance of poverty and affluence may be different in low-income countries, but it is still true that the more affluent flourish and the less affluent do not.

It does not have to be this way and it is not right that it should be like this. It is not an unfortunate cluster of random events, nor differences in individual behaviours, that consistently keep the health of some countries and population groups below others. Where systematic differences in health are judged to be avoidable by reasonable action globally and within society they are, quite simply, unjust. It is this that we label health inequity.

HEALTH EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH

Traditionally, societies have looked to the health sector to deal with its concerns about health and disease. Certainly, maldistribution of health care – not delivering care to those who most need it – is one of the social determinants of health. But the high burden of illness responsible for appalling premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age – conditions that together provide the freedom people need to live lives they value (Sen, 1999; Marmot, 2004).

Poor and unequal living conditions are, in their turn, the consequence of deeper structural conditions that together fashion the way societies are organized – poor social policies and programmes, unfair economic arrangements, and bad politics. These ‘structural drivers’ operate within countries under the authority of governments, but also, increasingly over the last century and a half, between countries under the effects of globalization. This toxic combination of bad policies, economics, and politics is, in large measure, responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible. Daily living conditions, themselves the result of these structural drivers, together constitute the social determinants of health.

Putting these inequities right is a matter of social justice. Reducing health inequities is, for the Commission on Social Determinants of Health (hereafter, the Commission), an ethical imperative. The right to the highest attainable standard of health is enshrined in the Constitution of the World Health Organization (WHO) and numerous international treaties (UN, 2000a). But the degree to which these rights are met from one place to another around the world is glaringly unequal. Social injustice is killing people on a grand scale.

A NEW AGENDA FOR HEALTH, EQUITY, AND DEVELOPMENT

We start from the proposition that there is no necessary biological reason why a girl in one part of the world, say Lesotho, should have a life expectancy at birth (LEB) shorter by 42 years than a girl in another, say Japan. Similarly, there is no necessary biological reason why there should be a difference in LEB of 20 years or more between social groups in any given country. Change the social determinants of health and there will be dramatic improvements in health equity.

We call for the health gap to be closed in a generation. This reflects our judgement that action – socially, politically, and economically – would lead to dramatic narrowing of the health differences between and within countries. This is not to predict that the social gradient in health within countries, or the dramatic differences between them, will be abolished in 30 years, but it is to demand that the appalling unfairness that we see around the world be placed at the top of the agenda for global, regional, and national action. The evidence, outlined in this report, both on the speed with which health can improve and the means needed to achieve change, encourages us that significant closing of the gap is indeed achievable, but it will take action starting now.

THREE PRINCIPLES OF ACTION TO ACHIEVE HEALTH EQUITY

The Commission’s analysis, following the social determinants of health as summarized above, leads to three principles of action:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.

2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.

3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

While the report that follows is structured around these three principles, there is not an implied order of action. Measuring the problem and taking action to resolve it must proceed at the same time. Taking action on the conditions of daily life and on the structural drivers of those conditions should proceed simultaneously. They are not alternatives.
The Commission’s work embodies a new approach to development. Health and health equity may not be the aim of all social policies but they will be a fundamental result. Take the central policy importance given to economic growth: Economic growth is without question important, particularly for poor countries, as it gives the opportunity to provide resources to invest in improvement of the lives of their population. But growth for its own sake, without appropriate social policies to ensure reasonable fairness in the way its benefits are distributed, brings no benefit to health.

Health systems have an important role to play. Ministries of health also have an important stewardship responsibility. The health sector should work in concert with other sectors of society. Health and health equity are important measures of the success of social policies. But beyond the health sector, action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies.

As processes of globalization bring us closer together as peoples and nations, we begin to see the interdependence of our aspirations – aspirations for human security, including protection against poverty and exclusion, and aspirations for human freedom (Sen, 1999), not just to grow and flourish as individuals but to grow and flourish together. We recognize the barriers to common global flourishing – particularly the entrenched interests of some social groups and countries. But we also recognize the value and necessity of collective action – nationally and globally – to correct the corrosive effects of inequality of life chances.

**TWO URGENT AGENDAS – HEALTH EQUITY AND ENVIRONMENTAL CHANGE**

There is, at last, widespread recognition that disruption and depletion of natural environmental systems, including climate change, is not simply a technical discussion among environmental experts but has profound implications for the way of life of people globally and for all living organisms. It was beyond the remit, and competence, of the Commission to design a new international economic order that balances the needs of social and economic development of the whole global population, health equity, and the urgency of dealing with global warming. But the sense of urgency and willingness to experiment with innovative solutions is the spirit required to deal with both issues.

**THE COMMISSION AND THE WORLD HEALTH ORGANIZATION**

In the spirit of social justice, the Commission was set up by the late Director-General of WHO, Dr Jong Wook Lee. He saw action on social determinants of health as the route to achieving health equity. The Commission, created to marshal the evidence on what can be done to promote health equity and to foster a global movement to achieve it, is a global collaboration of policy-makers, researchers, and civil society led by Commissioners who contribute a broad range of political, academic, and advocacy experience. Health equity is, necessarily, a truly global agenda. The current Director-General, Dr Margaret Chan, has embraced the Commission with enthusiasm. She said:

“*No one should be denied access to life-saving or health-promoting interventions for unfair reasons, including those with economic or social causes. These are some of the issues being addressed by the Commission on Social Determinants of Health ... When health is concerned, equity really is a matter of life and death.*” (Chan, 2007)

Director-General Chan has committed WHO to action on the social determinants of health, not only because it has the power to do so, but because it has the moral authority.

**FOSTERING A GLOBAL MOVEMENT FOR CHANGE**

The Commission seeks to foster a global movement for change. The indications are clear: health is universally valued, and people desire fairness. Where it has been studied, there is clear evidence of concern about the unfairness of living conditions (YouGov Poll, 2007) that lead to differences in levels of health (RWJF Commission, 2008). We have already encountered a great deal of support for our core conclusions. While WHO is a central and vitally important actor in taking forward the health equity agenda, the global movement is being built by a host of stakeholders. It is clear, too, that changing the social determinants of health and health equity is a long-term agenda requiring sustained support and investment.

**BEYOND ‘BUSINESS AS USUAL’**

A key concern of the Commission from its inception has been that implementing real change might be seen as unrealistic – that superficial changes would be more attractive to those who prefer to continue with ‘business as usual’. The evidence is compelling that business as usual is increasingly unfeasible. Among the enthusiasm for the work of the Commission, we have also encountered two types of criticism aimed at the social determinants of health: “We know it all already” and “You have no evidence to support action”. Between the two critiques, the Commission seeks to forge a new path to action. We do know much about the social determinants of health, it is true. Yet policy-making all too often appears to happen as if there were no such knowledge available. And we do not yet know enough. There is a pressing need to invest in a great deal more research, bringing together different disciplines and areas of expertise, to work out how social determinants create health inequality, and how action on these determinants can produce better, fairer health.

The Commission is unusual in having inspired and supported action in the real world from its inception. Over three years, a number of countries have signed up to the Commission’s vision. Brazil, Canada, Chile, Islamic Republic of Iran, Kenya, Mozambique, Sri Lanka, Sweden, and the United Kingdom each became partners of the Commission and have made progress on developing policies, across government, on tackling social determinants of health equity. More countries will follow (Argentina, Mexico, Poland, Thailand, New Zealand, and Norway have all expressed enthusiasm to join). From the rota of nations, the Commission’s list of country partners is, as

---

1 Civil society refers to the arena of uncoerced collective action around shared interests, purposes, and values. In theory, its institutional forms are distinct from those of the state, family, and market though, in practice, the boundaries between state, civil society, family, and market are complex. Civil society is often populated by organizations such as registered charities, development nongovernmental organizations, community groups, women’s organizations, faith-based organizations, professional organizations, trade unions, self-help groups, social movements, business associations, coalitions, and advocacy groups.
yet, relatively small. In many places, things have not changed and will, without doubt, take much time to change. But our country partners are a powerful expression of political will and practical commitment. Is it feasible to do things differently? Yes. These countries are already doing it. As Parts 3 and 4 of this report show, partnerships with other countries, civil society, WHO, other international bodies, and opinion formers are all vital in pursuing the social determinants of health agenda.

**WHY NOW?**

WHO made inspiring declarations 60 years ago, at its birth, and again 30 years ago, at Alma Ata. Those declarations are consistent with the call that we are making today. Why will things be any different now?

**Better knowledge**

There is now a great deal more knowledge, globally circulating, on both the nature of the problem of health inequity and what can be done to address the social determinants of health.

**Better development**

The dominant model of development is changing. The Millennium Development Goals (MDGs) reflect an unprecedented global concern to effect real, sustainable change in the lives of people in poor countries. There is growing demand for a new approach to social development – one that moves beyond an overriding focus on economic growth to look at building well-being through the combined effects of growth and empowerment (Stern, 2004).

**Stronger health leadership**

Convening the Commission, WHO signalled its desire to do things differently. Its Member States, too, are increasingly calling for a new model for health – from the point of view of both social justice and increasingly unsustainable reliance on the traditional health-care model.

**An unsustainable status quo**

What happens in one part of the world now has an impact everywhere – financial crises, conflicts, population movement, trade and labour, food production and food security, and disease. The scale of inequity is simply unsustainable. Underpinning the call for global human justice, the inescapable evidence of climate change and environmental degradation have set clear limits to a future based on the status quo and are prompting an increasing global willingness to do things differently.

**CAN THINGS CHANGE?**

The question – is closing the health gap in a generation feasible – has two clear answers. If we continue as we are, there is no chance at all. If there is a genuine desire to change, if there is a vision to create a better and fairer world where people’s life chances and their health will no longer be blighted by the accident of where they happen to be born, the colour of their skin, or the lack of opportunities afforded to their parents, then the answer is: we could go a long way towards it.

Achieving this vision will take major changes in social policies, in economic arrangements, and in political action. At the centre of this action should be the empowerment of people, communities, and countries that currently do not have their fair share. The knowledge and the means to change are at hand and are brought together in this Report. What is needed now is the political will to implement these difficult but feasible changes.

This is a long-term agenda, requiring investment across the lifecourse and starting now. Not to act will be seen, in decades to come, as failure on a grand scale to accept the responsibility that rests on all our shoulders.
CHAPTER 2
Global health inequity – the need for action

HEALTH INEQUALITY IN ALL COUNTRIES

“There are no conditions of life to which a man cannot get accustomed, especially if he sees them accepted by everyone around him.” (Tolstoy, 1877)

We have become all too accustomed to premature death and disease and to the conditions that give rise to them. But much of the global burden of disease and premature death is avoidable, and therefore unacceptable. It is inequitable. Health equity has two important strands: improving average health of countries and abolishing avoidable inequalities in health within countries. In both cases – average health of countries and distribution within countries – the aim should be to bring the health of those worse off up to the level of the best. If the infant mortality rate in Iceland (WHO, 2007c) were applied to the whole world, only two babies would die in every 1000 born alive. There would be 6.6 million fewer infant deaths in the world each year.

Yet the distribution of infant deaths is most unequal, both between countries and within them. Fig. 2.1 shows variation between countries in infant mortality from just over 20/1000 live births in Colombia to just over 120 in Mozambique. And it shows dramatic inequities within countries – an infant’s chances of survival are closely related to her mother’s education. In Bolivia, babies born to women with no education have infant mortality greater than 100 per 1000 live births; the infant mortality rate of babies born to mothers with at least secondary education is under 40/1000. All countries included in Fig. 2.1 show the survival disadvantage of children born to women with no education. If it is considered too unrealistic to contemplate an infant mortality rate of 2 per 1000 live births in low-income countries, we must at least acknowledge the scale of improvement in infant survival apparently offered by educating girls and women.

Figure 2.1: Inequity in infant mortality rates between countries and within countries by mother’s education.

Data from the Demographic and Health Surveys (DHS, nd) derived from STATcompiler. The continuous dark line represents average infant mortality rates for countries; the end-points of the bars indicate the infant mortality rates for mothers with no education and for mothers with secondary or higher education.


**INEQUITY IN HEALTH CONDITIONS**

LEB among indigenous Australians is substantially lower (59.4 for males and 64.8 for females in the period 1996-2001) than that of all Australians (76.6 and 82.0, respectively, for the period 1998-2000) (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005).

In Europe, the excess risk of dying among middle-aged adults in the lowest socioeconomic groups ranges from 25% to 50% and even 150% (Mackenbach, 2005).

Health inequalities are observed among the oldest old. The prevalence of long-term disabilities among European men aged 80+ years is 58.8% among the lower educated versus 40.2% among the higher educated (Huisman, Kunst & Mackenbach, 2003).

In the United States of America, 886 202 deaths would have been averted between 1991 and 2000 if mortality rates between whites and African Americans were equalized. This contrasts to 176 633 lives saved by medical advances (Woolf et al., 2004).

Cardiovascular diseases (CVDs) are the number one group of conditions causing death globally. An estimated 17.5 million people died from CVDs in 2005, representing 30% of all global deaths. Over 80% of CVD deaths occur in low- and middle-income countries (WHO, nd,a).

Of people with diabetes, 80% live in low- and middle-income countries. Diabetes deaths are likely to increase by more than 50% in the next 10 years without urgent action (WHO, nd,c).

Mental health problems will become increasingly important. It is estimated that unipolar depressive disorders will be the leading cause of the burden of disease in high-income countries in 2030, and it will be number two and three in middle- and low-income countries, respectively (Mathers & Loncar, 2005).

The lifetime risk of maternal death is one in eight in Afghanistan; it is 1 in 17 400 in Sweden, (WHO et al., 2007).

Maternal mortality is three to four times higher among the poor compared to the rich in Indonesia (Graham et al., 2004).

Every day, over 13 500 people worldwide die due to tobacco. The total number of smoking deaths will increase from 5 to 8 million in the next 20 years. Soon, it will become the leading cause of death in developing countries (as it is in high-income countries) (Mathers & Loncar, 2005).

Worldwide, alcohol causes 1.8 million deaths (3.2% of the total). Unintentional injuries alone account for about one third of the 1.8 million deaths (WHO, nd,b).

---

**Figure 2.2: Under-5 mortality rate per 1000 live births by level of household wealth.**

The social gradient is not confined to poorer countries. Fig. 2.3 shows national data for some areas of the United Kingdom (England and Wales) for people classified according to levels of neighbourhood deprivation. As can be seen, the mortality rate varies in a continuous way with degrees of deprivation (Romeri, Baker & Griffiths, 2006). The range is large: the difference in mortality between the most and least deprived is more than 2.5-fold.

Source: Gwatkin et al. (2007), using DHS data.
THE GRADIENT

The poorest of the poor, around the world, have the worst health. Those at the bottom of the distribution of global and national wealth, those marginalized and excluded within countries, and countries themselves disadvantaged by historical exploitation and persistent inequity in global institutions of power and policy-making present an urgent moral and practical focus for action. But focusing on those with the least, on the ‘gap’ between the poorest and the rest, is only a partial response. Fig. 2.2 shows under-5 mortality rates by levels of household wealth. The message here is clear: the relation between socioeconomic level and health is graded. People in the second highest quintile have higher mortality in their offspring than those in the highest quintile. We have labelled this the social gradient in health (Marmot, 2004).

The social gradient is not confined to poorer countries. Fig. 2.3 shows national data for some areas of the United Kingdom (England and Wales) for people classified according to levels of neighbourhood deprivation. As can be seen, the mortality rate varies in a continuous way with degrees of deprivation (Romeri, Baker & Griffiths, 2006). The range is large: the difference in mortality between the most and least deprived is more than 2.5-fold.

THE POOREST OF THE POOR AND THE SOCIAL GRADIENT IN HEALTH

The implications of Figs. 2.1, 2.2, and 2.3 are clear. We need to be concerned with both material deprivation – the poor material conditions of the 40% of the world’s population that live on US$ 2/day or less – and the social gradient in health that affects people in rich and poor countries alike.

Poverty is not only lack of income. The implication, both of the social gradient in health and the poor health of the poorest of the poor, is that health inequity is caused by the unequal distribution of income, goods, and services and of the consequent chance of leading a flourishing life. This unequal distribution is not in any sense a ‘natural’ phenomenon but is the result of policies that prize the interests of some over those of others – all too often of a rich and powerful minority over the interests of a disempowered majority.

People at the bottom of the range in Fig. 2.3 are rich by global standards. They are all living on well above US$ 2/day. They have clean water to drink, sanitary living conditions, and infant mortality rates below 10 per 1000 live births, yet they have higher mortality rates than those in the middle of the socioeconomic range. Those in the middle certainly are not materially deprived in the sense just described, but they too have higher mortality than those above them – the greater the social disadvantage, the worse the health. The steepness of the gradient varies over time and across countries. It is likely, then, that action on the social determinants of health would reduce the social gradient in health (Marmot, 2004).

In rich countries, low socioeconomic position means poor education, lack of amenities, unemployment and job insecurity, poor working conditions, and unsafe neighbourhoods, with their consequent impact on family life. These all apply to the socially disadvantaged in low-income countries in addition to the considerable burden of material deprivation and vulnerability to natural disasters. So these dimensions of social disadvantage – that the health of the worst off in high-income countries is, in a few dramatic cases, worse than average health in some lower-income countries (Table 2.1) – are important for health.

Figure 2.3: Death rates, age standardized, for all causes of death by deprivation twentieth, ages 15–64 years, 1999-2003, United Kingdom (England and Wales).

Dashed lines are average mortality rates for men and women in some areas of the United Kingdom (England and Wales).
Health inequity, as the data above illustrate, is a concern for all, in all countries worldwide. The urgency of that concern is compounded by the fact that the pattern of the health problems confronting countries, and requiring solutions, is converging. While the poorest countries have a high burden of communicable disease as well as non-communicable disease and injury, in all other regions of the world non-communicable diseases predominate (WHO, 2005c). The causes of heart disease, cancer, and diabetes are the same wherever these diseases occur. The action needed to combat them is likely, therefore, to be similar in rich and poor countries alike. The global picture of non-communicable and communicable disease dictates the need for a coherent framework for global health action.

**IS CLOSING THE HEALTH GAP IN A GENERATION POSSIBLE?**

The differences in health that we have illustrated above are so large that it may strain credibility to envisage closing the health gap in one generation. The fact is that health can change dramatically in a remarkably short time. With health equity, what can worsen can improve. The data show this. Child mortality of 50 per 1000 is unacceptably high. That was the situation in Greece and Portugal 40 years ago (Fig. 2.4). The latest figures show them to be just above the levels for Iceland, Japan, and Sweden. Egypt provides perhaps the most striking example of rapid change – from 235 to 35 per 1000 in 40 years. The figures for Egypt are lower now than those of Greece or Portugal 40 years ago.

But just as things can improve with remarkable speed, they can also deteriorate fast. In the 30-year period between 1970 and 2000, infant mortality was falling in both Russian Federation and Singapore. LEB, however, rose by 10 years in Singapore and fell by 4 years in Russian Federation. The divergence arose because of the rise in adult mortality in Russian Federation, a rise itself associated with ‘shock therapy’ changes in political, economic, and social systems in the country from 1992 onwards. Fig. 2.5 shows how quickly the magnitude of the social gradient in health can change for the worse, too, related to the level of educational attainment. Source: (UNICEF, 2007c).

---

**Table 2.1**

Male life expectancy, between- and within-country inequities, selected countries

<table>
<thead>
<tr>
<th>Place</th>
<th>Life expectancy at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom, Scotland, Glasgow (Calton)(^a)</td>
<td>54</td>
</tr>
<tr>
<td>India(^a)</td>
<td>62</td>
</tr>
<tr>
<td>United States, Washington DC (black)(^c)</td>
<td>63</td>
</tr>
<tr>
<td>Philippines(^a)</td>
<td>64</td>
</tr>
<tr>
<td>Lithuania(^a)</td>
<td>65</td>
</tr>
<tr>
<td>Poland(^a)</td>
<td>71</td>
</tr>
<tr>
<td>Mexico(^a)</td>
<td>72</td>
</tr>
<tr>
<td>United States(^a)</td>
<td>75</td>
</tr>
<tr>
<td>Cuba(^a)</td>
<td>75</td>
</tr>
<tr>
<td>United Kingdom(^a)</td>
<td>77</td>
</tr>
<tr>
<td>Japan(^a)</td>
<td>79</td>
</tr>
<tr>
<td>Iceland(^a)</td>
<td>79</td>
</tr>
<tr>
<td>United States, Montgomery County (white)(^c)</td>
<td>80</td>
</tr>
<tr>
<td>United Kingdom, Scotland, Glasgow (Lenzie N.J.)(^b)</td>
<td>82</td>
</tr>
</tbody>
</table>

\(^a\) Country data: 2005 data from World Health Statistics (WHO, 2007c).
\(^c\) Pooled data from 1997-2001 (Murray et al., 2006).
social gradient in health can change for the worse, too, related to the level of educational attainment.

BUILDING ON SOLID FOUNDATIONS: HISTORICAL EXPERIENCE

Bringing together global action for health equity under the rubric of social determinants of health is new. The ideas behind it are not. By one name or another, there is long experience relevant to our present concerns. Over centuries, collective actions, such as the emancipation of women, universal franchise, the labour movement, and the civil rights movement, have contributed to the improved living and working conditions of millions of people worldwide. Although not explicitly concerned with health, such movements have advanced people’s ability, globally, to lead a flourishing life.

The good health of the Nordic countries has long attracted attention. Analysis of the Nordic health improvements since the latter part of the 19th century emphasized the importance of civil rights, political rights, and social rights (Lundberg et al., 2007). Important features of the Nordic experience include commitment to universalist policies based on equality of rights to benefits and services, full employment, gender equity, and low levels of social exclusion. These are related to a relatively compressed income distribution and the absence of large differences in living standards between individuals and population groups.

Some low-income countries, Costa Rica, China, India (State of Kerala), and Sri Lanka, have achieved a level of good health out of all proportion to expectation based on their level of national income. This suggests strongly that good and equitable health do not depend on a relatively high level of national wealth. Cuba is another example. The lessons to be learned from these countries emphasize the importance of five shared political factors (Irwin & Scalı, 2005):

- historical commitment to health as a social goal;
- social welfare orientation to development;
- community participation in decision-making processes relevant to health;
- universal coverage of health services for all social groups;
- intersectoral linkages for health.

Founded in 1948, WHO embodied a new vision of global health, defining health as, “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity”. Thirty years later, in 1978, the community of nations came together again in Alma Ata, where then Director-General Halfdan Mahler advanced his vision that “Health for All” implied removing the obstacles to health quite as much as it did the solution of purely medical problems. The Alma Ata declaration (WHO & UNICEF, 1978) promoted Primary Health Care (PHC) as its central means towards good and fair global health – not simply health services at the primary care level (though that was important), but rather a health system model that acted also on the underlying social, economic, and political causes of poor health.

In the decades that followed, though, a social model of health was not often seen in practice (Irwin & Scalı, 2005). Neither intersectoral action (ISA) nor comprehensive PHC were really put into practice. Under the pressure of an ascendant global package of market-oriented economic policies, including significant reduction in the role of the state and levels of public spending and investment, a different development model was pursued from the 1980s. That model has been the target of a great deal of deserved criticism. Structural adjustment programmes, following the Washington consensus, had – and continue to have, in other policy and programme forms – an overreliance on markets to solve social problems that proved damaging. It has been noted, too, that the set of economic

---

**Figure 2.5:** Trends in male and female life expectancy at age 20, by educational attainment, Russian Federation.

Educational attainment: ○ elementary (open circles), ▼ intermediate (triangles), and ● university (filled circles).

Reprinted, with permission of the publisher, from Murphy et al. (2006).
principles being promoted in low-income countries were not the same as those being followed in high-income countries (Stiglitz, 2002; Stiglitz, 2006).

The proponents of health for all did not disappear. They remain numerous and vocal around the world. The PHC movement has its strong advocates. Indeed, PHC plays a central role in WHO’s current agenda and is the focus of the 2008 World Health Report. The 1986 Ottawa Charter on Health Promotion, and its renewal in Bangkok in 2005, embraced a global vision of public health action and the importance of a social determinants approach (WHO, 1986; Catford, 2005). The Latin American social medicine movement, Community-Oriented Primary Care that started in pre-apartheid South Africa (Kark & Kark, 1983) and spread to Canada, Israel, the United States, and United Kingdom (Wales) (Abramson, 1988), the community health movement in the United States (Geiger, 1984; Geiger, 2002; Davis et al., 1999), Canada (Hutchison, Abelson & Lavis, 2001), and Australia (Baum, Fry & Lennie, 1992; Baum, 1995), the Village Health worker (Sanders, 1985) and the People’s Health Movement, the General Comment on the Right to Health, and the broad social vision of the MDGs all reaffirm the central importance of health, the need for social and participatory action on health, and the core human value of equity in health (Tajer, 2003; PHM, 2000; UN, 2000a; UN, 2000b). The Commission acknowledges a great debt to these movements, and builds on their achievements and continuing vision.
CHAPTER 3
Causes and solutions

There is no question that differences in health within and between countries can change quickly. It is our judgement that this process can be encouraged by better economic and social arrangements.

SOCIAL POLICIES, ECONOMICS, AND POLITICS THAT PUT PEOPLE AT THE CENTRE

At the heart of our concern is creating the conditions in which people can lead flourishing lives. People need good material conditions to lead a flourishing life; they need to have control over their lives; and people, communities, and countries need political voice (Sen, 1999). Governments can create conditions for good and equitable health through careful use of social and economic policy and regulation. Achievement of health equity will take action across the whole range of government supported by an international policy environment that values holistic social development as well as economic growth. Money, while by no means the whole solution, is critical. The minister of finance may have more influence over health equity than the minister of health, the global financial architecture more influence than international assistance for health care.

But it is not just government that must act. Where government lacks capacity or political will, there must be technical and financial support from outside, and a push from popular action. When people organize – come together and build their own organizations and movements – governments and policymakers respond with social policies.

INEQUITY IN CONDITIONS OF DAILY LIVING

Of the 3 billion people who live in urban settings, about 1 billion live in slums. In most African countries, the majority of the urban population live in slums. In Kenya, for example, 71% of the urban population live in slums; in Ethiopia, 99%. It takes only 10-20 years for the urban population to double in many African countries (World Bank, 2006b).

Half of the rural population in Mozambique has to walk for longer than 30 minutes to get water; only 5% of the rural population have access to piped water (DHS, nd).

Around 126 million children aged 5-17 are working in hazardous conditions (UNICEF, nd,a).

In India, 86% of women and 83% of men employed in areas outside the agricultural sector are in informal employment (ILO, 2002).

In the African region, coverage for old-age income protection is lower than 10% of the labour force (ILO, nd).

Over 900 doctors and 2200 nurses trained in Ghana are working in high-income countries. Ghana has 0.92 nurse per 1000 population; the United Kingdom has over 13 times as many (WHO, 2006).

There will, of course, need to be a partnership with the health sector in both disease control programmes and the development of health systems. It is likely that paying attention to the social determinants of health, including health care, will make health services more effective. The health sector will also play a leadership and advocacy role in the development of policies to deal with the social determinants of health. But lack of health care is not the cause of the huge global burden of illness: water-borne diseases are not caused by lack of antibiotics but by dirty water, and by the political, social, and economic forces that fail to make clean water available to all; heart disease is caused not by a lack of coronary care units but by the lives people lead, which are shaped by the environments in which they live; obesity is not caused by moral failure on the part of individuals but by the excess availability of high-fat and high-sugar foods. The main action on social determinants of health must therefore come from outside the health sector.

Seeing health and its fair distribution as a marker of social and economic development has profound implications. Where policies – in whichever field of action – aim to improve well-being in the population, health is a measure of success of those policies. Health equity is a measure of the degree to which those policies are able to distribute well-being fairly.

One set of the Commission’s recommendations deals with the circumstances in which people are born, grow, live, work, and age. But people’s lives are shaped by a wider set of forces: economics, social policies, and politics. These, too, must be addressed and much of the report and its recommendations do this.

We stated that a toxic combination of poor social policies, unfair economics, and bad politics is responsible for much of health inequity. In low-income countries and some poor communities in rich countries, this translates into material deprivation: lack of the material conditions for a decent life. No one who has experienced the slums that house 1 billion of the world’s people, no one who has witnessed the lack of opportunities for economic livelihood of the world’s rural poor, can doubt the importance of combating poverty. The toxic combination is also responsible for the social gradient in health in those who are above the level of material deprivation but still lack the other goods and services that are necessary for a flourishing life.
STRUCTURAL DRIVERS OF HEALTH INEQUITIES

The top fifth of the world’s people in the richest countries enjoy 82% of the expanding export trade and 68% of foreign direct investment – the bottom fifth, barely more than 1% (UNDP, 1999).

In 1999, the developing world spent US$ 13 on debt repayment for every US$ 1 it received in grants (World Bank, 1999).

Of the population in the developed nations, 20% consume 86% of the world’s goods (UNDP, 1998).

In 1997, the East Asian financial crisis was triggered by a reversal of capital flows of around US$ 105 billion, a relatively small amount in global terms, but equivalent to 10% of the combined gross domestic product (GDP) of the region. Similar shocks have since affected Russia and Brazil (ODI, 1999).

Since 1990, conflicts have directly killed 3.6 million people, (UNICEF, 2004). Sudan has 5.4 million internally displaced people, Colombia 3 million, Uganda 2 million, Congo 1.7 million, and Iraq 1.3 million (UNHCR, 2005).

Many countries spend more on the military than on health. Eritrea, an extreme example, spends 24% of GDP on the military and only 2% on health. Pakistan spends less on health and education combined than on the military (UNDP, 2007).

Each European cow attracts a subsidy of over US$ 2/day, greater than the daily income of half the world’s population. These subsidies cost the European Union (EU) taxpayer about 2.5 billion per year. Half of this money is spent on export subsidies, which damage local markets in low-income countries (Oxfam, 2002).

BOX 3.1: INEQUITY AND INDIGENOUS PEOPLES – THE EFFECTS OF A TOXIC COMBINATION OF POLICIES

Indigenous People worldwide are in jeopardy of irrevocable loss of land, language, culture, and livelihood, without their consent or control – a permanent loss differing from immigrant populations where language and culture continue to be preserved in a country of origin. Indigenous Peoples are unique culturally, historically, ecologically, geographically, and politically by virtue of their ancestors’ original and long-standing nationhood and their use of and occupancy of the land. Colonization has de-territorialized and has imposed social, political, and economic structures upon Indigenous Peoples without their consultation, consent, or choice. Indigenous Peoples’ lives continue to be governed by specific and particular laws and regulations that apply to no other members of civil states. Indigenous People continue to live on bounded or segregated lands and are often at the heart of jurisdictional divides between levels of government, particularly in areas concerning access to financial allocations, programmes, and services. As such, Indigenous Peoples have distinct status and specific needs relative to others. Indigenous Peoples’ unique status must therefore be considered separately from generalized or more universal social exclusion discussions.
ECONOMIC GROWTH AND SOCIAL POLICIES

Wealth is important for health. The relation of national income to LEB is shown in Fig. 3.1 – the Preston curve (Deaton, 2003; Deaton, 2004). At low levels of national income there is a steep relation between income and LEB. This is consistent with the benefits of economic growth improving life chances and health. But there are two important caveats. First, at higher levels of income, above about US$ 5000 at purchasing power parity\textsuperscript{2}, there is little relation between national income and LEB. Second, there is great variation around the line. As described earlier, there are notable examples – Costa Rica, India (Kerala), Sri Lanka – of relatively poor countries and states achieving excellent health without the benefit of great national wealth. Among the lessons from those countries is the importance of good social policy emphasizing education, particularly for girls and women.

Economic growth gives the opportunity to provide resources to invest in improvement of people's lives. But growth per se, without appropriate social policies, brings no benefit to health. Economist Angus Deaton warns, "Economic growth is much to be desired because it relieves the grinding material poverty of much of the world's population. But economic growth, by itself, will not be enough to improve population health, at least in any acceptable time. ... As far as health is concerned, the market, by itself, is not a substitute for collective action" (Deaton, 2006a; Deaton, 2006b). Growth with equitable distribution of benefits across populations is the key. Collective action may involve building social institutions and adopting regulations that both deliver people's needs for housing, education, food, employment protection, environmental protection and remediation, and social security, and correct for market failure (Stiglitz, 2006).

ECONOMIC GROWTH AND ITS DISTRIBUTION

For any country – arguably most pressingly for countries with low incomes – economic growth brings the possibility of great benefit. But there has, to date, already been enormous global growth in wealth, technology, and living standards. The issue for the world is not whether it needs further economic growth in order to relieve poverty and achieve the MDGs. To do that, there is wealth and income in abundance. The question is how it is distributed and used.

First, the benefits of economic growth over the last 25 years – a period of rapid globalization – have been shared most unequally among countries. Table 3.1 shows that in 1980 the richest countries, containing 10% of the world's population, had gross national income 60 times that of the poorest countries, containing 10% of the world's population. By 2005 this ratio had increased to 122.

**Table 3.1** Increasing income inequality among countries

<table>
<thead>
<tr>
<th>Year</th>
<th>Richest countries*</th>
<th>Poorest countries*</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>US$ 11,840</td>
<td>US$ 196</td>
<td>60</td>
</tr>
<tr>
<td>2000</td>
<td>US$ 31,522</td>
<td>US$ 274</td>
<td>115</td>
</tr>
<tr>
<td>2005</td>
<td>US$ 40,730</td>
<td>US$ 334</td>
<td>122</td>
</tr>
</tbody>
</table>

*Containing 10% of the world's population. Data derived from Table 1 in the World Bank's World Development Reports for 1982, 2002, and 2007, respectively, and market exchange rates in the relevant years. The ratios among these nominal US$ figures are comparable across years.

Reprinted, with permission of the publisher, from Pogge (2008).

---

\textsuperscript{2}A purchasing power parity exchange rate equalizes the purchasing power of different currencies in their home countries for a given basket of goods.
Second, international flows of aid – grossly inadequate in themselves, and well below the levels promised by Organization for Economic Cooperation and Development (OECD) donor countries in 1970 – are dwarfed by the scale of many poor countries’ debt repayment obligations (UNDESA, 2006). The result is that, in many cases, there is a net financial outflow from poorer to richer countries – an alarming state of affairs. These financial flows are themselves small in comparison with the massive volumes of capital flowing through global financial markets – at a rate of US$ 3.2 trillion per day in 2007 (HIFX, 2007) – with enormous potential, through capital flight, to disrupt the socioeconomic development of low- and middle-income countries.

It has been calculated that the annual cost of bringing the 40% of the world’s population currently below the US$ 2/day line up to it would be US$ 300 billion – less than 1% of the gross national income of the high-income countries (Pogge, 2008). We will make the point throughout this report that money alone is not the central point. More important is the way the money is used for fair distribution of goods and services and building institutions within low-income countries. But this simple calculation shows that there is no global shortage of money.

Third, income inequality applies not only between but also within countries. The trend over the last 15 years has been for the poorest quintile of the population in many countries to have a declining share in national consumption (MDG Report, 2007). There has been a vigorous debate as to whether income inequality itself is a major contributor to the level of health of a country (Wilkinson, 1996; Deaton, 2003). However, income inequality is one marker of the unequal distribution of goods and services. There is therefore strong empirical justification for a concern with growing income inequalities. Governments have the power to reduce the effects of pre-tax income inequality. Fig. 3.2 shows, for a number of high-income countries, the effects of policy on poverty (Lundberg et al, 2007). It takes a relative definition of poverty as below 60% of median income and shows that in Nordic countries fiscal policy leads to a much lower prevalence of poverty than in the United Kingdom or the United States. Policy matters.

For countries at lower levels of national income, it should be obvious that greater economic growth will have a much smaller effect on income poverty the greater the income inequalities. The United Nations Development Programme (UNDP) has calculated that in Kenya, for example, at current economic growth rates, and with the present level of income inequality, the median family in poverty would not cross the poverty line until 2030. Doubling the share of income growth enjoyed by the poor means that reduction in poverty would happen by 2013. In other words, the MDG for reduction in poverty implies attention to the distribution of income not just economic growth.

Figure 3.2: Proportion relatively poor pre- and post-welfare state redistribution, various countries.

---

Poverty threshold = 60% of median equivalent disposable income.
*For these countries, the poverty threshold before redistribution is calculated on incomes net income taxes.

Data from the Luxembourg Income Study.
Reprinted, with permission of the authors, from Lundberg et al. (2007) citing Ritakallio & Fritzell (2004).
RETURNS FROM INVESTING IN HEALTH

Just as economic growth, and its distribution, is vitally important for health, investment in health and its determinants is an important strategy for boosting economic development (CMH, 2001). Raising the health status of people lower down the social hierarchy even to the population median level of health would have a major impact on overall health and should improve a nation’s productivity (Box 3.2) (Health Disparities Task Group, 2004; Mackenbach, Meerding & Kunst, 2007).

BOX 3.2: INVESTING FOR HEALTH AND ECONOMIC RETURN, CANADA

A study in Canada shows that reducing health disparities has the potential for major economic benefits resulting from a reduction both in health-care needs and in the costs of lost productivity.

Health-care spending in Canada is about 120 billion Canadian dollars per year (with the institutionalized population accounting for 26 billion Canadian dollars and the household population accounting for 94 billion Canadian dollars). The lowest income quintile of the household population accounts for approximately 31% of the 94 billion Canadian dollars, approximately double the utilization of the highest-income quintile. The study reported that if the health status and utilization patterns of those in the lower-income groups equalled those with middle income, significant savings on health-care costs could be possible.

In addition, the study reported that better health enables more people to participate in the economy. Reducing the costs of lost productivity by only 10-20% could add billions of dollars to the economy.

Source: Health Disparities Task Group, 2004