

Closing the global health gaps in a generation – how is it possible?

Denny Vägerö

Denny Vägerö is a social scientist and epidemiologist. Most of his career he spent at the cross road of medical and social sciences, working at the Swedish Institute for Social Research, Karolinska Institutet, London School of Hygiene and Tropical Medicine and the Max Planck Institute for Human Development in Berlin. Since 2000, he is the director of the Centre for Health Equity Studies in Stockholm (CHESS). The last three years Denny Vägerö was a member of the WHO Commission on Social Determinants of Health.

In 1948 the UN declared that everyone has the right to the highest attainable level of health¹. Sixty years after 1948 and 30 years after the Alma Ata Declaration² there is a new appeal to the world community. The Commission on Social Determinants of Health calls for a closing of the global and national health gaps in a generation³.

This, surely, is a formidable task. If it is possible or not depends entirely on whether or not we continue “business as usual” or whether we make a radical break with present social and economic trends, which in many ways are unsustainable. Global life expectancy has increased by more than two decades since the UN declaration of 1948, but the pace of improvement has been slowing down and large segments of the world population are in fact left behind.

The present global system, arranged to promote economic growth and trade, often disregards “negative externalities”, such as health risks, social disruption or climate change. The climate situation appears to be moving closer to a “tipping point” of irreversible change. The very large gaps in health and wealth across the globe are growing. The average life expectancy difference between two individuals randomly drawn from the human population is about 6 years⁴, but there is a 30–40 year difference in life expectancy when comparing Japan or Norway to Botswana, Sierra Leone and a host of other countries. Within countries, or indeed within cities, life expectancy gaps can be of a magnitude of 15–25 years, as for instance between areas in Glasgow, Scotland, between whites and blacks in parts of USA or between states in India³.

The global life expectancy gap has increased since around 1985/90, with a number of countries showing falls in life expectancy⁴. Within countries too, mortality and/or life expectancy differences seem to be growing during the same period. This is true in rich countries like Sweden, in transition countries like Russia, and in many poor countries³.

Are we solving the problem? Why not?

In anticipation of the new millennium, world leaders pulled themselves together to formulate Millennium Development Goals, which were to be reached by the year 2015. All MDGs are directly or indirectly related to health. MDG 4 and MDG 5 set quantitative health targets, which demand a reduction of child mortality (under 5 mortality, U5) by $\frac{2}{3}$ and maternal mortality by $\frac{3}{4}$ between 1990 and 2015⁵.

Monitoring of these goals now reveals that it is unlikely that they will be met. The “Countdown to 2015” group has followed the progress from 1990–2006 of 68 countries, which together carry 97% of the global U5 mortality burden. Sixteen countries were “on track” to meet MDG 4, meaning that their annual improvement for 1990–2006 was sufficient to reach that goal, if the improvement was sustained until 2015. The other 52 countries were not making sufficient progress and 12 of those were in fact moving backwards with increasing U5 mortality rates⁶. The progress in maternal mortality was equally bleak. I share the authors’ view that unequal access to reproductive and child health services is partly responsible for this lacking or insufficient progress. But it is equally true that a much broader set of policies, focussing on conditions of daily life, are necessary. In practice, a major reduction of U5 mortality globally requires gaps within and between countries to close radically.

However, it is the long term rise in adult mortality, in particular in Sub-Saharan Africa and former Soviet Union, which is driving the shift from convergence to divergence in global health. Adult mortality is increasingly determined by chronic, non-communicable disease, on all continents, an issue not addressed in the MDGs.

Addressing daily living conditions and the global economic and political system

Following Alma Ata, the WHO coined the phrase “Health for all by the year 2000”. Targets for reduction of health differences between countries and within countries were set up. We failed to achieve these targets, just like we risk failing the MDGs. The reason in both cases, CSDH believes, is that the policy change was not bold enough. CSDH presents in its report a number of recommendations, some of which are far-reaching. To reach far means addressing the root causes of ill-health, disease and mortality. These are embedded in our daily living conditions and, equally important, in the present system of global governance, politics and economy.

Thus, CSDH makes three over-arching recommendations for global health equity: 1) improve daily living conditions; 2) tackle the inequitable distribution of power, money and resources and 3) measure and understand the problem and assess the impact of action

Improving daily life, for instance by providing water, sanitation and electricity for all households (recommendation 6.2) and free schooling for all boys and girls everywhere (recommendation 5.4) are hardly controversial recommendations. But their realisation is. Consensus in principle is far from sufficient for implementation. The second overarching recommendation is certainly more controversial, since those enjoying power and resources do not usually like to loose or share them. However, a change in how the global system works is

necessary in order to implement the first set of recommendations. Experience also tells us that if a nation agrees that power and resources should be shared more equally among citizens, improvement of daily living conditions for the majority will often follow. Surely, the same is true for the global society: more fair arrangements of global trade (recommendations 6.4 and 12.2), regulation of trade with health-damaging commodities (recommendation 12.3), global tax options (recommendation 11.2) or massive programs for global “slum upgrading” (recommendation 6.2 and page 144) would benefit those most in need. Reform of the WHO (recommendation 15.3) and adoption of global health equity as a development goal by UN (recommendation 15.1) may help guide efforts in this way.

Targets and monitoring of success in “closing the gap”

The success of policies to achieve global health equity could be measured against both child and adult mortality: are improvements shared by all countries and all socioeconomic groups? A reduction of U5 mortality by 90% together with a halving of adult mortality rates between 2000 and 2040, in all countries and all socio-economic groups, are targets suggested by CSDH. Reaching these targets would represent a huge improvement of global health and would indeed define success in “closing the gap in a generation”³. How to achieve this is what is discussed in this challenging report.

References

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Address for correspondence

Denny Vägerö
Centre for Health Equity Studies, CHES
Stockholm University/ Karolinska
Institutet
106 91 Stockholm
Sweden
E-mail: denny.vagero@chess.su.se