Calling all Don Quixotes and Sancho Panzas: Achieving the dream of global health equity through practical action on the social determinants of health

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The international conference ‘Closing the gap in a generation: health equity through action on the social determinants of health’, November 2008 (1) was a global call to action - a call to develop and implement public policies, private sector responsibility and social action that put health equity as a central goal. Over the course of two days politicians, senior public servants, leaders of international organisations, civil society activists, and academics, from all regions of the world, discussed the issues, conclusions and recommendations made by the Commission on Social Determinants of Health (CSDH)(2). The CSDH was set up in 2005 by the World Health Organisation (WHO) as a major global effort to address health inequity between and within countries (3). Its Final Report was presented to Dr Margaret Chan, Director General of WHO in August 2008. Here we describe the key issues debated at the November conference and outline a global research, training and policy agenda for health equity.

Fair health

Sir Michael Marmot, the chair of the CSDH, used Puccini’s opera *Turandot* to illustrate the relationship between fairness of process, fairness of outcome and fairness in health. In the opera, those who compete for the princess’s hand are given a choice: Answer three riddles correctly and you marry the princess. Fail any of the three riddles and you are executed. No male is forced to make that choice, hence, arguably a fair process. The outcome is anything but fair - a trail of dead suitors and one chaste princess. Would we judge the society in which such a princess lived to be a fair society? Most of us think that fairness in society means more than freedom to choose. Freedom to choose after all is socially determined. It is influenced by power, money, and resources. Society is not organised in a way that gives all people freedom to choose. That inequity in freedoms is illustrated by the marked inequities in health, both between and within countries.

Central to health equity - the goal of the CSDH and purpose of the November conference – is empowerment of individuals, communities and nations. By empowerment we mean having enough physical and financial resources (material empowerment), control (psychosocial empowerment) and voice (political empowerment) to have the freedom to live healthy lives. The CSDH recommendations are all about creating the conditions (both structural and everyday life) that empower people, communities and nations.

When the CSDH final report was launched, Dr. Margaret Chan said, ‘This ends the debate decisively. Health care is an important determinant of health. Life styles are important determinants of health. But it’s factors in the social environment that determine access to health services and influence lifestyle choices in the first place.’

There was general consensus at the conference that the current model, the way of doing things, globally, is wrong. The model, implicitly, was “set the individual free and everything will be alright”. The marked inequities in health that we see today, the credit crisis and consequent economic recession, and the precarious environmental destruction are testaments to the fact that indeed things are not alright.

Dreaming of fairness

Can things get better? In Egypt, under-fives mortality declined from 235 to 35 per 1,000 live births in less than 40 years. The rates in Egypt in 2005 were less than in Portugal and Greece in 1970 (2). But just as things can improve with remarkable speed, they can also deteriorate fast, as witnessed, among others, in parts of Africa. Many issues were discussed at the conference, as being key to creating the conditions that will improve health equity, prevent further deterioration of health equity and move the world towards the aspiration of closing the health gap in a generation.

Money matters

The current credit crisis is an opportunity to begin to do things differently. It is an opportunity to re-consider our core values, and with this, the distribution of international financial flows and how national wealth is generated and allocated.

The UK found 900 billion dollars to save the banks. The US found 700 billion dollars. One billion people in the world live in slums. The CSDH estimated that upgrading of the slums could be done for 100 billion dollars. For one ninth of the money that was put in to save the banks, every urban resident in the world could have clean running water.

It has been estimated that between 11 and 17 billion dollars is needed globally to ensure that every child can go to school free at the point of use. Kenya abolished school fees, meaning more children are going to school. But there is an urgent need for school infrastructure, for teachers, for capacity, for budgets. In Kenya’s last two budgets 350 million more dollars were allocated to debt relief than to education.

The Secretary of State for Health, England, Alan Johnson, noted that Britain will honour its commitment to 0.7% of gross national income in overseas development assistance. But aid is only one part of it. In the context of debt service by region, in sub-Saharan Africa there is more aid going in than there is money coming out. But, in every other region of the world there is more money coming out in debt service than there is money going in, in overseas development assistance. There is an enormous amount that we can do in paying attention to these debts.

In sub-Saharan Africa, between 30 and 40% of government revenues come from trade tariffs. If, as part of trade negotiations, governments must abolish tariff protection, at a stroke sub-Saharan governments reduce 30 to 40% of their revenues. Saying then to those governments you must invest in social protection, schools and education seems somewhat ironic. If, as a global society, we want to promote free trade then let us do it in a fair way.

It is a reasonable question to ask why investments in slum upgrading, provision of free education, and infrastructure to sustain the education, have so far, been inadequate. If we think it is urgent enough, the money can be found. The fact is slum

upgrading and education, and the subsequent improve in people's health, have not been deemed important enough, either by the global community or within financially-able countries.

Social solidarity - Public sector leadership
Throughout the course of two World Wars, countries were drained of finances, institutional capacity and good infrastructure. Yet, even in times of severe economic hardship, in 1942 William Beveridge saw reason to provide strong public sector leadership and established the welfare state to help support and re-build a nation, based on principles of fairness.

Action on health inequity requires, as the British Prime Minister and Secretary of State for Health, England said at the conference, action across the whole of government. Pre-welfare state distribution, poverty levels - defined as less than 60% of the medium income - were higher in the UK than in the US. After distribution through the tax and benefit system, there is a 50% drop in poverty levels in the UK and 24% in the US. In the Nordic countries – Finland, Norway, Sweden – welfare state distribution leads to a 70% drop in poverty (4). The minister of finance can decide what the poverty level will be, with ramifications for health inequity. A progressive policy development would be the adoption of the principle 'health equity in all policies'. Institutionalizing health equity impact assessment of all major policy decisions, using already available tools and methods, is one way of making this principle practical.

Social solidarity – the power of community
Societal fairness is rooted not just in an equity focus in central national policy-making. Empowerment of social groups, communities and nations, through their representation in policy-related agenda-setting and decision-making is critical, and so too is action through bottom-up, grassroots approaches. Fran Baum, one of the CSDH Commissioners, talks about the nutcracker effect: commitment from the politicians and grassroots action (5). The struggles against the injustices encountered by the most disadvantaged in society, and the process of organizing and acting builds local people's leadership. It is empowering - giving people a greater sense of control over their lives and future.

David Satcher, one of the CSDH Commissioners and former US Surgeon General, invited the CSDH to a workshop in New Orleans, Louisiana. Hurricane Katrina, he suggested, illustrated the fault lines in American society. Pre Katrina, Louisiana had a higher percentage of i) African Americans, ii) children living in poverty, iii) elderly non-insured and iv) uninsured for medical care compared to the US average. Pre-Katrina, New Orleans was in a situation of poverty but there was also, it turns out, a lack of social organisation. Arguably, the combination of material poverty and lack of control turned a natural phenomenon, Hurricane Katrina, into a disaster. What the CSDH saw in New Orleans, in the re-generation of the city post-Katrina, was communities taking control of the situation using a community development approach. 'This is solidarity, they said, not charity'. That is empowerment.

Common agendas – social determinants, climate change and health inequity
Against the backdrop of endemic global health inequity, humankind is disrupting the global climate and other life-supporting environmental systems, thereby posing

serious risks to health and well-being, especially in vulnerable populations but ultimately for all. The underlying determinants of health inequity and of environmental change overlap substantially. They reflect, in particular, an economic system predicated on asymmetric growth and competition, shaped by market forces that mostly disregard health and environmental consequences and limits rather than by values of fairness and support (6).

The CSDH did not go far into the realm of climate change and environmental degradation. We did however recommend the need to ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity. In addition we said that when the IPCC recommendations are being implemented, consider the health equity impact of agriculture, transport, fuel, buildings and waste strategies. It is timely, indeed critical, that much more analysis of the relationship between the social determinants of health and environmental change and health inequities takes place – thereby identifying the potential benefits for people and planet from coherent cross-sectoral policies and programs at local, national and global levels. Today's global interconnectedness and inter-dependence enable the social and environmental determinants of health to be addressed in ways that will increase health equity, reduce poverty, and build societies that live within environmental limits.

Turning dreams into reality

Wishing for health equity is one thing. Making it reality is another. There are a number of challenges, some of which are listed below.

Rebalance the power distribution

The right to the conditions necessary to achieve the highest attainable standard of health is universal (7),(8). However the risk of having one's rights violated is not universal and this inequity in risk of violation results from entrenched structural inequities (9). Manifesting across a range of intersecting social categories – class, education, gender, age, ethnicity, disability, and geography – social inequity reflects deep and entrenched inequities in the wealth, power, and prestige of different people and communities.

Any serious effort to reduce health inequities will involve changing the distribution of power within society and global regions. The CSDH said change in power relationships can take place at various levels and we talk about the empowerment of social groups through representation in the policy related agenda and grassroots action. In the CSDH report we called for civil society to organise and act in a manner that promotes and realises the political and social rights affecting health equity. We said strengthen political and legal systems to protect human rights. Assure legal identity and support the needs and claims of marginalised groups, particularly indigenous people.

Political leadership

Making health equity a marker of the progress of society requires its adoption and leadership at the highest political level within a nation. The November conference, hosted by the Department of Health for England, was opened by the British Prime Minister, who expressed his profound commitment to global health equity. The Secretary of State for Health, asking how to apply the CSDH recommendations

domestically, set up a review – a national commission – to work out practical policies for England. Manmohan Singh, the Indian Prime Minister, asked what the CSDH recommendations meant for India. Like England, and Brazil too, India and other nations, could translate the principles outlined in the CSDH report into policies and programs suitable for the country context. But it need not just be an internal process – these national mechanisms can provide global learning.

The Ministry of Health

At the conference, the English Minister of Public Health, Dawn Primarolo noted that she believed ‘coherence, leadership, and intersectoral action’ to be vital for health equity. Ultimately, achieving health equity requires action across the whole of government. However, the health sector itself is a good place to start building support and structures that encourage action on the social determinants of health equity.

The ministry of health can put its own house in order and provide universal access to health care regardless of ability to pay. Mirta Rosas, WHO Director for the American region, PAHO, talks about ‘the sisterhood of primary health care and social determinants of health’. Primary health care, as an organizing framework for the health care sector, provides a platform from which the ministry of health can provide strong stewardship for intersectoral action for health equity. The ministry of health can be the advocate for a social determinants approach to health equity across government, with industry, and with civil society organisations.

Market responsibility

The CSDH report remarks that markets can provide considerable health benefits, but they need regulation. And certain public goods are not delivered well by markets. Having witnessed the credit crisis, is there anybody in the world who now doubts that markets need regulation?

Accountability

Genuinely addressing health equity is not a matter of just ticking the boxes. Ministerial public addresses, the establishment of national commissions or proclamations of corporate social responsibility means little if the quality of life and levels of population health do not improve. Public accountability is underpinned by data. Measuring and monitoring health inequities and evaluating the impact of public and private sector action on health outcomes are vital.

Towards the dream

The crucial next step towards the dream of fairness in health is turning the CSDH framework into practical action. The CSDH report was a call to action. The November conference was an important step in the elucidation of what is needed globally, nationally and locally and how to make it happen. A plethora of approaches are needed, including social action, community development, policy with action plans, and private sector responsibility.

The world needs dreamers and pragmatists. As Sir Michael Marmot noted in his closing speech at the November conference *‘I don’t think we can go forward with only the one or only the other. We need Don Quixote, the man with a funny hat, sitting on his old donkey thinking he’s a medieval knight. And we need Sancho Panza, the pragmatist.’*

Reference List

(1) Closing the Gap in a Generation Conference. 2008.http:www.csdhconference.org/.

(2) Commission on Social Determinants of Health. CSDH Final Report: Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: World Health Organization; 2008.

(3) Marmot M, Friel S, Bell R, Houweling TA, Taylor S. Closing the gap in a generation: health equity through action on the social determinants of health. Lancet 2008 November 8;372(9650):1661-9.

(4) Lundberg, O., Åberg Yngwe, M., Kölegård Stjärne, M., Björk, L., and Fritzell, J. The Nordic Experience: welfare states and public health (NEWS). Health Equity Studies No 12. Report for the Commission on Social Determinants of Health. Stockholm: Centre for Health Equity Studies (CHESS), Stockholm University/Karolinska Institutet; 2008.

(5) Baum F. Cracking the nut of health equity: top down and bottom up pressure for action on the social determinants of health. Promot Educ 2007;14(2):90-5.

(6) Friel S, Marmot M, McMichael AJ, Kjellstrom T, Vagero D. Global health equity and climate stabilisation: a common agenda. Lancet 2008 November 8;372(9650):1677-83.

(7) United Nations. The Universal Declaration of Human Rights. 1948.

(8) UNHCR. Article 12 of the International Convention on Economic, Social and Cultural Rights. http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article12; 1976.

(9) Farmer P. Pathologies of power: rethinking health and human rights. Am J Public Health 1999 October;89(10):1486-96.