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Commentary

Tackling global health inequalities: closing the health gap in a generation

"Social injustice is killing people on a grand scale."

WHO Commission on Social Determinants of Health (2008, page 26)

It is well established that good health is not evenly shared. Both between and within most nation-states, inequalities in health outcomes, health care expenditure, and health care utilisation among various social and ethnic groups are profound. Socially and economically disadvantaged groups and areas, as well as ethnic minority and indigenous populations, commonly have relatively worse health than more advantaged groups. The recording and revealing of health inequalities have a long history, which in England extends as far back as the pioneering work of Edwin Chadwick, Friedrich Engels, and others during the mid-19th century (Davey Smith et al, 2001). Chadwick, for example, documented the marked health gap between social class groups in Victorian London. For males in the parish of Bethnal Green, life expectancy ranged from 16 in the 'lower class' group to 45 among the 'middle class' (Chadwick, 1843). A life expectancy of 16 was sustained through persistently high infant mortality rates, and the significant number of the rural poor migrating into London. In Britain infant mortality rates peaked in the hot summer of 1905. By age group, by far the largest numbers of bodies buried in (often unmarked) Victorian graveyards were of newly born infants (Dorling, 2006).

By the end of Queen Victoria's reign, as many as a quarter of the infants born in English working-classes towns were dying within the first year of life. In his 1899 survey of poverty in York, Benjamin Seebohm Rowntree documented that the lowest recorded mortality rates among the least deprived classes were still as high as one in ten of all young children (Rowntree, 1901). Importantly, Rowntree noted a clear *gradient* in infant mortality across three working-class districts of the city that were arranged by occupation type and income (table 1). The rates incrementally decreased from the most deprived to least deprived district or group. For example, the infant mortality rate (under 12 months) of babies in the poorest area of the city was more than 2.5 times that of the 'servant-keeping' classes. For the first time, these studies

Table 1. Mortality rates in York, England in 1898 (source: Davey Smith et al, 2001, pages 102 – 104).

Working-class area	Overall[a, b]	Children aged 1 – 4 years[c]	Children under 12 months[d]	Persons over 5 years[a, b]
Area 1 (poorest)	22.78	13.96	247	13.8
Area 2 (middle)	20.71	10.50	184	10.2
Area 3 (highest)	13.49	6.00	173	7.5
Servant-keeping class			94	
Whole of York	18.50	7.37	176	11.1

Note. All figures exclude deaths in public institutions (eg workhouses).
[a] Deaths per annum per 1000 of the population.
[b] Figures not age adjusted.
[c] Deaths per annum per 1000 population of all living ages.
[d] Deaths per annum per 1000 children born.

began to reveal that health was causally related to social position, which itself was embedded in the social structures around which society was built.

More than a century later, inequalities in health in England, and most other countries, persist. This 'health gap' remains unrestricted to simple dichotomies (eg rich/poor, black/white) but, instead, a social gradient in health remains across all groups. When individuals or geographical areas are stratified by measures of poverty or socioeconomic status (eg wealth, education, ethnicity, occupation, or social deprivation), average health status incrementally improves from the least to most advantaged groups. Importantly, it has been observed that since the 1970s relative inequalities in health status have tended to widen both between (Dorling et al, 2006) and within (Mackenbach et al, 2003) many countries. For example, since the early 1980s in nation-states such as the United Kingdom, the United States, and New Zealand, geographical inequalities in life expectancy have sharply increased by between 50 and 60% (Pearce and Dorling, 2006; Shaw et al, 2005; Singh and Siahpush, 2006).

There is a substantial literature seeking to explain the recent social and spatial polarisation in health. A range of structural, material, and sociocultural factors have been implicated. The premise of the argument is that access to resources and opportunities such as wealth, education, employment, and health care are themselves unevenly distributed, and this injustice underlies the social distribution in health status. Recently, market-oriented economic and social policies intended to deregulate the labour market and constrain social security have widened inequalities in social position. However, the story is not straightforward. Recent evidence suggests that the uneven allocation of resources in nonegalitarian societies is not only disadvantageous for more socially deprived groups, but is also harmful to more affluent groups. National-level income inequality, a marker of social stratification, is also a key driver of a nation's health and well-being (Dorling et al, 2007). For example, among richer nations, countries that have maintained high levels of income inequality in recent years have the highest prevalence of mental illness. In the United States, the United Kingdom, Australia, and New Zealand, it takes the poorest fifth of society at least seven days to earn or be awarded what the richest fifth receive for a single day's labour (see www.worldmapper.org maps 151 and 152). The rates of inequality in these countries are the highest of all affluent nations worldwide. It is unlikely to be a coincidence that of the twelve countries with comparable data, it is the same four countries that also have the highest rates of mental illness. In other affluent countries where rates of inequality are 50% lower than in these four countries, the prevalence rates of mental illness are also halved (Wilkinson and Pickett, 2007, figure 1, page 1968). It is almost certain (but remains to be established) that the richest fifth of residents of more unequal countries do not fare as well as the richest fifth in more equitable affluent countries. Support for this notion is provided by recognising which cities in a variety of countries experience the lowest working-age mortality rates (Ross et al, 2005, figure 1). It is thought that inequalities create and nurture fear and anxiety in more unequal countries. They harm the mental health of all involved in living in the more competitive and cut-throat societies they foster. They harm the health of the poor the most, but also of those who supposedly benefit from their poverty: the rich. However, whilst there is a plethora of evidence describing and explaining the rising inequalities in health, to date many high-level reports and public inquiries into health inequalities have been reluctant to fully acknowledge the underlying drivers of social inequalities in health, as well as policy remedies that are likely to succeed in addressing these disparities.

Given this inertia, the recent publication of the report by the World Health Organisation's Commission on Social Determinants of Health entitled *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*

marks a welcome shift in emphasis (WHO Commission on Social Determinants of Health, 2008). The report questions, for example, how a child born in Japan can expect to live more than 80 years, whereas in many African countries less than 50. Stark inequalities in health are also evident at a local level including, for example, the 28-year difference in life expectancy between two Glaswegian children living only a few suburbs apart. The report, which was authored by a twenty-strong international commission from a range of academic, political, and advocacy backgrounds, is overt and sufficiently courageous to claim that "social injustice is killing people on a grand scale" (page 26). Given the breadth and the strength of the presented evidence, it is difficult not to be convinced by the authors' assertion that the social distribution in health is not a natural phenomenon but rather the "toxic combination of poor social policies and programmes, unfair economics, and bad politics is responsible for much of health inequity" (page 35). Importantly, the report is unequivocal in elucidating the causal pathways between an array of social factors and various health and health-related outcomes.

So what needs to be done? The Commission sets out a suite of policy priorities that provide an unambiguous agenda for action. The authors are appropriately ambitious, and challenge policy makers to close the health gap in a generation. The report is structured around three overarching recommendations (see table 2 for an overview) that are prescribed to achieve this radical objective:

(1) The first recommendation highlights the need to address the conditions of daily life such as improving educational levels, employment status, and working conditions; eradicating poverty and providing sufficient income and welfare; addressing key urban design issues such as affordable housing, transport, and the provision of water and sanitation; and ensuring universal health care. Whilst the authors of the report recognise that these and other social and material circumstances are important throughout the lifecourse, the living conditions into which children are born are identified as a priority.

(2) Second, the report recognises that it is the deeper social structures and processes that initially generate, and then perpetuate, the inequalities in the conditions required to lead a healthy life (the 'determinants of the determinants'). It is considered essential that the structural drivers of the inequities in social conditions are challenged, including the uneven distribution of power, money, and resources. The authors assert that responsibility for addressing health inequalities must be placed at the highest level of government, and a whole-of-government strategy that considers health inequalities in all aspects of policy making should be established. It is argued that coherent policy making is likely to strengthen governmental resolve to finance action on the social determinants of health, expand the commitment to global aid, as well as equitably allocate government resources for addressing the needs of marginalised populations including, for example, indigenous groups disadvantaged by the legacies of colonialism.

(3) Finally, it is necessary that the magnitudes of health inequalities are precisely measured and continuously monitored. The authors call for local, national, and international surveillance systems to be in place to improve the monitoring of both health inequalities and the social determinants of health. A consistent monitoring framework will better enable the evaluation of the impacts of various health and social policies.

The three principles are bold, and achieving these aims requires effective action from key players operating from the global to local level. Multilateral agencies, the World Health Organisation, national and local government, civil society, a chastened private sector, as well as the researcher community will all be integral. Importantly, successful policy initiatives will have to be underpinned by robust research findings.

Table 2. Recommendations from the World Health Organisation Commission on Social Determinants of Health (adapted from Davey Smith and Krieger, 2008).

Overarching recommendations	Subthemes
1. Improve daily living conditions: enhance the social and physical environments in which people are born, grow, live, work, and age.	Equity from childhood; healthy places; employment and working conditions; social protection across the lifecourse; universal health care.
2. Tackle the inequitable distribution of power, money, and resources: address the deeper social structures and processes that shape inequalities in daily living conditions.	Health equity across all government policies and programmes; target public finances to addressing the social determinants of health; market responsibility; empowerment of women; political empowerment and fair representation in decision making.
3. Measure and understand the problem and assess the impact of action: ensure the basic data systems for collecting vital statistics as well as monitoring health inequalities and social determinants of health are in place.	The social determinants of health: monitoring, research and training.

Research that describes and explains the current situation, generates new understandings, as well as identifying what works successfully in addressing health inequalities will all be required.

Geographers have made, and can continue to make, important contributions to the debates on health inequalities. Recent geographical work includes: monitoring spatial inequalities in health; evaluating macrolevel health determinants including income inequality; considering the role of mobility and migration in establishing health disparities; as well as the voluminous literature on 'place effects' such as neighbourhood poverty, housing, social capital, and access to assorted community resources (Curtis, 2004; Smyth, 2008). This research agenda has been successful in identifying and understanding pertinent structural and place-based determinants, numerous underlying social processes such as globalisation, poverty, and social exclusion, as well as the spatial mechanisms that are often important in rendering these processes into measureable inequalities in health status. Many of these findings have been translated into policy recommendations. Area-based interventions (eg the Healthy Cities model, New Deal for Communities) have had traction. Whilst this brief overview of the geographical work that has contributed to the health inequalities debate barely scratches the surface, the growing body of literature emphasises that understanding the implications for health inequalities of the geographical context in which people are born, live, and age will continue to be important.

The report from the WHO Commission on Social Determinants of Health is timely. The report reveals that globally, nationally, and locally, health is becoming increasingly socially and spatially polarised. The findings provide a stirring reminder that for most people health is not a choice that can be readily modified by simply expanding options in health care provision and encouraging greater personal responsibility in disease prevention. This point remains important because the health strategies of many national governments remain firmly fixated on health campaigns that encourage us to amend our health-related behaviour (quit smoking, eat better, exercise more, etc). Key health policy documents continue to ignore the social determinants of health framework and many health policy makers remain wedded to largely discredited

victim-blaming philosophies. At the time of writing (October 2008) the New Zealand general election campaign is in full swing. It is notable that in their manifestos for health both of the major political parties (National and Labour), as well as most of the smaller parties, continue to promote individual responsibility, and advocate providing greater (often private sector) choice in health care services. There is little explicit or implicit recognition (with the notable exception of the Green Party) that health is socially embedded. Similarly, it is instructive that the United Kingdom government's white paper on addressing the 'obesity epidemic' was entitled *Choosing Health: Making Healthier Choices Easier* (Department of Health, 2004), a title that would appear to downplay any recognition that obesity, like most health conditions, is strongly embedded in a range of social and economic issues. The tenet of these health policy statements is clearly at odds with the more holistic recommendations of the Commission.

Although increasing inequalities in health status over the past three decades are execrable, their rapid escalation also attests that health inequalities are amendable. Whilst an array of microlevel and macrolevel social forces are driving the widening health divide, addressing the common structural, material, sociocultural antecedents—unequal power, colonial attitudes, business 'ethics', and the like—will have considerable and rapid benefits. If there is global support for the report's recommendations then it has the potential to become a landmark document. Coupled with a heightened worldwide awareness that the financial systems that exacerbate health inequalities may not necessarily be beneficial for everyone in the long run, it is an opportune moment to relay the report's key message that reducing inequalities in health is important. The long-term success of the report will depend on the response of the WHO and the national governments, and peoples of the member states. A sustained commitment and the political will to implement a progressive social and economic agenda will be required.

The conclusions of the WHO report are a salient reminder to the governments of member states that reducing health inequalities should be a political priority. Not only are health inequalities unfair and avoidable but, at the very least, the spillover effects such as crime, violence, the spread of infectious disease, as well as alcohol and drug use, affect all of society. Further, determinants-oriented interventions to reduce inequalities in health are cost effective (Woodward and Kawachi, 2000). More probably, even the affluent in highly unequal Anglophone countries are not content with their circumstances. For many governments (including those of New Zealand and the United Kingdom), addressing health inequalities will require a radical shift in policy priorities away from a focus on individual responsibility, to a more potent upstream strategy for confronting the numerous and multifaceted social determinants of health, and the social processes that determine their unequal distribution.

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