

# Global health equity and self-preservation – but only at a price

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Seldom can one report have been greeted with such diverse reactions as the final report of the Commission on Social Determinants of Health.<sup>1</sup> To some, it is visionary, demanding both a personal response and urgent action by the world's policymakers. Others have dismissed it as a simple restatement of what we already know. The majority reaction seems to be that it is important but impossibly idealistic. Yet the judgment of history may be that it has not gone far enough.

The World Health Organization (WHO) set up the Commission on Social Determinants of Health in 2005 to marshal the evidence on what can be done to promote health equity. An astonishingly distinguished international panel of commissioners, led by the UK's Sir Michael Marmot, was asked to synthesise global evidence and to make recommendations. Their report concludes that much of the global burden of disease and premature death is avoidable, and therefore unacceptable. The poor health of those who live in poverty, the social gradient in health within countries and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics. The Commission's prescription is to improve the conditions of daily life, tackle the inequitable distribution of power, money and resources and expand the knowledge base for effective action.

Forty years ago, the WHO's Alma-Ata declaration called for 'health for all by the year 2000'.<sup>2</sup> The motivation at that time was similar: a desire for equity and social justice. The evidence base that informed the WHO's actions was not as impressive as has been assembled by the Commission, but it was substantial. Consequently, the cynics are saying that the Commission's report is nothing new. We have heard several calls for action since Alma-Ata – the most recent of which are the Millennium Development Goals<sup>3</sup> – yet *realpolitik* always seems to triumph.

The optimists say that these ideas may not be new but they are an eloquent expression of the need for social justice: any serious effort to reduce health inequities will involve changing the distribution of power, and the report is a clarion call to the nations of the earth to take action. These optimists warm to the kaleidoscope of evidence that has been mustered to support effective action and take heart from the fact that some low-income countries (Costa Rica, China and Sri Lanka, as well as the Indian state of Kerala) have achieved a level of good health out of all proportion to expectation based on their levels of national income. This strongly suggests that good and equitable health does not depend on a relatively high level of national wealth.

Most who read this will be clinicians who may belong to the cynical or optimistic camps or be somewhere in between. It can sometimes seem, for clinicians, that the social determinants considered by the Commission are distant, spatially and temporally, from patients and the coalface of healthcare. Yet clinicians have a key role to play in responding to inequalities. First, clinical interventions can help reduce inequalities in outcome – for example, maternal mortality in developing countries and chronic disease outcomes in industrialised countries. Second, clinical care is needed to respond humanely to the unequal impacts of the social determinants of health. Third, clinicians and their professional organisations can act as advocates and agents of social change.

Why might history judge that even the Commission's idealistic and comprehensive plan has not gone far enough? One of the lessons of history is that the health of the poor is only addressed when it impacts on the rich. The futures of everyone on the planet are now so intimately linked that there is an argument from enlightened self-interest that will force us all to act sooner or later.

The report makes mention of global warming and ties climate change<sup>4</sup> and health agendas together. However, it makes far too little of this dimension. Our finite world is currently experiencing exponential growth on three vital

fronts: population, energy use and money supply.<sup>5</sup> The best predictions are that the global population will stabilise at between nine and ten billion. Therefore, concerns about climate change need to be linked to resource depletion, the credit crunch and much more.

A long-recognised phenomenon, known as 'peak oil' or 'Hubbert's blip',<sup>6</sup> is set to bring the age of cheap oil to an end in the near future. This will occur not when oil runs out, but after only half of the oil reserves have been used – the production peak. This is likely to have a large, negative and sustained impact on Western economies, as multiple facets of these societies are built upon the cheap availability of oil. Through the impact on economic circumstances, the dwindling availability of energy

resources is likely to be the biggest challenge to public health in the foreseeable future.

The Commission gives the impression that inequalities can be addressed by levelling up. The poor can be given resources and power without this changing our way of life. Yet a world of more than nine billion people will demand an 80–90% reduction in carbon use by rich countries and drastic reductions in many other forms of consumption. If equity is to be a goal, we will have to achieve contraction in the richer world and convergence with the poorer world. Failure to do so will have health consequences that we find hard to predict but that will be much worse than anything set out by the Commission. In a finite world, we are all in this together.

## REFERENCES

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## RESPONDING TO OUR READERS

A year has elapsed since the results of our 2007 readership survey were published in the *Journal*. How have we responded to the views you expressed in that survey?

We have made two responses to requests for better international coverage of medicine. First, we have commissioned editorials on topics that we believe are of wide interest, including the delivery of medical care in difficult circumstances, the worldwide problem of alcohol abuse, transitional medical care and global health equity (in this issue).

Second, we are finalising recruitment to an international editorial network to promote ongoing assessment of and wide contributions to the *Journal*. Details of this network

will appear in the first issue of the *Journal* in 2009.

The *Journal* aims to be an interesting and stimulating support for the general medical knowledge of our readers and, in this regard, many of you asked for more opinions given by experts in their fields. Accordingly, the 'Clinical Opinions' section has been increased at the expense of 'Medibytes' (something had to go because of space constraints). In addition, the History section now carries regular contributions from our historical library and includes short articles on notable Fellows of the College. Finally, there were many requests for a more colourful and informative *Journal* cover, and we hope you like the colour, the pictures and the indications of what the *Journal* contains.

We believe the *Journal* must be reaching and appealing to more people, for we have noticed an increase in the number of manuscripts submitted for consideration of publication. This year to November we have had 92 unsolicited manuscripts, compared with 58 in all of 2007. These receive full attention from our Clinical Editor, Professor John Kelly, and our History Editor, Dr Morrice McCrae, and overall there is a 30% rejection rate.

Ultimately, a journal belongs to its readers and has to provide both interest and utility. In trying to do this we value your comments, and we hope you will all feel free to contact the Editor on any *Journal*-related matter.

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