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Narrowing World Health Disparities

By Laura Blue

On average, a black man living in Washington, D.C., does not live as long as a man in India, and he certainly doesn't live as long as a white man in his hometown. The reasons — just like the reasons that the Japanese and Swedes live longer than the Ukrainians, and why aborigines in Australia on average die 17 years earlier than non-aborigines — are almost entirely social, according to a new report from the World Health Organization (WHO) released today.

It may seem obvious, or even inevitable, that a poor person would live a shorter, sicker life than a rich one. But consider also that a "social gradient of health" exists even among the rich: the outlandishly wealthy live healthier and longer than the rich, who live better than the merely comfortable. In every country around the world, WHO's Commission on the Social Determinants of Health found that the very best off had better health than people a few rungs below them on the socioeconomic ladder. "Even in Sweden" — a country with a strong history of social and economic equality — "if you look over the last 10 years, life expectancy has improved across the board. But it's improved more for people with high education than it has for people with low education," says Michael Marmot, chair of the Commission and a U.K.-based epidemiologist.

Education, of course, is a major social determinant of health. More highly educated people tend to make more healthful lifestyle choices and, as they also tend to be richer, have greater access to health care. The Commission's "social determinants" cover a vast territory, encompassing virtually every factor that can be changed in a person's life by applying reasonable political and economic resources. (Early on, commissioners had considered adding the words *Environmental Economic, Political, and Cultural* to describe the determinants in their group's official title, but then figured that would make it too unwieldy. "It can get a bit silly," Marmot says. "So we just said, *Social* includes all that.") But the Commission's new report highlights social factors that go well beyond having enough money to buy a doctor's care or medication, and well beyond having the know-how to use it. The world's poor tend to die prematurely and log more life-years spent ill or suffering or depressed also because they are more likely to live in dangerous neighborhoods, have limited access to clean drinking water, be forced to endure long, sometimes arduous commutes to work, labor in unsafe environments and have little representation in the governance of their local society. If you're about to lose your job,

the effects of eating too many trans fats may not be high on your list of worries. "Behavior and lifestyle are determined by the circumstances in which people find themselves," Marmot says simply.

The Commission's ultimate finding, however, is that "it does not have to be this way." Differences in longevity have many causes — the poor in America, for instance, are more likely than the rich to suffer diabetes, obesity or death in a gang fight — but with the new report, WHO aims to uncover "the causes of the causes." It sets out not to cure diabetes or crack down on violence, but to pinpoint the social factors that make the more poorly likely to suffer, and this "gradient," or the degree to which different groups are unequal in health, is far steeper in the U.S. than in most other industrialized countries. One reason, according to commissioner David Satcher, a former U.S. Surgeon General, may be that the U.S. comprises a more diverse population than other places, mixing a high proportion of recent immigrants with long-time American dwellers, which makes it all the more difficult to tackle social determinants early in life. "Two," Satcher says, "[the U.S.] invests probably less in improving that social gradient. There are countries that really invest in making sure that all children have quality education regardless of the education of their parents. There are countries that invest in making sure that everybody has access to a [minimum] level of quality of [health] care. We're one of the few countries that does not do that."

The Commission brought together an international team of academics, politicians and medical experts from around the world, including two former heads of state (a president of Chile and a prime minister of Mozambique), as well as two former directors of the U.S. Centers for Disease Control and Prevention and, for good measure, an economics Nobel laureate, the Harvard-based Amartya Sen. The team of commissioners combed through health data from around the world, and based on that evidence, drew up recommendations to narrow the inequalities of circumstance and opportunity that affect health. The suggestions are broad, only semi-concrete policies that are general enough to be applied to almost every country in the world: increase prenatal care, increase early education and provide free elementary and secondary school for all children. The report suggests cleaning up slums, supplying clean water for everyone, and giving people around the world health insurance and unemployment insurance. And it recommends doing a better job overall of measuring health disparities in the first place.

These demands are, in a word, steep. But the report authors do not feel they are unreasonable. "Health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it," they write. Like any persuasive call to arms, the report is peppered with success stories: Marmot cites the national pension plan in Botswana, which shows that even poor nations manage to provide income security to their elderly; and an Indian rural employment guarantee, which assures workers a minimum number of days of paid manual labor for the state, demonstrating that the poor can still give workers some measure of job security. With better organization, the report authors believe, biological problems like infectious disease can also be brought under control through social policy. Mexico has in a matter of decades consigned widespread diarrheal diseases to the history books by cleaning its water supply.

The key may just be political will. Any government official — or doctor, for that matter — who tries to improve population health has basically just two options. One is to push the frontiers constantly, improving basic health knowledge and medical technology. The other is to work with existing knowledge and technology, but to concentrate on allocating it efficiently. Almost all the WHO's recommendations fall into the latter category, and the commissioners are convinced that focusing on the social determinants of health will save both lives and cash in the long run. "We're wasting a lot of the money that we invest in health and health care," Satcher says. "All sorts of studies show that targeting the social determinants of health is more cost-effective — for everybody, not just for those at the bottom. Everybody in this country, whether they know it or not, suffers from a system that is not committed to closing that [health] gap."

That's not to say that lab breakthroughs won't bring all kinds of new health benefits in the decades to come. "But we don't need to wait for those new breakthroughs to make enormous differences," Marmot says.