Building a Global Movement for Health Equity

2009 GIH Annual Meeting on Health Philanthropy Plenary Address

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Let us start with a little homily on language. We use the term *equity*. In the United States, you are accustomed to talking about *disparities*, a rather bland term, *disparities*. We use the term *equity*, and in a particular way: to refer to those inequalities in health that are judged to be avoidable. And because they are avoidable, they are unfair, they are unjust. So using the term *equity* captures the essence of unfairness, not just that there are disparities, not just that one is wide and one is thin, or one is tall and one is short, but that there is unfairness, the unfair distribution of health. It is inequitable.

On to another homily on language. When we talk about inequity in health, we do not mean inequity in health care. The way the language is used commonly is that when people talk about access to health, they mean access to health care. When they talk about inequities in health, they really mean inequities in health care. We do not. We mean inequities in health. Lack of access to health care is, of course, of vital importance to health, but it is only one of the social determinants of health.

THE HEART TO CLOSE THE GAP

Our concern is with those circumstances that lead to inequities in health in the first place, and then with the availability of the health care system, available to all, as a response to the unfair distribution of health. Social injustice is killing people on a grand scale, and our report from the Commission on Social Determinants of Health says that. A toxic combination of poor social policies, unfair economic arrangements, and bad politics is responsible for most of the inequities we see in the world today, within and between countries. To be clear, those are the causes, and we need to address the fundamental causes.

We called our report *Closing the Gap in a Generation*. This was not a prediction that we would close the health gap in a generation, but an assertion that we do indeed have in our hands the means and in our heads the understanding to do so. The question is: what do we have in our hearts? And if we have it in our hearts, as well as in our heads and in our hands, we could make an enormous inroad into closing the health gap in a generation. We put social justice right at the center of what we were trying to do.

The point had been put to me from the beginning that nobody would take our recommendations seriously to act on health inequities seriously unless we could show it was good for the economy, to those such as heads of state and finance ministers who deal with the bottom line. But I dug my heels in and said, "No. We're doing what we're doing because it is the right thing to do."

Michel Kazatchkine, the head of the Global Fund on AIDS, Tuberculosis, and Malaria, gave the *Lancet* lecture in London in November. He said, "We're not doing what we're doing for humanitarian reasons. We're doing it for good, hard-headed economic reasons. It makes good economic sense to control these major killing diseases." Richard Horton, the editor of the *Lancet*, who was chairing the session, turned to me and said, "What do you think?" My answer was, "You get two economists in a room, they will disagree. What if an economist said that controlling these major killing diseases was not good for the economy? Would you stop doing what you're doing? I doubt it."

At the dinner following the lecture, somebody came up to me and said, "Have you seen this week's *Economist*?" Indeed, in *The Economist* was an article quoting one of the leading economists of the United States, who is winner of the Clark Medal, who said that if one looked at the control of major killing infectious diseases post-World War II, that control of major killing diseases did not lead to increased gross national product per capita. So there it was. If you hitch your argument to some false economic analysis and then somebody comes along and says the economic analysis is flawed, your rationale is in tatters.

Taking action on avoidable inequalities, inequities, is the right thing to do; it is a matter of social justice. We put at the center empowerment of individuals, of communities, and indeed of whole countries. We think of empowerment as material – if you do not have the money to feed your children, you cannot be empowered; as psychosocial, having control over your life; and as political, having your voice count. We must create the conditions for people to take control of their lives to lead flourishing lives.

HEALTH INEQUITIES IN GLASGOW AND WASHINGTON, DC

Dramatic inequities dominate global health today. In the

Scottish city of Glasgow, men in the poorest part of the city have a life expectancy of 54. Men in the richest part of the city have a life expectancy of 82. There is a 28-year gap in life expectancy in areas about 12 kilometers apart, within one Scottish city. And men in the poorest part of Glasgow have life expectancy that is eight years shorter than the average in India. In Glasgow, when you turn on the tap, the water that comes out is clean and safe to drink. The food is not contaminated. In Glasgow, men die of heart disease and cancer and alcohol-related deaths. They die of the same causes that people die from in the richer parts. They just die more rapidly.

Looking at the Glasgow statistics brings to mind a previous report on health inequalities called the *Black Report*, set up in 1978, that asked the question: after 30 years of a national health service, why do we have the persistence of inequalities in health? And *Black* spent three years reviewing the evidence and concluded that the differences in health care access are not the reason for the inequalities in health. Inequalities in health arise from inequalities in society. The health care system is a response to those inequalities, and it is absolutely vital. But it is a response, not a cause.

In Washington, DC, life expectancy for men is more or less the same as the Indian average, but catch the Metro out to the suburbs in Montgomery County, Maryland, and the life expectancy is 17 years longer.

Although we highlight the gross inequities between countries, within the rich countries we have enormous problems that we have to deal with. These inequities are so dramatic that they overlap with the issues in poor countries.

THE SOCIAL GRADIENT IN HEALTH

One of the points that the commission highlighted was the social gradient in health. If we target only the poorest of the poor, we miss most of the health problem. After all, the poor people of Glasgow or the poor of Washington, DC, are fantastically rich on a global scale, compared to the 40 percent of the world's population who live on $2 a day or less. If we focus only on the poorest of the poor, we miss most of the health problem.

Look at the under-five mortality per thousand live births by wealth quintile. In India, for example, those in the second top wealth quintile have higher under five-mortality rates than those in the top quintile. Those in the third top have higher mortality than those in the second. It is a gradient. This is very important because most people would think that poverty is a bad thing and doing something about poverty is a good thing. But inequality, that is quite challenging.

People will give you reasoned political arguments why inequality is a good thing. It is supposed to be the engine that drives the economy, although that argument is looking pretty sick at the moment. Look where it has driven the economy. But inequality is the issue of the gradient, and taking action across the whole of society, not only targeting the poor, is the implication of this graded phenomenon. The differences can change rather rapidly.

For instance, take life expectancy. After the collapse of the Soviet Union, the probability of surviving to age 65 from age 20 increased for Russians with university education and dropped for those with elementary education. So the gap between them increased.

In the United States we did a comparison looking at white men and women ages 55 to 64 with seven major conditions. The Americans were sicker than the English, and in both the United States and in England there is a social gradient by income. The social gradient is relevant because the disparities in health are not the same as disparities in health care.

In the U.S. sample, in the health and retirement study from which these data come, more than 92 percent of people had health insurance. Certainly in the top two income categories, everybody had health insurance, an enormous amount of spending on health care. And yet there is more illness. It is not primarily a health care issue.

We see these gradients all over the place. In Porto Alegre in Brazil, take cardiovascular deaths by the socioeconomic level of districts – the lower the economic level of the district, the higher the cardiovascular disease mortality rate.

When thinking about the problem globally, there is, or at least should be, a convergence of challenges for these two reasons: in the poorest areas of the world, they now suffer from the double burden of communicable and noncommunicable disease. In addition, there are social determinants of health in the context of climate change.

Examine projected deaths by cause for high-, middle-, and low-income countries. For low-income countries in 2004, infectious diseases, HIV, tuberculosis, malaria, and maternal and perinatal deaths account for about half of the deaths. The other half is noncommunicable disease and injury. By 2015 the noncommunicable disease and injury will already be a majority, and by 2030 they will be an overwhelming majority. If you take the view, as I do, that the causes of disease are probably rather similar, the proximate causes wherever we find them, that means we need to work out a common agenda for control of these major killing diseases, whether they occur in high-income, middle-income, or low-income countries.

The issue of nutrition is a good illustration of the double burden. Looking at countries by gross domestic product (GDP) per capita, stunting, and obesity, it shows that as income goes up, stunting goes down but obesity rises. And those countries in the middle between $4,000 and $6,000 per capita GDP have both stunting and obesity. In Mexico, for example, about 60 percent of men are overweight or obese. At the same time, the country has children who are stunted because they are malnourished. Look at women in Egypt. Seventy percent of women are overweight or obese, while at the very same time, there are children who are stunted with malnutrition. So we have the double-burden problem with which we have to deal.

GLOBAL POVERTY AND HEALTH

When the Commission on Social Determinants of Health

came to New Orleans, one of the things that we learned was the same message we had learned elsewhere in the world: when you think of external events, they do not strike randomly. Whether it is war, the financial crisis, or environmental events, it is always the relatively poor and disadvantaged who are affected most.

Who suffered from the troubles in Northern Ireland? It was not the doctors and the lawyers and the business people. It was the poor. Who suffers from wars in general? It is the poor. As one of our commissioners said, "There are not environmental catastrophes; there are environmental phenomena, and social organization turns them into catastrophes."

Could that have been better illustrated than in New Orleans? The point that I got from the Kaiser Family Foundation when we came to New Orleans was that, pre-Katrina, Louisiana looked very bad on almost every indicator: the percent of the nonelderly with Medicaid was higher in Louisiana than in the United States as a whole; the percent of nonelderly uninsured was higher in Louisiana; percent living in poverty was higher in Louisiana; percent of children living in poverty was higher in Louisiana. And, of course, in New Orleans, poverty and being African American are closely associated. Then, with the data we were presented post-Hurricane Katrina, lives lost, people displaced, and so on, it was the poor and the relatively disadvantaged who were affected most.

We saw the same thing in Europe with the heat wave in 2003. The total excess deaths in August 2003 were about 14,000 in France, in Germany about 7,000. Who died in the heat wave? The elderly, those with loss of autonomy, socially isolated, essentially living in poverty. The heat wave did not strike randomly, as Hurricane Katrina did not strike randomly.

WRESTLING WITH ALLIGATORS

When we published our report, we said there were three principles of action for the Commission on Social Determinants of Health. And this is what we mean by social determinants of health: first, the conditions in which people are born, grow, live, work, and age; second, the structural drivers of those conditions at global, national, and local levels; and, third, the importance of monitoring, training, and research.

When people think about health inequities, commonly they think that it is the health care system. Colleagues of mine may say if the problem is smoking; we will just deal with smoking. Or if it is obesity, we will tell people to lose weight or to run around the block.

It was pointed out to me that Halfdan Mahler, the inspirational former leader of the World Health Organization (WHO), used the analogy of struggling with alligators in a swamp. Imagine the alligator in the swamp is the problem of health inequity. What tools should we use to fight the alligator? Should it be immunization of children, antismoking clinics, obesity programs? And Mahler said, "When you're up to your neck in mud fighting alligators, remember, you came to drain the swamp in the first instance."

The Commission on Social Determinants of Health was seeking to drain the swamp, not to fight the alligator with one weapon or another, but to drain the swamp. We need to change the conditions. These conditions of daily life are early child development and education, healthy places, fair employment, social protection, and universal health care. In the structural drivers, we emphasize the importance of health equity in all policies, good global governance, gender equity, political empowerment, inclusion and voice, market responsibility, and fair financing.

Many of our recommendations were aimed at government, and this is the sort of area where grantmakers could make a difference. We think that government is absolutely key. I have to say unashamedly, we looked at this pendulum between the public and the private. The pendulum had swung so far in the direction of saying everything public is bad and everything private is good. We put our meager weight behind this pendulum and tried to push it a little bit back toward the public. We wrote our report, of course, before the extent of the credit crisis had become clear. Does anybody doubt now the important role of the public sector? Can we really leave everything to the market? Is that a credible proposition? So the role of the public sector is absolutely vital. Governments have a key role to play in this agenda, and without the active role of government, things cannot get better.

GOVERNMENTS TAKING ACTION

We produced *Closing the Gap in a Generation*. Did anybody take any notice? The answer is yes, beyond my wildest dreams, really, people did take notice. We had a global conference in London, hosted by our Department of Health and the minister of health. I asked the minister of health if he could get the prime minister to attend. We did not know whether he was actually going to come. So I was to go down to the front of the building at nine o'clock and wait, and with any luck the prime minister will turn up. So I go down to the front of the big building, the Queen Elizabeth II Conference Center. And then, large as life, there was Prime Minister Gordon Brown walking from Number 10 Downing Street with the secretary of state for health. He walked into the building, said hello, shook hands, and made a very strong speech about the importance of global health equity. I will come back to that before I finish. We had representatives of 80 countries at this meeting in London.

In addition, we have just had a meeting in Sri Lanka hosted by the minister of health in Sri Lanka and supported by the Southeast Asian Region of WHO. Sri Lanka and Thailand are particularly active in this area.

A number of countries are translating the findings into programs. We have interest from Kenya. We hope there will be a resolution to go to the World Health Assembly in May of this year. The Economic and Social Council of the United Nations asked me to come and brief them, and they will have a high-level segment on global health, which will include social determinants of health.

We made a recommendation that there should be a global

report on social determinants. The Brazilians came forward and said they would like to host a global conference on the importance of capacity building. Brazil set up its own Commission on Social Determinants of Health, which wrote its own report. Brazil now has instituted this at a government level.

I had the honor to present our report to Manmohan Singh, the prime minister of India. He asked, "What do you want me to do?" I should tell the prime minister of a country of one billion people what he should do? I had rehearsed this, as I had been told what he would ask. I pointed out that in the last 30 years life expectancy for women in India has improved by 12 years. It is now 63. But life expectancy for women in Japan was 86. Why would you want to stop at 63? There is no good biological reason why life expectancy for women in India should not be the same as for women in Japan. That is the challenge. Should we not all have such good health? Then I said to him that the report of the commission had a problem, and it tried to make a virtue of necessity. The problem was that we were dealing with sub-Saharan Africa; and rural and urban India; and Latin America; and Washington, DC; and Glasgow. How can we make a set of recommendations that would be equally applicable in all these places?

There is no shortage of money. There is a shortage of will.

What was needed was to take the commission's recommendations and translate them into specific context. That is what would make a difference. There are glimmers that something might happen in India, and more particularly in Sri Lanka. It looks like Sri Lanka will set up a process to try and translate the commission's report into practical policies. The importance of having the head of state involved is that there should be a consideration of health equity in all policies. In other words, it is not just what happens within the health sector. It is what happens in all policies. And that implies collective action across the different domains of health, education, employment, trade, transport, environment, agriculture, energy, housing, welfare, across the spectrum.

GRANTMAKERS MAKE A DIFFERENCE

In talking to you as grantmakers in health, I wanted to give you examples of how you could make a difference, not just how governments can make a difference. One of our commissioners is a leader of the Self-Employed Women's Association (SEWA) in Gujarat in India. These are the poorest, most marginal women in India. We visited Gujarat and were given some insight into the lives of the vegetable sellers in the city of Ahmedabad. These women sit on the roadside in the marketplace with a rag in front of them and a small pile of vegetables. They sit there all day in the blinding sun and the monsoon rains selling a few vegetables and earning a few rupees. Of course, they are being ripped off because they were being loaned money to buy the vegetables at usurious interest rates and could not afford to function. So SEWA started a bank, the SEWA Bank, a microcredit project.

I went to a meeting of the governors of SEWA Bank. I had never been invited to a bank governors meeting before, but there were no men in pin-striped suits. These were women in colorful saris, and at the end of the governors meeting they clenched their fists and sang the Gujarati version of *We Shall Overcome*. I doubt that they do that at the Bank of America. Perhaps things would be different if they did.

These women also were being ripped off by the vegetable wholesalers. The vegetable wholesalers buy at a very low price from the growers and sell at a very high price to the retailers. So SEWA became the "middle women," even though others tried to hound them out. SEWA became the wholesalers to buy at reasonable prices from the growers and sell at reasonable prices to the retailers. Now, SEWA has to make a profit. It has to fund itself, so it is not just a philanthropic organization. It is a union, a self-help union. Still the women were being hounded by the police, harassed to stop their business. SEWA took their case of the legal rights of these women to pursue their business to the Supreme Court of India.

SEWA started child care. I went to the place where the children were being looked after, and I would have to say it was not luxurious. They could do much more in terms of stimulating these children, 35 children with two or three caregivers. But it is a good deal better than sitting there out in the sun or the rain. SEWA provides health care. Now the organization has a new problem: pensions, which is quite a good problem to have because these women are surviving.

When I was at Stanford a year ago, talking to people involved in community health in Palo Alto, they were wringing their hands saying, "Oh, we've got this terrible state and local government, and it's all too difficult, and we can't do anything." And I said, "You should see what they did in impossible conditions in Gujarat." Impossible conditions in Gujarat. Nothing is impossible – it is the power of community organization.

Now, to the issue of housing, the women were asked, "What do you want in terms of improved housing?" And the first thing they said is, "We do not want to be moved." And SEWA negotiated loans of $500 per household. The individuals had to contribute $50. If you are earning $1 a day, $50 is enormous. But the individuals had to engage with this. Following the investment in these slums, there was improvement in health: a decline in waterborne diseases, children started going to school. Women no longer had to wait in long lines to get water so they were able to take paid work. It is not luxury, but it is an improvement. Women could have running water. They could cook, and they had bathroom facilities.

We put in the report of the Commission on Social Determinants of Health that it would cost, based on the

SEWA experience, $100 billion to upgrade the slums in the world. One billion people in the world today live in slums; $100 billion would make an enormous difference. When we put this in our report, I thought, "This is bonkers. No one's going to take us seriously. Who's going to find $100 billion for anything?"

At last count, I counted up $5.2 trillion going into bailing out the banks. For 1/52 of the amount of money that bailed out the banks, every urban dweller could have clean running water. There is no shortage of money. There is a shortage of will. We do not do it because we do not want to do it. We do not think it is important enough. Of course, it is vital to save the financial sector. But so is it vital to make sure that everyone in the world has clean running water.

A difference can be made at the microlevel, too. You may have seen the results of this trial in South Africa. There was a microfinance scheme, which, as you probably know, is always directed at women, for obvious reasons. Women are more responsible than men, and that makes a difference. But within the context of the microfinance scheme, they got communities together, and they got community engagement around the issue of intimate partner violence. Essentially they said to women, "You're getting money. You're earning money. You don't have to put up with this rubbish anymore." So they had a baseline and a follow-up, an intervention, and a comparison group. There was a dramatic drop in intimate partner violence in the first 12 months.

Another example that the commission witnessed was in Rio de Janeiro. In the harbor area of Rio de Janeiro, the Gini coefficient – the measure of income inequality – was very high. The poverty rate is 22.7 percent, and nearly 31 percent live in slums. The homicide rate is 211. In the coast area, the measure of income inequality is much lower, 6 percent living in poverty rather than 23 percent, and 12 percent in slums. The homicide rate is one-third in the coastal area than in the harbor area. It is not the rich and the middle classes primarily who are the subject of homicide. It is the poor and disadvantaged killing each other.

The Adela Centro Paulo Freire is right on the edge of one of the big *favelas*. It is a project developed by the municipal secretary of health for the State of Rio that aims to train adolescents as health promotion representatives. They were giving them knowledge about HIV and drugs. But much more, they were actually engaging these young people in the community, in a sense of self, a sense of community, and a sense of future and belonging, against the background of drug trafficking and battles. Because of these great structural improvements, what we saw in the Adela Centro Paulo Freire was empowerment in action, empowerment of adolescents who said to us, "Were we not doing this, we would indeed be involved in doing drugs and violence."

Here is one low-key example of a participatory approach to nutrition. In a community in Kenya, Kirsten Haverman from Denmark got the community to articulate what their problems were. They said they had a problem with health and they had a problem with food security. They also said there is a problem with social disunity. The men are migrating to towns, and there is a breakdown of traditional family pattern and child support. So the community got engaged to try and deal with this, and they dealt with it across all of these areas.

Some results: looking at children aged 12 to 60 months in the control and intervention areas, such as height for age/stunting and weight for age/underweight, there was a reduction in the intervention areas, which was not seen in the control. Further, the women had extra time. They chose to use their extra time for child care, establishing networks, and ensuring representation. Men chose to spend time with their families, including child care, improved farming, and representation. And the children chose to spend their time in clubs gaining knowledge and later-life skills. This was community engagement around the issue of health problems and food security, but, in fact, it was about social cohesion and establishing family and community life. The lesson for policy is that enhancing social cohesion makes intersectoral collaboration possible.

Grantmakers can make a huge difference – very much at the local and community level, in research, in training, and in action.

Where I think grantmakers can make a huge difference – and the reason I chose the examples I did – is very much at the local and community level, in research, in training, and in action. I would like to see the three bundled up together: research, training, and action. Part of the research is finding out whether the action made any difference. Big grantmakers can make big grants and do things on a grand scale. Smaller grantmakers can make small grants.

I have nothing against the people at Stanford, but I would like to hear them saying not "There's nothing we can do," but rather, "We've got the community organized. We got some money from our grantmakers, and the community is getting themselves organized and empowered. We've put money into early child development clinics, and we're evaluating whether that model of early child development works." Or, "We're actually creating employment."

I have been looking at the figures. The increase in unemployment globally will be about 50 million. So it is not going to be the pin-striped bankers that are going to be unemployed. It is going to be the people in the world who live on $2 a day or less who are going to be unemployed. They will have a dramatic deterioration in their life circumstances. What can we do about that? We want governments to act, but communities can act as well, can get involved. What are the prospects in employment? How can we create this?

So it seems to me that there is a huge amount that grantmakers could do, depending on the scale, at the local level, community level, maybe the state level. And I would hope, if you get involved in grantmaking outside the borders of the United States, there is much you could do in middle- and low-income countries.

A SOCIAL MOVEMENT

We said in our report that all social advances come from social movements. Whether it is universal suffrage, emancipation of women, the civil rights movement, the labor movement, or community engagement, it comes from social movements. This is not something that individuals can simply do for themselves. Social cohesion is vital. But it can be reinforced through participatory social and health planning.

I said I would come back to the prime minister's announcement. We called the conference in London *Closing the Gap in a Generation* after the title of the report. Prime Minister Gordon Brown announced that he had invited me to conduct a new review of health inequalities in England. This may not sound terribly radical, but could you imagine a leader in the United States saying, "We will learn from other countries along the way"? Has any other country, other than the United States, ever grappled with the issue of fair financing or health care? Are there any lessons you could learn from any other country? Prime Minister Brown said, "We will learn from other countries along the way."

So I am now actively engaged in the area. I am interested in making a difference. We have modeled the review we are doing in Britain on the WHO Commission on Social Determinants of Health and have established nine task groups on early child development and education; employment arrangements and work conditions; on social protection; built environments; sustainable development; social exclusion and social mobility; priority public health conditions, such as obesity, cardiovascular disease, and smoking; economic analysis; and delivery systems. We are ambitious. We would like to make a contribution to the debate about what sort of society we want and at the same time, put forward practical policy recommendations that might be steps toward achieving that vision of the sort of society we want.

Let me quote, in closing, Martin Luther King:

> *We're confronted with the fierce urgency of now. In this unfolding conundrum of life in history, there is such a thing as being too late. We may cry out desperately for time to pause and have passage, but time is deaf to every plea and rushes on. Over the bleached bones and jumbled residues of numerous civilizations are written the pathetic words: "Too late."*

ABOUT MICHAEL MARMOT

Michael Marmot is chair of the World Health Organization's Commission on Social Determinants of Health and is director of the International Institute for Society and Health. He is also a research professor of epidemiology and public health at University College London. Dr. Marmot has led a research group on health inequalities for the past 30 years and is principal investigator of the Whitehall Studies of British civil servants, which is investigating explanations for the inverse social gradient in morbidity and mortality. He also leads the English Longitudinal Study of Ageing and is engaged in several international research efforts on the social determinants of health. He was a member of the Royal Commission on Environmental Pollution and is an honorary fellow of the British Academy. In 2000 he was knighted by Her Majesty Queen Elizabeth II for services to epidemiology and understanding health inequalities. Internationally acclaimed, Dr. Marmot is vice president at Academia Europaea, a foreign associate member of the Institute of Medicine. Dr. Marmot is the recipient of the 2004 Balzan Prize for Epidemiology, gave the Harveian Oration in 2006, and won the William B. Graham Prize for Health Services Research in 2008. Dr. Marmot is currently conducting a review of health inequalities at the request of the British Government.