

## Reducing health inequities in a generation: a dream or reality?

Shankar Prinja<sup>a</sup> & Rajesh Kumar<sup>b</sup>

Inequalities in health are an indicator of distributional differences in the health status of populations. Low-income countries, which contribute 56% of global disease burden, account for only 2% of global expenditure on health.<sup>1</sup> The WHO Commission on Social Determinants of Health has called for “closing the gap” – resolving health inequities between different groups – in the course of a generation. It aims to achieve this by improving conditions of daily living; tackling inequitable distribution of power, money and resources; and measuring and ascertaining the impact of interventions.<sup>2</sup> However, there are several challenges to realizing this dream.

Health is generally not high on the political agenda. Policy and planning are heavily influenced by a few elite groups who are least affected by health inequalities. Powerful interest groups, such as the pharmaceutical industry, influence health policies in most countries. The revenue of the top 10 global pharmaceutical companies is more than the gross national income of the 57 lowest-income countries.<sup>3</sup> Progressing towards the recommendations of the Commission would mean rejection of the biomedical model of disease causation and re-emphasizing the concepts of social medicine. None of this is in the interest of the power groups. Hence, the very step of agenda setting in the course of policy-making is laden with problems. It is difficult to convince politicians and bureaucrats about the long-term benefits of social interventions when they are focused on biomedical interventions that impact their status in the short term.

Estimates suggest that achievement of the Millennium Development Goal targets would require Kenya, Lesotho and Zambia to spend more than 40% of their gross domestic product on health by 2015.<sup>4</sup> This appears unrealistic and can only be achieved to some extent if donor countries honour their commitments of official developmental assistance. By 2010, the Group of Eight countries (Canada, France, Germany, Italy, Japan, the Russian Federation, the United King-

dom and the United States of America) will have only delivered US\$ 3 billion of the US\$ 21.8 billion committed in 2005 for Africa.<sup>5</sup>

It is difficult to attribute causation to social interventions for long-term outcomes. It is also difficult to conduct randomized controlled trials of social interventions designed to reduce inequities, generalize findings from one research context to another, or generate evidence for the cost-effectiveness of the social interventions. Given the scarcity of resources, such evidence is sorely needed.

Health prevention programmes, whether delivered to individuals or to populations, may worsen inequity. There is an inverse care law with regard to access to preventive services.<sup>6</sup> Adoption of a population-based approach that relies on health education to encourage healthy behaviour has worsened social inequalities in health as major benefits have been harnessed by upper socioeconomic classes.<sup>7,8</sup> To monitor the extent of inequality, vital statistics from all socioeconomic strata are needed. Yet globally, more than one-third (36%) of annual births are unregistered, with large regional variations behind this global average.<sup>2</sup>

To address health inequities that are deeply rooted in social determinants, concerted actions are required, mostly outside of the health sector. This involves intersectoral coordination, an issue that was highlighted in the primary health care approach<sup>9</sup> and has been again revisited in the Commission's report. However, intersectoral coordination is easier said than done. It requires interplay of many more actors than ever before. This also includes calling for greater roles for the for-profit, not-for-profit sector and civil society.<sup>2</sup> In order to manage these actors, health ministries have to increasingly play a stewardship role.

Policy changes are made when a specific problem, solution and political will converge. Presently, the first two determinants exist in totality and the third in a partial form. Health activists need to seize the window of political opportunity, with the Millennium Development

Goals,<sup>10</sup> 30 years since Alma-Ata<sup>11</sup> and now the Commission's report, all calling for multisectoral action on social determinants to reduce health inequity. Ideas and the frames in which an idea is projected have a great role in shaping policies.<sup>12</sup> Population health can be positioned as an asset that increases the productivity of countries. However, there are always competing investment priorities that may have a greater impact on the economy. Health and its inequities need to be brought to the policy agenda as a matter of social justice, as these affect everyone. Not acting now would be a loss to the welfare of our society. ■

### References

- Mathers CD, Lopez A, Murray CJL. The burden of disease and mortality by condition: data, methods and results for 2001. In: Lopez AD, Mathers CD, Ezzati CD, Murray CJL, Jamison DT, eds. *Global burden of disease and risk factors*. Washington, DC: Oxford University Press; 2006.
- Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva: World Health Organization; 2008.
- World development report: a better investment climate for everyone*. Washington, DC: The World Bank; 2005.
- Improving HNP outcomes in SSA*. Washington, DC: The World Bank; 2005.
- The data report*. Available from: <http://www.one.org/report/en/index.html>
- Independent inquiry into inequalities in health [Acheson report]*. London: Stationery Office; 1998.
- Hart N. Inequalities in health: the individual versus environment. *J R Stat Soc [Ser A]* 1986;149 (3):228-46.
- Reading R, Colver A, Openshaw S, Jarvis S. Do interventions that improve immunization uptake also reduce social inequality in uptake? *BMJ* 1994;308:1142-4. PMID:8173457
- Health system strengthening using primary health care approach: multisectoral coordination and its impact on health and quality of life*.
- Millennium Development Goals*. Available from: <http://www.un.org/millenniumgoals/>
- The future of primary health care: Alma Ata 30 years on. In: Alma-Ata Symposium, London, 11-12 September 2008.
- Lakoff G. Framing 101: how to take public discourse. In: *Don't think of an elephant: know your values and frame the debate*. White River Junction, VT: Chelsea Green Publishing Co.; 2004.

<sup>a</sup> London School of Hygiene and Tropical Medicine, Keppel Street, London, WC1E 7HT, England.

<sup>b</sup> School of Public Health, Postgraduate Institute of Medical Education and Research, Chandigarh, India. Correspondence to Shankar Prinja (e-mail: [shankarprinja@gmail.com](mailto:shankarprinja@gmail.com)).