Improving health through wealth

Last week, the WHO's Commission on the Social Determinants of Health set out its vision for tackling health inequity.

Lynn Eaton looks at one project that has put social determinants at the top of the agenda and how the commission is working

It's more than two years since the Make Poverty History campaign was launched, in January 2005, with the razzamatazz of pop stars, politicians, and the public flaunting their white wrist bands and calling on world leaders to tackle the root causes of poverty.

As pop star Bono, who was involved in the campaign, said at the time: "We can make extreme poverty history, I really believe that. The kind of stupid poverty where kids are dying for the lack of an immunisation that costs 20 cents, or for lack of food in a world of plenty. Don't we want to be the generation that says no to that?"

Against this groundswell in public opinion, the World Health Organization set up its Commission on the Social Determinants of Health in March 2005—albeit with a lot less fanfare. Its brief was to investigate the social factors that affect health, including unemployment, unsafe workplaces, urban slums, globalisation, and lack of access to health systems.

For many governments exposing the links between wealth and health is unpalatable—especially in societies based on capitalist models. In the UK, for instance, former prime minister Margaret Thatcher sought to bury Douglas Black's report on the inequalities of health.¹

Organisations like WHO and the Bill and Melinda Gates Foundation, meanwhile, have tended to take a disease based approach to health—offering treatments for tuberculosis or HIV infection but often failing to consider the social context in which these treatments are given. It's an approach adopted by many governments too, and

one that continues to frustrate practitioners who are trying to empower those affected by illness and disease.

"There is huge money for HIV/AIDS, but they don't make any connections," says Mirai Chatterjee, one of the 20 commissioners, speaking of her government in India. "We explained that you can't do anything without taking a broader and more holistic approach."

Integration in action

Dr Chatterjee is the coordinator of social security for India's Self-Employed Women's Association (SEWA), a trade union of over 200 000 self employed women. She is responsible for

the union's health care, child care, and insurance programmes.

"Our government takes this vertical approach," explains Dr Chatterjee. "If they are talking about HIV/AIDS, they won't look to the left or the right. It is blinkered vision. They don't build in cooperation between health and social security. Instead, it's all in boxes."

Encouraging politicians to make those connections is a tough call for WHO's commission. It is to run for only three years, until 2008, and its interim report was published this week.² The commission comprises an impressive array of academic and political luminaries (box). "I'm one of the few there who is working at the grass roots and felt a bit overawed in the presence of such heavyweights," admits Dr Chatterjee. "I guess the reason SEWA was involved was because we try to put into practice social determinants of health."

The union was set up in 1972 for poor, self employed women workers who were not entitled to welfare benefits. It originally included women working at home on textiles but then spread to other areas of work such as the construction industry. Although it stemmed from a need to improve the work and economic conditions of women, it was only a matter of time until the union tackled health issues as well.

"We realised very quickly that if you want to organise women and to help them reach self reliance, without looking to their well being, it is not going to start," says Dr Chatterjee. "Health and child care and insurance is also part of their economic condition. Without that you can't come out of poverty."

"We are not a health NGO [non-governmental organisation]. We are a trade union. But we have to work on several fronts," she says.

The union began to offer health care in 1984, initially in Gujarat, north west India, where it has the majority of its members. Health provision is now one of the union's

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Commission's movers and shakers

The commission is headed by Michael Marmot, director of the International Institute for Society and Health and professor of epidemiology and public health at University College, London.

Other commissioners include:

Ricardo Lagos, former President of Chile
Giovanni Berlinguer, Italian parliamentarian who introduced Italy's first national health plan in 1968
Monique Bégin, former health minister of Canada
Denny Vågerö, professor of medical sociology, Stockholm University
Yan Guo, professor of public health at the Peking University Health Science Centre
William H Foege, emeritus professor of international health, Emory University

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largest projects and has been developed in seven other states where the union has members, including Madhya Pradesh.

Members have access to health care that is run by the women themselves, and the emphasis is on health education. Most members pay an annual premium of 85 rupees (£1; €1.5; \$2) towards a health insurance policy. This covers the costs of inpatient care to a maximum of 2000 rupees a year.

The union has also run a series of campaigns to overcome the social determinants of health—including one for better water. Women in one Gujarat village, for example, have been trained to mend the pump for the wells and now have responsibility for repairs in 11 villages. And in areas where there are regular droughts, the women have campaigned for underground water tanks that are filled by delivered water. Its calls for improved food security have resulted in a programme to distribute food grain in remote areas of Gujarat.

The union also links up with government health services for immunisation, family planning, tuberculosis control. Its health team has also started two community based centres to diagnose and treat tuberculosis, in partnership with the government and WHO.

“What the commission is saying, instinctively all our members have been saying all these years,” Dr Chatterjee states.

Commission's role

So, if all this happened without the help of the commission, what difference does the commission make? “It is basically giving what we are doing on the ground the boost. It's coming up with the evidence not just in India or in SEWA. The commission is highly regarded in India. The minister of health is very much

Above: WHO visits Ethiopia to oversee a water pump
Right: A woman from SEWA demonstrates the Serai Cooker, which cooks food and keeps it warm for up to five hours using only 100 g of coal

PV/WHO

aware of the commission. You get listened to—although how much they do is another question. Everything moves in India at an elephant's pace.”

It's a two way process: it is not just about the commission trying to influence the Indian government, but about the trade union being able to inform the work of the commission and to show how its movement might be a model for women elsewhere.

Although Dr Chatterjee is meant to bring the “grass roots” voice, the commission is also going out to listen to the views of others on the ground through what it calls its civil society—a network of representatives who feed in their views. The commission also has a separate knowledge network of various experts across the globe, covering areas such as child development, public health, and social exclusion.

David Sanders, director of the School of Public Health at the University of the Western Cape, South Africa, is a member of the knowledge network. Despite this, he is critical of some aspects of the commission's work: “In theory the commission's approach has been good,” he says. “It is giving social determinants a higher profile in health policy discourse. But in practice, it is less good.”

He believes the commission has side stepped one of the key issues behind social determinants of health, which he describes as the political issue: “The issue of power imbalances that lie behind inequitable economic globalisation and other determinants, such as squalid urbanisation, social exclusion, and so on, seem to have been studiously avoided,” he said. These are, he says, “not merely a technical issue.”

The commission has not had the time or the money to involve the public in a meaningful way in its work, he argues. “Time constraints have been major, sometimes due to bureaucratic delays within WHO,” he says, citing delays in finalising the contracts with civil society coordinators. “Reports were often required at short notice for the commission.”

And he described the amount of money made available for civil consultation as having been derisory in Africa. “In fact, my impression is that much more has been spent on other components such as meetings of commissioners and invitees brought to

Geneva for short consultations, than on the whole civil society consultation process on three continents.”

Dr Chatterjee accepts that many people will criticise the commission as yet another talking shop. “I had some reluctance to join the commission,” admits Dr Chatterjee. “I didn't have time to be in a talking shop. Neither do the other commissioners.

“But my sense is that the people involved are action orientated. It's a great learning forum—it's not like we've got it all off pat here at SEWA.”

The jury may still be out on the commission's work to date but, if we like some want to say no to the kind of poverty that leaves children dying for lack of an immunisation, this is one place to start.

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From the archive: MK Ranson et al. Equitable utilisation of Indian community based health insurance scheme among its rural membership: cluster randomised controlled trial. *BMJ* 2007;334:1309-12, doi: 10.1136/bmj.39192.719583.AE.

- 1 Mayor S. UK report calls for policies to halt growing inequalities in health. *BMJ* 1998;317:1471.
- 2 Commission on the Social Determinants of Health. Interim report Interim statement of the Commission on Social Determinants of Health. Achieving health equity: from root causes to fair outcomes. 2007. www.who.int/social_determinants/en/.