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### Introduction
- The WHO Commission on Macroeconomics and Health
- The WHO Commission on the Social Determinants of Health
- The Latin American tradition of social medicine
- Conclusion

### 8 Conclusion

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Introduction

‘We’ve got the key to saving Grady!’, sang the protestors under the hot Atlanta sun. It was June 2007 – and the first Social Forum to be held in the United States. The march was peaceful, at times joyful. Music filled the air: along with the traditional drums that one hears at marches, protestors included a New Orleans marching band with tubas and trombones. The protestors were singing about Grady Memorial, the maligned and financially at-risk public hospital in Atlanta. One of the busiest trauma centres in the United States, the Grady serves a large population of low-income and uninsured people, as well as undocumented immigrants who otherwise would have little or no option for health care. The Grady’s chief executive officer was looking to cut costs by closing services, including its much-needed outpatient dialysis clinic, and the protestors made sure that it was not done quietly.

Alongside the Grady protestors, others carried the People’s Health Movement’s banner proclaiming ‘Health for all, now!’ I walked with protestors from Venezuela, who attended the Forum to describe their experiences with health care reform – where, with the help of thousands of Cuban doctors, they were providing free care to the poor. Their work brought health care to people who had been marginalized by the existing system. For many poor Venezuelans, this was the first time their diabetes, hypertension, and a host of otherwise undiagnosed conditions were being treated.

The protestors marching to save Atlanta’s public hospital have a great deal in common with the Venezuelans and Cubans working to provide health care in marginalized and economically deprived communities. Yet, I suspect that they had never met before the Social Forum, and further suspect that they have not worked together since. Their struggles are rooted in similar causes, including poverty, inequality, and discrimination. Both groups share a deep awareness that living conditions and health are inextricably intertwined. And they work with similar objectives: ensuring that all people have access to the health care they need, that medical advances are shared across the socioeconomic spectrum, and that all people have the support they need in times of illness. But they work independently of one another, divided by language, geography, and politics.

The research literature on health inequities mirrors this division, with the struggle for Atlanta’s public hospital being analyzed by researchers interested in ‘health disparities’ and the experiences in Venezuela examined by those in...
‘global health’, those who study so-called ‘developing’ countries. Though there is certainly some overlap, research on these cases would usually be presented in different conferences and published in different journals.1,2

My work as a sociologist is centred on the idea that these struggles are not independent of one another, that the links between north and south must be reconsidered, as briefly embodied in that march down Atlanta’s streets. ‘Global health’ matters not just because it tells us about patterns of disease around the world, but, more importantly, because of what analysis of global health can tell about the deep structural roots of health inequities. In order to develop this more layered analysis, we must first consider what is often meant in discussion of global health.

Recent years have seen the rise of two competing ‘lenses’, or ways of framing the global health conversation. One lens – closely tied to new ideas of globalization – sees an increasingly inter-connected world in which diseases spread from one place to another, from one population to another, with increasing frequency and with devastating effects. From this perspective, the new ‘global era’ may be marked not only by ‘a newfound power for individuals to collaborate and compete globally’ (Friedman, 2005: 10; emphasis in original), or an ‘awareness of the world as a single place’ (Cockerham and Cockerham, 2010: 3) – seemingly positive developments, but also by a new and extremely powerful capacity for the spread of disease, of contagion. This lens highlights the spectre of an influenza pandemic that would kill millions, along with the very real threats from ebola and other ‘emerging’ diseases like Severe Acute Respiratory Syndrome (SARS), or ‘re-emerging’ diseases like drug-resistant tuberculosis. Linked primarily to the idea of risk, this discourse securitizes global health (Davies, 2010; Price-Smith, 2009) – and we come to see ever-increasing threats in the world around us.

This lens has significant implications not only for how we see the world and our place in it, but also for how we come to understand human suffering. From this perspective, what we might call the ‘new global era’ holds great promise and, at the same time, offers significant new dangers. Globalization has achieved great things, most notably, bringing distant populations together as never before; resulting in what the sociologist Roland Robertson calls ‘the compression of the world’ (1992: 8). But this brings with it possibly grave implications, as has been acknowledged at the highest levels of global health governance. Consider the following comments from Dr Margaret Chan, the Director-General of the World Health Organization:

The world has changed dramatically since 1951, when the WHO issued its first set of legally binding regulations aimed at preventing the international spread of disease ... Since then, profound changes have occurred in the way humanity inhabits the planet. The disease situation is anything but stable. Population growth, incursion into previously uninhabited areas, rapid urbanization, intensive farming practices, environmental degradation, and the misuse of antimicrobials have disrupted the
equilibrium of the microbial world. New diseases are emerging at the historically unprecedented rate … Airlines now carry more than 2 billion passengers annually, vastly increasing opportunities for the rapid international spread of infectious agents and their vectors … These threats have become a much larger menace in a world characterized by high mobility, economic interdependence and electronic interconnectedness. Traditional defences at national borders cannot protect against the invasion of a disease or vector. Real time news allows panic to spread with equal ease. Shocks to health reverberate as shocks to economies and business continuity in areas well beyond the affected site. Vulnerability is universal. (WHO, 2007b: vi)

In describing vulnerability as universal, Chan urges us to grasp the very real threats that the ‘compression of the word’ has brought about. Yet, describing vulnerability as universal also erases important differences in susceptibility and actual lived experience.

I argue in this book that, rather than universalizing vulnerability, globalization has brought about its unprecedented segmentation. Contrary to popular accounts of the world becoming a ‘smaller’ place, and economics now being played on an ‘even playing field’ due to the rise of India and China (Friedman, 2005; Wolf, 2004), globalization’s deleterious effects are concentrated among the poor – whether they be poor in an industrialized country losing its manufacturing base, or in a country of the global south that has struggled to maintain a semblance of a welfare state in the midst of structural adjustment programmes.3,4

The ‘vulnerability is universal’ lens, for many global health scholars, is correct but ultimately misguided. In universalizing vulnerability and the underlying risk of avoidable morbidity and premature mortality, this lens glosses over the striking patterns of inequality that characterize our world. The result, argues the anthropologist Tim Brown, is that a disease is prioritized in global health discourse only if it is a threat to the security of industrialized countries, to the point where ‘the focus of current global health debate appears to be slanted towards the priorities of western nations’ (2011: 324). And going further, one might argue that the current global health debate does not actually slant towards the priorities of western nations as seen from the perspective of social justice and health equity, but towards the needs of the ‘worried well’ (Morall, 2009).

For example, the central topic of debate in Canadian health care discourse is not the health crisis in Aboriginal communities – where life expectancy is 10–15 years lower than the national average (Statistics Canada, 2005), and where the risk of death from diabetes is five times higher (Young et al., 2000). Neither is it the health of immigrants, which is known to deteriorate during the first ten years in the country (Beiser, 2005; De Maio, 2010b). Rather, the debate is focused on waiting times for elective surgeries and on a push for private for-profit medicine, testing the limits of Canada’s public medicare system.
Very little is said in Canadian health journals about the country’s practice of recruiting health professionals from the global south, although the ‘brain drain’ of new doctors from countries such as South Africa to countries such as Canada is a widely-recognized barrier to increasing access to health care services in some of the poorest countries in the world (Crush, 2002; Huish, 2009).

In the United States, the very politicized debate on President Obama’s Affordable Care Act has centred on its effect on the budget deficit and its underlying constitutionality – and not on what David Ansell calls the ‘caste system of health care’ in the country which ‘all but guarantees different health outcomes depending on the patient’s insurance status’ (2011: 212). Empirical research has shown that poor populations in the US have health indicators at the level of so-called ‘Third World’ countries (Barr, 2008; McCord and Freeman, 1990) – but that has not been part of the US health care debate. The only time that the health of the poor has featured in the discussion is when commentators raise concern over the exorbitant cost of providing first-line health care in the emergency room – which many poor, uninsured people in the United States rely on in the absence of a family physician. Along these lines, the health care needs of undocumented migrants in the United States were ignored from the early stages of deliberation, and the Affordable Care Act explicitly excludes them from benefits. But undocumented migrants do feature in media health reports when researchers raise the spectre of ‘Third World’ diseases such as Chagas posing a danger to the US population (Jauregui, 2012; McNeil, 2012). Contagion, the transmission of disease or risk/cost of disease from the poor, is the central story.

The second lens that one might discern in the contemporary discourse on global health emphasizes global health inequities, seeing health as a human right (Kim et al., 2000). From this perspective, vulnerability is not universal but, rather, highly-patterned along what the anthropologist and infectious disease specialist Paul Farmer (1999: 5) calls the ‘fault lines of inequality’. While not denying the potential of an increased flow of infectious diseases from one place to another, this perspective acknowledges that the vast burden of avoidable morbidity and premature mortality falls on the world’s poor, wherever they live.

We know from studies in the richest industrialized countries that the social determinants of health strongly shape patterns of population health; the wealthier one is, the longer one is expected to live (De Maio, 2010a; Marmot and Wilkinson, 2006). There is a well-documented ‘social gradient’, wherein the middle classes have better health than the poor and the rich have better health than the middle class. Studies of US data have documented steep gradients for stroke, heart disease, and diabetes (Barr, 2008). These gradients – important in and of themselves as markers of morbidity, suffering, and disability – ultimately go on to produce inequitable patterns of mortality. The gap in life expectancy between African-Americans with a low level of education and white Americans with a high level of education, for example, currently stands at more than 14 years for men and at more than 10 years for women – with evidence that the gaps are widening over time (Olshansky et al., 2012).
Other countries – even those with constitutional protections ensuring universal access to health care for their populations – also display social gradients in health. They are found, for example, in a wide range of health conditions in Canada (Raphael, 2004; Raphael et al., 2006) and the United Kingdom (Acheson, 1998; Marmot and Wilkinson, 2006; Townsend and Davidson, 1982). Social gradients also exist in countries of the global south, including South Korea (Joshi et al., 2008; Kim et al., 2008), Mexico (Barraza-Llorens et al., 2002), South Africa (Harling et al., 2008; Mayosi et al., 2009), Brazil (Moura et al., 2009), and Chile (Vega et al., 2001). A key question, which I explore in more depth in Chapters 2 and 3, relates to the extent to which social gradients are worsening over time in countries of the global south.

At the ‘ecological’ level of analysis, where we consider attributes of the places in which we live, income inequality has become a notable interest for epidemiologists and public health researchers. Under the income inequality hypothesis, which I describe in Chapter 2, we expect that our health is influenced not just by our own income, but also by how income is distributed in the place in which we live (Wilkinson and Pickett, 2006, 2007). The most striking results have been published using data from the United States, Nancy Ross et al. (2000) finding that, for every 1 per cent increase in the proportion of income that was earned by the poorest half of households, mortality among working-age people in US cities would decrease by 21 per 100,000 every year. Both the gradient and the ecological-level inequality effect exist not only among the richest industrialized countries – even among those with universal access to health insurance, but also among populations in the global south (Biggs et al., 2010; Moore, 2006), though the steepness of the gradient and the additional burden of inequality varies from place to place and group to group.

My work with colleagues in Argentina, for example, has highlighted the significant social gradients that exist in that country for diabetes and obesity (De Maio et al., 2009). We found that women with low educational attainment are twice as likely as women with high educational attainment to have a body mass index of 30 or more, the World Health Organization’s definition of obesity. They are also twice as likely to have been told by a medical professional that they have diabetes. Reflecting deep-rooted patterns of social inequality, gradients in health are both firmly entrenched and, nevertheless, dynamic – they can, and do, change over time. While our work with Argentina’s 2005 and 2009 National Risk Factor Surveys illustrates that social gradients in physical inactivity – an important risk factor for many chronic diseases, including diabetes and obesity – are steepening (Linetzky et al., 2013), we also found that social gradients for mammograms are decreasing (De Maio et al., 2012a). All of this implies that patterns of inequality can change, influenced in part by a range of factors including local, national, and international policies.

Health researchers sometimes debate the philosophical differences between a health inequality and a health inequity. The former is generally accepted as describing a *difference*, while the latter is typically associated with differences
that are deemed to be unnecessary, avoidable, and unfair (Kawachi et al., 2002; Whitehead, 1992). In many cases, this becomes a subjective assessment based on empirical data. When does an inequality become an inequity? All of us may hold different ideas about this, and of course, the context matters. For me, most cases where a health difference emerges out of segmented access to socioeconomic resources is an inequity – for I believe that such health differences are indeed unnecessary, avoidable, and unfair. This is admittedly a moral/political stance, one based on the notion that social inequality is the result of political and economic decision-making – its level is not ‘natural’, neither is it beyond control.8 In this book, however, I use these terms as reasonably interchangeable concepts. While I appreciate the nuance that their definitions can at times bring out, I am mindful that the usage of the terms is not entirely consistent in the literature. Blurring these concepts enables us to consider a broad range of literatures emerging out of different countries.

One of the arguments of this book is that global health should be conceptualized not as a security issue but, rather, as an equity issue. This brings into focus aspects of politics and economics – core elements of globalization – and how they shape the ‘social gradient’ in diabetes, obesity, and other risk factors for chronic diseases. These economic and political forces also influence one’s exposure to neglected tropical diseases such as Chagas. From this perspective, the rapid development of global ties in the latest phase of economic globalization has brought about new threats of disease for populations around the world. But the burden of that threat pales in comparison with the burden of the real lived experiences of the poor – whose lives are cut short, whose existence is threatened by a lack of material resources. It is here that globalization has arguably had a stronger impact: it influences patterns of undocumented migration by workers seeking subsistence (Holmes, 2012; Huffman et al., 2012; Larchanché, 2012) and it affects patterns of rural–urban migration in the global south (Bayer et al., 2009; Bowman et al., 2008). At the same time, globalization has effectively expanded restrictions to the manufacturing and distribution of life-saving medications (Bond, 1999; Havlir and Hammer, 2005) and its cultural and economic effects have promoted the spread of risk factors for chronic non-communicable disease (De Maio, 2011).

The result is a globalized world where the best-off countries have life expectancies of over 80 years, while the worst-off countries have life expectancies of 40 years, sometimes even lower; a world where the global pharmaceutical market is valued at US$650 billion (Smith et al., 2009), spends hundreds of millions on marketing, and yet 2.5 million children die of diarrhoeal diseases every year for want of a simple salt water solution that would alleviate their condition and a safe water supply that would ensure it never became a life-threatening episode.

Seeing health as patterned along the fault of lines of inequality allows us to grasp the fundamental cause of disease and illness in the world: structural violence. In this book, I borrow a definition of structural violence put forth by Farmer et al., and see structural violence as ‘social arrangements that put indi-
viduals and populations in harm’s way ... The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people' (2006: 1686, emphasis added).9 A key argument of this book is that structural violence is a tool with which we may interpret empirical data and question theoretical arguments about global health inequities. It allows us to question, for example, ‘cultural’ explanations that ignore issues of power and inequality. Ill-framed cultural arguments often place the blame for a community’s poor health on the community itself – their unscientific beliefs, their unhealthy lifestyles, or their high levels of political corruption, all of which limit how much can be done with scarce resources. From this perspective, health inequities – and we might be comparing the health of the rich and poor in a major city in an industrialized country, or the health of populations in rich and poor countries – are produced, in a significant way, by the beliefs and actions of the poor themselves. This approach inevitability holds individuals responsible: it is an individual who chooses to smoke tobacco, who fails to exercise as recommended by physicians, and who exhibits poor decision-making in their dietary habits. From this perspective, health is a personal responsibility and the unhealthy person is culpable for their plight.

Without negating personal agency, an analysis of global health inequities rooted in the concept of structural violence extends our explanatory model. Recognizing the existence of structural violence requires us to broaden and deepen our thinking about the causes of disease and illness; as Farmer argues: ‘to explain suffering, one must embed individual biography in the larger matrix of culture, history, and political economy’ (Farmer, 2003: 41). As a guiding theoretical concept, structural violence challenges us to see the complex interconnections between one’s biography and society – a task that C. Wright Mills (1959) eloquently described as the ‘sociological imagination’.

Too often, public health work has focused on individuals and communities in isolation from their geopolitical context, without adequately examining the economic and political constraints these populations face. For example, many Canadian studies of the health problems in First Nations communities have tended to ignore questions of colonialism and historical trauma (Samson, 2003). Similarly, in the United States, black–white infant mortality differentials have been attributed to the ‘poverty of the culture’ of the inner city, or to genetic differences between blacks and whites, and researchers are only beginning to acknowledge that what lies behind the significant black–white difference in infant mortality is actually the effect of racism and discrimination (Barr, 2008; Collins and David, 2009; Krieger, 2011). On a global level, we face the same challenge: identifying the ‘generative mechanisms’ (Scambler, 2001), which are often structural in nature, that lead to disease and manifest in patterns of health inequality.

The rise of these competing discourses in the global health literature has occurred at a time where the very definition of the field of global health has
come into focus. Much of the research examined in this book could be described as ‘public health’ – a long-standing academic discipline characterized by its focus on improving the health of people through collective actions. Further, some of the work in this book may be defined as ‘international health’ – in that it seeks to better understand and, indeed, improve the health of populations around the world. But interestingly, recent years have seen a subtle shift in terminology, from ‘international health’ to ‘global health’ (Koplan et al., 2009; Kruk, 2012). And the differences are beyond semantic. This new focus alters how we might go about research and what kinds of solutions we seek to develop.

Whereas international health in many ways was centred on health out there, in low- and middle-income countries, and while public health has historically been driven by a focus on populations and the idea of equity in health, neither of these perspectives adequately conceptualized the interconnections between policies and practices in the global north and the global south. Global health is increasingly not just about what happens out there, but is more concerned with how health/disease is shaped by global economic, political, and cultural forces that transcend national boundaries. In other words, ‘global health’ occurs here as well. When our health is influenced by international food processing regulations, we witness ‘global health’ in practice. When we work with or for companies with a global presence, we are part of a chain of events connected to global health; health ‘there’ is influenced by actions here. For Koplan et al., ‘global health’:

refers to any health issue that concerns many countries or is affected by transnational determinants, such as climate change or urbanisation, or solutions, such as polio eradication. Epidemic infectious diseases such as dengue, influenza A (H5N1), and HIV infection are clearly global. But global health should also address tobacco control, micronutrient deficiencies, obesity, injury prevention, migrant-worker health, and migration of health workers. The global in global health refers to the scope of the problems, not their location. (2009: 1994, emphasis added)

The shift from ‘international health’ to ‘global health’ has occurred at an important time: inequities in health outcomes are at their highest point in history. As noted earlier, the richest nations in the world currently have life expectancies of about 80 years. Yet, people born in the poorest nations in the world experience life expectancies of half that amount – about 40 to 45 years, with life expectancies in some sub-Saharan African countries now dipping below 40 as a result of the HIV/AIDS pandemic. And, as dismaying as these statistics may be, the picture is actually worse than they indicate, as national summary statistics (or what are also referred to as ‘aggregate data’) hide substantial within-country inequities based on gender, ethnicity, social class, and other factors that exist in all countries, even those with universal access to primary health care services.
Health inequities are produced by deep-lying structural forces. In other words, inequities in health are shaped by international, national and local phenomena – from international law and bilateral/multilateral trade agreements, to national laws and regulations governing not only health care systems but also the wide span of sectors that ultimately affect levels of population health, to seemingly individual ‘choices’ over tobacco use and physical activity. Understanding the complex interplay between these forces requires a nuanced appreciation of ‘globalization’.

While the term ‘globalization’ is commonly used in the academic literature and the popular press, there is no general consensus on how it is to be defined (Bisley, 2007; Martell, 2010). And this is problematic, for, as the University of London’s Andrew Jones argues, ‘globalization has become so pervasively “known” that it is becoming taken for granted, and few people question what it really means or even why “it” is important’ (2010: 1). In trying to understand global health inequalities, it is critical to open up debate of this fundamental concept.

How we define globalization is tied to how we might make sense of the structural forces that shape people’s capacity to lead long and healthy lives. For example, a Marxist understanding of globalization privileges its fundamental economic properties, the liberated flow of capital, and the restricted flow of labour and families. A Marxist perspective on globalization emphasizes conflict, exploitation, and unjust global trade rules that limit the distribution of life-saving medicines. In contrast, a neoliberal position on globalization – illustrated most clearly in the journalistic accounts of globalization offered by Thomas Friedman (1990, 2005) and Martin Wolf (2004) – emphasizes the creation of new markets, new supply chains, and rising levels of prosperity in the world (though this tradition, betraying neoliberal dogma that benefits trickle-down in the long run, glosses over the unequal distribution of this prosperity). These perspectives lead to radically different emphases on the nature of global health inequalities, as well as to different ideas concerning what could be done to reduce them.

There is also debate surrounding the historical nature of globalization. Is it something fundamentally new? Is it a profoundly different era in human history, marked by technological innovation, cultural exchange, and economic potential? Or is it an extension – perhaps intensification – of existing capitalist structures and systems of commodity exchange? At least three different schools of thought can be discerned in the literature: the hyperglobalizer, sceptic, and transformationalist perspectives (Held et al., 1999). The hyperglobalizer sees globalization as a whole new era in history; a fundamental break over what existed before. This position sees a truly ‘borderless world’, where individuals have a new-found freedom to engage with anyone across the globe. Often focused on the promise of communication technologies to enable people to work collaboratively across great distances, this is a fundamentally optimistic account of globalization, seeing it as route to global prosperity.
The sceptic position in this literature responds to the hyperbolic elements of these ideas, and argues that although globalization has indeed created new ties across the world, it does not represent a fundamental break in human history (Jones, 2010). Much of the research that we will see in this book concerned with neglected tropical diseases lends support to this position. Despite great advances in communication technologies, global networks, and other celebrated aspects of globalization, the majority of the world’s poor will continue to live and die as they have in previous decades, often of treatable diseases and without any of the benefits derived from modern medicine, let alone communication technologies.

The transformationalist view argues that globalization may indeed offer something new but its effect on the world’s poor is uncertain. From this perspective, globalization is an open-ended process offering many different possibilities for local, regional, national, and global connections. That is, rather than globalization marking a new distinct era in human history, it is best understood as an extension of pre-existing economic, cultural, and political processes. While something new many indeed be happening, it should be seen in deep historical terms. From this perspective, globalization offers hope for a more equitable world – but that result is by no means assured. Thus, we may emphasize that the current organization of global governance – dominated by non-democratic bodies such as the International Monetary Fund, the World Bank, and the World Trade Organization (WTO) – has resulted in the grossly unequal distribution of the benefits of globalization. This perspective links a variety of different thinkers, from the revolutionary ideas and actions of the Zapatistas to the ‘reformist’ perspective of the Nobel prize-winning economist Joseph Stiglitz.10

From the transformationalist perspective, the noted British sociologist Anthony Giddens offers an influential definition of globalization as ‘the intensification of worldwide relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice-versa’ (Giddens, 1990: 64). It is an open-ended definition, one which gives us great leeway in understanding globalization as comprising a number of complex (and, at times, contradictory) political, economic, and technological forces.11

In this book, I argue that the concept of globalization offers us a way of grasping how ill health – one of the most personal of all personal troubles – is explicitly social, how it is shaped by forces far removed from our bodies and our actions. Seeing health inequity from the perspective of globalization enables us to link our biology with global political economy, allowing us to see structural violence embodied as illness (Krieger, 2005, 2011; Krieger and Davey Smith, 2004). The end result is a nuanced sociological account of why some populations/subpopulations may live long and healthy lives, while others will not.
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