

Inaugural Address as WMA President

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Honoured Guests, Colleagues,

In May 2011 Mary hanged herself. She was found in the yard of her grandparents' house on a First Nations Reserve in the province of British Columbia in Canada. She was fourteen. She was a First Nations, aboriginal, Canadian.

Her story has particulars. All suicides do. She had been physically and emotionally abused at home and in her community, and possibly sexually abused. Her mother was mentally unstable and heard voices telling her to 'snap' her child's head. Officials attributed the suicide to a dysfunctional child welfare system, and to the fact that no one took her complaints of abuse seriously or acted on them.

There is another way to look at Mary's sadly foreshortened life, and that is to realise that though her personal tragedy was unique, there are many young aboriginal Canadians who experience similar tragedies. In fact, the aboriginal youth suicide rate in British Columbia is five times the average for all young Canadians. One cannot understand fully why Mary saw no way out without also asking why so many other young aboriginal people in British Columbia reached the same desperate point.

The starting point is poverty, bone-grinding poverty, low educational levels and high unemployment. But there were about 200 bands of aborigines in British Columbia, more or less all in poverty. Yet 90% of the adolescent suicides occurred in 12% of the bands. Why some and not others? The difference was empowerment of communities. Empowered communities participated in land claims; self-government; had control over educational, police and fire, and health services; and establishment of 'cultural' facilities. The results were clear: the greater the cultural continuity and community control over their destiny, the lower was the youth suicide rate. Poverty is bad but poverty is not destiny. Empowerment of communities can save lives. I draw similar lessons from studying the health of New Zealand

Maoris, Indigenous Australians, Native Americans or indeed that of excluded groups elsewhere in the world.

In January 2010, Haiti's earthquake wreaked havoc and 200,000 people died. Less than two months later a quake 500 times stronger hit Chile and the death toll was in the hundreds. Haiti was underprepared in every way imaginable. Chile was well prepared, with strict building codes, well-organised emergency responses and a long history of dealing with earthquakes. True, the epicentre of the Haitian earthquake was closer to population centres than that of the Chilean quake, but that was only part of the explanation for the different scale of devastation. What turns a natural phenomenon into a disaster is the nature of society. The number of people who died had more to do with Haiti's lack of societal readiness and response than with the strength of the quake.

In 2011 the London borough of Tottenham broke out in urban riots. The precipitant was the killing of a black man by police. But, unacceptable as that is, it was not the underlying cause. Inequality was the culprit. I had been citing an area of Tottenham as having the worst male life expectancy in London – 18 years fewer than in the best-off area. All in one of the world's premier global cities. London now has more high-end properties, a price tag more than \$5million, than Manhattan, Hong Kong, Singapore or Sydney. It is not surprising that the riots broke out in the area with the worst health. Ill-health does not cause riots. Nor do riots cause ill-health – at least not directly. Relative deprivation causes both urban unrest and ill-health. Ninety per cent of young people arrested in the riots were not in employment, education or training.

Similarly, in Baltimore in the US. When a black man was killed in police custody riots broke out. Not uniformly across the city, but in the area with condemned houses, low levels of education and income and a twenty year disadvantage in life expectancy compared to the area with leafy opulence.

Inequality strains the binds of a cohesive society. In Baltimore, those binds snapped. The immediate effect is civil unrest. The longer term effects is health inequity.

These examples illustrate that the way we organise our affairs, at the community level or, indeed at the whole societal level, are matters of life and death. As doctors we cannot stand idly by while our patients suffer from the way our societies are organised. Inequality of social and economic conditions is at the heart of it.

There are three aspects of Mary's tragedy worth emphasising. The first is the vital issue of violence to girls and to women. It can be fatal, both because it drives women to suicide and because they may be killed by their partners. Second, I emphasised empowerment of communities. But empowerment of individuals is also of vital importance. A key route to female empowerment, globally, is education. Evidence shows clearly: the greater the education of women the less the likelihood of being subject to domestic violence. Third is the importance of mental illness. Mental illness and substance use disorders constitute the number one cause of years spent with disability, globally. We cannot be concerned with health, globally and in our countries, and not be concerned with mental illness and substance use.

More generally we need to recognise the importance of the mind to health equity. The mind is the major gateway through which social determinants exert their effect on health. Recognizing the importance of the mind takes us back to early child development and what I have called: equity from the start.

In Aldous Huxley's dystopia, *Brave New World*, there were five castes. The Alphas and Betas were allowed to develop normally. The Gammas, Deltas, and Epsilons were treated with chemicals to arrest their development intellectually and physically, progressively more affected from Gamma to Epsilon. The result: a neatly stratified society with intellectual function, and physical development, correlated with caste.

That was satire, wasn't it? We would never, surely, tolerate a state of affairs that stratified people, then made it harder for the lower orders, but helped the higher orders, to reach their full potential. Were we to find a chemical in the water, or in food, that was damaging children's growth and their brains worldwide, and thus their intellectual development and control of emotions, we would clamour for immediate action. Remove the chemical and allow all our children to flourish, not only the Alphas and Betas. Stop the injustice now.

Yet, unwittingly perhaps, we do tolerate such an unjust state of affairs with seemingly little clamour for change. The pollutant is called social disadvantage and it has profound effects on developing brains and limits children's intellectual and social development. Note, the pollutant is not only poverty, but also social disadvantage. There is a clear social gradient in intellectual, social, and emotional development—the higher the social position of families the more do children flourish and the better they score on all development measures. This stratification in early child development, from Alpha to Epsilon, arises from inequality in social circumstances.

This social gradient in children's possibility to fulfil their potential, in its turn, has a profound effect on children's subsequent life chances. We see a social gradient in school performance and adolescent health; a gradient in the likelihood of being a 20 year old not in employment, education, or training; a gradient in stressful working conditions that damage mental and physical health; a gradient in the quality of communities where people live and work; in social conditions that affect older people; and, central to my concern, a social gradient in adult health. A causal thread runs through these stages of the life course from early childhood, through adulthood to older age and to inequalities in health. The best time to start addressing inequalities in health is with equity from the start. But intervention at any stage of the life course can make a difference. Relieving adult poverty, paying a living wage, reduction in fuel poverty, improving working conditions, improving neighbourhoods, and taking steps to reduce social isolation in older people can save lives.

The health gradient to which these life course influences give rise is dramatic. There is a cottage industry, taking subway rides in various cities and showing how life expectancy drops a year for each stop. I have referred to twenty year gaps in Baltimore and London; but the health differences between rich and poor, dramatic as they are, are only part of the problem. Commonly, people say to me: I am neither rich nor poor; what does any of this have to do with me? The evidence shows that there is a social gradient in health that runs from top to bottom of society. People in the middle have worse health than those above them in the social hierarchy, but better than those below. We calculated for England that if everyone enjoyed the same life expectancy as the top 10%, based on education, there would be 202,000 fewer deaths each year; over 500 a day.

One problem, then, is poverty. Another is inequality. Both damage health and lead to an unjust distribution of health.

I have spent my research life showing that the key determinants of health lie outside the health care system in the conditions in which people are born, grow, live, work and age; and inequities in power, money and resources that give rise to these inequities in conditions of daily life. Since the establishment of the WHO Commission on Social Determinants of Health in 2005, I have been using research knowledge to argue for policies on social determinants of health.

Yet here I am, humbled by assuming office as President of the World Medical Association. Is there not a contradiction? The World Medical Association, WMA, upholds the highest ethical standards of the practice of medicine. It speaks out fearlessly when the right of doctors to pursue their noble calling is threatened. As President, I want the WMA to use the same moral clarity to be active against the causes of ill-health and what I call the causes of the causes – the social determinants of health.

The opening sentence of my recent book, *The Health Gap: The Challenge of an Unequal World*, was: why treat people and send them back to the conditions that made them sick? No one is as concerned about health and disease as we in the medical and other health professions. It has been and will be my mission to encourage our concerns with the conditions that make people sick.

I am hugely encouraged already. My friends in the Canadian Medical Association conducted Town Hall meetings across Canada to engage the public in discussion on how the conditions of their lives related to their health. The Canadian Medical Association then took the initiative to suggest a meeting at BMA House in London. Twenty countries and 200 people asked to come, including our now-Chair of Council, Ardis Hoven, and then-president, Xavier Deau, and participated with enthusiasm. I apologise in advance: I already have more invitations from medical colleagues, enthusiastic for the health equity agenda, than I could possibly meet. We need a global social movement.

I have been arguing that we have the knowledge of what to do to act on social determinants and health equity; we have the means. We need to ensure that we have the will.

Do we really have the means? Consider. What do the following have in common?

48 million people of Tanzania

7 million people of Paraguay
2 million people of Latvia
top 25 US hedge fund managers

In 2013 each of these four groups had a total income of between \$21 and 28 billion. Imagine with me something totally fanciful: that the 25 hedge fund managers gave up their income for one year. It would double the income of Tanzania. The hedge fund managers wouldn't feel it, because they will earn an average of \$1 billion each the next year. I am not suggesting for a moment that we simply pass the cash to individual Tanzanians. But think of the clean water that could be piped, the schools that could be built, the nurses trained and employed.

There is a great deal of money sloshing about. Great inequality between countries stops the money being spent in ways that would benefit the poor and the needy.

Suppose, though, that there was reluctance to see ourselves as part of a global community. We would still have to address staggering levels of inequality of income and wealth within countries. Here is an even more fanciful thought. Suppose that the hedge fund managers of New York paid a third of their \$24 billion income in tax – unlikely I know – that money could fund 80,000 New York schoolteachers. 80,000.

What has this to do with doctors? At the meeting of National Medical Associations that we held in London we heard inspiring examples of how doctors are already working with communities to deal with the social causes of ill-health. In India I was taken by medical colleagues to a tribal area in Gujarat where the doctors are not only treating people who, hitherto, had no access to health care, but are working with others in community development and education to improve the conditions of daily life for marginalised people. In Brazil, the social gradient in stunting of young children is becoming progressively flatter. In Bangladesh and Peru inequalities in child mortality are decreasing. I am excited by the interest generated in social determinants of health globally in every region of the world: South Africa, Zambia, Morocco, Colombia, Cuba, Costa Rica, Panama, Surinam, Taiwan, Sweden, Norway, Finland, Iceland and ... I could go on.

Colleagues, we can make a difference to the causes of the causes of health equity, as part of the practice of medicine. There is another way we can make a difference, too. I do not go

for long without quoting the great German pathologist, Rudolf Virchow, who said that “physicians are the natural attorneys of the poor”. We can, we do, we should speak up about inequity in social conditions that damage the health of the populations that we serve.

It means too, that we should recognise and be vocal about any societal trends that are likely to affect health equity: climate change, trade, financial crises.

I hold a Bernard Lown visiting professorship at Harvard. Bernard Lown, great cardiologist and co-founder of International Physicians for the Prevention of Nuclear War, said: never whisper in the presence of wrong. Already WMA speaks up in a loud voice about the highest ethical standards of our profession. We should not whisper at the gross inequities in the world that give rise to health inequities.

In fact, so close is the link between social conditions and health that, I argue, health equity is a good measure of social progress; much better than income growth. Senator Robert Kennedy in a famous speech criticised Gross National Product as a measure of social progress. He said:

the gross national product does not allow for the health of our children, the quality of their education or the joy of their play. It does not include the beauty of our poetry or the strength of our marriages, the intelligence of our public debate or the integrity of our public officials. It measures neither our wit nor our courage, neither our wisdom nor our learning, neither our compassion nor our devotion to our country, it measures everything in short, except that which makes life worthwhile.

Health and health equity are not only worthwhile in themselves but they reflect much else that makes life worthwhile: the freedom to lead lives we have reason to value.

As doctors, at our best, we flourish in the cause of social justice. There is a great deal of injustice in the world. Can we really be optimistic? Let me quote from Nobel Prize winning poet Seamus Heaney:

*History says, don't hope
On this side of the grave.*

*But then, once in a lifetime
The longed-for tidal wave
Of justice can rise up,
And hope and history rhyme.*

*So hope for a great sea-change
On the far side of revenge.
Believe that further shore
Is reachable from here.
Believe in miracle
And cures and healing wells.*

I have had much reason to praise our medical students at the IFMSA, and our junior doctors. In the spirit of Heaney I say to our younger colleagues: believe in miracle and cures and healing wells not just for our patients but for society, too.

If this sounds idealistic I remember the words of Halfdan Mahler, former Director-General of WHO, who said when we published the report of the Commission on Social Determinants of Health: remember, idealists are the realists in human progress.

I have another poet who has been my companion. When we launched the Commission on Social Determinants of Health in Santiago Chile I quoted Pablo Neruda. I did again at each report we have published and I do so again now. I invite you to:

*Rise up with me...
Against the organisation of misery.*