World Health Report 1996: some millennial challenges

'Overall in the last 50 years, there have been substantial improvements in global health status. Disparities between the developed and the developing world have been reduced, but those between the developing world and the least developed countries as a group have widened. Gaps have also widened between population groups within countries. In recent years, health gains have slowed down and even reversed in some countries.'

This extract from the World health report 1996 comprises four important sentences. The truth of the first sentence and the first part of the second sentence are contentious and depend upon the criteria used to draw these conclusions. The remainder of the paragraph is true but it is the widely ignored basis for these trends, for example their relationship to military power and economic exploitation, that is most noteworthy.

The strength of the report lies in its pictorial and numerical description of disease patterns around the world. It weaknesses lie in its somewhat complacent trumpet blowing about the World Health Organisation's (WHO's) achievements, the absence of a section on mental health (not even a mention of the World mental health report 2), its failure to report comprehensively on crucial and pervasive economic, social and political determinants of health and suffering, and how these will have to be addressed to narrow gaps and reverse the adverse trends described. Indeed, the report is little more than a superficial biomedical commentary on global health. What is missing, I suggest, are chapters on at least the following topics that are central both to understanding the powerful forces that shape population health and to embarking on the complex global approaches necessary to rectify them.

World debt, its basis, and relevance to health and human development

The external debt of developing countries has grown by $100 billion annually. It doubled from $650 billion in 1980 to $1.3 trillion in 1990, and grew to $1.9 trillion by 1994. This represents an increase in the ratio of external debt to gross national product (GNP) from 26.8% in 1980 to 40.8% in 1994. Between 1985 and 1992, the 'south' paid $280 billion more in debt service than it received in private loans or government aid. In 1994, 45% of the world's population (2.5 billion people) lived on 4% of the global GNP and 358 billionaires lived on 4% of the global GNP.

In 1994, 30 million people died due to war and poverty. There is no absolute shortage of food in the world and yet hundreds of millions continue to starve. Why are some countries and some sections of the population within countries so rich and others so poor, and the gaps growing wider? The fault is not entirely that of the poorest and there are other much more complex reasons that are seldom discussed. The growing literature on this topic cannot be ignored by those interested in health unless they are ignorant or uncaring. In the specific sphere of health care, the way in which transnational pharmaceutical organisations operate, and how health care is increasingly being transformed into a market commodity, must also be acknowledged as major factors hampering the quest for better health for all. Reductionist solutions to global health remain a necessary component of progress, but they are not sufficient and will be of limited effectiveness without attention to the broader social context of health and disease, as has been illustrated for tuberculosis.

Expenditure on the military and implications for health and well-being

Developed countries spend on average 5.3% of their GNP on the military and 0.3% on aid to developing countries. The nuclear stockpile of over 37,000 weapons equals two tons of TNT for each person on earth. The 100 million landmines in situ in 62 countries, many in civilian and commercial areas, also threaten future generations. Civilian deaths in war have increased from 14% of war deaths in the First World War to 90% in wars in the 1990s. We need to understand the implications for health (and ultimately all life) of an annual global military expenditure of almost $1 trillion (much on nuclear weapons posing threats to life and the environment for tens of thousands of years), how the arms trade with developing countries has adversely affected economic and social development in many countries and how to embark on the processes required to facilitate shifting some military expenditure towards human development.

The social construction of human rights abuses and suffering

The world now has 18 million refugees and over 25 million displaced persons, many clustering in densely
populated camps. Torture continues to devastate many lives. The persistence, and even growth, of human rights abuses (many in the ‘home of the Enlightenment’) and the failure of human rights advocacy to sustain human dignity and liveable human lives is of great concern. This situation gives rise to questions about the powerful underlying economic and military forces that frustrate sincere human rights endeavours, and that underpin the comfortable lives of those who complacently posture about human rights. In relation to the latter we should find repellent statements by economists of world repute that two thirds of the world’s population are ‘... superfluous from the standpoint of the market. By and large we don’t need what they have; they can’t buy what we sell . . . In the perspective of world capitalism as we know it these people just don’t count . . . unless that part of the world develops the capacity for terrorist blackmail they will remain in the charity ward for a long time’.12,13

From 20th century to 21st century solutions

The defective way in which the WHO operates is deeply rooted in narrow and now outmoded thinking patterns. It has become an inefficient organisation in need of extensive restructuring. As we approach the next millennium there will have to be a fundamental shift in thinking about health, disease and suffering, perhaps equivalent in magnitude to the shift in thinking that occurred with the scientific revolution, if we are to find ways of using our vast knowledge with the wisdom needed to achieve the sustainable improvements in health and human dignity to which we aspire. The first step in this process should be to achieve widespread acknowledgement of the resemblance between the debt trade and the slave trade, and the extent to which the ‘pathology of poverty’ is due to pervasive economic and military policies that need to be contested and reversed. From the starting point of including such analyses in WHO Reports, work could then proceed along the difficult, but hopefully not impossible, pathway of progress away from narrow concepts of national security, endless consumerism and aspirations by wealthy countries for continuous national economic growth, towards sustainable achievement of health and human rights within broader and richer concepts of

human life and security in an interdependent world. As a body concerned about world health the WHO has a leadership role to play in this process.

References

1 World Health Organisation. World health report 1996: fighting disease, fostering development. Geneva: WHO, 1996.
2 Desjarlais R, Eisenberg L, Good B, Kleinman A. World mental health report: health problems and priorities in low-income countries. New York: Oxford University Press, 1995.
3 World debt tables 1994/95. Washington DC: World Bank, 1995.
4 Broad R, Cavanagh J. Don’t forget the impoverished South. Foreign Policy 1995;101:18–35.
5 Barnett RJ, Cavanagh J. Global dreams: imperial corporations and the new world order. New York: Simon and Schuster, 1994.
6 George S, Sabelli F. Faith and credit: the World Bank's secular empire. London: Penguin, 1994.
7 Pettifor A. Debt, the most potent form of slavery. London: Debt Crisis Network. c/o Christian Aid, 1996.
8 Benatar SR. Prospects for global health: lessons from tuberculosis. Thorax 1995;50:487–9.
9 Sidel V. The international arms trade and world health. Br Med J 1995;311:1677–80.
10 Kothari R, Falk R, Kaldor M, Ghee LT, et al. Towards a liberating peace. Tokyo, Lokvani, New Delhi: The United Nations University, 1988.
11 Donnelly J. Universal human rights in theory and practice. Ithaca and London: Cornell University Press, 1989.
12 Gardels N. The Post-Atlantic capitalist order. New Perspectives Quarterly 1993; Spring:2–5.
13 Heilbroner R. The rest of the world off the track: growth and the lumpen planet. New Perspectives Quarterly 1993; Spring:48–53.
14 Walt G. WHO under stress: implications for health policy. Health Policy 1993;24:125–44.
15 Ermakov V. Reform of the World Health Organisation. Lancet 1996;347:1536–7.
16 Chen L, Kleinman A, Ware N (eds). Health and social change in international perspective. Cambridge, MA: Harvard University Press, 1994.
17 Bergstrom S, Mocumbi P. Health for all by the year 2000? Br Med J 1996;313:316.
18 Benatar SR. Peace, or peace and development: South Africa’s message for peace and security. Medicine, Conflict and Survival 1997;13:125–34.
19 Carlsson J, Ramphal S (Co-Chairmen). Our global neighbourhood: report of the Commission on Global Governance. Oxford: Oxford University Press, 1995.
20 Kung H. Global responsibility: in search of a new world ethic. New York: Continuum, 1993.

Address for correspondence: Professor S R Benatar, Department of Medicine, University of Cape Town and Groote Schuur Hospital, Observatory, 7925, Cape, South Africa.