The political origins of health inequity : prospects for change

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This article was written by the Lancet-University of Oslo commission, an independent academic commission launched in Oslo in December 2011 comprising 18 renowned researchers and policy makers. They gathered to analyse the key issues in managing the global health, advising for new solutions to tackle health inequity.
Global health issues result not only from physical illness, but more broadly from anything that may physically and psychologically harm peoples' health (e.g. unsanitary life conditions, hunger, no social protection, but also psychological stress and insecurity due to the fear of war, discriminations and working uncertainty).

They identified five dysfunctions of the global governance resulting in the persistent health inequity. The majority of them result from power disparities that leads to systemic dysfunctions. The more powerful actors (wealthier states, big transnational companies) writing the rule for global governance to their advantage, they create and maintain this inequity.
The five dysfunctions are:

- a **democratic deficit**, promoting the interests of the more powerful. Some non-states actors such as the civil society, some marginalised groups or even health experts are often inadequately included in the international decision making process. However, there has been some improvements lately with new considerations of small states actors and NGOs.
- **weak accountability mechanisms and poor transparency**. Indeed, there is no global political authority to hold states accountable for when they violates rules, and no organisation to control non-states transnational actors.
- **institutional stickiness**, resulting from outdated systems resistant to reform.
- **inadequate policy space for health**, this concern being often subordinated to other objectives such as economic growth or national security.
- **missing or nascent institutions**. There is no institution to govern transnational non-states actors or issues (volatile markets, armed groups, illegal trafficking networks…). Through agreements upon rules, there are weak if no enforcement mechanisms.

They then illustrate these five dysfunctions via several case studies from the consequences on the health of the Greek financial crisis to the effect of irregular migrations and armed violence.

To tackle the political determinant of health they propose long term improvements via:

- the creation of a **UN multistakeholder platform** on global governance for health acting like a policy forum to set agendas, debate policies, identify barriers and propose solutions via recommendations to the decision making bodies.
- an **independent scientific monitoring panel** on global social and political determinants of health.

But for short term concerns they advise enforcing existing mechanisms in:

- strengthening the **base of human rights instruments for health**, by improving the recognition of health as a human right via a right-based agenda for sustainable development and a better use of existing institutions and advisor (e.g. extending the mandates for Special Rapporteurs, performing human-right audits…).
- strengthening **mechanisms for sanctions**: via apology, commitment not to repeat, policy changes or reparation ordered by national or international courts.
- strengthening and transforming **mechanisms for global solidarity and shared responsibility**, via an international financing based on the ability of each state to pay a compulsory or non-binding contribution.

They do not advise creating new institutions, that will soon suffer the same dysfunctions as existing ones, but including global health as a general urgent matter in all already existing structures, leading

to a more interconnected and simplified system of global governance.