Build back fairer: achieving health equity in the Eastern Mediterranean region of WHO

The Eastern Mediterranean region of WHO stretches from Morocco in the west to Pakistan in the east. This region's 22 countries and territories contain great contrasts. Life expectancy in Kuwait—84 years for women, 79 years for men—is 25 years longer than in Somalia.[1] The region contains among the richest countries in the world measured by income per person (Kuwait, Qatar, and United Arab Emirates) and among the poorest (Afghanistan, Djibouti, and Yemen).[2] Similar to other regions, non-communicable diseases are a major burden, and ischaemic heart disease is the leading cause of premature mortality in the region.[3] Unlike other regions, deaths related to conflict are increasing in the Eastern Mediterranean region. There have been more than 100 000 conflict-related deaths per year since 2014 in this region, and most such deaths in the world occur in the Eastern Mediterranean region.[4] Linked to conflict is massive displacement of people. By 2019, an estimated 6·7 million people had left Syria and 6·2 million had been internally displaced.[5] In Yemen and Iraq, the numbers of displaced people are in millions.[6,7] Looking more generally at migrants, large numbers are received by Iran, Jordan, Lebanon, Pakistan, and Saudi Arabia.[8]

Conflict and COVID-19 both expose and amplify existing inequities in society. Inequities in health can be linked to poverty and income inequality; inequities in social conditions through the life course; gender inequities; problems related to extremes of weather, made worse by climate change; and land degradation with impacts on supplies of food and water. Against this background, the Commission on Social Determinants of Health in the Eastern Mediterranean was charged with assembling the evidence on social determinants of health and on inequities in health within and between countries and to make recommendations. The Commission was convened in 2019 by the WHO Regional Office for the Eastern Mediterranean in collaboration with the Institute of Health Equity at University College London and the Alliance for Health Policy and Systems Research, Geneva. The Commission's report *Build Back Fairer: Achieving Health Equity in the Eastern Mediterranean Region* was published on March 31, 2021.[9] The *Build Back Fairer* title was chosen as a deliberate echo of a 2020 report on COVID-19 and socioeconomic and health inequalities in England.[10] Emerging from the COVID-19 pandemic, with its large impacts on society, is an opportunity to ask how, based on the best evidence, societies and health systems can be rebuilt in a way that benefits all people. Doing so will be a major step to building greater health equity.

A theme of this Commission on Social Determinants of Health in the Eastern Mediterranean, as of one for the Americas,[11] is to pursue policies that enable people to lead lives of dignity. Better health, and greater health equity, will be the results. In making its recommendations, the Commission adopted the approach of do something, do more, do better, which recognises the diversity of countries in the region and the health inequities within countries. For countries or population groups with shortages of the basic necessities of life—food, water, sanitation, and shelter—do something, it will make a difference. When these basic needs are met, do more: create the conditions for people to lead lives of dignity and purpose. For rich countries of the region, where there have been improvements in health over recent years, set your sights on achieving parity with other countries in the highly developed UN Development Programme group, and improve education and health commensurate with income. Doing better for rich countries should also entail committing 0·7% of gross national income to development assistance for poorer countries in the region. The aim should be to do something, do more, do better at the same time rather than in sequence. People with insufficient nutrition need to educate their children and have lives of dignity.

An important question the Commissioners (appendix) asked at the beginning of our work was: why is a Commission on Social Determinants of Health the appropriate mechanism? Our conceptual framework includes political economy, culture and religion, and climate change as structural drivers of inequities in the conditions in which people are born, grow, live, work, and age. Conflict in the region is related to global political and economic interests as well as religious frictions. There are health problems caused by displacement of people, by sanctions, and by occupation. Present and looming health inequities associated with the climate crisis have to be addressed in a region that derives much of its wealth from the production and consumption of fossil fuels. Could a WHO Commission really contribute to the relief of these large problems? Our starting and finishing point, and our modus operandi, is health equity. Our approach is at once moral and scientific. Our position is that the reason for taking action on these complex political, economic, and environmental issues is because the evidence shows how important they are for health equity. Improving the health of populations and advancing health equity should be central to the political debate. The question of what to do is answered by the evidence presented in the Commission's report. The question of why to do it is captured by the quote from the earlier WHO Commission on Social Determinants of Health: social injustice is killing on a grand scale.[12]

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