

# Global Health Disparities

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## Closing the Gap Through Good Governance

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# PREFACE

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## *Introduction*



*Global Health Disparities: Closing the Gap Through Good Governance* is a book about **what are rights for all**: universal access to basic health care, education, and access to clean water and sanitation and other essential services without which health disparities among and within nations remain wide. However, this book highlights the fact that through the implementation of the United Nation's primary health care for all and education for all programs, many countries have managed to narrow the disparities and, as of 2006, more than half of the world population is living longer and healthier than 50 years ago. This book also highlights the fact that millions of children are still deprived of access to primary health care and primary education, and millions of people are living without access to clean water and sanitation. In order to close the gap, nations must be accountable to their populations and must consider those basic services as rights, not privileges. This book argues that these rights are essential to living longer and healthier, and donor countries must attach them as a condition to their gifts.

This book came about primarily because of demands from my students over several years and as a result of my discussions with various stakeholders, including government officials from the most developed to the least developed countries, international civil servants, and national and international nongovernmental organizations. It was written as a stand-alone book for graduate-level short courses and seminars or supplemental reading for a graduate seminar in global health.

Like many of my colleagues, I have faced questions from my students who wanted me to assess the development programs that have worked and those that have not and why,



looking at who is responsible and what can be done most effectively. Every instructor and everyone working in the field of international health faces these questions because, despite all the efforts made in the second half of the 20th century, the health and longevity gap between and even within some nations remains wide.



## ***Using This Book in the Classroom***

Many of my students imagine the answers to their questions are simple. However, the answers, as this book attempts to explain, are by no means that simple. Additionally, data suggest that many of the assumptions underpinning development assistance need revisiting. The data throw up a number of surprises. For example, many countries labeled as developing countries have health indicators similar to those of developed countries, and the developed countries group is, in fact, two groups. These variables cannot be explained in a brief answer but must be examined closely with the help of reputable data over a period of time.

The answers I can provide are anchored by the premise that all children born today, anywhere in the world, need access to primary health care, primary education, and clean water and sanitation, without which no child survives, preventable diseases flourish, and health and longevity are compromised. By the end of the semester, the students are also answering their own questions with the help of their assignments and the individual country studies they complete, which address the demographic indicators for their assigned countries. They invariably conclude that all countries need committed, competent, and transparent governments accountable to their public to carry out healthcare programs based on individual rights to good health and longevity. This is what the book refers to as ***“good governance in health.”***

When students present their country studies and are allowed to debate the pros and cons of the outcome, the classroom benefits. By including an open-ended question, such as what health issues stand out in their assigned country, the students explore the issues that impact health care in that country, either positively or negatively. Several universities require their graduate students enrolled in graduate studies in global health to complete mandatory fieldwork experience abroad, which gives them the opportunity to put into practice the theories they have learned. Before they leave for their fieldwork, it is important they complete an individual country study using the sort of data presented in this book as well as consulting other sources.

At the end of each chapter, discussion questions are provided to give students and their instructors the opportunity to examine and debate how some countries achieved higher life expectancy and those that fell short, preventing them from reaching their potential. Students can develop their own case studies using the extensive data provided at the end of Chapters 1 through 7 and in the Appendix section, as well as the graphs and tables included in each chapter. For example, those who have regional responsibilities are provided with comparable data to help them assess health status in those countries and how they compare to the rest of the world.

There are those who think wealthy countries must help poor countries indefinitely and those who say poor nations must do more for themselves. We, the instructors, must help guide this important debate to ensure that international health students understand that the issues are complex and that many factors play into why some nations manage to provide good health for their populations despite natural resource and economic limitations. The conclusions the students reach, and their arguments, should be encouraged by way of class debates and presentations. After all, this is exactly what they will face when they start their international careers in the field of global health. Therefore, this book was written for both graduate students who will soon become international civil servants and midlevel managers who are already working in the field of international health.

## ***Using Data to Track Global Health***



Just a few years ago the available demographic data would not have allowed us to attempt to do what we are able to now. There is no better method than to examine at 5-year intervals a country's demographic indicators for at least a 30-year period to assess its health outcome. Reliable data is important to implement development programs and monitor governance. Without good data, governments cannot assess what has worked and what has not. We can now successfully gather and analyze data about any country. There are organizations that compile and provide us with comprehensive and reliable data about the health, economic, and social status of the world population. They include the Organisation for Economic Co-operation and Development (OECD), the Population Reference Bureau and the United Nations Statistical Division. The United Nations Statistical Division provides an important function. It collects national data; processes and disseminates information; standardizes data collection, data classification, and definitions; and assists nations to achieve their goals. Various UN and non-UN agencies and programs collect data relevant to their work and also disseminate information regularly. For example:

- The Population Reference Bureau produces “World Population Data Sheet”
- UNFPA produces “State of the World Population”
- UNICEF produces “The State of World's Children”
- UNDP produces Human Development Indices
- WHO produces “The World Health Report”

However, the most sophisticated and comprehensive data is the World Development Indicators (WDI), which is provided by the World Bank. The strength of the WDI is that it provides researchers in one location almost 800 indicators and links its data to the development banks, the UN statistical information system, and government data including the US Factbook. WDI is revised annually and is available in hard copy and CD-ROM (**Box Preface-1**). WDI, along with the UN data, is used extensively in this book.

### ***The World Development Indicators (WDI)***

The WDI is the statistical benchmark that helps measure the progress of development. It provides a comprehensive overview of development drawing on data from the World Bank and more than 30 partners.

The WDI is the World Bank's premier annual compilation of development data. It is a statistical reference that provides access to the most detailed and accurate development data available in print, online, or on CD-ROM.

The WDI print edition contains more than 800 indicators on 150 economies and 14 country groups, and includes more than 90 tables.

It provides a current overview of the most recent data available as well as important regional data and income group analysis in six thematic sections:

- World View
- People
- Environment
- Economy
- States and Markets
- Global Links

The WDI data are shown for 153 economies with populations of more than 1 million in selected tables.

The WDI Online and CD-ROM editions contain time series data for more than 200 economies from 1960–2008, single-year observations, and spreadsheets on many topics. They include more than 1,000 country tables, and CD-ROMs also include the text from the WDI 2010 print edition.

The mapping function allows users to see the results in a world map that can be resized and zoomed to the country level.

Users may also choose their preferred language interface: English, French, Spanish, Portuguese, Russian, Arabic, or Chinese.

Data from The World Bank, [www.worldbank.org](http://www.worldbank.org)

Data from 1945 to 2008 from the United Nations and the World Bank was consulted for this book. In 1945, the United Nations Educational, Scientific and Cultural Organization (UNESCO) included in its constitution full and equal opportunity for education for all (Appendix 6–2). In 1948, the United Nations gave the world its landmark human rights declaration, the Universal Declaration of Human Rights (Appendix II). In 1978, the World Health Organization (WHO) made another landmark decision, the Alma Ata Declaration to promote health care for all (Appendix 5–2), and in 2008, the second Alma Ata Declaration (Appendix 5–3). In the second half of the last century, life expectancy gradually increased globally due to improvements in medicine and nutrition, but most of the increases were achieved after 1978 following the WHO Alma Ata Declaration. This book gives the Declaration due credit because there is evidence to suggest that without it the current level of good health and longevity would not have been possible. Primary health care for all, primary education for all, and access to clean water and sanitation have been used to rank the 192 countries.

## ***A Framework for Studying Global Health Disparities***



The approach of this book is positive. It focuses on the fact that more than half of the world population is living longer and healthier and a third of the world population is making progress toward those ends. However, a third of the world population is doing poorly and needs immediate attention and a refocusing of development assistance for the promotion of health for the most vulnerable. Put another way, the four development groups employed in this book show that 8% of the world population have reached the highest achievable life expectancy, 44% have reached a higher life expectancy, 36% have reached high life expectancy, and only 12% are in need of immediate help.

As indicated earlier, 192 United Nations member countries are ranked using their 2006 life expectancy rates and other demographic indicators. When several indicators were matched against the life expectancy ranking of 2006, the 192 countries show distinct patterns, and it became necessary to create a new four-world category, which is addressed in the Overview. The four-group division illustrates a top-to-bottom ranking of the 192 countries: 24 countries are termed in this book the most developed group (Chapter 1), 76 countries are in the developed group (Chapter 2), 50 countries are in the developing group (Chapter 3), and 42 countries are in the least developed group (Chapter 4). Relevant demographic indicators specially prepared for this book accompany the four chapters. Regional patterns are highlighted.

- Europe belongs to the most developed countries group.
- Most of the countries from the Americas belong to the developed countries group.
- The Middle East and Arab States belong to the developed countries group.

- Most former Soviet Union (FSU) states belong to the developing countries group.
- Most Asian countries belong to the developing countries group.
- Almost all Sub-Saharan African countries belong to the least developing group.

In broader terms, the most developed countries group is represented by Europe, the developed group is represented by the Americas, the developing group is represented by Asia, and the least developed group is represented by Sub-Saharan Africa. These groupings are not based on the economic status of the countries. They are based on their relative life expectancies as of 2006, a direct outcome of the level of primary health care, primary education, and clean water and sanitation the countries have provided to their populations. These three sectors are highlighted in separate chapters: primary health care (Chapter 5); primary education (Chapter 6); and access to clean water and sanitation (Chapter 7). Relevant demographic indicators specially prepared for the book accompany the three chapters including important international water management regulations.

While secondary and tertiary services are also important to promote good health and longevity, this book focuses on access to primary services because they are the launching pad for future development. This book and other books have clearly stated that where these basic services are promoted universally, good governance in health also exists because these services must be provided, regulated, and monitored by governments. The book presents an argument that lack of universal access to these basic services has resulted in the 30- to 40-year life expectancy gap between the most developed and least developed nations. (Several examples are given in Chapters 1–7). Excerpts from two United States presidents, President Carter and President Obama, are included in Chapters 1 through 4 because President Carter linked his foreign policy to human rights—the first US president to do so—and President Obama some 30 years later elaborated the US government’s 21st-century foreign policy linking good governance to human rights in his inaugural speech and when he addressed the Ghanaian Parliament. Also included are the World Bank’s Structural Adjustment Program (SAP) and the United States Millennium Challenge Corporation’s programs and regulations relevant to good health and longevity.

Equally important to global health are the emerging global issues that are impacting everyone in the world, especially those living in developing and least developed countries: food security and obesity, tobacco use, urbanization and microhabitat, climate change and health, and the aging of the population. They are briefly addressed in Chapter 8. The definition of good governance in health is presented (Chapter 9) as a concluding chapter by contrasting various existing definitions and their relevance to promoting good health and longevity globally.

The book does not claim that life expectancy alone tells the whole story and must be compared to other indicators. The following observations are made based on the analysis of the data:

- The outlook is for better health and greater longevity for the world community (WHO and UNESCO).

- More than half of the world population is now living longer and in better health (Chapters 1 and 2).
- In a short period of time, it is possible that three quarters of the world population will live longer and in better health (Chapter 3).
- Sub-Saharan Africa has regressed in life expectancy given its prospects 30 years ago (Chapter 4).
- The United Nations and the OECD core countries share much of the credit for the current good health and longevity of the world population (Chapter 1).
- The Structural Adjustment Program (SAP) of the World Bank has contributed to good health and longevity, and the new United States Millennium Challenge Corporation (MCC), similar to SAP, attaches good governance and accountability as conditions for the receipt of its foreign aid.
- The United States is referred to as an outlier with each of the 50 states functioning as more or less autonomous entities. A subranking shows how the 50 states individually rank against the world community (Chapter 2). All fifty states are in the developed group but several states fall lower in ranking and Hawaii moves to the most developed group.
- There is a need for most developed and developed countries groups to change their relationship with developing and least developed countries from one of dependency to one of partnership and mentoring. The implications here are that providing development assistance alone without imparting knowledge has not worked in the past and has created crippling dependency (Chapter 9).
- Developing and least developed countries will need to pay special attention to the emerging global trends that could derail their progress (Chapter 8).
- There is a need for the least developed countries group to own their own development blueprint, learn from those countries that are ahead them, and implement programs based on individual rights and paying for them from internal sources (Chapters 5, 6, and 7).
- Declaring the eight United Nations Millennium Development Goals contributed to good health and longevity, and by the year 2015 the eight goals could be combined into four goals (Chapter 9).
- Looking back 60 years, only a quarter of the countries listed in this book were sovereign nations, but now that number is 192 (see Map I, the world in 1945, and Map II, the world now).





# OVERVIEW

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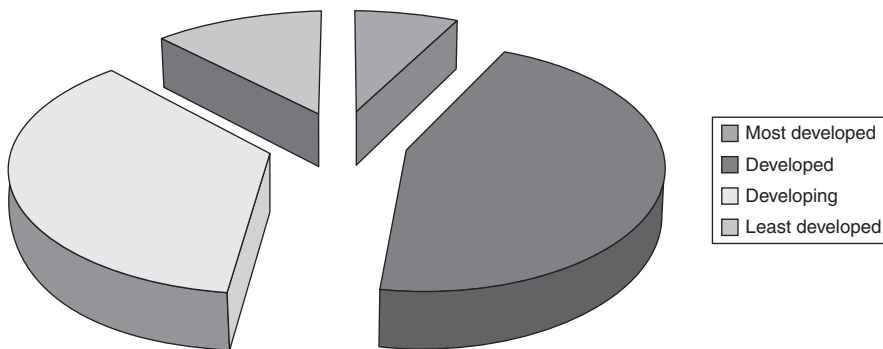
At the turn of the 21st century, there is good news all around as more than half of the world population live healthier and longer because their governments have made it possible for them to have universal or near universal access to primary health care, primary education, clean water, and improved sanitation, the definition of good governance in health. If the current trend continues, it would take less than a century for the world population to achieve an average life expectancy of 70 years because there is a strong correlation between higher life expectancy and universal access to primary health care, primary education, clean water, and sanitation. Many diseases of the 20th century are under control, and progress is now being made in new areas of medicine with the aim of preventing, and even curing, chronic diseases. However, most of Sub-Saharan African countries have either fallen behind or stayed as they were 50 years ago. Priorities must now shift to revising how development assistance has been provided in the past and refocusing on good governance (Chapter 9) and people-oriented programs based on the commitment of the recipient countries. Sub-Saharan African countries must make sure that they grow enough food or be able to purchase what they need; they must provide access to universal primary health care, primary education, clean water, and improved sanitation to their populations because without such services no development can be achieved (Chapters 5, 6, and 7). It is also important that donor countries revise their funding procedures by attaching conditions and demanding verifiable commitments from the recipient countries before they award their development assistance so that the funds they are giving improve the lives of the most vulnerable groups, especially children.

Illustrated by several indicators, this book maps out global health to show how in the second half of the 20th century good governance in health has started to flourish throughout

the world, resulting in good health and longevity for more than half of the world population. During the same period, several countries throughout the developing world started to embrace democratic systems of government, which also resulted in economic and health benefits that used to be available only to the wealthy. This book highlights several factors that show how governments shifted their priorities to providing access to primary health care, primary education, and clean water and, in a short period of time, achieved progress. It also illustrates the role the United Nations and the 24 core OECD member countries played in achieving that progress (Chapter 1).

In the book, several demographic indicators are used to assess how and why countries achieved higher life expectancy and why some lag behind. Access to primary health care, primary education, clean water, and improved sanitation is key to achieving good health and is explained in Chapters 5, 6, and 7. Maternal and child health indicators are included to identify the importance of the demographic transition process. Indeed, life expectancy ranking correlates directly with the demographic transition periods. The higher the life expectancy a country has, the lower the rate of fertility and vice versa. Therefore, the division of countries into three groups, developed, developing, and least developed, is based on national incomes, not on health outcomes. However, income alone does not tell us how well or how poorly nations perform when it comes to achieving good health and longevity. Although the economic progress of many countries has surged in recent times, equaling or coming close to those of developed countries, the focus of this book is not on ranking countries by their economic achievements, but by assessing their health outcomes. When 192 U.N. member countries are ranked based on their life expectancy indicators, interestingly they form four distinct groups (**Figure Overview–1**). Figure Overview–1 illustrates the shape of the world by the end of 2006:

- The most developed group has 506,138 people, 8% of the world population.
- The developed group has 2,914,142 people, 44% of the world population.



**Figure Overview–1** *Four-world category*

Source: UNdata 2008 and WDI 2008

- The developing group has 2,365,825 people, 36% of the world population.
- The least developed group has 794,729 people, 12% of the world population.

Life expectancy, the average life span of a newborn, is an indicator of the overall health of a nation. Although life expectancy is an average measurement and does not account for disparities within countries, it gives us a starting point to address shortfalls in those countries that have lower life expectancy. The previous graph shows that more than half of the world population now lives longer and healthier and a third of the world's population is making progress, but a sixth of the world's population live in poverty and ill health. We also know that the higher the average life expectancy of a nation, the higher the availability of primary healthcare services, primary education, clean water, and improved sanitation (Appendix 1–1). Disease burden is also an important indicator and it correlates with the four-world group as explained in Chapter 5. Those countries listed in Chapter 3 and 4 have a high prevalence of preventable diseases listed in **Table Overview–1** below.

Table  
Overview–1

***Selected global disease prevalence (in millions)***

<b>Conditions</b>	<b>World</b>	<b>Africa</b>	<b>The Americas</b>	<b>Eastern Mediterranean</b>	<b>Europe</b>	<b>Asia</b>
TB	7.8	1.4	0.4	0.6	0.6	4.9
HIV	2.8	1.9	0.2	0.1	0.2	0.3
Diarrhea	4,620.40	912.9	543.1	424.9	207.1	2,532.50
Malaria	241.3	203.9	2.9	8.6	0	26
Dengue	9	0.1	1.4	0.5	0	6.9
Childhood diseases	46.5	10.9	1.3	2.8	0.9	30.9
Maternal mortality	30	12.2	6.7	6.9	2	22.1
Lower respiratory	429.2	131.3	45.4	52.7	19	180.8
Heart failure	5.7	0.5	0.8	0.4	1.3	2.7
Stroke	9	0.7	0.9	0.4	2	5.1
Malignancy	11.4	0.7	2.3	0.5	3.1	2.7

Source: WHO Global Disease Burden 2004



## Population Growth Trend

We already know that developed countries have higher life expectancies, developing countries have moderate life expectancies, and least developed countries have lower life expectancies. While the actual labeling and ranking of countries can only be done by the United Nations, in this book a fourth category is added to illustrate distinct patterns that emerged at the beginning of the 21st century. Twenty four countries are placed in a new category of “most developed” nations. When 192 United Nations member countries are ranked by life expectancy, regional divisions emerged, which supports the four-world grouping: most developed, developed, developing, and least developed. What we did not know up until now was that several developing countries have also emerged as developed nations when ranked by life expectancy.

The four-world group is based on more than geographical locations. It is the affinity one member has with its neighbors and its historical and cultural roots. Australia and New Zealand have the same demographic indicators as Western Europe. Central and Eastern Europe have similar demographic indicators as Western Europe. Almost all of the Middle East and Arab states have the same demographic indicators, including those in North Africa. Almost all of the FSU states remain in the same group. Almost all Sub-Saharan African countries have similar demographic indicators. Haiti, the first independent black state in the Western Hemisphere, but populated by people who originated in Africa, has similar demographic indicators as Sub-Saharan African countries as opposed to its neighbors in the Americas (Chapter 2).

As illustrated in **Table Overview-2**, these distinct groupings are also confirmed by the facts that the most developed and the least developed groups represent their own continents, Europe and Africa respectively, and that no country from Europe belongs to the developing and least developed group. FSU states have their own group. No countries from the Americas or the Middle East and Arab states belong to the least developing group. Most Asian countries belong to the developing group.

At the beginning of the 20th century, there were only 2 billion people in the world and the average global life expectancy was hovering around age 40. By the middle of that century, 75% of the world population lived in developing countries. The current longevity status was only achieved over the last 50 years. In fact, a series of changes gradually happened. These changes came about through hard work by governments; access to vaccinations, antibiotics, and other medicines to prevent and control diseases; and improved nutrition and living conditions. As a result, in just 72 years, from 1927 to 1999, the global population increased dramatically to reach 6 billion (**Table Overview-3**). What was more dramatic than the growth of the population was the length of time the world population took to double. From a .25 billion to .5 billion took 650 years, from .5 billion to 1 billion took 204 years, and from 1 billion to 2 billion took 123 years. But it only took 47 years to reach from 2 billion to 4 billion. However, the world population growth is now stabilizing and we can be sure that it will take a very long time to double again (Chapter 5).

Table  
Overview-2**Regional distribution of the four-world category,  
2006**

<b>Life expectancy</b>	<b>80+</b>	<b>70–79</b>	<b>60–69</b>	<b>39–59</b>	<b>Total</b>
<b>Western Europe</b>	18	6	0	0	<b>24</b>
<b>Eastern/Central Europe</b>	0	12	0	0	<b>12</b>
<b>Former USSR States</b>	0	5	11	0	<b>16</b>
<b>The Americas</b>	1	26	8	0	<b>35</b>
<b>Asia</b>	4	10	24	2	<b>40</b>
<b>Middle East / Arab States</b>	1	14	3	0	<b>18</b>
<b>Africa</b>	0	3	4	40	<b>47</b>
<b>Number of countries</b>	<b>24</b>	<b>76</b>	<b>50</b>	<b>42</b>	<b>192</b>
<b>Total population in millions</b>	<b>506,138</b>	<b>2,914,142</b>	<b>2,365,825</b>	<b>794,729</b>	<b>6,580,834</b>
<b>Four-worlds category</b>	<b>Most Developed</b>	<b>Developed</b>	<b>Developing</b>	<b>Least Developing</b>	

At the beginning of the 21st century, 50 years after the United Nations was established, millions of people in more than 100 countries are living longer and are in good health. This is recognized throughout this book. Also recognized is the contribution made by the 24 OECD core member countries and the commitments made by those governments in 100 countries listed in Chapters 1 and 2 to those landmark United Nations declarations (Chapters 5 and 6). The contribution of the United Nations, which also includes the World Bank and International Monetary Fund (IMF), needs to be emphasized. There is no possible way that the global community could achieve so much in such a short period of time without the work of the United Nations. The organization may not be what everyone wants it to be, but it is the most democratic and highly effective institution that we have—we cannot replace it and we must enhance it. The failure of the League of Nations taught us important lessons. The League's failures led to World War II, but since the

Table  
Overview-3**Global population growth trend**

Year	AD							
	950	1600	1804	1927	1961	1974	1987	1999
<b>Worlds population in billions</b>	.250	.500	1	2	3	4	5	6
<b>Years to the next billion</b>				123	13	13	13	12
<b>Years it took to double</b>		650	204	123		47		

establishment of the United Nations, nations have avoided world wars. The conflicts the world has seen have been largely domestic in nature. The UN enforces international laws, manages peace and security, implements development programs, and promotes human rights and humanitarian assistance programs throughout the world.

An important first step for the United Nations was the Universal Declaration of Human Rights (UNDHR) in 1948 (Appendix II), which became the landmark declaration for progress made in enforcing human rights to date. This was the first time an organization with a global reach declared equal rights for all. Until that time, the world was a segregated place and disparities between and among nations were wide; women had a lower status with lower income and lower levels of education and no possible means of improving their future. This book highlights the impacts the UN has made on good health and longevity, which would not have been impossible otherwise. For example, Article 25 of the UNDHR provided the impetus for additional international declarations such as the Alma Ata Declaration (Appendix 5-2) by the United Nations World Health Organization (WHO). The Primary Education For All Declaration (Appendix 6-2) of the United Nations Educational Scientific and Cultural Organization (UNESCO) was enhanced by Article 26 of the UNDHR. Later, the United Nations Millennium Development Goal (UN-MDG) reinforced these important declarations to secure good health and longevity for many nations that are lagging behind, which is also a focus of this book (**Box Overview-1**).

Global life expectancy at a glance in 2006 (Appendix 1-1) supports the arguments presented in the book that many are living longer and must be healthier (**Figure Overview-2**), which is a compendium of Appendix-1 and illustrates the life expectancy of the global community (derived from 192 United Nations member states). To the very left of the graph are those countries with universal access to primary health care, primary education, and clean water (Chapters 1 and 2). The middle area is divided into two: in the left-center are those countries with near universal access to clean water, primary education,

## ***UDHR and the link to primary health care and education for all***

### **Universal Declaration of Human Rights, 1948: Article 25**

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

### **Excerpt from The Alma Ata Declaration (WHO)**

All governments should formulate national policies, strategies, and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally (Appendix 3).

### **Universal Declaration of Human Rights, 1948: Article 26**

Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance, and friendship among all nations, racial, or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

### **Excerpt from Education for All (UNESCO)**

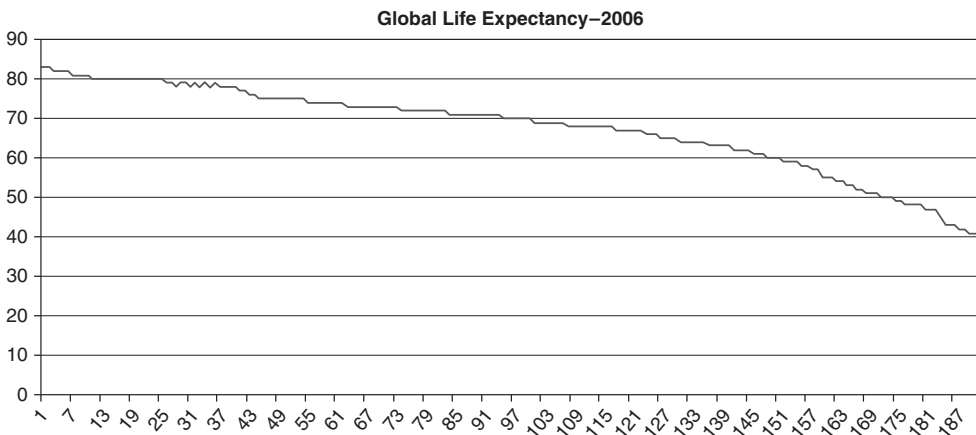
The right to education is a fundamental human right. It occupies a central place in human rights and is essential and indispensable for the exercise of all other human rights and for development. Individuals can exercise none of the civil, political, economical, and social rights unless they have received a certain minimum education.

*(continued)*

Box  
Overview-1***UDHR and the link to primary health care and education for all (continued)*****The UN Millennium Development Goal**

In September 2000, world leaders came together at United Nations headquarters in New York to adopt the UN Millennium Development Goal Declaration committing their nations to eight specific goals to be accomplished by 2015, a new global partnership to reduce extreme poverty and setting out a series of time-bound targets—with a deadline of 2015—that have become known as the Millennium Development Goals (Appendix 5 and 6).

Sources: United Nations Economic and Social Affairs, UNESCO, WHO



**Figure Overview-2** *Global life expectancy at a glance for 192 countries*

Source: WDI 2008

and primary health care and in the right-center are those with somewhat limited access (Chapter 3). The very right of the graph are countries with limited access to primary health care, education, and clean water (Chapter 4).

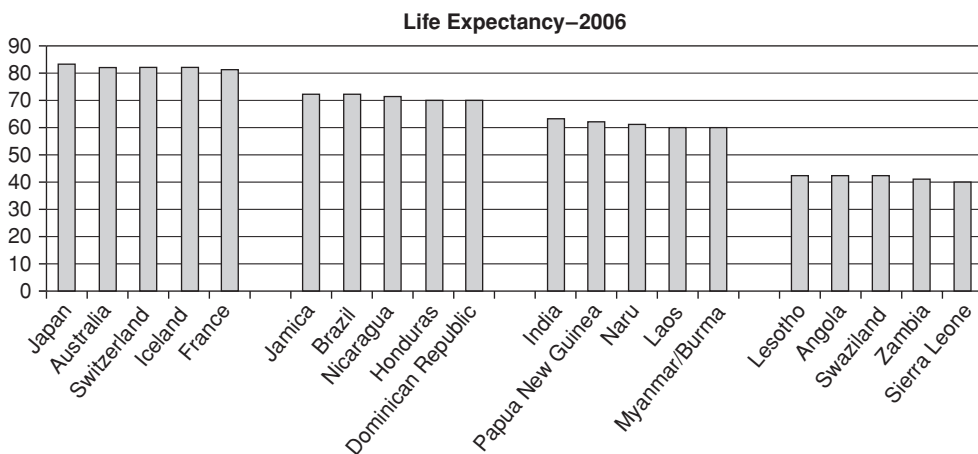
Universal access to primary health care is ingrained in the Universal Declaration of Human Rights. Without universal access to primary education no nation could achieve sustainable development and without access to primary health care, primary education,



and clean water, no nation could achieve sustainable development. Having access to primary health care and primary education without clean water, or having access to clean water and primary education without access to primary health care, has never worked. It is almost always true that achieving longevity and good health requires good governance because these services are provided and regulated by governments. These three sectors go hand-in-hand and when one is missing, the other two do not work effectively.

While three quarters of the world's population is now healthier as compared to 50 years ago, approximately one sixth of the population, mostly in Sub-Saharan African countries, still have life expectancies equivalent to that of the early 1900s. Almost 800 million people in 40 countries listed in Chapter 4 have limited access to primary health care, primary education, and clean water, and have the lowest life expectancy in the world. When the lowest ranked countries and the highest ranked countries are compared, there is a 40-year gap in life expectancy (**Figure Overview–3**). All of the countries listed in Chapter 4 are lagging 25 to 40 years behind in life expectancy when compared to countries listed in Chapter 1. This gap in life expectancy is too wide to be ignored because infant, child, and maternal mortality rates are still high in those countries. Therefore, countries listed in Chapter 4 will have to move out of a permanent economic downward spiral that has been impacting negatively on the health of their populations by following the examples of those countries listed in Chapter 3. They must also own their own development agenda and move out of dependency on foreign aid to provide for their basic services.

As explained above, there are distinct regional divisions in longevity ranking. While the intended goal of the book was to rank countries using a life expectancy scale, the regional classification came unexpectedly. Why most of Europe is highly developed, the Americas are progressing, Asia is doing well, and Africa is doing poorly cannot be



**Figure Overview–3** *Examples of life expectancy ranking in the four groups*

explained in a short book such as this and will require further study. However, it is clear that those countries that embraced good governance in health, despite economic resource limitations, have built infrastructures to support their development programs, and have completed their demographic transition periods (Chapter 5). Countries listed in Chapter 3, which are mostly Asian, plus 11 out of the 15 FSU states, have made substantial progress, living beyond age 60 years. Seventy-six countries listed in Chapter 2, mostly in the Americas and the Middle East and Arab States, are making impressive progress, living above age 70 years, and eight of these countries are set to join those countries listed in Chapter 1, the most developed group. The best health and longevity outcomes were amongst the 24 countries listed in Chapter 1—are mostly from Europe—which have provided universal primary health care, primary education, and access to clean water, and have the highest life expectancy in the world, 80 years and beyond.



## ***Rationale for a Four-World Categorization Scheme***

Different labels have been tried to classify those countries surging ahead in their economic development. The United Nations and the World Bank have classified nations based on their economic indicators and achievements including their GDP and GNI. The World Bank has four categories: low income (GNI of \$975 or less); lower middle income (GNI of \$976–\$3,855); upper middle income (GNI of \$3,856–\$11,905); and high income (\$11,906 or more). The World Bank acknowledges that classification by income does not reflect the development status of a country. Concerned about the restrictiveness of labeling nations by income alone, the United Nations Development Program in 1990 launched a new system of ranking nations based on three specific criteria to measure life expectancy, literacy, and standard of living, known as the Human Development Index (HDI). While it is easier to quantify life expectancy and literacy, it is very difficult to measure standard of living. The WHO ranks countries by life expectancy among other health indicators, and UNFPA produces a fertility index along with other primary healthcare indicators. Throughout this book major indicators are used to rank countries. Other rankings (high-income countries, advanced economies, upper-income countries, middle-income countries, and emerging economies) were also considered, but when the three indicators of life expectancy, access to primary health care, and clean water/sanitation are compared to other indicators, the four-world division became eminent. Since development is a process, it is acknowledged that countries in the three groups—developed, developing, and least developed—could easily enter a higher level of life expectancy.

Acknowledgment here is due that the “developed” group has split into two categories: most developed and developed. From the “developing” category, a great number of countries have achieved good health and longevity equivalent to that of the developed group and are included with the developed group. Therefore, in this book, the global community is divided into four groups instead of the traditional three (developed, developing, and least

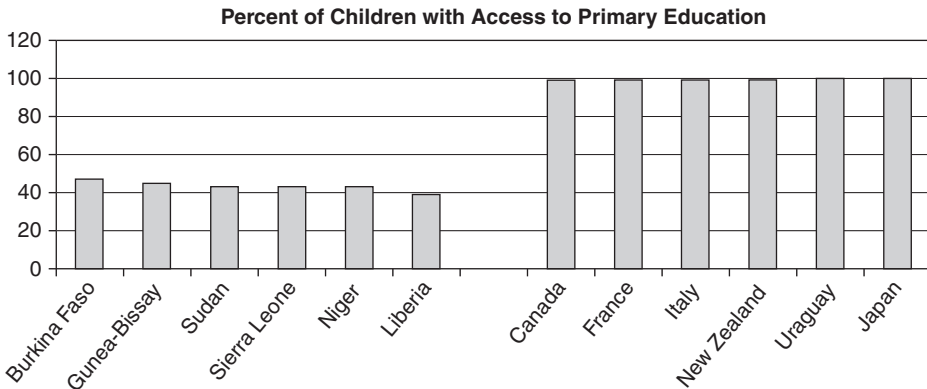
developed). We now need four groups: most developed, developed, developing, and least developed groups (Table Overview–2 and Figure Overview–3). By the year 2006, 24 countries emerged as most developed, reaching life expectancy above 80 years; 76 countries, approximately half of the world population, had reached national life expectancy levels of 70 to 79 years of age. Thirty years ago most of these countries were in their early stages of economic development and their life expectancy indices were not comparable to what they are now. Examination of their progress shows that they embraced good governance in health, and the countries that lag behind them in development could use their examples (Chapters 3 and 4). The four-world category was created by life expectancy ranking of 192 UN member countries matched against access to primary health care, primary education, clean water, and sanitation.

Twenty-four countries are given a new category, *most developed*, and their experiences are unique and irreversible. Only this group of countries, led by Norway, can claim to have achieved true sustainable development (Chapter 1). Countries listed in Chapter 2 are considered *developed* because, despite economic limitations, 76 countries have exercised best practices and embraced good health and longevity. They are a focus of this book. Best practices in this context are based on good governance in health, providing their populations with universal or near universal access to primary health care, primary education, clean water, and sanitation. There are 50 countries that are making progress and are *developing*. Several countries from this group, in a short period of time, could join the developed group, which would result in 75% of the world population living healthier and longer. The 42 countries listed in Chapter 4 should be considered the *least developing* countries. We do not have reliable data for Afghanistan and Iraq, now listed in this group. Countries listed in Chapter 4 are lagging behind and, in some cases, have shown regressions as a result of wars, continuous food shortage (Chapter 8), and the scourge of HIV/AIDS. While emergency humanitarian assistance must continue for this group, their governments must re-examine their priorities and embrace what worked for countries whose development has surged ahead of theirs. It is important to note that the life expectancy gap between the developing and the least developing countries is significant, and by the year 2006, in the latter group alone, millions of people were left without primary health care, primary education, and without clean water and sanitation.

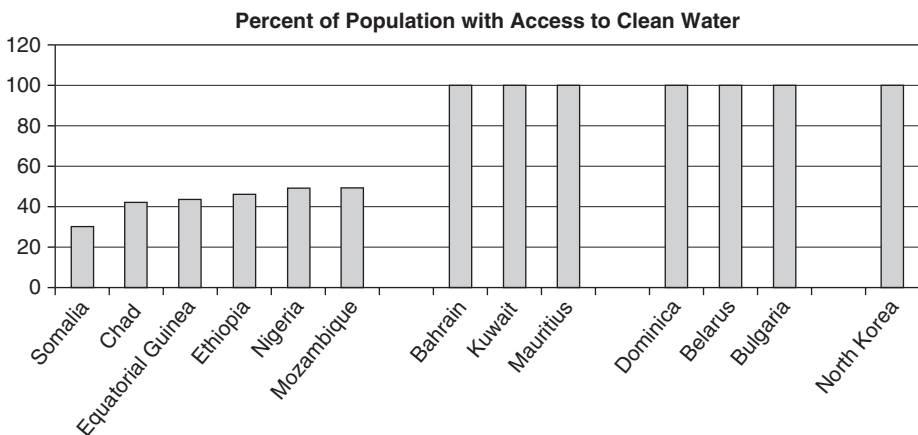
Everyone would agree that countries listed in Chapters 1 and 2 have provided good health and longevity for their populations. The countries listed in Chapter 3 are progressing but countries listed in Chapter 4 have not. The four groups are based on one important indicator, life expectancy, checked against other indicators. In order to avoid comparing extremes and to show the interrelatedness of the many indicators to life expectancy, the book has concluded that it is not possible to have higher life expectancy in any country without the provision of primary health care, primary education, and clean water. The four divisions show common themes that distinguish one group from another. The development continuum is a movement in one direction from scarcity of good health to the provision of universal health care, universal primary education, and universal clean water. Governments of those countries on the right side of the development continuum

implemented the Alma Ata Declaration (see Chapter 5), often by adjusting their constitutions. These countries also implemented UNESCO's declaration of primary education for all (**Figure Overview–4**) and provided clean water (**Figure Overview–5**) and improved sanitation in their respective countries. Therefore, the key element to their success is attributed to the implementation of universal access to basic services. In many countries this is done despite their economic limitations.

The examples of the 100 countries illustrate that successes were made when nations embraced good governance in health by creating and following their own development



**Figure Overview–4** Access to primary education for selected countries from the least developing and most developed groups



**Figure Overview–5** Access to clean water for selected countries from the least developing and most developed groups

blueprints. This is why good governance in health is essential to achieving the development goals of any country. Primary health care along with access to primary education and clean water are the three legs of the stool (Chapter 9) and are vital for moving nations to secondary and tertiary levels of development. These basic services are not privileges but rights ingrained in the Universal Declaration of Human Rights. We now have numerous best practices to measure progress in good health and longevity. More and more countries have now instituted systems that allow for citizen participation in governance and more and more countries are actively working to involve civil society in decision-making. Citizen participation will be one of the critical tests to promote good governance, which will lead to achieving good health and longevity. There is no disagreement that there is a strong correlation between higher life expectancy and access to universal primary health (Appendix 5–1), primary education (Appendix 6–1), and clean water and improved sanitation (Appendix 7–1).

Arguments are made that increasing development assistance without improvements in internal government policies that protect citizens' rights has not worked and will not work, and that the major impetus for advances must come from the recipient countries themselves (Chapters 4 and 9). Government commitment to development and accountability to their populations have worked in the most developed and developed countries and their examples should be promoted on behalf of vulnerable people in the least developing countries. When development programs are imposed by donor countries, sustainable development goals have not been reached and often were counterproductive and even damaging to the very people they were intended to help. No matter how we try to approach the subject, providing money without promoting and protecting fundamental human rights is counterproductive. Future development assistance programs, therefore, must shift to teaching and creating partners in health and development with governments committed to these goals, always giving priority to the most vulnerable groups.

The time has come for the group of developing countries to follow the examples of developed countries and for the least developing countries to follow what worked for developing and developed countries. The time has come for policy makers in donor countries to insist that recipient countries promote good governance in order to move away from their habitual dependence on development assistance. It is important to highlight that despite billions of dollars spent to assist the least developing groups, 65,000 people die daily from preventable diseases and 3,000 of those are children who die daily from malaria. Therefore, the time has come for donor countries to reassess their aid and to advocate on behalf of the vulnerable people that they set out to help. In a world of financial insecurity, providing foreign aid has become uncertain. The responsibility, therefore, must shift from reliance on external help to competent domestic governance requiring equitable distributions of natural resources. Recipient countries must adhere to accountability, transparency, and commitment to those international laws that worked for countries whose development has surged ahead of their own.

This book demonstrates that the different economic and political systems do not explain why some nations provide universal access to basic services and some do not, but it illustrates that it is the absence of competent governments that is the cause of disparities

in health that create the gap in life expectancy (Figure Overview–2). More than 1 billion people suffer from this disparity. While it is not possible for the countries listed on the right side of the graph to join those listed on the left any time soon, it is possible for this group to move forward quickly if they institute development programs that worked for those countries listed in Chapters 2 and 3. Access to primary health care, primary education, and clean water must be universal, mandatory, and provided in developing countries free of charge.

While the general meaning of governance, which is a system of governing, is easy to understand, good governance is difficult to measure because it involves creating a standard for a variety of cultures and economic systems (Chapter 9). Nevertheless, nations are managers of good governance. According to the World Bank, “Strong, efficient, and transparent government institutions are fundamental to economic growth and social development.” (World Bank 1997). The OECD took the World Bank’s definition further to include the rule of law; public sector management, including decentralization; control of corruption; and the reduction of excessive military expenditure as important dimensions of good governance (1993). The U.N. Development Program’s definition of good governance links capacity building, decentralization, economic and financial management, consensus among citizens, and promotion of the rules of law, which link economic, political, and public sector management (1997). The Commonwealth Secretariat defines good governance as making government more efficient by instituting measures to counteract corruption, promote transparency and accountability, improve service, improve partnership with nongovernmental organizations, and promote equitable electoral practices by promoting the role of opposition parties (1995, 1997, and 1998).

Thirty years after the Alma Ata Declaration, by the year 2008, half of the world population was living healthier and longer. Although a lot has been achieved in the 20th century, at the turn of the 21st century the global community felt the urgency and came together to declare another comprehensive declaration giving the other half of the world population a chance to act quickly to improve lives in their respective countries. The U.N. Development Goal (Appendix III) was designed to expedite the lagging development processes in developing and least developed countries to give them the opportunity to achieve good health and longevity. Even though declaring these goals does not magically lead to the desired outcomes, they provide a framework to advance and measure development outcomes (2007 UN-MDG Midterm report) (Appendix IV).

In addition to the four-world category and the three sectors (primary health care, primary education, and clean water), this book also addresses emerging health trends in Chapter 8, including tobacco use in developing and least developed countries and the adverse impact of obesity, micro-habitat and climate change, the aging of the population, and food security. The conclusion discusses good governance.

# ACRONYMS

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CDC	Centers for Disease Control and Prevention, US
CSDH	Commission on Social Determinant of Health
FCTC	Framework Convention of Tobacco Control
FSU	Former Soviet Union
GDP	Gross Domestic Product
GNI	Gross National Income
GNP	Gross National Product
HDI	Human Development Index
IM	Infant Mortality
ISEF	International Science and Engineering Fair, Intel
ITGA	International Tobacco Growers Association
IUCN	International Union for Conservation of Nature (Natural Resources)
LE	Life Expectancy
MCC	Millennium Challenge Corporation, US Government
MDG	Millennium Development Goals, UN
MDR	Multiple Drug Resistance
MEAS	Middle East and Arab States
MM	Maternal Mortality
MRC	Mekong River Commission
MSF	Médecins Sans Frontières, France (Doctors Without Borders, USA)
NGO	Nongovernmental organization
NHS	National Health Service, UK
OECD	Organisation of Economic Co-operation and Development

PRB	Population Reference Bureau
S-CHIP	State Children's Health Insurance Program
SAP	Structural Adjustment Program, WB
SEATCA	South Asia Tobacco Control Alliance
SSA	Sub-Saharan Africa, Sub-Sahara Africa
UN	United Nations
UN-Habitat	United Nations Human Settlement Program
UNCED	United Nations Conference on Environment and Development
UNDHR	United Nations Declaration of Human Rights
UNDP	United Nations Development Program
UNEP	United Nations Environmental Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFAO	United Nations Food and Agricultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
WB	World Bank
WCED	World Commission on Environment and Development, UN
WDI	World Development Indicators
WEDO	Women's Environment and Development Organization
WHO	World Health Organization, UN
WIC	Women, Infants, and Children, US
WiMAX	Worldwide Interoperability for Microwave Access
WWI	World War I
WWII	World War II



# ACKNOWLEDGMENTS

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I would not have been able to write this book had it not been for the opportunities I have had to travel, live, and work in many countries with a number of organizations, especially the United Nations, the organization that has guided many countries out of poverty and into good health and longevity. The United Nations gave us landmark development declarations and set international governance standards. I have, therefore, highlighted the impacts on human health of the United Nations' Universal Declaration of Human Rights, the World Health Organization's Alma Ata Declaration, and the United Nations Educational, Scientific, and Cultural Organization's Education For All declarations.

I want to give special thanks to Dr. Kazem Behbehani who kindly provided the foreword for this book and his guidance. Dr. Behbehani has an understanding of global health issues very few have and by having his endorsement, I am most encouraged. He is an expert in immunology and tropical diseases, a graduate of Kuwait's Medical School and the London School of Hygiene and Tropical Medicine and a Fellow at Harvard Medical School. Dr. Behbehani has served as a vice president and vice dean of scientific research institutions and is a winner of multiple scientific awards. In addition to his role as WHO Deputy-Director General and a Health Envoy, Dr. Behbehani led the organization's HIV/AIDS vaccine program; served as the organization's Manager of its Tropical Disease Program and the Director of the Eastern Mediterranean Liaison Office; was a member of the Board of Appeal and a Secretary of a number of intergovernmental committees and meetings, including the FCFT. At the same time, he served on advisory boards for the Cyprus International Institute of Environment and Public Health, as a Chairman of the IAEA's External Panel for the Evaluation of Human Health Program, and as a member of the Ethics Review Committee for the International Agency for Research on Cancer. Currently he is the Director-General

of the Dasman Institute and also serves as a member of the board of trustees of Baroness Nicholson's Foundation and J.K. Rowling's Children's High Level Group.

I am grateful to many of my colleagues, friends, and acquaintances who also contributed directly and indirectly to make me think beyond my immediate existence. My gratitude goes to many of my professors who encouraged me never to stop learning even when teaching: Professor Ferdo Basic, Professor Tomislav Budin, Professor Jasmina Hvraneck, Professor Vjekoslav Par, Professor Ivo Tursich and Professor Mesfin World-Maria. I am also grateful to Ms. Olga Bailey of WHO. I am indebted to Mr. Richard Fix of the World Bank who introduced me to the most powerful data and for his guidance and to his colleague, Ms. Blaine Tedros, for her continued support. I am grateful to Mr. Jacob Assa of the UN Statistical Division who provided helpful suggestions and instant training for researchers and policy makers.

I am grateful to the staff of Jones & Bartlett Learning for publishing this book. My special thanks to Ms. Jessica Cromier for her encouragement; my editor, Mr. Mike Brown, who is knowledgeable about healthcare subjects, for his guidance; associate editor Ms. Maro Gartside, senior production editor Ms. Katherine Crighton, and production manager Ms. Tracey Chapman, for working hard to finalize the manuscript; and Ms. Catie Heverling for working with me from start to finish and for her support and efficiency.

Finally, I want to give my heartfelt gratitude to my husband Neil Francis who believes in me and who equates women's rights with human rights. When he served as a diplomat at the Australian Mission to the United Nations, he initiated and advocated gender equality for the women of the UN Secretariat, which later became the law of the organization. This is no coincidence as he was born in New Zealand, the first country that allowed women to vote in 1893 and worked for Australia, the second country to allow women to vote.

I am eternally grateful that I have never had to fight for my rights thanks to the many who fought before me for equal rights for women. I am one of the beneficiaries of their hard work, but women still have a long way to go, which I have addressed in Chapter 6. I believe that, given access to basic services, we all have the ability to contribute, live longer and healthier, and through good governance we have the opportunity to narrow the gap in global health disparities.

# FOREWORD

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It is not often that the United Nations receives such a resounding endorsement supported by empirical data. Readers will find that human rights are at the center of this eloquently written book. The book provides new insights into how the global community is divided economically, socially, politically, and culturally and how this reflects on the gross disparities that exist in health, life expectancy, and health care service. The book comes at a time when the richest country in the world, the United States, is struggling with health care reform to provide health insurance to the one sixth of its population without coverage.

The book urges international agencies to embrace technology and promote eLearning and eHealth. Already technology is being used in remote areas that could help remove the global health and education disparities in developing and least developing countries. This could only happen when governments convert words into actions, and political leaders endorse resolutions and recommendations and sign up to global common goals and commit to making a difference in their respective countries. The author points out the value of good governance, which governments should embrace and sustain for the longer term. In this regard, the role of governments is critical and this book unreservedly advocates competent and committed governments to close the gap in global health disparities.

The author has depicted the United States as a 50-countries-in-one nation and the 50 states are ranked among the world community. This ranking shows the importance of qualitative and quantitative research and presents new ways and means to attempt to close the health disparity gap. The book provides a new category of “most developed” countries, thus creating a four-world category for the global community.

Although the emphasis of the book is on primary level services, it brings to our attention the emerging global trends that are threatening to reverse the success made so far.

Millions of people living in developing and least developing countries are still striving to survive the devastation of communicable diseases, which, with today's knowledge and tools, can be prevented, treated, and in some cases, cured. Global agencies and programs have mobilized human and financial resources for developing and least developing countries to reduce the burden of preventable diseases and to raise life expectancy, but as the author clearly states, more work is needed. On the other hand, in the most developed and developed countries, where life expectancy is high, it is beginning to be eroded by the epidemic of chronic diseases due to life-style changes, primarily caused by overweight and obesity. Preventable conditions such as diabetes, cardiovascular disease, renal disease, respiratory diseases, and cancer are increasing.

But, as stated by the author, the future is not all bleak because many countries have built permanent infrastructures to promote good health and longevity. New technologies and new discoveries are emerging, allowing new approaches to health care that are beneficial for the global community. We are advocating citizen-centered health care, which is more relevant to their needs and more cost-effective. Prosperity brings choices to people that they never had before and all those involved in population health have the obligation to ensure that they make the right choices. Individuals empowered by knowledge can make more appropriate decisions. It is also good governance to regulate producers and promoters of consumable and medical products so that those items that are known to cause ill health, including tobacco and trans-fats, are no longer promoted.

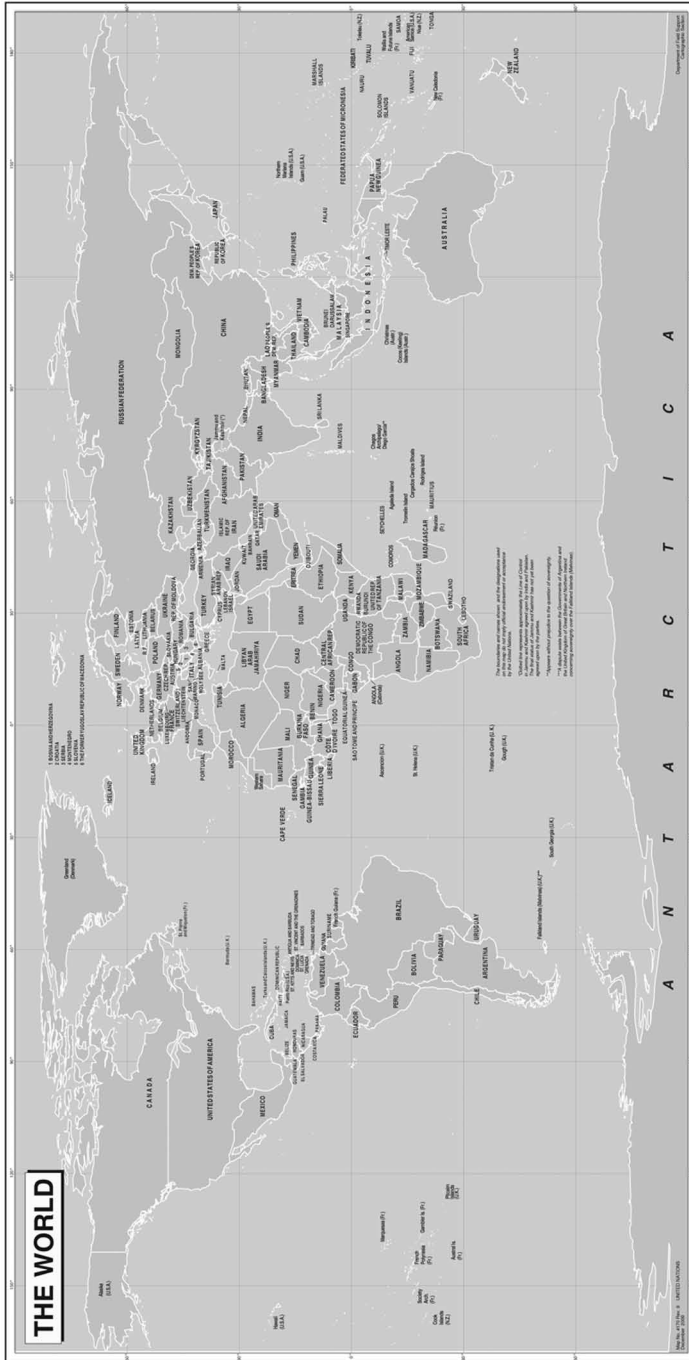
Citizens also have an important role to play and cannot wait for governments to act when it comes to their own health and that of their families. They cannot, and need not, be dependent upon governments. A new approach is being fostered involving the younger generation. This requires that people be knowledgeable enough to manage their own health, which requires education of present and future generations to create a knowledge-based society. This will greatly facilitate changes in attitudes and behavior, leading to healthier life styles.

Families, communities, industry, non-governmental agencies, and the private sector must be involved and committed to improving the environment and overcoming adverse health conditions. Communities and countries should share experiences in this regard toward a common goal, which is better education, health, and prosperity for the individual, family, community, the country, and the world. Through these means, the gap in health disparities could be closed.

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Map I A map of the world featuring countries and oceans. Courtesy of the UN Cartographic Section, no. World\_Map\_Rev. 9.



