Protecting health: the global challenge for capitalism

The quest to secure economic growth, after a financial crisis that raised serious questions about capitalism’s ability to protect and sustain the wellbeing of populations in rich and poor countries alike, is the overriding political priority for many governments today. And those prospects for growth seem good. The World Bank reported in January, 2014, that “advanced economies are turning the corner” and that "developing countries [will] regain strength after two weak years".1 Specifically, global growth is expected to be 3·2% in 2014, rising to 3·5% by 2016. In high-income countries, growth is predicted to be 2·2% in 2014, rising to 2·4% in 2016. And for developing countries, the expectations are little short of spectacular: projected growth of 5·3% in 2014, rising to 5·7% in 2016. By 2015 it is projected that sub-Saharan Africa will host seven of the world’s fastest growing economies. The World Bank concludes that the world is “finally emerging from the global financial crisis”.

This change in economic fortune should be good news for health. It will mean more resources to invest not only in the health sector, but also in related sectors that shape and influence health, such as education and housing. However, there are disparities between regions. The World Bank1 estimates that China can expect growth of 7·7% in 2014. Sub-Saharan Africa’s growth will likely be 6·4%, excluding South Africa. South Asia should come in at 5·7%, with India at 6·2%. But Latin America and the Middle East are expected to deliver dismal 2·9% and 2·8% growth rates, respectively. Meanwhile, some countries will do less well than their neighbours. Pakistan, 3·4% growth. South Africa, 2·7%. Brazil, 2·4%. Egypt, 2·3%. Central and eastern Europe, 2·1%. Iran, 1%. These between-country disparities will be compounded by within-country inequalities. The World Bank has less to say on this issue. But the lack of inclusive growth within a nation—that is, the exclusion of sectors of the population from the overall benefits of economic growth which should include improved health—will deepen inequality in ways that headline gross domestic product figures fail to reveal.

Economic growth alone will not deliver good health to the most vulnerable sectors of society without addressing the intertwined global factors that challenge or destroy healthy lives. Beyond the economy, recent extreme weather events experienced across most parts of the world are tentative (and incompletely understood) signs that the effects of climate change are already with us. The effect that climate has on the agriculture sector and food security, and the likely impact on nutrition and health outcomes, requires further deep evaluation and cooperation between disciplines. The worsening conflict in Syria, and the continued violence in Iraq, Afghanistan, South Sudan, and the Central African Republic, show the frightening ability of violence to damage health and wellbeing, not only directly, but also indirectly through the social chaos violence inevitably causes. Recent episodes of civil strife in Turkey, Thailand, and Brazil prove that despite considerable health gains, the political systems within which those health gains have taken place are fragile and unstable—lessons that all societies need to relearn, no matter how secure they feel today.

These challenges can be addressed only by reaching beyond the health sector. This might seem an obvious notion but its common understanding and application in global policy debate is weak. Decisions made in different political domains rarely have health at the core of their thinking.

One great gap in thinking about the future of health and wellbeing are the arrangements we put in place to organise our international institutions and policies to sustain the fortunes of societies. These arrangements are inherently political, as Ole Petter Ottersen and Chris Stowers/Panos

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Intraoperative radiotherapy for breast cancer

Intraoperative radiotherapy was developed to optimise local outcomes of radiotherapy because it offers excellent delineation of the tumour bed under visual control, very good dose homogeneity, and spares normal tissue. The technique was applied to many tumour sites with controversial results, and initial reports by French and US teams showed that intraoperative radiotherapy for breast cancer led to increased rates of local recurrence compared with whole-breast irradiation of 50 Gy given in daily fractions over 5 weeks plus an external boost of 10–16 Gy to the tumour bed, which offers excellent local tumour control, with local recurrence of about 6% after 10-year median follow-up. Despite increased risk of local recurrence, intraoperative radiotherapy remains an attractive option for some patients because it removes the need to attend a radiotherapy centre for 25–33 fractions for whole-breast irradiation.

In The Lancet, Jayant Vaidya and colleagues' present results of the TARGIT-A trial, while in The Lancet Oncology, Umberto Veronesi and colleagues' present results of the ELIOT trial. Each trial compared a different type of intraoperative radiotherapy with external whole-breast irradiation. Both groups of authors should be commended for their work in this very challenging area.

The TARGIT-A findings add to the first report. This non-inferiority study compared one intraoperative radiotherapy...