STATE OF GLOBAL AIR /2017
A SPECIAL REPORT ON GLOBAL EXPOSURE TO AIR POLLUTION
AND ITS DISEASE BURDEN

The State of Global Air is a collaboration between the
Institute for Health Metrics and Evaluation’s Global Burden of Disease Project
and the Health Effects Institute.
What is the State of Global Air?
This first issue of the State of Global Air report brings into one place important information on outdoor air quality and health for all countries around the globe. It is based on the most recent data available to provide a comprehensive picture of the latest global levels and trends (since 1990).

Who is it for?
The report is designed to introduce citizens, journalists, policy makers, and scientists to the Global Burden of Disease project, a comprehensive effort to estimate and track human exposure to air pollution and its impact on human health around the world.

How can I explore the data?
This report has a companion interactive website, which provides the tools to explore, compare, and download data tables and graphics with the latest air pollution levels and the associated burden of disease in individual countries, as well as regions, and their trends over the last 25 years (1990–2015).

Where will I find information on:
The Global Burden of Disease ............................................. page 1
Air Pollution Levels and Trends ....................................... page 3
Health Burden Due to Air Pollution ................................. page 8
Air pollution is now clearly recognized as an important global risk factor for disease. Decades of research conducted in numerous cities throughout the world show that when air pollution levels increase, so do the numbers of people dying. More important, studies of long-term exposure to air pollution demonstrate that people living in more polluted locations die prematurely, compared with those living in areas with lower levels of pollution. Research also provides details on how air pollution affects human health, with evidence clearly showing impacts on the rates of cardiovascular disease and stroke, in addition to the more easily appreciated effects on respiratory disease. While these impacts on health are large, there is also cause for optimism: documented examples from locations where air quality management approaches have reduced pollution show that when air quality improves, so does population health.

Increasing public awareness of air quality and the burden of disease caused by air pollution is an essential step in reducing air pollution and improving public health. Here we present the first annual State of Global Air Report — and the accompanying rich data resources of the State of Global Air interactive website. Together these resources provide the most current and comprehensive information on air pollution levels and their health impacts throughout the world and allow for detailed comparisons between countries and over time. The State of Global Air site is the only source where the most up-to-date estimates of global air pollution levels are available for downloading.

To understand the importance of air pollution and its contribution to health, it is critical to place air pollution risks in the context of other widely recognized risk factors for disease (e.g., smoking and diet). To do this, we build on the Global Burden of Disease (GBD) project, an extensive effort led by the Institute for Health Metrics and Evaluation (IHME), involving more than 2,000 researchers, to enumerate and track death and disability and the role of an extensive set of behavioral, dietary, and environmental risk factors for more than 300 diseases and injuries, by age and sex, from 1990 to the present, in 195 different countries and territories. As the most comprehensive compilation and analysis of global health information available, this massive data set allows for comparisons over time, across age groups, and among populations, and is annually updated as new data and epidemiological studies become available. These data can then be used at the global, regional, national, and even local levels to track health and risk factor trends over time and may have important implications for policy action. Although estimates of health impact by multiple institutes exist, increasingly scientists are relying on methods developed by IHME for the GBD project (see “Numbers, Numbers Everywhere” textbox on the next page).

Figure 1. Global ranking of risk factors for total deaths from all causes for all ages and sexes in 2015.

Exposure to PM$_{2.5}$, the leading environmental risk factor for death, accounting for about 4.2 million deaths, ranks 5$_{th}$ worldwide among all risks, including smoking, diet, and high blood pressure.
In this context, we focus on two measures of outdoor air pollution included in the GBD project — ambient fine particulate matter (airborne particles less than or equal to 2.5 micrometers in aerodynamic diameter, or PM$_{2.5}$) and ozone, a reactive gas — the most widely studied and monitored air pollutants worldwide.

From the most recent (2015) analysis of the GBD, exposure to PM$_{2.5}$ was the 5th highest ranking risk factor for death, responsible for 4.2 million deaths from heart disease and stroke, lung cancer, chronic lung disease, and respiratory infections. An additional 254,000 deaths were attributable to exposure to ozone and its impact on chronic lung disease (Figure 1). PM$_{2.5}$ was responsible for a substantially larger number of attributable deaths than other, more well-known risk factors, such as alcohol use or physical inactivity. It contributed to a similar number of deaths as did high sodium intake and high cholesterol. Although not the focus of this year's report, indoor air pollution from the household use of solid fuels (coal, wood, dung, etc.; see textbox on page 13) for cooking and heating also has a substantial impact on health, ranking 10th overall. It also contributes to outdoor air pollution.

This report describes key findings related to the levels of exposure to PM$_{2.5}$ and ozone and their impacts on health. On the State of Global Air website you can use the interactive feature to explore and visually compare air pollution levels and health impacts around the world in individual countries and among regions.

**Numbers, Numbers Everywhere**

As recognition of the world’s air pollution problems has grown, estimates of the numbers of deaths and years of healthy life lost attributable to outdoor air pollution have proliferated. Most of these health burden estimates are from the World Health Organization (WHO) or from the Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease (GBD) project. (This report is based on IHME estimates.)

In its most recent update, released in 2016, the WHO estimated there were 3 million deaths from PM$_{2.5}$ exposure for the year 2012, while the most recent GBD estimate was 4.2 million for the year 2015. Other estimates exist for outdoor air pollution–related deaths in individual countries or regions, alone and at times in combination with estimates for indoor air pollution. Over time, these numbers have been echoed in reports by several leading economic and energy institutions that have sought to put a monetary value on the health burden attributable to outdoor air pollution and its sources — the World Bank, the Organization for Economic Cooperation and Development, and the International Energy Agency, to name a few (see “Additional Resources” section for details).

**What can we make of all these numbers? Do their differences matter?**

The most important takeaway message is that they are all large numbers — the burden of disease from air pollution is substantial. And given the complexity of the process for developing them, these estimates are surprisingly consistent. Some variation from this kind of scientific analysis is to be expected. These are estimates made by different analysts at different points in time. They vary primarily because of different data or because of different methods used to assess exposure to pollutants, to characterize exposure–disease relationships, and to quantify the baseline rates of disease and mortality in populations — all of which go into estimates of the numbers of people affected by air pollution.

Increasingly, the methods for estimating the burden of disease are converging. Most of the data and methods have their origins with IHME’s GBD project and, particularly, its major update in 2010, which substantially expanded the analyses. WHO and IHME now use essentially the same methodologies for estimating air pollution levels around the world. Their estimates are therefore most sensitive to changes in exposure–response relationships that occur as new evidence is incorporated and, to a lesser degree, to changes in the baseline disease and mortality rates. Differences in the choice of exposure–response relationships largely account for the differences between the most recent mortality estimates from WHO and GBD: WHO relied on exposure–response relationships from GBD 2013 and WHO population mortality rate estimates for 2012, whereas the GBD 2015 report used an updated exposure–response function that predicted higher rates of mortality from PM$_{2.5}$ exposure and 2015 estimates of population mortality rates.

**Annual GBD Updates**

The GBD project now updates its estimates annually and, with each update, provides an analysis of the trends over time (e.g., for the 25 years from 1990 to 2015). Although these updates include improvements in data and methods that themselves contribute to differences from previous GBD estimates (e.g., GBD 2010, GBD 2013), each GBD update recalculates the entire temporal sequence so that its trends (based, e.g., on the years 1990–2015) are internally consistent. These are the data that will be featured in future State of Global Air reports.
Air pollution is a complex mixture of gases and particles whose sources and composition vary over space and time. While hundreds of different chemical compounds can be measured in air, governments typically measure only a small subset of gases and particles as indicators of the different types of air pollution and major sources contributing to that pollution. \( \text{PM}_{2.5} \) and ozone are the two indicators used to quantify exposure to air pollution in the GBD project. \( \text{PM}_{2.5} \) is the most consistent and robust predictor of mortality in studies of long-term exposure to air pollution. Ozone, a gas produced via atmospheric reactions of precursor emissions, is associated with respiratory disease independent of exposure to \( \text{PM}_{2.5} \). Exposure to each pollutant is represented by population-weighted average concentrations, which take into account the proportions of the population living with different levels of pollution (see also the textbox “How Are Air Pollution Levels Estimated Around the World?” on page 5).

The global map of population-weighted annual average ambient concentrations of \( \text{PM}_{2.5} \) in 2015 (see Figure 2) shows that there are marked differences in the levels of exposure experienced by human populations around the world. Identifying these patterns is an important first step toward understanding what sources and activities contribute to high levels of air pollution and, then, what can be done about them.

The highest concentrations of \( \text{PM}_{2.5} \) in 2015 related to combustion sources were in South and Southeast Asia, China, and Central and Western sub-Saharan Africa.

The highest concentrations of population-weighted average \( \text{PM}_{2.5} \) in 2015 were in North Africa and the Middle East, due mainly to high levels of windblown mineral dust. At the country level, estimates of...
Population-weighted average concentrations in 2015 were highest in Qatar (107 μg/m³), Saudi Arabia (106 μg/m³), and Egypt (105 μg/m³).

The next highest concentrations appear in South Asia (especially northern India and Bangladesh) and Southeast Asia, eastern China, and Central and Western sub-Saharan Africa, due to combustion emissions from multiple sources, including household solid fuel use, coal-fired power plants, agricultural and other open burning, and industrial and transportation-related sources. The population-weighted annual average concentrations were 89 μg/m³ in Bangladesh, 75 μg/m³ in Nepal, and 74 μg/m³ in India. The population-weighted average PM$_{2.5}$ concentration in China was 58 μg/m³, with substantial variation in concentrations among provinces (19–79 μg/m³).

In 2016, HEI published a report on the major sources of PM$_{2.5}$ related to human activity in China, a result of HEI’s Global Burden of Disease from Major Air Pollution Sources (GBD MAPS) project. It found that coal-burning by industry, power plants, and households accounted for nearly 40% of population-weighted PM$_{2.5}$ concentrations in China overall (see the textbox “Understanding the Major Sources of PM$_{2.5}$: The GBD MAPS Project” on page 7).

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Estimates for annual average population-weighted PM$_{2.5}$ concentrations were lowest (≤ 8 μg/m³) in Brunei, Sweden, Greenland, New Zealand, Australia, Finland, Canada, and several Pacific and Caribbean island nations.

**ASSESSING DIFFERENCES IN PM$_{2.5}$ CONCENTRATIONS**

One approach to putting global air quality into perspective is to compare the ambient concentrations to the WHO Air Quality Guidelines established by the WHO. In 2005, WHO set the Air Quality Guideline for annual average PM$_{2.5}$ concentration at 10 μg/m³, with three interim targets (ITs) for reaching that goal set at progressively lower concentrations (35 μg/m³, 25 μg/m³, and 15 μg/m³). Figure 3 shows where these limits are exceeded.

**Over 90% of the world’s population lived in areas with unhealthy air in 2015.**

Based on these data and information about the populations in each country for 2015, 92% of the world’s population lived in areas that exceeded the WHO 10 μg/m³ guideline. Fifty percent of the global population resided in areas with PM$_{2.5}$ concentrations above the WHO Interim Target 1 (IT-1 of 35 μg/m³); 64% lived in areas exceeding IT-2 (25 μg/m³); and 81% lived in areas exceeding IT-3 (15 μg/m³). Nearly all (86%) of the most extreme concentrations (above 75 μg/m³) were experienced by populations in China, India, Pakistan, and Bangladesh.

**MAIN TRENDS IN PM$_{2.5}$ CONCENTRATIONS**

Global population-weighted PM$_{2.5}$ concentrations increased by 11.2% from 1990 (39.7 μg/m³) to 2015 (44.2 μg/m³). Since 2010, the increase was somewhat more rapid. This increase reflects major changes in air pollution levels in the most populous countries of the world.

Figure 4 illustrates the trends in population-weighted PM$_{2.5}$ concentrations for the 10 most highly populated countries in the world along with the European Union from 1990 to 2015. India, Bangladesh, and China have experienced both high levels and increasing trends in PM$_{2.5}$ exposure, but there are noteworthy distinctions between countries. Although in China substantial increases in population-weighted concentrations occurred between 1990 and 2010, reflecting in part the dramatic scale of economic development over the last 25 years, the increases in exposure appear to have stabilized since...
2010. Bangladesh and India, on the other hand, have experienced the steepest increases in air pollution levels since 2010 and now have the highest PM$_{2.5}$ concentrations among the countries shown here. In a reverse phenomenon, the trend data suggest dramatic declines in PM$_{2.5}$ exposures in Nigeria over the last 25 years; limited evidence points to declines in mineral dust emissions and open burning.

Among the 10 most populous countries and the EU, Bangladesh and India now have the highest exposures to PM$_{2.5}$, having experienced the steepest increases since 2010.

Populous countries with the lowest population-weighted concentrations of PM$_{2.5}$ are clustered at the bottom of the figure and include, in decreasing order, Russia, Indonesia, the European Union, Japan, Brazil, and the United States. Concentrations in all these locations have declined slightly since 1990 and, with the possible exception of Japan, appear relatively stable over the last 10 years.

The disparities among these large countries have grown substantially over time. Less-polluted locations have become cleaner, while PM$_{2.5}$ concentrations have increased in the more polluted locations. As a result, what was a 7-fold range in average population-weighted concentrations among these countries in 1990 increased to a 10-fold range in 2015.

Figure 4. Trends in annual average population-weighted PM$_{2.5}$ concentrations in the 10 most populous countries plus European Union.

Explore the data on the State of Global Air interactive site.

HOW AMBIENT OZONE CONCENTRATIONS VARY

The global map of seasonal average population-weighted ozone concentrations around the world (Figure 5) indicates that ozone concentrations are generally less variable spatially compared with PM$_{2.5}$ (Scientists focus on seasonal, rather than annual, averages of ozone because ozone concentrations are higher in the warm season in the mid-latitudes, where most epidemiological studies have been conducted.)

Population-weighted ozone concentrations were relatively higher in the United States, Western and Central sub-Saharan Africa, and throughout the Mediterranean, the Middle East, South Asia, and China.

MAIN TRENDS IN OZONE CONCENTRATIONS

From 1990 to 2015, population-weighted ozone concentrations increased by about 7% globally (see global trend in Figure 6). This trend reflects a combination of factors, including increased emissions of ozone precursors such as nitrogen oxides, coupled with warmer temperatures, especially at mid-latitudes in rapidly developing economies.

Among the world’s 10 most populous countries and the European Union, the largest increases (14% to 25%) in seasonal average popu-
Figure 5. Seasonal average population-weighted ozone concentrations in 2015.

Figure 6. Trends in seasonal average population-weighted ozone concentrations in the most populous countries.

Explore the data on the State of Global Air interactive site.

Population-weighted concentrations of ozone over the last 25 years were experienced in China, India, Pakistan, Bangladesh, and Brazil (Figure 6). In Indonesia, decreases observed until 2005 have begun to be offset by more recent increases, reflecting regional trends in precursor emissions.

Not all regions of the world have seen these increases. In the United States, estimated population-weighted ozone concentrations have decreased by about 5% since 1990 and, in the European Union, by about 2% since 2000. These decreases most likely reflect the impact of air quality management programs.
We know that air pollution from fine particulate matter (less than or equal to 2.5 μm in aerodynamic diameter, or PM\textsubscript{2.5}) exacts a toll on human health, both globally and in individual countries. The Global Burden of Disease (GBD) 2015 report estimates that PM\textsubscript{2.5} contributed to more than 4 million deaths worldwide, over 50% of which occurred in China and India.

Coal-burning by industry, power plants, and for home heating accounted for 40% of PM\textsubscript{2.5} exposures and an estimated 366,000 deaths in 2013.

To reduce that toll requires that policy makers have a deeper understanding of the major sources of ambient PM\textsubscript{2.5}, both now and in the future. To meet that need, HEI launched the Global Burden of Disease from Major Air Pollution Sources (GBD MAPS) project beginning with its 2016 publication of a major report, Burden of Disease Attributable to Coal-Burning and Other Major Sources of Air Pollution in China. The bar graph here shows the major source sectors named in that report that contribute to deaths attributable to PM\textsubscript{2.5}.

The study found that coal-burning — by industry, by power plants, and for domestic heating — was the most important contributor to ambient air pollution in China (see map in this textbox). Coal-burning from these three sectors combined accounted for 40% of population-weighted ambient PM\textsubscript{2.5} concentrations and an estimated 366,000 deaths in 2013. China’s coal consumption rose from 1,055 billion metric tons in 1990 to 4,244 billion metric tons in 2013, making it the largest producer and consumer of coal in the world.

The industrial sector, comprising both coal (155,000 deaths) and noncoal (95,000 deaths) sources, was the largest contributor to mortality attributable to ambient PM\textsubscript{2.5}, accounting for about 27%. However, household burning of both coal and biomass (e.g., wood and agricultural waste) is also an important contributor to the burden of disease attributable to ambient PM\textsubscript{2.5}. Household combustion of these solid fuels had a combined impact (177,000 deaths) in 2015 that was larger than that from transportation (137,000 deaths) and power plant emissions. Although not represented here, additional mortality is associated with indoor exposures to air pollution from household use of solid fuels (see “How Household Burning of Solid Fuels Affects Public Health” textbox on page 13).

The GBD MAPS China report developed four policy scenarios to evaluate the impacts of different levels of future energy use and pollution control in China. Even under the most stringent policy scenarios, coal was projected to remain the single largest source contributor to ambient PM\textsubscript{2.5} and to continue to impose the largest health burden from exposure in China in 2030. The findings demonstrated the air quality and health benefits associated with continued aggressive strategies to reduce emissions from coal combustion, along with reductions in emissions from other major sources.

GBD MAPS is a multiyear collaboration among HEI, IHME, Tsinghua University, the University of British Columbia, and other leading academic centers. The next GBD MAPS report, on major air pollution sources in India, will be published in 2017.
What do we mean by “burden of disease” and how is it measured in the GBD project? The GBD project measures the burden of disease for all risk factors including air pollution in terms of (1) deaths in a given year and (2) healthy years of life lost from death or disability, represented by “disability-adjusted life-years,” or DALYs (see textbox “Understanding the Burden of Disease: Deaths and DALYs” on page 9). For each risk factor, such as air pollution, considered by the GBD project, these measures of disease burden are estimated for each country or subnational area at 5-year intervals from 1990 to 2015.

Estimating deaths and disease burdens attributable to ambient air pollution in geographical regions over time requires three major components: (1) estimates of population-weighted exposure to PM$_{2.5}$ and ozone, as described earlier in this report (these are compared against a “minimum risk exposure level,” an exposure level below which there is no evidence of additional risk of mortality or disease); (2) mathematical functions, derived from epidemiological studies, that relate the different levels of exposure to age, sex, and cause-specific health impacts (e.g., mortality from heart disease and stroke, and incidence of lung cancer); and (3) detailed spatial and temporal estimates of the underlying number of deaths and DALYs for each of the causes of death or disability linked to air pollution. References with more information on these methods are listed in “Additional Resources” at the end of this report.

What are air pollution’s effects on health? An extensive scientific literature has documented that long-term exposure to ambient air pollution increases mortality and morbidity from cardiovascular and respiratory disease and lung cancer, and reduces life expectancy.

Systematic reviews of this literature have been undertaken by organizations such as the WHO, the International Agency for Research on Cancer, and the U.S. Environmental Protection Agency, among others (see “Additional Resources”). Based on this large body of evidence, the GBD project concluded that certain diseases could be causally linked with exposure to ambient PM$_{2.5}$ — ischemic heart disease, cerebrovascular disease (ischemic stroke and hemorrhagic stroke), lung cancer, chronic obstructive pulmonary disease (COPD), and lower respiratory infections (LRIs). The GBD project includes only COPD in its assessment of the health impacts attributable to ozone.

A number of studies have also suggested associations between long-term and acute exposure to air pollution and a number of other diseases (e.g., asthma, various adverse birth outcomes, diabetes, and neurological disorders). To date, that evidence has not built to a level sufficient to be included in the GBD project, but it continues to be evaluated for potential inclusion in future GBD and State of Global Air reports.

In 2015, long-term exposure to PM$_{2.5}$ contributed to 4.2 million deaths and to a loss of 103 million years of healthy life. China and India each had the highest absolute numbers of deaths attributable to PM$_{2.5}$. Together, these two countries accounted for 52% of the total global deaths and 50% of the DALYs. On a global basis, long-term exposure to ambient PM$_{2.5}$ was responsible for 17.1% of mortality from ischemic heart disease, 14.2% from stroke, 16.5% from lung cancer, 24.7% from LRIs, and 27.1% from COPD in 2015. Of all deaths attributable to ambient PM$_{2.5}$ in 2015, deaths from ischemic heart disease and stroke accounted for the majority (together 57%).

Mainly because of age-related differences in mortality from chronic diseases, PM$_{2.5}$ disproportionally affects very old and very young people. DALYs for those over 70 years old constituted 28% of the total attributable burden, with 21% for children younger than 5 years old. Sixty-one percent of the overall burden attributable to
Understanding the Burden of Disease: Deaths and DALYs

The burden of disease due to exposure to a pollutant is calculated using an estimation of the number of deaths and disability-adjusted life-years (DALYs). The number of deaths attributable to air pollution in a given year includes deaths that have likely occurred months or even years earlier than might be expected in the absence of air pollution (as in the case of a child dying from an LRI). DALYs provide an overall measure of the loss of healthy life expectancy and are calculated as the sum of the years of life lost from a premature death and the years lived with disability (for example, blindness, caused by the disease diabetes). An important insight gained by using DALYs rather than just the numbers of deaths is that DALYs account for the age at which disease or death occurs. For example, air pollution contributes to LRIs in children, but the number of deaths is small relative to the numbers of primary air pollution–related deaths from heart disease, which tend to occur in older adults. However, because children who die from LRIs have lost many more years of healthy life, this burden is appropriately reflected in a larger number of DALYs.

Burden is also measured in terms of age-standardized death rates and DALY rates (i.e., the number of deaths or DALYs per 100,000 people). Age-standardized rates are important because they adjust for population size and the age structure of each country’s population. This means that the rates in two countries can be compared as if the countries had the same population characteristics. Otherwise, in a country with a large and older population, the total number of deaths attributable to air pollution would be larger than that in a country with a smaller or younger population, even if exposure levels were the same.

Ambient PM$_{2.5}$ was restricted to people 50 and older.

Deaths attributable to long-term exposure to ambient PM$_{2.5}$ in 2015 varied considerably among countries, which reflects the joint influence of air pollution levels and underlying social, demographic, and economic differences among populations. The GBD project has sought to measure these latter characteristics using a sociodemographic index (SDI; see Glossary on the interactive website). In countries with the highest levels of socioeconomic development, exposure to ambient PM$_{2.5}$ contributed to 4.9% of total deaths in 2015, compared with 9.3% in middle-SDI countries and 4.6% in low-SDI countries. These differences in PM$_{2.5}$-attributable deaths largely reflect differences among countries in the fraction of total deaths accounted for by cardiovascular disease, one of the major impacts of air pollution.

After accounting for population size and age structure, age-standardized rates of deaths due to PM$_{2.5}$ exposure differed widely by region of the world. The highest mortality rates were observed in southern (133 deaths/100,000 people), central (85 deaths/100,000 people), and eastern (83 deaths/100,000 people) Asia. Rates were 4- to 8-fold lower in high-income North American (26 deaths/100,000 people), Asia-Pacific (44 deaths/100,000 people), and Western European (41 deaths/100,000 people) countries.

The interactive website allows for detailed comparisons of ambient air pollution–attributable deaths and DALYs (both in absolute numbers and in age-standardized rates) between countries and among various regional groupings (including SDI, for example) for the 1990–2015 time period.

TRENDS IN BURDEN OF DISEASE ATTRIBUTABLE TO PM$_{2.5}$ EXPOSURES

On a global scale, the absolute number of deaths attributable to PM$_{2.5}$ increased from 3.5 million in 1990 to 4.2 million in 2015, due both to increases in air pollution and to growth and aging in the global population.

While the absolute numbers of deaths attributable to PM$_{2.5}$ increased by 20% from 1990 to 2015 globally, there was an overall 12.2% decrease in the rate of deaths attributable to PM$_{2.5}$, indicating that the increase in total deaths is largely due to changes in population characteristics. The global trend in PM$_{2.5}$-attributable deaths broadly reflects a balance among different trends in high-, low-, and middle-income countries. The global numbers and trends in PM$_{2.5}$-attributable mortality, while intriguing, can obscure important patterns at the country level that are likely to be more useful to scientists and policy makers interested in understanding and addressing the health burden attributable to poor air quality. India and Bangladesh experienced some of the largest increases in PM$_{2.5}$-attributable mortality, on the order of 50% to 60%. India now approaches China in the number of deaths attributable to PM$_{2.5}$. 
In the 10 most populous countries and the European Union, trends in the numbers of PM$_{2.5}$-attributable deaths (Figure 7) reflect a combination of sometimes competing factors — changes in PM$_{2.5}$ levels and in the size, age, and disease rates of the populations exposed. These same countries and the EU all experienced decreases in age-standardized DALY rates and mortality rates. In China, India, Bangladesh, and Japan, increases in exposure, combined with increases in population growth and aging, resulted in net increases in attributable mortality. Decreases in exposure in Russia, Brazil, Indonesia, and Pakistan were offset by population growth and population aging, resulting in net increases in attributable mortality. In the United States and the European Union, reductions in exposure over the past 25 years have offset the contributions of population growth and aging, resulting in net decreases in PM$_{2.5}$-attributable mortality (by 17% and 22%, respectively). A similar pattern contributed to a net decrease of 34% in PM$_{2.5}$-attributable mortality in Nigeria, although the reductions in exposure were likely due to factors different from those in the United States and EU. Within the EU, this pattern held in all member countries except Italy, Greece, and Malta, where attributable mortality increased from 1990 to 2015.

As discussed earlier, DALYs grant additional insight into the burden of disease attributable to PM$_{2.5}$ exposure by providing a comprehensive measure of years of healthy life lost, due both to dying...
prematurely and to the years living with disability (see earlier text-box, “Understanding the Burden of Disease”). Many scientists prefer age-standardized DALY rates (DALYs/100,000 people) because they allow direct comparisons between populations of different sizes and age structures. The DALY rates attributable to PM$_{2.5}$ for the 10 most populous countries, the European Union, and the world are therefore presented in Figure 8.

Pakistan, Bangladesh, and India had PM$_{2.5}$-attributable DALY rates that were 5 to 10 times the lowest rates, which were found in the United States and Japan. Although the DALY rates within countries have been improving in general from 1990 to 2015, reflecting some improvements in underlying life expectancy and health, the large disparities across countries have persisted and even increased.

**BURDEN OF DISEASE ATTRIBUTABLE TO OZONE EXPOSURES IN 2015 AND TRENDS**

Ozone contributes to the global health burden through its impact on deaths and disability from COPD. In 2015, ambient ozone contributed to 254,000 deaths, making it the 33rd highest ranking risk factor globally for deaths in the GBD 2015 analyses (see Figure 1). Ozone also contributed to 4.1 million DALYs globally.

**Globally there was a 60% increase in ozone-attributable deaths, with a striking 67% of this increase occurring in India.**

Although the number of deaths attributable to ozone is smaller than that for PM$_{2.5}$, ozone-attributable mortality has increased proportionally more — up nearly 60% globally since 1990. In 2015, ozone was responsible for 8% of global mortality related to COPD, up from 5% in 1990. Higher contributions (~10%) were experienced in India and Bangladesh.

The disparities between countries in the ozone-attributable health burden are illustrated in Figure 9, which shows trends in the numbers of deaths from COPD attributable to exposure to ozone for the 10 most populous countries and the European Union from 1990 to 2015. As the most populous countries, India and China account for most of the ozone-attributable COPD deaths across all years, but India accounts for much (about 67%) of the global increase since 1990. Over the last 25 years, India experienced a nearly 150% increase in ozone-attributable deaths, while China’s number remained about the same. The ozone-attributable COPD mortality rate decreased by about 1% over this time period in the United States and Indonesia, and remained relatively stable in Russia and the European Union.

As with PM$_{2.5}$-attributable mortality, the increases in deaths attributable to ozone exposure from 1990 to 2015 were driven by increases in concentrations of ozone throughout most of the globe (see Figure 6), by population aging, and by the increased rates of mortality from COPD, especially in South Asia.

**Figure 9. Trends in numbers of deaths from COPD attributable to exposure to ozone for all ages and sexes.**

![Figure 9](image)

Explore the data on the State of Global Air interactive site.
CONCLUSIONS

The GBD project plays a key role in identifying the factors that contribute most to disease and mortality — the first step toward identifying what can be done to improve public health. Among the 79 risk factors included in its comprehensive analysis, the GBD project reported that exposure to ambient air pollution from PM$_{2.5}$ ranked 5th globally in its contribution to mortality in 2015, accounting for over 4.2 million deaths, with an additional 254,000 attributable to exposure to ozone. The GBD project has also laid out the critical interplay between trends in population structure, underlying disease, and economic factors and trends in air pollution. Knowledge of these trends is essential to understanding patterns in the burden of disease experienced by the populations of different countries and regions and to helping to inform decision makers where policy action to reduce population exposure at the national or regional levels has the most potential to provide large benefits in improved health.

Progress in reducing the burden of disease attributable to air pollution will require continued tracking and analysis. This first annual State of Global Air report and the rich data resources found on the accompanying interactive website seek to build on GBD 2015 analyses to provide a deeper understanding of the regional and national patterns of PM$_{2.5}$ and ozone exposures and their contributions to death and disease. The State of Global Air site is the only source that makes available for exploration and downloading comprehensive air quality data for 1990 through 2015 (population-weighted, annual average air pollution levels), linked to health data (population estimates of attributable deaths and disease burden) for all countries and regions in the world.

FUTURE UPDATES

This year’s State of Global Air report and interactive website are only the beginning. Both will be updated each year as a companion to the annual release of the GBD results, adding pollutants and health outcomes as they meet the rigorous inclusion criteria of the larger GBD project. For example, the links between long-term and acute exposure to air pollution and a number of diseases other than those discussed in this year’s report (e.g., asthma, various adverse birth outcomes, diabetes, and neurological disorders) have been suggested by a number of studies. However, to date, the evidence has not been considered sufficient to be included in the GBD project. Other updates on the state of global air to be included in future years will focus on understanding important sources of air pollution and health impact, both at the global and national level. Household burning of coal, biomass, and other solid fuels is one such example (see the textbox “How Household Burning of Solid Fuels Affects Public Health” on page 13). Another will be the GBD MAPS study in India that is forthcoming in 2017. Because national averages can obscure important local differences, we plan further analysis of air pollution and health burden for provincial and other subnational units as data for them become available. Finally, next year’s report will highlight examples of cities and countries that have successfully improved air quality and public health and will share information on the actions they took to accomplish those improvements.
How Household Burning of Solid Fuels Affects Public Health

In many parts of the world, household burning of solid fuels—including coal, wood, charcoal, dung, and other agricultural residues for cooking and heating—can contribute to high levels of pollution exposure and to substantial impacts on mortality and health. Figure 1 in the main text shows that, worldwide, household air pollution ranks 10th among risk factors for mortality, contributing to approximately 2.85 million deaths in 2015 from cardiovascular disease, COPD, LRI, and lung cancer. Among children less than 5 years old, it is the 7th leading risk factor for death due to its impact on acute respiratory infections such as pneumonia. In South Asia, household air pollution is the 4th leading mortality risk factor. Among countries considered “low income” by the World Bank, household air pollution ranks even higher; it is the 2nd leading mortality risk factor for that population.

The burden of increased mortality and disease from household air pollution falls most heavily on countries in Africa and in Asia where solid fuels are more extensively used (see the global map in this textbox, showing health burden measured by the percentage of all DALYs in a country). Although still responsible for a substantial impact on global disease burden, the trends in percentage of all DALYs attributable to household air pollution are encouraging across all regions (see line graph in this textbox). Since 1990 there has been a 15.5% decrease globally in total deaths (a 39% decrease in death rates) and a 37% decrease in total DALYs (a 55% decrease in DALY rates) associated with household air pollution exposures.

Although household air pollution is tracked as an independent risk factor, it is also an important source of outdoor air pollution, so reducing household air pollution has added benefits for public health that are not reflected in these statistics.
GBD 2015
Details on the methods used to estimate PM$_{2.5}$ and ozone exposures and to estimate deaths and disability adjusted life years (DALYs) for the GBD 2015 analyses can be found in these studies and their related references:


At the GBD Compare website, data on mortality and disease burden for air pollution, as well as other risk factors, may be further explored and downloaded.

PM$_{2.5}$ AND OZONE HEALTH EFFECTS
For comprehensive reviews of the scientific evidence on the health effects associated with exposures to PM$_{2.5}$ and ozone from WHO, IARC, and the U.S. Environmental Protection Agency, see the following:


NUMBERS, NUMBERS EVERYWHERE
Listed below are the reports and papers referred to in the textbox “Numbers, Numbers Everywhere” on page 2:


CONTRIBUTORS AND FUNDING

CONTRIBUTORS

Health Effects Institute: HEI is an independent global health and air pollution research institute, a leader of the air pollution analysis within the Global Burden of Disease (GBD) project, and the producer, most recently, of the GBD Major Air Pollution Sources (GBD MAPS) report on China and the upcoming India report. HEI is the primary developer of the State of Global Air report, host and manager for the related website, coordinator of input from all other members of the team, and facilitator of contact with media partners.

The Institute for Health Metrics and Evaluation: IHME is an independent global health research center at the University of Washington, which provides rigorous and comparable measurement — through the GBD project — of the world’s most important health problems and the risk factors that contribute to them, and which evaluates the strategies used to address them. A key collaborator, IHME provides the underlying air pollution and health data and other critical support for this project.

University of British Columbia: Professor Michael Brauer of the School of Population and Public Health at UBC is a critical external expert advising on this project. Dr. Brauer is a long-time principal collaborator on the air pollution assessment for the GBD project and led the effort to define the project’s global air pollution exposure assessment methodology.

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Glossary

For a glossary of terms, see the State of Global Air website.

How to Cite This Publication


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