CLOSING THE HEALTH EQUITY GAP

Policy options and opportunities for action

World Health Organization

CLOSING THE HEALTH EQUITY GAP

Policy options and opportunities for action

World Health Organization

WHO Library Cataloguing-in-Publication Data

Closing the health equity gap: policy options and opportunities for action.

1.Health policy. 2.Health status disparities. 3.Socioeconomic factors. 4.Social justice. I.World Health Organization.

ISBN 978 92 4 150517 8 (NLM classification: WA 525)

Design & layout: L'IV Com, Villars-sous-Yens, Switzerland

Contents

Acknowledgements

This report, which highlights policy options for consideration within national discussions, was developed in conjunction with WHO regional offices and others across the Organization who are working on the social determinants of health and equity issues. The general approach to the report was discussed at a seminar within WHO's Information, Evidence and Policy cluster and with WHO regional advisors following the release of the final report of the Commission on Social Determinants of Health in August 2008. In January 2009 the 124th session of the WHO Executive Board supported the Commission's recommendations, and the subsequent deliberations of the Sixty-second World Health Assembly in May 2009 led to the passing of resolution WHA62.14 on reducing health inequities through action on the social determinants of health. This report aims to disseminate more detailed evidence-based policy options and opportunities for action by the health sector and other sectors in order to reduce health inequities. The financial support of the United Kingdom's Department of Health is gratefully acknowledged.

Support and guidance on the direction and finalization of this report were provided by Nick Drager, Tim Evans and Marie-Paule Kieny. The report was coordinated by Ritu Sadana and the principal writers were Ross Gribbin and Ritu Sadana. The material presented in this report does not necessarily represent the decisions, policy or views of the World Health Organization or of the Commission on Social Determinants of Health. The report primarily draws on the final reports and case studies of global knowledge networks set up by WHO to support the Commission, and was reviewed by all knowledge networks hub leaders.

We gratefully acknowledge the contributions of knowledge network hub leaders and key members: Joan Benach, Josiane Bonnefoy, Erik Blas, Jostacio Moreno Lapitan, Jane Doherty, Sarah Escorel, Lucy Gilson, Mario Hernández, Clyde Hertzman, Lori Irwin, Heidi Johnston, Michael P Kelly, Tord Kjellstrom, Ronald Labonté, Susan Mercado, Antony Morgan, Carles Muntaner, Piroska Östlin, Jennie Popay, Laetitia Rispel, Vilma Santana, Ted Schrecker, Gita Sen, Arjumand Siddiqi, and Ziba Vaghri. The report does not necessarily reflect the views of all members of the knowledge networks. Further details and references can be found in the full reports of each knowledge network, as listed at the end of this report.

The assistance and contributions provided by the following WHO staff are gratefully acknowledged: Anthony Mawaya, Chris Mwikisa Benjamin Nganda (African Region); Marco Ackerman, Luiz Galvao, (Region of the Americas); Mohamed Assai, Sameen Siddiqi, Susanne Watts (Eastern Mediterranean Region); Chris Brown, Sarah Simpson, Erio Ziglio (European Region); Davison Munodawafa, Than Sein (South-East Asia Region); Anjana Bhushan, Soe Nyunt-U (Western Pacific Region); and Daniel Albrecht, Avni Amin, David Evans, Meena Cabral de Mello, Benedickte Dal, Riku Elovainio, Matthias Helbe, Ahmad Hosseinpoor, Ivan Ivanov, Evelyn Kortum, Anand Sivansankara Kurup, Jennifer H Lee, Knut Lonnroth, Dheepa Rajan, Kumanan Rasanathan, Lori Sloate, Eugenio Villar, and Wim Van Lerberghe (WHO Headquarters).

Evelyn Omukubi, Nuria Quiroz and Karina Reyes-Moya provided valuable secretarial and administrative support.

The report was edited by David Bramley and Lindsay Martinez-Mackey.

Foreword

Health inequities are unfair, avoidable and remediable differences in health status between countries and between different groups of people within the same country. Health inequities are attracting increasing attention on national and global policy agendas. Despite this, few countries have been able systematically to reduce them. WHO convened the Commission on Social Determinants of Health in 2005 to survey the available worldwide evidence on health inequities and, most importantly, to look at the evidence for policy options that could reverse the trend of increasing inequities.

The result has been a three-year process involving hundreds of people from all over the world and producing over 100 publications – nothing less than the most comprehensive review ever undertaken of global health inequities and measures to address them. The Commission conclusively shows how health inequities are not natural phenomena but rather the result of policy failure. They are thus avoidable by improving policy choices.

The final report of the Commission, released in August 2008, provides a cogent diagnosis of the problem and an admirable survey of the range of policy interventions required. Necessarily, however, the report could not include more than a fraction of the material collected and produced by the various work streams of the Commission.

This report is explicitly aimed at policy-makers and others interested in acting on the social determinants of health in order to help them navigate the vast amount of work produced. It draws from the extensive work of the nine knowledge networks set up by WHO to generate evidence for the Commission. Essentially, it brings together a series of policy briefs, each roughly corresponding to a knowledge network and a specific social determinant of health, which together form an overall policy brief on options for policy-makers to act on the social determinants of health. This monograph first considers the essential role of the health sector in reducing inequities, and then discusses how the health sector can work with other sectors that are also vital to this task. It is thus designed for both health-sector policy-makers and those in other sectors.

This document should be seen as an input to the policy dialogue on how to implement the recommendations of the Commission both globally and within individual country contexts. As the Director-General of WHO has noted, when we think about the Commission's findings we must confront the paradox that, while health has risen to prominence on the international development agenda, within most countries health matters are often afforded lower priority than the concerns of other sectors. The World Health Assembly in May 2009 provided a strong mandate to work together in this area, through its resolution on reducing health inequities through action on the social determinants of health. The Rio Political Declaration on Social Determinants of Health in October 2011 endorsed by the World Health Assembly in May 2012 further strengthens this mandate. We hope that these policy briefs clearly show how the work of the Commission can be applied by policy-makers now to accelerate the difficult but important journey to achieving health equity in a generation.

Marie-Paule Kieny
Assistant Director-General
Health Systems and
Innovation Cluster
World Health Organization

Introduction

The health equity gap is demonstrated most simply and dramatically by comparing life expectancy at birth in different settings. A child's life expectancy depends on the place of birth – more than 80 years in Japan or Sweden but less than 50 years in many developing countries. However, equally important are the striking discrepancies seen worldwide within countries, with the poorest groups having higher rates of illness and premature mortality than the richer groups. The difference in health outcomes between a country's most privileged groups and its most disadvantaged ones is often greater than the differences between countries.

Why act to improve health equity?

Poor health outcomes are not confined to the worst-off populations. In countries at all levels of income, health and illness follow a social gradient whereby those who are more socially disadvantaged have less access to services, suffer more illness and/or die sooner than people in more privileged social positions. Box 1 shows how health status is affected by place of residence, education, income or household wealth, and ethnicity or race.

The Commission on Social Determinants of Health (referred to below as the Commission) has put forward compelling evidence – based on a vast body of research – that these disparities do not arise by chance *(1)*. Social factors, which can be changed and controlled by policy, are largely responsible for the differences in the health outcomes in different populations and groups. Moreover, it is often the lack of policies or frameworks for action that exacerbates growing inequities in the distribution of goods, opportunities and rights.

These factors are known as the social determinants of health. They are seen in every country and across the various elements of society. They include the conditions of early childhood and schooling, the nature of employment and working conditions, the physical form of the constructed environment, gender inequity, and the quality of the natural environment in which people live. Depending on the characteristics of these environments, individual groups will have different experiences of material conditions, psychosocial support, security and lifestyle options, which make them more or less vulnerable to poor health. Social status likewise influences access to health services, with consequences for disease prevention, for recovery from illness and for survival.

The fact that health is significantly determined by the social environment has profound implications for policy far beyond the health sector, as shown in Table 1.

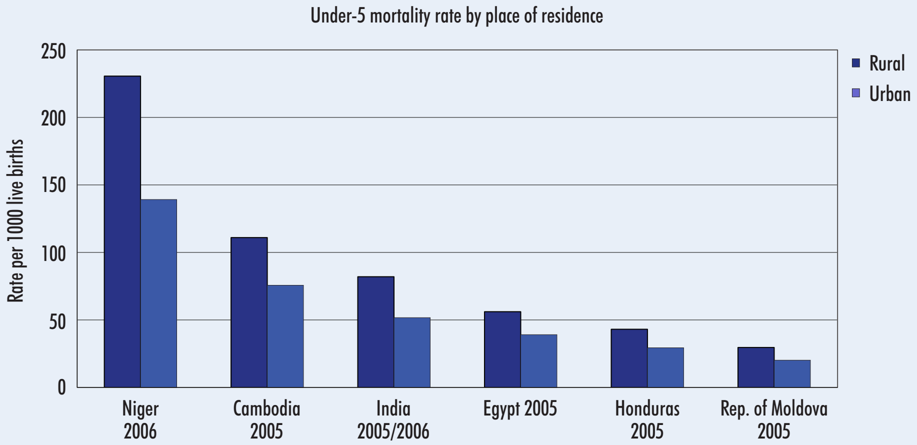
Table 1. Policy implications of the social determinants of health

POLICY IMPLICATIONS OF THE SOCIAL DETERMINANTS OF HEALTH	
Health policy implications	Broader policy implications
Action on disease prevention and control will leave many of the most vulnerable groups without better health prospects unless the root causes of ill-health are also tackled. The health sector has an important role in addressing these root causes, not only in its own services but also by advocating for change and through intersectoral action.	Major health benefits can accrue from changes in the social environment. However, incorrect policy decisions may be made if the health effects have not been considered. The health implications of policy decisions need to be taken into account in order to maximize opportunities for health benefits and to avoid the adverse consequences of government actions.

Box 1. Health and illness follow a social gradient

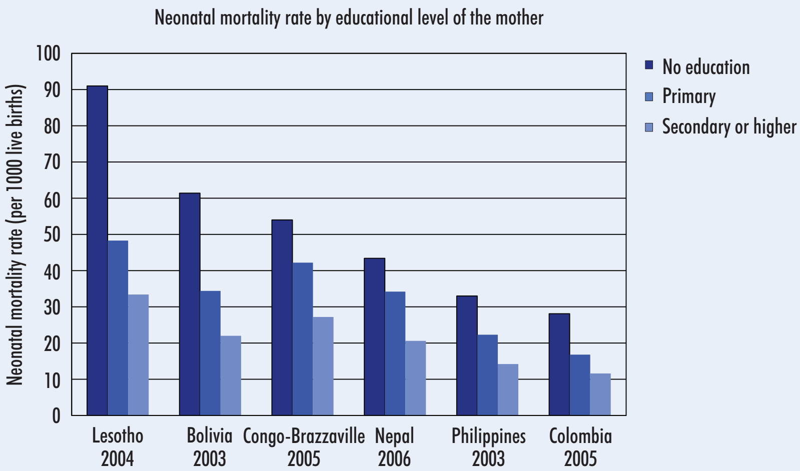
Health, as well as risk factors, access or coverage of services, well-being, functioning, illness and death are socially patterned across the entire spectrum of society, from the poorest to the richest groups in populations. Data from around the world show that socially constructed gradients exist in every country and can be described by differences in place of residence (Figure A), education (Figures B and C), income or household wealth (Figure D), and ethnicity or race (Figures E and F). These potentially avoidable differences in health outcomes or access — commonly referred to as health inequities — are due primarily to social factors. Although some differences by sex or age have biological causes, evidence indicates that up to half of the differences between men and women, for example, are socially determined and can also be considered unfair.

Figure A. Gradient by place of residence



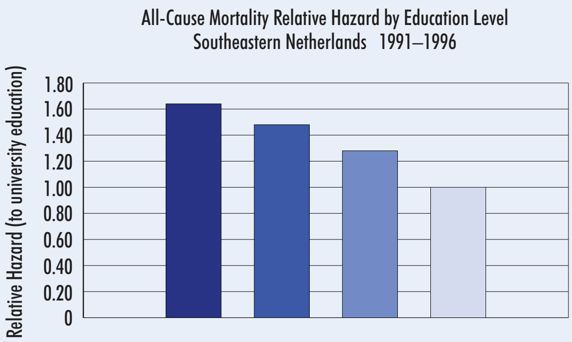
Source: Demographic and Health Surveys.

Figure B. Gradient by education level



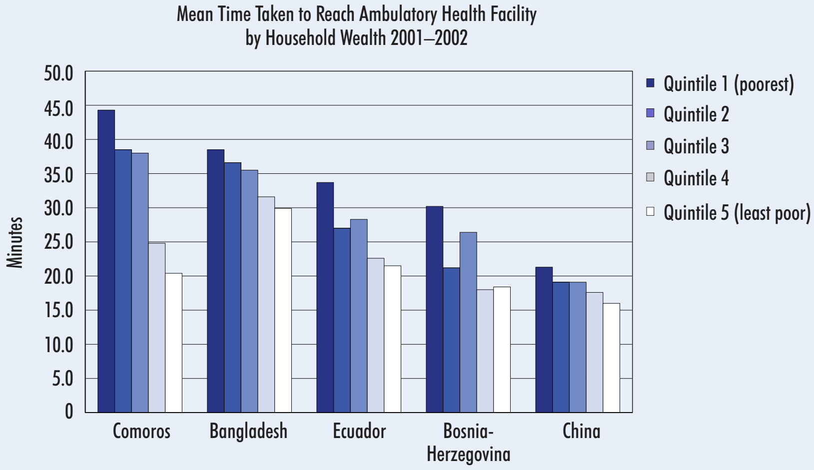
Source: Demographic and Health Surveys.

Figure C. Gradient by education level



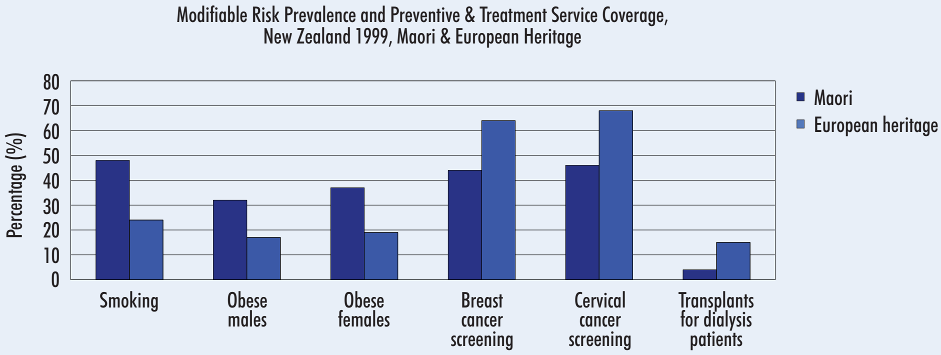
Source: Schrijvers et al. 1999. Schrijvers STM, Stronks K, van de Mheen HD, Mackenback J 1999. Explaining differences in mortality: the role of behavioral and material factors. AJPH 89(4):535-540.

Figure D. Gradient by household asset categories



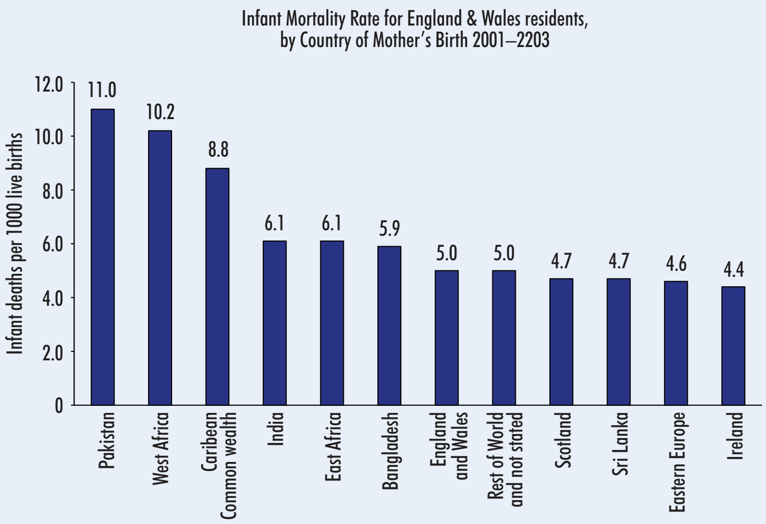
Source: World Health Survey, 2001–2002.

Figure E. Gradient by race or ethnic group



Source: Bramley et al. 2005. Bramley D, Hebert P, Tuzzio L, Chassin M 2005, Disparities in Indigenous Health: A Cross-Country Comparison Between New Zealand and the United States, AJPH 95(5):844-850.

Figure F. Gradient by country of origin



Source: Bowles et al. 2007. Bowles C, Walters R and Jacobson B. 2007 Born Equal? Inequalities in Infant Mortality in London. A Technical Report, London Health Observatory, London, UK.

The Commission on Social Determinants of Health has this to say about these systematic, avoidable and unfair differences which it calls health inequities:

"Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

It does not have to be this way and it is not right that it should be like this. **Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity.** Putting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice. Reducing health inequities is … an ethical imperative. Social injustice is killing people on a grand scale."

Source: Final Report of the Commission on Social Determinants of Health *(1)*.

The structure of this report

This report provides a brief overview of the best evidence regarding the principal social determinants of health and opportunities for action available to policy-makers. It draws on the work of nine knowledge networks set up by WHO to support the Commission through the most extensive collection, synthesis and examination to date of evidence-based actions to address the social determinants of health and to reduce health inequities. The knowledge networks brought together academics, health practitioners, policy-makers and senior decision-makers, and representatives of civil society and nongovernmental organizations (NGOs). Participants were included from low-, middle- and high-income countries and from each WHO region.

The material presented here is a sample of policy options or actions identified by the knowledge networks and that are consistent with the recommendations of the Commission. In practice, these options can contribute to policy dialogues on how to implement the recommendations of the Commission both globally and within individual country contexts, building on the ongoing work of WHO and its partners.

The Commission has reported in detail on the available evidence and has made three overarching recommendations to policy-makers, as shown in Figure 1. For ease of use by policy-makers, this report is structured by policy area. Section 1 focuses on the health sector and actions that it can take, both in its own domain and in promoting and supporting action in other sectors. Section 2 examines broader government policy and is intended for use both in the policy areas concerned and to support the health sector in initiating dialogue on intersectoral action. For both the health sector specifically and for the wider government, there are options for action in relation to each of the Commission's main recommendations.

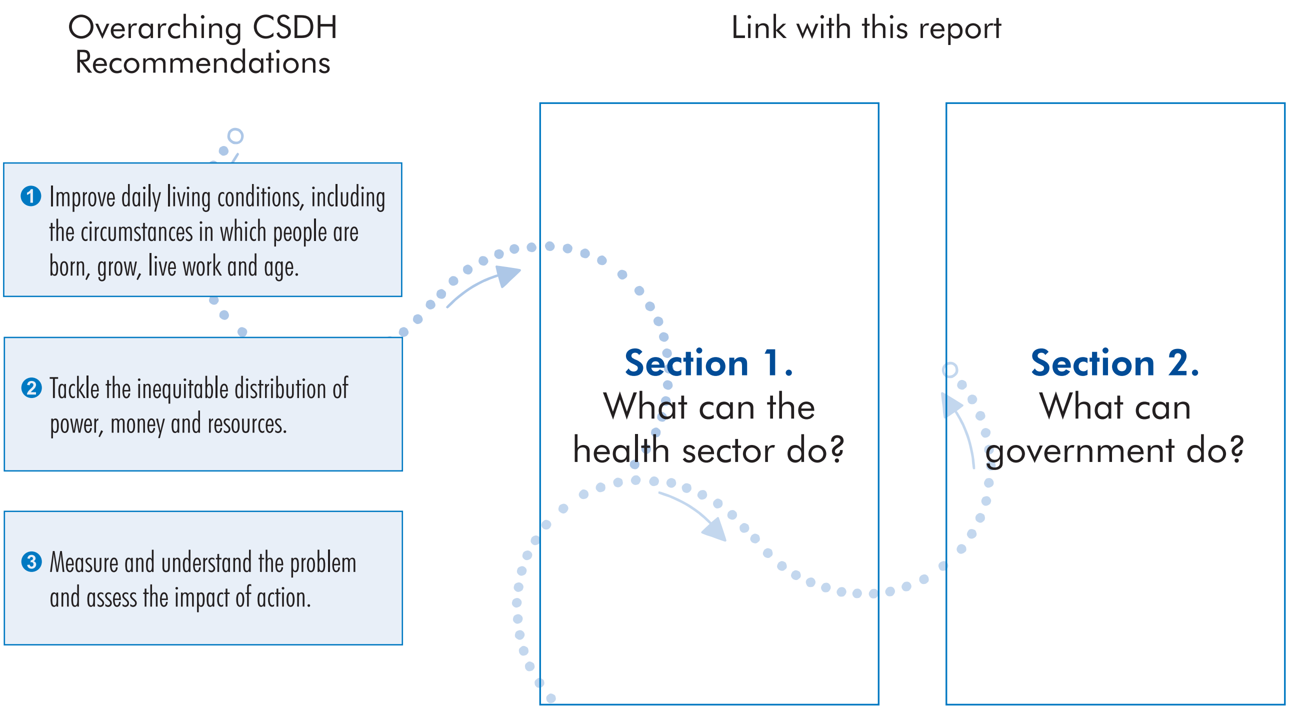
LINKS WITH EXISTING WORK AND OTHER POLICIES

Box 2 shows how this report links to the recommendations of the Commission on Social Determinants of Health. A wide range of activities that recognize the importance of social determinants for health is under way both in countries and internationally. Examples are provided of successful action taken by countries, sometimes in partnership with WHO, to address these issues. The material in this report is intended to support policy-makers in building on experience gained and developing their own locally-appropriate strategies. The policy actions outlined are based on the best current evidence of what works, while noting that countries will need to adapt them according to national circumstances and priorities.

Action on the social determinants of health will benefit from linking, wherever possible, with other national policies and strategies that already exist, have broad support, and are operational. The last section of the report provides guidance on how to build up a social determinants approach,

WHO's *World health report, 2008* (which had the theme *Primary health care: now more than ever*) proposed four sets of reforms for revitalized primary health care addressing 1) universal coverage, 2) service delivery, 3) leadership and 4) public policy. To be successful, each set of reforms requires action on the social determinants of health. This is particularly clear for public policy reforms where health is considered in all policies, and for universal coverage reforms, where the commitment to equity is made explicit by ensuring that all people receive the same access to, and quality of, all levels of services. Leadership reforms need to address inequities in representation to ensure that the views of vulnerable or excluded groups are heard and their concerns addressed. Service delivery reforms need to consider how universal health systems can best address the expectations of those with the greatest need, without falling into the trap of the inverse care law (i.e. those who are in the greatest need are least likely to receive care).

Figure 1. How this report links to the recommendations of the Commission on Social Determinants of Health



including connecting policies or interventions that reduce health inequities by changing or shaping the conditions under which people live and work. The social determinants approach also fits with the current move to revitalize primary health care and provide universal coverage. These complementary efforts draw on common values based on equity and social justice, and follow common strategies to pull together resources for health from across society.

All countries, rich and poor, face challenges and no single mix of policy options will work well in every setting. Any effective strategy for addressing the broader social determinants of health must be locally planned and developed.

More recently, the *World health report 2010* (on *Health systems financing: the path to universal coverage*) maps out options for countries to modify their health-financing systems so they can move more quickly towards universal coverage, so that all people have access to the health services they need – prevention, promotion, treatment or rehabilitation – without the risk of financial hardship associated with accessing services. Over the past century, a number of industrialized countries have achieved universal health coverage in the sense that 100% of the population is covered by a form of financial risk protection that ensures they can access a range of needed services. Successful experience gained in low-, middle- and high-income countries offers options for raising more money for health, for extending financial risk protection to the poor and sick, and for delivering health services more efficiently and in an equitable manner. While the report focuses heavily on domestic financing policies appropriate to countries at all income levels, it also describes how the international community can better assist low-income countries to develop domestic financing strategies, capacities and institutions by providing much more than simply additional funding.

Section 1. The health sector

Health systems are themselves important social determinants of health: they can reduce health inequities or make them worse. They do so not only through the way they provide health care but also by shaping wider societal norms and values.

The health system's influence on health equity is not limited to its direct interactions (or lack of these) with service users. Around the world, health systems provide a high-profile platform from which to shape social and economic norms and improve material conditions. For example, as major national employers, public health systems influence their employees' lives, particularly those of women, through workforce structures and practices, and increased household income. Health system development can also contribute to social cohesion by empowering socially marginalized groups and enabling dialogue between different groups within society, even in states with fragile economies and political structures.

Contextual factors are extremely important in any health system, and what is appropriate will vary in different settings. However, the positive impact of a health system on equity is consistently strongest where a primary health care approach is applied as the organizational strategy and underlying philosophy. This approach itself enables the implementation of other features of the health system that are important to promoting equity. There is evidence that health systems which successfully address equity tend to share several broad features. These health systems:

- aim at universal coverage and offer particular benefits to children, socially disadvantaged and marginalized groups, and others who are often not adequately covered;
- integrate social determinants approaches and consideration of health equity into public health programmes;
- measure inequities in health and monitor actions to address them;
- include organizational arrangements and practices that involve population groups and civil society organizations – particularly those working with socially disadvantaged and marginalized groups – in decision-making;
- possess leadership, processes and mechanisms that encourage intersectoral action across government departments to promote population health and that cooperate to meet the expectations of these other sectors as well.

This section of the report highlights evidence-based actions which can be taken in each of these five areas.

The way health systems organize, fund and deliver health care can exacerbate or make worse social stratification in four main ways, namely:

- the degree to which health systems actively work with and influence other sectors to address differential exposures and vulnerabilities which are the root causes of health differences;
- the extent to which health systems actively encourage and draw on social participation in decision-making at all levels;
- the presence or absence of access barriers (such as the costs of seeking care, lack of information and inaccessible services), and particularly those which disproportionately affect women and other disadvantaged groups;
- the extent to which loss of income due to illness and high out-of-pocket payments for health care are allowed to push poor people into poverty or worsen their existing poverty.

Working towards universal coverage

- Universal coverage is achieved when effective services are available for all, when they are accessible without financial barriers, and when users are protected from the financial consequences of using health services.

- At all levels of national income, steps can be taken towards universal coverage that will improve health outcomes and health equity.

- Even in systems of universal coverage, women and socially marginalized groups may be denied appropriate health care unless the system actively sets out to address social and cultural barriers.

Most societies support the view that everyone should be able to get the health care they need, when they need it. Despite this, the poorest groups often forego health care because it is unaffordable, unavailable or they face barriers to taking it up. Expanding coverage to all people is therefore a key condition for improving health equity.

Universal coverage is achieved when 1) services are available for everyone regardless of income level, ethnicity, social status or residency, 2) financial barriers to the uptake of services are removed, and 3) families are given protection against the financial consequences of their use of health care. Access to health care is improved through pooled progressive funding, usually by means of tax funding or mandatory health insurance. Mechanisms to administer universal coverage generally require less administrative capacity and are more sustainable than approaches that target specific subgroups of the population.

What can be done?

The timescale and the policy measures necessary to move towards universal coverage will vary between settings and over time. Even the intermediate steps can yield substantial beneficial impacts in terms of financial protection and access gains.

Steps can be taken towards universal coverage by all countries in order to extend services to people who are currently not covered, to include additional services that are not covered, and to reduce cost-sharing and fees in an equitable manner (see Table 2).

Moving towards universal coverage often requires specific measures that will benefit socially marginalized groups. Such measures include better targeting of investments in underserved areas, reduction of transport costs, better coordination between services

Table 2. Intermediate steps to universal coverage

INITIAL STEPS TOWARDS UNIVERSAL COVERAGE IN LOW-INCOME COUNTRIES COULD INCLUDE SOME OR ALL OF THE FOLLOWING ACTIONS:
• Advocate for and mobilize increased public funding for health care. • Reduce out-of-pocket payments, wherever possible, by removing public sector user fees. • Improve the availability of comprehensive services by investing in primary and secondary services in currently underserved areas and by improving coordination between levels of care. • Re-allocate government resources between geographical areas, taking account of population health needs and all available funding sources. • Address technical efficiency, especially in relation to pharmaceuticals. • Test and evaluate strategies to extend access and ensure the quality of non-state providers of health services that cater to low-income populations, providing that inequity and stigmatization are not reinforced
IN MIDDLE-INCOME SETTINGS, FURTHER ACTIONS CAN BE TAKEN TO MOVE TOWARDS UNIVERSAL COVERAGE, SUCH AS:
• Expand prepayment funding through a combination of tax funding and mandatory health insurance (ensuring that insurance contributions are related to income and that the tax deductibility of insurance contributions is limited for higher-income groups). • Widen the package of health-care entitlements of poorer groups over time. • Reduce fragmentation and segmentation within the health-care system by pooling funds and harmonizing contribution levels and benefit packages between population groups. • Explore the use of risk-equalization mechanisms, where appropriate, to ensure equitable resource allocation between financing schemes. • Strengthen purchasing strategies, such as contracting arrangements, to leverage performance improvements and cost containment, particularly in relation to private health-care providers. • Regulate private insurance to prevent distortions in the overall system that undermine equity, and ensure that it acts primarily as top-up insurance for higher-income groups.

and, most importantly, improved responsiveness of health services when dealing with the poor and marginalized.

The acceptability of public services, particularly for women and marginalized groups, is also an important issue that needs to be taken into account. Acceptability is determined by the social and cultural distance between health systems and their users, and depends on factors such as differences between lay and professional health beliefs and the influence of organizational arrangements for health care on patients' responses to services. Acceptability affects more than user attitudes to a service. It also influences the opportunities for effective diagnosis and treatment, patient adherence to advice and treatment, and self-reported health status. Interventions that support the implementation of universal coverage include those that encourage a client-centred approach to service delivery, enabling patients and society in general to participate in decision-making about health and health care, and tackling health workers' low morale and poor attitudes to patients. Moreover, health systems can be made more women-friendly by upgrading the skills of health professionals so that they apply gender perspectives in their work.

Public health programmes

- Sustainable improvements in control of communicable and noncommunicable diseases will not be achieved in many settings without tackling the social determinants of health.

- Individual programmes can address social determinants in their management and incentive structures as well as by collecting information on condition-specific distribution of health in populations.

- There is potential for public health programmes to collaborate in tackling social determinants that are common to many diseases.

Box 2. Social determinants and tuberculosis

There is a strong socioeconomic gradient for TB, both across and within countries. Poor and vulnerable social groups are more at risk from TB due to factors that include malnutrition, crowding, HIV/AIDS, smoking, alcohol abuse, indoor air pollution, and poor access to health services.

The current global TB control strategy (the Stop TB Strategy) mainly focuses on reducing the incidence of TB through cutting transmission of the disease by curing patients with infectious TB. However, recent evidence suggests that while the strategy effectively reduces death rates and prevalence, the impact on incidence is less than expected. For example, both Morocco and Viet Nam have successfully implemented the control strategy yet, in those countries, incidence has remained stable or has been reduced less than expected.

From such findings, it seems likely that further progress in TB control in many settings will require additional preventive measures, in particular targeting the proximate TB risk factors, such as crowding and malnutrition, and their social and economic determinants, including poverty and poor living conditions.

Source: Lönnroth et al., 2009 *(2)*.

Evidence from the growing body of research on the social determinants of health has significant implications for public health programmes. The Commission's findings indicate that the balance of resources needs to be adjusted so that investment is made not only directly in disease prevention and control but also indirectly in reducing the causes of ill-health at the source. Without this adjustment, it will be impossible in many settings to achieve sustainable improvements in reducing communicable and noncommunicable diseases, and many international targets will not be achieved. Such adjustments also represent a move towards adopting a systems approach in the management, organization and delivery of public health programmes, that places the principles of primary health care at its core, is not limited to the provision of health care or other health services and addresses the social determinants of health.

Programmes on both tobacco and injury have successfully demonstrated that health-sector-based programmes can address upstream determinants of health and can work effectively with other sectors. Many of the interventions can also be usefully applied in disease control programmes. For instance, in the case of tuberculosis (TB) there is evidence that, in some contexts, approaches to controlling the disease through early detection and cure are unlikely to succeed fully on their own (see Box 2). In other words, unless a "social determinants approach" is integrated into public health programmes, there is a risk that increases in inequity will be greater than the benefits from treatment and cure of disease.

What can be done?

Specific action points for individual public health programmes pursuing a social determinants approach include:

- Changing programme incentives to acknowledge cross-cutting issues as a short-term measure will enhance the capacity of programmes to address the social determinants of health. Such cross-cutting issues tend to be lost when management is focused on short-term outcomes or a results-based framework. In the longer term, reforming education and management within public health systems can develop this further.

- Developing or improving information systems in order to collect information on the social gradient or distribution of health in populations is likely to be an important first step in many country programmes towards gaining insight into the role of social determinants. Evidence is patchy – and in most cases absent – which tends to limit the ability to implement a social determinants approach.

- Allowing for and encouraging a range of intervention packages that are relevant to different social patterns of disease, such as situations of mass deprivation where, except for the most wealthy, almost no one has access to services, or a social exclusion pattern where specific marginalized groups do not have access, whether due to poverty or to other demographic characteristics.

Enormous untapped potential exists for closer collaboration and joint action between programmes. Starting points for collaboration might include:

- creating an institutional mechanism for identifying social determinants that are common to different conditions, particularly where they are present in the same population groups (e.g. HIV and TB);
- developing intervention packages targeting the circumstances and needs of population groups that are vulnerable to a range of conditions (e.g. coordination can reduce the prevalence of a variety of infections and better tackle common risk factors such as tobacco, indoor air pollution and unsafe sex);
- identifying and prioritizing the collection of information that is relevant to common social determinants, disaggregated by different population characteristics so that the evolution of social patterns can be monitored and reported.

International programmes can support the actions of national public health programmes by acknowledging the importance of the social determinants of health. National policy-makers can strengthen this recognition by incorporating action on social determinants into the results frameworks of donor programmes.

Various approaches to action on social determinants have been tried. Experience indicates that success depends on integrating the action into the core agenda of each health programme. Focal points or centres of specific expertise are useful supporting mechanisms, but independent social determinants units will often struggle to have their agenda taken up by programmes.

Dedicated disease control programmes have a special appeal to the public because such programmes deal directly with real people rather than with systems. This presents a communications challenge: how can one utilize the power of disease-specific or condition-specific programmes for resource mobilization while also addressing upstream social factors that increase vulnerability to the disease and lead to its inequitable distribution? One response is to develop strategies with more than one time horizon. In the short and medium term, available tools and services for disease control can be applied to compensate for inequities. At the same time, programmes can start to take action with a longer-term perspective to tackle the upstream determinants of the disease.

Measuring inequities in health

- Social gradients include all sections of the population, from the wealthiest to the poorest. To be comprehensive, measurements need to cover the entire population.

- Disaggregating data in health and other sectors by income, education, ethnicity, sex, occupation and place of residence is an important prerequisite for understanding the social pattern of diseases or conditions within a population.

- The effects of new policies or other interventions need to be carefully monitored because the evidence base on interventions to tackle the social determinants of health is evolving and needs to be strengthened.

- Setting specific targets to decrease systematic and unfair differences in health at national, state or local level raises awareness and provides a vision for collective action.

Good data and measurement provide the basis for political action and accountability on the determinants of health and the improvement of health equity. A number of high-level considerations about *how* to measure and *what* is to be measured are relevant to policy-makers. Ministries of health can provide evidence to health practitioners, communication strategies oriented to different audiences, and support their own advocacy function within government by adhering to certain principles.

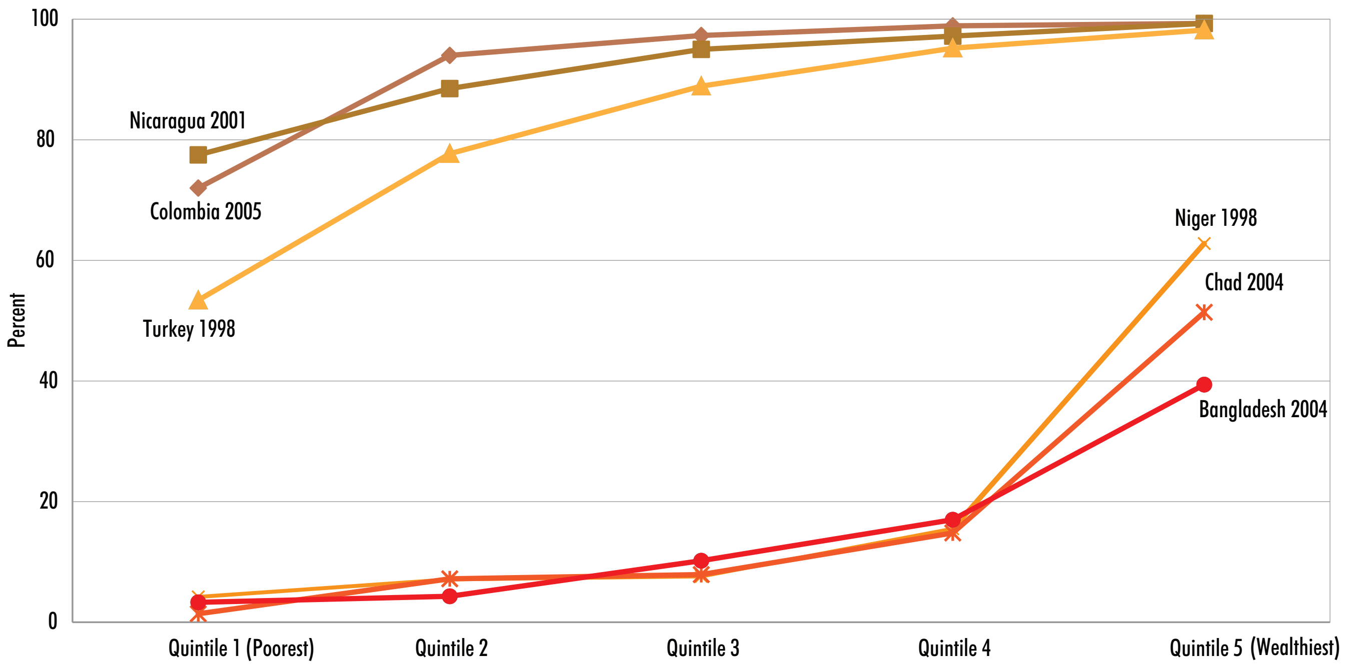
An approach which takes into account the whole of the gradient in health equity in a society and not only the most disadvantaged groups is an important starting point. This is so because health and illness follow a social gradient. While in some circumstances targeting policy or interventions towards the most disadvantaged groups may be the best and most appropriate action, this is not necessarily the case. As Figure 2 shows, very different patterns of access to health services exist. The example here is for births attended by a trained health worker, shown by household wealth quintile. However, similar systematic patterns of access can be observed by other characteristics that measure the social position of individuals or groups (such as place of residence, ethnic group, educational level or sex - see Box 1). Such patterns can be seen across many different services, as well as for health outcomes such as mortality due to specific causes.

These observations show the importance of measuring the pattern of inequality accurately as an input to policy formation. When only the poorest do not have access to a service (the three upper lines on Figure 1), policies probably need to focus on expanding provision to particular groups that are excluded or marginalized or on the processes that lead to exclusion. When almost everyone does not have access to a service (the three lower lines), more wide-ranging strategies are usually required. In many settings the pattern will fall somewhere between the two extremes and a combination of strategies will be needed, with specific policies taking into account each national context.

To support the development of actions in the areas outlined in this report, health and other data (e.g. on environment, housing, labour, education) will need to be disaggregated by socioeconomic status and by other social stratifiers that measure social position. The appropriate stratifiers to measure will depend on the local context but as a minimum they are likely to include:

- income;
- sex;
- place of residence;
- education;

Figure 2. Different patterns of access to health services-Percentage of births attended by trained personnel by household wealth



Source: World health report, 2008

A key strategy for most countries is to increase coverage of socioeconomic and other social stratifiers that describe individuals within national data sources, including:

- vital statistics, such as birth and death registrations;
- population-based surveys, such as population censuses and demographic and health household surveys;
- routine disease-specific statistics collected through health surveillance systems (e.g. TB or cancer registers);
- service-generated activity data, such as hospital statistics or financial transactions.

Box 3. Tracking health inequalities at the local level in the United Kingdom

The government of the United Kingdom and Northern Ireland has a commitment to reducing health inequalities. Specific targets have been set to decrease inequalities in infant mortality and life expectancy at birth by 10% by 2010. A "health inequalities intervention tool" has been introduced to assist local government and health commissioners to measure differences in life expectancy. The tool compiles good-quality data on key indicators at the local level and puts these into an easy-to-use format that shows the pattern of inequality in each local area. The tool also allows local areas to model the likely effects of specific interventions and to estimate which will have the highest impact on narrowing the equity gap.

Further details on the tool are available from the London Health Observatory website at www.lho.org.uk.

- ethnicity or race;
- occupation.

Improvements in measurement, monitoring and evaluation would improve understanding of the impact of policies and of more specific health interventions on health equity. In particular, disaggregating health data by sex and analysing them is an important step towards developing actions to improve gender equity (as described further in Section 2). There remain challenges to measuring both absolute and relative measures of health inequalities and inequities and how to interpret information (e.g. the categorization of "urban" versus "rural" given the increasing complexity and variation of who lives within urban areas).

What can be done?

Where good data exist, measurement and analysis can serve as powerful inputs in the design and evaluation of interventions (see Box 3).

An effective policy is one which achieves both absolute and relative improvements in the health of the poorest groups or across the social gradient. The choice of whether to use absolute or relative measures can affect the assessment of whether a health inequity exists and how big it is. Sometimes a difference on the relative scale may not appear to be a difference on the absolute scale. It is critical that researchers and policy-makers are clear about which type of measure is being used and, where possible, that they use both relative and absolute measures of health inequities (i.e. both rate ratios and rate differences comparing two or more contrasting groups) to ensure that inequities are identified.

One step towards intersectoral action is to negotiate access to data from other sectors – such as education, justice, housing and environment – and to link these data together. This is needed in all countries in order to better link and target policies to reduce health inequities through addressing the social determinants of health. Provincial, district or municipal policy-makers and programme managers can also better analyse local data in order to develop, implement and evaluate solutions with the appropriate sectors and levels of government involved.

The effects of policies and programmes on inequities need to be measured, monitored and evaluated. Not only will this provide an evidence base on the effectiveness of interventions (which may be lacking in many areas or countries), but it can also help reinforce the case for action. Demonstrating success is likely to be a key element in building broader political support for action. The health sector can facilitate action and can support its own advocacy role by investing resources in the analysis of actions both within and outside the health sector.

Facilitating mobilization of people and groups

- Social mobilization is essential for increasing overall performance and accountability of health systems.

- Participatory processes to mobilize individuals, households, communities, and informal and formal organizations are indispensable for addressing the social determinants of health.

- Health systems can support social mobilization by recognizing its importance and by taking steps to facilitate action.

- Accountability can be improved by specifically involving disadvantaged and marginalized groups in priority-setting, planning and resource allocation processes.

Box 4. Participatory approaches to reducing neonatal mortality in Nepal

A pilot community-based programme in Makwanpur district, Nepal, used participatory methods to reduce neonatal mortality. During the project, groups of women were supported by a facilitator through an action-learning cycle — where groups work regularly and collectively on complicated problems, take action, and learn as individuals and as a team — in which they identified perinatal problems that occurred locally and formulated strategies to address them. The intervention was shown to be associated with significant reductions in maternal mortality and improvements in birth outcomes, as well as higher use of antenatal care, institutional delivery and trained birth attendance. The participatory intervention led to a 30% reduction in neonatal mortality and a larger reduction in maternal mortality, and an evaluation found it to be highly cost-effective.

Source: Manandhar et al., 2004 *(4)*.

Social mobilization strategies encompass a range of activities aimed at increasing social awareness of health and health systems, strengthening health literacy, and enhancing social capacities to take health actions.

Social mobilization has been shown to improve the performance and accountability of health systems, as well as health outcomes for communities – especially in relation to health promotion and public health activities. Participatory processes that engage individuals, households, communities, social networks, formal organizations and more informal groups of people actively in planning and resource allocation can deliver benefits in addressing the social determinants of health (see Box 4). Social mobilization is also instrumental in furthering the redistribution of power, money and resources towards more equitable health opportunities, as stated in the Commission's report.

Strategies to improve health system accountability are likely to be most effective and representative when directed towards health policy and management decisions, and when disadvantaged and marginalized groups participate in decision-making in a meaningful way.

It is important to note that poverty and lack of power may exclude disadvantaged and marginalized groups (e.g. women, the elderly, unemployed persons) from social action. Therefore, it is necessary to develop institutional mechanisms and appropriate governance procedures that directly address the inclusion of such groups and build trust. Additionally, participation alone is insufficient if strategies do not also build the capacity of individuals and community organizations in decision-making and advocacy.

What can be done?

Health officials can encourage social mobilization by taking actions such as:

- bringing professionals into roles that support social mobilization, and supporting and rewarding these roles;
- recognizing, supporting and funding mechanisms for direct participation by communities;
- implementing mandatory consultations with stakeholders on new policies and their implementation;
- promoting existing and new accountability mechanisms by widely advertising their existence in the media and holding public hearings;
- public target-setting, with independently verifiable monitoring and evaluation;
- institutionalizing access to decision-making through, for example, clinic committees that help to forge closer working relations between the community and health clinics;
- drawing up service charters that set out entitlements and how they will be provided.

Intersectoral action

- The health sector can play a central role in initiating intersectoral action, even though it does not directly control many of the interventions that tackle social determinants of health.

- Action to support intersectoral action includes tailoring advocacy messages to particular sectors, establishing organizational arrangements that promote ongoing cooperation across sectors, and institutionalizing health equity goals.

- Cooperation across sectors also means that the health sector contributes to the strategic priorities of other sectors, emphasizing joint benefits.

Ministries of health generally do not implement interventions that address the structural determinants of health disparities. Nevertheless, ministers of health and health managers can play a central role in initiating and monitoring intersectoral action that has an impact on health and health equity. However, those with the capacity to intervene on many important social determinants often do not know what to do or what the consequences are of not intervening.

Expending resources, effort and political capital in tackling the upstream determinants of health can be a highly effective way to address unfair or inequitable health consequences. Section 2 of this report outlines some of the key areas where such action might take place.

What can be done?

At government level the health sector can promote action on the social determinants of health through the following interventions:

- Make the case for intersectoral action on health. Use sound epidemiological and other evidence and, where possible, make the case for how intersectoral action can address economic and budgetary concerns.

- Take the strategic needs of other sectors into account. Frame objectives in ways that are commonly understood and share responsibilities. Emphasizing joint benefits and opportunities for improving public policy in general can support cross-government coalitions.

- Set explicit goals and objectives. These should give a clear mandate and should be clearly linked to activities which show measurable results, thereby helping to build confidence as well as providing a good basis for evaluation.

- Establish organizational arrangements that promote ongoing dialogue and cooperation across sectors, such as sharing accountability mechanisms and budgets between sectors.

- Work towards institutionalizing health equity as a central goal of government policy. This could involve Cabinet-level ownership and coordination of action on health equity, binding targets for other ministries, or requirements to conduct a health impact assessment (including potential effects on equity) of new policies.

The health sector can also play an important role in supporting the delivery of key intersectoral actions on the social determinants of health. For instance, in early child development (ECD) services, the health sector is usually the first point of contact with public services for most children. Thus the health sector can transform this entry point to help ECD interventions reach a high proportion of the population. Similarly, while the health sector does not have all of the policy levers to improve urban environments directly, it may be able to facilitate dialogue among stakeholders at local level, leading to empowerment of communities through engagement and participation. The specific requirements in these areas are discussed further in Section 2.

Section 2. What can government do?

Section 2. Cross-government actions

A key message for policy-makers from the Commission is that actions in all areas of government policy affect health. Policies in areas as diverse as trade policy and the urban environment have important implications for health.

Box 5. Working across government to achieve universal social protection in Chile

In recent years, Chile has implemented a range of social protection strategies and directed attention towards coordinating government action on the social determinants of health. Policies and programmes include:

- *Chile Crece Contigo* (Chile Grows with You) which addresses early child development through improved training of health professionals on the development needs of children coupled with increasing the access of communities to health facilities and social services;
- *Chile Solidario* (Chile Solidarity), an initiative for the poorest families, which provides a range of support, including cash transfers, day care, and psychosocial services.

Improving social protection and reducing health inequities have been on the agenda of several ministries. The Ministry of Labour has implemented a set of reforms to increase the security of workers in the informal sector and encourage formalization of their work; to provide increased access to child care, especially for the poorest communities; to reduce gender discrimination in access to work and pay; and to strengthen the ability of workers to organize and negotiate fairly and collectively with their employers. The Ministry of Health and the Ministry of Labour have increasingly cooperated on intersectoral activities, including programmes such as the National Plan for the Eradication of Silicosis.

The Ministry of Health has also supported the creation of a "social cabinet" which will serve as a coordination mechanism between the ministries of health, planning, finance and labour, along with agencies such as the National Service of Day Care Facilities, the National Children's Agency, and the National Service for Women. This social cabinet tries to ensure that government policies across sectors promote, or at least do not undermine, efforts to address social determinants of health and to coordinate better implementation of policies with national, regional and local authorities.

Actions taken across government can therefore improve population health, particularly for the most vulnerable groups. However, these are not the only advantages to accrue from action on social determinants of health. In many areas, there is a significant generic benefit for public policy and for the sectors where the action is being taken. For instance, improving delivery of ECD services will not only reduce stunting and infant mortality but can also raise educational outcomes and reduce crime rates. Instituting policies which improve women's rights and social status can greatly reduce girls' and women's vulnerability to disease and has also been strongly correlated with economic growth. Engaging effectively and appropriately with civil society has consistently improved the quality of health in communities, and the same groups and organizations can help improve other areas of government policy.

In financial terms, tackling the social determinants of health is not necessarily, or even often, a matter of how much is invested but rather how resources are distributed and on whose account the costs show up. Some sectors may have short-term gains from ignoring the effect of their actions on population health but the long-term costs will eventually show up elsewhere – first in the health sector and then later in social, political and economic sectors.

We must not underestimate the challenge that governments and government sectors face in balancing competing priorities and negotiating across groups with different sets of values and agendas. In every country at every income level there are multiple demands on public policy and financial resources. In many sectors, tackling the social determinants of health can benefit all those involved. In others, by taking a comprehensive social view of costs and benefits when allocating and regulating the flow of resources, national governments and planners — complemented by non-state actors and a cooperative private sector — can deliver more effective policy. For an example, see Box 5.

This section outlines policy implications and evidence-based actions in several key areas. These are grouped into three themes according to the different levels at which government action may affect population health, namely:

- Priority areas for coordination of intersectoral actions, such as
  - early child development,
  - urban settings;
- Specific government policy areas with significant implications for health, such as
  - globalization and increasing economic interdependence,
  - employment and working conditions,
  - policy and attitudes towards women and girls;
- Changing how government acts, such as
  - inclusive policies,
  - engaging civil society.

While each of these areas is critically important, even together they do not represent a comprehensive list of all areas of government policy which may impact on health. For example, a focus on urban settings is not intended to downplay the importance of rural policies on the health of those who live in rural areas. Likewise, the absence of specific suggestions on education, climate change or food does not imply that these are not important social determinants of health. Rather, the knowledge networks set up to support the Commission focused attention on those areas where there was a perceived need for further research and for synthesis of available evidence in order to identify options for action. The following chapters aim to present material which is new and relevant to policy-makers worldwide.

Early child development

- The early childhood period is the most important developmental phase of life. Experiences during this time determine health, education and economic prospects throughout life.

- Social and emotional development are key dimensions of early life and impact on physical and educational outcomes.

- ECD interventions (including parenting and caregiver support, child care, nutrition, education, and social protection) yield benefits throughout life that are worth many times the original investment.

- Hallmarks of successful government action on ECD include:
  - strong interministerial coordination on ECD;
  - integration of ECD into the formal agenda of each sector;
  - use of existing platforms such as health services for delivery of ECD programmes;
  - identification and scaling-up of existing models in local settings.

Experiences in early life are crucial determinants of health and of social outcomes throughout life. Many challenges in adult society – including mental health conditions, obesity, stunting, heart disease, criminality, gender inequity, and poor literacy and numeracy – all have their roots in childhood. While considerable attention is directed to supporting children, recent research has highlighted the following two crucial points which are often not integrated in current policy:

- The first three years of life provide a critical development opportunity because a child's early environment has a vital impact on the way the brain develops. It is at this stage that a developing child is most sensitive to the influences of the external environment. Brain development is adversely affected, leading to cognitive, social and behavioural delays when children spend their early years in non-stimulating and emotionally and physically unsupportive environments. Thus intervention only at preschool age may be too late to ensure the child's optimal development.

- *Social and emotional development is a key dimension of early life and influences physical and educational outcomes.* The more stimulation the early environment offers in terms of positive social interaction, the more secure the child feels and the better he or she thrives in all aspects of life – including physical, cognitive, emotional and social development. Child survival and child health agendas are therefore indivisible from ECD programmes.

Consequently, to reach their potential, young children need to live in caring, responsive environments that protect them from neglect, from preferential treatment based on gender norms, and from inappropriate disapproval and punishment. While parents and families have the principal role and responsibility for ECD, an important policy implication is the need to provide a favourable legislative context.

Children benefit when national governments adopt "family-friendly" social protection policies that guarantee adequate income for all, maternity benefits, affordable child care, financial support for the poorest, and allow parents and caregivers to devote time and attention to young children (for some examples, see Table 3). Globally, societies that invest in children and families in the early years – rich or poor – have the most literate and numerate populations. These societies also have the best health status and lowest levels of health inequities.

What can be done?

Success in promoting ECD does not depend upon wealth. Because ECD programmes rely primarily on the skills of caregivers, the cost varies with the wage structure of a society. Increasing preschool enrollment to 25% or 50% in low- and middle-income countries will result in a 6–18-fold increase in benefits to costs *(5)*. In fact, economists now assert that investment in early childhood is the most productive investment a country can make, with benefits throughout life that are worth many times the original investment.

ECD services include parenting and caregiver support, child care, nutrition, primary health care, education and social protection. While delivery of these will be highly dependent on the local context, the case studies in this section illustrate that successful programmes can be implemented at all income levels. Hallmarks of successful government action on ECD include:

- *Strong interministerial coordination on early child development*, which is essential for successful delivery of services that are centred on the child. National governments can lead the way in this regard. An interministerial policy framework for ECD that clearly articulates the roles and responsibilities of each sector, and how they will collaborate, is an effective way to facilitate such coordination.

- Integration of *ECD* into the formal agenda of each sector, with appropriate performance measures and metrics to drive performance.

- *Use of existing platforms for delivery of ECD programmes,* which is known to be the most effective route for implementation. For example, the health system has a pivotal role to play since it is usually the child's first point of contact with public services and can serve as a gateway to other early childhood services.

- *Identification and scaling-up of existing models from local settings,* which are likely to be more effective than the creation of new models. In doing this, it is important to retain local accountability and involvement, even once a programme has been rolled out or scaled up at national level. Schemes which have strong roots in local communities are likely to be more successful. Local flexibility is therefore more important than ensuring consistency across programmes.

Table 3. Examples of ECD interventions

WHAT WAS DONE TO PROMOTE DEVELOPMENT?	WHAT WERE THE RESULTS?
The Reach Out and Read (ROR) programme in the USA uses doctors and nurses who encourage parents to read aloud to their young children, and offer age-appropriate advice and encouragement. This is supported by the provision of books and reading-friendly health-care environments	Children enrolled in ROR showed significant improvement in preschool language scores, which is a good predictor of subsequent literacy.
When counselling caregivers on care for early child development, WHO and UNICEF used an interactive strategy to incorporate messages regarding development, feeding and caregiving practices into child health visits in Turkey. This illustrates the feasibility of integrating simple ECD interventions into existing services.	Simple ECD interventions can be integrated into existing health-care services with a positive impact on parenting behaviours and on the selection of toys to stimulate psychosocial development.
The PROGRESA programme in Mexico offers cash transfers to families provided that children aged 0—60 months are immunized and attend well-baby, or preventive care, visits. During these visits the children's nutritional status is monitored, they are given nutritional supplements, and parents and caregivers are offered health education.	Children born during the two-year intervention period who were part of the programme experienced 25% less illness in the first six months of life than the children who did not receive the intervention. In general, children in the PROGRESA programme were 75% less likely to be anaemic, and grew one centimeter more on average.

Urban settings

- Where people live is an important social determinant of their health. Increasing urbanization throughout the world has major global health implications.

- The challenges posed by the urban environment, including air quality, standards of accommodation and sanitation, can adversely affect many of the social determinants of health.

- Actions can be taken at all income levels to improve urban settings. These actions will improve health, and can also create major returns for the economy.

- Multisectoral interventions promoting good governance in urban settings are the key to making improvements and ensuring multiple benefits.

The challenges of urban settings are not limited to low-income countries. Pockets of poverty and deprivation exist within cities worldwide. For instance, in extremely wealthy cities, there are concentrations of obesity (poor urban planning has been linked to falling exercise levels), infectious disease (globally, HIV incidence is 1.7 times higher in urban than in rural areas) and violence (homicide rates are higher in cities in many high-income countries in comparison to low-income countries).

In their overall approach to slums, governments are faced with three main options: to remove them, upgrade them or leave them as they are.

Substantial evidence indicates that upgrading is the most effective way to improve conditions in most instances. In addition to being generally cheaper than whole scale removal, upgrading avoids dislocations of population groups that impact on people's livelihoods and social networks. Regularizing tenure is often an important part of upgrading because it allows official (public or private) utilities to extend infrastructure and services to previously excluded groups.

Urbanization can be a positive force for improvement in living standards and health outcomes. Technical and social development is driven by the economic strength of cities; the rise to wealth of today's high-income countries was intrinsically linked with the growth of cities. However, in many areas of the world, a combination of rapid growth of urban populations and neglect of longstanding problems found in all cities, such as environmental pollution, poses major challenges to societies.

Urban settings are therefore a social determinant of health. Despite all of the positive opportunities offered by cities, poor management and governance, inadequate infrastructure, and policy failures will magnify the effects of poverty, inequity and unhealthy conditions. For instance, a problem of inadequate housing for a scattered population in a rural area, if reproduced on a large scale in a densely populated city, would result in a crowded slum settlement where infectious diseases spread much more easily.

A complex web of interlinking determinants related to the quality of the physical environment influences health in urban settings. The main factors include water and sanitation, air quality, cramped conditions, housing and shelter quality, land use, planning and transport.

Consequently, infant and child mortality rates among groups of the urban poor often approach or exceed rural averages in low-income countries. This fact renders traditional stratifiers of place of residence – i.e. "urban" and "rural" – less meaningful. In addition to their direct impacts on health, these factors also exacerbate other health risks. The absence of social support networks, lack of empowerment and increased social exclusion can directly and indirectly affect health. Women, the elderly, and the disabled are particularly affected by these vulnerabilities. The stresses of poverty contribute to poor mental health, with studies in developing countries showing that up to one half of urban adults living in slums suffer from some form of depression or other mental health problem.

Reducing the burden of disease, disability and death for the 3.3 billion people living in urban areas requires special attention to be given to the particular problems of those settings and to the socially patterned distribution of broader determinants of health.

What can be done?

Investments in healthy cities produce major returns for economies. The Commission on Macroeconomics and Health documented this and it has been reaffirmed in recent studies. For example, in developing regions a US$ 1 investment in improving water supplies can lead to economic benefits ranging from US$ 5 to US$ 28.

Improving the urban living environment is an essential step to improving the health of the urban population. Important areas for action include:

- improving access to clean and sufficient drinking-water and sanitation;
- creating healthy housing and neighbourhoods;
- controlling air pollution;
- promoting good nutrition and physical activity;
- preventing urban violence and substance abuse;
- promoting social cohesion within urban communities by providing opportunities to build social capital.

There are numerous examples of successful interventions in these areas *(6)*. Interventions to support the improvement of the urban environment will vary by city context. For example, public information campaigns on improving stove design, home ventilation, food storage, or appropriate solid waste management in households, can lead to improvements in each of these areas (See example in Box 6.) Providing technical support for improved housing structures or extensions can gradually improve housing standards.

Improving urban settings is not only about what is done but also how it is done. Typically, cities are subject to the power of higher government bodies who determine, to a considerable extent, the resources available and actions that can be taken.

Good governance – which is locally based and involves the community at all levels – in addition to the formal government entities can result in more effective and more equitable cities with the resources available.

Devolving decision-making and accountability to local level, making systems more transparent, and involving civil society in policy design and implementation are likely to improve health in cities. To be successful, the community itself needs to drive the agenda, whether in a slum area or a more affluent neighbourhood. Governments at all levels can encourage and facilitate such community involvement.

Fostering opportunities for exchange of information, experience and networking between cities and communities is a powerful strategy for promoting mutual learning and implementation of best practices.

Box 6. Civil society and urban improvements in Dhaka

The city corporation in Dhaka, Bangladesh, could not provide waste removal services to large sections of the city. Neighbourhoods were left with accumulations of waste in the streets. The city engaged in a cooperative effort with neighbourhood organizations to set up waste removal services covering active composting, collection, proper disposal and recycling. The city constructed transfer stations for secondary collections in order to centralize the local communities' waste collection drop-offs. This cooperative effort has led to a substantial increase in the number of areas of the city covered by waste removal services and has done so at minimal extra cost to the Dhaka city corporation.

Globalization and increasing economic interdependence

- Globalization represents many complex processes and can have both positive and negative effects on health.

- Careful "sequencing" of trade liberalization policies together with strengthened economic, labour and social protection policies can mitigate some of the potential negative effects of increased global market integration on health and health systems.

- Actions that could reverse increasing inequities in health include:
  - expanding capacity for health impact assessment of trade policy and foreign investments, particularly incorporating impact on equity across all population groups;
  - improving the collection of statistics on the impact of globalization on national health systems (how the benefits and risks are shared and distributed across countries and within countries, and evidence on what actions reduce inequities) in order to better inform policy options;
  - increased global and national policy coherence addressing related challenges such as migration of health professionals from poorer to richer countries, reduced food security associated with climate change, and global convergence towards diets high in saturated fat, sugar and refined foods.

The world's growing economic interdependence is characterized by trade liberalization and financial deregulation, as well as by greater movement of goods, services, capital, technology and to some extent labour across national borders.

For some people, globalization has brought health benefits that include more rapid diffusion of new technologies, stronger demand and support for rights-based approaches to development, and increased funding for global health initiatives. Globalization has also increased risks and negative impacts on health – such as more rapid transmission of old and new forms of communicable diseases, increased migration of health professionals from poorer to richer countries, and greater exposure to hazards such as unsafe drinking water, pollution, and dangerous working conditions. These processes underline the need for coherent international and national policies that mitigate the actual and potential harmful effects of globalization on health in both the less industrialized and more industrialized countries alike *(7)*.

An important dimension of globalization is the restructuring of national economies and societies as these become integrated into the global marketplace. For example, trade policy can be a powerful mechanism for improving standards of living. However, trade policy can also adversely affect the viability of national health systems if reductions in tariffs significantly reduce governments' capacities for generating revenues for essential programmes, such as health and education, unless approaches to replace revenues lost from tariffs or increase the efficiency of revenue collection are also put in place. Trade policy can also have more far-reaching effects on health by changing the distribution of economic opportunities within a society. Box 7 gives examples of some international trade agreements that may influence health policies, while Box 8 addresses the need for governments to ensure that health is not prejudiced by such agreements.

Despite this complexity, the health impacts of economic policy choices are seldom considered systematically, whether within countries or at the international level, and the distribution of these impacts within a country even less so. Part of this oversight is due to differences in bargaining power and resources during the process of trade negotiations. For many countries, this also reflects the limited involvement of health and other social ministries in such processes.

In many countries, rapid outflows of investment funds have sparked national financial crises with the domino effects of increasing poverty, unemployment and lost productivity. On a larger scale, inadequate regulation of the global financial system led to a worldwide economic crisis in 2008 that dramatically revealed the extent of global economic interdependence, the uneven distribution of globalization's risks and rewards, and the consequences for health.

Early warning signs point to a "triple crisis" reflecting financial, food and climate instabilities *(8)*, which will worsen existing patterns of inequity and deprivation. This situation shows the need for shared responsibility for improved international governance and greater national policy coherence that is pro-health.

Other aspects of globalization also have health impacts. A growing interdependence between domestic and health foreign policy is apparent worldwide. For example increasing

Box 7. International trade agreements that can influence health policy

International trade and trade rules that maximize health benefits and minimize health risks, especially for poor and vulnerable populations, should be pursued. Multilateral trade agreements have the potential to influence health and health policies in positive or negative ways, reflecting specific policies, timing, negotiation points and implementation. Examples of such trade agreements include:

- **The Agreement on the Application of Sanitary and Phytosanitary Measures (SPS)** contains rules for countries wishing to restrict trade to ensure food safety and the protection of human life from plant- or animal-carried diseases.
- **The Agreement on Technical Barriers to Trade (TBT)** allows countries to restrict trade for legitimate objectives (e.g. protection of human health or safety, protection of animal or plant life or health, protection of the environment).
- **The General Agreement on Trade in Services (GATS)** allows countries to choose which service sectors (e.g. health services) to open up and which modes of service to liberalize.
- **The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)** establishes minimum standards for many forms of intellectual property regulation and includes patent protection for pharmaceutical products.

urbanization, rising incomes and different employment patterns have interacted with increasing liberalization of trade, foreign direct investment in food, and advertising and global branding of food. In many low- and middle-income countries, this has led to diets high in saturated fat, sugar and refined foods (nutrition transition) and to the prevalence of overweight and obesity at levels approaching those in high-income countries, with rising incidence of cardiovascular disease and diabetes *(9)*. Every opportunity should be taken to address the role of trade and investment treaties in relation to tobacco or obesogenic foods, such as at international high-level meetings and in declarations that address noncommunicable diseases.

What can be done?

Overall, social and economic policy should emphasize "rights, regulation and redistribution" to counterbalance the influence of the global marketplace on the distribution of opportunities for people to lead healthy lives. Cross-government actions and initiatives focused on social determinants of health are essential to such an approach. For instance:

- *Measure success not only in terms of economic growth but also in terms of improvement in people's lives and how benefits are shared within a country.* Collect, analyse and widely share disaggregated data to measure social progress consistent with national priorities. At the same time, continue to reorient aid architecture away from a charity or "donor interest" model and towards health and development goals that are consistent with multilateral agreements, such as the Millennium Development Goals. Governments can track how the beneficial effects of development assistance may be offset or undermined by other financial flows such as capital flight and debt servicing.

- *Expand capacity for health equity impact assessment of both domestic and foreign policy, including trade and foreign investment policy, actively involving civil society organizations.* Governments can better ensure that national health and social priorities are not negatively affected by economic policy choices by:
  - building up their capacity for analysing potential impacts of trade policy and foreign investment;
  - widening consultation processes to include public and private health-care providers, consumers, and civil society organizations;
  - enhancing the capacity of health ministries to document and express pro-health views in discussions on economic policy.

- *Appropriate "sequencing" of trade policy commitments* (e.g. through full use of trade treaty flexibilities governing intellectual property rights to protect access to essential medicines) can help avoid negative impacts on the social determinants of health and avoid widening inequities in health. At the same time, policies to increase social protection will mitigate negative impacts and improve social cohesion.

- *Labour market and social policies can buffer the negative impacts of globalization, particularly for workers at the low end of the income scale.* These policies should be universal, funded through progressive taxation and not tied to employment, since many of the world's poorest workers are in the informal economy or lack access to employment-based social insurance schemes. Governments need to ensure safe working conditions and adherence to the International Labour Organization's core labour standards (10) of free association, collective bargaining, the elimination of economic discrimination by gender, and the elimination of forced labour.

Box 8. Making space for public health policies within bilateral and multilateral trade and investment treaties, and ongoing monitoring of the impact on health, should be a requirement, not an option

Looking back: TRIPS and medicines for AIDS

In April 2001, the South African government legislated to allow parallel importation of medicines to treat HIV/AIDS, asserting that this was legal under TRIPS. Pharmaceutical companies challenged the decision in court, but later – pressured by local and global civil society protests and growing political support for the South African government's position – withdrew their case. The decision by the South African government was followed by a sharp upsurge at the United Nations of international statements on treatment as a human right and articulations of state obligations on the availability of antiretroviral (ARV) drugs. The same year saw the World Trade Organization issue its Declaration on TRIPS and Public Health. These commitments were matched by considerable policy and price shifts. ARV treatment costs in many low-income countries fell from US$ 15 000 to US$ 150—550 per year.

In other cases, however, countries have had limited ability to make use of the flexibilities provided by TRIPS and "TRIPS-plus" provisions in bilateral and regional trade agreements. For instance, the Central American Free Trade Agreement (CAFTA) has been widely viewed as limiting access to essential medicines by delaying or precluding the production of generic medicines. The ongoing monitoring and evaluation of the impact of trade and investment policies will add to the growing evidence base on health impacts.
Sources: Shaffer & Brenner, 2009 *(11)*; Smith, Correa & Oh, 2009 *(12)*.

Looking forward: nutrition transition and childhood obesity

Governments should ensure that trade and investment liberalization does not take precedence over domestic policies that protect population health. For instance, national regulations that limit advertising of foods high in fat, salt or sugar targeted to children, or taxes on such foods and their advertisements, could contribute to slowing the incidence of childhood overweight and obesity.

Employment and working conditions

- Employment or economic policies which increase work insecurity can be harmful to employees.

- Unemployment or employment that is temporary, informal or precarious can lead to increased risk of poor health and reduced life expectancy, whereas employment policies which provide permanent or stable fixed-term jobs result in important associated benefits for health and well-being.

- Working conditions affect health and health equity in countries at all stages of economic development.

- Measures to improve workplace conditions include:
  - worker representative organizations are supported;
  - worker representatives are required to be trained in occupational health;
  - workers are informed of work-associated risks and can act on them.

Employment can provide many benefits to an individual, including financial security, social status, personal development, social relations, self-esteem, and protection from physical and psychosocial hazards. Each of these factors is also an important determinant of the individual's health – and often of the health of others in the same household. Employment and workplace policies therefore have an important bearing on health and well-being.

Employment conditions. While it has long been established that unemployment leads to poor health, employment itself does not guarantee an absence of adverse effects on health.

The conditions of employment are crucial in determining the impact on employee health. For example, informal employment is not covered by statutory regulations protecting working conditions, wages, occupational health and safety, or injury assistance.

Evidence shows that:

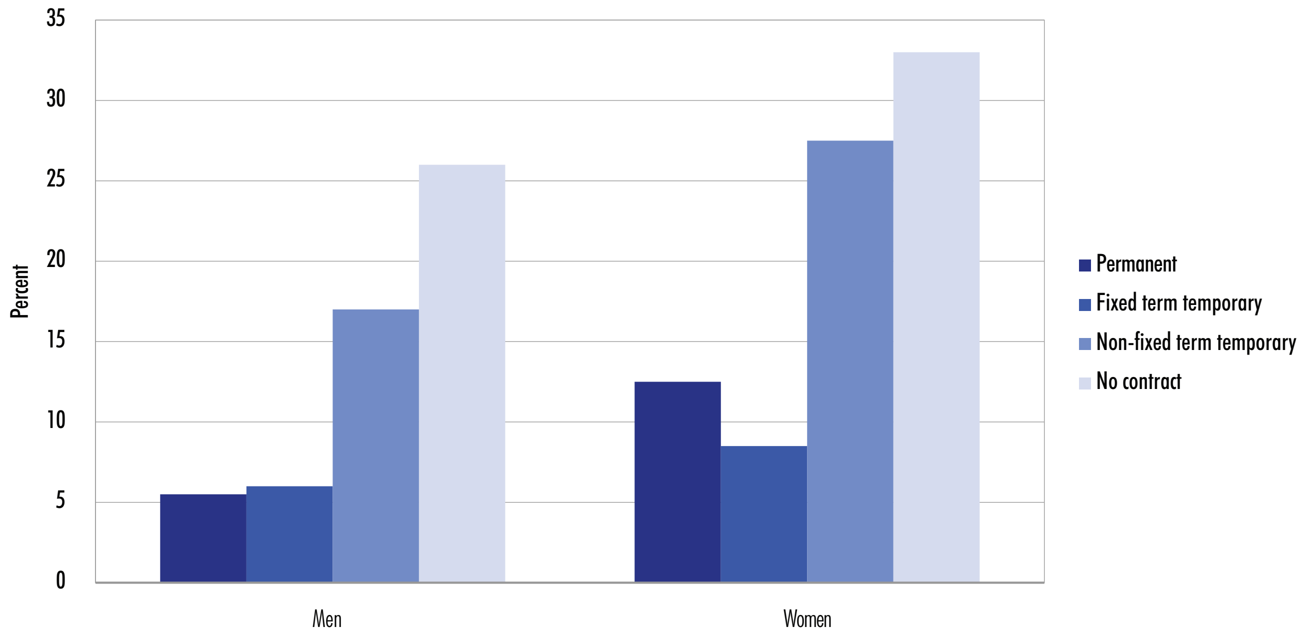
- Mortality is significantly higher among temporary workers than among workers with permanent jobs
- Workers who experience job insecurity report significant adverse effects on their physical and mental health (see Figure 3).
- Workers in the informal economy have less favourable health indicators than those in the formal economy.

There is therefore a "health premium" on permanent and stable employment compared to temporary and insecure jobs. This premium can be very large, as illustrated in Figure 2. Evaluating employment policies solely in terms of their impact on the total employment rate misses many important costs and benefits of employment. Policies which achieve an increase in permanent employment are likely to be much more beneficial for people than policies which achieve a similar level of overall employment but in informal or temporary settings. For example, policies that liberalize and deregulate financial markets in the pursuit of greater foreign investment may be harmful to workers where there are no social protection policies in place.

Working conditions. These are conditions related to the tasks performed by workers, the way the work is organized, the physical and chemical work environment, ergonomics, the psychosocial work environment, and the technology being used. Working conditions affect health and health equity in countries at all stages of economic development.

Work-related fatalities through hazardous exposures continue to be an extremely serious problem, with around 2 million deaths per year related to work. In high-income countries the direct risk of injury or death at work is usually less (although still present) than

Figure 3. Prevalence of poor mental health among manual works in Spain by type of contract



Source: Artazcoz et al., 2005

in lower-income countries, but working conditions also have other important effects on health. For example, stress at work is associated with a 50% excess risk of cardiovascular disease. Across all countries the adverse conditions that expose individuals to a range of hazards tend to cluster in lower-paid occupations.

Lack of training on, and of equipment for protecting against, workplace risks is an important determinant of death and injury among workers. This oversight has particularly negative effects among workers with no contract, with a temporary contract, or in manual occupations.

What can be done?

- *Acknowledging health effects when comparing different national employment policies would allow for a more accurate evaluation of options in both economic and social terms.* Full-time and secure employment carries with it significant benefits, as outlined in this section. Employers' desire for flexibility to adjust to demand should be balanced with appropriate social protection policies that protect workers and their families.

- *Develop active labour market policies* (such as interventions to facilitate access to employment among women, young people and older persons).

- *Promote regulation to avoid employment discrimination against foreign-born, migrants and other vulnerable workers*. These groups are disproportionately represented in precarious and informal employment.

- *Legislation to require enterprises to have worker representatives trained in occupational health and responsible for prevention in the workplace is a low-cost measure that can improve workplace safety.* In countries with low rates of occupational injury and ill-health, workers' organizations have often played a fundamental role in reducing health risks. Extending the scope for collective action and protection, such as by supporting the formation of workers' organizations in the informal sector, would enable improvements.

- *Occupational health and safety (OHS) policy and programmes can be applied to all workers* – formal and informal – and the coverage of these programmes can be expanded to include work-related stressors and inappropriate behaviours such as harassment, as well as exposure to material hazards.

- *Increases in enforcement budgets and/or capabilities would enable better enforcement of regulations.* Failure of existing regulations to protect vulnerable workers can often be traced to failures in enforcement. In most contexts, there is considerable scope for more rigorous enforcement of standards; this could be enabled by better funding of the enforcement agencies.

Policy and attitudes towards women

- Gender inequity is one of the most influential social determinants of health. Women and girls in many settings face discrimination, increased exposure to disease, and public services which do not adequately meet their needs. This situation damages the physical and mental health of vast numbers of girls and women worldwide.

- Gender inequity can be reduced through effective political leadership, well designed policies and programmes, and institutional incentives and structures that influence social norms and household behaviours.

- Improving girls' and women's educational and economic opportunities will not only improve health outcomes but will also lead to other benefits such as raised productivity.

- Social norms which harm women are not fixed and can be challenged and changed over time. For instance, social marketing and public awareness campaigns and legal changes have contributed to changing attitudes on domestic violence.

- A relatively low-cost action is to equalize the balance of men and women in government departments and political and research institutions, as well as in other decision-making bodies from local to international levels.

The way in which they are perceived and treated by society damages the health of vast numbers of women and girls worldwide. Women have less land, wealth and property in almost all societies, yet they often have greater burdens of work than men do. Girls in some contexts are fed less, educated less and are more physically restricted than boys, and women are typically employed and segregated in lower-paid, less secure, and more informal occupations than men. These factors lead to inequitable health outcomes through four interrelated routes:

1. *There are discriminatory values, norms and behaviours that affect health within households and communities.* Examples include practices relating to selective abortions due to the pressure to bear sons, the social acceptability of sexual abuse or physical violence towards women, and the consequences of widowhood.

2. *It is often poorly recognized that women and men experience differential exposures and vulnerabilities to a range of health problems.* The Global Burden of Disease estimates that combine morbidity and mortality data for 2001 *(14)* indicate that, for 68 of the 126 heath conditions and health risk factors, at least 20% differ between women and men. While some differences may be explained by biological factors, such as those related to reproduction, most relative differences are shaped by a complex interaction of both biological and social factors. For instance, women's increased vulnerability to HIV infection is not only due to female biology but can also be attributed to women's lack of power in sexual relationships. The Global Burden of Disease 2004 update *(15)* shows that HIV/AIDS, neuropsychiatric conditions and sense organ disorders remain the three main causes of the burden of disease in women.

3. *There are biases in the way public services, and particularly health systems, treat women.* Furthermore, women compensate for inadequate health systems through unpaid health-care work within families but receive little support, recognition or remuneration (see also Section 1).

4. *Gender imbalances affect the content and process of health research* through gender imbalance in government-sponsored committees, research funding, study populations and advisory bodies. This leads to slow recognition of health problems that particularly affect women, a lack of recognition of women's and men's differential health needs, and poor attention to the interaction between gender and other social factors, such as class, occupation, race and ethnicity.

What can be done?

There are several routes through which government can make a difference:

- *Effective implementation of laws to support women can help change norms and establish rights.* Structural factors of society which disadvantage women and contribute to health inequities can often be addressed. Examples of specific action that could be taken include strengthening laws on domestic violence, ensuring a legal right to equal pay for equal work, or conducting an audit of existing laws to identify existing cases of discriminatory legislation.

- *Improving female education can deliver major improvements in women's health, reduction in infant mortality rates and increased economic growth.* Globally, 64% of illiterate adults are women and it is known that people with low levels of literacy are 1.5 to 3 times more likely to experience poor health. The children of women who have never received an education are 50% more likely to suffer from malnutrition or to die before the age of five; and of the 76 million children who were out of primary school in 2006, 53% were girls. As with many other actions to improve gender equity, increasing female literacy is likely to have considerable co-benefits for other areas of policy: it is estimated that each year of schooling lost means a 10–20% reduction in girls' future incomes. Equalizing education across boys and girls could lead, on average, to a 1–3% increase in economic growth.

- *Campaigns involving public information, social marketing and education have proved successful in changing attitudes on issues such as domestic violence.* Alongside changes in laws, such campaigns can challenge the norms and social attitudes which underpin the unequal and harmful ways women are treated. An example is provided in Box 9.

- *Including the value of unpaid work in national accounts would formally identify its contribution to the economy.* Public policy often ignores the very substantial contribution of unpaid work to the economy, thus directing attention away from this important area of economic activity. A high-level approach to address this would ensure that it is reflected in public policy discussions. More specifically, social insurance and protection systems could formally recognize and protect unpaid workers.

- *Setting up a central unit to support gender equality can lead these changes and act as an important signal of the government's intent.* Government can lead the way in mainstreaming the equal treatment of women in organizations. Government can establish and enforce high standards for equality within state organizations that it manages directly, as well as by applying pressure on contractors, private sector partners and NGOs with links to the state. For example, equalizing the balance of men and women in government-run research committees, and funding, publication and advisory bodies would be a simple, zero-cost way to make a difference.

- *Channelling funding to grassroots organizations may be a particularly cost-effective way of raising the profile of gender issues.* In common with other social determinants, support from civil society is likely to be a strong driver of change.

Box 9. The Soul City intervention in South Africa

As from 1999, the Soul City intervention operated at multiple, mutually-reinforcing levels (individual, community and sociopolitical) to address domestic violence by increasing knowledge about it and shifting perceptions of social norms on the issue. An evaluation showed that the Soul City intervention successfully reached 86%, 25% and 65% of audiences through television, booklets and radio respectively. There was a shift in knowledge relating to domestic violence, including 41% of respondents hearing about the helpline. Attitude shifts were also associated with the intervention, with a 10% increase in respondents agreeing that domestic violence is not a private matter.

Seven approaches that can make a difference

1. Address the structural dimensions of gender inequity.
2. Challenge gender stereotypes and adopt multilevel strategies to change the norms and practices that directly harm women's health.
3. Reduce the health risks of being a woman or a man by tackling the exposures and vulnerabilities that differ due to gender norms, roles or relationships.
4. Improve health systems' awareness and handling of the problems of women, as both producers and consumers of health care, by improving women's access to health care, and making health systems more accountable to women.
5. Take action to improve the evidence base for policies by changing gender imbalances in both the content and the processes of health research.
6. Take action to make organizations at all levels function more effectively in mainstreaming gender equality and equity and empowering women for health by creating supportive structures, incentives and accountability mechanisms.
7. Support women's organizations which are critical to ensuring that women have the capacity to act and have meaningful influence on policy decisions that impact their lives.

Inclusive policies

- Participation in economic, social, political and cultural relationships are important to people's lives. Policies which focus on particular "excluded" groups miss many of the problems of exclusion and may stigmatize the intended beneficiaries of the policies.

- An alternative approach is for policy to address exclusionary processes, rather than the excluded groups, thereby directing attention to the root causes of social problems.

- Universalist policies are the most successful in reaching disadvantaged and marginalized groups as such policies avoid the problems of social stigma that are inherent in targeting.

- Where policies do follow a targeted approach, measures can be taken to facilitate their uptake (e.g. simplifying eligibility criteria and means tests).

Current policies to address disadvantage and marginalization often focus on particular groups that are defined as being excluded from mainstream society. However, such an approach has significant limitations as a framework for policy development. Identifying certain groups as suffering from disadvantage is unhelpful where large proportions of the population are living in poverty. Furthermore, participation in economic, social, political, and cultural relationships are important to people's lives. Processes which exclude access, participation and relationships in these areas adversely affect health and well-being not just in extreme cases but across the population to different degrees.

An alternative framework for policy development is therefore to consider the exclusionary processes which cause problems rather than to focus on particular groups that are "excluded". Such an approach recognizes a continuum of possible outcomes and that many different groups and individuals can be affected in different ways by the same exclusionary processes. This does not deny the existence of extreme states but it helps avoid the stigmatization inherent in labelling particular groups as excluded.

Perhaps most importantly, such an approach is of practical value to policy-makers because it directs attention towards the root causes of social exclusion rather than having a limited focus on the differential outcomes of specific groups.

In addition to showing the importance of a broader conceptualization of social exclusion, recent evidence highlights a number of important new points for policy-makers to consider when developing policy approaches to reduce social exclusion.

What can be done?

TARGETED POLICIES

Contemporary policies aimed at reversing exclusionary processes are often selective, targeting groups living in poverty and involving some kind of test based on minimum assets, requirement or threshold. Targeted cash transfers or policies providing access to essential services such as health care and education have also improved incomes or service coverage in some contexts. However, such policies also risk increasing the stigmatization of those in receipt of the resources and services. There are also practical drawbacks. Considerable resources tend to be spent on complex administrative systems for policing and monitoring the means test, and there is a high incidence of fraud. Furthermore, differential access to information, complex eligibility rules and stigma all restrict the reach of selective policies, disadvantaging those in most need. Other things being equal, simplifying eligibility criteria and access mechanisms will improve the delivery of targeted policies. Investing resources in promoting access and understanding eligibility for means-tested services will improve their uptake.

"Conditional transfers" are an increasingly popular form of targeted policy whereby a benefit is made contingent on particular behaviours, often in addition to being targeted at certain groups (see Box 10). Conditional transfer programmes can have significant positive impacts in alleviating poverty and improving living standards and health outcomes, but two important limitations should be noted. First, evidence on the need for conditional requirements to motivate behaviour change is often inconclusive. For example, evaluations of South Africa's support grant and of child benefit in the United Kingdom suggest that mothers will spend additional cash on promoting the health and well-being of their children without any

Box 10. The experience of the Programa Bolsa Familia in Brazil

The Programa Bolsa Familia (PBF) is a large-scale national conditional cash transfer programme focusing on low-income families with dependent children. Established in Brazil in 2003, PBF was introduced in the context of universal national health and education services. The programme includes: school registration of children, completion of immunization programmes, attendance at clinics for monitoring the growth and development of children, and attendance at prenatal clinics.

Positive results have been obtained as a result of PBF: 11 million families received a stipend, increasing income on average by 21%, and around 87% reported that family life has been better or much better since receipt of the stipend. There are also some areas for improvement within PBF: while an estimated 90% of the 15 million families registered for PBF met the eligibility criteria, only 79% of them are in receipt of a stipend, and uptake among eligible families is lowest among those on the lowest incomes. Local research has also suggested that the services that must be used in order to meet some of the conditions (particularly schools) are often of poor quality.

conditional requirements. Second, insufficient attention is often given to the quality of the services that are available. For instance, when conditionality refers to participation in the labour market, the quality and sustainability of employment has often been neglected or ignored.

Implementation of conditional transfer programmes will usually benefit from attention to the quality and availability of services required to meet conditionality requirements. It is also advisable to ensure careful monitoring of conditional programmes, as well as to compare with other methods, in view of the uncertainty surrounding the specific value added by setting conditions and the limited nature of the evidence base on effectiveness in some areas and contexts.

UNIVERSAL APPROACHES

The tackling of exclusionary processes through universal approaches is typically found in high-income industrialized countries, but a number of low- and middle- income countries are pursuing similar policies. While there are clearly challenges in funding such systems, these are by far the most successful systems for encouraging increased uptake of, and improved access to, public services. For example, the introduction of comprehensive systems of social protection in Brazil, South Africa and Venezuela has in each case been associated with improved access to services. In Brazil, the conditional cash transfers programme is clearly linked to its universal health-care and national education systems. Better health and educational outcomes also result as additional benefits of such comprehensive programmes. In addition to these practical and quantifiable gains, universal approaches have the important added advantage of promoting social cohesion.

Engaging civil society

➲ Appropriate engagement of target communities in decision-making and policy implementation increases the likelihood that government policies and actions will be appropriate, acceptable and effective.

➲ Actions to address the social determinants of health are generally more effective where such engagement with civil society has taken place, with adequate resources.

➲ National governments can take a number of specific actions to support and derive the most benefit from the contribution of civil society, including:

- systematically involving civil society in policy development, implementation and monitoring;
- providing dedicated resources as part of programme budgets to support ongoing community engagement and empowerment;
- reforming professional education to give greater status to lay and indigenous knowledge;
- encouraging public debate on health matters and supporting the media in holding the system to account.

Box 11. Protection of women from domestic violence in India

India's Protection of Women from Domestic Violence Act was passed in 2005. An early draft in 2002 of India's Domestic Violence Bill had many loopholes, including lack of recourse for a woman who might be thrown out onto the streets by a violent husband if she dared to challenge his use of the law. As a result of strong lobbying by women's groups and effective re-drafting by feminist lawyers, the draft was changed.

The improved Act uses a broad definition of violence to include beating, slapping, punching, forced sex, insults or name-calling and allows abused women to complain directly to judges instead of to the police who usually side with men and rarely act on complaints. Moreover, the Act covers not only wives and live-in partners but also sisters, mothers, mothers-in-law or any other female relation living with a violent man. This is one of the most far-reaching pieces of legislation on domestic violence to date worldwide.

Civil society includes community groups, formal civil society organizations (CSOs) such as labour organizations, indigenous peoples' groups, and other large-scale social movements such as the anti-apartheid movement in South Africa. These actors can play an important role in contributing to the improvement of health equity, particularly if correctly supported and engaged by governments, as has been shown in many different contexts. For example, women's organizations have been at the forefront in generating new and compelling evidence of gender inequality and inequities in health, in experimenting with innovative programmes, in mobilizing political support effectively, and in demanding accountability from governments and the intergovernmental system (see Box 11).

CSOs can also be powerful drivers for broader government action on the social determinants of health in several ways, including by: facilitating social processes and community-led action (including exposing and redressing power imbalances that hamper opportunities for health in disadvantaged groups); monitoring the performance of health systems in line with priorities; providing mechanisms for engaging with marginal groups; supporting the development of social capacities for engaging with bureaucracies and authorities; and engaging with formal local and national political leaders to strengthen political support for social action and participatory processes.

Additionally, community organizations may be best placed to support the delivery of health programmes. With their extensive community networks, civil society groups can organize and implement some projects more effectively (and more efficiently) than would be possible through direct government control. Moreover, considerable evidence suggests that power devolved to communities is more likely to lead to an equitable distribution of resources. Monitoring and assessment of implementation ensures a growing and objective evidence base that incorporates innovations that are often pioneered by civil society.

What can be done?

Systematically involving civil society in policy development, implementation and monitoring can significantly improve policies and the effectiveness of their delivery. Methods to achieve this include, but are not limited to:

- incorporating formal consultation mechanisms into the policy development process;
- expanding the involvement of civil society in governance arrangements;
- legal protection for CSOs;
- allowing CSOs to deliver services in addition to or in partnership with state-run enterprises;
- involving CSOs in research, monitoring and programme evaluation.

Providing dedicated resources as part of programme budgets will ensure support for ongoing community engagement and empowerment. While there is strong evidence that civil society can support and improve health policies, such groups are also likely to lack resources and have a limited base from which to operate. It is therefore important to ensure dedicated financing to support civil society efforts.

Reforming professional education to give greater status to lay and indigenous knowledge can support better and more equitable provision of health care. In many countries the knowledge of lay people, particularly indigenous peoples, is often devalued and ignored, with the consequence that health policies and services are designed without taking into account important cultural, economic and social contexts. Civil society can play a role in better documenting this knowledge and assessing its application in improving health across many sectors. Overlooking lay knowledge can severely inhibit the effectiveness of public services, preventing innovations and potentially discriminating against particular groups.

Encouraging public debate on health and allowing the media to hold the health system accountable supports better health policy. The media have an important role in this area. Powerful synergies have emerged when civil society, public health programmes and the media have joined forces to stimulate and sustain sound national and international public debates (e.g. on infant feeding, essential drugs, tobacco use, or access to HIV treatment). The actions required to support this will vary greatly between countries but an important theme is to work towards increased transparency in health information and governance.

An example programme of action

BUILDING UP HOME-GROWN POLICIES TO REDUCE HEALTH INEQUITIES BY ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

Table 4 summarizes a hypothetical programme of action to reduce health inequities. It is offered not as a specific recommendation of what should be done, as this will vary by country. Rather, it is a demonstration that extensive, specific, evidence-based actions that cover a range of social determinants are possible, and that these can be linked together on the basis of the objectives and enabling mechanisms of each country in order to build up home-grown policies to reduce health inequities.

As highlighted throughout this report, every sector can play a role in improving health equity and, in many instances, doing so will support other social objectives. The dividing line between the health sector and other sectors can vary in each country depending on the mandate of the health sector. The majority of actions outlined here require only limited additional investment of public funds. They do, however, require leadership and concerted action to mobilize private-sector funds and broader civil society engagement.

Table 4. Programme of action to reduce health inequities involving many sectors

COMMISSION* RECOMMENDATION	HEALTH SECTOR	OTHER SECTORS
1. Improve daily living conditions, including the circumstances in which people are born, grow, live, work and age.	**Primary health care** approach adopted as organizational strategy **Public health programmes** HIV and TB programmes set up joint programme board, identify shared objectives on social determinants and build these into local delivery structures **Facilitating intersectoral action** Cabinet committee on health inequities and or social determinants convened and specific objectives agreed with each sector and across government **Social empowerment** Mechanism created for community consultation on health spending	**Early child development** • ECD programme delivered through primary health clinics that offer parents advice on child care • New Cabinet-level committee on early years set up **Urban Settings** • Additional investment in improved water supply and access • Public information campaign on safe indoor fuel alongside investment in new affordable and safe fuel sources • Legislation to regularize tenure of slum-dwellers • Devolving of control of slum upgrading programme (including resources) to community NGOs **Employment** • National employment policies place premium on permanent employment • Legislation to require occupational health worker representation in all workplaces

<table>
<tr>
<td>2. Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions – globally, nationally and locally.</td>
<td>Universal health care
• Advocate for and mobilize increased public funding for health services
• Test and evaluate strategies to extend access to more people and ensure quality of non-state providers
• Expand prepayment of services through pooling of funds, such as through a combination of sources, taxes or health insurance schemes
• Staff in public training programmes altered to reflect diversity and sensitivity to gender issues

Leading intersectoral action
Dedicated unit within Ministry of Health to deal with trade and investment issues</td>
<td>Globalization: focus on trade and investment
• Expand capacity and requirements for health impact assessment of trade policy and foreign investments that incorporate impact on equity and health
• Improved statistics on trade in health services in order to better understand and communicate key trends
• Improved capacities of health officials to engage in trade and investment negotiations and articulate the health consequences of domestic social and economic policies

Gender
• Action programme to increase female education and new laws on equal pay
• Social marketing campaign on addressing domestic violence
• Policy of gender equity integrated throughout government departments

Universal policies
• Gradual phasing-out of means-testing to reach specific population groups, when these are evaluated as inefficient
• Move towards assessing all social and economic policies for health impact ("health in all policies")

Civil society
• Mandatory consultation period for all new policy announcements and earmarked funds to support = engagement
• Shift from awareness on the right to health to concrete mechanisms for different parties to ensure access to health services</td>
</tr>
<tr>
<td>3. Measure and understand the problem and assess the impact of action.</td>
<td colspan="2">Measurement
• All government data routinely broken down by socioeconomic status, sex, age and ethnicity
• Support for disaggregated analysis of existing data from different sources, including national household surveys (16)
• Dedicated unit created within the Ministry of Health to promote and support all ministries in using health impact assessments that integrate equity analysis, including gender equity and sex-disaggregated data
• Support for monitoring and evaluation of innovative interventions implemented in partnership with civil society, in health and other sectors, that address social determinants of health
• Funds earmarked to pay for analysis of impact of all new policies on social determinants of health</td>
</tr>
</table>

*Commission on Social Determinants of Health

Questions and next steps

The following questions may be helpful in facilitating policy dialogue and debate in countries about the appropriate next steps in developing policy options and opportunities to reduce health inequities:

WHO ARE THE OTHER IMPORTANT ACTORS IN THIS AREA?

This document has focused almost exclusively on the opportunities for action at government level, but success regarding improving health equity and addressing the social determinants of health will require action at multiple levels, including by communities, local governments, and regional, national and global authorities. The Commission's report *(1)* provides recommendations for action at each of these levels and this detailed set of potential actions may provide helpful inputs to policy and action. For instance, consultations involving participation of communities and affected population sub-groups also help identify starting points for specific interventions to reduce health inequities.

WHAT ARE THE OTHER IMPORTANT SOCIAL DETERMINANTS?

While each of the areas discussed in this document is critically important, they do not represent a comprehensive list of topics or government policies which may impact on health and its distribution within a country. In each area, there will be important matters of context to consider in setting policy. The use of health impact assessments as inputs to policy dialogue and programme design would be one way to provide a tool for evaluating major new government policies and programmes and for incorporating the consideration of equity and social determinants, ensuring that important effects are not missed.

WHAT ARE SPECIAL CONSIDERATIONS FOR COUNTRIES WITH MINIMAL RESOURCES AND CHALLENGING CONTEXTS?

The options for policies and actions are based on experiences in low-, middle- and high-income countries. Nevertheless, the options for the least economically developed countries are likely to depend particularly heavily on external donor support, given the likely context of weaker human resources and higher economic vulnerability in comparison to other countries. Aligning country-specific frameworks for action with health systems strengthening is one means to increase consistency in donor investments and coordination. Another is to adapt models from other relevant frameworks. For example, the World Trade Organization's *Integrated framework of action for the least developed countries (17)* begins to address issues of market access, special and differential treatment provisions, and participation in the multilateral trading system, among other areas. Moreover, combining international frameworks with tools that can be used within individual countries to support the development of home-grown policies and strategies, such as those addressing a range of social determinants (e.g. employment, gender, trade) can offer a mechanism to address social determinants of health in a coordinated and country-specific way.

WHERE ARE THE KEY POINTS OF OPPOSITION IN THE SYSTEM?

There will inevitably be opposition to any new policies in some quarters. Economic concerns, vested interests, opposition from professional groups or other ideologies may present barriers to implementation of a programme of action. These elements can usually be overcome through a combination of dialogue, negotiation, advocacy and control. A WHO book on mediation and conflicts may be a useful tool for policy-makers *(18)*.

WHAT ARE THE EXISTING POLICIES IN THIS AREA? HAVE THEY BEING EVALUATED AND CAN THEY BE SCALED UP?

The material in this document is intended to support policy-makers in building on existing policies. In many contexts it will be easier to build on and scale up existing policies than to develop new ones. One important step is to share and review implementation frameworks developed in different sectors; another is to support innovative research, as well as ongoing monitoring and evaluation that contributes to a growing national and global evidence base in this area.

WHAT ARE THE MAIN SYSTEMS FOR CROSS-GOVERNMENT WORKING AND DO THEY NEED TO BE STRENGTHENED?

As noted in Section 1 and elsewhere in this document, the coordination of intersectoral action can benefit from institutionalizing tools and instruments (see Box 12). An international conference on "health in all policies" in 2010 reached consensus *(19)* that policies that support health for cross-government policy and action work best when: there is a clear mandate that makes joined-up government an imperative; systematic processes take account of interactions across sectors; mediation occurs across interests; accountability, transparency and participatory processes are present; engagement occurs with stakeholders outside of government; and practical cross-sector initiatives build partnerships and trust by considering the benefits for other sectors.

WHAT ARE THE IMPLICATIONS FOR THE WORKFORCE?

The readiness of the workforce is one of the key elements of action in order to make programmes operational that aim to reduce health inequities and address social determinants of health, and is also one of the key building blocks identified by WHO in efforts to strengthen health systems *(20)*. An audit of skills and capacity, not only in the Ministry of Health but elsewhere, can help prepare for action.

WHAT NEW EVIDENCE IS THERE FROM WITHIN THE COUNTRY?

The aim is to encourage national policy-makers and technical experts to understand and incorporate evidence from their own country. This is a powerful way to guide the development of new policy options or support the evaluation of implemented policies. A recent framework *(21)* for analysing public policies outlines four steps on how to do so:

1. Compile an inventory of public policies that could address the targeted health problem, and choose the policy on which the knowledge synthesis will focus.
2. Make explicit the intervention logic (logic model) – i.e. the sequence of effects expected to link the policy under study to the targeted problem.
3. Conduct a literature review and synthesize data on the effects of this policy in contexts in which it has already been implemented (effectiveness, unintended effects, effects related to equity) and on the issues related to its implementation (cost, feasibility, acceptability).
4. Enrich and contextualize the data drawn from the literature through deliberative processes that bring together actors and stakeholders who are concerned with the health problem or its determinants, and are working within the context where the policy was implemented.

HOW CAN THIS KNOWLEDGE BE TRANSLATED INTO AN ACTIONABLE AGENDA?

Building on a commitment that all people should have equal opportunities to improve or maintain their health, evidence from within the country can be combined with global evidence on potential policy and programme options. Objective information on different options for action and consultation with a wide range of stakeholders, can build up an action agenda – whether aiming for fundamental changes or simply fine tuning existing strategies. This report provides many examples of policy options and opportunities for action, within the health sector and in other sectors. Monitoring, evaluation and reporting on how policies and actions are implemented, and their impact on health equity, will also provide further evidence on what works to improve health equity.

Box 12. Tools and instruments that have shown to be useful at different stages of the policy cycle:

- interministerial and interdepartmental committees
- community consultations and "citizens' juries"
- cross-sector action teams
- partnership platforms
- integrated budgets and accounting
- cross-cutting information and evaluation systems
- impact assessments
- joined-up workforce development
- legislative frameworks

Source: Adelaide statement on health in all policies, 2010 *(19)*.

The Knowledge Network reports

Available at: www.who.int/social_determinants/themes/en

Benach J, Muntaner C, Santana V. *Employment conditions and health inequalities.* (Final report of the Employment Conditions Knowledge Network of the Commission on Social Determinants of Health). Geneva, World Health Organization, 2007.

Blas E, Sivasankara Kurup A (eds.) with inputs and contributions from the members of the Knowledge Network. *Equity, social determinants and public health programmes.* (Final report of the Priority Public Health Conditions Knowledge Network of the Commission on Social Determinants of Health). Geneva, World Health Organization, 2010.

Bonnefoy J et al. *Constructing the evidence base on the social determinants of health: a guide.* (Report of the Measurement and Evidence Knowledge Network of the Commission on Social Determinants of Health). Geneva, World Health Organization, 2007.

Gilson L et al. *Challenging inequity through health systems.* (Final report of the Health Systems Knowledge Network of the Commission on Social Determinants of Health). Geneva, World Health Organization, 2007.

Irwin LG, Siddiqi A, Hertzman C. *Early child development: a powerful equalizer.* (Final report of the Early Child Development Knowledge Network of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2007.

Kelly MP et al. *The social determinants of health: developing an evidence base for political action.* (Final report of the Measurement and Evidence Knowledge Network of the Commission on Social Determinants of Health). Geneva, World Health Organization, 2007.

Kjellstrom T et al. *Our cities, our health, our future: acting on social determinants for health equity in urban settings.* (Final Report of the Urban Settings Knowledge Network of the Commission on Social Determinants of Health). Geneva, World Health Organization, 2007.

Labonté R et al. *Towards health-equitable globalization: rights, regulation and redistribution.* (Final Report of the Globalization Knowledge Network of the Commission on Social Determinants of Health). Geneva, World Health Organization, 2008.

Popay J et al. *Understanding and tackling social exclusion.* (Final Report of the Social Exclusion Knowledge Network of the Commission on Social Determinants of Health). Geneva, World Health Organization, 2008.

Sen G, Östlin P, George A. *Unequal, unfair, ineffective and inefficient . Gender inequity in health: why it exists and how we can change it.* (Final Report of the Women and Gender Equity Knowledge Network to the WHO Commission on Social Determinants of Health). Bangalore and Stockholm, Indian Institute of Management and Karolinska Institutet, 2007.

Siddiqi A, Irwin LG, Hertzman C. *Total environment assessment model for early child development: evidence report.* (Report of the Early Child Development Knowledge Network of the Commission on Social Determinants of Health). Geneva, World Health Organization, 2007.

Commission on Social Determinants of Health Knowledge Networks, Lee JH, Sadana R, eds. *Improving equity in health by addressing social determinants.* Geneva, World Health Organization, 2011 (http://whqlibdoc.who.int/publications/2011/9789241503037_eng.pdf , accessed 1 June 2012).

References

1. Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health.* Geneva, World Health Organization, 2008. Available at: http://www.who.int/social_determinants/thecommission/finalreport/en/index.html (accessed 16 April 2012).

2. Lönnroth K et al. Drivers of tuberculosis epidemics: the role of risk factors and social determinants. *Social Science and Medicine,* 2009, 68:2240–2246.

3. *World health report, 2008.* Geneva, World Health Organization, 2008.

4. Manandhar DS et al. Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trail. *The Lancet,* 2004, 364:970−979.

5. Engle PF et al. Strategies for reducing inequalities and improving developmental outcomes for young children in low-income and middle-income countries. *The Lancet,* 2011, 378:1339−1353.

6. UN-HABITAT has documented more than 1700 initiatives from across the world aimed at improving the urban environment. Available at: http://www.unhabitat.org/content.asp?typeid=19&catid=34&cid=10256 (accessed 1 June 2012).

7. *Divided we stand: why inequality keeps rising.* Paris, Organisation for Economic Co-operation and Development, 2011 Available at: http://www.oecd.org/document/51/0,3746,en_2649_33933_49147827_1_1_1_1,00.html (accessed 16 April 2012).

8. Addison T, Arndt C, Tarp F. The triple crisis and the global aid architecture, Working Paper 2010/01. Helsinki, United Nations University/World Institute for Development Economics Research, 2010. Available at: http://www.wider.unu.edu/publications/working-papers/2010/en_GB/wp2010-01/_files/82784791381278751/default/2010-01.pdf (accessed 16 April 2012).

9. Hawkes C et al. (eds). *Trade, food, diet and health: perspectives and policy options.* Oxford, Wiley Blackwell, 2010.

10. *Declaration on fundamental principles and rights at work. Adopted by the International Labour Conference, Eighty-sixth Session, Geneva, 18 June 1998* (Annex revised 15 June 2010). Geneva, International Labour Organization, 1998. Available at: http://www.ilo.org/declaration/thedeclaration/textdeclaration/lang--en/index.htm (accessed 16 April 2012).

11. Shaffer ER, Brenner JE. A trade agreement's impact on access to generic drugs. *Health Affairs,* 2009, 28(5): w957−w968.

12. Smith RD, Correa C, Oh C. Trade, TRIPS, and pharmaceuticals. *The Lancet,* 2009, 373(9664):684−691.

13. Artazcoz L et al. Social inequalities in the impact of flexible employment on different domains of psychosocial health. *Journal of Epidemiology and Community Health,* 2005, 59(9):761−767.

14. The World Bank. *The global burden of disease and risk factors.* New York, NY, Oxford University Press, 2006. Available at: http://www.dcp2.org/pubs/GBD (accessed 1 June 2012).

15. *The global burden of disease: 2004 update.* Geneva, World Health Organization, 2008. Available at: http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html (accessed 1 June 2012).

16. National and regional analyses are encouraged. For example, see the report *Health inequities in the South-East Asia Region: selected country case studies.* New Delhi, World Health Organization Regional Office for South-East Asia, 2009. Available at: http://203.90.70.117/PDS_DOCS/B4288.pdf (accessed 16 April 2012).

17. *An integrated framework for trade-related technical assistance, including for human and institutional capacity building, to support least-developed countries in their trade and trade-related activities.* Document WT/LDC/HL/1/Rev.1. Geneva, World Trade Organization, 1997. Available at: http://www.wto.org/english/tratop_e/devel_e/framework.htm (accessed 16 April 2012).

18. Drager N, McClintock E, Moffitt M. *Negotiating health development: a guide for practitioners.* Cambridge, MA, and Geneva, Conflict Management Group and the World Health Organization, 2000.

19. *Adelaide statement on health in all policies: moving towards a shared governance for health and well-being. Report from the International Meeting on Health in All Policies, Adelaide 2010.* Adelaide and Geneva, Government of South Australia and the World Health Organization, 2010. Available at: http://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf (accessed 16 April 2012).

20. *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action.* Geneva, World Health Organization. 2007. Available at: http://www.who.int/healthsystems/strategy/everybodys_business.pdf (accessed 16 April 2012).

21. Morestin F et al. *Method for synthesizing knowledge about public policies.* Montreal, National Collaborating Centre for Healthy Public Policy/Institut national de santé publique du Québec, 2010. Available at: http://www.ncchpp.ca/172/publications.ccnpps?id_article=536 (accessed 16 April 2012).

Photo credits

Cover	Shoeb Faruquee/awarded photograph in WHO photo contest "Images of Health and Disability 2007" www.who.int/classifications/icf
p 4	© Irene R. Lengui/L'IV Com Sàrl
p 10	WHO/Christopher Black
p 12	WHO Bulletin/Pharmaccess
p 14	© Fabienne Pompey/IRIN
p 15	© UNICEF/NYHQ2006-0779/Noorani
p 18	© Siegfried Modola/IRIN
p 21	WHO/Onasia/Vinai Dithajohn
p 23	UNAIDS
p 25	UN Photo/Eskinder Debebe
p 28	WHO/ Harold Ruiz
p 31	IARC/Roland Dray
p 34	Daniel Hayduk/IRIN
p 38	Shoeb Faruquee/ awarded photograph in WHO photo contest "Images of Health and Disability 2007" www.who.int/classifications/icf
p 41	UNICEF/ HQ05-2388/Anita Khemka
p 44	WHO /Pierre Virot
p 47	UN Photo/Rossana Fraga
P 49	UN Photo/Luiz Roberto Lima

World Health Organization
20, avenue Appia
CH-1211 Geneva 27
Switzerland

http://www.who.int

ISBN 978 92 4 150517 8