Annex 2

CLOSING THE GAP:
POLICY INTO PRACTICE ON SOCIAL DETERMINANTS OF HEALTH

| DISCUSSION PAPER |

All for Equity

World Conference on Social Determinants of Health

RIO DE JANEIRO | BRAZIL | 19–21 OCTOBER 2011

World Health Organization

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Acknowledgements

Closing the gap: policy into practice on social determinants of health: Discussion paper for the World Conference on Social Determinants of Health was produced under the overall direction of Rüdiger Krech (Director). The principal writer and editor was Kumanan Rasanathan. Funding to assist in the preparation and production of this discussion paper was received from the Government of Brazil.

Significant contributions in the form of text, figures, and boxes were provided by Carmen Amela Heras, Ilona Kickbusch, Bernardo Kliksberg, Taru Koivisto, Jennifer Lee, Rene Loewenson, Belinda Loring, Miranda MacPherson, Michael Marmot, Don Matheson, Lorena Ruano, Victoria Saint, Jeanette Vega, and David Woodward.

Key inputs and peer review for drafts of the discussion paper were provided by the Advisory Group, the Organizing Committee and WHO Regional Focal Points for the World Conference on Social Determinants of Health. The members of these groups included Silvio Albuquerque, Carmen Amela Heras, Mohammed Assai, Eduardo Barbosa, Anjana Bhushan, Jane Billings, Paulo Buss, Nils Daulaire, Maria Luisa Escorel, Kira Fortune, Luiz A. C. Galvão, Suvajee Good, Ilona Kickbusch, Bernardo Kliksberg, Taru Koivisto, Rüdiger Krech, Michael Marmot, Alvaro Matida, Malebona Precious Matsoso, Abdi Momin, Davison Munodawafa, Jai Narain, Luiz Odorico, Rômulo Paes de Sousa, Alberto Pellegrini, Felix Rigoli, Carlos Santos-Burgoa, Tone Torgersen, Agis Tsouros, Eugenio Villar Montesinos, Susan Watts, and Erio Ziglio.

Valuable comments, suggestions, criticisms, and assistance were also received from Daniel Albrecht, Francisco Armada, Alanna Armitage, Jim Ball, Leopold Blanc, Ashley Bloomfield, Ludo Bok, Josiane Bonnefoy, Matthias Braubach, Danny Broderick, Chris Brown, Kevin Buckett, Andrew Cassels, Genevieve Chedeville-Murray, Maggie Davies, Barbara de Zalduondo, Marama Ellis, Sharon Friel, Michelle Funk, Peter Goldblatt, Volker Hann, Patrick Kadama, Rania Kawar, Meri Koivusalo, Theodora Koller, Jacob Kumaresan, Ronald Labonté, Eero Lahtinen, Pierre Legoff, Michael Lennon, Margot Lettner, Bridget Lloyd, Knut Lönnroth, Brian Lutz, Peter Mamacos, Nanoot Mathurapote, Hooman Momen, Davide Mosca, Carles Muntaner, Benjamin Nganda, Monireh Obbadi, Eeva Ollila, Jeffrey O'Malley, Cyril Pervilhac, Maravand Pinto, Sandy Pitcher, Amit Prasad, Mario Raviglione, Marilyn Rice, Katja Rohrer, Ana Lucia Ruggiero, Xenia Scheil-Adlung, Gerard Schmets, Ted Schrecker, Claudio Schuftan, Hani Serag, Alaka Singh, Anand Sivasankara Kurup, Zsofia Szilagyi, Martin Tobias, Peter Tugwell, Nicole Valentine, Vivian Welch, Deborah Wildgoose, Carmel Williams, Holly Wong, Ilcheong Yi, and Hongwen Zhao.

Further valuable contributions were gratefully received through the submissions made to WHO during the public web consultation held on the first draft of this discussion paper during May and June 2011. The discussion paper also strongly builds on the prior work of the Commission on Social Determinants of Health.

Editorial production and the public consultation were managed by Victoria Saint. The paper was copy edited by Julie McCoy.

Administrative support in the preparation of the discussion paper was provided by Nathalie Chenavard, Lucy Mshana, Susanne Nakalembe, Joyce Oseku and Nuria Quiroz.

WHO Library Cataloguing-in- Publication Data

Closing the gap : policy into practice on social determinants of health : discussion paper.

"This discussion paper aims to inform proceedings at the World Conference on Social Determinants of Health [Rio de Janeiro, Brazil 19-21 October, 2011]"

1.Socioeconomic factors. 2.Health care rationing. 3.Health services accessibility. 4.Patient advocacy. I.World Health Organization.

ISBN 978 92 4 150240 5 (NLM classification: WA 525)

Design and layout: paprika-annecy.com

Photo credits: Assistant Director-General's photograph: WHO (p. vii); executive summary: Craig Cloutier, Creative Commons (p. 4); conceptual basis: DVIDSHUB, Creative Commons (p. 8); chapters 1-5: Zoltan Balogh (p. 11); McKay Savage, Creative Commons (p. 16); © Triangle, Creative Commons (p. 17); © WHO/Harold Ruiz (p. 23); hdptcar, Creative Commons (p. 24); Jakob Montrasio, Creative Commons (p. 29); Zoltan Balogh (p. 32); © OCHA, Creative Commons (p. 35); © WHO/Tom Pietrasik (p. 38); conclusion: © Pierre Holtz/UNICEF, Creative Commons (p. 43).

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Printed in Brazil

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FOREWORD

In the time it takes to read this discussion paper, hundreds of people will die needlessly as a result of health inequities – unfair and avoidable or remediable differences in health outcomes between different population groups. Health inequities cause unnecessary suffering and result from adverse social conditions and failing public policies. These inequities are sentinels of the same factors that undermine development, environmental sustainability, the well-being of societies, and societies' capacity to provide fair opportunities for all. Health inequities are a problem for all countries and reflect not only differences in income and wealth, but also differences in opportunity on the basis of factors such as ethnicity and racism, class, gender, education, disability, sexual orientation, and geographical location. These differences have profound consequences and represent the impact of what we know as social determinants of health.

Yet health inequities, by definition, are not inevitable. Millions of people need not die of preventable causes each year. In 2008, the WHO Commission on Social Determinants of Health compiled recommendations to create an extensive prescription of what is required to "close the gap" through action on social determinants across all sectors of society. After considering the Commission's report at the 2009 World Health Assembly, Member States resolved to put these recommendations into practice, adopting Resolution 62.14, "Reducing health inequities through action on the social determinants of health."

Accordingly, many countries are implementing action on social determinants, with encouraging progress in reducing health inequities in a few cases. In recent years, many countries have taken important steps in moving towards universal coverage of health care. There is improved understanding of the contribution of health to other goals such as social cohesion and economic development, along with the need to coordinate the efforts of different sectors in improving health. More countries are disaggregating data to uncover health inequities masked by national averages. There is, however, a need to build upon and accelerate these efforts. Since the launch of the Commission's report in 2008, the world has faced a number of crises that have exacerbated global health inequities. Therefore, it is urgent that we — in governments, in civil society, in the private sector, and in international organizations — redouble our efforts to act on social determinants to address health inequities.

In this context, the World Conference on Social Determinants of Health represents a tremendous opportunity. This discussion paper aims to inform the proceedings and contribute to fulfilling the purpose of the World Conference, as mandated by Resolution 62.14: to share experiences on how to address the challenges posed by health inequities and to mobilize commitment to the urgent implementation of feasible actions on social determinants in all countries. The paper does not provide a blueprint, but instead lays out the key components that all countries need to integrate in their own context in implementing a social determinants approach. The discussions at the World Conference will further consider these themes and show how, in all contexts, it is possible to put policy into practice on social determinants of health to improve health, reduce health inequities, and promote development.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
Commission	Commission on Social Determinants of Health
CSO	Civil Society Organization
DHS	Demographic and Health Survey
EU	European Union
GDP	Gross Domestic Product
GNP	Gross National Product
HIA	Health Impact Assessment
HiAP	Health in All Policies
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
ISA	Intersectoral Action
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
NCDs	Noncommunicable Diseases
NZDep	New Zealand Deprivation Index
OECD	Organization for Economic Cooperation and Development
Social determinants	Social Determinants of Health
SPF-I	Social Protection Floor Initiative
UHC	Universal Health Coverage
UN	United Nations
UNASUR	Union of South American Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
Urban HEART	Urban Health Equity Assessment and Response Tool
WHO	World Health Organization
World Conference	World Conference on Social Determinants of Health

EXECUTIVE SUMMARY

This discussion paper aims to inform proceedings at the World Conference on Social Determinants of Health ("World Conference") about how countries can implement action on social determinants of health ("social determinants"), including the recommendations of the Commission on Social Determinants of Health ("the Commission"). Evidence from countries that have made progress in addressing social determinants and reducing health inequities shows that action is required across all of five key building blocks, which have been selected as the five World Conference themes:

1. Governance to tackle the root causes of health inequities: implementing action on social determinants of health;
2. Promoting participation: community leadership for action on social determinants;
3. The role of the health sector, including public health programmes, in reducing health inequities;
4. Global action on social determinants: aligning priorities and stakeholders;
5. Monitoring progress: measurement and analysis to inform policies and build accountability on social determinants.

While relevant action needs to be adapted to the specific needs and context of each country, together these components represent the constituent parts of a "social determinants approach" reflecting the need for action on social determinants to be undertaken across society.

Both this discussion paper and the World Conference will build on the extensive work of the Commission, as endorsed in World Health Assembly Resolution 62.14. The proposed focus is on how to implement the Commission's recommendations (see Table 1), which were grouped under three goals: to improve daily living conditions; to tackle the inequitable distribution of power, money, and resources; and to measure and understand the problem and assess the impact of action.

Conceptual basis and rationale for action on social determinants

The bulk of the global burden of disease and the major causes of health inequities, which are found in all countries, arise from the conditions in which people are born, grow, live, work, and age. These conditions are referred to as *social determinants of health*, a term used as shorthand to encompass the social, economic, political, cultural, and environmental determinants of health. The most important determinants are those that produce stratification within a society — *structural* determinants — such as the distribution of income, discrimination (for example, on the basis of gender, class, ethnicity, disability, or sexual orientation), and political and governance structures that reinforce rather than reduce inequalities in economic power. These structural mechanisms that affect the social positions of individuals constitute the root cause of inequities in health. The discrepancies attributable to these mechanisms shape individual health status and outcomes through their impact on intermediary determinants such as living conditions, psychosocial circumstances, behavioural and/or biological factors, and the health system itself.

The rationale for action on social determinants of health rests on three broad themes. First, it is a moral imperative to reduce health inequities. Second, it is essential to improve health and well-being, promote development, and reach health targets in general. Third, it is necessary to act on a range of societal priorities — beyond health itself — that rely on better health equity.

Political considerations in implementing action on social determinants

Poor progress in the implementation of a social determinants approach reflects in part the inadequacy of governance at the local, national, and global levels to address the key problems of the 21st century. Health inequities challenge the traditional division of societies and their governments into sectors for organizational purposes. Rather than such divisions, the reduction of these inequities demands coherent policy responses across sectors and across countries, with firm political commitment by all parties. General principles, which must be adapted to each country's needs and context, can be identified for overcoming the political and technical obstacles to action on social determinants. First, action on social determinants to reduce health inequities requires long-term, sustained implementation. Benefits can become apparent in the short term, however, and the sooner countries start to implement a social determinants approach, the better. Second, the initial step is to build public understanding of health inequities and social determinants of health. Third, equitable health and well-being need to be placed as a priority goal for government and broader society. Fourth, ensuring coordination and coherence of action on social determinants is essential. Fifth, a social determinants approach cannot be a "programme" that is rolled out, but rather requires a holistic approach incorporating all of the five building blocks applied across society.

Priority strategies for implementing action on social determinants of health

Priority strategies for action can be identified in each of the five building blocks:

1. Governance to tackle the root causes of health inequities

Build good governance for action on social determinants. Coherent policy responses to reduce health inequities require establishing governance that clarifies the individual and joint responsibilities of different actors and sectors (for example, the roles of individuals, different parts of the state, civil society, multilateral agencies, and the private sector) in the pursuit of health and well-being as a collective goal linked to other societal priorities. UNDP's five principles of good governance (legitimacy, vision and strategic direction, performance, accountability, and equity and fairness of processes) are useful in framing what is required.

Implement collaborative action between sectors ("intersectoral action"). Many necessary policies for action on social determinants require intersectoral action. Successful implementation of intersectoral action requires a range of conditions, including the creation of a conducive policy framework and approach to health; an emphasis on shared values, interests, and objectives among partners; the ability to ensure political support and build on positive factors in the policy environment; the engagement of key partners at the outset, with a commitment to inclusivity; sharing of leadership, accountability, and rewards among partners; and facilitation of public participation.

2. Promoting participation

Create the conditions for participation. The governance required to act on social determinants is not possible without a new culture of participation. The essential elements are institutionalizing formal, transparent, and public mechanisms through which civil society organizations can contribute to policy development; providing resources for participation in the form of incentives and subsidies; considering the impact of previous policies and practices on the ability of communities to participate; and building knowledge and capacity by providing accessible information and training for all stakeholders.

Broker participation and ensure representativeness. Governments have a role in brokering participation with the aim of facilitating empowerment, in working towards equitable public representation through targeted mechanisms to reach underrepresented groups, and in ensuring the legitimacy and addressing conflicts of interest of those who claim to be community representatives.

Facilitate participation by civil society. Governments can facilitate the key role of civil society by formalizing civil society organization involvement in policy-making (particularly in ensuring accountability), encouraging "shadow reports", and recognizing the potential for civil society organizations to provide data to inform policy-making.

3. The role of the health sector, including public health programmes, in reducing health inequities

Execute the health sector's role in governance for social determinants. There are four broad, interrelated functions through which the health sector can make a useful contribution to governance for action on social determinants: advocating for a social determinants approach and explaining how this approach is beneficial across society and for different sectors; monitoring health inequities and the impact of policies on social determinants; bringing sectors together to plan and implement work on social determinants; and developing capacities for work on social determinants.

Reorient health care services and public health programmes to reduce inequities. Health care service providers in all sectors need to contribute to reducing health inequities by measuring how existing services perform through the continuum of care for different population groups; addressing factors that cause differential performance (for example, funding, location, and timing of services and the competencies and attitudes of health workers); and working with other sectors to address other barriers.

Institutionalize equity into health systems governance. Governments can reform health system governance through a primary health care approach towards a publicly led system, with equity as an institutionalized priority. The aim must be to move towards universal health care coverage that is accessible, affordable, available, equitable, and of good quality for all and that is funded through taxation, social insurance, or another prepayment pooling mechanism.

4. Global action on social determinants: aligning priorities and stakeholders

Align global stakeholders and priorities. Given the interconnectedness of the modern world, national action on social determinants is not sufficient. International organizations, nongovernmental agencies, and bilateral cooperation partners need to align their efforts on social determinants broadly with those of national governments. There is also a need for better alignment among global priorities. For example, the challenges of achieving the MDGs, building social protection, addressing climate change, and tackling noncommunicable diseases are closely linked. All require action on social determinants and have impacts on health inequities. In addressing these challenges, national governments, international organizations, nongovernmental agencies, and bilateral cooperation partners can strive for coherence among global governance endeavours (including international agreements) in a manner that promotes a social determinants approach. This effort needs to be underpinned by a consistent focus on equity, with the positioning of health equity as an overarching development goal for all sectors.

5. Monitoring progress: measurement and analysis to inform policies and build accountability on social determinants

Identify sources, select indicators, collect data, and set targets. Effective action on social determinants requires monitoring and measurement to inform policy-making, evaluate implementation, and build accountability. Inequities in health outcomes, social determinants, and the impact of policies must be monitored. Key requirements are collecting and monitoring indicators of social determinants from different sectors, linking with health outcomes, and monitoring inequities; establishing whole-of-society targets towards the reduction of health inequities; and disaggregating data to better understand baseline levels and potential impacts of policies.

Move forward despite unavailability of systematic data. In many settings, the availability of data for integrated action on social determinants is poor. However, lack of data is not an excuse for inaction. By making use of surveys and of input from communities and civil society organizations and by prioritizing the strengthening of systems to capture the most vital required data, governments can develop policies that are reflective of population needs and informed by the best available information.

Disseminate data on health inequities and social determinants, and integrate these data into policy processes. The existence of data by itself does not automatically translate into action. Rather, data must be formulated so that different audiences can use it and must be linked to the policy-making process. To ensure that data catalyse action on social determinants, governments and academic institutions can institutionalize mechanisms to integrate analysis of social determinants into the policy development process in order to develop evidence-informed policies; improve sharing of information across sectors; and conduct health and equity assessments of all policies before implementation, using tools such as health impact assessment.

Table 1. Summary of recommendations of the Commission on Social Determinants of Health[1]

1. Improve Daily Living Conditions

- Improve the well-being of girls and women and the circumstances in which their children are born
  - Strongly emphasize early childhood development and education for both girls and boys
- Manage urban development
  - Increase the availability of affordable housing
  - Invest in urban slum upgrading, especially provision of clean water, sanitation, electricity, and paved streets
- Ensure that urban planning promotes healthy and safe behaviours equitably
  - Promote walking, cycling, and the use of public transport
  - Undertake retail planning to manage access to unhealthy foods
  - Implement good environmental design and regulatory controls (e.g. the number of alcohol outlets)
- Ensure that policy responses to climate change consider impacts on health equity
- Make full and fair employment a shared objective of international institutions and a central part of national policy agendas and development strategies
  - Strengthen representation of workers in the creation of employment policy, legislation, and programmes
- Use international agencies to support countries' efforts to protect all workers
  - Implement core labour standards for formal and informal workers
  - Develop policies to ensure a balanced work–home life
  - Reduce negative effects of insecurity among workers in precarious work arrangements
- Progressively increase social protection systems
  - Ensure that systems include those in precarious work situations, including informal work and household or care work
- Build quality health care services with universal coverage, focusing on a primary health care approach
  - Strengthen public sector leadership in equitably financing health care systems and ensuring universal access to care regardless of ability to pay
  - Redress health brain-drain, focusing on investment in increased health-related human resources and training and on bilateral agreements to regulate gains and losses

2. Tackle the Inequitable Distribution of Power, Money, and Resources

- Place responsibility for action on health and health equity at the highest level of government and ensure its coherent consideration across all policies
  - Assess the impact of all policies and programmes on health and health equity
- Strengthen public finance for action on social determinants of health
- Increase global aid towards the 0.7% target of GNP and expand the Multilateral Debt Relief Initiative
- Develop coherent social determinants of health focus in Poverty Reduction Strategy Papers
- Institutionalize consideration of health and health equity impact in national and international economic agreements and policy-making
- Reinforce the primary state role for basic services essential to health (such as water/sanitation) and regulation of goods and services with a major impact on health (such as tobacco, alcohol, and food)
- Create and enforce legislation that promotes gender equity and makes discrimination on the basis of gender illegal
- Increase investment in sexual and reproductive health services and programmes, building towards universal coverage and rights
- Strengthen political and legal systems
  - Protect human rights
  - Assure legal identity and support the needs and claims of marginalized groups, particularly Indigenous Peoples
- Ensure fair representation and participation of individuals and communities in health-related decision-making
- Facilitate the role of civil society in the realization of political and social rights affecting health equity
- Make health equity a global development goal

3. Measure and Understand the Problem and Assess the Impact of Action

- Ensure routine monitoring systems for health equity locally, nationally, and internationally
  - Ensure that all children are registered at birth
  - Establish national and global health equity surveillance systems
- Invest in generating and sharing new evidence on social determinants and health equity and on effectiveness of measures
  - Create dedicated budget for generation and global sharing of evidence
- Provide training on social determinants of health to policy actors, stakeholders, and practitioners, and invest in raising public awareness
  - Incorporate social determinants of health into medical and health training
  - Train policy-makers and planners in health equity impact assessment
  - Strengthen capacity within WHO to support action on social determinants

INTRODUCTION

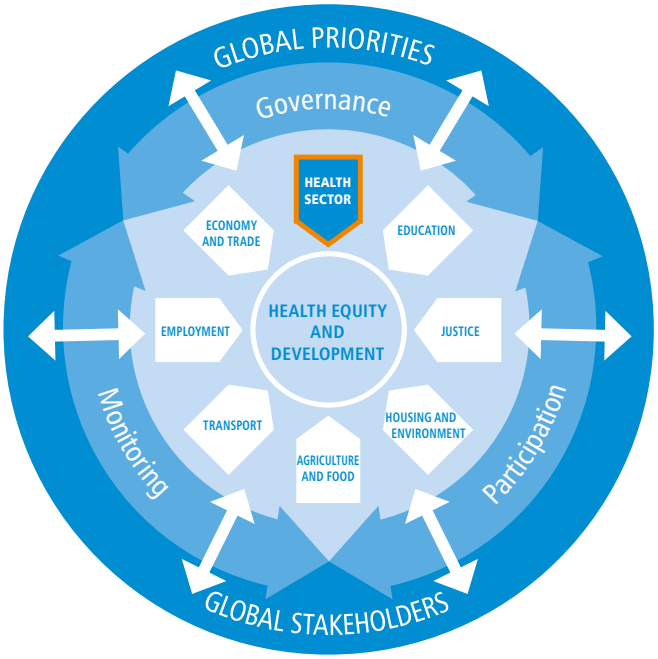
This discussion paper aims to inform proceedings at the World Conference on Social Determinants of Health ("World Conference") about how countries can implement action on social determinants of health ("social determinants"), including the recommendations of the Commission on Social Determinants of Health ("the Commission") (Table 1).[1] The paper is organized into three sections. First, it explains the conceptual basis of the social determinants and establishes why the implementation of coherent policy responses is essential to development, to progress in alleviating health inequities, and to other national and global priorities. Second, it addresses some of the political challenges that will be faced in moving forward on social determinants and that will need to be considered by the World Conference in leading up to the "Rio Declaration" — a commitment for action — and in subsequently implementing action. Third, it aims to provide a relatively technical overview of how to implement action on social determinants of health, highlighting key strategies based on the five World Conference themes:

1. Governance to tackle the root causes of health inequities: implementing action on social determinants of health;
2. Promoting participation: community leadership for action on social determinants;
3. The role of the health sector, including public health programmes, in reducing health inequities;
4. Global action on social determinants: aligning priorities and stakeholders;
5. Monitoring progress: measurement and analysis to inform policies and build accountability on social determinants.

These five closely interrelated themes (Figure 1) have been selected because they emphasize key mechanisms by which countries can incorporate action on social determinants into policy goals and can implement such policies in all sectors. Evidence from countries that have made progress shows that holistic action is required on all of these themes, which together represent the building blocks for a "social determinants approach", reflecting the need for action on social determinants across society. The inclusion of a separate theme on the role of the health sector is not intended to diminish the vital role of other sectors, but reflects the large health-sector constituency expected at the World Conference and highlights some of this sector's key responsibilities.

The primary audience for this paper consists of policy-makers at the national level. Other audiences who may find this document useful include municipal leaders, civil society groups, multilateral agencies, and bilateral development agencies. Both this paper and the World Conference will build on the extensive work of the Commission, as endorsed in World Health Assembly Resolution 62.14,[2] and on the substantial body of literature on social determinants. In line with its length and scope, the paper focuses on how the Commission's recommendations can be implemented rather than extensively considering specific issues or health conditions or repeating in detail what the Commission has already established (particularly, for example, on the causes of health inequities).

Figure 1. The relationship of the five themes of the World Conference



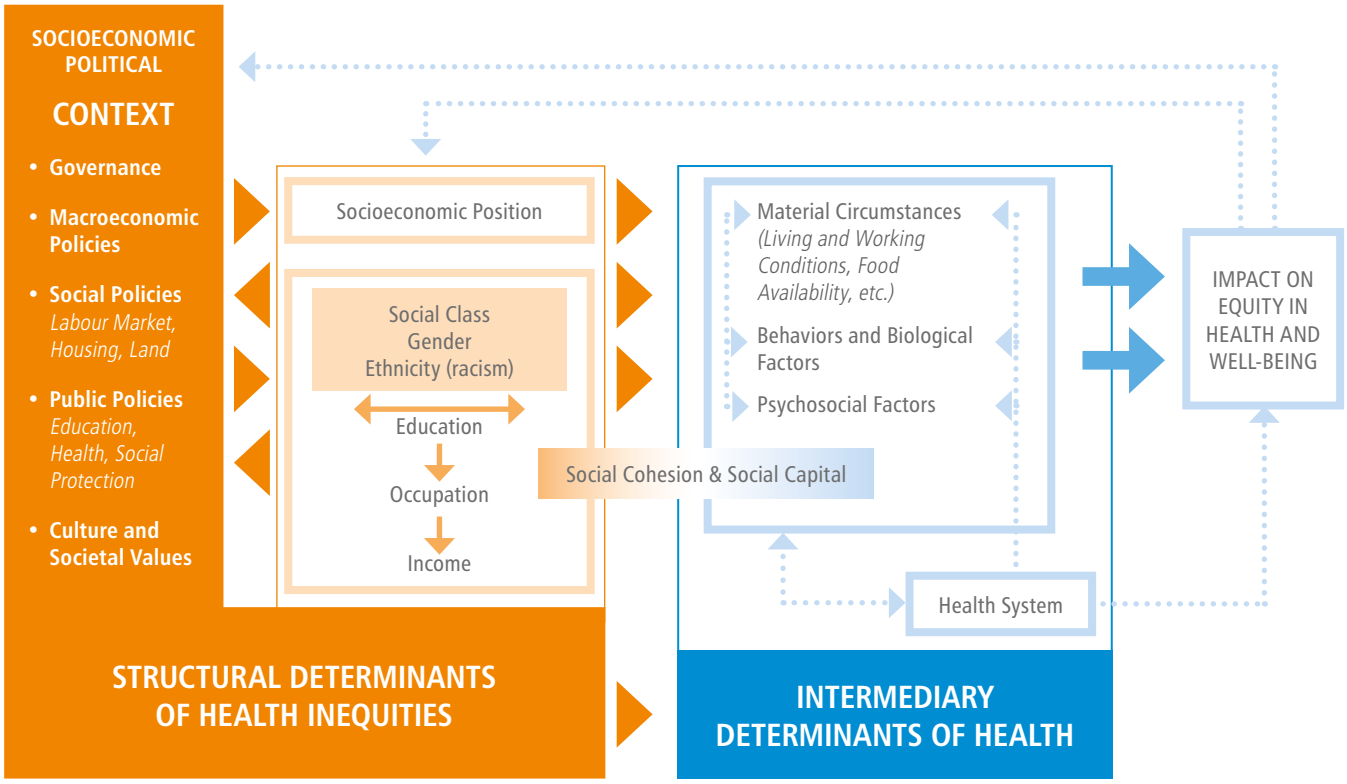
CONCEPTUAL BASIS AND RATIONALE FOR ACTION ON SOCIAL DETERMINANTS

It has long been known that social conditions decisively influence health[3] and therefore that action across all sectors is required to promote well-being – as highlighted in the Declaration of Alma Ata adopted in 1978 by the International Conference on Primary Health Care[4] and in the 1986 Ottawa Charter for Health Promotion.[5] The bulk of the global burden of disease and the major causes of health inequities, which are found in all countries, arise from the conditions in which people are born, grow, live, work, and age.[1] These conditions are referred to as *social determinants of health*, a term used as shorthand to encompass the social, economic, political, cultural, and environmental determinants of health.

Not all determinants are equally important. The most important are those that produce stratification within society — *structural* determinants — such as the distribution of income; discrimination on the basis of factors such as gender, ethnicity, or disability; and political and governance structures that reinforce rather than reduce inequalities in economic power. These determinants establish a set of socioeconomic positions within hierarchies of power, prestige, and access to resources. Mechanisms that produce and maintain this stratification include formal and informal governance structures; education systems; market structures for labour and goods; financial systems; attention to distributional considerations in policy-making; and the extent and nature of redistributive policies, social provision, and social protection. These structural mechanisms that affect the differential social positions of individuals are the root cause of inequities in health. These differences shape individual health status and outcomes through their impact on intermediary determinants such as living conditions, psychosocial circumstances, behavioural and/or biological factors, and the health system itself. The Commission's final report used this framework[6] (Figure 2) to inform its recommendations.

The social determinants approach requires coordinated and coherent action in the sectors of society that influence structural determinants to improve health and reduce inequities. In return, it is now well recognized that better health contributes to other important societal priorities, such as increased well-being, education, social cohesion, environmental protection, increased productivity, and economic development.[7] In this "virtuous circle", improvements in health and its determinants feed back into each other, providing mutual benefits.[8]

Figure 2. Conceptual framework of the social determinants of health



Source: Solar and Irwin, 2010[6]

Underpinning the social determinants approach is therefore an appreciation of the broader value of health to society and the dependence of health on actions far beyond the health sector. The Commission's call for broad actions reflects the occurrence of risks for health and the benefits of action at all levels of governance — local, national, and global. As both problems and solutions are systemic, public policies are centrally important — for example, transport and housing policies at the local level; fiscal, environmental, educational, and social policies at the national level; and financial, trade, and agricultural policies at the global level.

The social determinants approach also reflects the reality that health inequities cannot be addressed without addressing social inequalities. Coordinated action to achieve good health is essential in sustaining a strong economy and preserving social stability and national and global security. Adopting a focus on social determinants supports the integration of coherent action across a number of priorities, including, for example, building social protection and addressing climate change. Moreover, the social determinants approach considers intergenerational equity, which has often been ignored but is now central to public policy challenges. Climate change, which is symbolic of environmental degradation as a whole, significantly threatens the well-being of future generations. Trends such as increasing rates of noncommunicable diseases (NCDs) and diminishing economic opportunities and welfare entitlements, which are being seen in countries at all income levels, are already resulting in intergenerational inequalities, decreasing expectations of health, and social unrest.

All sectors have an interest in and responsibility for creating fairer and more inclusive societies by implementing coherent policies that increase opportunities and promote development. Health is a defining factor of good governance.[9] Efforts are increasing to broaden the definition of what is important in evaluating societal goals beyond narrow economic indicators such as gross domestic product (GDP).[10] The success of societies must be measured not only in terms of economic growth but also in terms of sustainability and the increased well-being and quality of life of citizens.

Health is a key contributor to this wide range of societal goals. The social determinants approach therefore identifies the distribution of health, as measured by the degree of inequity in health, as a key indicator not just of a society's fairness and social justice, but also of its overall functioning. Health inequities constitute a clear indicator of a lack of success and coherence of a society's policies across many domains.

Addressing social determinants is also essential for improving health in general. Without action on social determinants, the health-related Millennium Development Goals (MDGs) cannot be attained and targets for combating NCDs cannot be met, nor can prevention strategies be effectively implemented to reduce suffering and unsustainable health care spending on technologies for the treatment of chronic diseases. Care must be taken, however, that such action on social determinants does not, in fact, increase inequities by more rapidly improving conditions for those better off; hence the need for a clear focus on equity. Health and social systems that aim to reduce health inequities by delivering better performance and improving outcomes more rapidly for disadvantaged groups may, in fact, perform more effectively for people in all societal strata.

In conclusion, the rationale for action on social determinants of health rests on three broad themes. First, it is a moral imperative to reduce health inequities. Second, it is vital to improve health and well-being, promote development, and achieve health targets in general. Third, and most important, action on social determinants is required to achieve a range of societal priorities, which benefit from reducing health inequities.

POLITICAL CONSIDERATIONS FOR IMPLEMENTING ACTION ON SOCIAL DETERMINANTS

Progress, obstacles, and the effect of crises

Many countries are moving forward to implement a social determinants approach. Their experiences inspired and informed the recommendations of the Commission. Since the launch of the Commission's report, further progress has been made. Brazil, the host of the World Conference, convened a National Commission on Social Determinants of Health[11] and has continued to achieve reductions in inequities in childhood mortality and stunting that parallel its progress in reducing income inequality and poverty rates and in expanding its universal health system.[12] In response to the Commission's report, a review of health inequities in England led to action at the local and central government levels.[13] Countries as diverse as China,[14] India,[15, 16] the United States of America,[17] and Sierra Leone have taken gradual but significant steps towards universal health care coverage. Spain championed social determinants as one of its priorities during its presidency of the European Union in 2010.[18] The European Region is currently reviewing social determinants to guide future regional health policy, while the African Region last year endorsed a regional strategy on social determinants at its WHO Regional Committee meeting.[19] In South America, UNASUR's Council of Ministers of Health has identified tackling social determinants in the region as one of five priorities in the organization's 2010–2015 plan of action.[20]

These examples show that the lessons of the Commission have been taken to heart – that is, that there are solutions to the problems that cause health inequities and that action on social determinants is feasible in moving towards the Commission's vision of a world where social justice is taken seriously. Yet, despite many examples such as those described above, progress among countries has been slow in general. In most cases, the countries that are continuing to make progress are those in which efforts had already started before the Commission's report. Acknowledging this lag in progress, the World Conference aims to mobilize political commitment among countries to the implementation of necessary actions as part of national policies on social determinants.

Moving forward requires addressing the obstacles to implementing a social determinants approach. These obstacles include a lack of technical knowledge and capacity. The World Conference provides an opportunity for countries to share experiences and build awareness of the available knowledge and tools. Subsequent sections of this paper provide an overview of priority strategies to implement the Commission's recommendations.

The greater challenges, however, are political. These political challenges are the context within which any technical approach to the implementation of action on social determinants operates.

Implementing a social determinants approach requires addressing influential sectors whose interests do not always coincide with improving health equity. For example, the private sector is crucial to most determinants, yet many private sector activities are damaging to health and the environment. Addressing this challenge requires moving beyond the corporate social responsibility paradigm that up to now has delivered far less than it has promised. Governments have an important role in setting up a regulatory framework for private sector activities that aligns with health and development and to enforce these rules if commercial enterprises act in a manner that undermines these goals.

Moreover, poor progress in implementing a social determinants approach partly reflects the inadequacy of governance at local, national, and global levels in addressing the key problems of the 21st century. Health inequities are illustrative of a complex problem that demands coherent policy responses — across sectors and across countries — based on firm political commitment by all parties. These interconnected problems challenge the traditional division of societies and their governments into sectors for organizational purposes. The social determinants approach requires reorientation of policies and policy coherence so that, instead of working at cross-purposes, different sectors, different types of actors, and different levels of governance (global, national, and local) are aligned to mutually contribute to sustainable human development and promote one another's goals. Governments need to take responsibility for this realignment, including the use of regulation where necessary.

This approach also requires greater consideration of each society's key goals. Economic growth has long been pursued as the highest priority, but this principle is starting to be questioned. Broader measures of societal well-being are closely related to health, as shown, for example, by the report of the Commission on Measurement of Economic Performance and Social Progress established by the Government of France.[10] A healthy population is important for economic growth, but it does not follow that economic growth necessarily improves general health, enhances societal happiness and well-being, or reduces health inequities. While a strong economy can contribute to health, it is well documented that this correlation becomes weaker once GDP per capita increases over a threshold of $5000.[21]

The need to implement a social determinants approach has been brought into sharper relief by new or exacerbated crises in realms such as finance, food, public health, and the environment since 2008.[22] As these crises have clearly demonstrated, the interconnectedness of the modern world means that countries cannot confront these challenges on their own or through action in single sectors. Rather, a consistent, focused effort is required at all levels, from local to

global. These emergencies have also uncovered failures of regulation and the problems of an overemphasis on narrow indicators of economic stability, demonstrating the need for coordinated action and a strong state. For example, despite prevailing doctrine over the past 30 years, those who have suffered most from these crises have often been those who contributed least to the problems that caused them. Governments have come together to coordinate policy and have raised funding to stabilize economic systems in an unprecedented manner. In so doing, they have highlighted the need for and feasibility of action on social determinants. By opening space for real debate on policy issues and objectives, these multiple crises have therefore created an unprecedented opportunity to adopt a social determinants approach.

At the same time, these same crises have paradoxically intensified the political challenges to implementing a social determinants approach in some countries, especially aspects that relate to redistribution, rights, and regulation. In response to reductions in fiscal space, calls have been made for reductions in social services that have significant impacts on social determinants. This trend risks repeating errors of the past that had serious and extensive negative effects on health equity. Lessons need to be learned from countries that have protected and even expanded spending on key social determinants in times of crisis.

Principles and requisites for action

In this complex context, the World Conference provides a forum for consideration of how, with the help of international organizations, countries can assist one another in managing these political challenges. The political statement to be issued from the World Conference, the "Rio Declaration", will reflect the outcome of these deliberations. There is no blueprint for how a country can overcome political and technical obstacles to implementation of a social determinants approach. Each country will need to proceed according to its own priorities and circumstances. However, some general principles and key requisites for action can be identified.

First, **action on social determinants to reduce health inequities requires long-term, sustained implementation**. Benefits can become evident in the short term, however, and are likely to accrue in other sectors in which policies are applied to determinants before becoming apparent in reduced health inequities. For countries that have yet to implement a social determinants approach, the message is that the sooner they start, the better. Countries whose efforts have already begun have the opportunity to expand and deepen those efforts.

Second, **the initial step is to build public understanding of health inequities and social determinants of health**. Civil society organizations can play an important role in raising awareness. Public understanding of the importance of these issues will generate a demand for action. Starting to measure health inequities and social determinants by key factors that stratify populations (such as geographical location, ethnicity, income, or sex) can assist with this task and lay the foundation for further work. Social determinants must be explained in language that enables sectors beyond health to understand their relevance and potential contribution to the general good.

Third, **equity in health and well-being need to be placed as a priority goal for government and broader society**. Positioning health and well-being as key features of successful, inclusive, and fair societies implies endorsement of a set of values that includes a commitment to human rights and health equity, democratization of health and well-being, and solidarity for health at the national and international levels. Investment in social determinants and reduction of health inequities — to realize the right of all people to have equal opportunities for health and to pursue lives that they value — is a moral imperative that coincides with the commitments all countries have made to health and human rights through international human rights treaties. Even if human rights–based and social determinants approaches are not always completely aligned,[23] they are strongly complementary.[24] While different societies prioritize different aspects of fairness and justice, all countries can agree on the equality of opportunity that health equity entails.

Fourth, as discussed further in the section on building governance, **ensuring coordination and coherence of action on social determinants is essential**. Key political considerations include (1) combining central stewardship with conditions that enable different sectors to collaborate and (2) prioritizing action. A central message of the social determinants approach is that other sectors can contribute to health by doing their own work well and in a way that promotes their own goals. However, in each context, there is a need to identify the areas in which action is most important and to focus on these. While implementing a social determinants approach will sometimes require new resources, existing government expenditures can also be evaluated in terms of how they can be realigned. Furthermore, coherence between social and economic policies is a key priority. Even in countries where social policies actively aim to reduce inequities, economic policies often pull in the opposite direction. Consideration and monitoring of the consequences (both intended and unintended) of policy decisions on health and health equity can be institutionalized in policy-making. To this end, significant improvements are required in the capacity within governments to undertake these analyses.

Fifth, **a social determinants approach cannot be a "programme" that is rolled out**. Instead, it requires systematic implementation and learning from the resulting experience in each context. Countries that have been successful have started with high-priority issues and have made progress based on their experiences. Acting on social determinants implies a different mode of policy-making and implementation. Monitoring and evaluation (as discussed further below) are crucial in determining whether an approach is making a genuine difference in terms of social determinants and health equity. Better methods and tools are required to evaluate which specific policies are most useful in each context. While there is evidence for the effectiveness of acting on social determinants to reduce health inequities, more research and knowledge are needed to better inform policy-makers of what works best in their particular context.[25]

1. GOVERNANCE TO TACKLE THE ROOT CAUSES OF HEALTH INEQUITIES: IMPLEMENTING ACTION ON SOCIAL DETERMINANTS OF HEALTH

Taking a social determinants approach requires governments to coordinate and align different sectors and different types of organizations in the pursuit of health and development — for all countries, rich and poor — as a collective goal. Building governance, whereby all sectors take responsibility for reducing health inequities, is essential to achieve this goal. *Intersectoral action* — that is, effectively implementing integrated work between different sectors — is a key component of this process.

Health in All Policies (HiAP) is a policy strategy that illustrates how health can be established as a shared goal across the whole of government and as a common indicator of development.[26] HiAP highlights the important links between health and broader economic and social goals in modern societies, and it positions improvements in population health and reductions in health inequities as high-priority, complex problems that demand an integrated policy response across sectors. This strategy considers the effects of policies on social determinants as well as the beneficial impact of improvements in health on the goals of other sectors. Examples of this type of policy response are shown in Table 2. While HiAP is a useful strategy, it needs to be adapted to each country's specific historical and cultural context.[27]

This section focuses on governance at the national level. However, many promising examples of a social determinants approach come from the municipal and subnational levels (for example, in states or provinces, as shown in the box below on South Australia). Similar principles apply in these cases, and indeed it can be easier to integrate policy-making towards social determinants in these smaller-scale jurisdictions.

Table 2. Examples of policies integrating a social determinants approach

Sectors and issues	Interrelationships of health and other societal goals
Economy and employment	• Economic resilience and growth are stimulated by a healthy population. Healthier people can increase their household savings, are more productive at work, can adapt more easily to work changes, and can remain in the workforce for longer. • Work and stable employment opportunities improve health for all people across different social groups.
Security and justice	• Rates of violence, ill health, and injury increase in populations whose access to food, water, housing, work opportunities, and a fair justice system is poorer. Justice systems within societies must deal with the consequences of poor access to these basic needs. • The prevalence of mental illness (and associated drug and alcohol problems) is associated with violence, crime, and imprisonment.
Education and early life	• Poor health of children or family members impedes educational attainment, reducing educational potential and abilities to solve life challenges and pursue opportunities. • Educational attainment for both women and men creates engaged citizens and directly contributes to better health and the ability to participate fully in a productive society.
Agriculture and food	• When health is considered in food production, manufacturing, marketing, and distribution, food security and safety are enhanced, consumer confidence is promoted, and more sustainable agricultural practices are encouraged. • Healthy food is critical to people's health; good food and security practices reduce animal-to-human disease transmission and support farming practices that have a positive impact on the health of farm workers and rural communities.
Infrastructure, planning, and transport	• Optimal planning of roads, transport, and housing requires the consideration of health impacts, which can reduce environmentally costly emissions and improve the capacity of transport networks as well as their efficiency in moving people, goods, and services. • Better transport opportunities, including cycling and walking opportunities, build safer and more liveable communities and reduce environmental degradation, enhancing health.
Environment and sustainability	• Optimizing the use of natural resources and promoting sustainability, which can best be achieved through policies that influence population consumption patterns, can also enhance human health. • Globally, one quarter of all preventable illnesses are the result of the environmental conditions in which people live.
Housing and community services	• Housing design and infrastructure planning that take health and well-being into account (e.g. insulation, ventilation, public spaces, refuse removal) and involve the community can improve social cohesion and support for development projects. • Well-designed, accessible housing and adequate community services address some of the most fundamental determinants of health for disadvantaged individuals and communities.
Land and culture	• Improved access to land can support improvements in health and well-being for Indigenous Peoples, as their health and well-being are spiritually and culturally bound to a profound sense of belonging to land and country. • Improvements in indigenous health can strengthen communities and cultural identity, improve citizen participation, and support the maintenance of biodiversity.

Source: Adapted from WHO and Government of South Australia, 2010[9]

Building good governance for action on social determinants

The term *governance* has to do with how governments (including their different constituent sectors) and other social organizations interact, how these bodies relate to citizens, and how decisions are taken in a complex and globalized world.[28] Governance represents a process whereby societies or organizations make decisions, ascertain who should be involved in these decisions, and determine how accountability for actions can be ensured. Coherent policy responses to reduce health inequities require establishing governance that clarifies the individual and joint responsibilities of different actors and sectors (for example, the roles of individuals, different parts of the state, civil society, multilateral agencies, and the private sector) in the pursuit of health and well-being as a collective goal linked to other societal priorities. Other necessary features of governance include political leadership and long-term commitment, an engaged civil society, human resources with appropriate skills and knowledge, and a "learning environment" that allows policy innovation and conflict resolution. Finally, consistency among different policy-making spheres is required.

Building governance for action on social determinants is a complex task that is highly dependent on each country's political system and on who needs to be involved in each context. While there is no 'one-size-fits-all' recipe, common issues need to be addressed by the differing models of governance that may be used to institutionalize health as a shared goal across society, with health equity as a measure. These issues include establishing who drives the action and takes the initiative; clarifying the roles of different sectors and groups; ensuring the participation of disadvantaged groups; ensuring accountability for the shared goal; and considering how to monitor progress. Useful tools and instruments in this regard are listed in Table 3.

Table 3. Useful tools and instruments for implementing policy on social determinants

• Inter-ministerial and inter-departmental committees	• Cross-sector action teams
• Integrated budgets and accounting	• Cross-cutting information and evaluation systems
• Integrated workforce development	• Community consultations and Citizens' Juries[30]
• Partnership platforms	• Health lenses[29]
• Impact assessments	• Legislative frameworks

Source: Adapted from WHO and Government of South Australia, 2010[9]

The United Nations Development Programme (UNDP) has established five principles of good governance that are useful in framing what is required.[28] First, the implementation of policies on social determinants needs to be part of a process that has **legitimacy** and provides a **voice** for all parties. Central government agencies — at the executive level — have a key role in driving action and framing health as a shared goal as well as in mediating conflicts and building consensus among sectors. Governance is particularly demanding when there are no mutual policy interests. Governments must adhere to key principles and confront interests that actively undermine health equity rather than adopting a stakeholder approach in which each interest is equally weighted. The need for and the value of true participation in policy-making for social determinants are discussed further below.

Second, work on social determinants requires **direction** and a strategic vision for the sustained action needed to reduce health inequities and in particular to tackle the "short-termism" that often leads to rapid implementation of inadequate measures. Understanding the common benefits across society that accrue from work on social determinants is a key part of the necessary vision. The formulation of national strategies or plans is a useful opportunity to establish a process to develop and implement policies utilizing a social determinants approach. In terms of building governance, the process employed in doing so can be more important than the final document.

Third, there is a need to ensure **performance** in both the process and its outcomes. The mechanisms for decision-making on social determinants should be responsive to all stakeholders, and the process and resultant implementation of policies need to be effective and efficient, making best use of resources in terms of the common goals identified. Budgeting approaches, such as participatory budgeting, can increase both responsiveness and performance.

Fourth, **accountability** must be clear. All actors, whether in different sectors of government, civil society, or the private sector, need to be held accountable for decisions made with regard to the shared goals that have been identified and the impact of these decisions on health and health equity. Accountability for health and equity outcomes cannot be limited to the health sector. Targets can be useful in addressing particular policy problems; there must be specific targets for each sector in line with the social determinant upon which it acts. Transparency of the process is vital in terms of who makes decisions and who is responsible for the implementation of agreed-upon policies and their outcomes. The use of health lenses, which make joint decision-making explicit and identify common benefits, can clarify accountabilities.[29]

"Our government is moving towards health and environment based taxation. Our earlier experience shows that fiscal means are very effective in increasing health in general and especially in increasing health equity. This government will raise the taxes on, for example, alcohol and tobacco, sweets, chocolates, and ice cream. The economic situation is uncertain and it is good to have measures that work both for increasing revenues and for improving health equity."

Ms Jutta Urpilainen, Minister of Finance, Finland

1.

IMPLEMENTING HEALTH IN ALL POLICIES IN FINLAND

Finland has a long history of intersectoral action for health. In 1972, the Finnish Economic Council published a report on health policy simultaneous with the initiation of public health action across Finnish society aimed at reducing mortality rates from cardiovascular disease. In 1986, Finland became a pioneer for WHO's "Health for All" policy, launching a national strategy. Subsequent national health policies have included intersectoral policies for health. Since 1997, there has been an intersectoral Advisory Board for Public Health, nominated by a Council of State, whose mandate is to foster intersectoral policy-making for health among the various administrative sectors, organizations, and other relevant bodies.

In 2006, Finland consolidated its experiences in implementing a "Health in All Policies" (HiAP) approach, positioning HiAP as the core public health theme during the Finnish presidency of the European Union (EU). The HiAP approach in Finland — and also as approved within the context of EU policies — applies to government (as the executive) as well as to broader political decision-making and accountability at all levels of governance. It emphasizes the need for both public support and political leadership. The health sector is important in advocating for health and providing its expertise for intersectoral policy-making. Implementation of HiAP on local and regional levels is now legally required in Finland.

While Finland has continued to implement its own national HiAP approach, its EU presidency resulted in HiAP also becoming one of the four overarching principles of the EU's new health strategy, "Together for Health: A Strategic Approach for the EU 2008–2013".

More information on the Finnish experience can be found at http://bitURL.net/bwxq or by consulting the following publications:

Ollila E et al. Health in All Policies in the European Union and its member states. Policy brief available from http://bitURL.net/bye6.

Puska P, Ståhl T. Health in All Policies - The Finnish Initiative: background, principles, and current issues. *Annual Review of Public Health,* 2010, 31:27.1–27.14.

Fifth, processes in decision-making on social determinants and implementation of these decisions, with the aim of reducing health inequities, need to be **fair**. Progress on health inequities is unlikely without equitable processes and access to interventions. Legal frameworks — for example, the enshrining of rights to health and its determinants in national constitutions — can be helpful, but only if they are enforced fairly.

These principles apply equally to and are at least as important in global governance. International institutions should ensure legitimacy by affording an equal and effective voice to those affected by their decisions – a position referred to as "genuine equality of influence" in the Commission's report. These organizations should provide direction and strategic vision for concerted global efforts to promote social determinants and should seek ways of overcoming the short time horizons that inevitably arise from political cycles. They should seek to ensure that such efforts are both effective and responsive to the needs and priorities of those affected. Their governance structures should ensure effective accountability to the global population as a whole. Finally, international institutions should aim proactively to be fair in all their decision-making processes as well as in the execution of their activities.

"South Australia has made "Health in All Policies" more than a catch phrase. Using the framework of South Australia's Strategic Plan, innovation from our Thinkers in Residence programme, and leadership from the Department of Premier and Cabinet, "Health in All Policies" is central to the decisions we make as a Government."

Hon Mike Rann, Premier, South Australia

Implementing intersectoral action

Some actions on social determinants require whole-of-society and whole-of-government approaches with an explicit concern for health equity through national policy or legislation. Others simply require that individual sectors do their own jobs well (for example, designing and implementing tax or education policy). However, many necessary policies require collaboration among sectors, or intersectoral action (ISA).[31] For example, communities, especially the disadvantaged, rarely conceive their needs in terms of fragmented sectors. Meeting these needs therefore requires the integrated delivery of services. The idea of ISA is not new to health, having been championed by the primary health care and health promotion movements over the past 30 years. Nevertheless, the lack of development of the necessary governance and systems to implement coherent policies on social determinants has been a significant obstacle to progress. Moreover, ISA has often involved the instrumentalization of resources from other sectors to health care rather than efforts to mutually improve each sector's policies.[21]

Major challenges include deciding which problems require ISA and identifying common goals for different sectors with differing interests. Not all sectors need to be involved; instead, the priority sectors for each issue and context should be identified and their buy-in sought. Central agencies have the main role in this regard, although many municipal authorities have been particularly successful at the local level. All sectors involved need to see the benefits of collaborative work, and these potential advantages need to be foremost in identifying and translating common goals for ISA. For work on social determinants, the benefits conferred on other sectors by improvements in health and health equity need to be clearly articulated in terms of each sector's own priorities and agendas.

This task requires bridging different understandings of the same problem as well as the divergent language that different sectors use to describe the same issue. It also involves identifying the sectors with vested interests in activities that may address the problem; this stage of the process requires a sound understanding of each sector's interests and objectives. A conceptual model showing the interplay of various social determinants, with all sectors represented, can be helpful in demonstrating how all sectors concerned have a role to play. Necessary steps for successful ISA are described in Table 4. Lessons can also be learned by adapting innovative intersectoral approaches used by other sectors; for example, environmental impact assessments have strongly influenced the development of health impact assessment methodologies.

Table 4. Necessary steps for successful implementation of intersectoral action

1.	Create a policy framework and an approach to health that are conducive to intersectoral action.
2.	Emphasize shared values, interests, and objectives among partners and potential partners.
3.	Ensure political support; build on positive factors in the policy environment.
4.	Engage key partners at the very beginning; be inclusive.
5.	Ensure appropriate horizontal linking across sectors as well as vertical linking of levels within sectors.
6.	Invest in the alliance-building process by working towards consensus at the planning stage.
7.	Focus on concrete objectives and visible results.
8.	Ensure that leadership, accountability, and rewards are shared among partners.
9.	Build stable teams of people who work well together, with appropriate support systems.
10.	Develop practical models, tools, and mechanisms to support the implementation of intersectoral action.
11.	Ensure public participation; educate the public and raise awareness about health determinants and intersectoral action.

Source: Adapted from Public Health Agency of Canada, 2007[32]

Conflicts and trade-offs between short- and long-term goals and between the interests of different sectors are inevitable. There are numerous "win-win" possibilities during action on social determinants, but some necessary actions will result in unsatisfactory outcomes for some parties. In managing these conflicts, governments need to consider imbalances in power between different sectors and determine where the greatest interests for health and health equity lie. For example, when communities and trade unions are involved in disputes with corporations over economic development projects related to concerns about working conditions and environmental impacts, governments need to consider power imbalances and possible health impacts and must critically analyse where any economic benefits will accrue. Governments also have a responsibility to advocate for those with less power and to confront interests that undermine health equity.

Useful Resources (available on accompanying DVD)

- Graham J, Amos B, Plumptre T. Principles for good governance in the 21st century. Policy brief no.15. New York, UNDP, 2003.
- Kickbusch I, Buckett K, eds. *Implementing Health in All Policies: Adelaide 2010.* Adelaide, Department of Health, Government of South Australia, 2010.
- *Crossing sectors - experiences in intersectoral action, public policy and health.* Ottawa, Public Health Agency of Canada, 2007.
- *Health equity through intersectoral action: An analysis of 18 country case studies.* Ottawa, Public Health Agency of Canada and WHO, 2008.
- Adelaide Statement on health in all policies. Adelaide, WHO and Government of South Australia, 2010.

IMPLEMENTING HEALTH IN ALL POLICIES IN SOUTH AUSTRALIA

Since 2007, the State of South Australia has adopted a "Health in All Policies" (HiAP) approach, placing it strategically as a central process of government to improve health and reduce inequities rather than implementing it as an approach run by and for the health sector and imposed on other sectors. This approach has been framed as essential in achieving not only health priorities but also a range of goals in the State's main planning document, the South Australian Strategic Plan.

Strong intersectoral relationships have been built to explore interconnections of various targets within the Strategic Plan and social determinants and to work towards the joint achievement of individual agencies' goals and population health improvements. A health lens analysis process has been used, building on traditional health impact assessment methodology and incorporating additional methods, such as economic modelling, to improve rigour and flexibility and to accommodate the policy goals of the agencies in the partnership. As a consequence, the health lens is modified for each project and evaluation is built in. A range of projects involving different sectors have been undertaken. These projects include water security, migrant settlement, and access to digital technology. The foundations for the success of the Health in All Policies approach in South Australia have been identified as:

- a strong cross-government focus;
- a central government mandate and coordination;
- flexible and adaptable methods of enquiry, using health lens analysis;
- mutual gain and collaboration;
- dedicated health resources for the process;
- joint decision-making and joint accountability.

In 2011, the South Australian Government incorporated specific provisions in new public health legislation to strengthen the mandate and sustainability of this approach. More information on the South Australian experience can be found at http://bitURL.net/bhsn or by consulting the following publication:

Kickbusch I, Buckett K, eds. *Implementing Health in All Policies: Adelaide 2010.* Adelaide, Government of South Australia, 2010. Available at http://bitURL.net/bhsp.

2. PROMOTING PARTICIPATION: COMMUNITY LEADERSHIP FOR ACTION ON SOCIAL DETERMINANTS

The governance required to act on social determinants is not possible without a new culture of participation that ensures accountability and equity. Facilitating participation can help safeguard equity as a principle and ensure its inclusion in public policies. Besides participation in governance, other aspects of participation, such as individual participation in taking up services or participation of communities in service delivery, are also important for reducing health inequities. However, the participation of communities and civil society groups in the design of public policies, in the monitoring of their implementation, and in their evaluation is essential to action on social determinants. There are many examples whereby participation has resulted in greater emphasis on health, ranging from various experiences with participatory budgeting to youth-driven advocacy such as the "Nine is Mine" campaign by children in India.[33, 34]

Participation is therefore a key intervention to strengthen political sustainability at national and global levels and to ensure that policies and interventions reflect people's needs. Of particular importance is the involvement of communities in guaranteeing accountability for decisions. Countries such as Brazil and Thailand that have had recent success in reducing health inequities have placed renewed emphasis on this dimension of participation (see box below). Sustaining necessary action on social determinants across a range of sectors, particularly ensuring that services are responsive to the needs of disadvantaged populations, is extremely difficult without broader societal involvement.

Participation conceived in this way has intrinsic value in respecting people's autonomy and right to be involved in decisions that affect them. For action on social determinants, participation is part of the overall goal itself: improved agency, well-being, dignity, and quality of life for all members of society. However, the participation of communities in policy-making can also be instrumental in driving new initiatives, increasing accountability, and sustaining change.

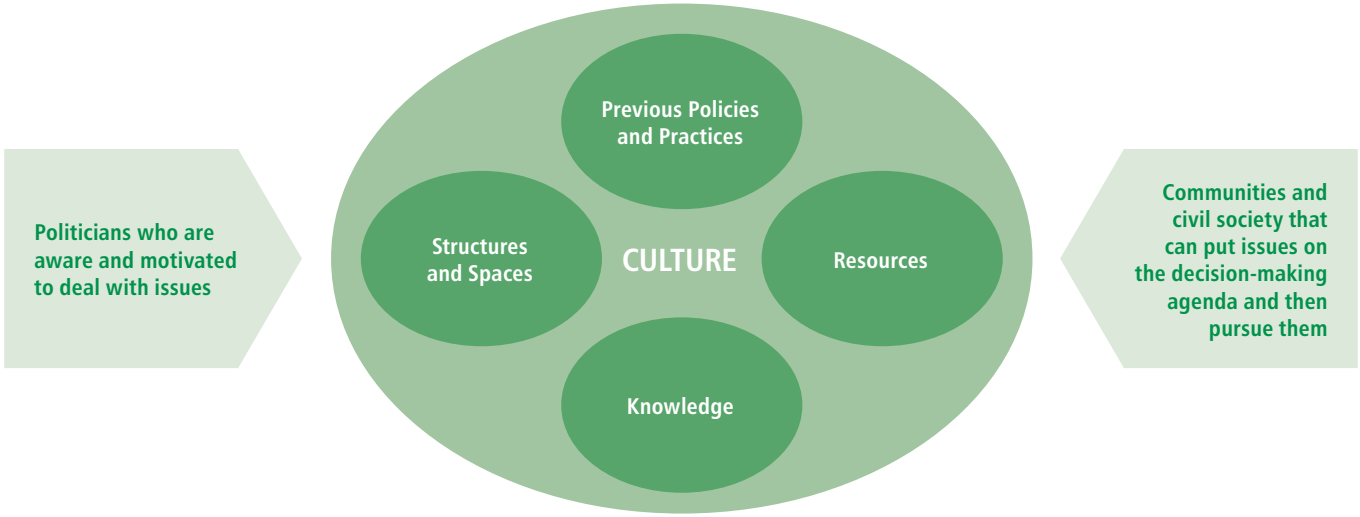
There is no "magic bullet" to ensure participation in policy-making. Participation that leads to social change arises from social movements in specific contexts. However, many government actions can actively *obstruct* the ability of communities to raise concerns about their daily living conditions and propose solutions for problems. Furthermore, there is often resistance among policy-makers and "experts" to participatory efforts. Governments can help overcome these barriers and create conditions that are conducive to the participation of empowered communities in making decisions that affect their health in the context in which they live. In this regard, it is critical to avoid tokenism. At the same time, civil society organizations can consider how best to contribute to action on social determinants, including building awareness of health inequities, helping communities to organize, advocating for better and more inclusive governance, and ensuring accountability in the implementation and effects of policies.

Creating the conditions for participation

Promoting participation can seem risky for policy-makers, as this effort implies a shift in power relationships in favour of population groups that often have historically been excluded and marginalized. These are key social determinants upon which action is required to reduce inequities. Doing so requires a willingness to transfer real power to communities and to bear the consequences of people's demands for what may be transformative change. Yet participation also offers many rewards for political leaders who seek reform. By creating a broader constituency to take ownership for policy processes and credit for changes and their ensuing benefits, the participation of communities can drive difficult reforms and create a significant legacy that is unlikely unless change can be sustained.

Figure 3 depicts how the culture of participation in policy-making is created between communities and civil society on one side and governments on the other. This culture consists of four key

Figure 3. The context and resources that influence social participation



"The National Health Assembly is a process to develop participatory healthy public policies involving all stakeholders. Its job is to weave vertical threads representing top-down decisions with horizontal threads representing the demands and needs of people into a new harmonious pattern. Its mission is beyond the Ministry of Public Health because it involves health in all policies."

Dr Amphon Jindawatthana, Secretary-General of the National Health Commission Office, Thailand

components: the structures and spaces that allow participation to occur, the resources that stakeholders have to participate, the knowledge necessary to participate, and the impact of previous policies and practices on participation. This framework is not exhaustive, but effectively facilitating participation requires addressing at least these four elements.

Institutionalizing mechanisms for participation

Political, physical, and institutional structures, along with their rules, regulations, and relationships, can either inhibit or promote participation in policy-making as they define where participation occurs and who can access processes. These structures can be either formal or informal. To facilitate participation, processes need to be as transparent as possible and informal procedures need to be minimized, as they are often less accessible to disadvantaged communities. Stable mechanisms are necessary to institutionalize participation as central to the policy-making process.

The success of the mechanisms chosen to institutionalize participation is highly dependent on the context and process whereby they are incorporated into governance. Assemblies and councils have been successful in countries where they are closely linked to the decision-making process. In other nations, they have had minimal impact on policy. Similarly, decentralization, where funding and resources are devolved to subnational bodies, has been useful in encouraging community involvement in many countries. However, there have also been many negative experiences, particularly where commitment, resources, or knowledge have been insufficient to implement action in response to heightened expectations. Other tools, such as dialogues, participatory budgeting, and citizen juries, are likewise only as useful as the extent to which they can influence policy.

Providing resources

Participation has many benefits, but it is also costly. Stakeholders need sufficient time, money, institutional capacity, and human resources to participate effectively in policy-making that promotes their interests. Moreover, because policy-making is an ongoing process, participation requires the availability of resources over a sustained period.

Governments can invest in participation by offering incentives, subsidizing costs, and considering the timing and venue of participatory processes to maximize the possibility that people will be able to attend. Civil society organizations can provide resources required for participation and can help communities identify which issues they should prioritize for action.

Considering the impact of previous policies and practices

Lack of mechanisms and lack of resources are not the only barriers to participation. People's previous experiences as well as the political and historical context in dealing with government strongly influence their perception and ability to participate in policy-making. Groups that face discrimination are especially unlikely to engage with participatory mechanisms; governments therefore need to proactively facilitate their participation not only by allocating resources but also by actively recognizing their culture and their agency to contribute to their own well-being. In many countries, changes must be made in the practices of the government and its staff, with participation established as a central component in the mission of government agencies.

Building knowledge and capacity

Effective participation requires knowledgeable and skilled stakeholders who understand the process, have a clear vision of what can be achieved, and have the social and political skills to navigate through bureaucratic processes while promoting their agenda. Addressing inequalities in access to information is therefore essential. Knowledge and literacy needed for effective participation can be acquired through formal training or through advocacy experience. Stakeholders who lack the necessary skills can be assisted in obtaining them through incentives and access to information and training.

As just mentioned, an essential aspect of ensuring that marginalized groups are adequately represented in policy processes is building their capacity and literacy to participate. Communities require access to information, but they also need to be able to interpret and use it. Thus data must be made publicly available, using platforms that people can access, presenting the information in ways that make sense to communities, and building skills in interpreting this information. In addition to analytical capacity, communities require increased "bureaucratic literacy" to demystify the bureaucratic structures, actors, and processes involved in policy-making; to increase their awareness of the opportunities that exist to influence the policy process; and to enable them to participate from a position of strength. Government organizations need to build their capacity to facilitate participation, in particular their responsiveness to community demands and their ability to engage with proposals expressed in language different from what they may be used to.

INSTITUTIONALIZING PARTICIPATION IN BRAZIL AND THAILAND

Brazil and Thailand are two countries that have shown impressive improvements in health and reductions in health inequities over the past 20 years. They have also been at the forefront of increasing public participation in policy-making.

In Brazil, participatory approaches to decision-making relevant to health have been inspired by the social movements that drove the establishment of the universal health system as well as subsequent improvements in primary health care and social protection. The 1988 Brazilian Constitution established health — including the right to participate in health governance — as a human right for all. This commitment provided the space for institutionalizing public participation at the municipal, state, and national levels. Participation through health councils at each of these levels (including municipal health councils in 5564 cities, where half the councillors represent health system users) is supplemented by regular national health conferences. Innovative models such as participatory budgeting have also been implemented in some jurisdictions.

In Thailand, civil society assemblies over the last decade have led to the institutionalization of the National Health Assembly, which has been held annually since 2008 as mandated by the new National Health Act. Adapting the machinery used at the WHO World Health Assembly, the National Health Assembly brings together more than 1500 people from government agencies, academia, civil society, health professions, and the private sector to discuss key health issues and produce resolutions to guide policy-making. Policy impacts attributable to Assembly resolutions have included protection of budgets for universal health coverage, endorsement of strategies for universal access to medicines, and establishment of National Commissions on Health Impact Assessment and Trade and Health. Further information can be found at http://en.nationalhealth.or.th/.

More information on the Brazilian and Thai experiences can be found by consulting the following publications:

Cornwall A, Shankland A. Engaging citizens: lessons from building Brazil's national health system. *Social Science and Medicine,* 2008, 66:2173–2184.

Rasanathan K et al. Innovation and participation for healthy public policy: the first National Health Assembly in Thailand. *Health Expectations,* 2011, doi: 10.1111/j.1369-7625.2010.00656.x.

Brokering participation and ensuring representativeness

Governments can broker participation in a number of ways, with the aim of facilitating empowerment. Figure 4 provides an overview of this continuum, from provision of information to transfer of power. The most disadvantaged groups need to be identified in advance and a plan developed for ensuring that those groups are adequately represented. Often marginalized groups face additional barriers that make them less likely to be reached by efforts to engage. This situation may require flexible, novel approaches – for example, convening female-only forums, using new communication technologies to reach youth, and giving strict attention to cultural appropriateness for ethnic minorities and Indigenous Peoples. Regional processes are critical in strengthening and reinforcing national efforts to seek participation. Governments also have a role in working with communities to ensure the legitimacy of those who claim to be community representatives and in addressing conflicts of interest and lobbying by vested interests at the national and global levels.

Facilitating the role of civil society

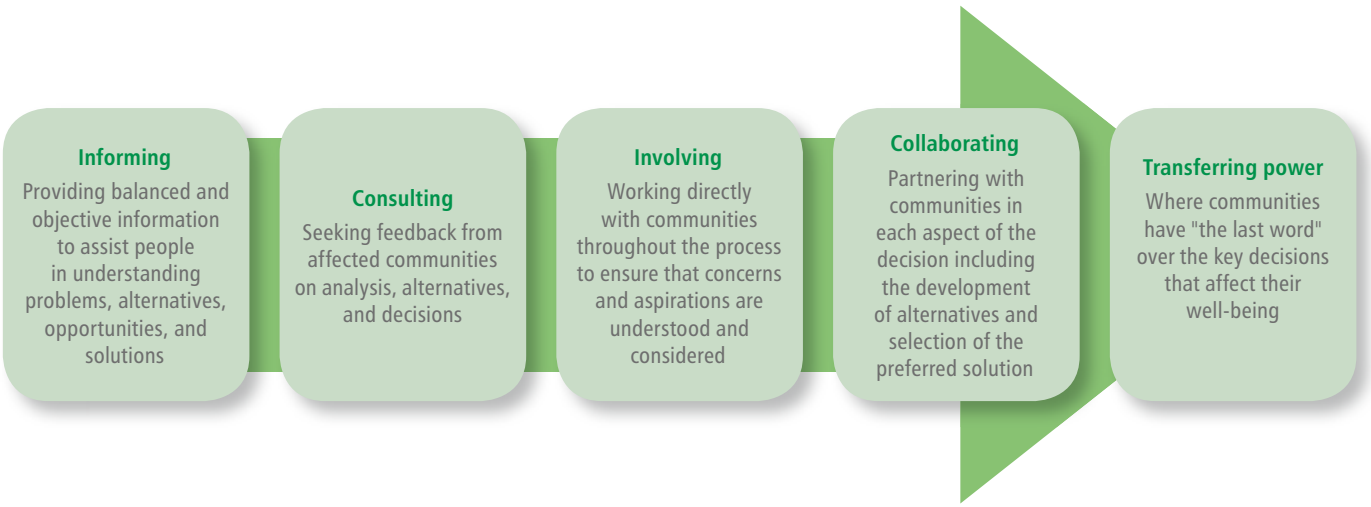
Civil society can play a number of important roles in implementing action on social determinants. A key function is to hold policy-makers and programme implementers accountable for the responsibilities they undertake and the commitments they make; this oversight includes monitoring of spending on budget commitments. Civil society organizations can influence accountability by encouraging institutional checks and balances and, indirectly, by strengthening institutions of accountability (for example, electoral democracy and independent media). Civil society organizations can also generate evidence for work on social determinants. Both the accuracy of information provided by civil society and the ability of these groups to be a source of credible research are sometimes questioned. As with other sources of data, there can be issues of rigour, but civil society certainly can provide access to information that is unavailable elsewhere. In settings where government data and information are inadequate, civil society groups can be the principal source of credible and up-to-date data to inform policy-making on social determinants.

Governments can actively facilitate the role of civil society in action on social determinants. They can formalize the involvement of civil society organizations in policy-making processes — for example, by supporting their role in maintaining accountability through setting up civil society advisory bodies and formally engaging with watchdog initiatives. At both the national and global levels, official bodies can consider and encourage "shadow reports" from civil society organizations – independent assessments that complement and often raise issues overlooked in official publications. Examples include the civil society shadow reports for the UN General Assembly Special Session on HIV/AIDS and the civil society report of the Commission on Social Determinants of Health.[36] These examples emphasize the need for governments to be better informed about the value and utility of knowledge produced by civil society groups and to build the capacity of these groups to undertake and present research in a form that is comprehensible to other audiences.

Useful Resources (available on accompanying DVD)

- Civil Society Report to the Commission on Social Determinants of Health, 2007.
- International Association for Public Participation. Public participation tool-box. Available at http://bitURL.net/bzdg.
- Valentine N et al. *Health equity at the country level: Building capacities and momentum for action. A report on the country stream of work in the CSDH. Social determinants of health implementation discussion paper 3.* Geneva, WHO, 2008.

Figure 4. Techniques for seeking community engagement in the policy process



Source: Adapted from Solar and Irwin, 2010[6], itself adapted from International Association for Public Participation, 2007[35]

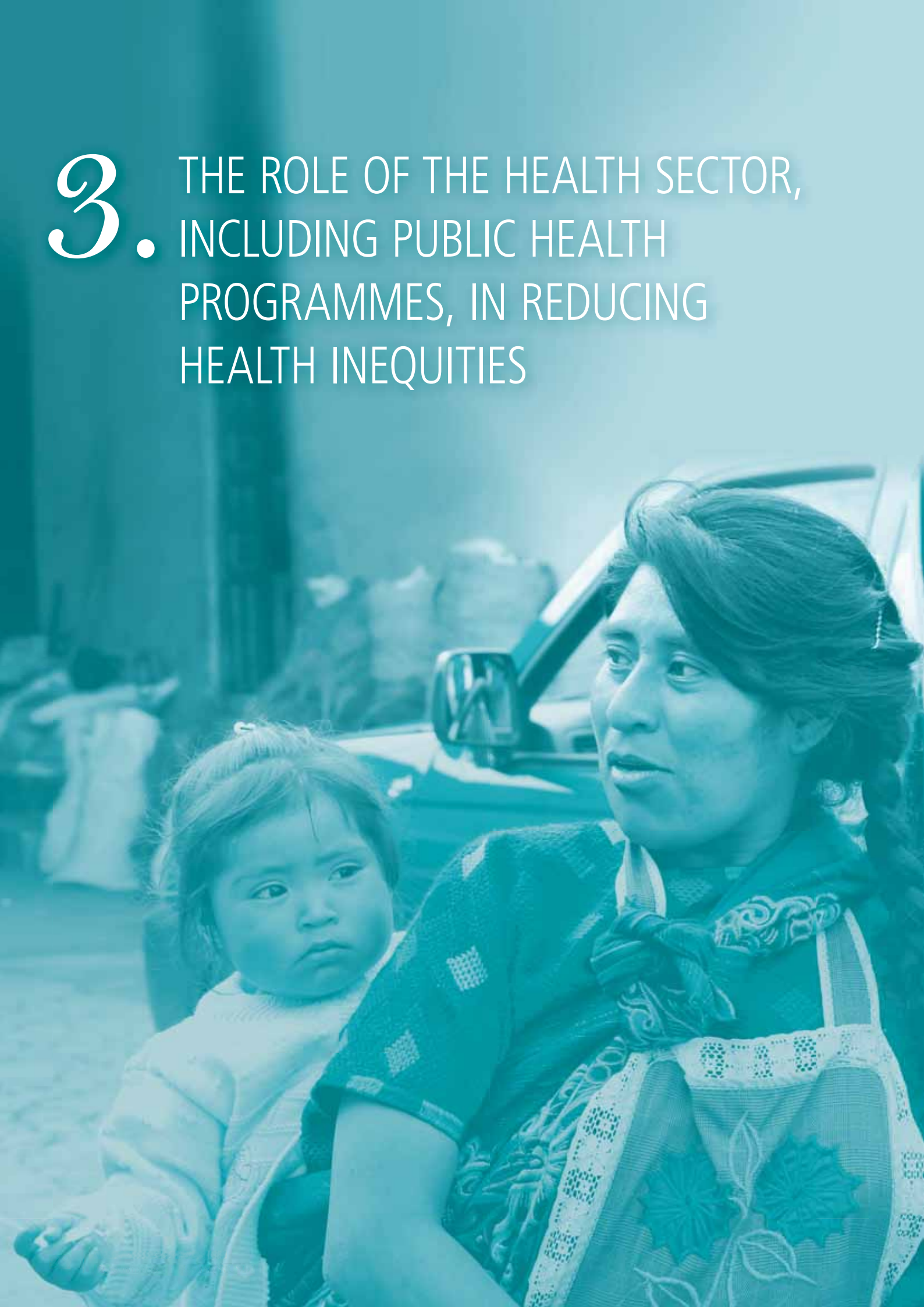
PARTICIPATION IN ACTION IN ROSARIO, ARGENTINA

The city of Rosario in Argentina (population >1 million) has in recent years developed a public health system with a strong emphasis on primary care in which participation is a central component. Co-financed by the provincial and municipal governments, the system provides free health services to all city residents. It is underpinned by the principles of community participation; the participation of health workers in management; universal and equitable access; the right to health; decentralized planning; and autonomy and responsibility for health workers.

The system is based on primary care centres. Community organizations have significant influence in these centres and work together in a federation to analyse and discuss municipal projects. Along with this community participation, health workers also participate in management of the centres.

Through this participatory process, health has become a municipal priority. In 1988, the health budget represented less than 8% of the municipal budget; by 2003, this figure rose to 25%. Infant mortality dropped from 25.9/1000 births in 1988 to 11.4/1000 births in 2002. Consultations in the health centres increased by 314% during the same interval. In 2009, the city opened a new hospital providing universal access; the hospital's design took patients' viewpoints into account.

3. THE ROLE OF THE HEALTH SECTOR, INCLUDING PUBLIC HEALTH PROGRAMMES, IN REDUCING HEALTH INEQUITIES



While implementation of policies across the social determinants is essential to improve health and reduce inequities, the health sector has a vital role to play. The health sector should be instrumental in establishing a dialogue on why health and health equity are shared goals across society and identifying how other sectors (with their own specific priorities) can benefit from action on social determinants. The health sector must work in this way with other sectors to reduce differences in exposure and vulnerability to health threats.

Moreover, health systems themselves (the actors, institutions, and resources that undertake actions primarily to improve health), including public health programmes, constitute a social determinant. In fact, instead of reducing health inequities, the health sector often makes them worse by providing better access and quality of care to segments of society with comparatively lesser need. Direct payment for health services drives 100 million people into poverty each year.[37] Choices about health system financing and the location of health care services, along with the attitudes of health workers towards different groups in society, are crucial in determining whether the health sector has a positive or negative impact on health inequities. Ensuring that the health sector reduces rather than increases health inequities requires equitable provision of health care services to all groups in society, at all stages of care. Strengthening the competence of public health programmes to address social determinants is a key step in this direction.[38, 39] If it is not acting to reduce inequities, the health sector is in a poor position to ask other sectors to take action on social determinants.

The primary health care approach holds increasing equity as a central value for the health sector, along with ensuring universal coverage, undertaking intersectoral action, and facilitating participation and negotiation in leadership of the health sector.[21] The primary health care approach has much in common with a social determinants approach and aims at similar goals.[3] To compensate for shortfalls in performance for disadvantaged population groups, any strategy to strengthen health systems and public health programmes needs to institutionalize an explicit focus on equity through the continuum of care and all health system functions. This task entails going beyond average measures of progress to unmask disparities not only in health outcomes but also in the use and quality of services. This type of assessment is important not only in improving health equity but also in making progress on health priorities. For example, the likelihood of meeting priority health targets such as the MDGs and the elimination of tuberculosis is lowered by poor service delivery to "hard-to-reach" populations.[40, 41]

The reforms advocated for the renewal of primary health care (universal coverage; people-centred care; equitable public policies; and improved leadership, stewardship, and participation)[21] can facilitate better performance in terms of equity if applied across all health system "building blocks" or functions: service delivery; health workforce; health information systems; access to medicines, vaccines, and technologies; health financing; and leadership.[42]

Executing the health sector's role in governance for social determinants

There are four broad, interrelated functions through which the health sector can make a useful contribution to governance for action on social determinants. First, the health sector has a key role in advocating for a social determinants approach and explaining how this approach is beneficial both across society and for different sectors. In particular, the health sector needs to articulate why health inequities are a high-priority indicator of a society's lack of well-being that justifies an integrated response. Second, the health sector has particular expertise in and responsibility for monitoring health inequities and the impact of policies on social determinants. Third, through marshalling of evidence and successful advocacy, the health sector can play an important role in bringing sectors together to plan and implement work on social determinants — for example, identifying issues that require collaborative work, building relationships, and identifying strategic allies in other sectors as potential partners. Fourth, the health sector has an important role in the development of capacities for work on social determinants. An important caveat is that the health sector should avoid claiming any of these roles as its exclusive function.

To effectively undertake these functions, a range of specific responsibilities and tasks can be identified:[9]

- understanding the political agendas and administrative imperatives of other sectors;
- building the knowledge and evidence base of policy options and strategies;

- assessing comparative health consequences of options within the policy development process;
- creating regular platforms for dialogue and problem solving with other sectors;
- evaluating the effectiveness of intersectoral work and integrated policy-making in partnership with other stakeholders;
- building capacity through better mechanisms, resources, agency support, and skilled and dedicated staff;
- working with other arms of government to achieve their goals and, in so doing, advance health and well-being.

Many of these responsibilities involve new terrain for the health sector, which therefore needs to build its own capacity to work effectively on social determinants.

Reorienting health care services and public health programmes to reduce inequities

Placing equity at the heart of health care services first requires evaluating the performance of existing health services and programmes in reducing health inequities. This assessment entails understanding the way in which existing services operate, including their aims, objectives, and targets (that is, the "logic" of services and programmes), and how the activities of these services interact with the generation of health inequities in a society.

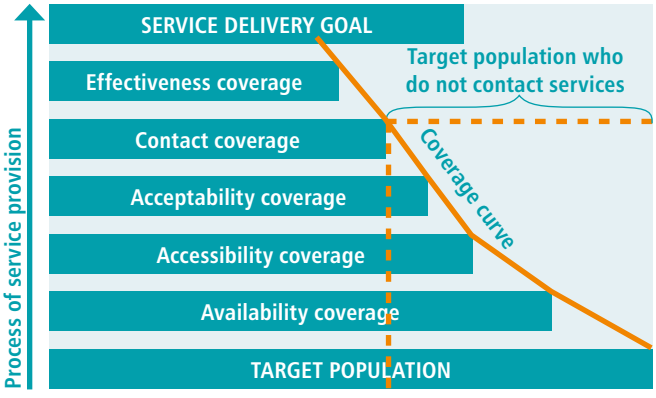
A number of models are useful in considering whether existing health services exacerbate or alleviate health inequities.[38, 43, 44] Figure 5 shows the Tanahashi model, which considers access to, provision of, and use of health care services to conceptualize the necessary steps a person takes between experiencing a health issue and receiving effective care from health services. At each step, "loss" of people by health services and programmes results in avoidable suffering. For example, to receive effective care, individuals with high blood pressure need to know that they have a problem, seek care for this condition, gain access to care, receive appropriate advice, obtain the prescribed treatment, adhere to the treatment, and obtain effective relief from the treatment, with satisfactory resolution of their problem.

Ensuring that this complex pathway is navigated successfully and in a timely manner is a major aim across health care services and programmes. Failure to ensure this successful navigation results in poor performance and failure to attain the desired public health outcomes. For almost all health care services, the rates at which people do not receive effective care at each step and the quality of care received differ according to population groups. This discrepancy is a key mechanism through which health care services and programmes increase health inequities. Measuring performance by disaggregating data for key population groups, especially those socially disadvantaged according to the context, is a prerequisite in identifying ways for health services to reduce their contribution to health inequities.

From this basis, entry points for interventions by health care services to alleviate health inequities can be defined.[39] Once it is known which groups benefit from services and programmes and — more important — which groups do not benefit or receive poorer-quality service, the reasons for these discrepancies can be considered and the barriers to care, which are concentrated in these groups, identified. Many of these barriers will lie outside the health sector in other social determinants. However, the health sector can make an important contribution by first addressing those factors within its control, such as the funding, location, and timing of services and the competencies and attitudes of health workers. It can also work with communities to identify barriers and solutions, including ensuring that care extends beyond curative services to promotion and prevention activities.

This strategy provides a basis for the reorientation of services and programmes to reduce inequities and for continued monitoring to see whether the changes have the intended effect. It can also be aligned with human rights–based approaches to strengthening health systems, which focus on ensuring that health-related facilities, goods, and services are available; accessible at affordable cost; acceptable; appropriate; and of good quality. After existing services have been reviewed, specific interventions must be defined in an analysis of how barriers to care can be reduced. These interventions can involve not only changes in the delivery of care (for example, changes in or improved management of services offered) but also attempts to address social determinants that hamper access. While programmes cannot be responsible for all potential interventions, they can undertake a range of measures to reduce differences in exposure and vulnerability to health threats, especially differences that arise once people become ill. In addition, programmes can engage partners in other sectors to act on the social differences that result in health inequities.

Figure 5. Tanahashi model for service delivery and coverage



Source: WHO, 2010[43], adapted from Tanahashi, 1978[45]

There is potential for collaboration between programmes that identify common issues resulting in differences in exposure or difficulties in accessing care. For example, key determinants of the tuberculosis epidemic are smoking, harmful use of alcohol, diabetes, indoor air pollution, and HIV/AIDS.[46] These conditions are often clustered in disadvantaged population groups, driven by common social determinants such as poverty, discrimination, and poor education and housing. Furthermore, screening for and diagnosis of HIV/AIDS, tuberculosis, and NCDs are often hampered by poor coverage and quality. Reorientation to address social determinants in a coherent manner provides these public health programmes with significant opportunities to mutually improve their performance towards common goals and their own targets.

Institutionalizing equity in health systems governance

Reorientation of the delivery of health care services must be supported by reforms in the governance of health systems through a primary health care approach. This course is necessary to improve the health sector's capacity to design policies that improve equity across all health system functions. Institutionalizing equity in health systems places particularly high demands on the governance capacity of national health ministries to usher in change, particularly in countries where a large proportion of health systems are beyond the ministries' direct control. It is difficult to negotiate and steer change in services run by subnational authorities, the private sector, and nongovernmental organizations (including faith-based groups). However, progress depends on embedding equity in these services as a primary consideration or at least on evaluating their contribution to the health system as a whole. Directing resources to disadvantaged groups who lack political power or making the case for sufficient funding to provide equitable health care are further difficult but essential tasks.

Addressing these challenges requires clear and transparent planning at the central level, with national health ministries acknowledging the importance of other providers and stakeholders in health systems but also asserting their mandate and role to steer the whole system. The development of national health strategies that engage these other partners provides an opportunity to build the capacity of national health ministries to steward the entire health system (for example, by setting priorities for addressing inequities) and to implement mechanisms for negotiation between and regulation of the different stakeholders. The development of strategies can also be used to ascertain whether the key issue of equity is addressing health problems experienced by the most disadvantaged groups, reducing gaps in health status between groups, "levelling up" across the social gradient for all groups, or a combination of all three. Efforts by the health sector to address health inequities will vary with the country context, the nature and extent of the health inequities present, and the structure of social and health systems. Thus the governance of health systems must respond appropriately in allocating resources and prioritizing disadvantaged groups across all health system functions.

Health care financing to ensure equitable universal health coverage (access to and use of quality services through the continuum of care for all people in a society) also poses particular challenges for health system governance.[47] Equitable universal health coverage (Figure 6) requires ensuring access and effective coverage for all groups ("breadth"), for all necessary care ("depth"), at affordable costs under acceptable conditions, with specific resources to address the differential needs of the least well-off ("height"). Achieving universal health coverage is not easy, as has become evident even in high-income countries. If there is not sufficient emphasis on equity, with prioritization of the worst-off for both existing and new services, increasing coverage can actually worsen inequities.[48] However, the evidence indicates that moving equitably towards universal health

"We in the health sector have a crucial role to play in acting on social determinants, even though they mostly lie beyond our direct control. We can ensure that we ourselves are not making the problem of health inequities worse. We also have essential tasks in advocating for action, in working across sectors, and in making the evidence available to decision-makers in all sectors."

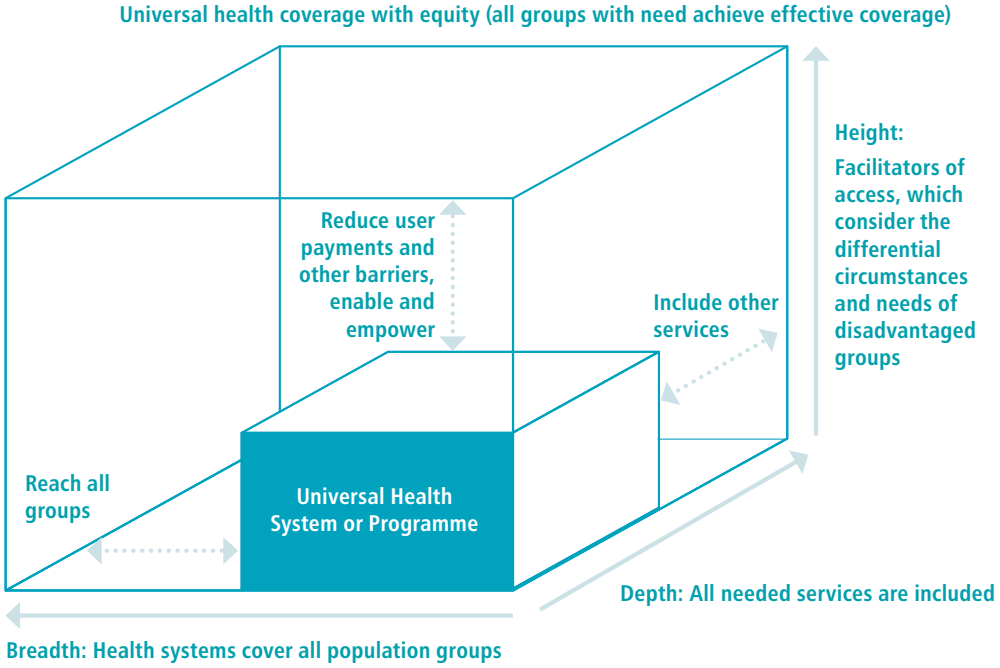
Professor Sir Michael Marmot,
President of the British Medical Association 2010-2011 and
former Chair of the Commission on Social Determinants of Health

coverage is possible in countries of all income levels. Financing of health systems is a key area for consideration. Point-of-service fees have been shown unequivocally to deter appropriate use of health care, driving millions of people into poverty. All countries therefore need to implement prepayment pooling mechanisms to fund health services from taxation, social insurance schemes, or a mix of both.

Of course, universal health coverage requires more than just financing mechanisms or access to a basic package of services. It requires consideration of a range of complex issues, including performance, quality, effectiveness, acceptability, and prioritization of need as well as the impact of the social determinants on these issues. Increasing health literacy of communities and developing cultural competencies among health workers can reduce inequities in the quality of services provided.

Even in countries where the conditions for universal health coverage have been broadly created, marked inequities persist between socioeconomic, ethnic, and geographical groups. Thus other financing mechanisms need to be considered, such as linking provision of health services to wider social-protection schemes and providing targeted assistance to groups with greater needs. Funding formulas that take into account needs and social determinants (rather than population numbers only) are a useful tool in this regard. Financial protection is also required to ensure income at times when people become ill and are unable to work.

Figure 6. **Achieving equitable universal health coverage (UHC)**



Source: Frenz and Vega, 2010[49] adapted from WHO, 2008[21]

REORIENTING PUBLIC HEALTH PROGRAMMES IN CHILE

Chile has recently embarked on a reorientation of its public health programmes to reduce health inequities. In 2008, equity assessments using a Tanahashi-based framework were initiated for six major public health programmes: Child Health, Reproductive Health, Cardiovascular Health, Oral Health, Health of Workers, and Red Tide (algal blooms). The aims of these assessments were to identify differential barriers and facilitators to prevention, case detection, and treatment success and to provide guidelines to reorient each programme so as to improve equity in access to care.

Multidisciplinary teams undertook the assessments, with participation of health workers from all levels of the health system, communities, health bureaucrats, and decision-makers from other sectors. In 2010, all programmes applied the resulting recommendations, using intersectoral and participatory strategies. For example, the Cardiovascular Health programme implemented 67 good-practice interventions identified by its assessment and assisted all regional health teams in developing specific action plans to put these interventions into practice. In the Red Tide programme, strategies were developed for improved handling of the issue, with reduction of negative effects on fishermen through temporary diversification and restructuring of working conditions. This process resulted in the development of a set of indicators and methodologies for assessing equity of access to public health programmes.

More information on the Chilean experience can be found at http://www.equidad.cl/.

Useful Resources (available on accompanying DVD)

- Blas E, Sivasankara Kurup A, eds. *Equity, social determinants and public health programmes.* Geneva, WHO, 2010.
- Frenz P, Vega J. Universal health coverage with equity: what we know, don't know, and need to know. Background paper for the global symposium on health systems research. 2010. Available from: http://biturl.net/bzdv.
- Rasanathan K et al. Primary health care and the social determinants of health: essential and complementary approaches for reducing inequities in health. *Journal of Epidemiology and Community Health,* 2011, 65:656-660.
- Narrowing the gaps to meet the goals. New York, UNICEF, 2010. Available from: http://bitURL.net/bzdw.
- *Putting our own house in order: examples of health-system action on socially determined health inequalities.* Copenhagen, WHO Regional Office for Europe, 2010.
- *Monitoring equity in access to AIDS treatment programmes: A review of concepts, models, methods and indicators.* Geneva, WHO, 2010.
- *World health report 2008: Primary health care: now more than ever.* Geneva, WHO, 2008.
- *World health report 2010: Health systems financing: the path to universal coverage.* Geneva, WHO, 2010.

4. GLOBAL ACTION ON SOCIAL DETERMINANTS: ALIGNING PRIORITIES AND STAKEHOLDERS

Action on social determinants is required not only within countries but also internationally. Increasing integration of the global economy has resulted in increasing cross-border flows of goods, services, money, and people, affecting health and health equity both directly and through economic consequences. This trend has also resulted in a major reduction in the policy space available to governments for addressing social determinants. There is growing concern, particularly within civil society, that this process has prioritized economic considerations over health.

Increasing the ability of global actors (including bilateral cooperation agencies, regional agencies, philanthropic groups, and international organizations) to contribute to national and local action on social determinants requires improvements in global governance. Also essential are coherent global policies that do not undermine each other but instead mutually contribute to development. Like national governance mechanisms, global governance mechanisms are currently inadequate to address multifaceted problems like health inequities along with other global priorities. This situation challenges global institutions to reform in order to accommodate the changing realities of the 21st century.

The current circumstances thus make it particularly important to ensure that health, health equity, and social determinants are fully and appropriately integrated into new models of economic policy and global governance as they emerge. This task will require health sectors — both nationally and globally — to engage actively in debates relevant to reform of the global system in order to ensure a coherent policy regime that is oriented towards health equity and social determinants and is supportive of national efforts directed to these ends. The technical capacity of the health sector (in government and in civil society) to participate meaningfully and effectively in these debates needs to be expanded.

A global system better oriented towards social determinants will require fulfilment of commitments made (for example, in the Monterrey Consensus, the Doha Declaration, and the Gleneagles Summit) to move towards the 0.7% target for overseas development assistance by high-income countries, supported by enhanced South-South assistance. Complementary improvements in the quality and allocation of such assistance, in accordance with the priorities of recipients, will also be necessary. Reflection on development considerations, both in the current Doha "development round" of multilateral trade negotiations and in post-crisis reforms of the international financial system, will be indispensable. A key consideration in all these endeavours is to ensure that sufficient policy space is reserved to allow national governments to address social determinants effectively.

Aligning global stakeholders

Global governance must be aligned across sectors for action on social determinants, with health equity as a central objective of policy and a marker of policy coherence. This effort can build on recent progress in understanding the strategic importance of health for the development agenda as well as for issues such as foreign policy, security, and economic growth. Moreover, alignment of the different stakeholders involved in development is urgently required to support countries' efforts to develop and implement national strategies on social determinants. Development cooperation can act as a barrier to work on social determinants if it is fragmented; tied to specific sectors, projects, or procurement sources; or conditional on policies that may be damaging to equity and/or health. Similarly, stakeholders advancing conflicting aims make it difficult for countries to undertake the whole-of-government strategies necessary to address problems like health inequities.

The aid-effectiveness agenda provides a strong platform to build upon. The principles of the Paris Declaration on Aid Effectiveness[50] (that is, country ownership, alignment with national strategies and institutions, harmonization of development assistance, managing for results, and mutual accountability) are critical in enhancing the contributions of global actors to country action on social determinants. The Accra Agenda for Action[50] also needs to be fully implemented.

In addition to improving their own alignment, global actors can ensure that they build — rather than undermine — governance capacity in recipient countries to coordinate development assistance. This endeavour requires building negotiation and management skills in governments and mobilizing sufficient will in development assistance agencies to execute coherent planning processes that establish and pursue a long-term vision for countries in line with their own national priorities. Civil society can also play a constructive role by monitoring interactions and activities between government sectors and development assistance agencies and by advocating directly for action on health inequities and against national and international policies with potentially adverse effects on social determinants.

There is increasing potential for cooperation between low- and middle-income countries in showcasing initiatives and building capacity for integrated action on health inequities. The experiences and successes of many of these countries with regard to social determinants can provide valuable impetus, ideas, and means for other countries to address similar concerns and challenges. Such cooperation can increase the flow of information, resources, expertise, and knowledge among developing countries at reduced cost. Technology transfers between low- and middle-income countries and capacity-building in action on social determinants are important contributors to development. Global actors can further assist this exchange by improving monitoring, evaluation, and impact-measuring tools. They can also facilitate the provision of exchange mechanisms (for example, clearing-houses or searchable databases) to enable countries to identify and access available technical resources and networks, and they can foster technical cooperation arrangements. These initiatives need to be brought into the aid mainstream and aligned with cooperation efforts from traditional sources.

Global actors can play a vital role in the development of capacity for action on social determinants. Two key areas are monitoring social determinants and increasing access to technology. Global actors can improve access to and use of information technology and innovation in key social determinants — for example, agricultural productivity, water management and sanitation, energy security, and public health. Existing efforts can be expanded to facilitate the use of technologies and strengthen national capacity for innovation, research, and development.

However, aid is only one aspect of global governance for action on social determinants. It is also essential that the global governance system as a whole is coherent and that potential tensions and conflicts are resolved in a manner conducive to promoting social determinants and health equity. Relevant aspects of global governance include international agreements in areas such as trade and security, the international financial system, the regulation of migration, and the role of multilateral agencies. The increasing global mobility of capital results in major losses of public revenues necessary for action on social determinants through capital flight, tax avoidance, and tax competition. This mobility also contributes to harmful macroeconomic instability. Furthermore, exposure to international financial markets and international trade agreements can represent important constraints on policy space in relation both to development and to social provision. There is growing evidence of the negative effects of the increasing migration flows associated with rising global inequality on health and health equity — for example, the migration of health workers to higher-income settings. Unless these issues are addressed effectively and appropriately at the global level and national governments have the policy space and the necessary external support to manage their effects successfully, progress on social determinants of health within countries may be seriously constrained.

Health sectors in all countries (both in government and in civil society) need to debate key global issues with potential relevance to social determinants and to advocate for global structures and policies consistent with the promotion of health equity at the national and

A CATALYST FOR NATIONAL, EUROPEAN UNION, AND GLOBAL ACTION ON SOCIAL DETERMINANTS: THE SPANISH PRESIDENCY OF THE EUROPEAN UNION IN 2010

One of the key priorities of the Spanish presidency of the European Union (EU) in 2010, "Innovation in public health: monitoring social determinants of health and reduction of inequalities in health", was coordinated by the Government of Spain in collaboration with the European Commission and WHO. The promulgation of this strategy followed the identification of health equity and social determinants of health as a priority, with monitoring as a key first step, by the Spanish Ministry of Health in 2007.

During its EU presidency, Spain advanced the issues of monitoring social determinants at the national, EU, and global levels and of considering the role of the EU in contributing to the reduction of global health inequities. The result was the report "Moving forward equity in health: monitoring social determinants of health and the reduction of health inequalities", which reviewed existing work and outlined key priorities for further progress in this area. The other main outcome at the EU level — the conclusions on "Equity and Health in All Policies" — was approved by the EU Employment, Social Policy, Health and Consumer Affairs Council of Ministers.

At the national level, the Spanish EU presidency triggered the development of a national strategy for health equity based on deliberations by the National Commission for the Reduction of Social Inequalities in Health, which was convened for this purpose. The main strategic themes are:

1. to develop health equity information systems to guide public policies;
2. to promote and develop knowledge and tools for intersectoral work, advancing towards the concept of "Health and Equity in All Policies";
3. to promote policies aimed at ensuring equity during childhood and youth and a good start in life for all children, regardless of their parents' circumstances;
4. to develop a plan for political visibility of the National Strategy on Health Equity and Social Determinants of Health.

These main themes have been implemented at subnational level (through autonomous communities), with ongoing training on how to integrate a focus on social determinants and health equity into health strategies, programmes, and activities. Additional efforts towards health equity have focused on Roma, Spain's largest ethnic minority, who experience a disproportionate burden of ill health. These efforts have involved engagement with Roma civil society at national and local levels.

More information is available at http://bitURL.net/byt6.

global levels. Both the capacity to take on these challenges and the potential influence of these activities on policy can be enhanced through international cooperation and the formation of strategic alliances with other constituencies with broadly overlapping objectives (for example, social protection, education, employment, and environmental protection).

The United Nations (UN) system can set an example for policy coherence and better alignment of global governance by accelerating its own harmonization process to support capacity development by Member States in addressing social determinants at both the global and national levels. In particular, by reorganizing its country presence so that all agencies work together in an integrated manner on priority issues (including health inequities), the UN can greatly improve its capacity to help countries tackle complex challenges. The recent initiative to implement the UN Social Protection Floor provides an example of a comprehensive approach to accelerating progress on social determinants (see box below). UN agencies can build on these efforts by constructing a common platform to further social determinants approaches and by incorporating action on social determinants into key agreements and targets. These considerations need to be kept foremost in the final push towards achieving the MDGs but also in framing global priorities in the post-MDG environment to adopt a social determinants approach. It may be possible to use UN system mechanisms and governance structures to further improve intersectoral coordination for action on social determinants.

Aligning global priorities

Health inequities are among the many complex problems straining the capacities of global governance to mount an effective response. Many of these global priorities are closely linked. For example, progress on climate change is necessary to ensure that gains on the MDGs are not endangered. If coherence is poor, progress on one priority can have unintended adverse consequences for other issues. The failure to consider equity within countries in the original MDG targets raises the strong possibility that, in some countries, improvements in average outcomes have perversely resulted in increasing inequities.[51, 52] Global actors therefore need to ensure policy coherence in moving forward on different global priorities, with initiatives supporting rather than undermining one another.

Positioning health equity as a cross-cutting goal of development can facilitate greater alignment, as social determinants are relevant to all major global priorities. For example, achieving the health-related MDGs requires public health interventions to tackle specific risk conditions accompanied by interventions to reduce poverty and promote social protection, education, and empowerment. Most of the immediate risk factors for tuberculosis, malaria, HIV/AIDS, and maternal and infant mortality are associated with social conditions. In addition, tuberculosis, malaria, HIV/AIDS, and maternal and child health share social determinants with other key public health conditions. These social determinants encompass other MDGs, such as those on poverty, gender equity, education, and the environment.

Noncommunicable diseases (NCDs) are not addressed in the MDGs but are increasingly recognized as a major threat to social and economic development in all countries. Three weeks before the World Conference, the UN General Assembly will convene a high-level meeting on NCD prevention and control. Tackling NCD epidemics is impossible without acting on social determinants and considering both the common drivers of health inequities and the conditions addressed in the health-related MDGs. Combating these problems requires actions involving a range of sectors including finance, trade, agriculture, community planning, transport, and environment. For example, fiscal policies can be used to control NCD risk conditions by reducing tobacco consumption and fat, alcohol, and salt intake; preventing obesity; and promoting physical activity.

Addressing health inequities, tackling NCDs, and preventing harm from climate change are clearly linked.[53] For example, shifting to cleaner energy sources and more efficient household stoves can reduce emissions of black carbon, a potent greenhouse gas, and prevent large numbers of deaths from respiratory disease among the world's poorest communities. However, the challenge for global governance regarding action on social determinants lies less in recognizing these "win-win" situations when aligning priorities and more in managing tensions. For example, addressing tensions between the reduction of emissions and the creation of equitable opportunities for health and development requires balancing the fair sharing of burdens (that is, the "common but differentiated responsibilities" cited by the UN Framework Convention on Climate Change) with WHO's constitutional declaration that all people have a right to "the highest attainable standard of health".[54] Not all measures that can be implemented to reduce emissions will improve development for the most disadvantaged and reduce

IMPLEMENTING THE UNITED NATIONS SOCIAL PROTECTION FLOOR INITIATIVE

Extending social protection to all people is a fundamental strategy to support action on health inequities and other global priorities. A social protection floor approach promotes nationally defined strategies and comprises a basic set of social rights, services, and facilities that every person should enjoy. The UN suggests that a social protection floor could consist of two main elements that help to realize human rights:

- services: geographical and financial access to essential services such as water and sanitation, health, and education;
- transfers: a basic set of essential social transfers, in cash or in kind, to provide minimum income security and access to essential services, including health care.

The UN Social Protection Floor Initiative (SPF-I) provides a framework for the systematic build-up of more comprehensive social protection systems as countries develop further and economies recover from recent crises.

The SPF-I is supporting a growing number of countries in their endeavours to build social protection systems at any stage of the process. The tools for the planning and implementation of such action have been developed. SPF-I actors have collected evidence, documented experiences, and developed tools (for example, Social Protection Expenditure Reviews, social budgeting, actuarial models, needs assessments, costing assessments, capacity-building, and monitoring and evaluation) to support countries in their endeavours to build their own social protection floor. Requests for technical assistance can be directed to any of the participating UN agencies.

Several international and national organizations have endorsed the SPF-I. This initiative provides a model for intersectoral action on social determinants, transcending the mandate of any individual UN agency. The SPF-I is being implemented through a coherent, system-wide approach involving joint UN country responses, with each UN agency offering cutting-edge advice in its respective areas of expertise to ensure the optimal use of experts, resources, and logistical support.

More information on the UN Social Protection Floor Initiative can be found at http://biturl.net/bhtc.

"Addressing the social determinants of health is key for progress towards achieving universal health coverage. Most promising are coordinated policy approaches such as the ILO/WHO-led Social Protection Floor initiative."

Mr Assane Diop, Executive Director, Social Protection Sector, International Labour Organization

health inequities, and vice versa. Furthermore, not all partners will necessarily accept health equity as a shared measure of progress on global priorities. Regardless, the actions necessary to reduce carbon emissions to a level consistent with limiting global warming to 2°C must be undertaken in a way that also ensures the prospects for sustainable human development and for the economic capacity to address the social determinants in low- and middle-income countries.

In short, the issues that global governance needs to consider in managing these conflicts are similar to those discussed above for national governance. The upcoming UN Conference on Sustainable Development (Rio+20) presents an excellent opportunity to deepen these discussions and to find ways to strengthen coordinated actions in the fields of health and environment. The expiry of the MDG targets in 2015 also provides a stimulus for global actors to consider how to proceed with the reforms necessary for policy coherence, with implementation of a social determinants approach to harmonize action on key priorities.

Useful Resources (available on accompanying DVD)

- Committee for Development Policy. *Implementing the Millennium Development Goals: Health inequality and the role of global health partnerships.* New York, United Nations, 2009.
- Friel S et al. Climate change, noncommunicable diseases, and development: the relationships and common policy opportunities. *Annual Review of Public Health,* 2011, 32:133–147.
- Koller T et al. Global health inequalities and social determinants of health: opportunities for the EU to contribute to monitoring and action. In: *Moving forward equity in health: monitoring social determinants of health and the reduction of health inequalities.* Spain, Ministry of Health and Social Policy, 2010:50–59.
- Global health and foreign policy: strategic opportunities and challenges. Note by the Secretary-General. A/64/365. New York, UN General Assembly, 2009.
- WHO. *Global status report on noncommunicable diseases 2010.* Geneva, WHO, 2011.

5. MONITORING PROGRESS: MEASUREMENT AND ANALYSIS TO INFORM POLICIES AND BUILD ACCOUNTABILITY ON SOCIAL DETERMINANTS

Effective governance for social determinants requires monitoring and measurement to inform policy-making, evaluate implementation, and build accountability. Inequities in health outcomes, social determinants, and the implementation and impact of policies must be monitored.[55] This information needs to be institutionalized as part of accountability mechanisms to guide policy-making in all sectors.

Inadequate information on health inequities in many countries offers one explanation for a lack of action to combat these problems. Without efforts to compare the health status of different population groups, health inequities remain invisible, and progress in average health indicators often masks persisting or worsening differences between groups. Improvements in data collection and analysis of disparities have helped put health inequities on policy agendas, particularly in some high-income countries. While necessary, however, measurement of differences in health outcomes is not sufficient to support governance of action on social determinants. The availability of data varies greatly between countries, yet in all countries there is an urgent need for better measurement of social determinants and their impact on health and for analysis of the impact of all policies on health inequities.

Monitoring of social determinants requires the collection of data and the dissemination and application of these data in the policy process. Measurement of inequities in health outcomes is generally more developed than measurement of the social production of health and disease. Moreover, less information is routinely collected about the distribution of social and environmental risks for ill health than about biological risk factors. This dearth of information is a barrier to monitoring the effects of policy and to developing and evaluating evidence-based interventions on social determinants to reduce inequities. There is a need to move beyond traditional epidemiology to consider other methods that are linked to people's cultural context, value systems, goals, and expectations.[10] A narrow focus on health and disease outcomes obscures the relationship of social determinants to broader development goals.

Monitoring of health inequities and social determinants needs to be fully integrated into policy-making, particularly into accountability mechanisms. This integration requires sensitivity to the vast differences between country contexts in terms of data availability, political setting, and the nature of the health inequities themselves. Most importantly, it requires the provision of usable information that informs the design of effective policies to address social determinants, permits monitoring of changes in inequities, and explains the impact of specific strategies and choices.

It is critical to understand which data are most important for a given setting and to know how to turn data into information that can be used by the different audiences (including communities and civil society) who contribute to policy-making. As much attention needs to be given to the dissemination and availability of usable data on social determinants and related policies as to the generation of data. In all cases, data collection has costs and places a burden on providers; thus it is important to focus collection and analysis on what is required to inform and monitor policies rather than to gather data just for the sake of doing so.

Identifying sources and collecting data

Policy-making requires information on both social determinants and health outcomes. Monitoring social determinants requires information from beyond the health sector. Routine data collection systems in other sectors (for example, education and housing) can be rich sources of information on key social determinants as well as measures of development. As policies on social determinants need to act across sectors, monitoring requires a systems approach, with identification of necessary information through the pathways of social determinants required for reduction of health inequities. The reliable availability of the data needed to make the link between these social determinants and health inequities is crucial for progress.

Ideally, monitoring systems need to be sensitive in order to capture inequities across the entire social gradient rather than focusing only on population averages or known marginalized groups. Data on inequities in health outcomes and on health system performance can be derived from a number of sources commonly used by health information systems. However, these systems are not usually designed for routine generation, synthesis, or dissemination of data and information on social determinants, health inequities, or the associations between the two. Health measures are not well linked to policy-monitoring systems in other sectors.

Vital statistics, including birth and death registries, provide a sound basis for analysing disparities in health outcomes. Cause-of-death registries allow monitoring of death rates according to social factors such as education, occupation, sex, ethnicity, and place of residence. Censuses provide highly useful information on population groups and can also yield information on social determinants, especially if linked to mortality data. Population-based surveys can provide essential data in the absence of systematic health information systems or for investigating specific concerns. Health records can provide information on health outcomes and the performance of the health sector; however, they are often incomplete and exclude individuals who do not use health services.

Efforts to expand coverage of civil registration, which currently excludes more than half of the world's population, represent a significant step in reducing inequities. Information is often especially sparse for marginalized groups (for example, rural communities, undocumented migrants or the urban poor) who are critical to an understanding of health inequities. Issues of quality and timeliness of data are also important. Collection of information on social factors associated with disadvantage and an ability to analyse data by geographical location can greatly assist policy efforts, but ensuring quality and timeliness is often disproportionately difficult in poorer and marginalized groups.

Disaggregating data

To monitor health inequities and social determinants, data must be separated, analysed, and compared — or "disaggregated" — according to the main factors known to be associated with health inequities. These social "stratifiers" include age, income, education, class, occupation, sex, ethnicity (or "race" in some jurisdictions), disability, and place of residence (to the smallest administrative unit possible). Disaggregation is essential for implementing policies that address inequities, but it also allows better decision-making and accountability at the local level. Advances in geographical information systems can facilitate the collection of disaggregated geographical data and the dissemination of these data in a usable form.

The selection of stratifiers depends on the context, as it is not feasible or even desirable to disaggregate by all possible factors, given limited resources for data collection. For example, in settings where levels of employment and education are universally high, employment status and level of education may be poor proxies for socioeconomic position. In low-income settings and in communities that are not entirely cash based, income may not be an accurate marker of socioeconomic position, and alternative measures may need to be identified. Other context-specific ways to examine individual and household wealth include ownership of material goods (for example, a refrigerator, radio, or bicycle), agricultural wealth (for example, livestock or land ownership), and access to key services (for example, running water, toilets, bank accounts, and health care facilities).

Selecting indicators and targets

To inform policy change, monitoring systems require the establishment of agreed-upon goals for reduction of health inequities, with clear indicators and targets, across different sectors. Monitoring systems should include indicators that measure social determinants and methods for linking data from different sectors to elucidate their impact in reducing or exacerbating health inequities. In selecting indicators, issues of timeliness, comparability, harmonization, and accessibility need to be considered.

These indicators should also include a balance between measures reflecting factors that increase the risk of ill health and measures promoting the well-being of populations. Indicators and targets are needed in terms of health gaps, access to services, and social determinants. Indicators already developed for monitoring the implementation of human rights–based approaches or for considering specific aspects of inequity (for example, gender inequities) can also be used. Setting targets and indicators must not be a merely technical endeavour; as with indicators used for other purposes, it needs to be part of the policy-making process to reduce health inequities.

Table 5. Potential basket of indicators for monitoring of social determinants and health inequities

	Social determinant indicator	Data source
1.	Total debt service as percentage of gross national income	World Bank
2.	Extent to which a country's citizens are able to participate in selecting their government; extent of freedoms of expression, association, and the media	World Bank
3.	Total government expenditure on health and education as percentage of total government expenditure	WHO; UNESCO
4.	Ratio of wages to corporate profits	World Bank
5.	Proportion of young people not in school or employment, by age and sex	OECD
6.	Informal sector employment (%)	ILO
7.	Gini coefficient (income distribution)	World Bank
8.	Adult literacy rate (%) for the population over 15 years of age *	UNDP; UNESCO
9.	Ratio of highest-paid to lowest-paid workers *	ILO
10.	Net primary school enrolment ratio of females to males *	UNDP; UNESCO
11.	Completion of primary/secondary education by ethnic/ "race" group in a country *	UNESCO
12.	Access to improved water (%) *	WHO
	Health outcome	
1.	Healthy life expectancy (male, female) *	WHO
2.	Deliveries attended by skilled birth attendant (% by wealth quintiles) *	WHO
3.	Under-5 mortality ratio (rural, urban) *	WHO
4.	Infant mortality ratio (by wealth quintiles) *	WHO
5.	Newborns with low birth weight (% by mother's education) *	WHO
6.	Children aged <5 years with moderately or extremely low values for weight and height (rural, urban) *	WHO
7.	Prevalence of obesity among adults (15 years and older) (by wealth quintiles) *	WHO
8.	HIV prevalence among adults aged 15-49 (male, female) *	WHO

Indicators reflect a spectrum across types of determinants (root causes to risk conditions). All reflect existing indicators with data available for multiple countries, with the source noted. Indicators marked with an asterisk (*) should be stratified by one or more dimensions — for example, socioeconomic status, education, occupation, sex, and/or ethnicity (religion, "race", tribal affiliation).

Types of within-country potential differentials are provided in parentheses for health outcome indicators. For a number of indicators included in the proposed list, sufficiently stratified data are available to make monitoring possible. For others, data collection efforts at the national level need to be strengthened.

Indicators selected for monitoring policies aimed at reducing health inequities need to be clearly understood by policy-makers across the different sectors that influence the social determinants as well as by communities. Thus simpler measures may be more transparent and easier to interpret than complex summary measures. Health inequities can be assessed through relative and absolute measures; since the two types of measure illustrate different aspects, both are needed over time for comprehensive analysis and as inputs to policy-making.

Table 5 presents a potential list of indicators to monitor social determinants and health equity that derives from a draft list developed during the Commission process[56] and since refined. Chile and England have already used a similar approach in recent work on social determinants, selecting specific indicators and then publishing data by each territorial jurisdiction. The World Conference provides an opportunity for discussion of these indicators and generation of momentum towards an internationally agreed-upon list. The intention is for a small number of indicators to be selected for international comparison and for the chosen indicators to reflect both inequities in health outcomes and key stages in the accumulation of social disadvantage across the life course. A wider set of indicators would be needed to monitor key policies appropriate to the local or national context. These indicators need to be identified at the relevant operational level in order to accurately reflect the local situation, but at the same time they must be consistent with an understanding of the framework of pathways that lead to health inequities.

Moving forward despite unavailability of systematic data

Globally, monitoring of health inequities ranges from countries with little routinely collected health data to countries that measure health inequities routinely but may still lack data on social determinants. Strengthening data collection systems to remedy these gaps is often a slow process. In this situation, lack of data should not preclude action to reduce health inequities. After all, policy-makers frequently must make decisions without systematic information or evidence.

Several options can help overcome a lack of routine population-based data. Population-based surveys conducted at regular intervals can be used to provide some information. For example, the Demographic and Health Surveys (DHS), which are conducted in many countries at 5-year intervals, collect data on the education and employment status of individuals within participating households and are a valuable resource in describing between-group health differences related to social factors. Other useful surveys include the Multiple Indicator Cluster Surveys (MICS) and the World Health Survey. Health facility reporting data can also be used in some instances to compare communities in terms of geographical patterns in illness and service use.

Better use can be made of qualitative methodologies such as observational evidence, evaluations, and natural policy experiments. Generation of the evidence required for action on health inequities requires a multidisciplinary approach reflecting the range of sectors that need to be involved in the action. Disadvantaged social groups and key social problems are likely to be well known. Rich sources of additional data can be found by tapping into the knowledge base of those working most closely with communities and of the communities themselves. Civil society groups, including trade unions and community organizations, often have in-depth information and data on problems and on the processes that are necessary to implement action on social determinants. In addition, community leaders, health practitioners, programme implementers, and political leaders are all sources of existing knowledge about problems influencing social determinants and health inequities as well as their potential solutions. Countries with poor data can make use of evidence from other settings, considering how their own contexts differ from those in the countries from which the information is drawn.

Effective action on health inequities generally does require some investment in expanding monitoring systems, particularly to obtain more information on social determinants. Even with well-developed monitoring systems, most of the available information relates to health outcomes, with much less focus on measuring social determinants (and inequities in their distribution). To address this issue, two key strategies are required: (1) collection of new data on some factors and (2) better linkage, harmonization, and sharing of existing data by different sectors. Countries can aspire to systems that routinely collect information on social determinants, health outcomes, and relevant health determinants in a coherent fashion. The challenges in choosing to collect new data are to identify the key factors that need to be studied, in light of the context (for example, which communities are most disadvantaged), and to ensure that new data can be rapidly used to inform policies and monitor planned interventions.

"We must not ignore ethnic health inequities when they arise. We must be purposeful and bold in the response we make to ensure we achieve the change we need. In New Zealand, some important gains have been made in beginning to assess the prevalence and impact of racism on Māori health and inequalities, such as measures included in the New Zealand Health Survey."

Hon Tariana Turia, Associate Minister of Health, New Zealand

Disseminating information on health inequities and social determinants to inform action

The availability of evidence highlighting health inequities or the effectiveness of particular policy or programme options does not automatically result in the implementation of systematic policies on social determinants. Translating evidence into useful information for action on social determinants and health equity requires mechanisms for assessing the information and communicating it to policy-makers and other stakeholders. Data on social determinants must be made more broadly available to all sectors to allow analysis, interpretation, and advocacy by a wide range of actors, including civil society and communities. In particular, information needs to be fed back and integrated into accountability mechanisms for the implementation of policies.

Improved dissemination of information needs to be accompanied by efforts to present information in a way that is meaningful to the audience and to build the community's capacity to interpret and use such information. For example, public websites and simple mechanisms such as traffic-light coding can be used to compare the progress of different geographical areas or social groups in terms of key social determinants. Synthesis of evidence through the use of reviews, policy briefs, or guidelines for action can make this evidence available in a form that is digestible for policy-makers. Setting up systems for feedback and sharing of knowledge, such as communities of practice, can provide opportunities for comparisons and for peer learning among practitioners and policy-makers. "Observatories" have proved useful institutions in many countries to analyse and disseminate health-related data and synthesize these data into a useful form for policy-makers, but there is a need for a greater focus in their work on social determinants.

Integrating data into policy processes

Political processes within society do not operate solely on the basis of rationality and evidence but rather rely on negotiation among various — and often contradictory — interests. Moreover, the process by which data and information are translated into the implementation of policies is complex. The system for collecting data on health inequities and social determinants must be aligned with policy-making processes so that data are communicated to policy-makers in a meaningful and timely manner and government objectives and accountabilities are taken into consideration. Information on health inequities and social determinants needs to inform problem identification and the development of policy options. Data for problem identification can come from routine collection and reporting as well as from specific initiatives. A range of tools can be helpful in considering the impact of different policies on health inequities. Tools such as scorecards and benchmarks can simplify and summarize health equity issues for input into policy-making. However, the key is not to choose exactly the right tool but rather to integrate awareness of social determinants and health inequities into the overall process.

Assessing the health and equity impacts of different policy options

Once reducing health equities is identified as a high priority across policy-making, it is important to use a range of tools to consider the impact of various sectors' policies on equity. Two key approaches are health impact assessment and health equity assessment tools. Gender mainstreaming and human rights tools can also be of value.

Health impact assessment (HIA) is an important tool in facilitating integrated action on social determinants by helping policy-makers systematically assess how different policy options will affect health and thus enabling them to take health consequences into account when choosing between options. HIA draws on the methodologies developed for environmental impact assessment and shares similar steps and procedures with other impact assessments, including poverty, social, and strategic impact assessments. Four key values underpin HIA in informing decision-making: democracy, equity, sustainable development, and ethical use of evidence. HIA provides recommendations on how a proposed policy, plan, or strategy can be modified or adapted to avoid health risks, to promote health gain, and to reduce health inequities.

Likewise, health equity assessment tools aim to orient policy-making with regard to effects on health inequities. For example, the Urban Health Equity Assessment and Response Tool (Urban HEART, see http://www.who.or.jp/urbanheart.html) is a tested tool developed by WHO to systematically incorporate health equity considerations into the planning cycle, specifically in urban settings. Health equity audits can be used to judge the fairness of the distribution of services or resources, given the health needs of different groups and areas, and to identify priority actions.

Useful Resources (available on accompanying DVD)

- Marmot M et al. *Fair society, healthy lives: strategic review of health inequalities in England, post-2010, the Marmot Review.* London, UCL, 2010.
- Sadana R et al. Overview: Monitoring of social determinants of health and the reduction of health inequalities in the EU. In: *Moving forward equity in health: monitoring social determinants of health and the reduction of health inequalities.* Madrid, Spain, Ministry of Health and Social Policy, 2010:23–31.
- Stiglitz J et al. *Report by the Commission on the Measurement of Economic Performance and Social Progress.* Available from: http://www.stiglitz-sen-fitoussi.fr/en/index.htm.
- WHO. *Urban Health Equity Assessment and Response Tool (Urban HEART).* Available from http://www.who.or.jp/urbanheart.html.

THE EQUITY WATCH IN EAST AND SOUTHERN AFRICA

Almost all countries in East and Southern Africa have policy commitments to promote health equity. In 2007, EQUINET, a network of professionals, civil society, state, parliament, and academics within the region that promotes health equity, analysed and reported on regional health equity. This report contributed to a 2010 East, Central, and Southern Africa Regional Health Ministers Meeting resolution to track and report on progress in addressing health inequities. In addition, the report was used in 2009, in consultation with institutions in the region, to develop a framework for gathering and analysing evidence on health equity at the national and regional levels. In an endeavour termed the "Equity Watch", national teams — involving state and nonstate actors and working with EQUINET — organize, analyse, and accessibly present a range of existing quantitative and qualitative evidence to assess progress in addressing health inequities, to evaluate social determinants and health care, and to inform social dialogue on proposals for strengthening health equity. In addition to areas of importance for specific countries, 25 progress markers are included in all Equity Watch reports:

- five markers of advancing equity in health;
- seven markers of access to national resources and social determinants;
- eight markers of resourcing redistributive health systems;
- five markers of a more just return from the global economy.

The Regional Health Community Monitoring and Evaluation Expert Group provided input into the progress markers. At a national level, the pilot Equity Watch in Zimbabwe and the dialogue it prompted led to strengthened civil-society and parliamentary advocacy for primary health care. The Mozambique Equity Watch was discussed in 2010 to identify follow-up work that is now being pursued, including improvement of equity in resource allocation and follow-up research on social determinants and health inequities *within* districts. At a review meeting on the recently completed report from the Zambia Equity Watch in June 2011, stakeholders proposed that it be repeated annually in conjunction with monitoring of the implementation of the National Health Strategic Plan and proposed to use it to inform action across key sectors involved in social determinants. The Kenya and Uganda Equity Watch reports are being finalized (with evidence from the Kenya report feeding into the new National Health Policy), and a second regional Equity Watch is being compiled to share evidence on progress, gaps, and promising practice, including for report-back on the Health Ministers resolution.

More information is available at http://www.equinetafrica.org.

MONITORING HEALTH INEQUITIES AND SOCIAL INDICATORS IN NEW ZEALAND AND ENGLAND

In New Zealand, the reduction of health inequities has become a priority in the past two decades. The New Zealand Public Health and Disability Act 2000 explicitly identified the need for the health sector to reduce inequities. Developments in policy and practice have been assisted and even driven by substantial expansion of the evidence for health inequities. This progress has resulted in reductions in ethnic health inequities between indigenous Māori and non-indigenous New Zealanders over the past decade. Key advances have included:

- the development of the New Zealand Deprivation Index (NZDep), a small-area, census-based summary index of deprivation that is based on several socioeconomic factors and provides a measure of socioeconomic status according to place of residence;
- the development and enforcement of data protocols for the recording of ethnicity in the health sector;
- the New Zealand Census-Mortality Study, an ongoing project that links mortality data to census records, providing more and better-quality data for monitoring of health inequities;
- the expansion of the New Zealand Health Survey, with the inclusion of questions on experience of racial discrimination to enhance understanding of the impact of interpersonal racism on ethnic health inequities;
- the establishment of a series of New Zealand Social Reports that measure social well-being over time in terms of ten social outcome domains (including but not limited to health).

More information on the New Zealand experience can be found in the following publications:

Crampton P et al. *Degrees of deprivation in New Zealand.* Wellington, Bateman, 2002.

Ministry of Health. *Ethnicity data protocols for the health and disability sector.* Wellington, Ministry of Health, 2004. Available from http://biturl.net/bhue.

Harris R et al. Racism and health: the relationship between experience of racial discrimination and health in New Zealand. *Social Science and Medicine,* 2006, 63:1428–1441.

Blakely T et al. *Tracking disparity: trends in ethnic and socioeconomic inequalities in mortality, 1981–2004.* Wellington, Ministry of Health, 2007. Available from http://biturl.net/bhuf.

Pega F et al. *Monitoring social well-being: the case of New Zealand's Social Reports / Te Pūrongo Oranga Tangata. Social Determinants of Health Discussion Paper 3 (Case Studies).* Geneva, WHO, 2010. Available from http://biturl.net/bhuc.

In England, following the review of heath inequities chaired by Sir Michael Marmot, national targets in three areas were proposed: health outcomes across the social gradient (life expectancy, health expectancy, and well-being); child development across the social gradient (readiness for school and young people not in education, employment, or training); and income sufficient for healthy living. Not all of the targets could be directly measured immediately, especially in terms of their social or geographical distribution. In the short term, the best available proxy indicators for most of these targets were identified and used to monitor across the life course. In addition to life expectancy and disability-free life expectancy, the indicators included:

- early childhood development;
- the proportion of 16- to 18-year-olds not in education, employment, or training (a measure related to the transition between school and work);
- the proportion of people on means-tested benefits (a measure of adult poverty).

The analysis was conducted and published for every local authority in the country on the one-year anniversary of the Marmot Review. The slope index of inequality was also produced for the two health measures to quantify the social gradient within each local authority. The analysis was simple, generated great interest, and permitted the monitoring of progress. More information can be found at http://www.marmotreview.org and at http://bitURL.net/bwu6.

CONCLUSION: URGENT STEPS

Acting on social determinants to build inclusive societies, improve health, and achieve broader development can be a difficult task. Action is possible, however, in all countries, at all income levels. Every country can begin to implement a social determinants approach in order to improve the functioning of its society and to set out on the path towards reducing health inequities. Moreover, with the necessary political will, considerable progress can be made in increasing the attention paid to social determinants of health and to crafting policies that are more coherent with this objective at the global level.

In highlighting key processes for implementation, this discussion paper is far from exhaustive. However, while the execution of national strategies will need to be adapted according to realities in each country, priority themes can be identified for action at the outset.

First, there is a need to build governance for action on social determinants at every level, from the local to the global. This effort must integrate work across the whole of a country's government, across the whole international system, and — at both levels — within the health sector and between sectors. Holistic action on social determinants requires the consideration of all interests and the inclusion of all parties affected in the decision-making process, especially those that are most disadvantaged. It also requires agreement on shared higher goals across sectors; health inequities must be recognized as a common measure of policy failure, and conflicts among different interests must be resolved in terms of these shared goals. In the context of increasing global concern about the social impacts of growing disparities in life opportunities, it is an excellent time to institutionalize a greater concern for equity across decision-making processes in the whole of government and the whole system of global governance. In cooperating with individual countries and developing rules, norms, and policies at the international level, the global community has a particular responsibility to consider how its actions support or detract from a concern for equity. Potential priority actions for further consideration and discussion at the World Conference are presented in the box below.

Second, the inequitable distribution of power among different classes and groups within society must be ameliorated by promoting the participation of previously excluded groups in decision-making. Promoting the political participation of communities is essential to creating a broad social base of support for innovative policies on social determinants. Community participation can significantly enhance the quality and responsiveness of health and other social services, improving management, monitoring, accountability, and evaluation. In facilitating and strengthening participation, governments need to recognize the leadership of social movements and civil society organizations. The current gap between the rhetoric of participation and the reality must be closed by addressing the obstacles to full participation, many of which may lie within governments and international agencies themselves. These entities need to invest in community participation, creating favourable conditions and facilitating the empowerment of all stakeholders.

Third, monitoring of health inequities cannot be limited to the health sector and the measurement of health outcomes. Measurement of inequities in health outcomes alone defines the problem but supplies little ammunition for its solution. Monitoring of inequities in key social determinants and linking of data from different sectors can help optimize policy design through a social determinants approach, with changes implemented when adverse outcomes are identified.

Fourth, implementing the range of processes highlighted in this paper requires urgent and sustained political and technical capacity-building at all levels — among policy-makers, among government workers involved in service delivery, within civil society, and in the private sector. In building the capacity for work on social determinants, the global community can play a vital role by facilitating further exchange of expertise and knowledge, creating and disseminating tools, and providing training. These activities may prove most useful when they involve countries whose contexts are similar.

"There is enough evidence associating health indicators to social issues. We already know, for instance, that public policies are fundamental to address the social determinants of health. We have to admit there is also enough evidence to prove that it is possible to do things differently. Political will and cooperation between countries are fundamental."

Dr Alexandre Padilha, Minister of Health, Brazil

Fifth, despite the overarching need for work across all sectors, action within the health sector remains crucial. Institutionalizing equity in the health sector not only makes it possible for this sector to contribute significantly to reducing health inequities but also provides a clear signal to other sectors. Unless the health sector "puts its own house in order"[57] and provides effective measures reflecting the scale of the problem, the motivation to act and subsequent progress on health inequities will be undermined. In all of the areas discussed in this paper, the health sector has an important role to play, both nationally and globally, in generating and promoting increased attention to social determinants. While it cannot expect to play a dominant role in this process, the health sector should exercise leadership in building strategic alliances with other sectors that have broadly overlapping agendas (for example, social protection, education, employment, and environmental protection). Moreover, the health sector can influence debates and guide the formulation of policies that affect social determinants.

Finally, countries that have made progress on health inequities have not necessarily employed all of the strategies covered in this paper. These countries have identified desired outcomes — not always related to health — and proceeded to act. In an era of overwhelmingly complex problems, action on social determinants is urgently needed to make the final push towards fulfilment of the MDGs; to address environmental challenges, including climate change; to tackle NCDs; to protect economic and social development; to build social protection systems; and to ensure the inclusion of every societal group through exercising of the freedom that exists in fair opportunities for all. The World

Conference provides an opportunity for countries, the global community, civil society, and the private sector to resolve to act together on social determinants in order to achieve these shared goals and prevent the needless loss of millions of lives to social injustice each year.

POTENTIAL PRIORITY ACTIONS FOR CONSIDERATION DURING THE WORLD CONFERENCE

- Agreement on a global monitoring framework through which countries can measure social determinants
  - Integration of a social determinants approach into new measures of societal goals
  - Revision, validation, and implementation of the indicators presented in this paper
- Integration of a social determinants approach and harmonized targets in addressing key global priorities in the post–MDG period
  - Climate change
  - Food security
  - UN Social Protection Floor
  - Women's and children's health
  - Noncommunicable diseases
  - HIV/AIDS, tuberculosis, and malaria
- Common UN platform for work on social determinants of health
  - Advocacy
  - Research agenda
  - Capacity-building and toolkit
  - Joint technical assistance

GLOSSARY

Accra Agenda for Action (AAA): An international agreement, adopted in 2008, that highlights the need for specific reforms in the aid sector to achieve improved aid effectiveness.[58]

Capacity-Building: The process by which individuals, organizations, institutions, and societies develop abilities to perform functions, solve problems, and set and achieve objectives. Developing capacity requires action at three interrelated levels: individual, institutional, and societal.[59]

Civil Society: The space for collective action around shared interests, purposes, and values. Civil society is generally distinct from government and commercial for-profit actors, although these boundaries can be blurred. Civil society is not homogeneous, encompassing charities, development nongovernmental organizations, community groups, men's and women's organizations, faith-based organizations, professional associations, trade unions, social movements, coalitions, and advocacy groups. There is certainly no one 'civil society' view, and civil society actors contend with issues of representativeness and legitimacy similar to those encountered by other representatives and advocates. The inclusion of civil society, despite its complexity and heterogeneity, is essential to build public support and to give expression to marginalized individuals and groups and to others who often are not heard. Civil society actors can enhance the participation of communities in the provision of services and in policy decision-making.

Commission on Social Determinants of Health (CSDH): A global network of policy makers, researchers, and civil society leaders brought together by WHO to provide support in tackling the social causes of poor health and health inequities. The CSDH had a three-year mandate (2005–2008) to gather and review evidence on what was needed to reduce health inequities within and between countries and to report its recommendations for action to the Director-General of WHO.

Demographic and Health Surveys (DHS): Nationally representative household surveys with large sample sizes (usually between 5,000 and 30,000 households). These surveys provide data on a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition. Typically, the surveys are conducted every five years to allow comparisons over time.[60]

Environmental Impact Assessment: A process to predict the environmental effects of proposed initiatives before they are implemented. More specifically, an environmental assessment may identify possible environmental effects; propose measures to mitigate adverse effects; or predict whether there will be significant adverse environmental effects.[61]

Epidemic: The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area, or season.

Equity Assessment: A structured process for assessing the potential impact of a programme or policy on inequities and/or on disadvantaged populations.

Governance: The process by which governments (including their different constituent sectors) and other social organizations interact, relate to citizens, and take decisions in a complex and globalized world. In this process, societies or organizations make decisions, determine whom they involve in doing so, and identify ways to ensure accountability for actions.[28]

Health: A state of complete physical, mental, and social well-being, as opposed to the mere absence of disease or infirmity.[62]

Health Disparity: Differences in health status between population groups. This term is used to describe both health inequities and health inequalities, particularly in the United States of America.

Health Equity: The absence of differences in health that are not only unnecessary and avoidable but are also considered unfair and unjust. Health equity does not imply that everyone should have identical health outcomes, but it does imply that all population groups should have equal opportunities for health and therefore that there should not be systematic differences in health status between groups.

Health Equity Assessment Tool: A tool designed to facilitate the consideration of health equity and inequities in the policy development process. (See *Urban HEART* below for an example of a health equity assessment tool).

Health Equity Audit: A specialized audit used to judge the fairness of the distribution of services or resources, given the health needs of different groups and areas, and to identify priority actions.

Health Impact Assessment (HIA): A combination of procedures, methodologies, and tools by which a policy, programme, product, or service may be assessed in terms of its effects on the health of populations.[63]

Health in All Policies Approach: A policy strategy that establishes health as a shared goal across the whole of government and as a common indicator of development. This strategy highlights the important links between health and broader economic and social goals in modern societies. In addition, it positions improvements in population health and reductions in health inequities as complex high-priority problems that demand an integrated policy response across sectors. This response needs to consider the impacts of policies on social determinants as well as the benefits of improvements in health for the goals of other sectors.[26]

Health Inequality: A difference in health between groups of people. In some jurisdictions health inequality is used to denote the same meaning as health inequity.

Health Inequity: Unfair and avoidable or remediable inequalities in health between populations within countries and between countries. These differences arise from social processes and are not natural or inevitable.

Health Lens: An important component of a Health in All Policies approach, used to identify key relationships between population health and well-being and other societal goals and deliver mutually beneficial outcomes. Five key steps in using a health lens include fostering strong relationships with other sectors and agreeing upon a focus of policy; elucidating impacts between health and the policy area under focus and identifying evidenced-based policy options; producing final policy recommendations jointly owned by all partner agencies; steering recommendations through the decision-making process; and evaluating the effectiveness of the health lens.[29]

Health System: The structured and interrelated set of all actors and institutions whose primary intent is to improve or maintain health.

Intersectoral Action (ISA): Integrated work between different sectors towards a collective goal. In the context of health, ISA refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly — but not necessarily — in collaboration with the health sector.

Millennium Development Goals (MDGs): The UN MDGs are eight goals that all 191 UN Member States have agreed to try to achieve by the year

2015. The UN Millennium Declaration, signed in September 2000, commits world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. The MDGs are derived from this Declaration, and all have specific targets and indicators.

Multiple Indicator Cluster Surveys (MICS): A survey programme developed by UNICEF to provide internationally comparable, statistically rigorous data on the situation of children and women.[64]

Needs Assessment: A systematic procedure for determining the nature and extent of health needs in a population, the causes and contributing factors to those needs, and the human, organizational, and community resources available to respond to those needs.[63]

Noncommunicable Diseases (NCDs): Also referred to as *chronic diseases*, NCDs are diseases of long duration and generally slow progression. The four main types of NCDs are cardiovascular diseases (for example, heart attacks and stroke), cancer, chronic respiratory diseases (for example, chronic obstructed pulmonary disease and asthma), and diabetes.

Paris Declaration on Aid Effectiveness: The Paris Declaration on Aid Effectiveness expresses the international community's consensus on the direction for reforming aid delivery and management to improve effectiveness and achieve results.[58]

Participatory Budgeting: A participatory approach to national budgeting designed to strengthen collaboration between the government, the private sector, and civil society. Participatory budgeting processes can facilitate more effective and equitable use of public resources, deter corrupt practices, and achieve more sustainable outcomes.

Prepayment Pooling Mechanisms: The funding of health services from taxation, social insurance schemes, or a mix of the two, reducing the need for out-of-pocket payment at point of service.

Primary Health Care: An approach to health equity and health systems emphasizing the importance of primary care (that is, the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practising in the context of family and community) as well as the need to work across different sectors, address the social and economic factors that determine health, mobilize the participation of communities in health systems, and ensure the use and development of technology that is appropriate in terms of setting and cost. Primary health care efforts aim to move care closer to where people live, to ensure the involvement of people in decisions about their own health care, and to address key aspects of the physical and social environment essential to health, such as water, sanitation, and education. This approach was codified in the Declaration of Alma Ata in 1978.[65]

Social Determinants of Health: The conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities. This term is also shorthand for the wider social, political, economic, environmental, and cultural forces that determine people's living conditions.

Social Gradient: Health differentials affecting the entire global population that are often tied to socioeconomic status but are seen in all countries, regardless of income level. The poorest of the poor, around the world, have the worst health. Within countries, the evidence shows that, in general, the lower an individual's socioeconomic position, the worse his or her health.

Social Impact Assessments: The processes of analysing, monitoring, and managing the intended and unintended social consequences, both positive and negative, of planned policies and programmes as well as any social change processes invoked by those interventions. The primary purpose of social impact assessment is to bring about a more sustainable and equitable biophysical and human environment.[66]

Social Justice: The organization of society towards an available common good for all, to which all are expected to contribute. To promote and respect social justice means to be part of a society where all members, regardless of their background, have basic human rights and equitable access to their community's wealth and resources.

Social Protection: The set of policies and programmes designed to reduce poverty and vulnerability by promoting efficient labour markets, diminishing people's exposure to risks, and enhancing people's capacity to protect themselves against hazards and interruption/loss of income. The policies and procedures included in social protection involve five major kinds of activities: labour market policies and programmes, social insurance programs, social assistance, micro- and area-based schemes, and child protection.[67]

United Nations Framework Convention on Climate Change: An international treaty, established in 1992, dedicated to exploring opportunities to reduce and address global warming. More recently, a number of nations have approved the Kyoto Protocol, which is a legally binding addition to the treaty.[68]

United Nations Social Protection Floor Initiative (SPF-I): A joint UN effort to build a global coalition of UN agencies, international nongovernmental organizations, development banks, bilateral organizations, and other development partners that are committed to collaborating at the national, regional, and global levels to support countries in building national social protection floors for their populations. The SPF-I corresponds to a set of essential transfers, services, and facilities that all citizens everywhere should enjoy to ensure the realization of the rights embodied in human rights treaties.[69]

Universal Health Coverage: Access to and use of quality services through the continuum of care for all people in a society. Universal health coverage ensures that disadvantaged groups with greater health needs receive the resources necessary for the provision of appropriate health services to meet their needs.

Urban Health Equity Assessment and Response Tool (Urban HEART): A tested tool developed by WHO to systematically incorporate health equity considerations into the planning cycle, specifically in urban settings. Urban HEART is a tool intended to give policy-makers and key stakeholders at the national and local levels a user-friendly guide to assess and respond to urban health inequities.[70]

REFERENCES

1. Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health: Commission on Social Determinants of Health final report.* Geneva, WHO, 2008.
2. Resolution WHA62.14. Reducing health inequities through action on the social determinants of health. Geneva, 2009. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA62-REC1/WHA62_REC1-en-P2.pdf.
3. Rasanathan K et al. Primary health care and the social determinants of health: essential and complementary approaches for reducing inequities in health. *Journal of Epidemiology and Community Health,* 2011, 65:656-660.
4. WHO, UNICEF. Declaration of Alma-Ata. Alma-Ata, USSR, 1978.
5. WHO. Ottawa Charter for Health Promotion. Ottawa, 1986.
6. Solar O, Irwin A. *A conceptual framework for action on the social determinants of health.* Social determinants of health discussion paper 2 (policy and practice). Geneva, WHO, 2010. Available from: http://whqlibdoc.who.int/publications/2010/9789241500852_eng.pdf.
7. Commission on Macroeconomics and Health. Macroeconomics and health: investing in health for economic development: report of the Commission on Macroeconomics and Health. Geneva, WHO, 2001.
8. Wilkinson R, Marmot M, eds. *Social determinants of health: the solid facts.* 2nd ed. Copenhagen, WHO Regional Office for Europe, 2003.
9. WHO, Government of South Australia. Adelaide Statement on health in all policies. Adelaide, 2010.
10. Stiglitz J, Sen A, Fitoussi J-P. Report by the Commission on the Measurement of Economic Performance and Social Progress. Available from: http://www.stiglitz-sen-fitoussi.fr/en/index.htm.
11. Brazilian National Commission on Social Determinants of Health. *The social causes of inequities in health in Brazil.* Rio de Janeiro, Fiocruz, 2008. Available from: http://cmdss2011.org/site/wp-content/uploads/2011/07/relatorio_cndss.pdf.
12. Paim J et al. The Brazilian health system: history, advances, and challenges. *Lancet*, 2011, 377:1778-1797.
13. Marmot M et al. *Fair society, healthy lives: strategic review of health inequalities in England, post-2010, the Marmot Review.* London, UCL, 2010.
14. Chen Z. Launch of the health-care reform plan in China. *Lancet,* 18, 373:1322-1324.
15. Nandan D. National rural health mission: turning into reality. *Indian Journal of Community Medicine*, 2010, 35:453-454.
16. Kumar AKS et al. Financing health care for all: challenges and opportunities. *Lancet,* 2011, 377:668-679.
17. Koh HK, Sebelius KG. Promoting prevention through the Affordable Care Act. *New England Journal of Medicine,* 2010, 363:1296-1299.
18. Ministry of Health and Social Policy of Spain. *Moving forward equity in health: monitoring social determinants of health and the reduction of health inequalities.* Madrid, Ministry of Health and Social Policy of Spain, 2010.
19. AFRO/RC Resolution 60.1. A strategy for addressing key determinants of health in the African Region. Malabo, 2010. Available from: http://www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=5726.
20. 2010-2015 five-year plan of action. Quito, UNASUR South American Health Council, 2010.
21. *World health report 2008: Primary health care: now more than ever.* Geneva, WHO, 2008.
22. *The global social crisis: report on the world social situation 2011.* New York, UN, 2011.
23. Rasanathan K, Norenhag J, Valentine N. Realizing human rights-based approaches for action on the social determinants of health. *Health and Human Rights,* 2010, 12:49-59.
24. Braveman P. Social conditions, health equity, and human rights. *Health and Human Rights,* 2010, 12:31-48.
25. Ostlin P et al. Priorities for research on equity and health: implications for global and national priority setting and the role of WHO to take the health equity research agenda forward. Geneva, WHO, 2010. Available from: http://www.who.int/social_determinants/publications/measurementandevidence/finalreportnovember2010.pdf.
26. Kickbusch I. Health in All Policies: the evolution of the concept of horizontal health governance. In: Kickbusch I, Buckett K, eds. *Implementing Health in All Policies: Adelaide 2010.* Adelaide, Department of Health, Government of South Australia, 2010:11-23. Available from: http://www.who.int/sdhconference/resources/implementinghiapadel-sahealth-100622.pdf.
27. Ollila E. Health in All Policies: from rhetoric to action. *Scandinavian Journal of Public Health,* 2011, 39(6 Suppl):11-18.
28. Graham J, Amos B, Plumptre T. Principles for good governance in the 21st century. Policy brief no.15. New York, UNDP, 2003.
29. *Health Lens Analysis.* Adelaide, SA Health (http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/health+in+all+policies/health+lens+analysis, accessed 15 August 2011).
30. Crosby N, Hottinger JC. *The Citizens Jury Process.* CSG Knowledge Center (http://knowledgecenter.csg.org/drupal/content/citizens-jury-process, accessed 15 August 2011).
31. *Health equity through intersectoral action: An analysis of 18 country case studies.* Ottawa, Public Health Agency of Canada and WHO, 2008. Available from: http://www.phac-aspc.gc.ca/publicat/2008/hetia18-esgai18/pdf/hetia18-esgai18-eng.pdf.
32. *Crossing sectors - experiences in intersectoral action, public policy and health.* Ottawa, Public Health Agency of Canada, 2007. Available from: http://www.phac-aspc.gc.ca/publicat/2007/cro-sec/index-eng.php.
33. *Nine is mine.* (http://nineismine.in/home, accessed 4 August 2011).
34. Kumar A. *1 million people in 1 day: campaigning… Indian style.* London, Oxfam International. 2008 (http://oxfaminternational.wordpress.com/2008/08/20/1-million-people-in-one-daycampaigning-indian-style, accessed 23 July 2011).
35. Spectrum of public participation. Practitioners tools. Thornton, International Association for Public Participation, 2007. Available from: http://www.iap2.org/associations/4748/files/IAP2%20Spectrum_vertical.pdf.
36. Civil Society Report to the Commission on Social Determinants of Health. 2007. Available from: http://www.who.int/entity/social_determinants/resources/cso_finalreport_2007.pdf.
37. Xu K et al. Protecting households from catastrophic health spending. *Health Affairs,* 2007, 26:972-983.

38. Blas E, Sivasankara Kurup A, eds. *Equity, social determinants and public health programmes.* Geneva, WHO, 2010.

39. Vega J. Steps towards the health equity agenda. Draft working paper prepared for the World Conference on Social Determinants of Health.

40. *Narrowing the gaps to meet the goals.* New York, UNICEF, 2010. Available from: http://www.unicef.org/publications/files/Narrowing_the_Gaps_to_Meet_the_Goals_090310_2a.pdf.

41. Lönnroth K et al. Tuberculosis control and elimination 2010-50: cure, care, and social development. *Lancet,* 2010, 375:1814-1829.

42. *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action.* Geneva, WHO, 2007.

43. *Monitoring equity in access to AIDS treatment programmes: A review of concepts, models, methods and indicators.* Geneva, WHO, 2010.

44. Tugwell P et al. Applying clinical epidemiological methods to health equity: the equity effectiveness loop. *British Medical Journal,* 2006, 332:358-361.

45. Tanahashi T. Health service coverage and its evaluation. *Bulletin of the World Health Organization,* 1978, 56:295-303.

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

47. *World health report 2010: Health systems financing: the path to universal coverage.* Geneva, WHO, 2010.

48. Gwatkin DR, Ergo A. Universal health coverage: friend or foe of health equity? *Lancet,* 2011, 377:2160-2161.

49. Frenz P, Vega J. Universal health coverage with equity: what we know, don't know, and need to know. Background paper for the Global Symposium on Health Systems Research. 2010. Available from: http://www.hsr-symposium.org/images/stories/9coverage_with_equity.pdf.

50. *Paris Declaration and Accra Agenda for Action.* Paris, OECD (http://www.oecd.org/dataoecd/30/63/43911948.pdf, accessed 13 August 2011).

51. Gwatkin DR. How much would poor people gain from faster progress towards the Millennium Development Goals for health? *Lancet,* 2005, 365:813-817.

52. Committee for Development Policy. *Implementing the Millennium Development Goals: Health inequality and the role of global health partnerships.* New York, UN, 2009.

53. Friel S et al. Climate change, noncommunicable diseases, and development: the relationships and common policy opportunities. *Annual Review of Public Health,* 2011, 32:133-47.

54. Walpole SC, Rasanathan K, Campbell-Lendrum D. Natural and unnatural synergies: climate change policy and health equity. *Bulletin of the World Health Organization,* 2009, 87:799-801.

55. Sadana R et al. Overview: Monitoring of social determinants of health and the reduction of health inequalities in the EU. In: *Moving forward equity in health: Monitoring social determinants of health and the reduction of health inequalities.* Madrid, Ministry of Health and Social Policy, 2010:23–31.

56. Sadana R et al. Briefing Note: Monitoring global health inequities. Prepared for the Ninth Meeting of the Commission on Social Determinants of Health, 24-26 October 2007, Beijing, China.

57. *Putting our own house in order: examples of health-system action on socially determined health inequalities.* Copenhagen, WHO Regional Office for Europe, 2010.

58. *Accra HLF3 - Accra Agenda for Action.* (http://www.accrahlf.net/WBSITE/EXTERNAL/ACCRAEXT/0,,contentMDK:21690826~menuPK:64861649~pagePK:64861884~piPK:64860737~theSitePK:4700791,00.html, accessed 13 August 2011).

59. Committee of Experts on Public Administration. Compendium of basic terminology in governance and public administration. Definition of basic concepts and terminologies in governance and public administration. New York, UN Economic and Social Council, 2006. Available from: http://unpan1.un.org/intradoc/groups/public/documents/un/unpan022332.pdf.

60. *International survey programs.* IHSN (http://www.ihsn.org/home/index.php?q=tools/questionnaire/standard, accessed 10 August 2011).

61. *Frequently Asked Questions.* Canadian Environmental Assessment Agency (http://www.ceaa.gc.ca/default.asp?lang=En&n=CE87904C-1#wsA3AB7524, accessed 13 August 2011).

62. *Constitution of the World Health Organization.* Geneva, WHO, 1948.

63. Smith BJ, Tang KC, Nutbeam D. WHO Health Promotion Glossary: new terms. *Health Promotion International,* 2006, 21:340-345.

64. *Statistics and Monitoring - Multiple Indicator Cluster Survey (MICS).* UNICEF (http://www.unicef.org/statistics/index_24302.html, accessed 12 August 2011).

65. Evans T, Rasanathan K. Primary care in low- and middle-income countries. In: Longo DL et al, eds. *Harrison's principles of internal medicine,* 18th ed. New York, McGraw-Hill, 2011:e1.

66. Vanclay F. International principles for social impact assessment. *Impact Assessment and Project Appraisal,* 2003, 21:5-11.

67. *Social Protection.* ADB (http://www.adb.org/socialprotection, accessed 10 August 2011).

68. *Essential Background.* UNFCCC (http://unfccc.int/essential_background/items/2877.php, accessed 10 August 2011).

69. *The Social Protection Floor (SPF).* ILO Global Extension of Social Security (http://www.ilo.org/gimi/gess/ShowTheme.do?tid=1321, accessed 11 August 2011).

70. *Urban HEART.* Kobe, WHO Kobe Centre (http://www.who.or.jp/urbanheart.html, accessed 8 August 2011).

All for Equity

World Conference on Social Determinants of Health

RIO DE JANEIRO | BRAZIL | 19–21 OCTOBER 2011

The World Conference on Social Determinants of Health represents a tremendous opportunity to reduce the toll of thousands of lives lost, each day, due to social injustice. This discussion paper aims to inform the proceedings and help fulfil the purpose of the World Conference: to share experiences on how to reduce health inequities and to mobilize commitment to urgently implement action on social determinants. The paper does not provide a blueprint, but instead lays out the key components (which form the World Conference themes) that all countries need to integrate in implementing a social determinants approach. The paper aims to show that, in all countries, it is possible to put policy into practice on social determinants of health to improve health and well-being, reduce health inequities, and promote development.

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ISBN 978 92 4 150240 5