CHAPTER 17
Sustaining action beyond the Commission on Social Determinants of Health

Taking action on the social determinants of health and health equity is an ambitious agenda that needs global champions, committed leadership, and bold action at all levels. The foundations have been laid. The Commission was designed with the intention that it would be a broad partnership of those who do research, those who devise policy, those who implement policy, and those who advocate and act. The effect of top-down political commitment and policy action combined with bottom-up action from communities and civil society groups has been called ‘the nutcracker effect’ (Fig. 17.1) (Baum, 2007).

Foundations for sustained action

Global leaders

It is vital that the international and global policy environment supports action on the social determinants of health and health equity. To this end, the Commissioners – including former heads of government, government ministers, national policy-makers, and international advisors; leaders in international organizations; leading academics; and representatives of civil society – are a vital resource. Together they constitute a small but powerful caucus of global champions, advocating the adoption of a social determinants approach to health and health equity. Building leadership within the UN system – in global governance, policy-making, and development financing – and through global social movements will help to establish health equity as a priority on the global agenda for the 21st century.

WHO

The Commission worked closely with WHO at country, regional, and global levels. Although the judgements reached by the Commission are independent of WHO’s decision-making process and governing bodies, it is of course critical that WHO, the UN body mandated to provide leadership in global health, takes the recommendations forward.

And there are positive signs. Already WHO is taking steps to institutionalize the social determinants of health approach across all its working sectors. This is laid out in WHO’s Medium Term Strategic Plan for 2008–2013 (MTSP) (WHO, 2007a) – which includes the strategic objective, “to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches” – and the organization-wide expected results that are being used to measure accomplishment of the objective (Box 17.1). According to the MTSP, the objective is underpinned by an approved budget of almost US$ 66 million for the 2008–2009 biennium.

Figure 17.1 Cracking the nut of health equity.

Cartoon by Simon Kneebone. Reprinted, with permission of the publisher, from Baum (2007).
To implement these expected results at a technical level, WHO has followed three strategies: mainstreaming health equity across programmes, strengthening cross-cutting functions related to health equity, and enhancing its existing monitoring capacities. As part of mainstreaming, WHO began a review of the potential for programmes to improve efficiency and equity in 2006 under a cross-programmatic network, the PPHCKN, which is looking at ways to incorporate social determinants of health approaches and address equity more directly through global and national health programmes. WHO has appointed regional focal points to coordinate action on the social determinants of health and supported analysis and dissemination of existing data at the national and regional level from an equity perspective.

The Commission supports the aims of these various processes and calls on all countries to initiate the development of action plans on social determinants of health to improve health equity.

Country partners
Action at country level is one of the primary vehicles for using the Commission’s global evidence base, implementing the recommendations of the Commission, and sustaining awareness and understanding of social determinants of health among political leaders, ministers of health, and other major stakeholders.

The Commission collaborated with a number of partner countries, supporting the development of national policies aimed at reducing health inequities through a variety of mechanisms. Brazil, Canada, Chile, Islamic Republic of Iran, Kenya, Mozambique, Sri Lanka, Sweden, and the United Kingdom each became a Commission ‘country partner’, through a formal process of a written letter of commitment to making progress on the social determinants of health to improve health equity. As the work of the Commission gained momentum, other supportive countries added both to the accumulation of technical work on tackling social determinants for health equity (e.g. Norway provided case studies on ISA) and to sharing experiences and advice on improving policy coherence in this field (e.g. Thailand).

The Commission’s formal country partners continue to create momentum for change in different ways, which has been documented (for more on the Country work stream, see CW, 2007). Some countries focused on generating political interest in social determinants of health. Others, such as Brazil, Canada, and Chile, established new mechanisms and institutional structures to promote intersectoral policy development. Brazil, for instance, launched a National Commission on Social Determinants of Health in March 2006. The Public Health Agency of Canada set up the Canadian Reference Group, an influential advisory group making real political progress in advancing the social determinants of health agenda in Canada and internationally. In England, the Scientific Reference Group advises on policy and has developed indicators to measure health inequities.

Another approach countries used was to explore processes for inter-country sharing of lessons and joint research initiatives (e.g. Canada, Chile, Sweden; in the United Kingdom: England and Scotland). A Nordic reference group, set up with representatives from five countries, led the Commission evidence on national policies from that region. A similar group was established in East Asia. These models of collaboration between countries of similar sociopolitical context could be utilized elsewhere.

Joint efforts by all the various Commission country partners have amplified the call to tackle the social determinants of health inequities in different regional and global public health and human development fora. More countries will follow – Argentina, Mexico, New Zealand, Poland, and Thailand have all expressed enthusiasm. In Australia, a social determinants of health approach has been established as a central element in the government’s plan, announced in 2007, to close the LEB gap between Indigenous Peoples and the overall population within a generation (COAG, 2007). The aim for the future is that more countries will engage politically with the approach set out in this report and that this political process will translate into policies and programmes that measurably improve population health and reduce health inequities.

**BOX 17.1: WORLD HEALTH ORGANIZATION STRATEGIC OBJECTIVE (SO) NUMBER 7 AND RELATED ORGANIZATION-WIDE EXPECTED RESULTS**

SO7: “To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.”

**Expected Result 7.1:** Significance of social and economic determinants of health recognized throughout the organization and incorporated into normative work and technical collaboration with Member States and other partners.

**Expected Result 7.2:** Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty reduction and sustainable development.

**Expected Result 7.3:** Social and economic data relevant to health collected, collated, and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions such as disease or disability).

**Expected Result 7.4:** Ethics- and rights-based approaches to health promoted within WHO and at national and global levels.

**Expected Result 7.5:** Gender analysis and responsive actions incorporated into WHO’s normative work and support provided to Member States for formulation of gender-sensitive policies and programmes.
Cities

In addition to the cities represented in the KNUS, the cities of New York, Glasgow, London, and New Orleans have all made links with the Commission and are working to take the agenda forward through a sharing of practice-based evidence. The Healthy Cities movement (coordinated by the WHO Regional Office for Europe) and the WHO Kobe Centre’s healthy urbanization programme are both strong allies.

Civil society

Civil society groups are powerful protagonists in the global health equity agenda. From the beginning, the Commission actively sought the involvement of representatives of civil society groups in Africa, Asia, the Americas, and Europe. Members of civil society groups were engaged in the Commission’s knowledge-gathering processes. They helped to shape the Commission’s thinking and will be active partners for change in the future (for more on the Civil Society work stream, see CS, 2007).

Building and sharing knowledge

The Commission has built a global evidence base for understanding the social determinants of health and establishing effective action to promote health equity. To support that process, the Commission created nine Knowledge Networks – including academics and practitioners from universities and research institutions, government ministries, and international and civil society organizations around the world. These networks, in a variety of forms, will continue to generate global knowledge for action. The Commission built further evidence-gathering partnerships through two continuing regional networks (the Nordic and Asian networks) and with researchers in additional key thematic areas, such as ageing, Indigenous Peoples, food and nutrition, violence and conflict, and the environment. The reports produced by the Knowledge Networks and all other background papers and reports, including reports from the Country and Civil Society work streams, are available on the Commission’s website: www.who.int/social_determinants/en.

An unfinished agenda

The list of determinants of health inequities explored by the Commission was not exhaustive. Other areas of vital global importance, such as climate change, were not addressed in detail. The Commission recognizes this critical agenda, and the amount of work already ongoing to address it, and aligns itself with the goals of equitable and sustainable development.

Climate change

Climate change stands out as a priority area for attention in relation to health inequities. Climate change, urbanization, rural development, agriculture, and food security are intertwined determinants of population health and health equity. It is critical to ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity. But much more analysis of the relationship between social determinants, environmental change, and health inequities is needed to inform the necessary development of policy and practice. The Stern report demonstrated compellingly that if action is not taken, the overall costs of climate change will be equivalent to losing at least 5% of global GDP each year (Stern, 2006). Therefore, the investment that takes place in the next 10–20 years will have a profound and long-lasting effect not only on the climate but on the health of our children and our children’s children. It is likely that effects will be stronger among those at socioeconomic disadvantage.

Research agenda

The Commission has brought together an unprecedented global evidence base on social determinants of health and action for health equity. There is a need, though, to expand the scope of evidence across thematic areas and across country contexts. In addition, the social and economic drivers of health inequities are dynamic, changing over time. A regular review of key research gaps can help to identify the most pressing research needs. Some of the overarching research needs that have emerged from the work of the Commission are:

1. The determinants of health inequities in addition to the determinants of average population health:
   - understanding reasons for the relationship between stratification and health outcomes;
   - understanding the interaction between aspects of stratification (for example, gender, ethnicity, and income) and health inequities;
   - quantifying the impact of supra-national political, economic, and social systems on health and health inequities within and between countries.

2. Interventions, global to local, to address the social determinants of health and health equity:
   - evaluating the impact of societal-level action (policies and programmes) on health inequities;
   - research on the social, economic, and health costs and benefits of reducing health inequities.

3. Policy analysis:
   - analysing policy processes towards health equity-related interventions;
   - understanding contextual barriers and enablers to ISA and coherence in national and local governance and policy-making;
   - identifying current good practice and developing tools for ISA.

4. Monitoring and measurement:
   - developing new methodologies for measuring and monitoring health inequities, and for assessing the impact of population-level interventions.

Goals and targets for health equity

The Commission has made its recommendations and has set global challenges. Progress towards health equity requires goals and measurable objectives along the way. Goals and targets can redirect policy, improve resource allocation, and improve development outcomes. Regular public reporting, and the development of data systems, globally and nationally, ensure that the world can see which targets are being met and where further efforts are needed.

This has been seen with the MDGs. The MDGs have also brought into focus the importance of good statistics in setting and monitoring major targets in development policy. Achieving the health-related MDGs and targets at the country level implies a reduction of absolute between-country health inequities. Currently, these goals do not embody a perspective of health equity within countries. Indeed, the MDGs for health
outcomes are formulated in terms of population averages, rather than including the distribution of health outcomes within and between countries.

Extending beyond the current focus of the MDGs and their timeline of 2015, the Commission concerns itself certainly with the health inequity between countries, but also with the social gradient in health within high-, middle-, and low-income countries, and with the impact on adult mortality due to communicable and non-communicable diseases and violence/injury.

The goal that the Commission would like to see the world – its leaders, international organizations, national governments, and civil society groups – aspire to is:

**Close the health gap in a generation**

Progress towards this aspirational goal requires a narrowing of the gap between the worst off and the best off over time. It also involves a progressive flattening of the health gradient by improving the health of all social groups to a level closer to that of the most advantaged.

It is for international agencies and national governments to develop detailed goals and targets for health equity and the social determinants of health through consultative processes and to institute action plans that demonstrate clearly how the targets are to be achieved and what resources will be required. As a starting point, the Commission proposes three targets (below). They are challenging and illustrate the scale of the problem. However, if pursued through action as recommended by the Commission, much will be done towards closing the health gap in a generation. The Commission urges WHO to develop these health equity targets in consultation and to take the lead in achieving them.

**Target 1:** Reduce by 10 years, between 2000 and 2040, the LEB gap between the one third of countries with the highest and the one third of countries with the lowest LEB levels, by levelling up countries with lower LEB.

Halve, between 2000 and 2040, the LEB gap between social groups within countries, by levelling up the LEB of lower socioeconomic groups.

**Target 2:** Halve, between 2000 and 2040, adult mortality rates in all countries and in all social groups within countries.

In effect, achieving this target means reducing the gap in adult mortality between and within countries by half.

**Target 3:** Reduce by 90%, between 2000 and 2040, the under-5 mortality rate in all countries and all social groups within countries, and reduce by 95%, between 2000 and 2040, the maternal mortality rate in all countries and all social groups within countries.

In effect, achieving this target means reducing the gap in under-5 mortality between and within countries by 90%, and reducing the gap in maternal mortality between and within countries by 95%.

As stated in Chapter 1, while we do not anticipate the absolute abolition of health differences in a generation, we do see the potential to reduce – dramatically – inequity within and between countries. In order to define the targets set out here, past trends of well-performing groups of countries were projected forward. In the case of Target 1 (LEB), the trend between 1950 and 1980 was considered – a period when there was a reduction in the global LEB gap. In some cases, in particular in the case of within-country inequities in LEB, few data were available to use as a basis to define the target.

Target 3 roughly projects MDGs 4A and 5A to 2040. Targets 2 and 3 are based on the principle that decreases in mortality should be at least proportional across countries and across social groups within countries. More specifically, countries and social groups with the highest mortality levels should achieve at least the same proportional mortality decline as countries and social groups with lower mortality levels. Achieving these targets, with the above principle, will assure that absolute mortality inequities between countries and between social groups within countries will decline. Relative inequities will either stay the same or, if a more than proportional mortality increase is achieved, will decline. More ambitiously, the Commission would like to see accelerated improvement within social groups and countries with worse health outcomes.

Achieving the targets will be challenging. First, it is well known that the world is having serious difficulty with achieving MDGs 4 and 5, in particular in sub-Saharan Africa but also in countries in other regions. India, for example, is not on track to meet MDG 4 (Countdown Group, 2008). Similarly, these countries and regions will face great challenges achieving the magnitude of mortality reductions laid out above. It is, however, a global responsibility to achieve these goals, not least because of the global-level determinants of health inequalities between and within countries. The strong declines in childhood mortality between 1950 and 1980 suggest that it should be feasible to achieve MDG 4 and Target 3 for under-5 mortality. Indeed, there are countries that are performing well on MDGs 4 and 5. Indonesia and Peru, with their 6.2% and 7.1% average annual reduction in under-5 mortality, for example, are on track to reach MDG 4 (Countdown Group, 2008) as well as Target 3 for under-5 mortality. Reduction in under-5 mortality in India (less than 3% per year) is, however, insufficient to meet MDG 4 (Countdown Group, 2008).

Achieving these Targets will require commitment to sustained investment in the social determinants of health, and will only be realistic if very strong and focused efforts are made – with particular attention to those countries and regions that are currently not expected to meet the MDGs. Yet while highly ambitious, achieving the Targets is possible with sufficiently proactive measures. In India maternal mortality in 2005 was 450 per 100 000 live births; in China the rate is one tenth that in India, namely 45 per 100 000 live births (Countdown Group, 2008). Target 3 means that maternal mortality in India in 2040 – more than three decades from now – should be 22.5 per 100 000 live births, in absolute terms not much less than China’s maternal mortality rate today.

These Targets are proposed for consultation and further development. The process of setting targets, if carried out in a consultative fashion, can itself build collaborative partnerships.

11 MDG 4A: Reduce by two thirds, between 1990 and 2015, the under-5 mortality rate. MDG 5A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.
that support achievement of the intended outcomes (Kickbusch, 2003). Steps towards achieving and, importantly, monitoring the targets can be taken now, as outlined in the recommendations throughout this report. Countries and international organizations are invited to reassess existing targets and incorporate an equity component within them. The general principle of at least proportional mortality decline across countries and social groups may be applied across a number of existing targets.

It is critical that international organizations and countries integrate measures of health equity and the social determinants of health in their existing monitoring systems. Targets for the social determinants of health and health equity will need to be defined on the basis of the framework laid out in Chapter 16 (The Social Determinants of Health: Monitoring, Research, and Training).

### Milestones towards health equity – short- to medium-term deliverables

Having proposed recommendations for action and suggested targets, it is also important that milestones be set. Using these, it will be possible to monitor the progress of action on the social determinants of health and health equity within the global and national arenas and also help to ensure international institutions, national governments, civil society, and the private sector are held to account. To initiate such a process, the Commission outlines below a timeline of key but partial deliverables.

**Table 17.1: Milestones towards health equity**

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<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
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<tbody>
<tr>
<td>2008–09</td>
<td>Creation of post-Commission global alliance to take forward the social determinants of health agenda in partnership with WHO.</td>
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<td>2008–09</td>
<td>Economic and social costing of Commission recommendations and costs of not taking action.</td>
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<td>2009</td>
<td>Meetings of Commissioners and social determinants of health champions to advance global plan for dissemination and implementation of Commission recommendations.</td>
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<td>2009</td>
<td>World Health Assembly resolution on social determinants of health and health equity.</td>
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<td>2008–13</td>
<td>Research funders progressively dedicate more resources to research on social determinants of health, especially in areas highlighted by the Commission.</td>
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<tr>
<td>2008–13</td>
<td>Increasing numbers of countries adopt a social determinants of health approach to health equity and develop and implement social determinants of health policies, so that by 2013 at least 50% of all low-, middle-, and high-income countries have a committed plan for action to reduce health inequity through action on the social determinants of health, with evidence that they are implementing the plan.</td>
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<td>2009–10</td>
<td>The Economic and Social Council, supported by WHO, set up a UN interagency mechanism for social determinants of health with working groups dedicated to specific thematic areas, initially on ECD, gender equity, employment and working conditions, health-care systems, and participatory governance, including all relevant multilateral agencies and civil society stakeholders.</td>
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<tr>
<td>2010</td>
<td>The Economic and Social Council, supported by WHO, prepare for consideration by the UN the adoption of health equity as a core global development goal, with appropriate indicators to monitor progress both within and between countries.</td>
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<td>2010</td>
<td>1st Report on Health Equity (report on global and national health equity surveillance framework indicators and targets) to 1st Global Forum of UN Member States on social determinants of health and health equity.</td>
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<td>2013</td>
<td>Review of progress on WHO social determinants of health targets.</td>
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<tr>
<td>2020–2040</td>
<td>5-yearly reviews of progress on reducing health inequities within and between countries.</td>
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