There is not a great deal of mystery as to why poor people in low income countries suffer from high rates of illness, particularly infectious disease and malnutrition: little food, unclean water, low levels of sanitation and shelter, failure to deal with the environments that lead to high exposure to infectious agents, and lack of appropriate medical care. Similarly, we have a great deal of knowledge of the causes of noncommunicable disease that represent the major burden of disease for people at the lower end of the social gradient in middle and high income countries. The WHO/World Bank Global Burden of Disease study identified underweight, overweight, smoking, alcohol consumption, hypertension, and sexual behaviour as major causes of morbidity and mortality (Lopez et al., 2006). In both situations the question is how these causes, and their inequitable distribution, come about. That is, what are the causes of the causes? This brings us to the social determinants of health and health equity.

Conceputalizing the causes

The question that the Commission is ultimately seeking to answer is what would social action to tackle these inequities look like? Recommendations to this end will be made in the Commission’s Final Report in 2008. In order to answer that question we first seek to understand and articulate the causes of health inequities. The Commission believes that these health inequities are the result of a complex system operating at global, national, and local levels.

The global context affects how societies prosper through its impact on international relations and domestic norms and policies. These in turn shape the way society, at national and local levels, organizes its affairs, giving rise to forms of social position and hierarchy. Where people are on the social hierarchy affects the conditions in which they grow, learn, live, work and age, their vulnerability to ill-health, and the consequences of ill-health.

Contextualizing all of these levels is the natural environment, and the macro/micro-level impacts of environmental change. Risks to health include the impacts of heatwaves and other extreme weather events, changes in infectious disease patterns, effects on local food yields and freshwater supplies, impaired vitality of ecosystems, and loss of livelihoods. If present trends continue, the adverse health impacts from human-induced environmental changes will be distributed unequally. The poor, the geographically vulnerable, the politically weak and other disadvantaged groups will be most affected. Addressing the intersection between social determinants of environmental change and the impact of environmental change on health inequities will benefit sustainable ecology and population health alike (McMichael et al., in preparation). A background paper on the conceptualization of social determinants of health can be found in Solar & Irwin, 2007.
**Thematic determinants**

In order to translate this conceptual understanding into action on the social determinants of health, the Commission convened nine thematic Knowledge Networks: Globalization, Health Systems, Urban Settings, Employment Conditions, Early Child Development, Social Exclusion, Women and Gender Equity, Measurement and Evidence, and Priority Public Health Conditions. Each network is reviewing evidence of what we know, what is likely to work, and why. In addition other key factors such as violence and conflict, food and nutrition, and the environment were investigated. The full range of issues investigated within the knowledge work stream is listed in the Annex. Recommendations based on a comprehensive analysis of this work will be reported in the Commission’s Final Report in 2008.

The discussion that follows outlines what the Commission believes to be major social determinants of health and health equity. It draws on work from the above thematic areas and is organized around key groups of social determinants of health, working from intermediate factors towards more structural determinants.

Panels 1 to 3 illustrate case-studies from low, middle and high income countries. The examples not only embody the range of social determinants of health – the causes of the causes – but, perhaps more importantly, illustrate types of action that can be taken. Action is needed that tackles the range of health determinants – from structural conditions of society to the more immediate influences, at all levels from global to local, across government. It should be emphasized that the Commission sees action as a truly multi-stakeholder process, including government and non-government actors, civil society more broadly (including trades unions, political parties, popular movements and alliances), private sector organizations and, critically, health practitioners themselves. Crucial to multilevel, multisectoral action is coherence. None of the three case-studies captures all elements of the ideal comprehensive strategy necessary to tackle health inequities. Rather, the case-studies illustrate a variety of approaches currently used to prevent and redress the unequal distribution of health within these countries.
Many Indians, both urban and rural dwellers, experience severe disadvantage as a result of low social status, the combined effect of caste, education and income. They have poor housing, with limited access to clean water and sanitary facilities. They have little in the way of financial resources and experience difficulty pursuing their rightful livelihoods. Their children have had little opportunity for development and education, especially where they forego schooling to work with their parents. When ill, they have little access to health care, which is frequently only available for a fee.

In Ahmedabad, there are around 100,000 street vendors, forming a sizeable proportion of the informal employment sector in the city. They sell fruit, vegetables, flowers, fish, clothes, vessels, toys, footwear, and many other items for daily and household use. Most vendors have been selling in the city’s markets and streets for generations.

Like other poor self-employed women, the vegetable sellers of Ahmedabad live in poor parts of the city. They start work at dawn, buying their wares from merchants in the wholesale markets. They frequently need to borrow money, incurring very high rates of interest, and routinely face harassment and eviction from their vending sites by local authorities. The Self-Employed Women’s Association (SEWA), a union of almost one million workers, is a striking example of collective action by these women and others like them, to challenge and change these conditions.

To strengthen control over their livelihoods, vegetable sellers and growers (all SEWA members) linked together to set up their own wholesale vegetable shop, cutting out exploitative middlemen. As a result, both growers and sellers have seen improved incomes through better prices for their produce. SEWA also organizes child care, running centres for infants and young children, and campaigns at the state and national level for child care as an entitlement for all women workers. Further, SEWA members are improving their living conditions through slum upgrading programmes to provide basic infrastructure such as water and sanitation. This happens in partnerships with government, people’s organizations and the corporate sector.

In order to solve the problem of access to credit, the SEWA Bank provides small loans and banking facilities to poor self-employed women, such as the vegetable sellers, avoiding the huge interest rates demanded by private loan agents. The Bank is owned by its members, and its policies are formulated by an elected Board of women workers.

In times of health crisis, poor families not only lose work and income, but often also have to sell assets to secure the wherewithal to pay for treatment. Poor informal sector workers and their families are pushed further into the cycle of poverty and indebtedness. With SEWA, however, when the vegetable sellers or their family members fall ill, collectively organized health insurance can be used to pay for health-care costs. SEWA has started an integrated insurance scheme for women in times of crisis.

Frequently harassed by local authorities, the vegetable sellers campaigned with SEWA to strengthen their status, through formal recognition in the form of licences and identity cards, and representation on the urban Boards that govern market activities and urban development. That campaign, started within Gujarat, subsequently went all the way to the India Supreme Court, and inspired international attention and alliances.

SEWA web site:
http://www.sewa.org/services/bank.asp
Panel 2: Conditional income transfer (Bolsa Familia), Brazil

In many ways, Brazil in recent years is a good example of managed growth and commitment to poverty reduction. However, even though the government of President Lula Da Silva has set a course to redress the high rates of inequality in the country, chronic poverty in parts of Brazil means that the poorest households continue to suffer from multiple forms of disadvantage. Such households are frequently unable to secure adequate nutrition for the family, and in rural areas can be highly vulnerable to environmental hazards such as drought and flood. The poorest urban households are not connected to either water or sewage systems, and poor communities have no waste collection services. Poor access to education leads to relatively high rates of illiteracy, compromising employment opportunities for young men and women.

The period of “re-democratization” from the mid-1980s brought with it significant changes in Brazil’s approach to governance, social policies, and poverty reduction. A key component of this new policy environment is the Family Stipend Programme, or Bolsa Familia, a form of conditional cash transfer targeted at poor and extremely poor families to mitigate key aspects of extreme poverty and reduce inequality.

Bolsa Familia, launched in October 2003, unified four federal programmes designed to deal with key aspects of household wellbeing among the poorest families. These were: the School Stipend, Food Stipend, Food Card, and Fuel Support Programmes. Conditionalities stipulated that children between seven and 15 years of age should regularly be attending school, and that growth, nutrition, development and immunization status of children from birth to six years of age should be monitored regularly. The programme also included pre-natal care for pregnant women.

Complementary interventions, designed to safeguard household income and promote further poverty reduction, included adult literacy classes, aid to family-based agriculture, access to microcredit, and professional/vocational training. At the federal level, the programme was coordinated through an Inter-Ministerial Management Committee. Originally, the Bolsa Familia secretariat was directly linked to the President’s office. While municipalities were responsible for registering eligible families, the legislation enacting Bolsa Familia established local councils, including the participation of civil society organizations, to monitor interventions (Magalhaes et al., 2007).

Bolsa Familia represents a holistic approach to social welfare, reduction of poverty, and the interconnected conditions that lead to poor and inequitable health. Coordinated across sectors through interministerial management, the programme acts on key aspects of wellbeing at the family and household level – from child development through stimulating uptake of health and education services, through nutrition for children and mothers, to living conditions with the fuel subsidy, and employment through vocational training, support to family agriculture, and microcredit facilities.

Although the share of total income represented by the conditional income transfers has been relatively small, the programme’s outstanding targeting (using a unified registry) has resulted in an impressive equalizing impact, responsible for about 21% of the fall in the Brazilian Gini index (Soares et al., 2007).
Panel 3: Multilevel intersectoral action for health, Sweden

Sweden is, in general, a healthy place to live; life expectancy is among the highest in the world and infant mortality among the lowest (National Board of Health and Welfare, 2006). Comparing absolute levels of mortality for manual and non-manual workers, Sweden has lower health inequities than other European countries (Vågerö & Erikson, 1997). Health in Sweden is contextualized by a stable, wealthy democracy with strongly developed social welfare policies broadly based on equal treatment (Navarro et al., 2006). The changing global context, in combination with an economic recession in the early 1990s, is, however, affecting the way work and life are organized. Although health is improving for all groups, health inequalities are growing.

Structural intervention

Norrbotten, an area in the north of Sweden, is characterized by traditional livelihoods in logging and mining. The region has started to see effects of globalization in the increasing segmentation of traditional sectors, and increasingly precarious forms of employment – reflected in high and rising rates of sickness absence. The region has among the lowest rates of disposable income per person in the country. There are higher rates of death from cardiovascular diseases, suicide and alcohol-related diseases, particularly among men. Norrbotten’s unemployment rates are higher and education levels are lower than the national averages. The FRISK Initiative by the governor of Norrbotten is aimed at structural drivers in the field of employment and working conditions. While concerned initially with sickness absence it now takes an integrated approach to: (i) management training with a focus on positive health effects and health promotion; (ii) improving the work environment and increasing worker safety; (iii) providing information resources for the expansion of professional networks; and (iv) supporting the rehabilitation of individuals who have been long-term unemployed (http://www.euro.who.int/socialdeterminants/socmarketing/20070220_3).

Community intervention

A more disease-oriented approach, combining individual and population-level efforts involving multiple sectors, is the Västerbotten Intervention Programme. Västerbotten, a county in northern Sweden, had the highest cardiovascular mortality in the country. A long-term prevention programme was initiated in 1985 to work towards solving this problem. In particular, the community intervention in Norsjö has been followed carefully and offers valuable experience for other communities. Contrary to other models, the health sector and its primary health-care providers took an active role in the work, including health counselling and food labelling. In the 10-year evaluation, the intervention area had a significantly larger decline in cholesterol, systolic blood pressure and predicted coronary disease mortality (Weinehall et al., 1999, 2001). People with lower education seemed to benefit the most from the prevention programme, suggesting that the reduction of health inequality is possible through this type of approach.
Growing, living and working

The three panels demonstrate how a combination of environments – home, school, work, neighbourhood, and the health-care system – can unequally expose different groups to health damaging factors; but they also show how action on the conditions within the environments can improve people’s material conditions, psychosocial resources, and behavioural opportunities.

Each year, 4 million babies die within the first four weeks of life; 450 babies every hour (Lawn, Cousens & Zupan, 2005).

The growing environment: child survival, early child development and education

The tragedy of infant and child deaths in poor countries is that the majority are preventable. Child mortality shows a clear social gradient (Figure 5) (Gwatkin et al., 2000). There is no necessary biological reason why this should be so. In the ideal situation that inequalities in under-5 mortality were eliminated, under-5 mortality would be reduced by 30–60% in most low and middle income countries (Houweling, 2007).

Figure 5: Under-5 mortality (per 1000 live births) by wealth group

Source: Gwatkin et al., 2000.
A comparison of the Indian state of Kerala with the rest of India (Figure 6) shows how a combination of technical and social interventions is necessary. Women in Kerala are better nourished and better educated than the average in India. It is a reasonable speculation that the better survival and lesser stunting of their children is a direct result of maternal education and better nutrition for mothers and children. Bolsa Familia in Brazil (Panel 2), like many other cash transfer programmes around the world, takes maternal and child nutrition as one of its key areas for intervention. There is a body of evidence that points to the importance of education of women for child survival (Cleland & van Ginneken, 1988).

**Figure 6:** Impact of better education and nutrition for women on nutrition and health for families, Kerala, India

- % women 15-49 with no education
- % underweight women (BMI below 18.5)
- Infant mortality *
- Stunted children **

* Infant mortality per 1000 live births in the previous five years.
** Percentage of children under the age of three years who are stunted (too short for age).

Child survival is essential – but so is the quality of children’s development. The seeds of adult health and health inequity are sown in early childhood. Over 200 million children worldwide are not reaching their development potential (Grantham-McGregor et al., 2007). There are four major preventable risk factors, each directly connected with poverty: stunting, iodine deficiency, iron-deficiency anaemia, and inadequate cognitive stimulation. The figure of 200 million children not achieving their development potential is based on defining poverty at $2 a day. If poverty is bad for children’s development it is likely to be a graded phenomenon just as is child survival: hence the likelihood of many more than 200 million children who are being harmed by omission. The Commission’s Early Child Development Knowledge Network stresses the need for a balanced approach to children’s development, comprising physical, cognitive/language, and social/emotional components.

In addition to economic circumstance, each component of child development is dependent on the nature of the environments in which children exist. A child’s early environment has a vital impact on the way the brain develops. The more stimulating the environment, the more connections are formed in the brain and the better the child thrives in all aspects of life: physical development, emotional and social development, and the ability to express himself or herself and acquire knowledge. While physical health and nutrition are important, a young child needs to spend its time in caring, responsive environments that protect from inappropriate disapproval and punishment. Children need opportunities to explore their world, to play, and to learn how to speak and listen to others.

In Brazil, the Bolsa Familia programme clearly illustrates a central concern with supporting and improving the development of children and the household conditions that contextualize that development. Although originating in a relatively top-down policy-driven approach, the conditional income transfer model focuses centrally on the empowerment of households to break intergenerational poverty through enhanced and more equitable support to childhood as a critical goal.
Education and the life-course

While vitally important for childhood health, early child development has far reaching societal impact, accumulating over the life-course with implications for health inequities in adult life. One key factor that may mitigate adverse child development is education. Education and the associated high social standing in adult life may protect against health-damaging early life exposures (Barker et al., 2001).

Universal primary education is one of the Millennium Development Goals. It is likely that inadequate education plays a key causal role in generating health inequities (Smith, 2005), at least in part, because it has a profound influence on income, employment status and living conditions in adulthood. Removing the numerous barriers to achievement of primary education will be a crucial part of action on the social determinants of health. Prominent among these will be removing the financial barriers that prevent the poorest children from attending school, as in the recent removal of user fees in primary education in Kenya.

The importance of education is not limited to primary education nor to low income countries. A key measure of social stratification in countries rich and poor is education – at a fundamental level, this raises the central role of literacy in health equity. The influence of education on health is seen not only as a difference between those with some and those with none but it is a gradient that runs to the highest level (Erikson, 2001).

Over 121 million primary school-age children are out of school (UNICEF 2004).

Female adult literacy varies from 12% in Mali and 13% in Afghanistan to 100% in Cuba, Estonia, Latvia, Lithuania, and Slovakia (World Bank, 2006a).
The urban living environment

*Of the 3 billion people who live in urban settings, about a billion live in slums (UN-HABITAT, 2005).*

In 2007, more than half the world’s population lives in urban areas. Urban dwelling has long been a way of life in high income countries where nearly 100% of the urban population have access to improved sanitation facilities. In low income countries only 61% of urban dwellers do (World Bank, 2006a). In most African countries the majority of the urban population lives in slums. In Kenya, for example, 71% of the urban population are slum dwellers.

Both the physical environment and social conditions can influence health and lead to health inequities. To create decent living conditions in the rapidly growing urban areas is a major challenge for government authorities at all levels: local, regional and national. Better housing and living conditions, access to safe water and good sanitation, efficient waste management systems, safer neighbourhoods, food security, and access to services such as education, health, welfare, public transport, and child care are examples of social determinants of health that can be addressed through good urban local governance.

The scale of the urban problem may seem vast and unmanageable. However, urban areas can provide a healthy living environment; indeed, they can improve health via their various material, service provision, cultural and aesthetic attributes (Kirdar, 1997). The improvements over the last 50 years in mortality and morbidity in highly urbanized countries such as Japan, the Netherlands, Singapore and Sweden give testimony to the potentially health-promoting features of modern cities.

*Only 38% of the population in low income countries have access to improved sanitation facilities, whereas the figure is 100% in high income countries (World Bank, 2006a).*

*Over 60% of children in South Asia and sub-Saharan Africa are deprived of reasonable shelter (UNICEF, 2004).*
The working environment

For most people in the world, living conditions are largely determined by economic opportunity afforded through the labour market. A major challenge to health is the working environment: working conditions, the nature of employment contracts, and the availability of work itself. In high income countries, much action has been taken on physical and chemical hazards in the workplace. Now, however, the labour market is mainly segmented and precarious employment has become more prevalent. These labour market changes pose major health risks from the psychosocial and economic hazards associated with less job control, insecurity, lack of worktime flexibility and access to paid family leave, and unemployment (Benach & Muntaner, 2007; Bartley, Ferrie & Montgomery, 2006; Marmot, Siegrist & Theorell, 2006). The example from Sweden (Panel 3) shows how changing employment conditions towards less job security and control are influencing people’s wellbeing and health in a high income country. The example also shows how joined-up governmental action at the regional level, supported by national intersectoral action, can be designed to mitigate such adverse impacts, providing protection against globalization’s downsides.

In low income countries these risks are in addition to major persisting physical and chemical hazards. Employment conditions provide a fertile area for major improvements in conditions of the physical and social environment with real opportunities for change. In many countries, the majority of workers are excluded from labour protection. These include workers in cottage industries, agricultural workers (except for

Around 126 million children aged 5–17 years are working in hazardous conditions. Around 5.7 million children are trapped in bonded labour (UNICEF, n.d.).

Unemployment rates in France are about twice as high among its immigrant population (ILO, 1998).
plantations), local vendors and workers in small enterprises, domestic workers and homeworkers. Other workers are deprived of effective protection because of weaknesses in labour law enforcement.

A key issue for SEWA is that its members, like more than 80% of workers in India and the majority of people in developing countries, are outside the formal employment sector. They are usually excluded both from the protection afforded by labour standards and from whatever social security provisions are linked to formal employment. Producing goods for export, for example in textiles and clothing, provides employment for people in low income countries. This benefit should not be at the cost of substandard employment conditions that damage health. The price of “cheap” consumer goods for people in high income countries should not be poor health in low income countries.

In India 86% of women and 83% of men employed in areas outside the agricultural sector are in informal employment (ILO, 2002); in China, there are now between 100 and 200 million migrant labourers, mostly moving from rural to urban areas (Reuters 2007).
Contextualizing behaviour

Contemporary public health interventions have often given primary emphasis to the role of individuals and their behaviours. The Commission recognizes the important role of these factors, but sets them in the wider social context in order to illustrate that behaviour and its social patterning, as shown in Figures 7 and 8, is largely determined by social factors. Cirrhosis mortality shows that the harm associated with heavy drinking is more common in lower socioeconomic groups. We believe that unless action also takes account of the structural drivers of inequity in behaviour, it will not tackle health inequities.

Figure 7: Socioeconomic inequalities in male cirrhosis of the liver mortality, manual and non-manual workers, Australia

Figure 8: Smoking prevalence (%) and inequalities in smoking by educational level, Europe

National tobacco control efforts demonstrate the responsiveness of health-damaging behaviours to intersectoral action. Globally, the WHO Framework Convention on Tobacco Control (WHO, 2005b) embraces a social determinants approach to tobacco control that encompasses multilevel, intersectoral action. Countries with more restrictive alcohol policies tend to have lower levels of alcohol consumption, lower levels of liver cirrhosis mortality, lower levels of other alcohol-related mortality, and fewer social problems caused by alcohol use (Room, Babor & Rehm, 2005). There is growing evidence that alcohol would lend itself to a control model similar to that of the tobacco framework.

A relatively new global phenomenon is the “nutrition transition” (Popkin, 1993) – increasing consumption of fats, sweeteners, energy-dense foods, and highly processed foods. The world now faces a double burden of malnutrition – under- and over-nutrition – both of which are socially patterned (Hawkes et al., 2007). Community-based approaches to tackle household food insecurity such as SEWA’s are important parts of the solution.

Similarly, the knowledge, attitudes and behaviour focus of the community health promotion intervention in Sweden (Panel 3) demonstrated positive changes in the cardiovascular risk profile of the population, using approaches that required no additional costs. However, addressing nutrition inequities in a sustainable manner also requires action on the structural drivers of food availability, accessibility and acceptability at the global and national levels (Friel, Chopra & Satcher, in preparation).

*Childhood malnutrition is an underlying factor in more than 50% of under-5 deaths* (Black, Morris & Bryce, 2003).

*In a rich country like Ireland, single parent households with one child would have to spend 80% of their weekly household income in order to purchase a food basket that is compliant with national dietary guidelines* (Friel, Walsh & McCarthy, 2006).
We have made the point that inequities in health result from the social conditions that lead to illness. That said, given the high burden of illness particularly among the socially disadvantaged, it is urgent to make health systems more responsive to population needs. International, national and local systems of disease control and health services provision are both a determinant of health inequities and a powerful mechanism for empowerment. Central within these systems is the role of primary health care (PHC), as illustrated in the community-based programme in Sweden (Panel 3).

In some instances, health systems actively perpetuate injustice and social stratification. In low and middle income countries, public money for health care tends to go to services that are used more by the rich than by the poor (Gwatkin, Bhuiya & Victora, 2004). Reforms that lead to charging at the point of use are a disincentive to use of health care. Out-of-pocket expenditures for health care tend to deter poorer people from using services, leading to untreated morbidity (Palmer et al., 2004). Such expenditures can also lead to further impoverishment (Whitehead, Dahlgren & Evans, 2001) or bankruptcy (Gottlieb, 2000). The larger the proportion of health care that is paid out of pocket, the larger the proportion of households that is faced with catastrophic health expenditures (Xu et al., 2007).

The conditional cash transfer model of Bolsa Familia, for example, stimulates uptake of health services that typically do not get to poor communities. While financial support to improve access to and use of health services among the poor is vital in the short term, the underlying issue for policy intervention is the need to reduce and remove financial barriers to such services. National health systems are pivotal in tackling health inequities; in order to do so effectively they need to be adequately resourced, function well, and be accessible to all. Appropriately configured and managed health systems provide a vehicle to improve people's lives, protecting them from the vulnerability of sickness, generating a sense of life security, and building common purpose within society; they can ensure that all population groups are included in the processes and benefits of socioeconomic development and they can generate the political support needed to sustain them over time. Current efforts to revitalize primary health care globally (PAHO, 2007) should go hand in hand with attention to the social determinants of health.

Just as a social determinants approach to improving health equity must involve health care, so must programmes to control priority public health conditions include attention to the social determinants of health. Such action has to involve multiple sectors in addition to the health-care sector. It is not sufficient,
for example, to provide treatment for people with diabetes in middle income countries and not deal with the drivers of the obesity epidemic; to be concerned with childhood illness and not education of women who will become mothers; to deliver health education to individuals and not be concerned with their poverty; or to deal with stress-related illness and ignore the conditions in which people live and work that gave rise to it.

The Commission has convened a network on Priority Public Health Conditions at WHO headquarters in Geneva, working with a number of disease control programmes to bring these approaches together. For example, work by the WHO Stop TB programme notes that tuberculosis is associated with patterns of social and economic development that include rapid urbanization, inequitable economic growth and presence of large pockets of social deprivation. Lasting control of tuberculosis requires the combination of treatment and preventive action, taking into account biological and health behavioural factors, health service responsiveness, and socioeconomic conditions.

Over half a million women die each year during pregnancy, delivery or shortly thereafter, virtually all in developing countries (WHO, 2005a)

In the USA, health-care use is lower among the uninsured (Hadley, 2007), more than 40 million people.

More than 100 million individuals globally are impoverished through direct health-care expenditure (Xu et al., 2007).
The shape of society

Health inequities reflect the unequal distribution of power, prestige and resources among groups in society. All societies are stratified along lines of ethnicity, race, gender, education, occupation, income and class. We see this very clearly in each of the case-studies from India, Brazil and Sweden described in the panels. Although at very different stages of economic development, the differentiation of certain groups – be it by gender, caste, education, place, or income – is key to the way health inequity is generated.

Stratification creates advantage and disadvantage across social groups. Progressive disadvantage can lead to marginalization and disproportionate vulnerability among those excluded from societal benefits. These processes of disempowerment can operate not only at the level of individuals, households, groups, and communities, but also among countries and global regions.

Gender is perhaps one of the most powerful illustrations of imbalance in societal power, prestige and status, and its effects in the unequal health experiences of men and women worldwide. At the core of gendered health inequity are social norms and structures that support and perpetuate bias.

In sub-Saharan Africa, women undertake more than 75% of agricultural work, yet they own less than 10% of the land (UN Millennium Project, 2005).

In Mexico, 35.2% of young women aged 15–24 years are not in the labour force and not in education, compared with 5.3% of young men in that age group (World Bank, 2007).

Gender bias affects almost every aspect of social organization and consequent conditions of life and work, from unequal access to and control over property, economic assets and inheritance; division of labour within and outside the home; unequal participation in political institutions from village to international level; to restrictions on physical mobility, reproduction and sexuality, and sanctioned violence against women and girls.

The marginalization of working women in India is dramatic and clear from SEWA’s account. The emphasis in conditional cash transfer programmes – such as that in Brazil – on channelling resources via female household members demonstrates the importance that the policy of such programmes places on supporting women’s role in protecting children’s development and promoting family health. The Swedish example, too, shows how global and national changes in the organization of production can have disproportionate effects on women. The response of the regional government to focus on gender equity as a core objective reflects the concern for this pervasive phenomenon.
SEWA’s range of actions shows the importance of a multilevel approach to addressing gender inequity. While supporting its members’ material circumstances and working arrangements, SEWA also takes action to challenge the Indian legal system, taking the local experience of empowered SEWA women to the national level of equity-related governance.

Because of the numbers of people involved and the magnitude of the problems, taking action to improve gender equity in health and to ensure women’s rights to health care is one of the most direct and potent ways to reduce global health inequities and ensure effective use of health resources.

150 million girls under the age of 18 years experienced forced sexual intercourse or other forms of physical and sexual violence in 2002 (Pinheiro, 2006).
Economic and social policies affect the distribution of the social determinants of health, including resources for education, health, and financial security. It is clear, therefore, why the relationship between ministries of health and ministries of finance is so vital to a social determinants view of health. Recognition of the importance of social determinants of health means that government social policy, not just health policy, is vitally important for health equity. This taps deep into the value system of society. The promotion of health equity relies on values but it also requires the strengthening of evidence in policy formation.

As Figure 9 illustrates, pro-health equity policies appear to rely in many cases on the state in providing an adequate degree of security – via welfare programmes and the provision of a universal social safety net. Such policies may include: housing, health and safety standards, family-friendly labour policies; active employment policies involving training and support; the provision of social safety nets, including those for income and nutrition; and the universal provision of good quality health, education, and other social services.

**Figure 9:** Total family policy generosity and child poverty in 15 countries, 2000 or nearest

Notes: Net benefit generosity of transfers as a percentage of an average net production workers’ wage. Poverty line 50% of median equivalized disposable income.

Source: Lundberg et al., 2007, based on Luxembourg Income study data.
Sweden has, for much of the post-Second World War period, maintained very strong state-led welfare policies. The political support for this policy orientation has much deeper roots in the way in which Sweden, and to a degree other Nordic countries, developed over several centuries. Following three decades of military dictatorships, Brazil has emerged into a period of democratization. With this, a strong commitment to tackle both poverty and inequity has taken centre-stage in the political sphere. In India, the material conditions of the vegetable sellers of Ahmedabad can be improved in the short term through local forms of collective action and empowerment; but a more sustained empowerment for workers comes from action at the structural level: action through the state and national legislature, and improved access to credit.

Women account for only 17% of parliamentarians worldwide (IPU database).

Many countries spend more on the military than on health. Eritrea, an extreme example, spends 24% of GDP on military and only 3% on health. Pakistan spends less on health and education combined than on military (World Bank, 2006a)
The global arena

While action by countries and local communities is of profound importance to the social determinants of health, so too is the global context. The global level exercises an increasingly powerful influence on relations between countries and conditions within them. Globalization, with its remarkable acceleration of trade and knowledge and resource flow, offers unprecedented promise for improving human health. Yet, to date, many feel that this promise has been unfulfilled.

The emphasis placed on globalization as an engine of economic growth on a new global scale has overlooked or underestimated the initial conditions of inequality between rich and poor countries, and within them. Where the social institutions through which people share resources are relatively strong and fair, moderate inequality can be “constructive”, driving the efforts and risk-taking at the micro level that underpin economic success. But where institutions governing the distribution of societal resources are weak, corrupted, or structurally inequitable, as they are both within many countries and between the rich and poor regions, inequality can act destructively, suppressing local enterprise and perpetuating impoverishment (Birdsall, 2007). So far, the benefits of globalization have been largely asymmetrical, creating among countries and within populations winners and losers, with knock-on effects on health.

There is great benefit to be had from increased trade openness, increasing interdependence among nations, and an expanded policy space at the global level to deal with the major issues – environment, health, security – common to all countries (Cline, 2004). Nevertheless there is something profoundly wrong in the assumption that all countries come to these new global fora equally equipped (Birdsall, 2006). Long historical trajectories bring countries together under globalization at dramatically differing levels of institutional capacity and strength. A globalization that does not provide for institutional building among the developing nations is liable to foster and even increase inequity, and to continue to disappoint both its supporters and its critics.
Figure 10: Net financial flows in developing economies, 1993–2005

The poorest countries of the world, notably in sub-Saharan Africa, receive only small portions of global financial flows. In fact, net flows are increasingly from developing economies to high income countries, as shown in Figure 10. As a result, developing countries rely heavily on official development assistance to finance critical public expenditure, including health. Such assistance continues to be important as a source of financing, complemented by more extensive forms of debt cancellation. Aid has the potential to lift as many as 30 million people out of absolute poverty each year, although its effectiveness is undoubtedly affected by issues relating to delivery. Strengthened social security systems would in the longer term act as a buffer against detrimental health effects of those benefiting less from trade liberalization (OECD, 2002).

The expansion and liberalization of trade globally has had both positive and negative impacts on health in rich and poor countries. Increased global trade in food products, for example, is associated with the nutrition transition described earlier. The growth of transnational supermarkets has led to changes in food availability, accessibility, price and, through global marketing, desirability. Unregulated, these changes can have very negative health consequences. Trade negotiations that take a balanced view of health and commercial considerations can be beneficial for all in society.

While the Commission recognizes the contribution that economic growth can make to the availability of resources for improving access to social determinants of health and reducing health inequities, it asserts that growth per se is not a sufficient prescription for equitable improvements in population health – nor is growth with inequality a simple or automatic trade-off. Rather, action within and between countries to mitigate and remove structural, destructive inequality is the necessary counterpart to global growth itself and the policies that aim to support it.

Over 60% of the total increase in official development assistance between 2001 and 2004 went to Afghanistan, the Democratic Republic of Congo, and Iraq – in spite of the fact that the three countries account for less than 3% of the developing world’s poor (World Bank, 2006)