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Erik Blas, Lucy Gilson, Michael P Kelly, Ronald Labonté, Jostacio Lapitan, Carles Muntaner, Piroska Östlin, Jennie Popay, Ritu Sadana, Gita Sen, Ted Schrecker, and Ziba Vaghri

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# Addressing social determinants of health inequities: what can the state and civil society do?

Erik Blas, Lucy Gilson, Michael P Kelly, Ronald Labonté, Jostacio Lapitan, Carles Muntaner, Piroška Östlin, Jennie Popay, Ritu Sadana, Gita Sen, Ted Schrecker, Ziba Vaghri

World Health Organization, Geneva, Switzerland (E Blas DrPH, R Sadana ScD); WHO Centre for Health Development, Kobe, Japan (J Lapitan PhD); School of Public Health and Family Medicine, Faculty of Health Sciences, University of Cape Town, Observatory, South Africa (Prof L Gilson PhD); National Institute for Health and Clinical Excellence, London, UK (Prof MP Kelly PhD); Institute of Population Health, University of Ottawa, Ottawa, ON, Canada (Prof R Labonté PhD, T Schrecker MA); University of Toronto, Toronto, ON, Canada (Prof C Muntaner MD); Karolinska Institutet, Department of Public Health Sciences, Division of International Health, Stockholm, Sweden (P Östlin PhD); Division of Health Research, Lancaster University, Lancaster, UK (Prof J Popay MA); Centre for Public Health Policy, Indian Institute of Management, Bangalore, India (Prof G Sen PhD); and International Research Initiatives Program, Human Early Learning Partnership, University of British Columbia, Vancouver, BC, Canada (Z Vaghri PhD)

Correspondence to: Prof Michael P Kelly, National Institute for Health and Clinical Excellence (NICE), Mid City Place, 71 High Holborn, London WC1V 6NA, UK [mike.kelly@nice.org.uk](mailto:mike.kelly@nice.org.uk)

In this Health Policy article, we selected and reviewed evidence synthesised by nine knowledge networks established by WHO to support the Commission on the Social Determinants of Health. We have indicated the part that national governments and civil society can play in reducing health inequity. Government action can take three forms: (1) as provider or guarantor of human rights and essential services; (2) as facilitator of policy frameworks that provide the basis for equitable health improvement; and (3) as gatherer and monitor of data about their populations in ways that generate health information about mortality and morbidity and data about health equity. We use examples from the knowledge networks to illustrate some of the options governments have in fulfilling this role. Civil society takes many forms: here, we have used examples of community groups and social movements. Governments and civil society can have important positive roles in addressing health inequity if political will exists.

Research and action to promote greater health equity has a long tradition. However, the launch of the report of the WHO Commission on the Social Determinants of Health (CSDH)<sup>1</sup> represents an important milestone, calling as it does for renewed and sustained action to achieve greater health equity by focusing attention on the central role of action to address the social determinants and by collation of global evidence to support this action. Nine knowledge networks, established to aid the CSDH, have been synthesising knowledge on opportunities for improved action in key areas: early child development,<sup>2</sup> employment conditions,<sup>3</sup> health systems,<sup>4</sup> urban settings,<sup>5</sup> globalisation,<sup>6</sup> social exclusion,<sup>7</sup> women and gender equity,<sup>8</sup> priority public-health conditions,<sup>9</sup> and measurement and evidence.<sup>10</sup> More than 350 researchers, practitioners, policy makers, and civil-society representatives, and 100 institutions across countries of low, middle, and high incomes, had a role in these networks, which appraised a rich diversity of actions by many actors, including United Nations agencies, national governments, international and national donor institutions, private-sector organisations, and civil society. In this Health Policy article, our intention is not to summarise the work of the knowledge networks as a whole. Rather, our aim is more modest: to draw on selected evidence from across the knowledge networks to highlight the pivotal role of national governments and civil society in the pursuit of greater health equity.

## Approach to evidence

The conventional biomedical approach to determinants of health does not generally embrace causal pathways to illness that originate in laws, tax systems, the behaviour of multinational organisations, or global financial systems. The implication of the social determinants approach, however, is that causal chains run from macro social, political, and economic factors to the pathogenesis of disease. These causal factors produce disease not only in individuals but also in highly patterned ways in populations. These patterns are shaped by distributions of socioeconomic advantage and disadvantage and are observable across entire societies, rich and poor alike, and between groups.<sup>10,11</sup> The two causal chains of individual disease and of

population patterns of disease—present challenges for research. Although much is already known, evidence of relevant causal pathways must continue to be refined, partly on the basis of enhanced disaggregation of population-health data. Similarly, methodological developments are needed in evaluative research to ensure that we are able adequately to appraise the effect of the diverse actions described in the knowledge networks' reports. In view of the limitations of the current evidence base both epidemiological and evaluative on the social determinants of health and health inequities, the networks had to be flexible, multidisciplinary, and inclusive in the type of data they used. There was also a concern to incorporate findings on the subjective experiences of people most directly affected by health inequities, to let their voices be heard. For these reasons, no single hierarchy of evidence was adopted.

Notwithstanding the difficulties and limitations of the knowledge available, the political challenge is to ensure that action is taken on the basis of the abundant information that is already available. The work of the knowledge networks points to the potential for action by many actors at many levels,<sup>12</sup> but findings from all networks emphasised the pivotal part to be played by national governments and civil society, whether as informal groupings of communities of interest or place, formal organisations, or wider social movements. In the following sections, we describe the broad contours of these roles and present examples of this for governments, drawing selected cases from across the knowledge networks.

## Role of national governments and state action

Successful governmental actions can reduce health inequity in at least three ways. First, they can ensure provision of basic services and protect and promote

human rights (including entitlements to services such as health care and education) and the right to a decent standard of living,<sup>13</sup> thus making sure resources are distributed in more equitable ways. Second, they can establish and maintain legislative and regulatory frameworks to influence the action of others and their own. Third, they can monitor the health status of different population groups, health outcomes of social inequalities, and effects and progress of action to reduce inequities and use this information to inform ongoing interventions.

### **Human rights and essential services**

Without doubt, the universal welfare systems introduced after World War II in most OECD (Organisation for Economic Cooperation and Development) countries substantially reduced poverty, reversed exclusionary processes, promoted social cohesion, and enhanced population health.<sup>7,14-16</sup> For example, the early child development knowledge network has gathered strong evidence from around the world that shows the best developmental outcomes for children are achieved both by ensuring universal access to quality child care, nutrition, health services, and education, and when policies support families and communities. Comprehensive welfare policies in France and Sweden have diminished child poverty to levels that are some of the lowest in OECD nations. However, the potential is not confined to high-income countries.<sup>4</sup> Outside the OECD, evidence from Thailand, Sri Lanka, Cuba, South Africa, and Brazil shows that good leadership, even under challenging circumstances, can provide innovative interventions and benefits to socially marginalised groups or other subpopulations.<sup>4</sup> Irrespective of economic development, countries with a more generous welfare state and regulated labour markets have reduced unhealthy employment and working conditions to a greater extent than those that do not. For example, data from wealthy countries such as Canada, Australia, the USA, and the UK show that workplaces at which unions are present are safer than those without unions and that union representatives are well placed to record occupational risks and advocate for change.<sup>3,17</sup>

Since the late 1970s, a widespread shift has taken place away from state involvement in the provision of universal social protection, health services, and education funded through taxation and social insurance, towards more individualistic models of welfare—what Jacob Hacker, writing in the US context, has called the privatisation of risk.<sup>17</sup> This process of forming a market for public services in countries of low and middle income is promoted by the problematic conditions attaching to aid, loans, or debt relief from governments in high-income nations and international financial institutions.<sup>6</sup> Evidence collated by the knowledge networks suggests that these approaches to the provision of basic services for poor populations create many difficulties from the perspective

of health equity.<sup>4,17</sup> In 2001, for example, Colombia introduced a dual system of health-care insurance: a contributory scheme for those who can afford it; and a subsidised scheme that covers 20.2 million people with low incomes—47.7% of the population. This scheme left 5.6 million individuals (13.3% of the population) ineligible for either scheme, so a partial subsidy was initiated to allow these people to access free emergency health care in certain public facilities.

But counter forces have also operated. For example, in countries of low and middle incomes, publicly funded and administered social protection policies have reduced financial and other forms of labour market insecurity. Across OECD countries, in particular the Nordic social democracies, governments have maintained a commitment to spending on social protection.<sup>16,18</sup> Governments such as those of South Africa, Venezuela, and Brazil, are developing universal approaches that also aim for enhanced social cohesion and solidarity: these warrant greater attention and evaluation in the future. The international human rights framework was identified in a background paper for the WHO commission as “the appropriate conceptual structure within which to advance towards health equity through action on [social determinants of health]”.<sup>19</sup> Constitutional rights to health services are just one way in which national governments can at least create a climate in which an equitable distribution of resources to meet basic needs can be pursued. Another, suggested by the United Nations’ Special Rapporteur on the right to health, entails development of a right-to-health impact assessment framework that can be applied in an anticipatory way to the provisions of trade agreements.

### **Legislative and regulatory frameworks**

Policy frameworks that regulate or enable actions towards the goal of health equity are another means by which governments can exert leadership. These frameworks might focus on a nation’s relationship with external agents—eg, with respect to regulation of global trade relations—or be concerned with internal issues, such as achievement of greater gender equity or support of cross-sector work. Typical characteristics of successful frameworks are that they outline roles and responsibilities (including legal responsibilities, such as those related to human rights) of every sector, how collaboration will proceed, and what resources will be available.

The need for robust national policy frameworks to regulate the action of international agencies with the aim of promotion of health equity is nowhere more relevant than in relation to globalisation. Globalisation brings indirect health benefits through increased economic growth and poverty reduction.<sup>20</sup> Yet, reality is not that simple. For example, lost revenues resulting from rapid reduction of tariffs in many countries of low and middle income have not always been replaced by growth or alternative tax structures. Losses affect public financing of health services, education, water and sanitation

services, and other social protection investments. A necessary, but not sufficient, condition for any further liberalisation of trade is creation of regulatory frameworks that ensure establishment of effective alternative means of public revenue generation and greater equity in access to health services and other schemes related to social determinants of health.<sup>6</sup>

National policy frameworks are also needed to challenge the argument that deregulated labour markets and low wages are inevitable. For example, despite high wages and benefit levels, some countries with so-called active labour market policies are amongst the most competitive in global markets.<sup>3</sup> In countries of low and middle income in particular, governments must put in place the regulatory frameworks needed to ensure that protection of labour legislation is extended to workers in informal labour markets, who might represent most of the employed population.

National policy frameworks also offer a mechanism for making sure of the success of multisector action on social determinants. For example, in Eritrea, a holistic approach to early child development—including families, caregivers, community institutions, health and community centres, schools, and development agencies—has resulted in better infrastructure and increased preschool and primary school enrolment levels compared with other countries in the region.<sup>2</sup> Experiences from Mexico, Sri Lanka, Chile, Sweden, and the UK<sup>4</sup> highlight that intersectoral action for health and improvements in health equity are attributed not only to the performance of the health sector but also to the coordinated action of all ministries to promote socioeconomic development.<sup>4</sup>

Within the health sector, governments can directly influence the degree to which public-health programmes are mandated to act on broader determinants of health and are accountable for improvements in health equity. In nations of low and middle income, sizeable portions of national budgets (government and donor funding) are directed to strategies to prevent and treat specific conditions or diseases (eg, tuberculosis, malaria, maternal and child health, and HIV/AIDS). Analyses done by 14 priority public-health nodes (alcohol, cardiovascular diseases, child health and nutrition, diabetes, food safety, HIV/AIDS, making pregnancy safer, malaria, mental disorders, neglected tropical diseases, oral health, sexual and reproductive health, tuberculosis, and violence and injuries), which are all existing WHO programmes, show that ample opportunities exist to adjust the design and coordinated implementation of these initiatives to enhance health equity when a social determinants approach is adopted. This can include augmentation of access to poor and other marginalised subpopulations and directly addressing the conditions that put these people at high risk of disease.<sup>9</sup>

National regulatory and legislative frameworks have also been shown to have substantial positive effects on gender equity. For example, over the past 40 years in

Tunisia, changes in personal status laws have raised women's legal and social status, thus outlawing repudiation and polygamy, establishing a minimum age for marriage, and providing equal wages for men and women.<sup>21</sup> In Sweden, creation of a division of gender equality within the national administration—coupled with enforcement of a gender equality strategy that requires public and private organisations to undertake systematic gender analysis of all policies and services—has resulted in greater health equity.<sup>8</sup>

### **Monitoring of health status**

Systems to monitor health equity must involve analysis of age, sex, socioeconomic group (eg, as an indication of education and wealth), race, ethnic origin, and place of residence, and other key factors that define socioeconomic (dis)advantage.<sup>10</sup> Currently, analyses and interpretation of relations between health and these variables are rarely undertaken outside of high-income countries.<sup>3</sup> Some governments have successfully mandated that new policies and interventions, irrespective of their primary intent, are evaluated from a health-equity perspective.<sup>10</sup> Support for nations of low and middle income as they augment their capacity to implement these tasks is urgently needed. Similarly, governments can demand increased coordination and integration of international agencies, and likewise, international agencies—including donors—can support civil society organisations specifically to advance health equity irrespective of the state's role or position.

### **Role of civil society**

Civil society actors can be powerful drivers for positive social, political, and economic changes that affect health equity. These actions include those of informal community groups, formal civil society organisations such as labour unions, and large-scale social movements such as the anti-apartheid movement in South Africa.

People who are the intended beneficiaries of government policies and actions have a right to participate in their design, delivery, and assessment. Evidence shows that successful engagement of target communities in decisions about how to address social determinants of health will increase the likelihood of policies and actions being appropriate, acceptable, and effective<sup>7</sup> and can have a direct effect on individual health by raising people's sense of control over their lives.<sup>9,22</sup> In Dhaka, Bangladesh, one of the most populated urban areas in the world, integration of local communities in the design and delivery of an overall waste collection system proved a highly successful way of supplying a service that was previously non-existent for marginalised populations. In Marikina City, Philippines, a comprehensive plan that integrated health services, infrastructure development, and environmental upgrading, with strong community involvement, led to a sharp reduction in dengue.<sup>5</sup>

A large-scale example of participative democracy in action is the *Barrio Adentro* primary health-care programme in Venezuela, which enabled 17 million people on low income to gain access to health services within 3 years, and has now extended into other policy areas. Neighbourhood health committees are a key element in this initiative. At first, these committees—elected from local residents—were responsible for identification of accommodation in the Barrio for new doctors and the clinics they were to open. However, over time they are becoming a force to promote local social cohesion. The committees retain oversight of strategic development of health care in their neighbourhoods. By 2006, almost 9000 elected neighbourhood health committees were registered with the national health committee coordinating office set up by the Ministry of Health. These committees are becoming involved in implementation of other social missions in their neighbourhoods and are seen as a key building block in the new participative democracy the Venezuelan government is seeking to build.

Early positive outcomes of the Venezuelan social experiments focusing on health care, literacy, land reform, and other social determinants have been described.<sup>23</sup> However, in many countries, the knowledge and perspectives of lay people, particularly indigenous populations, is frequently devalued and ignored.<sup>24,25</sup> Policy changes can and have addressed this issue, but to be successful they must acknowledge the change in power balance implied by community engagement and address the resistance this shift might lead to within professional groups and the organisations in which they work.<sup>7</sup>

Formal civil society organisations have enabled improvements to social determinants of health at all levels of society, through advocacy, monitoring, mobilisation of communities, provision of technical support and training, and giving a voice to the most disadvantaged sections of society.<sup>4</sup> Women's organisations have been at the forefront of this success, with generation of new and compelling evidence of gender inequality and inequities in health, experimentation with innovative programmes, political mobilisation, and demands for accountability from governments and the intergovernmental system.<sup>8</sup> In doing so, they have had a catalytic role in changing the social and political climate nationally, regionally, and globally and in pushing governments to exercise their leadership roles.

An example is the process that led to India's Protection of Women from Domestic Violence Act 2005. An early draft in 2002 of the Domestic Violence Bill left many loopholes, including no recourse for a woman who might be thrown out onto the streets by a violent husband if she dares to challenge him with the law. As a result of strong lobbying by women's groups and effective redrafting by feminist lawyers the draft was changed, and a considerably enhanced Act uses a broad

definition of violence to include beating, slapping, punching, forced sex, insults, or name-calling. The Act allows abused women to complain directly to judges instead of police, who usually side with men and rarely act on complaints. Moreover, it covers not only wives and live-in partners but also sisters, mothers, mothers-in-law, or any other female relation living with a violent man. As such, it is one of the most progressive pieces of legislation on this subject to date.<sup>8,26</sup>

Many contemporary social movements are working for greater social and health equity at local, national, regional, and global levels. Some political or religious aims are contested and do not always conform to national policies. In the case of Latin American indigenous movements, the central claim is for recognition of their culture, autonomy, and collective ownership of their ancient lands. A well established effective movement is the *Zapatistas* in Chiapas, Mexico. This movement has established its own systems to provide food, housing, education, and health services, with traditional health providers complementing occidental medicine. The Zapatista health services have delivered important health outcomes sometimes in very short timescales, including a sharp decline in maternal mortality. The indigenous communities in the north of Guatemala have been developing similar services—including health-care provision that combines traditional and occidental medicines—with very good results.<sup>27–30</sup>

Labour associations have had, and continue to have, a role in augmentation of employment conditions. In addition to trade unions, new social movements—such as informal workers' alliances in countries of low and middle income, fair-wear garment workers, fair-trade basic food producers, and antichild labour campaigns—are now also developing and affecting employment conditions. Social movements typically bring together several civil society organisations and others towards a common cause. In Norway, an extensive alliance of unions and community groups has formed *For velferdsstaten* (For the Welfare State) to campaign in favour of social welfare and public services. In South Africa, broad-based post-apartheid social movements are diverse and address land equity, gender, sexuality, racism, environment, education, conditions of formal and informal labour, access to infrastructure, housing, eviction, HIV/AIDS treatment, crime and safety, debt, and geopolitics. These movements focus on material improvement of poor people's lives, legal rights, social and environmental justice, and stigma and discrimination.<sup>7</sup>

Finally, civil society in all its forms usually supports generation of information on population preferences and needs. In turn, these organisations can be used to affect resource allocation and hold health officials accountable at national and international levels, such as The People's Health Movement.

The evidence reviewed by the knowledge networks and described above suggests that if national governments support civil society activity, this action can have a positive effect on inequity of social determinants of health. Such support can be entirely consistent with the normal role of government in setting regulatory frameworks for civil society and should include: (1) recognition of the political legitimacy of civil society and a community's voice;

(2) involvement of civil society in all its forms in policy development, implementation, and monitoring;

(3) ratification and implementation of legal protection for civil society organisations; (4) design of policies that transfer real power to people; (5) resourcing of policy implementation to support community empowerment; and (6) reform of professional education to give greater status to lay and indigenous knowledge.

Properly functioning civil society needs a free and responsible press that takes up issues of inequity, encourages public debate, and challenges government and other interest groups to be transparent and fair. Powerful synergies have emerged when civil society, public-health programmes, and the media have joined forces to stimulate and sustain sound national and international public debates—for example, promotion of exclusive breastfeeding, trade policy measures that restrict access to essential medicines (notably in the case of HIV infection), and restrictions on tobacco marketing.

In their funding policies, multilateral agencies and international development partners (or donors) have supported good practices by provision both of incentives for national governments to work effectively with communities and civil society organisations and of resources for capacity building for civil society action and community involvement. More broadly, the international community has a powerful advocacy role to promote legal protections for civil society organisations and community action within nation states.

## Conclusions

We have drawn on evidence from across the nine knowledge networks to show the key parts to be played by national governments and civil society in action to achieve greater health equity. The data suggest that health equity is substantially enhanced when national governments accept responsibility for protection and promotion of human rights, thus guaranteeing universal provision to meet needs, including for example, health care, sanitation and safe water, social protection, and education. Establishment and maintenance of policy frameworks, such as legislation and regulations, including financial regulation, has also been shown to be an effective mechanism national governments can use to shape the action of others—both external and internal to the state—to promote greater equity in health and the social determinants of health.

A diverse body of evidence also suggests that a dynamic and engaged civil society—in all its forms—can

enhance the relevance and acceptability of actions addressing the social determinants of health equity, and by increasing people's sense of control over their lives it can work through psychosocial pathways to enhance health directly. Therefore, in the pursuit of greater health equity, the state has an important role in fostering democratic engagement, political freedoms, and free speech, to actively promote development of a vibrant civil society. However, civil society action in the form of community engagement cannot be the 21st century's magic bullet: local community action is inevitably constrained by the wider context in which it operates. Local community action is fairly powerless in the face of global forces driving powerful exclusionary processes, weak or corrupt governments unable or unwilling to act for greater equity, or both of these factors. By contrast, major social organisations—such as the anti-apartheid movement—have shown the potential of large-scale civil society action to affect the larger national and international stage.

These lessons raise challenges that are both scientific and political. Scientific challenges are to describe as precisely as possible the two overlapping but analytically separate causal pathways that account for both individual and population patterns of disease, drawing on knowledge and best practice examples from around the world, and to develop methods for robust assessment of action to enhance health equity. Politically, the key players—namely states, governments, corporations, and civil society—need to recognise and act on what is already known about the social determinants of health. Political actors, in particular, must change their behaviour substantially. Thus, a key part of our collective future work is to ensure that reduction of health inequity by addressing its social determinants remains high on the political agenda.

### Contributors

All authors wrote the report. The following were co-authors of the nine knowledge networks' reports, on which this article is based: Jens Aagaard Hansen, Awa Aidara Kane, Daniel Albrecht, Francisco Armada, Joan Benach, Chantal Blouin, Josiane Bonnefoy, Jennifer Butt, Claire-Lise Chaignat, Haejoo Chung, Sarah Escorel, Francisco Espejo, Mark Exworthy, Christopher Fitzpatrick, Michelle Funk, Gauden Galea, Francis Grenier, Mario Hernandez Alvarez, Clyde Hertzman, Lori G Irwin, Ernesto Jaramillo, Heidi Johnston, Stella Kwan, Kelley Lee, Knut Lönnroth, Shawn Malarcher, Jose Miguel Martinez, Matthews Mathai, Jane Mathieson, David Meddings, Shanthi Mendis, Antony Morgan, Landon Myer, Thelma Narayan, Anne Marie Perucic, Poul Erik Petersen, Michael Quinlan, Kumanan Rasanathan, Dag Rekve, Laetitia Rispel, Gojka Roglic, Vivien Runnels, Vilma Santana, Robert Scherpbier, Arjumand Siddiqi, Anand Sivasankara Kurup, Orielle Solar, Emma Stewart.

### Conflict of interest statement

We declare that we have no conflicts of interest. All authors, except those identified as WHO staff, were members of the different knowledge networks. The views expressed within this paper are those of the authors and not necessarily those of WHO.

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