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The way forward: Acting on the evidence and filling knowledge gaps

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## The way forward: acting on the evidence and filling knowledge gaps

*Jennifer H. Lee and Ritu Sadana<sup>1</sup>*

Greater equity in the health status of populations, within and between countries, should be regarded as a key measure of how we, as a civilized society, are making progress.

*Margaret Chan, WHO Director General*

### 1. Introduction

The chapters in this book bring together a synthesis of global evidence that demonstrates the significance of broader determinants (e.g. social, economic, and political) on health outcomes and health equity. The evidence stresses the importance of action on these determinants to achieve better health for all and improve health equity, and points to what actions should be taken. As stated by the Commission on Social Determinants of Health Report (CSDH, 2008), inequalities in health reflect disparities in daily living conditions and in access to power, resources, and societal participation. This report majored on the *fact* that social justice, economic systems and political arrangements are the principal macro, or social, determinants of health and disease within and between societies. This was a profound shift scientifically, because the report makes clear that economic systems, political processes, social structures and legal arrangements can be as toxic to populations as any viral or bacterial pandemic. Moreover, the consequences of these macro determinants of health are not in any sense random or evenly spread. Quite the contrary; the patterning of health inequities across the globe within and between societies is associated with

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systematic inequalities in access to the social, economic, political and cultural resources and systems necessary to promote health or prevent disease. For some people, these systems are health enhancing while for others, they are lethal. Improving the understanding of the causal pathways of health inequities globally and locally, and informing action to reduce them, requires new directions in our thinking about these matters.

Policies and interventions in and particularly outside the health sector (e.g., housing, education, transportation, and employment) provide opportunities to improve health outcomes and reduce inequities in health within and across populations (Bambra et al., 2008). The evidence gathered through the Knowledge Networks on key areas described in the previous chapters suggests that much can be done to address the causes of inequities and ultimately reduce those that exist. This chapter provides a summary of what the evidence shows and ways in which different actors can work together to move forward to address social determinants of health (SDH) and thereby reduce health inequities.

## 2. What does the evidence tell us?

Inequities in health arise because of the circumstances in which people grow, live, work and age and the systems put in place to deal with illness (CSDH, 2008). The conditions of these environments are shaped by political, social and economic forces and vary around the world. Unequal distribution of power and wealth contribute to such things as differential access to health care, resources and opportunities associated with better health outcomes. For instance, socioeconomic inequalities in early childhood are a key source of inequities in many health outcomes and mortality in adolescence and throughout adulthood (Chapter 5). Childhood experiences or exposures determine educational attainment and income attainment later in life which are clearly linked to health outcomes (Feinstein, 1993; Bradley & Corwyn, 2002; Brooks-Gunn, Duncan & Mariato, 1997; Sirin, 2005).

Gender inequities affect health norms and practices, exposures and vulnerabilities to health problems and ways in which health systems and research respond. Women in almost all societies have fewer land rights, less wealth and are often viewed as less capable or able than men (Chapter 3; Fazio 2004; Wagner, Ford & Ford, 1986). They are subjected to restrictions on their mobility, sexuality, and reproductive capacity as well as physical or sexual violence. Women often have poor nutrition in terms of quantity and quality of food and employed in lower-paid, less desirable jobs while bearing a disproportionate share of domestic duties (Leslie, 1991; Chapters 2 & 3).

The environment in which people live and work has a great impact on health outcomes and in creating health inequities. Individuals living in urban areas are subject to environmental hazards such as air and water pollution, crime, lack of living space and sanitation and solid-waste management (Chapter 6). Unhealthy living conditions compromise early child development and can increase the risk of communicable and noncommunicable disease and injuries. Additionally, particularly in low-

and middle-income countries, urbanization is often associated with a large informal employment sector which lacks proper regulations of working conditions, work hours and a minimum wage (Chapter 6). Poor working conditions can be found in all countries and contribute to increased risk of injury and poor health through exposure to toxic chemicals, excessive noise, poor sanitation, violence and sexual assault (Chapter 7). Psychosocial relations, management and control, and job satisfaction are also important determinants of health across countries. Contract and occupational status, stress from the workplace, or lack of control or autonomy over one's job are linked to various illnesses and injuries, including cardiovascular disease, musculoskeletal conditions and psychological disorders (Chapter 7).

Despite major differences in living standards around the globe, there is substantial agreement among researchers on the basic or underlying social determinants that shape disease patterns and social gradients in low-, middle- and high-income countries (Wilkinson & Marmot, 2003; Bartley, 2005; Benach et al., 2000; Diderichsen, Evans & Whitehead, 2001; Donkin, Goldblatt & Lynch, 2002; Iyer, Sen & Östlin, 2008; Wagstaff, 2000; Graham, 2007). This commonality in the "causes of the causes" implies substantial opportunities for intersectoral approaches that address disease prevention and health promotion through a focus on the underlying social determinants.

## **2.1 Addressing the underlying causes of health and health inequity**

To address inequities in health, the Commission on Social Determinants of Health made three overarching recommendations (CSDH, 2008):

1. Improve daily living conditions, including the circumstances in which people are born, grow, live, work and age;
2. Tackle the inequitable distribution of power, money and resources; and
3. Measure and understand the problem and assess the impact of action.

### **Entry points for policies and programmes addressing health inequities**

Based on the CSDH conceptual framework presented in Chapter 1, there are different potential entry points for interventions and policies directed towards addressing health inequities. Gender-biased values and discrimination affect people's daily lives as well as key determinants of health through inequalities in such areas as nutrition, decision-making power, employment, political voice, access to health services and allocation of resources, such as education and income. A fundamental approach to addressing gender-based inequity is to change gendered norms and values about the relative worth or importance of girls versus boys and men versus women through the creation, implementation and enforcement of formal agreements, codes and laws that enforce women's rights to full and equal participation throughout society (Chapter 3).

Policy interventions targeting structural factors are also important to address issues that undermine healthy child development such as poverty, inequality in material resources (e.g. housing,

child care and nutritious foods), lack of employment and/or social and economic support available to families, and gender discrimination. Beneficial policy responses to promote and support positive and equitable child development focus on providing social and economic support for families (e.g. universal access to parenting and caregiver support, quality childcare, nutrition, social protection and basic education) (Chapter 5).

To address issues related to urbanization, improved governance<sup>1</sup> coupled with increasing social capital and empowerment of marginalized communities, is considered a pre-condition for success in improving urban settings (Chapter 6). Healthy urban governance policies empower local residents to gain a greater share of decision-making to improve their living environment and work towards building healthier cities.

## 2.2 Understanding and addressing the socioeconomic gradient is key to improving equity

Many of the chapters describe clear and consistent gradients, or patterns of inequity, in access to and security of key health resources (e.g. education, income, employment, housing, and access to health services) based on an individual or group's socioeconomic status or position in society. These patterns are evidenced in health outcomes such as mortality rates, child and adult developmental outcomes and life expectancy. Similar gradients exist for all priority public health issues identified by the Commission through the Knowledge Network on Public Health Priorities<sup>2</sup> (Chapter 9), although the steepness and shape of the gradients varied across populations and time (Chapters 5, 9 & 10). Unless researchers, policy-makers and the media move beyond looking at national averages or aggregate health outcomes, health inequity and its economic, social and political causes will remain invisible (Whitehead, 2009).

The extent and depth of inequity varies from region to region within countries, but also between countries. A focus on improving population averages can potentially increase inequity unless specific measures are taken to extend improve health in all population groups simultaneously. As described in Chapter 10, narrowing health gaps means raising the health of the poorest, fastest; that is, improving the health of the poorest and doing so at a rate which outstrips that of the wider population. For groups historically excluded from access to services for geographic, economic, ethno-cultural or other reasons, programmes targeting their specific requirements are needed to achieve pro-health equity outcomes. A rigorous understanding of the distribution of health outcomes and opportunities across socioeconomic groups is an essential tool for policy-makers to appropriately and effectively tailor interventions that address patterns of health inequity.

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<sup>1</sup> The confluence of governmental and non-state actors in setting forth policy and programme directions

<sup>2</sup> Alcohol-related disorders; cardiovascular disease; child health; diabetes; food safety; HIV; maternal health; malaria; mental health; neglected tropical diseases; nutrition; oral health; sexual and reproductive health; tobacco and health; tuberculosis; and violence and injuries

**Box 5: Common themes**

The evidence presented across chapters highlights these common themes:

- **Power relations:** Power imbalances are identified as generators of inequities such as gender discrimination, social stratification, or unequal employment relations. In order to address this issue, participation and empowerment policies are recommended at all levels. Components of such policies could include ensuring autonomy in decision-making (chapter 3), enhancement of communities' ability to act (chapter 6); transfer of real power and resources to support lay people to be involved (chapter 4); enhancement of social capacities for action; and strengthening health literacy (chapter 8).
- **Education:** Basic education is a key action to address SDH. In addition to basic education, improvements in girls' education and the expansion of secondary education are priorities.
- **Early childhood development (ECD) policies:** Support for universal access to quality ECD services with more direct public expenditure, guaranteeing parents' adequate time balance between work and home, and integrating ECD services into existing primary health care systems.
- **Social protection:** Universal and progressively tax-funded (when possible) social protection policies (e.g. health insurance, income maintenance and other services to address social and income inequality) should be available for individuals unable to attain or sustain livelihoods at a level necessary for their physical, mental and social well-being.
- **Basic services and infrastructure:** Ensure universal access to clean water, sanitation and sewage, solid waste disposal, housing and other services in order to address SDH.

Some issues where recommendations diverged include:

- **Microcredit:** Although microcredit can be an important tool to address health inequalities, evidence on its effectiveness is mixed.
- **Conditional cash transfers: There is some evidence that** cash transfers can improve health, but the evidence is inconclusive and the conditionality of transfers may stigmatize and disempower individuals and/or groups. One possible solution is to focus on "conditions" at the community rather than individual or household levels in an effort to minimize stigmatization and/or exclusion (chapter 4).

### 3. Policy options

The effort to reduce social inequalities in health consists of broad globally and locally integrated policies and of specific public health and occupational programmes and interventions (Chapter 7). Actions taken across government can improve population health, particularly for the most vulnerable groups.

Because there are many entry points for intervention, most calling for the contribution of multiple sectors, a policy approach to reduce health inequities is more complex than traditional efforts taken by policy-makers in the field of health. It requires consideration of non-biological causes of ill health, implementing policies not commonly addressed, and engaging multiple stakeholders in policy processes (WHO, 2007b). A comprehensive overview of the evidence points to several policy options for different sectors and mechanisms to tackle root causes of health inequities. Possible options for intervention and key movers are outlined by sector in Table 16.

### 4. Working together to ensure progress in policy, programmes and research

#### A. Empowerment

Empowering individuals and communities, especially those who are marginalized, to improve social conditions that affect their health is integral for positively improving health outcomes and health equity. Public health interventions are most effective when target communities and groups are involved in all aspects of policy and programme development, implementation and evaluation (Sen, Östlin & George, 2007; Östlin et al., 2007; A/Rahman et al., 1996). Their involvement in both the research process and programme and policy development increases the likelihood that policies and actions are informed, appropriate, acceptable and effective (Blas et al., 2008).

Chapter 3 emphasizes that empowerment is critical to fostering transformation of vulnerabilities related to gender. The empowerment of women and women's organizations allows them to collectively press for greater accountability for gender equality and equity. Individual empowerment fosters transformation of gendered vulnerabilities through means such as providing positive alternatives that support individuals and communities to take action against social norms that perpetuate gender inequities (Chapter 3). As described in Chapter 6, a strong community facilitates social capital which can generate the conditions necessary for mutual support and care; the mechanisms required for communities and groups to exert effective pressure to influence policy structures; and a firm base for urban health equity interventions and programmes that build stronger communities. Chapter 8 proposes that social empowerment generated by primary health care-oriented systems can have direct influence over vicious cycles of social stratification and health inequity by giving power to otherwise socially marginalized groups, such as ethnic and indigenous groups and people with disabilities. For this reason, a need exists not only for participatory research on the experiences of people most severely affected by the social determinants of health inequities, but also for research on how most effectively to involve them in the design and implementation of

**Table 16:** Possible entry points, key movers and interventions for each knowledge network

Sector	Entry Points/Key Movers	Possible Interventions
<p><b>Globalization and Trade</b> (Chapter 2)</p>	<p><b>Entry Point</b> Socioeconomic &amp; political context Policy</p> <p><b>Key Movers</b> Legislative bodies Multilateral agencies Labour organizations Social welfare departments</p>	<p>Policies that generate livelihoods for all people, providing stable incomes at a level necessary for their physical, mental and social well-being and complementary social policies that ensure social protection for those unable to attain or sustain such a livelihood.</p> <p>Legislated and enforced core labour standards.</p> <p>Policies to provide all women with access to child care, free of charge or at minimal cost, through direct public expenditure by national governments and development assistance providers.</p> <p>Expansion of social protection policies such as health insurance using universal, progressively tax-funded means when possible, and not tied to employment.</p> <p>Trade policies that ensure that national health and SDH priorities are not negatively affected, including governments' full use of trade treaty flexibilities governing intellectual property rights and caution in making liberalization commitments in service sectors important to health equity.</p> <p>Debt cancellation for low income countries that take account of "odious debts" using internationally agreed upon legal definitions.</p>
<p><b>Gender</b> (Chapter 3)</p>	<p><b>Entry Point</b> Gender, cultural and societal norms and values Social policy</p> <p><b>Key Movers</b> Legislative bodies Multilateral agencies Civil Society Researchers</p>	<p>Comprehensive policies that support the balance between work and family commitments for women and girls who function as the 'shock absorbers' for families, economies and societies through their responsibilities in caring for household members.</p> <p>Create, implement and enforce formal international and regional agreements, codes and laws to change norms and practices that directly harm women's health (e.g. violate women's right to health).</p> <p>Reduce the health risks of being women or men by tackling gendered-exposures and vulnerabilities – tackle social biases that generate differentials in health related risks and outcomes.</p> <p>Transform gendered politics within health systems by improving awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women – develop skills, capacities and capabilities among health professionals at all levels of the health system to understand and apply gender perspectives in their work.</p> <p>Action to improve the evidence base for policies by changing gender imbalances in both the content and the processes of health research – women should be included in clinical trials and other health studies in appropriate numbers and the data generated from such research should be analysed using gender-sensitive tools and methods.</p> <p>Action to make organizations at all levels function more effectively to mainstream gender equality and equity, and empower women by creating supportive structures, incentives, and accountability mechanisms – gender mainstreaming in government and non-government organizations has to be owned institutionally, funded adequately, and implemented effectively.</p>

<p><b>Social Exclusion</b> (Chapter 4)</p>	<p><b><u>Entry Point</u></b> Cultural and societal norms and values Social policy</p> <p><b><u>Key Movers</u></b> Multilateral agencies Donor agencies Legislative bodies Community Groups Researchers</p>	<p>Development of ways to fund universal systems of social protection and essential services free at point of use in low- and middle-income countries.</p> <p>Greater emphasis in the design of conditional transfer programmes based on evidence – higher levels of cash transfers; more attention to quality and sustainability of services; focus on conditions at community rather than individual/household levels; involve communities in programme design and delivery; and embed in universal welfare systems.</p> <p>Action to protect and promote human rights and full and equal inclusion – provision of universal access to living standards which are socially acceptable to all members of a society.</p> <p>Promote full and equal inclusion for all groups while respecting cultural diversity – ensure that human rights are met and protected.</p> <p>Reverse exclusionary processes – increase efforts to promote more egalitarian relationships between countries and regions, support the extension and protection of human rights, and require and support others to reverse exclusionary processes and promote positive inclusion including genuine community empowerment.</p> <p>Create and maintain the conditions required for genuine delegation of power and control to people who are the targets of policy.</p>
<p><b>Early Childhood Development</b> (Chapter 5)</p>	<p><b><u>Entry Point</u></b> Policy</p> <p><b><u>Key Movers</u></b> Legislative bodies Social welfare departments Community Groups Researchers</p>	<p>Local, regional, national and international policies that incorporate the science of early child development.</p> <p>Combine the agenda for child survival and health with the agenda to improve early child development.</p> <p>Use an inter-ministerial policy framework for ECD that clearly articulates the roles and responsibilities of each sector and how they will collaborate.</p> <p>Build upon established child survival and health programmes to make ECD programmes accessible through existing platforms, such as the health care system.</p> <p>Integrate ECD policy elements into the agendas of each sector to ensure that they are considered routinely in sectoral decision-making.</p> <p>Develop strategies for adapting effective local programmes for the national context that preserve the features that have been key to local success.</p> <p>Initiate government, NGO, and community action on social determinants of ECD at all levels, especially at the level of the residential and relational community.</p> <p>Organize strategies at the local level to provide families and children with effective delivery of ECD services – to improve safety, cohesion and efficacy of residential environments; and to increase the capacity of local and relational communities to better the lives of children.</p>

<p><b>Urbanization</b> (Chapter 6)</p>	<p><b>Entry Point</b> Governance</p> <p><b>Key Movers</b> Community Groups Legislative bodies Planning and development, transportation departments Water sector</p>	<p>Organization and empowerment of communities to enhance their capabilities to act, including education and deliberations with people concerning their own environment, risks, rights, responsibilities and capabilities.</p> <p>Promotion of healthy communities through policies that provide safe drinking water and sanitation, improved energy supply and air pollution control and healthy housing.</p> <p>Promotion of good nutrition, physical activity and creation of safer and healthier workplaces.</p> <p>Policies and action against urban violence and substance abuse.</p> <p>Assess institutions and create opportunities to build alliances and ensure intersectoral collaboration.</p> <p>Monitoring and evaluation of process and impacts from the early stages of all programmes/policies.</p> <p>Organizing and financing more equitable health systems within urban settings.</p> <p>Policies that promote social cohesion within urban communities by providing opportunities to build social capital.<sup>1</sup></p>
<p><b>Employment and Working Conditions</b> (Chapter 7)</p>	<p><b>Entry Point</b> Policy Social position Occupation</p> <p><b>Key Movers</b> Labour organizations Multilateral agencies Private business Legislative bodies</p>	<p>Changes in power relations, especially related to labour market conditions and social policies, which can occur between the main political and economic actors in society – international regulatory agencies could influence governments to put more emphasis on full-time permanent employment and the adoption of fair employment policies.</p> <p>Changes in employment conditions in order to reduce exposures and vulnerabilities – strengthen public capacity for regulation and control regarding employment conditions. Actions to modify working conditions such as health-related workplace material hazards, behaviour changes, and psychosocial factors.</p> <p>Different types of interventions on employment and working conditions that may reduce the unequal consequences of ill-health – social and health policies should include universal access to health care, safe working conditions, an adequate compensation and benefit system (e.g. living wage), regardless of the employment conditions as well as specialized medical and social services for injured workers.</p> <p>Adoption and effective implementation of the International Labour Organization’s four core labour standards that address free association, collective bargaining, elimination of economic discrimination by gender, and the elimination of forced labour.</p>

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<sup>1</sup> The process of developing shared values, shared challenges and equal opportunities within a community, allowing communities and citizens to compensate for weak and dysfunctional government structures (Chapter 6).

<p><b>Health Systems</b> (Chapter 8)</p>	<p><b><u>Entry Point</u></b> Healthcare system</p>	<p>Revitalize and promote a primary health care approach that provides patient-focused care for a range of illnesses and effectively address illnesses disproportionately affecting poorer groups; tackle differential access, use and experience of health care through their financing and organizational arrangements; and contribute to action on differential exposure and vulnerability through preventive care.</p>
	<p><b><u>Key Movers</u></b> Health care providers Patient groups Civil society Community groups Legislative bodies</p>	<p>Health care financing and provision arrangements that aim at universal coverage and redistribute resources towards poorer groups with greater health needs.</p> <p>Leadership, processes and mechanisms that leverage intersectoral action<sup>1</sup> to promote population health.</p> <p>Practices that enable social empowerment<sup>2</sup> among population groups and civil society organizations to be involved in decisions and actions that identify, address and allocate resources to health needs.</p> <p>Strengthen political action within national policy development and implementation processes.</p>
<p><b>Public Health Programmes</b> (Chapter 9)</p>	<p><b><u>Entry Point</u></b> Healthcare system</p>	<p>Support generation of knowledge on the causes of ill-health and translate these into proposals for action based on a package of individual interventions deemed appropriate for specific circumstances and patterns of gradients.</p>
	<p><b><u>Key Movers</u></b> Researchers Community groups Health care providers Legislative bodies Healthcare system</p>	<p>Engage partners in key sectors that have a more direct responsibility to intervene in addressing the determinants of poor health and health inequities.</p> <p>Collaborate with other partners to identify and help population groups that are most exposed to risk factors and vulnerable to poor health outcomes.</p>
<p><b>Measurement and Evaluation</b> (Chapter 10)</p>	<p><b><u>Entry Point</u></b> Ministries of health Academic and research institutions</p>	<p>Acknowledge multidimensional character of SDH and health equity, paying particular attention to historical context, social dynamisms inherent in its respective definitions and the interrelationships with other social stratifiers.</p>
	<p><b><u>Key Movers</u></b> Legislative bodies Researchers Practitioners</p>	<p>Use a variety of inequality indices, pursuant to the relevant objective, to depict the multi-dimensional nature of health inequalities.</p> <p>Social inequalities in health should be evaluated according to the most appropriate measures of socioeconomic position in the country or region.</p> <p>Both relative and absolute measures of health inequalities (i.e. both rate ratios and rate differences comparing two contrasting groups) should be used to ensure that inequalities are identified.</p> <p>Multiple methods, diverse epistemologies and a broad range of data should be used – appraisal of evidence should be based on whether the research method used is appropriate for the research question and the knowledge being collected, and the extent to which in terms of its own methodological canon it is considered to be well executed.</p>

<sup>1</sup> Recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone (WHO, 1997).

<sup>2</sup> People's ability to act through collective participation by strengthening their organizational capacities, challenging power inequities and achieving outcomes on many reciprocal levels in different domains (Wallerstein, 1992).

interventions. Chapter 9 argues that empowering women through effective access to quality educational opportunities for girls has potential long-term benefits for both women and children.

Genuine engagement must involve a transfer of real power with resources dedicated to support the involvement of lay people. As Chapter 4 states, without support, community activists can be blamed by their communities for failing to deliver real change and held accountable by professionals for the communities they represent. Policy changes can address this issue but they must acknowledge the change in power balance and address the resistance this shift might lead to within professional groups and the organizations in which they work (Blas et al., 2008). Moreover, Chapter 8 recommends for social empowerment strategies to be context specific and take account of the nature of the relationships between the state and civil society and the values and norms that underpin policy.

## **B. Governments**

Action by governments can reduce health inequity by ensuring the provision of basic services, redistributing resources, and protecting and promoting human rights such as health care, education, sanitation and safe water, and the right to a decent standard of living (Blas et al., 2008). Within the health sector, governments can directly influence the degree to which public health programmes are mandated to act on broader determinants of health (Blas et al., 2008). Analyses show that many opportunities exist to adjust the design and coordinated implementation of public health initiatives to enhance health equity when a social determinants approach is adopted. This can include extending access to poor and other marginalized sub-populations and directly addressing the conditions that put them at higher risk of disease. Governments can mitigate negative health impacts by expanding social protection policies such as universal health insurance not tied to employment (Chapter 2).

Governments can establish and maintain legislative and regulatory frameworks, including financial regulation, to influence the action of others and their own. For example, governments can ensure that national health and SDH priorities are not negatively affected by trade policy choices (Chapter 2). National policy frameworks offer a mechanism for ensuring the success of multisectoral action on social determinants. National regulatory and legislative frameworks have also been shown to have substantial positive effects on gender equity. Examples of alternative policy interventions for governments include the establishment of minimum wages that ensure a decent standard of living, universal minimum labour standards that support the regulatory protection of the formal sector and school feeding programmes for improving school attendance (Chapter 7).

Governments can monitor the health status of different population groups, health outcomes of social inequalities, and effects and progress of action to reduce inequities. The findings can then be used to inform current and future programmes and policies to tackle inequities. Additionally, as pointed out in Chapter 2, an important issue in governmental action is ensuring that policy-makers, specifically those in the health sector, have the necessary expertise and resources to consider the health impacts of issues outside the health sector (e.g., macroeconomic policy and trade) and develop the necessary evidence base in order to contribute to policy discussions on topics relevant to health.

### **C. Civil society organizations**

A dynamic and engaged civil society makes valuable contributions towards reducing health inequities. Civil society organizations (CSOs) can be powerful drivers for positive political, social, and economic changes that affect health equity (Blas et al., 2008).

The evidence encourages CSOs to be assertive in demanding government and community collaborative actions on social determinants at all levels but especially at the level of the residential and relational community. These groups have an established role in working to reverse exclusionary processes at global, national and local levels through advocacy; monitoring the impact of policies and action; mobilizing community action for change; providing technical support and training to improve governance systems; providing channels for negotiation and giving a voice to the most disadvantaged sections of society (Chapter 4).

For example, women's organizations have helped to generate new and compelling evidence of gender inequity and inequalities in health, develop innovative programmes, facilitate political mobilization, and demand accountability from governments and the intergovernmental system (Chapter 3). Chapter 5 proposes that civil society groups are well positioned to advocate on behalf of children to ensure that governments and international agencies adopt policies that positively benefit children's well-being and development. Furthermore, as highlighted in Chapter 4, CSOs can act as pressure groups to change repressive or discriminating policies, legislations and programmes, delivering services to support economic and human development.

The evidence encourages national governments to support civil society activity as a way to tackle inequities in the social determinants of health. Such support can be consistent with the normal role of government in setting regulatory frameworks for civil society and could include: recognition of the political legitimacy of civil society and a community's voice; involvement of civil society in all its forms in policy development, implementation, and monitoring and evaluation; ratification and implementation of legal protection for civil society organizations; design of policies that transfer real power to people; resourcing of policy implementation to support community empowerment; and reform of professional education to give greater status to lay and indigenous knowledge.

### **D. Bilateral and multilateral agencies**

Bilateral and multilateral agencies, along with other international donors, have an important role to play in supporting community engagement in policy-making and actions that promote equity and do no harm. It is of critical importance for international agencies to work with nations and countries to avoid interventions that result in unintended adverse consequences.

Multilateral agencies have the ability to influence agendas and take action. Chapter 8 emphasizes the importance for international agencies to act on the basis of evidence and make clear the values and principles that motivate action. An example is to create alternatives to the patent system for encouraging research on diseases that disproportionately affect low-income countries (Chapter 2). To reverse socially exclusionary processes, multilateral agencies and donors can develop ways for universal systems of social protection and essential services free at point of use to be funded

in low- and middle-income countries (Chapter 4). Organizations can set an example and promote good practice in their relationships with CSOs and communities. As suggested in Chapter 4, they can provide financial incentives for governments to work effectively with communities and CSOs, while simplifying regulations for grants so that smaller community and voluntary groups can access funds.

## **4.1 Mechanisms to address SDH**

### **A. Intersectoral action**

Addressing SDH requires an intersectoral, multidisciplinary approach, respective to the complex causal pathways of inequities (Petticrew et al., 2009). While elusive in practice, intersectoral action across government departments is key in promoting health as a priority in policy agendas. Chapter 5 suggests that intersectoral coordination can be achieved through the creation of an interministerial policy framework for early childhood development that clearly delineates the roles and responsibilities of each sector and how they will collaborate. Ministers of health and health managers can play a central role in initiating and monitoring intersectoral action. Health officials can also contribute to wider political action to offset opposition from powerful actors threatened by Intersectoral Action for Health (IAH) initiatives, such as the opposition of tobacco companies to anti-smoking campaigns and legislation (Chapter 9). IAH is particularly effective in tackling physical and social environments (many of which are interrelated), thereby addressing differential exposure and vulnerability to ill-health (Chapter 9). For example, addressing the social determinants of neglected tropical diseases through intersectoral action (Aagaard-Hansen & Chaignat, 2010) is essential to reduce the exposure and vulnerability of poor populations, mostly from low- and middle-income countries, affected by those diseases (Box 6).

### **B. Health impact assessments**

Another approach to addressing disparities is Health Impact Assessments (HIA). HIAs are used to assess the potential health impacts both positive and negative of existing and proposed policies, programmes and projects within and outside of the health sector. An equity focus in HIA emphasizes the importance of evaluating the impact distribution and whether they are inequitable within a population in terms of characteristics such as gender, occupational status, ethnic background, wealth and other markers of socio-economic status (Harris-Roxas, Simpson & Harris, 2004). HIA is also a mechanism for facilitating community participation in decision-making. The Gothenburg consensus paper, which clarifies concepts and identifies an approach for carrying out HIA, emphasizes the need for participation to underpin the assessment process in order to maintain values of democracy, transparency and equity (European Centre of Health Policy, 1999). Through the use of HIA, recommendations are produced for decision-makers and stakeholders with the aim of maximizing positive health effects, minimizing negative health effects or understanding how to manage risks, and engaging all sectors to consider health impacts and the determinants of health in their deliberations (Harris et al., 2007).

**Box 6:** Addressing social determinants of neglected tropical diseases (NTDs) through intersectoral action

**Action 1: Addressing water, sanitation and household-related factors (the “preventive package”).** The analysis shows overwhelming evidence of how the intermediary social determinants of accessibility to water and sanitation, and housing and clustering determine NTDs. Consequently, there is a need to address these risk factors in endemic communities to provide sustainable prevention for clusters of NTDs.

**Action 2: Reducing environmental risk factors.** Environmental factors are essential determinants for many of the NTDs. These factors are often introduced by humans, either directly or indirectly. Planning based on health impact assessments for new projects and mitigating revisions of existing schemes are needed in order to control NTDs.

**Action 3: Improving health of migrating populations.** Migration encompasses the movements of nomads, labour migrants, people subjected to forced resettlement and refugees from natural disasters or armed conflict. Their movements influence exposure and vulnerability to some NTDs, and access to health care systems is reduced. The particular NTD issues that relate to these groups should be addressed in ways that are tailored to local conditions (patterns of morbidity, mobility, environmental and sociocultural factors).

**Action 4: Reducing inequity due to sociocultural factors and gender.** Sociocultural factors, which are often closely linked to gender roles, interact with NTDs in various ways. In some cases NTDs incur added burdens due to stigma, isolation and other negative consequences. These factors may also reduce the acceptability of health services, leading to differential health care outcomes. There are unexplored potential advantages in addressing these issues from a multi-disease perspective.

**Action 5: Reducing poverty in NTD-endemic populations.** Poverty emerges as the single most conspicuous social determinant for NTDs; partly as a structural root cause for the intermediary social determinants and partly as an important consequence of NTDs, either directly (leading to catastrophic health expenditure) or indirectly (due to loss of productivity). Consequently, poverty should be addressed both in general poverty alleviation programmes and more particularly by ensuring affordable treatment.

**Action 6: Setting up risk assessment and surveillance systems.** NTDs are characterized by complex combinations of environmental and social determinants. Pockets of multi-endemic population groups are likely to “disappear” within statistical averages and must be identified in order to address inequity and direct curative or preventive interventions to NTD hot spots. Cross-disciplinary risk assessment and surveillance systems should be established based on combinations of epidemiological, environmental and social data, providing not only early warnings for epidemics, but also evidence for long-term planning under more stable conditions.

## 5. Evidence gaps

Evidence on social determinants, health systems and health outcomes is rapidly increasing, yet there are still many gaps in the research. Evidence gaps affect the level of detail, the ability to make generalizations and discuss a potential fit within different contexts, and in many cases, the ability to target recommendations at the appropriate level of action, whether local, national or global (WHO, 2007a). The predominant focus of most non-biomedical health research is on risk factors. The social context that frames the distribution and modifies the effect of these risk factors is often neglected or is only seen as contextualizing individual risk (Östlin et al., 2010).

There are five key areas where evidence is lacking:

1. Lack of disaggregated data and primary studies for many themes;
2. Under-reporting of experiments and experiences;
3. Inadequate contextualization of experience;
4. Limited documentation of successful policy interventions where impact on health equity is demonstrated (i.e., across social gradient or specific disadvantaged and marginalized groups); and
5. Limited or no synthesis, particularly incorporating low- and middle-income country experiences and community-level innovation.

For example, existing evidence on health inequities stemming from employment and working conditions is insufficient for effective public health action because these inequities are mostly invisible, neglected or unknown. Empirical evidence concerning the impact of employment relations on health inequities is particularly scarce for low-income countries, small size firms, and rural settings (Chapter 7). Studies of employment dimensions are also not typically stratified by social class, sex, age, ethnicity, and migration status.

Current evidence on approaches to integrate health and social outcomes could be greatly improved by reporting on the impact interventions have on health equity (Petticrew et al., 2009). There is a key evidence gap around the positive and negative outcomes of community empowerment initiatives. Evidence on the effectiveness of some internationally-promoted interventions is ambiguous (Chapter 4). For example, conditional cash transfers are widely accepted even in the absence of evidence about the added value or potentially negative consequence of conditionality. Additionally, primary studies often neglect to collect, analyse and present data on differential effects of interventions addressing social determinants of health within populations even when the data are available (Chapter 10).

## 6. Priorities for future research

The aim of health equity research is to generate policy and enhance research competency. With this in mind, four areas are identified as top priorities for new research (Östlin et al., 2010).

1. Global factors and processes that affect health equity;
2. Structures and processes that differentially affect people's chances to be healthy within a given society;
3. Health system factors that affect health equity; and
4. Policy interventions to reduce health inequities in the determinants of health and health care (i.e. how to influence 1-3 effectively).

The next section discusses topics and types of studies that fall within the purview of these priorities, followed by ways to enhance research policies and processes.

### 6.1 Topics and types of studies for future research

Topics for further research and evidence gathering can be organized into three broad groups: (1) new studies reflecting current hot topics or new approaches; (2) better or more rigorous synthesis to use as inputs to policy and decision making; and (3) investigation of ways to push for alternatives to "business as usual" (WHO 2007a). Specifically, the chapters identify the following priority topics for additional research: impacts of consumer boycotts, civil society mobilization campaigns and evaluation of specific government responses to improving working conditions, labour rights and gender equity in low- and middle-income country export factories or zones (Chapter 2); approaches to mandate corporate social responsibility through international and national legislation and regulation (Chapter 4); effects of environments, from the most proximal (i.e. the family) to the most distal (i.e. the global environment), on biological embedding and early childhood development (Chapter 5); participatory and community based interventions to address social determinants in urban settings (Chapter 6); projections of climate change impacts, socio-economic pattern of impacts on people and ways to adapt to climate change in urban areas (Chapter 6); links and pathways that create employment dimensions leading to poor health outcomes (Chapter 7); epidemiological, social and operational research to understand the "why" of health inequities and "how" to address those (Chapter 9); and the intersection of the two axes of the health gradient (e.g. health inequities and degree of social inequality in each society or stratification) (Chapter 10).

The chapters also recommend conducting different types of studies: analyses of available country experiences of processes to bring about and sustain policy (particularly equity-oriented) changes (Chapter 8) and the design and synthesis of case studies to draw out lessons for other contexts and consider how these contexts may impact on the delivery, uptake and effectiveness of interventions (Petticrew et al., 2009).

## 6.2 Ways to enhance research policies and processes

As further research is crucial to identifying and understanding present and future inequities as well as where to act, it is essential to broaden the focus of research by adopting methodologies and research strategies that:

- go beyond the behavioural and other individual determinants of illness;
- examine the intersections among different social hierarchies (e.g. socioeconomic status and gender) and their cumulative impacts on health status and health inequities;
- examine the connections between proximal and structural (distal) determinants of ill health, which are often poorly conceptualized and integrated into research;
- consider the dynamic nature of equity in different country contexts, which would introduce a temporal dimension in accordance with the dynamic nature of both social structures and public policies;
- describe the institutions and processes that influence the allocation of resources related to health and its social determinants;
- focus on how the global context affects choices about resource allocation at national and sub-national levels; and
- ensure involvement of populations with the least amount of power.

Specific recommendations for adding to knowledge on fundamental or cross-cutting issues include further developing theoretical frameworks; investigating biological or social interfaces (e.g., the extent and nature of sex-specific needs in health conditions that affect women and health) (Chapter 3); and documenting costs and effectiveness of interventions incorporating an equity perspective (e.g., early childhood programmes in low income countries) (Chapter 5).

## 6.3 Norms, standards and methods for better research

Although much is already known about the causal pathways of disease, the empirical evidence must continue to be refined, including the availability of enhanced disaggregation of population health data (Blas et al, 2008). The equity perspective highlights the need to facilitate greater disaggregation by equity-stratifiers (e.g., income, sex, race, age, region, occupation, education, etc. or some combination). This step is important to provide a picture of the social patterning of processes and outcomes within routine information systems and health programmes. An example of a good practice described in Chapter 3 is Sweden's annual confirms its commitment to gender equality during the Annual Statement of Government Policy. Since 1994, there has been a requirement to integrate a gender equality perspective in all aspects of government policy. One of the main measures that have been taken under this policy is to disaggregate all official statistics by sex.

It is important to acknowledge that appropriateness of the measures chosen to study inequity is context specific. No single measure can be applied universally in the study of social inequalities in health, especially in countries with large disparities in wealth and economic opportunities. Monitoring SDH and health equity requires particular attention to the historical context, the social dynamisms inherent in its respective definitions and the interrelationships with other social stratifiers (Chapter 10). For example, simply looking at data disaggregated by sex only allows the investigator to describe whether there is a difference between men and women and how big the difference is. Gender analysis is necessary to be able to understand and explain the differences or lack thereof (Chapter 3). Rigorous analysis means incorporating issues relative to gender power relations (e.g. violence by intimate partners or unpaid work) and using indicators that illustrate the power relationship between both genders.

Chapter 5 emphasizes the importance of creating a global measurement system to monitor early childhood development. However, the absence of methods (including a set of global health equity indicators) and international mechanisms to monitor global health inequities, hamper efforts to monitor and evaluate progress on addressing the social determinants of health as well as the impact of past global actions on health equity. Clear benchmarks are essential to understand whether or not a shift in inequity has occurred. Moreover, developments in methodology are needed to evaluate the effect of the diverse actions recommended across the chapters (Blas et al., 2008).

Additionally, much evidence on social determinants of health is unused. Some of the evidence documenting inequities and the relationship between social determinants of health and health outcomes is qualitative and is not considered by some researchers and policy makers to be rigorous (Chapter 10). However, this is not the case; it is essential that researchers and policy-makers alike recognize the value of both qualitative and quantitative evidence, generated using a variety of methodologies and disciplines. Current study designs are limited for evaluating natural policy experiments. Additionally, research that gives an authentic voice to the people who are most disadvantaged in health social and political terms should be supported.

Guidance and capacity building on how to translate results including the knowledge and research synthesized in this book into practice. This requires strategies on how to make research and findings from research more accessible to various audiences.

**Recommendations to strengthen research processes include:**

- The democratization of research involving lay people in the research process from funding allocation, through question generation and study design to the dissemination of results
- Taking an approach which considers the whole of the gradient in health equity in a society and not only the most disadvantaged groups
- Increased collection and synthesis of data disaggregated by socioeconomic status and other social stratifiers

- Negotiating access to data from other sectors, such as education, justice, housing and environment, and linking these data together
- Measuring, monitoring and evaluating the effects of policies and programmes on inequities
- Identifying what types of measures to monitor equity are valid and meaningful
- Applying more rigorous and theoretically-grounded single and multiple country case studies of interventions
- Improving methods for synthesizing evidence for action gathered using a variety of methodologies, at different levels and in different contexts.

## 7. Conclusion

The evidence synthesized throughout the book reinforces the fundamental impact of social determinants on health outcomes and in creating health inequities. There are many options for policies and interventions to improve health outcomes while improving health equity. Across the knowledge networks, there are common actions that were identified as key to reducing inequities in health related to social determinants – increase universal access to public education, establish a minimum living wage, improve social protection, and reduce discrimination based on gender, race, ethnicity, etc. Whatever the entry point, action should involve multiple sectors while clearly outlining each sector's responsibility and employing careful intersectoral and intrasectoral coordination. Additionally, attention should be paid to social gradients when addressing inequalities to avoid intentionally or unintentionally increasing inequities. The shape of social gradients varies within and across countries, which is an important consideration to make when determining which policy option to take. Policies should improve health for all socioeconomic groups and at rate of improvement that increases at each step down the socioeconomic ladder. Narrowing health gaps requires improving the health of the poorest at a rate that is faster than the rate of the wider population. Effective policies are necessary to achieve both an absolute and a relative improvement in the health of the poorest group.

The report by the Commission on Social Determinants of Health represents a watershed moment in public health. It marks the first systematic and truly comprehensive attempt to draw together data and evidence on social determinants that is pluralistic and diverse methodologically, empirically and theoretically. It is a rallying cry for political action in support of the action against those elements which do so much damage to human health, and it is an important signpost for action political and scientific.

Recently, WHO convened a global conference in Rio de Janeiro, Brazil to build support for the implementation of action on social determinants of health. The conference provided a global platform for dialogue on how to implement the recommendations from the Commission's report on

SDH. At the conclusion of the conference, 125 participating Member States adopted the Rio Political Declaration on Social Determinants of Health pledging to work towards reducing health inequities by taking action across five core areas related to the evidence synthesized across this book: 1) Adopt better governance for health and development; 2) Promote participation in policy-making and implementation; 3) Further re-orient the health sector towards reducing health inequities; 4) Strengthen global governance and collaboration; and 5) Monitor progress and increase accountability (WHO, 2011).

The evidence compels action and the momentum generated by the Rio Declaration confirms that it is imperative for *all* to act to reduce health inequities.