Building of the global movement for health equity: from Santiago to Rio and beyond

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Health inequalities are present throughout the world, both within and between countries. The Commission on Social Determinants of Health drew attention to dramatic social gradients in health within most countries and made proposals for action. These inequalities are not inevitable. The purpose of this article is to report on activity that has taken place worldwide after the report by the Commission on Social Determinants of Health. First, we summarise the global situation. Second, we summarise an interim report of the emerging findings from an independent review of social determinants and the health divide, which was commissioned by the WHO European region. The world conference on social determinants of health will be held in Rio de Janeiro, Brazil, in October, 2011. This summit provides an opportunity to galvanise support, prioritise action, and respond to the call by the Commission on Social Determinants of Health for social justice as a route to a fair distribution of health.

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Introduction

> "Social Injustice is killing on a grand scale"
>
> "A toxic combination…of poor social policies and programmes, unfair economic arrangements, and bad politics…is responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible."
>
> *Commission on Social Determinants of Health*[1]

In Afghanistan, the lifetime risk of a maternal death is one in 11; in Europe, the lowest is one in 31800.[2] Some of the appalling premature loss of women's lives could be mitigated by provision of skilled birth attendants. But much of it arises because of the nature of social and economic arrangements, both globally and locally. The evidence brought together by the Commission on Social Determinants of Health (CSDH) attributed health inequities to the circumstances in which people are born, grow, live, work, and age, in addition to the health-care systems put in place to deal with illness. Wide inequities in the distribution of power, money, and resources account for these conditions of daily life.[1] Inequities in health are noted in men and women, children and elderly people, and people of working and childbearing age.

Health inequities are not confined to poor health for people in poor countries and to good health for everyone else. The CSDH drew attention to dramatic social gradients in health recorded within most countries. Within London, England, there is as much as a 17-year difference in male life expectancy between Tottenham Green, a deprived area, and Queens Gate Ward, a wealthy one.[3] In Glasgow, Scotland, the difference between the most deprived and least deprived areas is 28 years.[4] Although the CSDH report recognised the importance of health-care-based solutions to health inequities within and between countries, it concluded that health inequities are manifestations of societal inequities. Gross social inequities deprive subgroups of the population of the opportunity to benefit from economic and social development and damage social cohesion and integration with consequent social and health effects. Reduction of these inequities is a matter of social justice and requires action at the societal level—globally, nationally, and locally.

At the launch of the CSDH in 2005, the then Director General of WHO, J W Lee, referring to the need for action on social determinants of health, said: "The Commission on Social Determinants of Health can be a powerful means of catalysing and strengthening such activities in all countries. It will complete its initial work in 2008. That will be 30 years after the Declaration of Alma-Ata (in 1978), and 60 years after the beginning of WHO (1948). Those were moments of great clarity about the needs and opportunities for health in the world. We should now start preparing, with the help of this Commission, for another such moment of clarity."[5] The CSDH did its work with this encouragement and the ambition to create a social movement for health equity.

Margaret Chan, the Director-General of WHO, welcomed the focus on social justice in the CSDH report: "The Commission on Social Determinants of Health… responded to a situation in which the gaps, within and between countries, in income levels, opportunities, health status, life expectancy and access to care are greater than at any time in recent history…In the final analysis, the distribution of health within a population is a matter of fairness in the way economic and social policies are designed. By showing how social factors directly shape health outcomes and explain inequities, the report challenged health programmes and policies to tackle the leading causes of ill-health at their roots, even when these causes lie beyond the direct control of the health sector."[6]

Margaret Chan put fairness at the heart of social policy. Indeed, the CSDH argued for the ethical basis of action on social determinants of health. Commissioners were strongly of the view that good health, fairly distributed, was a value in itself. That is to say that health equity is much prized as a social goal, not only because health is a means to achieve some other goal such as economic growth. Influenced by Amartya Sen, a member of the CSDH, the CSDH argued for substantive freedoms—

creating conditions that enable people to lead lives they have reason to value.[7,8] The CSDH used the language of empowerment—creating conditions for people to have control over their lives.

The CSDH did not argue an economic case for action on social determinants of health. Nonetheless, other benefits to society are likely that could have immediate economic benefits. For example, a more cohesive, educated population is likely to have lower rates of crime and civil disorder, a more highly skilled workforce, and enable people to lead lives that they have reason to value, and to have better health and greater health equity. It is important that these links to other social goals are kept at the forefront of debates about health inequity—this is an agenda for the whole of society.

For more on the **Asia Pacific HealthGAEN: Action Plan** see http://www.healthgaen.org

For more on the **Self Employed Women's Association** see http://www.sewa.org

Panel 1: **Examples of action on the social determinants of health**

Outside Europe

Chile

- Ministry of Health undertook a review of how all its policies fit the recommendations of the Commission on Social Determinants of Health

Argentina

- The government appointed a vice-Minister of Health with responsibility for health equity

Brazil

- Commission on Social Determinants of Health was set up

Costa Rica

- A whole-of-government approach is planned

Australia

- WHO and South Australia undertook an initiative, the Adelaide Statement on Health in All Policies

The Asia-Pacific Network of HealthGAEN (Global Action for Health Equity Network)

- This regional collective is committed to making progress on the health-equity agenda

Initiatives in India: case studies

*Civil society**

- The Self Employed Women's Association (SEWA) is an organisation and movement representing poor, self-employed women workers

*Government initiatives**

- Rural employment guarantee scheme
- Food security bill
- Consideration of restructuring the Integrated Child Development Scheme
- Health-care expenditure is to rise from 1·2% to 3% of gross domestic product in the context of action on the social determinants of health
- Plans to extend coverage of social security for informal workers
- Extension of the right to education
- Improve housing and basic infrastructure for urban and rural poor people

Anticorruption

- Widespread demonstrations called for strong anticorruption legislation after a hunger strike by Anna Hazare in April, 2011, when government talks broke down
- The government has accepted Hazare's revisions to the Jan Lokpal Bill, a proposal to establish an independent anticorruption body[1,4]

(Continues on next page)

The evidence brought together by the CSDH has led to much support for action to reduce the unnecessary loss of life and loss of healthy life experienced worldwide, but much more is needed. Additionally, many of the responses to the global financial crisis have slowed progress. The world conference on social determinants of health, to be held in Rio de Janeiro in October, 2011, will be hosted by the government of Brazil and WHO. All member states have been invited; 450 representatives are expected, with 750 experts and members of civil society organisations. The Rio summit provides an opportunity to do more to galvanise support, prioritise action, and respond to the CSDH's call for social justice as a route to a fairer distribution of health. Its goals are to report on progress since the CSDH and stimulate further global and national action on social determinants of health and health equity.

The WHO European region has set up a European review of social determinants and the health divide. The review will publish its conclusions and recommendations in 2012. In this paper, we summarise an interim report giving emerging findings.[9] First, we begin with a review of global actions on the social determinants of health.

Principles of action

Not all inequalities are inequitable. Among those who accept that equality is important, the question is equality of what? In this case equality of opportunity or equality of outcome.[10,11] We are, of course, concerned with health outcomes not only opportunities. The CSDH endorsed the view that health inequalities, between social groups or populations, which are deemed avoidable by reasonable means, are unjust. These are labelled as health inequities.[12]

Some of those who emphasise opportunities also emphasise personal responsibility. In practice a focus on outcomes and one on personal responsibility might not differ greatly. If analysis of high mortality rates—ie, outcomes—shows that they result from the conditions in which people are born, grow, live, work, and age, we would argue that individuals cannot take personal responsibility for health without social action creating the conditions for people to have control over their lives. The debate should not be about whether reductions in inequality in health outcomes are desirable—they are—but about what is avoidable by reasonable means. For example, smoking contributes to health inequities, but declaring it illegal is not a reasonable means to the end of reducing the contribution that smoking makes to health inequity.

There need be no trade off between health equity and health improvement. We are committed to both social goals: to improve health for everybody and to improve equity. In practice, they are complementary and both are important.[3]

Health care has an important role in addressing the social determinants of health. The CSDH concluded that

the main determinants of health inequity lie outside the health-care system. That said, there are three important roles for the health-care system (webappendix p 1). First is to ensure universal access to high-quality care, with increased focus on prevention and health promotion.[13] Second, people in the health sector—from the Minister of Health to primary care professionals and medical and health organisations—should be the advocates for action on social determinants of health. There are good examples of cooperative working between health and other sectors. Third, ensure that routine monitoring systems are in place for health equity and the social determinants of health, undertake evaluation of policies on these topics, and increase the knowledge base.

Action on the social determinants of health

A strength of the CSDH recommendations was in their global reach—a call for all countries, and relevant global stakeholders, to take action. But this global reach also posed challenges. Formulation of recommendations that were simultaneously appropriate for sub-Saharan Africa and still relevant to north America or northern Europe was difficult. The CSDH aimed for a level of recommendation somewhere between high-level aspirations and impossibly detailed. Although worthy, high-level aspirations might not help in advancing action; conversely detailed aims, although more concrete, would be voluminous and difficult for a global commission to formulate. The CSDH, therefore, made a virtue of necessity. It argued that countries should use its report, *Closing the gap in a generation*,[1] to develop local action plans based on local evidence and mechanisms for policy development and monitoring. Panel 1 and webappendix pp 1–3 show the progress that has been made.

Challenges to action on the social determinants of health

In countries where social and health need is greatest, there is often little information on policy action and the social distribution of health. However, many countries have explicitly embraced social determinants of health. Additionally, there could be a great deal more policy action relevant to social determinants of health but not labelled as such—that described in India (panel 1), for example, might be true of many other countries. The recommendation to hold a global summit was partly so that there could be both accounting of action in all countries and a spur to further action. In Africa, where the need is great, countries such as Kenya and Mozambique have expressed real interest in social determinants of health, but we are unaware of what specific action might have followed.

In Europe and the Americas, action on the social determinants of health is better developed than in other regions. We would speculate that this situation indicates a stronger political will in many countries, based on a longer history of social welfare and social justice; more extensive evidence base on causal relations between determinants and outcomes; and more extensive monitoring data.

In all regions, the global financial crisis has added urgency to consideration of dramatic financial inequities, within and between countries, which preceded it. As standards of living decrease in many countries, and government revenues are tightened, we would argue that it is even more urgent that the distributional effects of all policies are taken into account in policy decision making.

Similar to the global financial crisis, there is already evidence that the health consequences of climate change also damage health equity.[20] Actions taken towards mitigation and adaptation should also not adversely affect the social determinants of health and health equity.

The European review of social determinants and the health divide

In addition to actions at the national and local level in Europe, there has been transnational activity. In 2009, the European Union published a communication[21] that emphasised the importance of reducing health inequity within Europe and set out a framework for action. Health equity as a core component of good governance was a key theme of the Spanish presidency of the European Union in the first half of 2010.

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Examples of European countries activities

In Europe, several countries and transnational organisations (such as WHO European region and the European Union) have been active

Norway

- Policies have been established to address the social gradient in health

Denmark

- Review of social determinants of health led by Finn Diderichsen[15]

Sweden

- The city of Malmo has set up a Commission[16]

Slovenia

- Committed itself to cross-government action based on a report[17]

UK

In England, the government issued a public health white paper,[18] putting reduction of health inequalities at the centre of its public health strategy, after publication of *Fair society healthy lives*.[3] This report's domains for recommendations were:

- To give every child the best start in life
- Education and lifelong learning
- Employment and working conditions
- Minimum income for healthy living
- Healthy and sustainable communities
- Social determinants approach to prevention

Action at subnational level includes health inequality plans for London, the North West, and Yorkshire and the Humber regions and plans for more than 30 local areas.[19] Scotland and Wales have their own strategies. Northern Ireland is developing a strategy.

*Information for these case studies from India provided by Mirai Chatterjee, SEWA.

See Online for webappendix

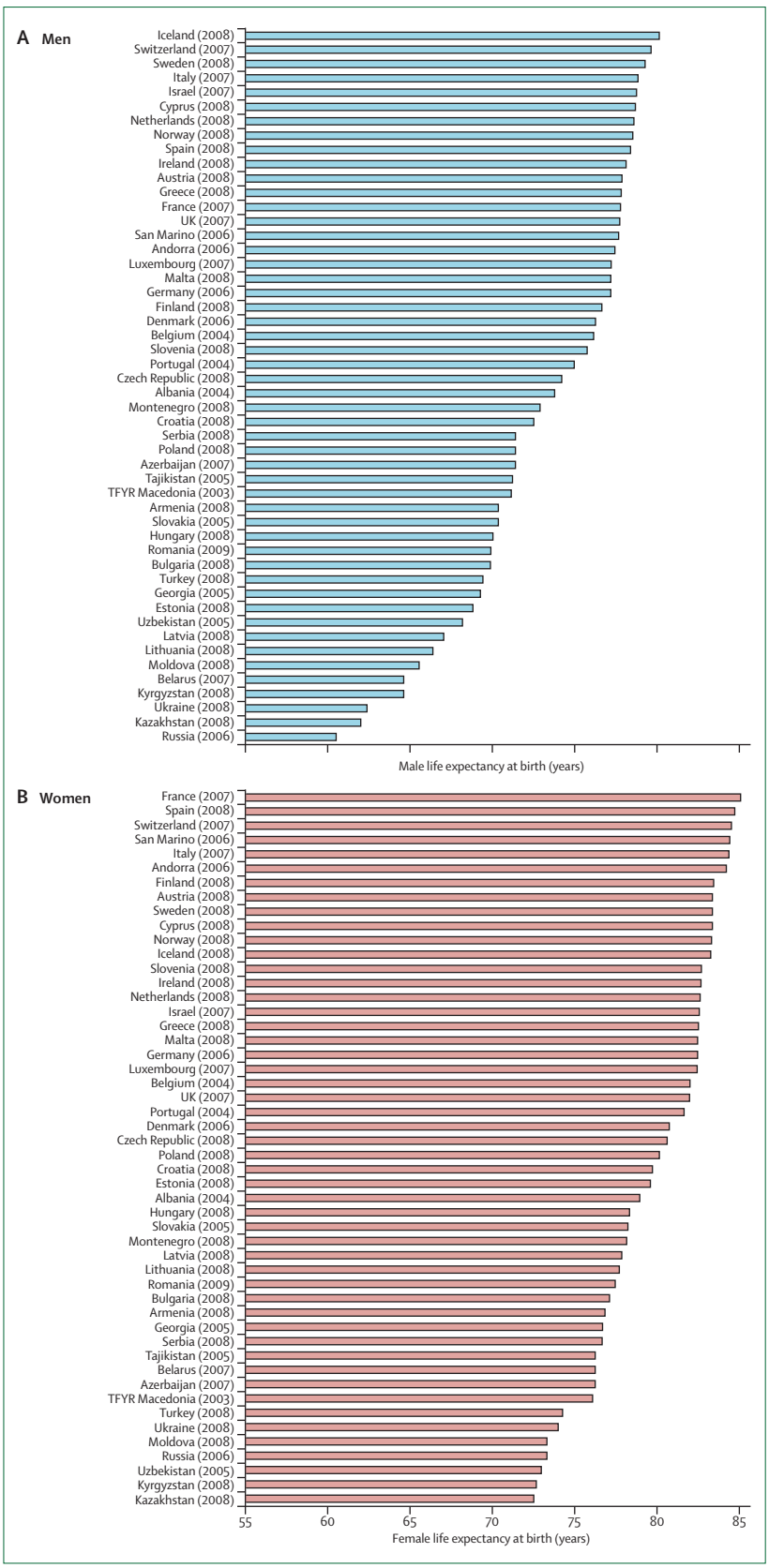

Figure 1: **Life expectancy at birth by sex for countries in the WHO European region, 2008 or latest available year**
Data are from the WHO European Health for All database.[24] TFYR=the former Yugoslav Republic.

On her election as WHO Regional Director for Europe in 2010, Zsuzsanna Jakab invited Michael Marmot to chair a review of social determinants and the health divide. The aim is to interpret the CSDH recommendations in a form that is suitable to achieve health equity in the diverse environments that make up the WHO European region. The final report will be published in 2012.

The health divide in Europe: emerging findings from the WHO European review

Between countries

The new evidence presented in the interim first report on social determinants and the health divide in the WHO European region[22] illustrates the type of health differences that the CSDH was addressing. Although population health has improved overall in recent decades in the 53 diverse countries that make up this region, substantial health inequalities remain, including in countries with close to the world's longest life expectancy and those with poor overall health.

The countries with the lowest life expectancy are in central and eastern Europe and the Commonwealth of Independent States (CIS, which consisted of Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova [Republic of Moldova], Russia [Russian Federation], Tajikistan, Turkmenistan, Ukraine, and Uzbekistan when the data were collected). The range of life expectancy is 20 years for men and 12 years for women (figure 1). Men in Russia have life expectancy of 61 years, 1 year shorter than that in India,[23] compared with 81 years in Iceland; women in Kazakhstan have life expectancy of just less than 73 years compared with 85 years in France.

Figure 2 summarises these differences in aggregate terms. In the latest data from the WHO European Health for All database,[24] female life expectancy at birth was 4·3 years lower in the 12 countries that joined the European Union after May, 2004, than in the 15 countries that were members before May, 2004 (EU15). The difference between CIS countries and EU15 was more than twice as large, at 9·7 years. The corresponding differences for men were more than 50% higher than for women, at 6·9 years and 15·0 years, respectively.

Figures 1 and 2 show the size and variability of the gap between male and female life expectancy across Europe. Life expectancy for men was about 4–7 years lower than for women in most of the region, but life expectancy for men was 12 years lower than for women in Belarus, Lithuania, Russia, and Ukraine, and 13 years lower in Latvia. Although there is a biological component to women's longer life expectancy, social conditions are likely to affect the variability in the male–female gap. Societal transformation in central and eastern Europe

and CIS countries after 1989 was accompanied by divergence in life expectancy between countries in the 1990s.[25–27] The fluctuation in mortality in the CIS in the 1990s was the largest ever recorded in any country with existing vital statistics; the increase in mortality in the first half of the 1990s in Russia alone has been estimated to be equivalent to about 3 million extra deaths above the long-term mortality rate.[28]

In the introduction we drew attention to the difference between Afghanistan and Europe in maternal mortality. Within Europe there are significant inequities—eg, reported data from 2008 show that maternal mortality varies from 70 per 100 000 livebirths in Kyrgyzstan to less than five per 100 000 livebirths in some countries in the region.

We report life expectancy data, or mortality rates, because they are readily available. Morbidity, disability, and mental illness are key issues that account for much loss of healthy life in Europe and globally. The apparent female advantage in health diminishes greatly when these non-fatal measures of ill health become the focus.[22]

Social gradient within countries

The CSDH emphasised that even for the poorest countries health inequalities are not confined to poor health but follow a social gradient. There is evidence of social gradients in health within countries in Europe according to such social factors as income, education, social position, and employment.[29,30] The relations between self-reported health and levels of income in Sweden and Latvia (figure 3) provide examples of social gradients. Despite different levels of self-reporting of health between Latvia and Sweden, there is a notable gradient in self-reported health in both countries. Findings from several studies[31,32] have shown that self-reported health is a good predictor of future health.

Mackenbach and colleagues[33] have undertaken a systematic comparison of gradients in mortality inequalities in men and women according to educational level, based on individual information obtained by the Eurothine project from studies in 16 European Union countries. The evidence from this project shows substantial variation across these countries in levels of inequality in mortality, on the basis of the length of education of individuals included in these studies (figure 4). Inequality in mortality based on educational level was greatest in countries in central and eastern Europe included in the project, and least in Italy, Spain, and Sweden.

There are many reasons why the European review is needed. First, there are several health problems that must be addressed: the health divide across Europe continues to be unacceptably large; there are persistently large, and in some cases growing, health inequalities within countries; the global economic crisis has profound importance for health and wellbeing and worsens health inequalities; sustaining a growing ageing population across Europe places an increased focus on prolonging

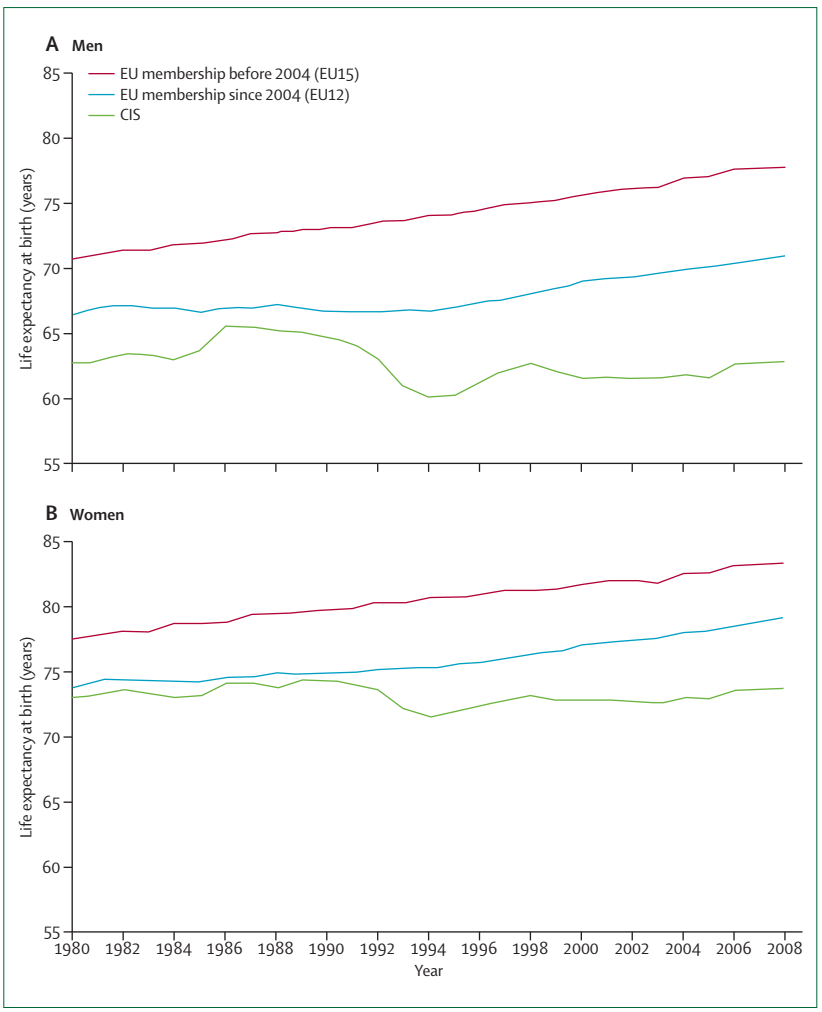

Figure 2: **Trends in life expectancy in the EU15, EU12, and CIS, 1980–2008**
Data are from the WHO European Health for All database.[24] The CIS consisted of Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan when data were collected. EU=European Union. CIS=Commonwealth of Independent States.

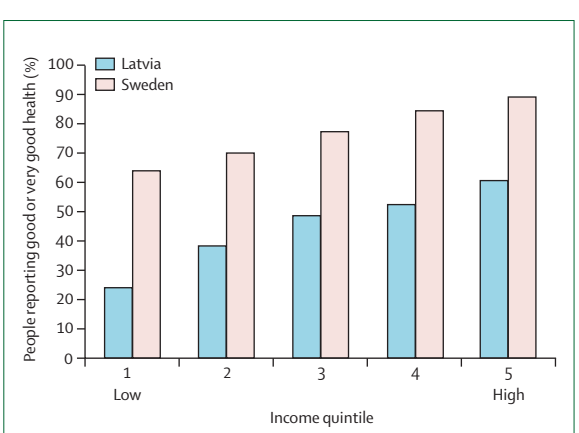

Figure 3: **Percentage of people reporting their health as being good or very good by household income quintile in Latvia and Sweden, 2008**
Analysis from the first interim report of the review,[22] based on the European Union Statistics on Income and Living Conditions (EU-SILC) 2008 database.

For more about the **EU-SILC database** see http://epp.eurostat.ec.europa.eu/portal/page/portal/microdata/eu_silc

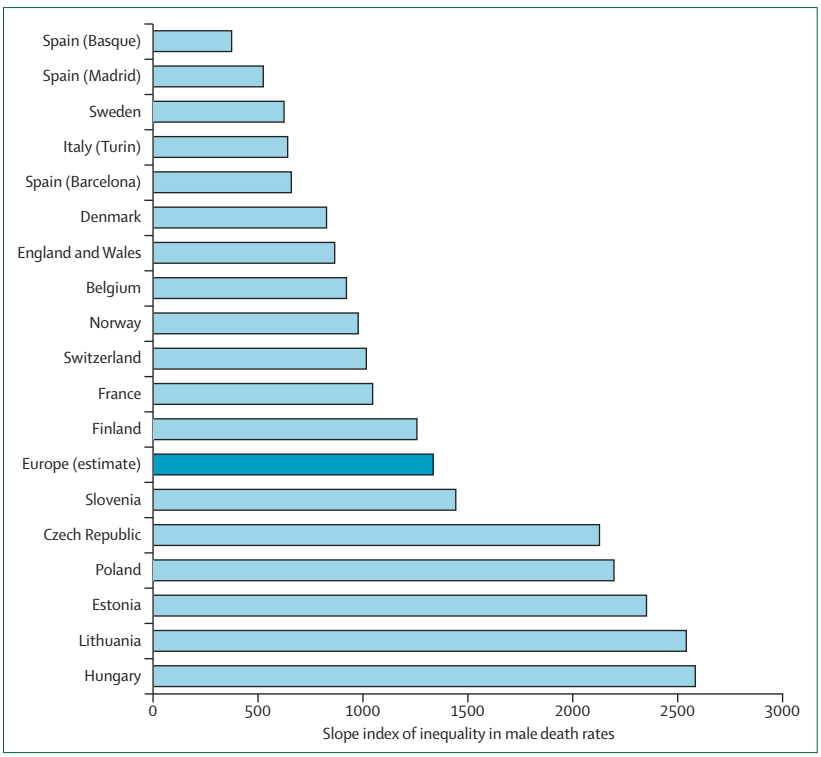

Figure 4: **Absolute inequality (slope index of inequality) in male death rates by level of education in selected European Union and European Free Trade Association countries**
Data are from Mackenbach and colleagues.[33] The slope index of inequality is calculated by, first, estimation of the slope of the best-fitting line through the datapoints (in this case death rates according to years in education), and second, by calculation of the gap on this slope line between the health level of the most and least advantaged.

good health and wellbeing throughout the life course; and climate change and the rapid depletion of natural resources threatens catastrophic consequences for health and equity (webappendix p 4).

Second, it is timely to bring together new evidence. To this end the European review will be informed by 13 task groups, and by action in countries, cities, and regions.

Third, interest in local action on the social determinants of health is growing, but local action is frequently constrained by national and global economic factors that affect the distribution of power, money, and resources. Therefore, a concerted, multilevel approach is needed to produce sufficient coherence, scale, and intensity of actions that has the capacity to transform health equity across society.

Fourth, action on social determinants of health contributes to the production of other social benefits such as wellbeing, improved education, lower crime rates, more sustainable communities, balanced and sustainable development, and improved social cohesion and integration. These benefits challenge the notion of health as a drain on public resources.

Conceptual framework

The conceptual framework developed for the CSDH is being adapted for the European review to emphasise the main pathways by which social, economic, political, environmental, and cultural factors affect health. In recent decades much public health has focused on proximate causes of ill health. In relation to chronic disease the focus has been on lifestyle factors: smoking, diet, alcohol consumption, and physical activity. The CSDH, and our, perspective is that these aspects of lifestyle are affected by the social, legal, and political context—to paraphrase Rose,[34] these are the causes of the

Panel 2: Key concepts emerging from the European review

Causation
- View exclusion as a process, rather than simply focussing on who has been excluded.[9]
- Assets and vulnerabilities resulting from the social determinants of health are at the centre of the review's conceptual approach.
- How does wellbeing relate to health inequalities?
- Human rights principles and efforts to improve health equity should be mutually reinforcing.
- Gender inequity continues to be an issue in all countries, but has a particularly large role in some countries of the region.

Organisations and governance
- Recommendations should identify the levels at which particular types of policy changes and interventions should be led.
- Co-production with families and communities is essential.
- The role of the private sector in affecting health equity is important, but too often ignored.

Interventions and policies
- Concerted action is needed across the life course and across the various sectors and levels affecting the whole social gradient in health.
- The lower people are in the socioeconomic hierarchy, the greater is their likely need. All should benefit from societal efforts—ie, proportionate universalism. Contextually relevant interventions across the diversity of countries in the WHO European region will be a major challenge.
- Empowerment of civil society is crucial.

Wider agendas
- The review will emphasise global processes and the effects of global factors, alongside national and local processes.
- Action is needed to tackle health inequity links with the agenda for climate change and environmental sustainability.[3]

Economic issues
- Evidence is needed for the social and economic costs of inequities in health and the costs and benefits of action on the social determinants of health.
- Mainstream budgets and investment instruments should accommodate action on the social determinants of health, so as to achieve sufficient scale, intensity, and consistency of action.

causes. These distal factors, acting across the life course, lead to the accumulation of relative social and economic advantage and disadvantage. As socioeconomic differences widen, they create a social gradient in health, and health inequalities related to sex and ethnic group, both through their direct effects and through the effect that they have on lifestyle and behaviour.

Tackling of health inequity requires the participation of all of government and of grass roots social movements, in addition to other sections of society. The cumulative effect of interventions across society will have a cumulative effect in the reduction of health inequity and improvements in overall health within each country.

Emerging key concepts from the European review

The task groups for the European review have produced their first interim reports, from which we have identified key concepts (panel 2, webappendix pp 5–6). As we enter the final phase of the review we will consult on these ideas and refine them.

Conclusion

Action on social determinants of health is at a crucial juncture. On one side some governments and other stakeholders seem to have embraced this agenda and recognised the need for action across the whole of government on the key social determinants of health. They accept the argument that actions to enhance health equity will have other substantial societal benefits. Furthermore, many in the health community have embraced the findings and recommendations of the CSDH and have made common cause with workers, policy, and practice in other domains: early child development, education, employment and working conditions, antipoverty campaigns, environment, and sustainable development. In the European region of WHO, the Regional Director has put her prestige and influence behind Health 2020 and set up the European review to ensure that recommendations for social determinants of health are incorporated into that process. Similarly, the Pan American Health Organization has made social determinants of health and health equity a priority. It is on the agenda for all WHO regions, and WHO headquarters is organising the Rio summit.

On the other side, many observers take a less positive view of progress. Social determinants of health have barely penetrated the global agenda—eg, health equity is hardly a consideration in trade talks; governments are too diverted by the global financial crisis and their domestic economic problems to give focus to health equity; and the default position of people in the health sector is to focus on health services and prevention of specific diseases. In some regions, what the CSDH described as a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics is all too evident. Related to this situation is the gap between rhetoric and performance, in which corruption plays a major part.

At the beginning of this article we quoted J W Lee saying that his hope for the CSDH was that it would bring a moment of great clarity similar to the founding of WHO in 1948, and the Alma Ata Health for All Declaration of 1978. As we approach the Rio summit on social determinants of health the comparison with Alma Ata is instructive. There is little doubt that the global health community were inspired by the call for Health for All by 2000. But many critiques have pointed out that the vision of comprehensive primary health care was hardly implemented; and the fact that Alma Ata had a strong statement on social determinants of health (by another name) was almost completely ignored.

The Rio summit offers the opportunity to ensure that failure to implement a widely supported agenda does not happen again. However, the audience for these discussions should not be confined to health ministers. The whole of government should be involved. A clear example is economic policy. If the effect on health equity were regarded as an important element of policy making, then contrasting economic policies—eg, those that give primacy to cutting deficits as against Keynesian policies that emphasise the government role in stimulation of demand—should be assessed for the effect on the lives that people are able to lead. If one set of policies is more likely than another to cause a greater decrease in living standards for people on low incomes, predictably it will have an adverse effect on health equity. If a set of policies widens the educational divide or employment opportunities along the social gradient, predictably these policies will have an adverse effect on health equity and on other desirable societal outcomes. Social cohesion, an educated population, good employment and working conditions, and policies that foster processes of social inclusion will be good for health and good for society as a whole.

Contributors

MM drafted the article. The other authors provided additional content and comments to inform subsequent redrafting.

Conflicts of interest

We declare that we have no conflicts of interest.

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