World Conference on Social Determinants of Health (WCSDH)

Technical Paper

FIRST DRAFT

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This technical paper aims to provide policy-makers with an overview of how to implement action on social determinants of health ("social determinants") to improve health, reduce health inequities, and contribute to development. It will inform discussions at the *World Conference on Social Determinants of Health*, and is therefore organized according to its five themes. The primary audience for this paper is policy-makers at national level. Other audiences who may find this document useful include municipal leaders, civil society groups, multilateral agencies, and bilateral donors.

Background to the World Conference on Social Determinants of Health

The World Health Organization (WHO) convened the Commission on Social Determinants of Health in 2005 to provide advice on how to reduce health inequities. The Commission's final report[1] made three overarching recommendations: to improve daily living conditions, to tackle the unequal distribution of power, money and resources, and to better measure and understand health inequities. WHO Member States discussed the report and passed a resolution urging action on social determinants at the 2009 World Health Assembly.[2] The resolution strongly called for a "Health in All Policies" approach and a renewed commitment to intersectoral action (ISA) to reduce health inequities, as well as the implementation of a social determinants approach across public health programmes and improved capacity to measure health inequities and monitor the impact of policies on social determinants. The resolution also requested the Director-General of WHO "to convene a global event before 2012 to discuss renewed plans for addressing the alarming trends of health inequities through addressing social determinants of health". The Government of Brazil is hosting this WHO global conference – the *World Conference on Social Determinants of Health* - in Rio de Janeiro from 19-21 October 2011, bringing together global leaders to discuss how to implement the recommendations of the Commission to reduce health inequities.

Implementing action on social determinants of health

Complex problems that are global priorities, such as reducing health inequities, require coherent policy responses across sectors and across countries. In the period that has elapsed since the launch of the final report of the Commission on Social Determinants of Health in 2008, the global community has become increasingly aware of how rapidly problems spread across the world, with new or exacerbated crises in finance, food, public health and the environment, among others. Moreover, these crises have clearly demonstrated how the interconnectedness of the modern world means that countries cannot confront these challenges on their own, or through action in single sectors. Action on social determinants through coordinated interventions in multiple sectors is essential not only to improve health and reduce inequities, but also to overcome other national and global obstacles to development. This requires coherence between policies of different sectors, types of actors, and of different levels (for example, between global, national and local) so instead of working at cross-purposes to undermine each other, they are aligned to mutually contribute to development.

The need for coherence is not new. For example, it has long been known that social conditions decisively influence health and therefore action across all sectors is required to promote wellbeing. The bulk of the global burden of disease and the major causes of health inequities, which are found in all countries, arise from the conditions in which people are born, live, work and age—referred to

as social determinants of health. Many social factors influence people's health, but not all determinants are equally important. The most important are those that produce stratification within society - "structural" determinants - such as the distribution of income or discrimination according to gender and ethnicity. These determinants establish a set of socioeconomic positions within hierarchies of power, prestige and access to resources. Mechanisms that produce and maintain this stratification include governance; education systems; labour market structures; and the presence or absence of redistributive welfare policies. These structural mechanisms that affect the differential social positions of individuals are the root cause of inequities in health. These differences shape individual health status and outcomes through their impact on intermediary determinants such as living conditions, psychosocial circumstances, behavioural and/or biological factors, and the health system itself. Health inequities are therefore a clear indicator of the coherence of a society's policies.

Using this framework,[3] the Commission's final report presented an exhaustive overview of what measures are possible, across different sectors, to act on social determinants to improve health and reduce inequities. The aim of the World Conference is to increase understanding on how these measures can be implemented as well as highlight how the coherent policy responses necessary to reduce health inequities are also required to address other development challenges. This technical paper highlights strategies and examples of how integrated action on social determinants can be achieved, reflecting the significant advances in knowledge on how to use a social determinants approach to improve health and thus contribute to other development goals, thereby reducing health inequities.

A number of political challenges need to be addressed if these strategies are to be applied. Without identifying and addressing these political issues, improved technical understanding of how to implement coherent policy will face obstacles in practice. Acknowledging this, the broader aim of the World Conference is to mobilize political commitment among countries to implement the necessary actions in national policies on social determinants.

These political considerations centre on the values prioritized in policy-making. Health inequities can be defined as differences in health outcomes between different population groups that are avoidable, unfair and remediable. These differences are not in any way natural but rather the result of unfair policy choices. Action to reduce health inequities therefore rests on notions of fairness in health outcomes and social justice as political goals. Societies that reject fairness as a core value in process, opportunities, and in health outcomes will find it difficult to implement actions on health inequities, regardless of technical expertise.

Underpinning the social determinants approach is also a claim for the broader value of health to society. The contributions of health to other important societal priorities such as education, social cohesion and economic development are now well understood. The rationale for the whole of society to adopt a social determinants approach and engage in efforts to reduce health inequities is linked to these benefits. However it goes further. The social determinants approach places the distribution of health, as measured by the degree of inequity in health, as a key indicator not just of fairness and social justice in a society, but also of its overall functioning. Health and health inequity are therefore of interest beyond the health sector not just because of the benefits of improved health, but because all sectors have an interest and responsibility in creating fairer and more

inclusive societies by implementing coherent policies that increase opportunities and promote wellbeing.

This conception of inequity in health, or even of social justice, is clearly not universally accepted. Inequity is however increasingly being seen as the key challenge to societies in many parts of the world and at the global level – where the Millennium Development Goals represent an unprecedented global commitment. These political challenges are the context within which any technical approach to implement action on social determinants operates. Policy-makers who seek coherent responses to reduce health inequities need to grapple with how societies come to value increased fairness, and reduced health inequities as a measure of this societal fairness. Better understanding of how acting on social determinants contribute to other development goals, such as environmental protection and economic growth, can contribute to increased prioritization of health outcomes, including inequities, as a measure of societal progress. Increased knowledge is also needed to show how systems that reduce health inequities, by delivering better performance and improving outcomes more rapidly for disadvantaged groups, may perform more effectively for all.

Addressing these political challenges is highly context-dependent so this paper does not attempt to offer a blueprint. While the political context is vital for action on social determinants, Member States have increasingly asked for guidance on how it can be implemented. The World Conference will provide a forum for consideration of how political challenges can be managed, leading to the conference declaration, and for sharing experiences and knowledge on how strategies can be implemented. The rest of this paper informs the latter goal of the World Conference by providing an overview of strategies to implement coherent policies on social determinants, organised by the five conference themes.

Principles and rationale of the World Conference themes

The five themes of the World Conference have been selected to highlight key aspects of how to successfully implement policies on social determinants. These themes, described below, are closely inter-related, reflecting the need for action on social determinants to be undertaken across society.

1. Governance to tackle the root causes of health inequities: implementing action on social determinants of health

Governance is about how governments (including their different constituent sectors) and other social organizations interact, how these bodies relate to citizens, and how decisions are taken in a complex and globalized world.[4] It is therefore a process whereby societies or organizations make decisions and determine whom they involve in doing so, and also how they ensure accountability for actions. Coherent policy responses to reduce health inequities require establishing governance that clarifies the individual and joint responsibilities of different actors and sectors (for example, the roles of individuals, different parts of the state, civil society, multilateral efforts and the private sector) in the pursuit of health and wellbeing as a collective goal.

The necessary governance for social determinants of health, in navigating multiple stakeholders with differing interests, needs to clearly set common responsibilities across different sectors for improvements in health and reduction of health inequities, linked to other development priorities. This is a political choice, but it also requires strategies to support the required governance and implementation of policies. As with other governance, decision-making processes for social

determinants need to consider legitimacy and voice; strategic vision; performance; accountability; and, most crucially for work on social determinants, fairness. Such processes also need to consider who takes the initiative for action.

Action on social determinants requires strengthening existing systems and building new ones. Previous phases of social change that resulted in significant advances in health, such as widespread provision of sanitation and universal healthcare, brought the establishment of new systems to implement policies and provide services. Complex, interconnected problems like health inequities challenge the traditional division of societies, and their governments, into sectors for organizational purposes. As no one sector on its own can mount an effective response, systems and governance are required to deliver a range of actions on social determinants. Despite new insights into the impact on health of poverty, environmental degradation, poor housing and urban planning, lack of education, discrimination and stigma, among other key determinants, systems in all countries remain inadequate to coherently implement whole-of-government strategies and approaches working between different sectors to address these.

Systems are also required to discriminate between the types of actions needed on social determinants. Some do require whole-of-society and whole-of-government approaches with an explicit concern for health equity, while others simply require individual sectors doing their job well in their own sectors (for example in designing and implementing tax or education policy). But many necessary policies require collaboration between different sectors, or intersectoral action (ISA), for example, to provide integrated delivery of services to meet communities' needs, especially the disadvantaged, which are often not conceived in terms of fragmented sectors. The idea of ISA is not new to health, having been championed by the primary health care and health promotion movements over the last thirty years. However, the lack of development of the necessary governance and systems to implement coherent policies on social determinants has been a significant obstacle to progress.

"Health in All Policies" is a policy strategy that tries to show how health can be placed as a shared goal across the whole of government and as a common indicator of development, conceptualizing an innovative approach to ISA. Health in All Policies highlights the important links between health and broader economic and social goals in modern societies, and positions improvements in population health and reducing health inequities as priority complex problems that demand an integrated policy response across sectors. This response needs to consider the impacts of policies on social determinants as well as the benefits of improvements in health for the goals of other sectors.

2. The role of the health sector, including public health programmes, in reducing health inequities

While implementation of policies across the social determinants, which span all of society, is essential to improve health and reduce inequities, the health sector remains vital for progress. It has an important role in the governance required for action on social determinants of health, although it should not expect to lead this all, or even most of the time. Instead, the health sector needs to construct a dialogue on why health and health equity are shared goals across society and identify how other sectors can benefit from work on social determinants, in terms of their own priorities. The health sector also has an important role in working with other sectors to reduce differences in

exposure and vulnerability to health threats. It should aim to facilitate the necessary action on social determinants to do this, but, again, not necessarily expect to play a leadership role.

Moreover, health systems, including public health programmes, are themselves a social determinant. This is particularly in terms of access to health care and in mediating the consequences of becoming ill in people's lives. By improving the delivery of health care, the health sector can significantly improve health outcomes and reduce inequities. Ensuring equitable performance of health care services for all groups in society, at all stages of care, can combat inequities in health outcomes resulting from differences in prevalence and severity of disease caused by social inequality. Without reducing inequities itself, the health sector is also poorly placed to ask other sectors to take actions on social determinants.

The health sector can make an essential contribution to reducing health inequities by ensuring universal health coverage - access to and utilization of quality services through the continuum of care for all people in a society. This includes ensuring that disadvantaged groups with greater health needs receive the resources necessary for the provision of appropriate health services to meet their needs. But universal health coverage, receiving increasing priority as part of the agendas of health systems strengthening and the renewal of primary health care, is much more than providing access to a basic package of services. It requires considering a range of complex issues including performance, quality, effectiveness and prioritization of need, including the impact of the social determinants on these issues. Instead of reducing health inequities, the health sector often makes them worse by providing better access and quality of care to those groups with comparatively lesser need. Choices about health system financing and the location of health care services, as well as the attitudes of health workers towards different groups in society, are crucial to whether the health sector has a positive or negative impact on health inequities.

The primary health care approach places equity as a central value for the health sector along with ensuring universal coverage and facilitating participation and negotiation in leadership of the health sector. Any strategy to strengthen health systems and public health programmes needs to institutionalize an explicit focus on equity through the continuum of care and all health system functions, if it wants to make up for shortfalls in performance for disadvantaged population groups. This means going beyond average measures of progress to unmask disparities not only in health outcomes, but also in the usage and quality of services. This is important not only to improve health equity, but also to make progress on health priorities. For example, achievement of priority health targets such as the Millennium Development Goals and the elimination of tuberculosis are endangered by poor service delivery to "hard-to-reach" populations.

3. Promoting participation: community leadership for action on social determinants

The participation of communities and civil society groups in decision-making is a key aspect of the governance required for action on social determinants across all sectors. Facilitating this participation can help safeguard equity as a principle and ensure its implementation in public policies. Other aspects of participation, such as individual participation in taking up services or participation of communities in service delivery, are also important for reducing health inequities. However, the involvement of communities and civil society in policy-making and implementation is relevant to both governance for social determinants and the specific role of the health sector. It is

therefore a key intervention to strengthen political sustainability at national and global levels and to ensure that policies and interventions reflect people's needs, particularly through communities ensuring accountability for decisions made. A range of countries that have shown recent success in reducing health inequities have placed renewed emphasis on this dimension of participation. Sustaining the necessary action on social determinants across a range of sectors seems difficult without broader societal involvement, particularly to ensure that services become more responsive to the needs of disadvantaged populations.

Participation conceived in this way has intrinsic value in respecting the human right and autonomy of people to be involved in making decisions that affect them. For action on social determinants, participation is part of the overall goal itself – of improved agency, wellbeing, dignity and quality of life for all members of society. But there is also instrumental value whereby the participation of communities and civil society in policy-making can drive new initiatives, increase accountability and sustain change.

Promoting participation in a genuine manner can sometimes seem risky for policy-makers as it implies a shift in power relationships in favour of population groups that have often historically experienced exclusion and marginalization. These are key social determinants upon which action is required to reduce inequities. Doing so requires a willingness to transfer real power to communities and to bear the consequences of people demanding even transformative change. Yet participation also offers many rewards for political leaders who also seek reform. By creating a broader constituency to take ownership for policy processes and credit for change and its ensuing benefits, the participation of communities can drive difficult reforms and create a significant legacy, which is unlikely unless change is sustained.

Governments can take an active role in facilitating participation and avoiding tokenism. At a minimum, governments can act to ensure that they do not obstruct attempts at participation. They can also respond to the demands of empowered communities by facilitating structures, capacities, knowledge and representativeness for participation, and integrate participatory processes with other aspects of policy-making, as part of governance for social determinants. They can also encourage civil society groups in their watchdog function.

4. Global action on social determinants: aligning priorities and stakeholders

Governance for action on social determinants is not only required within countries. Many social determinants are increasingly affected by global processes, or by the movement of people and goods across borders. Policies to reduce health inequities are also closely related to efforts to address other global priorities. Together, these priorities are straining existing governance for collaboration between nations, calling for new mechanisms beyond traditional forms such as aid.

For example, realizing the Millennium Development Goals (MDGs), addressing climate change and responding to the global epidemic of non-communicable diseases (NCDs) call for changes in global governance, as existing models and agreements are struggling to achieve these goals. These global priorities also overlap with efforts to address social determinants and inequities. Indeed, efforts for all of these themes are undermined by the existence of health inequities and inadequacies in governance to act on social determinants, both nationally and globally. It is no longer possible to make progress on these issues without, for example, addressing the needs of marginalized groups.

Climate change and NCDs require work on common social determinants that also result in health inequities. Coherent policies are therefore also required globally that do not undermine each other and instead mutually contribute to development.

Global partners therefore have an important role in developing governance to support country action on social determinants linked to these global priorities. International commitments for work on social determinants, including the discussions and follow-up to the World Conference, can build upon and cohere with international momentum on achieving the MDGs, addressing climate change, combating NCDs and building social protection. The global community also has an important role in supporting capacity development for research, planning, implementation and management of actions on social determinants through funding, coordination and technical support.

This requires consideration of how to use international agreements and instruments such as overseas development assistance to support required actions on social determinants. Enhanced financing for development is required for the global community to make a substantive contribution to addressing global social determinants, fulfilling commitments made on the 0.7% target for overseas development assistance for high-income countries and in the Monterrey Consensus, Doha Declaration and Gleneagles Summit. In all activities, there is a need for the precautionary principle, for coordination and harmonization, for long-term commitment and for parsimony. The UN system can itself set an example and achieve greater gains by accelerating its own harmonization process to support capacity development by Member States in addressing social determinants, at both global and national levels. South-South cooperation is an important potential source of innovation, but is not of itself immune to well recognized challenges in development assistance.

5. Monitoring progress: measurement and analysis to inform policies on social determinants

Effective governance for social determinants requires monitoring and measurement to inform policy-making, evaluate implementation and build accountability. For example, inadequate information on health inequities in many countries is one explanation for a lack of action to combat them. Monitoring is required of inequities in health outcomes, social determinants, and the impact of policies.

Without efforts to compare the health status of different population groups, health inequities remain invisible as progress seen in average health indicators often masks persisting or worsening differences between groups. Improvements in data and analysis of disparities have helped put health inequities on policy agendas, particularly in many high-income countries. But while necessary, measurement of differences in health outcomes is not enough to support governance of action on social determinants. Availability of data varies greatly between different countries, yet in all countries there is an urgent need for better measurement of social determinants and their impact on health, and for analysis of the impact of policies on health inequities.

Measurement of inequities in health outcomes is generally more developed than measurement of the social production of health and disease. Compared to biological risk factors, less information is routinely collected about the distribution of social and environmental risk factors for ill health. This is a barrier to the development and monitoring of evidence-based interventions on social determinants to reduce inequities. There is also a need to move beyond traditional epidemiology to

consider other methods, such as quality of life assessment, linked to the context of culture and value systems in which people live and their goals and expectations. A narrow focus on health and disease outcomes obscures the relationship of social determinants to broader development goals.

Monitoring of health inequities and social determinants needs to be fully integrated into policy-making. This requires sensitivity to the vast differences between country contexts in terms of data availability, political setting and the nature of the health inequities themselves. Most importantly, it requires the provision of usable information that informs the design of effective policies to address social determinants, monitors changes in inequities and explains the impact of specific strategies and choices.

This implies improved understanding of which data is most important for a given setting, and of how to turn data into information that can be used by the different audiences, including communities and civil society, who contribute to policy-making. As much attention needs to be given to the dissemination and availability of data on social determinants and related policies, as to its generation. Furthermore, there needs to be pragmatism and parsimony in collecting data. If there is not the political possibility to act, its collection should be carefully considered. In all cases, data collection has costs, so it is important to collect the least that is required to inform and monitor policies, as opposed to for its own sake.

1. Governance to tackle the root causes of health inequities: implementing action on social determinants of health

Taking a social determinants approach requires the ability to steer different sectors and different types of organizations in the pursuit of health and wellbeing as a collective goal. Building governance, whereby all sectors take responsibility for a fairer distribution of health outcomes, is essential to achieve this, including effective ways of implementing integrated work between different sectors ("intersectoral action"). Other necessary features of required governance include political leadership and long-term commitment, an engaged civil society, human resources with appropriate skills and knowledge, and a "learning environment" to allow policy innovation and resolution of conflicts. There is also the need for policy consistency between different spheres of policy-making. The health sector is one sector among many in this enterprise, and therefore should not expect a leadership or privileged role in governance for action on social determinants. There are, however, a number of specific functions that it needs to perform.

Building governance for action on social determinants

Building governance for action on social determinants is a complex task, highly dependent on each country's political system, and on the actors who need to be involved in each context. But while there is no 'one-size-fits-all' recipe, common questions need to be answered by the differing models of governance that may be used to institutionalize health as a shared goal across society, with health equity as a measure. These include establishing who drives action and takes the initiative; clarifying the roles of different sectors and groups; ensuring the participation of disadvantaged groups; ensuring accountability for the shared goal; and considering how to monitor progress.

The United Nations Development Programme (UNDP) five principles of good governance are useful to frame what is required.[4] First, the implementation of policies on social determinants needs to be part of a process that has **legitimacy** and provides a **voice** for all parties. Central government agencies, at the level of the executive, have a key role in driving action and framing health as a shared goal, as well as in mediating conflicts and building consensus between different sectors. The need for, and value of, true participation in policy-making for social determinants is discussed further below.

Second, work on social determinants requires **direction** and strategic vision that can respond to the need for sustained action required for reductions in health inequities to occur, and in particular tackle the "short-termism" that often leads to rapid, but inadequate, measures being implemented. Understanding the common benefits across society from working on social determinants is a key part of the necessary vision. The formulation of national strategies or plans is a useful opportunity to establish a process to develop and implement policies across sectors that place health equity as a shared goal. National strategies on social determinants can assist, but the process of arriving at the strategy is more important than the final document for building governance.

Third, there is a need to ensure **performance** in both the process and its outcomes. The mechanisms for decision-making on social determinants should be responsive to all stakeholders, and the process and resultant implementation of policies need to be effective and efficient, making best use of resources in terms of the common goals identified. Budgeting approaches, such as participatory budgeting, can contribute to increasing both responsiveness and performance.

Fourth, **accountability** must be clear. All actors, whether in different sectors of government, civil society, or the private sector, need to be made accountable for decisions made, in terms of the shared goals identified for health and health equity. Accountability for health outcomes cannot only be placed with the health sector. Targets can be useful for particular policy problems, as long as there are specific targets for each sector according to the social determinant upon which they act. Transparency is vital, both in terms of whom in the process makes decisions and who is responsible for the implementation of agreed policies and their outcomes. The use of health lenses, which make joint decision-making explicit and identify common benefits, can help to make accountabilities clearer.

Fifth, processes in decision-making and implementation on social determinants, aiming for a fair distribution of health, need to be **fair** themselves. Progress on health inequities is unlikely without equitable processes and access to interventions. Legal frameworks can assist with this, such as the enshrining of rights to health and its determinants in national constitutions, but only if they are enforced in a fair manner.

In building governance for action on social determinants that incorporate these principles, the ensuing systems also need to be considered. Systems that have multiple actors and aim at multiple outcomes, as in work on social determinants, are complex and dynamic, reflecting the complexity of the problems they try to address. A focus on how values are embedded, how systems organize themselves and respond to changing environments, and how their relationships are organized, is therefore also important in each specific governance context.

Implementing intersectoral action

Collaborative work between different sectors on social determinants – intersectoral action (ISA) – is one of the necessary instruments to institutionalize health and health equity as a shared goal across society. Much of the required work is at the level of national policy and legislation, or can be achieved by single actors or sectors working by themselves. However, ISA is essential to realizing shared benefits when addressing common goals, and also in linking action on different complex problems.

Major challenges are therefore deciding which problems require ISA, and identifying common goals between different sectors with differing interests. Central agencies have the main role in resolving these issues, although many municipal authorities have been particularly successful at local level. All sectors involved need to see a benefit in collaborative work, and this needs to be foremost in identifying and translating common goals for ISA. For work on social determinants, the benefits to other sectors of health and health equity improvements therefore need to be clearly articulated in terms of their own priorities and agendas.

This requires bridging differing understandings between sectors of the same problem - and the divergent "language" that different sectors use to describe the same issue. It also involves

identifying which sectors have vested interests in activities to address the problem – which requires a sound understanding of the interests and objectives of different sectors in the first place. Employing a conceptual model showing the interplay between various social determinants, with all sectors represented, can be helpful in demonstrating how all sectors concerned have a role to play.

Conflicts and trade-offs between short- and long-term goals, and between the interests of different sectors, are inevitable. There are numerous "win-wins" in acting on social determinants, but some necessary actions will result in negative impacts or costs for some parties. These conflicts need to be carefully managed, considering how any "losses" can be minimized, how to ensure continued collaboration from the sector who "loses", and identifying mechanisms to share benefits with the "losing" sector.

Fundamental to managing conflicts in this way is transparency about who "wins" and who "loses" over time in sustained action on social determinants. This can be informed by a cost-benefit analysis of alternatives (through both formal and informal calculations depending on what is required to make the decision) and an objective evaluation of the reasoning and data underpinning decisions. Sectors who "win" need to be willing to assist those who do not benefit or increase their chances of benefitting later. Losses are more likely to be sustainable in the short term if it is perceived that long-term benefit could accrue from the short-term gains to other sectors. Means for compensating sectors for losses can also be considered, to turn a "win-lose" situation into one where the sector that incurs costs has these mitigated to an extent, for example, through compensation settlements or adjustments. A particular challenge is that those who need to bear short-term losses often do not personally benefit from potential long-term gains that are beyond both political and budgetary cycles.

Health sector 's role in governance for social determinants

There are four broad, inter-related functions to which the health sector can make a useful contribution to governance for action on social determinants, while not automatically claiming a more important role than any other sector. First, the health sector has a key role in advocating for a social determinants approach and explaining how this contributes to benefits across society and for different sectors. In particular, the health sector needs to be able to articulate why health inequities are a high-priority indicator of a society's wellbeing that justifies an integrated response. Second, the health sector has particular expertise and responsibility to monitor health inequities and the impact of policies on social determinants. Third, through marshalling the evidence and successful advocacy, the health sector can play an important role in bringing sectors together to plan and implement work on social determinants, for example by identifying issues that need collaborative work, building relationships and identifying strategic allies in other sectors as potential partners. However, the health sector should avoid claiming this as an exclusive role, and facilitate rather than claim leadership. Fourth, the health sector has an important role in the development of capacities for work on social determinants, although again this is not a function that only the health sector can perform.

To effectively undertake these functions, a range of specific responsibilities and tasks can be identified:[5]

- Understanding the political agendas and administrative imperatives of other sectors

- Building the knowledge and evidence base of policy options and strategies
- Assessing comparative health consequences of options within the policy development process
- Creating regular platforms for dialogue and problem solving with other sectors
- Evaluating the effectiveness of intersectoral work and integrated policy-making
- Building capacity through better mechanisms, resources, agency support and skilled and dedicated staff
- Working with other arms of government to achieve their goals and in so doing advance health and well-being

Many of these responsibilities involve new terrain for the health sector, which therefore needs to build its own capacity to effectively work on social determinants.

Implementing Health in All Policies in South Australia

Since 2007, the state of South Australia has adapted a "Health in All Policies" approach, placing it strategically as a central process of government to improve health and reduce inequities, rather than an approach run by and for the health sector and imposed on other sectors. This approach has been framed as essential to achieve not only health priorities, but also the range of goals in the state's main planning document, the South Australian Strategic Plan. Starting with a preparatory and awareness raising phase and a proof of concept phase, leveraging the expertise of a visiting global expert, all sectors have been engaged and had demonstrated the value of the Health in All Policies approach for their own goals, as well as broader societal gains. The implementation phase has now commenced with a range of projects involving different sectors. These include water security, migrant settlement and access to digital technology. The foundations for the success of the Health in All Policies approach in South Australia have been identified as:

- A strong cross-government focus
- Central government mandate and coordination
- Flexible and adaptable methods of enquiry, using health lens analysis
- Mutual gain and collaboration
- Dedicated health resources for the process
- Joint decision-making and joint accountability

More information on the South Australian experience can be found at **http://bitURL.net/bhsn** or by consulting the following publication:

Kickbusch I, Buckett K, eds. Implementing Health in All Policies: Adelaide 2010. Adelaide: Government of South Australia; 2010. Available at **http://bitURL.net/bhsp**

Perspectives from senior policy-makers*: (To be added in the final draft)*

2. The role of the health sector, including public health programmes, in reducing health inequities

Beyond its important role in building governance for action on social determinants, the health sector also has a vital role in addressing its own contribution to health inequities, as well as contributing to the measuring and monitoring of social determinants (discussed in theme 5). Ensuring that the health sector reduces rather than increases health inequities requires putting equity at the core of the organization of health services, as well as institutionalizing equity in the governance of health systems (the actors, institutions and resources that undertake actions primarily to improve health). Applying the reforms highlighted for the renewal of primary health care (universal coverage, people-centred care, equitable public policies, and improved leadership, stewardship, and participation) can facilitate this if applied across all of the health system "building blocks" or functions: service delivery; health workforce; health information systems; access to medicines, vaccines and technologies; health financing; and leadership.

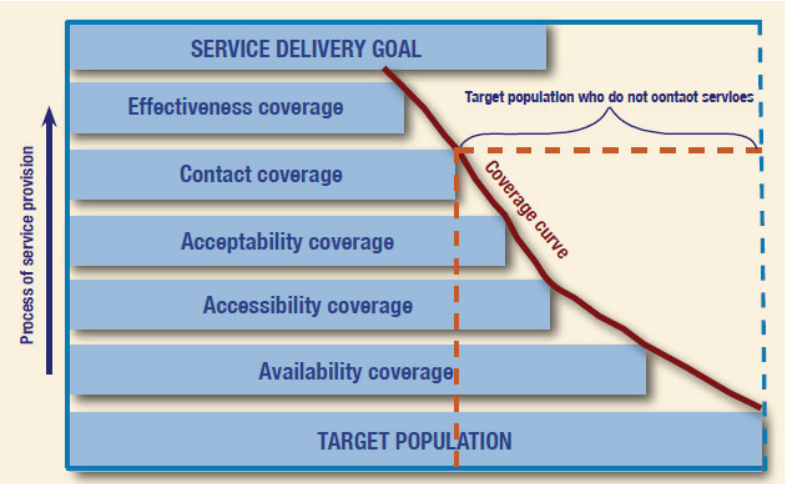
Redesigning health care services and public health programmes to reduce inequities

Placing equity at the heart of health care services first requires evaluating the performance of existing health services and programmes in reducing health inequities. This entails understanding the way in which existing services operate, including their aims, objectives and targets (the "logic" of services and programmes), and how these interact with the generation of health inequities in a society.

A number of models can be useful in considering whether existing health services exacerbate or alleviate health inequities. Figure 1 shows the Tanahashi model that considers access, provision and utilization of health care services to conceptualize the steps that need to be navigated between a person experiencing a health issue and receiving effective care from health services. At each step, people are "lost" by health services and programmes, resulting in avoidable suffering. For example, to receive effective care, a person with high blood pressure needs to know that they have a problem, seek care for this condition, be able to access care, receive the appropriate advice, be able to obtain the prescribed treatment, adhere to the treatment, and then obtain effective relief from the treatment to receive satisfactory resolution of their problem.

Ensuring that this complex pathway is realized in a timely manner is a major aim across health care services and programmes. Failure to do so results in poor performance and lack of achievement of public health outcomes. For almost all health care services, there are differences according to population groups in the rates at which people do not receive effective care at each step, or in the quality of care received. This is a key mechanism through which health care services and programmes increase health inequities. Measuring performance in this way - disaggregating data for key population groups, especially those socially disadvantaged according to the context - is a prerequisite to identify ways for health services to reduce their contribution to health inequities.

Figure 1 Tanahashi model for service delivery and coverage



Source: WHO, 2010[6], adapted from Tanahashi, 1978[7]

From this basis, entry points for interventions for health care services to alleviate health inequities can be defined. Once it is known which groups benefit from services and programmes, and more importantly, which groups do not or receive poorer quality of service, consideration can be given to why this occurs and why barriers to care are concentrated in these groups. Many of these barriers will lie outside the health sector in other social determinants. However, the health sector can make an important contribution by first addressing those factors within its control, such as the funding, location and timing of services and the competencies and attitudes of health workers. It can also work with communities to identify barriers and solutions, including ensuring that care extends beyond only curative services to promotion and prevention activities

This strategy provides a basis for the redesign of services and programmes to reduce inequities, and continued monitoring to see whether the changes have the intended effect. It can also be aligned with human rights-based approaches to strengthening health systems, which focus on ensuring that health-related facilities, goods and services are available, accessible, acceptable, appropriate and of good quality. Following the review of existing services, specific interventions need to be defined based on the analysis of how barriers to care can be reduced. These can involve changes in the delivery of care, such as changes in services offered or improved management, but also attempts to address social determinants that hamper access. While programmes cannot be responsible for all of these potential interventions, they can undertake a range of interventions to reduce differences in exposure and vulnerability to health threats, and especially in reducing differences that occur once people become ill. They can also engage partners in other sectors to act on the social differences that result in health equities.

There is potential for collaboration between programmes that find common issues resulting in differences in exposure or difficulties in accessing care. For example, key determinants of the tuberculosis epidemic are smoking, harmful use of alcohol, diabetes, indoor air pollution and HIV/AIDS. These conditions are often themselves clustered in disadvantaged population groups, driven by common social determinants such as poverty, discrimination and poor education and housing. Furthermore, screening and diagnosis for HIV/AIDS, tuberculosis and NCDs is often

hampered by poor coverage and quality. Redesigning these public health programmes to address social determinants in a coherent manner provides significant opportunities to mutually improve their performance towards common goals and their own targets.

Institutionalizing equity into health systems governance

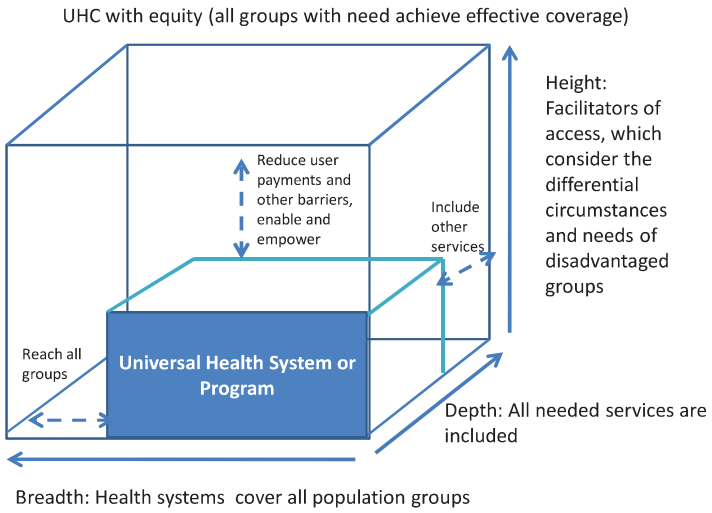
Redesigning the delivery of health care services need to be supported by reforming the governance of health systems through a primary health care approach. This is necessary to improve health sector capacity to design policies that improve equity across all health systems functions. Institutionalizing equity in health systems places particularly high demands on the governance capacity of national health ministries to usher in change, particularly in countries where a large proportion of health systems are beyond their direct control. Negotiating and steering change in services run by sub-national authorities, the private sector, non-governmental organizations and faith-based organizations is difficult but without embedding a consideration for equity in these services, or at least considering their contribution to the health system as a whole, progress is elusive. Directing resources to disadvantaged groups who may lack political power or making the case for sufficient funding to provide equitable health care are further difficult but essential tasks.

Addressing these challenges requires clear and transparent planning at the central level, with national health ministries acknowledging the importance of other providers and stakeholders in health systems, but also asserting their mandate and role to steer the whole system. The development of national health strategies that engage these other partners provides an opportunity to build the capacity of national health ministries to steward the entire health system,- by setting priorities for addressing inequities and also to implement mechanisms to negotiate between and regulate the different stakeholders. This process can also be used to consider whether the key issue of equity is addressing health problems experienced by the most disadvantaged groups, reducing gaps in health status between groups, “levelling up” across the gradient for all groups, or a combination of all three. Health sector efforts to address health inequities will vary depending on country context, the nature and extent of the health inequities present, and the structure of social and health systems – so the governance of health systems needs to be able to respond appropriately in allocating resources and prioritizing disadvantaged groups across all health system functions.

Health care financing to ensure equitable universal health coverage also poses particular challenges for health system governance. Equitable universal health coverage (see Figure 2) requires ensuring access and effective coverage for all groups (“breadth”), for all necessary care (“depth”), at affordable costs under acceptable conditions, with specific resources to address the differential needs of the least well-off (“height”). Achieving universal health coverage is not easy, as has been seen even in high-income countries. If there is not sufficient emphasis on equity, with prioritization of the worst off for both existing and new services, increasing coverage can often worsen inequities. However, there is enough evidence that moving equitably towards universal health coverage is possible in countries of all income levels. The financing of health systems is a key area in which to consider whether health resources are being appropriately directed to need. Fees for services at point-of-use have unequivocally been shown to deter appropriate use of health care. All countries therefore need to implement pre-payment pooling mechanisms to fund health services from either taxation or social insurance schemes, or a mix of both.

Even in countries where the conditions for universal health coverage are broadly achieved, marked inequities persist between different socioeconomic, ethnic and geographic groups. Other financing mechanisms therefore also need to be considered, such as linking provision of health services to wider social protection schemes and providing targeted assistance to groups with higher needs. Funding formulas that take into account needs and the social determinants (rather than only population numbers) are one useful tool to achieve this. Other possible measures include subsidizing people – not services – to take up care, for example through the use of conditional cash transfers.

Figure 2 Achieving equitable universal health coverage (UHC)



Source: Frenz and Vega, 2010[8] adapted from WHO, 2008[9]

Redesigning public health programmes in Chile

Chile has recently embarked on a process to redesign public health programmes to reduce health inequities. In 2008, equity assessments using a methodology based on the Tanahashi framework were commenced for six major public health programmes: Child Health, Reproductive Health, Cardiovascular Health, Oral Health, Health of Workers, and Red Tide (algal blooms). The aim of these assessments was to identify differential barriers and facilitators to prevention, case detection and treatment success, and to provide guidelines to redesign each programme to improve equity in access to care.

Multi-disciplinary teams undertook the assessments, with participation from health workers from all levels of the health system, communities, health bureaucrats and decision-makers from other sectors. In 2010, all programmes applied the recommendations, using intersectoral and participatory strategies. For example, the Cardiovascular Health programme implemented 67 good practice interventions identified by the assessment and assisted all Regional Health teams to develop specific action plans to put them into practice. In the Red Tide programme, strategies were developed for improved handling of the issue and reducing negative impacts for fishermen through temporary diversification and restructuring of working conditions. The process also resulted in the development of a set of indicators and methodologies for assessing equity of access in evaluating public health programmes.

More information on the Chilean experience can be found at **http://www.equidad.cl/**

***Perspectives from senior policy-makers**: (To be added in the final draft)*

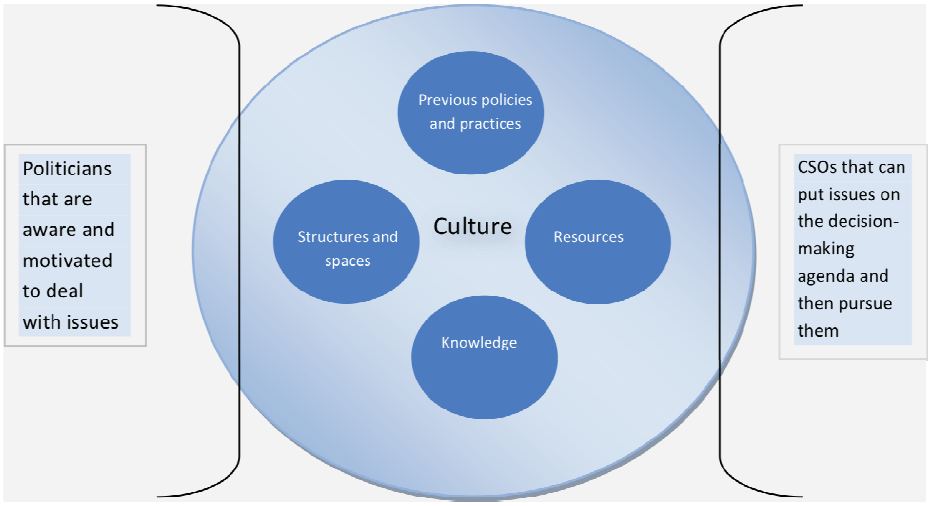
3. Promoting participation: community leadership for action on social determinants

Participation is key to the creation of inclusive societies. Yet there is no "magic bullet" to ensure participation in policy-making. Participation that leads to social change arises from social movements in specific contexts. Governments cannot generate participation in the same way they cannot generate social movements. However, many government actions can actively obstruct the ability of communities to raise concerns about, and propose solutions for, their daily living conditions. Governments can therefore create conditions that are conducive for the participation of empowered communities to make a difference to the health impacts of the context in which they live. At the same time, civil society can consider how best to focus its actions to contribute to action on social determinants, including building awareness of health inequities, helping communities to organize, and advocating for better and more inclusive governance.

Creating the conditions for participation

The framework in Figure 3 conceptualizes how the culture of participation in policy-making is created between communities and civil society on one side and governments on the other. It consists of four key components: the structures and spaces for participation to occur, the resources that stakeholders have to participate, the knowledge necessary to participate, and the impact of previous policies and practices on participation. This framework is not exhaustive, but effectively facilitating participation requires addressing at least each of these four elements.

Figure 3 The context and resources that influence social participation



Source: Unpublished WHO draft in development

Institutionalizing mechanisms for participation

Political, physical and institutional structures, along with their rules, regulations and relationships, can either inhibit or promote participation in policy-making as they define where participation occurs and who can access processes. These structures can be either formal or informal. To facilitate

participation, processes need to be as transparent as possible and informal procedures minimized, as they are often less accessible to disadvantaged communities. Stable mechanisms are necessary to institutionalize participation as central to the policy-making process.

The mechanisms chosen to institutionalize participation are less important than the process whereby they are incorporated into governance. Assemblies and councils have been successful in countries where they are closely linked to the decision-making process. In other nations, they often have minimal impact on policy. Similarly, decentralization, where funding and resources are devolved to sub-national bodies, has been useful in encouraging community involvement in many countries. There have also been many negative experiences, particularly where insufficient commitment, resources or knowledge have been available to implement action in response to heightened expectations. Other tools such as dialogues, participatory budgeting and citizen juries are again only as useful as the extent to which they can influence policy.

Providing resources

Participation has many benefits, but it is also costly. Stakeholders need sufficient time, money, institutional capacity and human resources to participate effectively in policy-making to promote their interests. Policy-making is also an ongoing process therefore participation requires resources to be available over a sustained period.

Governments can assist by investing in participation through offering incentives, subsidizing costs, and considering the timing and venue of participatory processes to maximize the possibility for people to attend. Civil society organizations can assist with the resources required for participation, as well as in helping communities identify which issues they should prioritize for action.

Considering the impact of previous policies and practices

The barriers to participation are not only a lack of mechanisms and resources. People's previous experiences, and the political and historical context in dealing with governments, strongly influence their perception and ability to participate in policy-making. Groups that face discrimination are especially unlikely to engage with participatory mechanisms. Governments therefore need to proactively facilitate their participation by allocating resources, but moreover by actively recognizing their culture and agency to contribute to their own wellbeing. In many countries, this requires changes in the practices of government and its staff, starting with placing participation as central to the mission of government agencies.

Building knowledge and capacity

Effective participation requires knowledgeable and skilled stakeholders who understand the process, have a clear vision of what can be achieved and have the social and political skills to navigate through bureaucratic processes while promoting their agenda. Knowledge and literacy for participation can be built through formal training or through advocacy experience. Stakeholders who lack the necessary skills can be assisted to obtain them through incentives and accessible information and training.

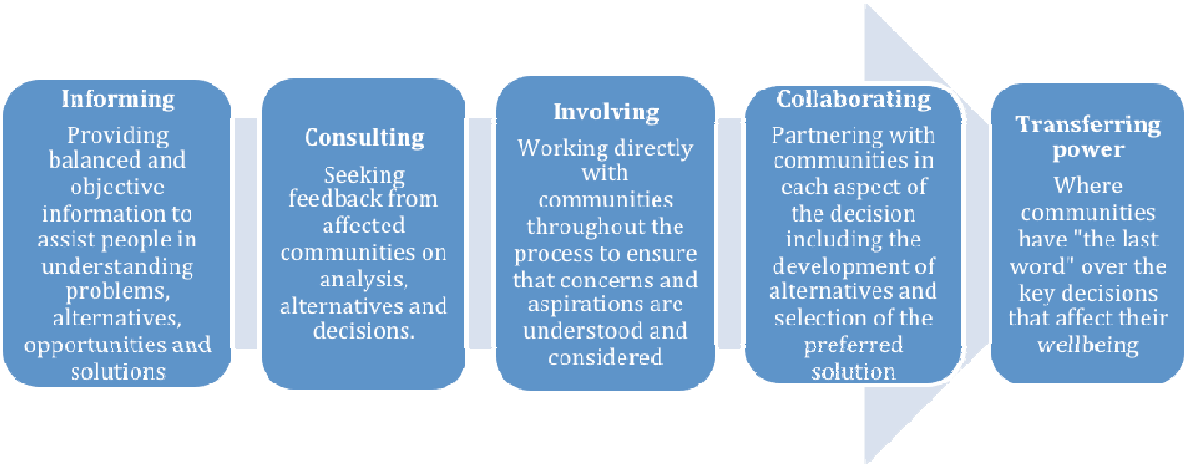
An essential aspect of ensuring the voices of marginalized groups are adequately represented in policy processes is building their capacity and literacy to participate. This involves the continuum of activities from information provision to empowerment described above. Communities require access to information, but they also need to be able to interpret and use it – this means making data

publicly available, using platforms that people can access, presenting it in ways that make sense to communities, and building skills in interpreting this information. In addition to analytical capacity, communities require increased "bureaucratic literacy" to demystify the bureaucratic structures, actors and processes involved in policy-making, to increase their awareness of the opportunities that exist for them to influence the policy process and to enable them to participate from a position of strength. Government organizations also need to build their capacity to facilitate participation, in particular their responsiveness to community demands and their ability to engage with proposals expressed in different ways to the language they may be used to.

Brokering participation and ensuring representativeness

There are a number of ways that governments can broker participation, with the aim of facilitating empowerment. Figure 4 provides an overview of this continuum, from provision of information to transfer of power. The most disadvantaged groups need to be identified in advance, and a plan developed for ensuring those groups are adequately represented. Often the most vulnerable groups experience additional barriers that make them less likely to be reached by efforts to engage. This may require flexible and novel approaches – for example female-only forums, utilizing new communication technologies to reach youth, and ensuring cultural appropriateness for ethnic minorities and indigenous peoples. Regional processes are critical to strengthen and reinforce national efforts to seek participation. Governments also have a role in working with communities to ensure the legitimacy of those who claim to be community representatives.

Figure 4 Techniques for seeking community engagement in the policy process



Source: Adapted from Valentine et al, 2008[10]

Facilitating civil society

Civil society can play an important role in implementing action on social determinants in a number of different ways. A key function is holding policy-makers and programme implementers to account for their responsibilities and commitments during policy-making, including monitoring spending on budgeting commitments. Civil society groups can influence accountability by encouraging institutional checks and balances, and, indirectly, by strengthening institutions of accountability such as electoral democracy and independent media. Civil society organizations can also generate evidence for work on social determinants. The accuracy of knowledge produced by civil society

groups, as well as their ability to be a source of credible research, is sometimes questioned. As with other sources of data, there can be issues of rigour, but civil society can provide access to information unavailable elsewhere. In settings where government data and information is inadequate, civil society groups can provide the principal source of credible and live data to inform policy-making on social determinants.

Governments can actively facilitate the role of civil society in action on social determinants. They can formalize civil society involvement in policy-making processes to support their role in maintaining accountability, for example, through setting up civil society advisory bodies and formally engaging with watchdog initiatives. Governments can also be better informed about the value and utility of knowledge produced by civil society groups, and build their capacity to undertake and present research in a form that is comprehensible to other audiences.

Institutionalizing participation in Brazil and Thailand

Brazil and Thailand are two countries that have shown impressive improvements in health and reductions in health inequities over the last twenty years. They have also been at the forefront of increasing public participation in policy-making.

In Brazil, participatory approaches to decision-making that impacts on health is seen in many forms, inspired by the social movements that drove the establishment of the universal health system, and subsequent primary health care and social protection improvements. The 1988 Brazilian Constitution established health as a human right for all, including the right to participate in health governance. This provided the space for institutionalizing public participation at municipal, state and national levels. This has occurred through health councils at each of these levels, supplemented by regular national health conferences. Innovative models such as participatory budgeting have also been implemented in some jurisdictions.

In Thailand, civil society assemblies over the last decade have led to the institutionalization of the National Health Assembly, held annually (as mandated by the new National Health Act) since 2008. It brings together over 1500 people from government agencies, academia, civil society, health professionals and the private sector to discuss key health issues and produce resolutions to guide policy making, adapting the machinery used at the WHO World Health Assembly. Policy impacts from Assembly resolutions have included protection of health budgets for universal health coverage, endorsement of strategies for universal access to medicines, and establishment of National Commissions on Health Impact Assessment and Trade and Health. Further information can be found at **http://en.nationalhealth.or.th/**

More information on the Brazilian and Thai experiences can be found by consulting the following publications:

Cornwall A, Shankland A. Engaging citizens: lessons from building Brazil's national health system. Soc Sci Med. 2008; 66: 2173-84.

Rasanathan K, Posayanonda T, Birmingham M, Tangcharoensathien V. Innovation and participation for healthy public policy: the first National Health Assembly in Thailand. Health Expect. 2011 doi: 10.1111/j.1369-7625.2010.00656.x.

Perspectives from senior policy-makers*: (To be added in the final draft)*

4. Global action on social determinants: aligning priorities and stakeholders

Increasing the ability of global partners (including donors, regional agencies, philanthropies and international organizations) to contribute to national and local action on social determinants requires improvements in global governance. Global governance mechanisms, similar to the situation within countries, are currently inadequate to address complex problems like health inequities, along with other global priorities. This is partly due to a failure to reform global institutions to accommodate the realities of the 21st century, with shifts in power and new trends of accelerated globalization, transnational markets for goods and services leading to increased movement of people and goods, and advances in technology occurring at the same time as dramatic increases in inequity. Global partners in development need to rise to the challenge of addressing social determinants as part of a more coherent policy framework, mediating between both different stakeholders and different aims.

Aligning stakeholders

Global governance needs alignment across sectors for action on social determinants, placing health inequities as a marker of policy incoherence. This can build on recent progress in understanding the strategic importance of health for the development agenda, and issues such as foreign policy, security and economic growth. Alignment is also urgently required between the different stakeholders involved in development. Global partners must harmonize their individual efforts to support those of countries to develop and implement national strategies on social determinants. Development cooperation that is fragmented, or tied to specific sectors and projects, can serve as a barrier for work on social determinants. Similarly, stakeholders advancing conflicting aims make it difficult for countries to undertake the whole-of-government strategies necessary for problems like health inequities.

The aid effectiveness agenda provides a strong platform to build upon. The principles of the Paris Declaration for Aid Effectiveness (of country ownership, alignment with national strategies and institutions, harmonization of donor actions, managing for results, and mutual accountability) are critical to making progress on how global partners can better contribute to country action on social determinants. The Accra Agenda for Action therefore also needs to be fully implemented.

In addition to improving their own alignment, global partners can also ensure that they build, and not undermine, governance capacity in recipient countries to coordinate donor funding. This requires building negotiation and management skills in governments and mobilizing sufficient will in donors to execute coherent planning processes that establish and pursue a long-term vision for countries. Civil society can also play a constructive role, by mediating between government sectors and donors, monitoring activities, and advocating directly for action on health inequities.

There is increasing potential for cooperation between low- and middle-income countries in showcasing initiatives and building capacity for integrated action on health inequities. Experiences and successes that many of these countries have achieved on social determinants can provide valuable impetus, ideas and means for other countries to address similar concerns and challenges.

Such cooperation can increase the flow of information, resources, expertise and knowledge among developing countries at reduced costs. Technology transfers between low- and middle-income countries and capacity building in action on social determinants are important contributors for development. Global partners can further assist this exchange by improving monitoring, evaluation and impact-measuring tools. They can also facilitate the provision of exchange mechanisms (for example, clearing-houses or searchable databases) to enable countries to identify and access available technical resources and networks, as well as fostering technical cooperation arrangements. These initiatives also need to be brought into the aid mainstream, and themselves aligned with cooperation efforts from traditional sources.

But improving global governance for action on social determinants is not only about aid. Global partners also need to consider coherence, including potential conflicts, between the aims of development cooperation and other mechanisms of global governance. These include international agreements, for example on trade and security, the regulation of migration, and the role of multilateral agencies. The recent global financial crisis has raised questions about the governance of global financing flows and the regulation of transnational markets. Countries are unlikely to be able to progress on social determinants unless they can address the impacts of these issues. For many countries, this will require global partners playing a positive role.

The United Nations system, and its interaction with other global partners, can set an example for policy coherence and better alignment of global governance by successfully implementing its "One UN" strategy. In particular, by reorganizing its country presence so that all agencies work together in an integrated manner on priority issues (including health inequities) the UN can greatly improve its capacity to help countries tackle complex challenges. The recent initiative to implement the UN Social Protection Floor in this way provides an example of what is possible (see below).

Aligning global priorities

Health inequities are just one of the many complex problems straining the capacities of global governance to mount an effective response. Many of these global priorities are closely linked. For example, progress on climate change is necessary to ensure that gains on the Millennium Development Goals (MDGs) are not endangered. Poor coherence can lead to progress on one priority having unintended consequences for other issues. The failure to consider equity within countries in the original MDG targets has meant that in some countries, improvements in average outcomes have perversely resulted in increasing inequities. Global partners therefore need to ensure policy coherence in moving forward on different global priorities, with initiatives supporting rather than undermining each other.

Positioning health equity as a crosscutting goal of development can facilitate greater alignment, as social determinants are relevant to all major global priorities. For example, achieving the health-related MDGs requires public health interventions to tackle specific risk conditions accompanied by interventions to reduce poverty and promote social protection, education, and empowerment. Most of the immediate risk factors for tuberculosis, malaria, HIV/AIDS and maternal and infant mortality are associated with social conditions. In addition, tuberculosis, malaria, HIV/AIDS, maternal and child health share social determinants with other key public health conditions. These social determinants encompass other MDGs such as those on poverty, gender equity, education and the environment.

Non-communicable diseases (NCDs) are absent from the MDGs, but are being increasingly recognized as a major threat to development in low- and middle-income countries. Three weeks prior to the World Conference, the United Nations General Assembly will convene a High-level Meeting on NCD prevention and control. Tackling the NCD epidemics is impossible without acting on social determinants, considering common drivers of health inequities and the conditions addressed in the health-related MDGs. This includes actions involving a range of sectors including finance, trade, agriculture, community planning, transport and environment. For example, fiscal policies can be used to control NCD risk factors by reducing tobacco consumption and fat, alcohol and salt intake, preventing obesity, and promoting physical activity.

There are also clear links between addressing health inequities, tackling NCDs and preventing harm from climate change. For example, shifting to cleaner energy sources and more efficient household stoves can reduce emissions of black carbon, a potent greenhouse gas, and prevent large numbers of deaths from respiratory disease in the world's poorest women and children.

But the challenge for global governance for action on social determinants lies less in realizing these "win-win" situations when aligning priorities, and more in managing tensions. For example, addressing tensions between reducing emissions and creating equitable opportunities for health and development requires balancing the fair sharing of burdens embodied in the United Nations Framework Convention on Climate Change's language of "common but differentiated responsibilities" with WHO's constitutional declaration that all people have a right to "the highest attainable standard of health". All measures that can be implemented to reduce emissions will not improve development for the most disadvantaged and reduce health inequities, and vice versa. Furthermore, all partners will not necessarily accept health equity as a shared measure of progress on global priorities.

Global governance therefore needs to consider similar issues in managing these conflicts to those discussed for countries above. Consideration of how to proceed following the expiry of the MDG targets in 2015 provides a stimulus for global partners to make the necessary reforms to achieve policy coherence by implementing a social determinants approach to harmonize action on key priorities.

Supporting capacity development

Global partners can play a vital role in capacity development for action on social determinants. Two key areas for this are in monitoring of social determinants and increasing access to technology.

By providing direct investment and technical assistance to strengthen monitoring systems and facilitate access to and better use of improved information at country and global levels, global partners can strengthen the capacity to design and implement national strategies on social determinants. The Health Metrics Network provides important lessons on what is possible. It has emphasized the need to enhance entire health information and statistical systems, rather than just for specific diseases, and concentrated efforts on strengthening country leadership for health information production and use. There is scope to build on these approaches across other sectors to strengthen a focus on inequities and improve the sharing of data between different sectors.

Global partners can improve access to and use of information technology and innovation in key social determinants, for example for agricultural productivity, water management and sanitation,

energy security and public health. Existing efforts can be expanded to facilitate the availability of technologies and strengthen national innovation, research and development capacity. One priority area lies in upgrading the quality and quantity of existing telecommunication infrastructure, particularly in the poorest countries, to support more modern applications and greatly increase connectivity.

Implementing the United Nations Social Protection Floor Initiative

Extending social protection to all people is a fundamental strategy to support action on health inequities and other global priorities. A social protection floor approach promotes nationally defined strategies (comprising a basic set of rights and transfers) that protect a minimum level of access to essential services and income security. The United Nations (UN) Social Protection Floor Initiative (SPF-1) provides a framework for a systematic build-up of more comprehensive social protection systems as countries develop further and economies recover from recent crises.

The Social Protection Floor Initiative is supporting a growing number of countries in their endeavours to build social protection systems at any stage of the process. The tools for the planning and implementation of such action have been developed. SPF-1 actors have collected evidence, documented experiences and developed tools like Social Protection Expenditure Reviews (SPER), social budgeting, actuarial models, needs assessments, costing assessments, capacity building, and monitoring and evaluation to support countries in their endeavours to build their own social protection floor. Technical assistance requests can be directed to any of the participating UN agencies.

Several international and national organizations have endorsed the SPF-I. It provides a model for intersectoral action on social determinants, with the initiative transcending the mandate of any individual UN agency. It is being implemented through a coherent, system-wide approach, involving joint UN country responses with each UN agency offering cutting-edge advice in their respective areas of expertise to ensure the optimal use of experts, resources and logistical support.

More information on the UN Social Protection Floor Initiative can be found at **http://biturl.net/bhtc**

Perspectives from senior policy-makers*: (To be added in the final draft)*

5. Monitoring progress: measurement and analysis to inform policies on social determinants

Monitoring of health inequities and evaluating the impact of policies on social determinants requires the collection of data, and the dissemination and application of this data in the policy process. Both tasks require equal attention and the contribution of a number of different stakeholders within countries (such as governments, academia and civil society), as well as the support of global partners (including donors, regional agencies, philanthropies and international organizations).

Identifying sources and collecting data

Policy-making requires information on both social determinants and health outcomes. Monitoring social determinants requires information from beyond the health sector. Routine data collection systems of other sectors, for example, education and housing, can provide rich sources of information on key social determinants as well as measures of development. As policies on social determinants need to act across different sectors, monitoring requires a systems approach, identifying necessary information through the pathways of social determinants required for reductions in health inequities. Making the link with data between these social determinants and health inequities is crucial to progress.

Ideally, monitoring systems need to be sensitive in order to capture inequities across the entire social gradient, rather than focusing only on population averages or known vulnerable groups. Data on inequities in health outcomes, as well as health system performance, can be derived from a number of sources commonly used by health information systems. However, these systems are not usually designed to routinely generate, synthesize or disseminate data and information on social determinants, health inequities or the associations between the two. Health measures are not well linked to policy monitoring systems of other sectors.

Vital statistics, including birth and death registries, provide a sound basis for analysing disparities in health outcomes. Cause of death registries allow monitoring of death rates according to social factors such as education, occupation, gender, ethnicity or place of residence. **Censuses** provide highly useful information on population groups and can also provide information on social determinants, especially if linked to mortality data. **Population-based surveys** can provide essential data in the absence of systematic health information systems, or for investigating specific concerns. **Health records** can provide information on health outcomes and the performance of the health sector. However, they are often incomplete and exclude those who do not access health services.

Efforts to expand coverage of civil registration, which currently excludes more than half of the world's population, are therefore an important step to reduce inequities. Information is often poorest about marginalized groups such as rural communities or the urban poor – groups who are most important to understanding health inequities. Issues of quality and timeliness of data are also important. Collecting information on social factors associated with disadvantage and being able to analyse data by geographical location can also greatly assist policy efforts.

Disaggregating data

To monitor health inequities and social determinants, data must be able to be separated, analysed and compared, or "disaggregated", according to the main factors known to be associated with health inequities. These social "stratifiers" include age, income, education, occupation, gender, ethnicity, and place of residence (to the smallest administrative unit possible). Disaggregation is essential for implementing policies to address inequities, but it also allows greater decision-making and accountability at the local level. Advances in geographic information systems (GIS) can improve the ability to collect disaggregated geographic data and disseminate it in a usable form.

The selection of stratifiers depends on the context, as it is not feasible or even desirable to disaggregate by all possible factors given limited resources for data collection. For example, in settings where employment and education are universally high, employment status and level of education may be poor proxies for socio-economic position. In low-income settings, and in communities that are not cash-based, income may not be an accurate marker of socio-economic position and alternative measures need to be found. Other ways to examine individual and household wealth include ownership of material goods (such as a refrigerator, radio or bicycle), agricultural wealth (such as livestock or land ownership) and access to key services (such as running water, toilets, bank accounts, and healthcare facilities).

Selecting indicators and targets

To inform policy change, monitoring systems require the establishment of agreed goals across different sectors to reduce health inequities, for which indicators and targets can be identified. Monitoring systems should include indicators that measure social determinants and methods for linking data from different sectors to understand their impact in reducing or worsening health inequities. In selecting indicators, issues of timeliness, comparability, harmonization and accessibility need to be considered.

These indicators should also include a balance of measures reflecting factors that increase the risk of ill health and those that promote the wellbeing of populations. Indicators and targets can span reducing health gaps, access to services, and intersectoral approaches to support disadvantaged populations or act on social determinants across the general population. Use can also be made of indicators already developed for monitoring the implementation of human rights-based approaches, or for consideration of specific aspects of inequity such as gender inequities. Setting targets and indicators cannot only be a technical endeavour – as with indicators for other purposes, it needs to be part of the policy-making process to reduce health inequities, ensuring accountability.

Indicators selected for policies aimed at reducing health inequities need to be clearly understood by policy-makers across the different sectors that influence the social determinants, and also by communities. As such, simpler measures may be more transparent and easier to interpret than complex summary measures. Health inequities can be measured through relative and absolute measures: both are needed over time for comprehensive analysis and as inputs to policy-making, since they illustrate different aspects.

Moving forward despite unavailability of systematic data

Globally, monitoring of health inequities ranges from countries with little routinely collected health data to countries that measure health inequities routinely, but often still lack data on social determinants. Strengthening data collection systems to remedy these gaps is often not possible, or a slow process. In this situation, lack of data should not preclude action on reducing health inequities. After all, policy-makers often need to make decisions without systematic information or evidence.

There are several options to help overcome lack of routine population-based data. Population-based surveys conducted at regular intervals can be used to provide some information. For example, the Demographic and Health Surveys (DHS) are collected in many countries at five-yearly intervals. DHS collect data on education and employment status of individuals within participating households, and are a valuable resource for describing differences in health between groups related to social factors. Other useful surveys include the Multiple Indicator Cluster Surveys (MICS) and the World Health Survey. Health facility reporting data can also sometimes be used to compare geographic patterns in illness and service utilization between communities.

Better use can also be made of qualitative methodologies, such as observational evidence, evaluations and natural policy experiments. Generating the evidence required to take action on health inequities requires a multi-disciplinary approach, reflecting the range of sectors that need to be involved in action. Rich sources of data can be found by tapping into the knowledge of those working most closely with the targeted communities, and of the communities themselves. Disadvantaged social groups, and key social problems, are likely to be well known. Community leaders and civil society groups, health practitioners, programme implementers, and political leaders are all sources of existing knowledge about problems influencing social determinants and health inequities, and potential solutions. Countries with poor data can also draw on evidence from other settings, considering how their own contexts differ from information on inequities and successful programmes to address them drawn from elsewhere.

However, effective action on health inequities generally does require some investment in expanding monitoring systems, particularly to expand information on social determinants. Even in systems with well-developed information systems, most of the information available relates to health outcomes, with much less focus on measuring social determinants, and inequities in their distribution. To address this, two key strategies are required: collection of new data for some factors and better linkage and sharing of data that is already collected between different sectors. Countries can aspire to systems that routinely collect information on social determinants, health outcomes and relevant health determinants in a coherent fashion. But the challenge in choosing to collect new data is identifying which are the key factors that need to be collected dependent on the context, including which communities are most disadvantaged, and ensuring that any new data that is produced can be rapidly used to inform policies and monitor planned interventions.

Disseminating information on health inequities and social determinants to inform action

Evidence highlighting health inequities or the effectiveness of particular policy or programme options does not automatically result in the implementation of systematic policies on social determinants. Translating evidence into useful information for action on social determinants and

health equity requires mechanisms to share, assess and communicate the evidence to policy-makers and to other stakeholders. Data on social determinants can be made more broadly available to all sectors to enable analysis, interpretation and advocacy by a wide range of actors, including civil society and communities. In particular, information needs to be fed back and integrated into accountability mechanisms for the implementation of policies.

This needs to be accompanied by efforts to present the information in a way that is meaningful to the audience, and to build community capacity to interpret and use such information. For example, public websites and simple mechanisms such as traffic light coding can be used to compare the progress of different geographical areas in terms of key social determinants. Synthesizing the evidence, by the use of reviews, policy briefs or guidelines for action, can make evidence available in a form that is digestible for policy-makers. Setting up systems for feedback and sharing of knowledge, such as communities of practice, can provide opportunities for comparisons and peer learning for practitioners and policy-makers.

Integrating data into policy processes

The process by which data and information are translated into the implementation of policies is complex. There is a need to align the data collection system for health inequities and social determinants with policy-making processes, with data communicated to policy-makers in a meaningful and timely manner, taking into account government objectives and accountabilities. Information on health inequities and social determinants needs to feed into problem identification and the development of policy options. Data for problem identification can come from routine collection and reporting, as well as specific initiatives. A range of tools can assist with considering the impact on health inequities of different policies. Other tools, such as scorecards and benchmarks, can assist with simplifying and summarizing health equity issues for input into policy-making. However, the key is to integrate awareness of social determinants and health inequities into the overall process, as opposed to choosing exactly the right tool.

Assessing the health and equity impacts of different policy options

If reducing health equities is identified as a high level priority across policy-making, there is the possibility to make use of a range of tools to consider equity impacts of policies of various sectors. Two key approaches are the use of health impact assessment and health equity assessment tools. Gender mainstreaming and human rights situation analysis tools can also contribute.

Health impact assessment draws from the methodologies developed for environmental impact assessment, also now being used for poverty and social impact assessments. Not all health impact assessment methodologies, however, focus on health inequities. Equity-focused health impact assessment is a structured process for assessing the potential health equity impacts of a proposal (positive and negative, intended and unintended) and making recommendations for improving the proposal.

Health equity assessment tools, aim to orientate policy-making towards considering impacts on health inequities. For example, the Urban Health Equity Assessment and Response Tool (Urban HEART, see http://www.who.or.jp/urbanheart.html) is a tested tool developed by WHO to

systematically incorporate health equity considerations into the planning cycle, specifically in urban settings. Health equity audits can be used to judge the fairness of the distribution of services or resources, given the health needs of different groups and areas, and identify priority actions required.

Monitoring health inequities and social indicators in New Zealand

The reduction of health inequities has become a priority in New Zealand in the last two decades, with the New Zealand Public Health and Disability Act 2000 explicitly identifying the need for the health sector to reduce inequities. Development in policy and practice have been assisted and even driven by substantial advances in the evidence for health inequities. Together, this progress has resulted in reductions in ethnic health inequities between indigenous Maori and non-indigenous New Zealanders over the last decade.

Key advances have included:

- The development of the New Zealand Deprivation Index (NZDep), a small area census-based summary index of deprivation based on several socio-economic factors, which gives a measure of socio-economic status according to place of residence.
- The development and enforcement of data protocols for the recording of ethnicity in the health sector.
- The New Zealand Census-Mortality Study, an ongoing project that links mortality data to census records, providing better quality and greater data for monitoring of health inequities.
- Expansion of the New Zealand Health Survey, with the inclusion of questions on experience of racial discrimination, providing new understanding of the impact of interpersonal racism on ethnic health inequities.
- The establishment of a series of New Zealand Social Reports that measure social wellbeing, over time, in terms of ten social outcomes domains (including but not limited to health), compared to OECD reference populations.

More information on the New Zealand experience can be found by consulting the following publications:

Crampton P, Salmond C, Kirkpatrick R, Scarborough R, Skelly C. Degrees of deprivation in New Zealand. Wellington: Bateman, 2002.

Ministry of Health. Ethnicity data protocols for the health and disability sector. Wellington: Ministry of Health, 2004. Available from **http://biturl.net/bhue**

Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Racism and health: The relationship between experience of racial discrimination and health in New Zealand. Soc Sci Med 2006; 63: 1428–41.

Blakely T, Tobias M, Atkinson J, Yeh L-C, Huang K. Tracking disparity: trends in ethnic and socioeconomic inequalities in mortality, 1981–2004. Wellington: Ministry of Health, 2007. Available from **http://biturl.net/bhuf**

Pega F, Valentine N, Matheson D. Monitoring Social Well-being: the case of New Zealand's Social Reports / Te Pūrongo Oranga Tangata. Social Determinants of Health Discussion Paper 3 (Case Studies). Geneva: WHO; 2010. Available from **http://biturl.net/bhuc**

***Perspectives from senior policy-makers**: (To be added in the final draft)*

Conclusion: urgent steps

Acting on social determinants to build inclusive societies, improve health, and achieve broader development can be a difficult task. Immediate action is possible, however, in all contexts. Every country can begin to implement a social determinants approach to improve the functioning of their societies and start on the path to reducing health inequities. In highlighting key processes for implementation, this technical paper has not tried to be exhaustive. But while the execution of these strategies will need to be adapted according to the realities of each country, priority themes can be identified in beginning to act.

First, there is a need to build governance for action on social determinants at a number of levels – to integrate work across the whole of government and between different sectors; within the health sector; and at the supranational level in terms of bilateral and multilateral co-operation. The holistic work of acting on social determinants requires the ability to consider all interests and include all those who are affected in the decision-making process, especially those who are most disadvantaged. It also requires agreement on shared higher goals across sectors, including setting health inequities as a common measure of policy failure, and the ability to resolve conflicts between different interests in terms of these shared goals. In the context of increasing global concern about the social impacts of growing disparities in life opportunities, there is an excellent opportunity to institutionalize a greater concern for equity across decision-making processes in the whole of government. The global community has a particular responsibility to consider how its actions support or detract from a concern for equity in engaging in cooperation with individual countries.

Second, despite the overarching need for work across all sectors, the health sector remains crucial. Institutionalizing equity in the health sector not only provides the possibility of making a significant contribution to reducing health inequities, but also provides a clear signal to other sectors. Without the health sector "putting its own house in order", and providing effective measurement of the scale of the problem, motivation to act and subsequent progress on health inequities will be undermined.

Third, the necessary monitoring cannot be limited to the health sector and the measurement of health outcomes. Measurement of only inequities in health outcomes provides a problem definition, but little ammunition for solutions. Monitoring is therefore required of inequities in key social determinants, and, moreover, linking of data from different sectors to inform the impact of policies on social determinants and assist the implementation of course corrections.

Fourth, implementing the range of processes highlighted in this paper requires urgent capacity-building at all levels – in policy-makers, government workers involved in service delivery, civil society and the private sector – and a fundamental reconsideration of training curriculum for all sectors. In building capacity for work on social determinants, the global community can play a vital role in facilitating further exchange of expertise and knowledge, building and disseminating tools, and providing training. This may most usefully occur on a bilateral basis between countries whose contexts are similar.

Finally, countries that have made progress on health inequities have not necessarily employed all of the strategies in this paper. They have identified desired outcomes, not always related to health, and proceeded to act. In an era of overwhelming complex problems, action on social determinants is

urgent for the final push towards the MDGs, to address climate change and NCDs, to protect economic and social development, and to build social protection systems; but moreover, to ensure inclusion for all groups in societies and the freedom that exists in fair opportunities for all. The World Conference provides an opportunity for countries, the global community and civil society to resolve to act together on social determinants to achieve these shared goals common to all.

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