

# Policy Brief

for the WHO Eastern Mediterranean Region

No. 1

## Tackling health inequities through action on the social determinants of health



Commission on  
Social Determinants of Health

### 1) What are social determinants of health?

“The social determinants of health refer to both specific features and pathways by which societal conditions affect health and that potentially can be altered by informed action.”<sup>1</sup>

This definition can be broken down into:

- specific personal and group characteristics (e.g. gender, income levels or assets, occupation, employment, education) that affect health outcomes;
- differentials that characterize people living in particular geographical areas (e.g. rural or urban, or particular provinces, regions or districts);
- inter-related determinants including economic, environmental and political elements (e.g. poverty, an underlying cause of poor mental and physical health, is also associated with limited employment opportunities, poor education levels, lack of knowledge of and access to resources, and poor environmental and housing conditions);
- processes by which these determinants affect health, especially those determinants that result in poor health.

### 2) What is health equity?

How can health equity be defined and monitored?

The principles of equity in health derive from the fields of philosophy, ethics, economics, medicine and public health, among other disciplines. Health equity can be defined as the absence of systematic disparities in health (or its social determinants) between more and less advantaged social groups. Social advantage means wealth, power, and/or prestige—the attributes defining how people are grouped in social hierarchies. Health inequities put vulnerable groups at further disadvantage, thus diminishing opportunities to be healthy.<sup>2</sup> Common to most definitions of health equity is the idea that certain health differences are unfair or unjust, linking equity to human rights. Box 1 delineates the steps for monitoring health equity and its determinants.

What is the distinction between equity in the provision and in the financing of health services?

*Equity in the provision of health services* is the accessibility of an essential package of health services to all, regardless of social position or place of residence.

*Equity in financing of health services* is the ability to pay according to need. Financing is considered to be fair when contribution to



Regional Office for the Eastern Mediterranean

### BOX 1 | Eight steps in policy-oriented monitoring of equity in health and its determinants<sup>3</sup>

**Step 1.** Identify the social groups of a priori concern. Consult representatives of social sectors and civil society, including advocates for disadvantaged groups. How do these groups identify themselves, and how are they identified by “outsiders”?

**Step 2.** Identify general concerns and information needs relating to equity in health and its determinants. Again consult representatives of groups identified.

**Step 3.** Identify sources of information on the groups and issues of concern. Consider both qualitative and quantitative information.

**Step 4.** Identify indicators of a) health status, b) major determinants of health status, and c) health care (financing, resource allocation, utilization, and quality) that are particularly suitable for assessing gaps between more and less advantaged social groups.

**Step 5.** Describe current patterns of avoidable social inequalities in health and their determinants.

**Step 6.** Describe trends in those patterns over time.

**Step 7.** Generate an inclusive and public process of considering the policy implications of the patterns and trends. Include all the appropriate participants in this process.

**Step 8.** Develop and set in motion a strategic plan for implementation, monitoring, and research, within the context of the specific social setting, and considering political and technical obstacles, and including the full range of appropriate stakeholders in the planning process.

health is proportional to household income. Out-of-pocket payment is usually the most regressive way to pay for health and the way that most exposes people to catastrophic financial risks.

Why are the social determinants of health and health equity considered together?

Globally, up to half of all ill health can be explained in terms of differences between the most advantaged persons or groups, compared to the most disadvantaged. Societies in which differentials in health status between certain groups and areas are small are usually societies in which social position, rights and opportunities are relatively equally distributed. In other words, equity in health is highly correlated with social equity. Progress on health equity cannot be achieved without taking action on the social determinants of health.

## BOX 2

### Global Commission on Social Determinants of Health

The global Commission on Social Determinants of Health (CSDH) was launched by WHO in March 2005. The Commission's mandate is to turn "existing knowledge on social determinants [of health] into actionable global, regional and national policy agendas" based on the relevant evidence and existing interventions to address them. Suggested options ranged from correcting "health disparities" by recommending specific health care strategies, to taking a stronger stand for health equity that requires far reaching social change.<sup>5</sup>

### 3) Why social determinants of health now?

In the 1980s tackling health determinants was considered an integral part of the Health for All through primary health care approach. Intersectoral collaboration was the principal strategy adopted. However, due to lack of ownership at community level and the absence of workable models the strategy did not succeed. In addition the narrower focus on specific vertical disease-related interventions, which could more easily be evaluated, soon became more attractive for policy-makers and donors. Today there is a need to revisit the area of intersectoral collaboration if social determinants of health are to be effectively tackled. Also, policy-makers need to recognize that work on social determinants requires a long-term approach, as social processes change slowly and are difficult to measure in quantitative terms.

National policies in general and national health policies in particular, in most developing countries, do not give adequate attention to social determinants of health. Health equity is not high on the agenda of national governments. The continuing drive for "cost effectiveness" in health reform focuses on improving management and training, and leaves little room for considering equity.

The establishment of the global Commission on Social Determinants of Health (CSDH) in March 2005 stressed the importance of the upstream health determinants, i.e. those in the social sector (Box 2).<sup>4</sup> The initiative provides an opportunity to place social determinants of health on the national agenda and include them in national policies and priorities. The needs of the poor, marginalized and disadvantaged are likely to remain unmet unless special efforts are made. This is because they are hard to reach and they have greater health needs than the rest of the population.

### 4) What influences health outcomes?

All policy-makers and programme managers are keen to see better health outcomes for the populations they serve. Better health outcomes are achieved through:

- well functioning health systems, characterized by good governance (including transparency), adequate and fair financing, optimal distribution of resources and accessible services;
- priority health programmes targeting the problems that are responsible for the major burden of diseases;
- promotional components that tackle the upstream health determinants in the social sector.

The relationship between these three components and health outcomes is shown in Figure 1. The last component is the most

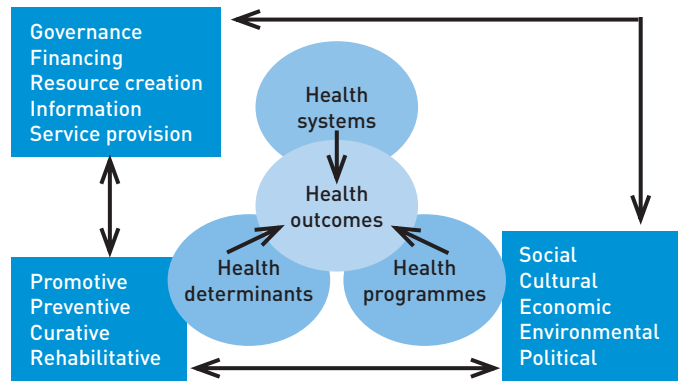


Figure 1. Relationship between health systems, programmes and health determinants

overlooked of the three principal strategies.

### 5) How do social determinants of health influence health outcomes?

Health outcomes can be affected by a series of inter-connected determinants which should, where possible, be tackled together rather than in isolation. For ministries of health it is logical to see this process as moving from (unsatisfactory) health outcomes to social determinants that might improve outcomes, rather than vice versa.

Causal pathways through which social determinants affect health are often complex and multi-dimensional and depend on local circumstances. Proximal determinants are identified at the local level, for individuals, households and communities. These determinants are, in turn, affected by distal determinants, those that operate at the national and global level and which affect the resources available for people to maintain good health. For example, Box 3 shows that both proximal and distal determinants affect maternal mortality, which continues to be high in several countries of the Region.

## BOX 3

### Social determinants of high maternal mortality

#### Proximal determinants

- Low level of mothers' education
- Lack of decision-making power among women about their health
- Cultural norms which encourage women to downplay their health problems
- Delays in making decisions about going to a health facility due to economic and social constraints
- Reluctance of women to be examined by males in some societies
- Poor quality of local health services

#### Distal determinants

- Poverty, an underlying determinant related to economic conditions that fail to provide resources for health and well-being.
- Lack of national financial and managerial resources for health care
- Lack of concern for the status of women on the part of governing elites
- National and global failure to prioritize women's reproductive health needs.

## 6) What works and how?

Primary health care is the foundation of a social determinants of health approach to health equity. During the 1980s good quality and accessible primary health care was the basis on which countries such as Costa Rica, Sri Lanka, Cuba and the state of Kerala in India achieved high coverage of health services among deprived populations. As a result they succeeded in increasing “average” health indicators to a level that would be expected in countries with much higher gross national products.<sup>5,6</sup>

Community organization and participation has long been recognized as an essential aspect of primary health care. The basic development needs approach, a component of the regional community-based initiatives programme, fosters community action in the poorest areas and thus directly addresses health and social inequity.<sup>7,8</sup> Interventions supported include:

- conventional child health programmes, such as the promotion of breastfeeding, safe motherhood and diarrhoea control;
- improving access to basic physical and social needs such as access to health services, nutrition, safe water, sanitation, shelter and empowerment;
- social programmes such as literacy, vocational training, food and nutrition, youth development, water and sanitation and income-generating projects.

Community-based research provides local knowledge appropriate for local strategies and an input into national policy, as well as increasing local involvement and ownership of projects. Community-based “population laboratories”, initiated in the Islamic Republic of Iran, are being developed in several countries of the Eastern Mediterranean Region.<sup>9</sup>

Positive deviance is a strategy for tackling social determinants of health at the community level. Its premise is that: “In every community there are certain individuals whose uncommon practices or behaviours enable them to find better solutions to problems than their neighbours who have access to the same resources.” Rather than having health staff identify harmful behaviours (which “blame the victim” and can be disrespectful of local norms and behaviour), community members and health staff work together to identify healthful behaviours that can become a source of pride for local people and a model for others.<sup>10</sup>

## 7) Country actions

Brazil, Islamic Republic of Iran and Morocco have adopted different approaches to institutionalizing social determinants of health in policy-making. These represent alternative models, which may depend for their success on different local circumstances and on flexibility in adaptation. They are recent innovations, and it is too soon to assess their success in achieving their goals.

Brazil provides a model for a commitment to health equity over more than three decades. It established a National Commission on Social Determinants of Health, in March 2006 to:

- generate information on social determinants of health;
- contribute to the formulation and evaluation of public policies aimed to promote health equity;
- mobilize sectors of government and civil society to address social determinants.

Commissioners are mostly academics, but also include well known public figures such as a cartoonist, a musician, an actress and representatives of civil society. Activities of the National Commission, thus far, include: advocacy work and the initiation of a plan for work on social determinants of health; a methodological seminar on evaluation of interventions on social determinants of health; and a call for research proposals.<sup>11</sup>

In the Eastern Mediterranean Region, the Islamic Republic of Iran has a long-standing commitment to health equity and is a partner country for work on social determinants of health. Primary health care reform expanded coverage. In rural areas, paid community health workers attached to “health houses” provided basic primary health care. Female community health workers visited mothers and supported child health activities, while male community health workers worked with local people to improve water and sanitation and other issues of community concern.

In 1985 medical education was integrated into the new Ministry of Health and Medical Education in order to provide medical education that is fully integrated with the public health system and focused on achieving health equity. Heads of provincial medical universities later became responsible for health care in the province. In August 2005 the Ministry of Health and Medical Education established a social determinants of health unit, with the support of the highest national authority and mandating collaboration with partners in other ministries, and with stakeholders beyond the government sector. The unit is preparing a situation analysis and national plan for social determinants of health and health equity.

Morocco launched a National Human Development Initiative (Initiative nationale pour le Développement humain) in May 2005, which is designed to tackle social and health inequities in the poorest urban and rural communities through literacy training, employment opportunities and social action. This initiative has the full backing of the highest authorities and collaborates with relevant ministries and with civil society.

## 8) What are the priorities for action in the Region?

Box 4 shows which social determinants of health require priority action from regional and country perspectives in the Region. Conflict and post-conflict emergencies need to be included among the wider social determinants of health. Around 22% of the population of the Region lives in countries in conflict or post-conflict and every country is affected by the regional and global

### **BOX 4** | Priority social determinants of health in Eastern Mediterranean Region

- **Women’s enablement: low status and gender discrimination at all stages in the life cycle limit women’s contribution to health and well-being, as well as harming their own health**
- **Child labour and street children: these under-reported problems endanger children’s health and well-being**
- **Migrant workers and their health: limited health services and health rights are available for non-citizen workers, legal and illegal**
- **Social exclusion: low status occupational groups, the disabled and those with stigmatized diseases are deprived of health and social rights**
- **Inequitable health systems: do not provide access and appropriate services for the disadvantaged**
- **Environmental conditions: lack of access to safe water and sanitation, safe working conditions, and air pollution affect the health of individuals and communities**
- **Socially determined lifestyles and behaviour: smoking, and traffic accidents are largely socially determined and are responsible for an increasing proportion of morbidity and mortality**
- **Conflicts and post-conflict emergencies: affect the health of people in six countries in the Region**

politics that fuel these conflicts. The health impacts go beyond the death and injuries directly resulting from violence, to the high levels of mortality and morbidity that follow the collapse of health systems. Broader social determinants, such as poverty and unemployment, destruction of the social fabric, lack of security, and environmental problems associated with the collapse of infrastructure, all contribute to poor health, especially stress and mental illness.

## 9) What are the policy options for the Region?

Develop a solid evidence base and use it in advocacy and policy-making

- Evidence on social determinants of health and health inequities, and on “what works”, should be collected, collated and used. This includes local knowledge accessed and analysed by residents.
- Health information systems that provide data on health and social inequities should be developed, in order to identify differentials between the health status of the best off and the worst off social groups and geographical areas, as well as the routine averages; if differentials decrease over time then some progress has been made towards health equity.

Advocate the inclusion of social determinants of health in national policies and programmes

- Information should be widely disseminated; dissemination of evidence is as important as its availability.
- Health, as a concern for everyone, is an ideal entry point for community-based discussion and action on related social development issues that can benefit health, such as safe water and sanitation, improvements in housing conditions, educational and employment opportunities.
- Innovative means of communication for advocacy should be developed by ministries of health, other line ministries, civil society organizations, academia and the media.

Improve health systems and financing

- Health systems that perform well and are fairly financed are essential for improving aggregate and distributional aspects of health outcomes. Equitable health systems provide the appropriate platform for the effective implementation of health programmes and for tackling health determinants that are responsible for the disease and risk burden of all, especially the poor and marginalized segments of the population.
- The goal of any well functioning health system is to achieve universal coverage by making accessible an essential package of promotive, preventive, curative and rehabilitative health services to all. In line with the primary health care approach] and Health for All, the health system should not be a barrier to the provision and affordability of essential health care to all. Some of the essential attributes of such health services are good quality of care; greater involvement of health staff and community members in decision-making; outreach by health staff and/or volunteers to reach disadvantaged populations in their own homes; and accessibility of essential medicines for the uninsured poor.

Foster intersectoral collaboration

- Ministries of health need to take the leadership role in establishing intersectoral coordination committees to work with other ministries to address social determinants of health. All the ministries concerned need to share information and experience on what are the main determinants that need to be tackled, and how they can collaborate in taking action on: labour and employment, child welfare, education, women’s affairs, social welfare, housing, water and sanitation, public information and finance.

Expand partnerships with social determinants of health stakeholders

- Civil society institutions, especially nongovernmental and civil society organizations, are recognized by the Commission as key players. Nongovernmental organizations can act as grassroots links with communities, helping them to identify their health and other social needs and supporting community health volunteers and researchers, in addition to their more common role in the Region as providers of primary health care and social services. Civil society organizations with a developmental focus, engaged in fostering sustainable improvements in health and social conditions, are better equipped as partners than those providing charity.
- Academia, including government-run research centres, state and independent universities, can help to: set a research agenda; identify and carry out appropriate research; train social and health researchers; and train and support community volunteers to conduct research in communities and in collaboration with civil society organizations.
- Media, which in the Region includes state controlled media as well as rapidly expanding private television and print media, can help to spread messages about health and health equity. To do so effectively they need to have access to carefully evaluated and balanced health information and to give it air time.

## References

- 1) Krieger N. A glossary for social epidemiology. *Journal of epidemiology and community health*, 2001, 55:693–700.
- 2) Braveman P, Gruskin S. Defining equity in health. *Journal of epidemiology and community health*, 2003, 57:254–8.
- 3) Braveman PA. Monitoring equity in health and health care: conceptual framework. *Journal of health, population and nutrition*, 2003, 21:181–92.
- 4) Irwin A et al. The Commission on Social Determinants of Health: Tackling the social roots of health inequities. *PLoS medicine*, 2006, 3:106.
- 5) Action on the social determinants of health: learning from previous experiences. Background paper prepared for the CSDH, Geneva, World Health Organization, March 2005. [http://www.who.int/social\\_determinants/resources/en/index.html](http://www.who.int/social_determinants/resources/en/index.html) accessed 17 Jan 07
- 6) Cooper RS, Kennelly JF, Orduñez-García P. Health in Cuba. *International journal of epidemiology*, 2006, 35:817–24.
- 7) CBI website: [www.emro.who.int/cbi/index.htm](http://www.emro.who.int/cbi/index.htm) accessed 16 January 2007.
- 8) Assai M, Siddiqi S, Watts S. Tackling social determinants of health through community based initiatives. *BMJ*, 2006, 333:854–6.
- 9) Malekafzali M. Iran’s women investigate health priorities. *Real health news*, 2006, 6:1–4.
- 10) <http://www.positivedeviance.org> accessed 16 January 2007.
- 11) <http://www.determinants.fiocruz.br/> accessed 16 January 2007.

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