



World Health  
Organization



Commission on  
Social Determinants of Health

# Closing the gap in a generation

Health equity through action on  
the social determinants of health





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# The Commission calls for closing the health gap in a generation

Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. We watch in wonder as life expectancy and good health continue to increase in parts of the world and in alarm as they fail to improve in others. A girl born today can expect to live for more than 80 years if she is born in some countries – but less than 45 years if she is born in others. Within countries there are dramatic differences in health that are closely linked with degrees of social disadvantage. Differences of this magnitude, within and between countries, simply should never happen.

These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.

Social and economic policies have a determining impact on whether a child can grow and develop to its full potential and live a flourishing life, or whether its life will be blighted. Increasingly the nature of the health problems rich and poor countries have to solve are converging. The development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health.

In the spirit of social justice, the Commission on Social Determinants of Health was set up by the World Health Organization (WHO) in 2005 to marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it.

As the Commission has done its work, several countries and agencies have become partners seeking to frame policies and programmes, across the whole of society, that influence the social determinants of health and improve health equity. These countries and partners are in the forefront of a global movement.

The Commission calls on the WHO and all governments to lead global action on the social determinants of health with the aim of achieving health equity. It is essential that governments, civil society, WHO, and other global organizations now come together in taking action to improve the lives of the world's citizens. Achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it.



# A new global agenda for health equity

Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

It does not have to be this way and it is not right that it should be like this. Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity. Putting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice. Reducing health inequities is, for the Commission on Social Determinants of Health (hereafter, the Commission), an ethical imperative. Social injustice is killing people on a grand scale.

## The social determinants of health and health equity

The Commission, created to marshal the evidence on what can be done to promote health equity and to foster a global movement to achieve it, is a global collaboration of policy-makers, researchers, and civil society led by Commissioners with a unique blend of political, academic, and advocacy experience. Importantly, the focus of attention embraces countries at all levels of income and development: the global South and North. Health equity is an issue within all our countries and is affected significantly by the global economic and political system.

The Commission takes a holistic view of social determinants of health. The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.

The global community can put this right but it will take urgent and sustained action, globally, nationally, and locally. Deep inequities in the distribution of power and economic arrangements, globally, are of key relevance to health equity. This in no way implies ignoring other levels of action. There is a great deal that national and local governments can do; and the Commission has been impressed by the force of civil society and local movements that both provide immediate local help and push governments to change.

And of course climate change has profound implications for the global system – how it affects the way of life and health of individuals and the planet. We need to bring the two agendas of health equity and climate change together. Our core concerns with health equity must be part of the global community balancing the needs of social and economic development of the whole global population, health equity, and the urgency of dealing with climate change.

## A new approach to development

The Commission’s work embodies a new approach to development. Health and health equity may not be the aim of all social policies but they will be a fundamental result. Take the central policy importance given to economic growth: Economic growth is without question important, particularly for poor countries, as it gives the opportunity to provide resources to invest in improvement of the lives of their population. But growth by itself, without appropriate social policies to ensure reasonable fairness in the way its benefits are distributed, brings little benefit to health equity.

Traditionally, society has looked to the health sector to deal with its concerns about health and disease. Certainly, maldistribution of health care – not delivering care to those who most need it – is one of the social determinants of health. But the high burden of illness responsible for appalling premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age. In their turn, poor and unequal living conditions are the consequence of poor social policies and programmes, unfair economic arrangements, and bad politics. Action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies. Policies and programmes must embrace all the key sectors of society not just the health sector. That said, the minister of health and the supporting ministry are critical to global change. They can champion a social determinants of health approach at the highest level of society, they can demonstrate effectiveness through good practice, and they can support other ministries in creating policies that promote health equity. The World Health Organization (WHO), as the global body for health, must do the same on the world stage.

## Closing the health gap in a generation

The Commission calls for closing the health gap in a generation. It is an aspiration not a prediction. Dramatic improvements in health, globally and within countries, have occurred in the last 30 years. We are optimistic: the knowledge exists to make a huge difference to people’s life chances and hence to provide marked improvements in health equity. We are realistic: action must start now. The material for developing solutions to the gross inequities between and within countries is in the Report of this Commission.

# The Commission's overarching recommendations

## 1 Improve Daily Living Conditions

Improve the well-being of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all, and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments, and global institutions.

## 2 Tackle the Inequitable Distribution of Power, Money, and Resources

In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities – such as those between men and women – in the way society is organized. This requires a strong public sector that is committed, capable, and adequately financed. To achieve that requires more than strengthened government – it requires strengthened governance: legitimacy, space, and support for civil society, for an accountable private sector, and for people across society to agree public interests and reinvest in the value of collective action. In a globalized world, the need for governance dedicated to equity applies equally from the community level to global institutions.

## 3 Measure and Understand the Problem and Assess the Impact of Action

Acknowledging that there is a problem, and ensuring that health inequity is measured – within countries and globally – is a vital platform for action. National governments and international organizations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should evaluate the health equity impact of policy and action. Creating the organizational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health. It also requires a stronger focus on social determinants in public health research.

### Three principles of action

- ① Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
- ② Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
- ③ Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

These three principles of action are embodied in the three overarching recommendations above. The remainder of the Executive Summary and the Commission's Final Report is structured according to these three principles.

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# 1. Improve Daily Living Conditions

The inequities in how society is organized mean that the freedom to lead a flourishing life and to enjoy good health is unequally distributed between and within societies. This inequity is seen in the conditions of early childhood and schooling, the nature of employment and working conditions, the physical form of the built environment, and the quality of the natural environment in which people reside. Depending on the nature of these environments, different groups will have different experiences of material conditions, psychosocial support, and behavioural options, which make them more or less vulnerable to poor health. Social stratification likewise determines differential access to and utilization of health care, with consequences for the inequitable promotion of health and well-being, disease prevention, and illness recovery and survival.





# Equity from the start

## What must be done

A comprehensive approach to the early years in life requires policy coherence, commitment, and leadership at the international and national level. It also requires a comprehensive package of ECD and education programmes and services for all children worldwide.

**Commit to and implement a comprehensive approach to early life, building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development.**

- Set up an interagency mechanism to ensure policy coherence for early child development such that, across agencies, a comprehensive approach to early child development is acted on.

- Make sure that all children, mothers, and other caregivers are covered by a comprehensive package of quality early child development programmes and services, regardless of ability to pay.

**Expand the provision and scope of education to include the principles of early child development (physical, social/emotional, and language/cognitive development).**

- Provide quality compulsory primary and secondary education for all boys and girls, regardless of ability to pay. Identify and address the barriers to girls and boys enrolling and staying in school and abolish user fees for primary school.

Early child development (ECD) – including the physical, social/emotional, and language/cognitive domains – has a determining influence on subsequent life chances and health through skills development, education, and occupational opportunities. Through these mechanisms, and directly, early childhood influences subsequent risk of obesity, malnutrition, mental health problems, heart disease, and criminality. At least 200 million children globally are not achieving their full development potential. This has huge implications for their health and for society at large.

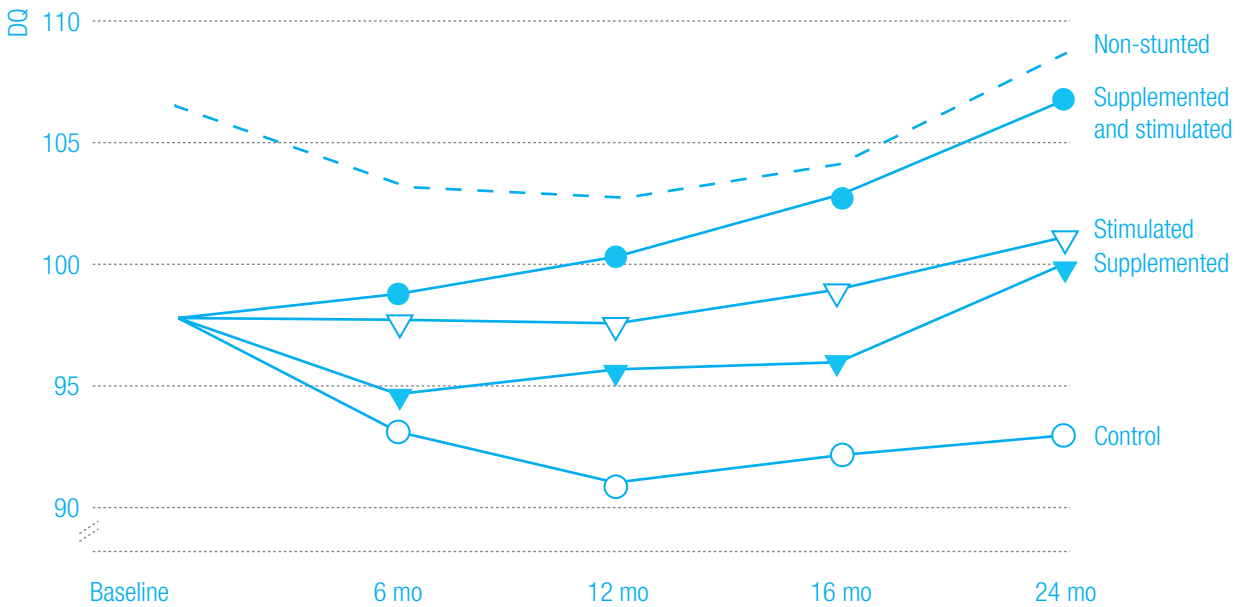
### Evidence for action

Investment in the early years provides one of the greatest potentials to reduce health inequities within a generation. Experiences in early childhood (defined as prenatal development to eight years of age), and in early and later education, lay critical foundations for the entire lifecourse. The science of ECD shows that brain development is highly sensitive to external influences in early childhood, with lifelong effects. Good nutrition is crucial and begins *in utero* with

adequately nourished mothers. Mothers and children need a continuum of care from pre-pregnancy, through pregnancy and childbirth, to the early days and years of life. Children need safe, healthy, supporting, nurturing, caring, and responsive living environments. Preschool educational programmes and schools, as part of the wider environment that contributes to the development of children, can have a vital role in building children's capabilities. A more comprehensive approach to early life is needed, building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development.



Effects of combined nutritional supplementation and psychosocial stimulation on stunted children in a 2-year intervention study in Jamaica<sup>a</sup>.



<sup>a</sup> Mean development scores (DQ) of stunted groups adjusted for initial age and score compared with a non-stunted group adjusted for age only, using Griffiths Mental Development Scales modified for Jamaica. Reprinted, with permission of the publisher, from Grantham-McGregor et al. (1991).



# Healthy Places Healthy People

## What must be done

Communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being and that are protective of the natural environment are essential for health equity.

### **Place health and health equity at the heart of urban governance and planning.**

- Manage urban development to ensure greater availability of affordable housing; invest in urban slum upgrading including, as a priority, provision of water and sanitation, electricity, and paved streets for all households regardless of ability to pay.
- Ensure urban planning promotes healthy and safe behaviours equitably, through investment in active transport, retail planning to manage access to unhealthy foods, and through good environmental design and regulatory controls, including control of the number of alcohol outlets.

### **Promote health equity between rural and urban areas through sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their homes.**

- Counter the inequitable consequences of urban growth through action that addresses rural land tenure and rights and ensures rural livelihoods that support healthy living, adequate investment in rural infrastructure, and policies that support rural-to-urban migrants.

### **Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity.**

Where people live affects their health and chances of leading flourishing lives. The year 2007 saw, for the first time, the majority of human beings living in urban settings. Almost 1 billion live in slums.

### **Evidence for action**

Infectious diseases and undernutrition will continue in particular regions and groups around the world. However, urbanization is reshaping population health problems, particularly among the urban poor, towards non-communicable diseases, accidental and violent injuries, and deaths and impact from ecological disaster.

The daily conditions in which people live have a strong influence on health equity. Access to quality housing and shelter and clean water and sanitation are human rights and basic needs for healthy living. Growing car dependence, land-use change to facilitate car use, and increased inconvenience of non-motorized modes of travel, have knock-on effects on local air quality, greenhouse gas emission, and physical inactivity. The planning and design of urban environments has a major impact on health equity through its influence on behaviour and safety.

The balance of rural and urban dwelling varies enormously across areas: from less than 10% urban in Burundi and Uganda to 100% or close to it in Belgium, Hong Kong Special Administrative Region, Kuwait, and Singapore. Policies

and investment patterns reflecting the urban-led growth paradigm have seen rural communities worldwide, including Indigenous Peoples, suffer from progressive underinvestment in infrastructure and amenities, with disproportionate levels of poverty and poor living conditions, contributing in part to out-migration to unfamiliar urban centres.

The current model of urbanization poses significant environmental challenges, particularly climate change – the impact of which is greater in low-income countries and among vulnerable subpopulations. At present, greenhouse gas emissions are determined mainly by consumption patterns in cities of the developed world. Transport and buildings contribute 21% to CO<sub>2</sub> emissions, agricultural activity accounts for about one fifth. And yet crop yields depend in large part on prevailing climate conditions. The disruption and depletion of the climate system and the task of reducing global health inequities go hand in hand.







# Fair Employment and Decent Work

## What must be done

Through the assurance of fair employment and decent working conditions, government, employers, and workers can help eradicate poverty, alleviate social inequities, reduce exposure to physical and psychosocial hazards, and enhance opportunities for health and well-being. And, of course, a healthy workforce is good for productivity.

**Make full and fair employment and decent work a central goal of national and international social and economic policy-making.**

- Full and fair employment and decent work should be made a shared objective of international institutions and a central part of national policy agendas and development strategies, with strengthened representation of workers in the creation of policy, legislation, and programmes relating to employment and work.

**Achieving health equity requires safe, secure, and fairly paid work, year-round work opportunities, and healthy work–life balance for all.**

- Provide quality work for men and women with a living wage that takes into account the real and current cost of healthy living.
- Protect all workers. International agencies should support countries to implement core labour standards for formal and informal workers; to develop policies to ensure a balanced work–home life; and to reduce the negative effects of insecurity among workers in precarious work arrangements.

**Improve the working conditions for all workers to reduce their exposure to material hazards, work-related stress, and health-damaging behaviours.**

Employment and working conditions have powerful effects on health equity. When these are good, they can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial hazards. Action to improve employment and work must be global, national, and local.

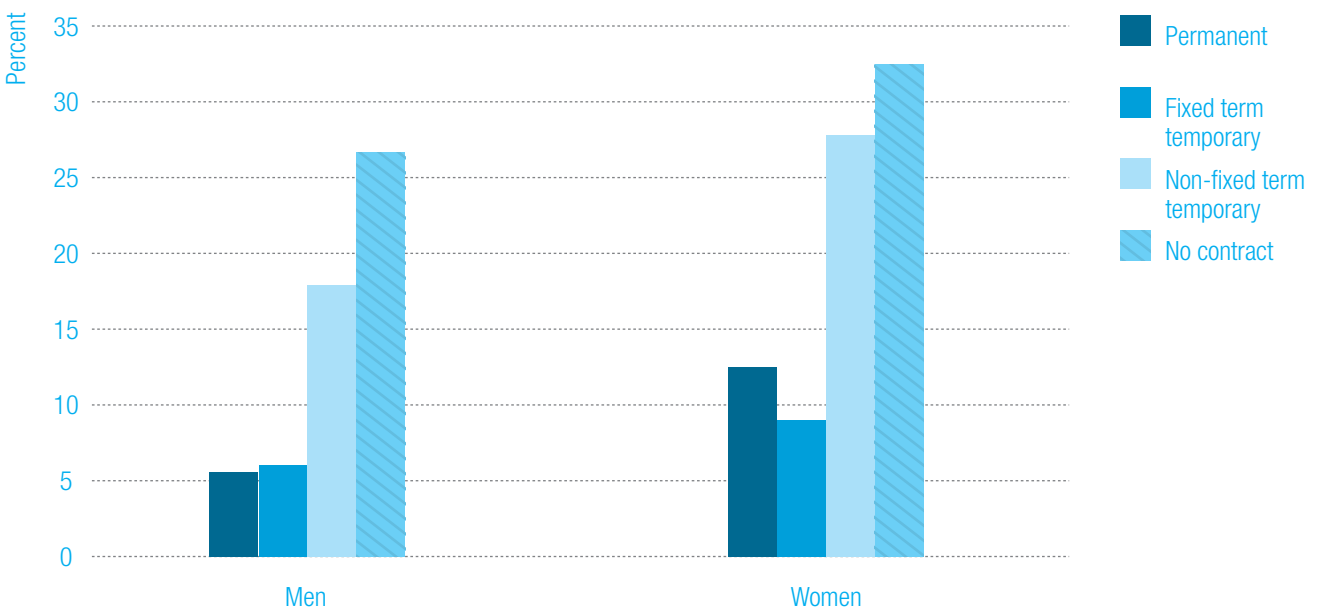
### Evidence for action

Work is the area where many of the important influences on health are played out. This includes both employment conditions and the nature of work itself. A flexible workforce is seen as good for economic competitiveness but brings with it effects on health. Evidence indicates that mortality is significantly higher among temporary workers compared to permanent workers. Poor mental health outcomes are associated with precarious employment (e.g. non-fixed term temporary contracts, being employed with no contract, and part-time work). Workers who perceive work insecurity experience significant adverse effects on their physical and mental health.

The conditions of work also affect health and health equity. Adverse working conditions can expose individuals to a range of physical health hazards and tend to cluster in lower-status occupations. Improved working conditions in high-income countries, hard won over many years of organized action and regulation, are sorely lacking in many middle- and low-income countries. Stress at work is associated with a 50% excess risk of coronary heart disease, and there is consistent evidence that high job demand, low control, and effort–reward imbalance are risk factors for mental and physical health problems.

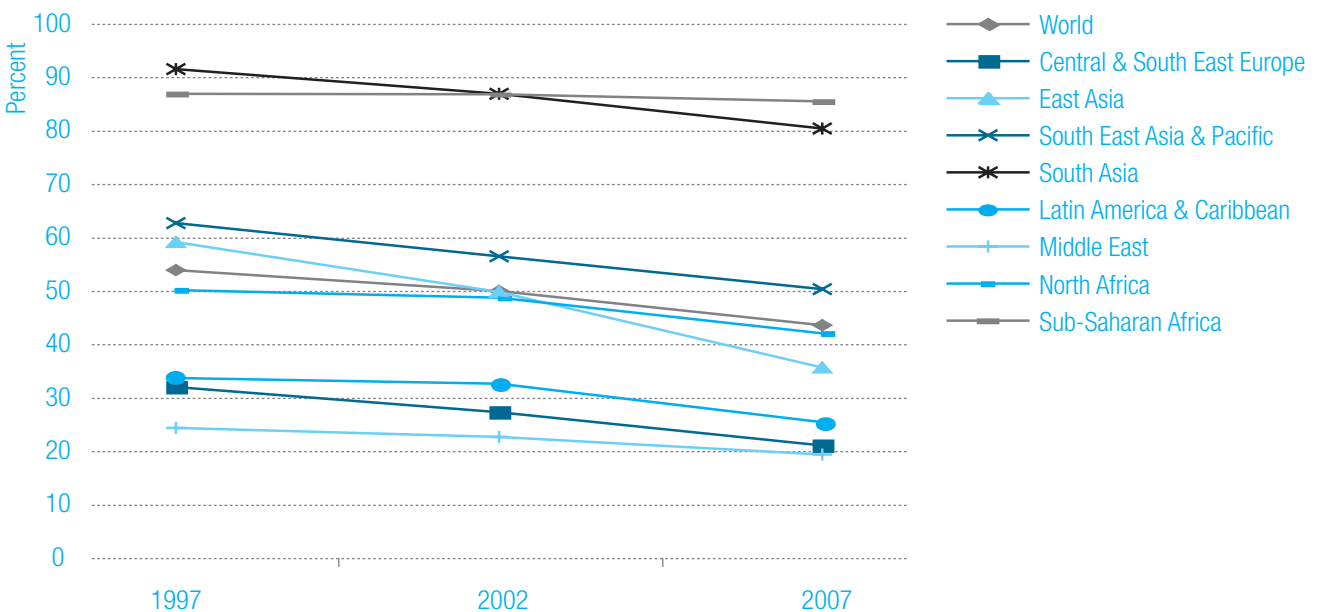


Prevalence of poor mental health among manual workers in Spain by type of contract.



Source: Artazcoz et al., 2005

Regional variation in the percentage of people in work living on US\$ 2/day or less.



2007 figures are preliminary estimates.  
 Reprinted, with permission of the author, from ILO (2008).

# Social Protection Across the Lifecourse

## What must be done

Reducing the health gap in a generation requires that governments build systems that allow a healthy standard of living below which nobody should fall due to circumstances beyond his or her control. Social protection schemes can be instrumental in realizing developmental goals, rather than being dependent on achieving these goals – they can be efficient ways to reduce poverty, and local economies can benefit.

### **Establish and strengthen universal comprehensive social protection policies that support a level of income sufficient for healthy living for all.**

- Progressively increase the generosity of social protection systems towards a level that is sufficient for healthy living.
- Ensure that social protection systems include those normally excluded: those in precarious work, including informal work and household or care work.

All people need social protection across the lifecourse, as young children, in working life, and in old age. People also need protection in case of specific shocks, such as illness, disability, and loss of income or work.

### **Evidence for action**

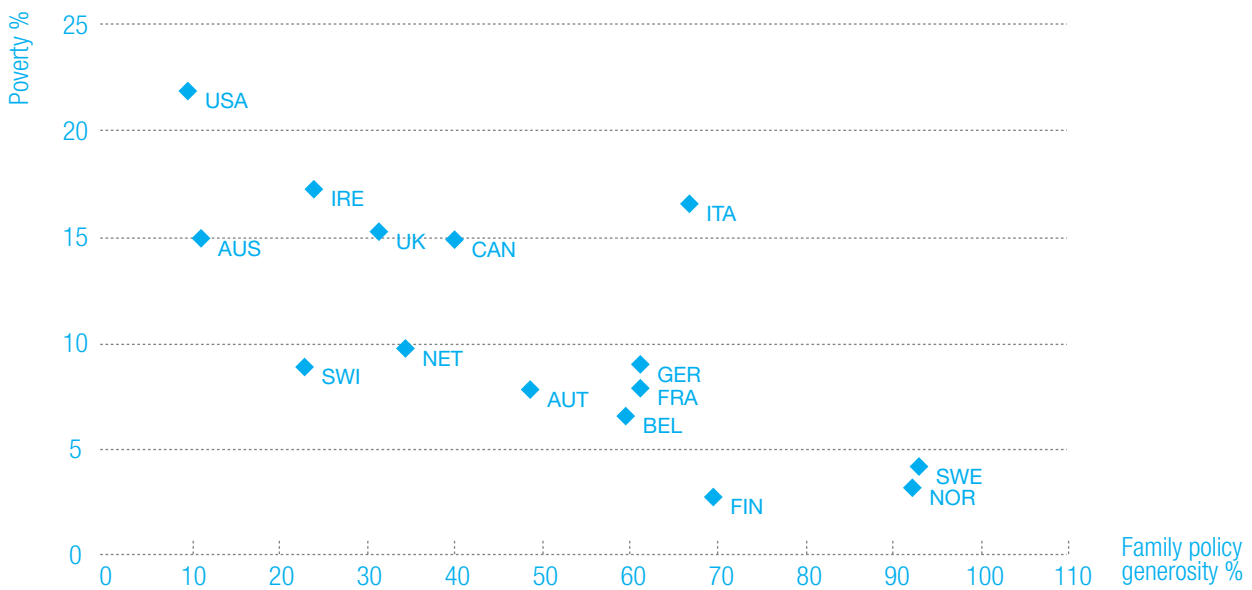
Low living standards are a powerful determinant of health inequity. They influence lifelong trajectories, among others through their effects on ECD. Child poverty and transmission of poverty from generation to generation are major obstacles to improving population health and reducing health inequity. Four out of five people worldwide lack the back-up of basic social security coverage.

Redistributive welfare systems, in combination with the extent to which people can make a healthy living on the labour market, influence poverty levels. Generous universal social protection systems are associated with better population health, including lower excess mortality among the old and lower mortality levels among socially disadvantaged groups. Budgets for social protection tend to be larger, and perhaps more

sustainable, in countries with universal protection systems; poverty and income inequality tend to be smaller in these countries compared to countries with systems that target the poor.

Extending social protection to all people, within countries and globally, will be a major step towards securing health equity within a generation. This includes extending social protection to those in precarious work, including informal work, and household or care work. This is critical for poor countries in which the majority of people work in the informal sector, as well as for women, because family responsibilities often preclude them from accruing adequate benefits under contributory social protection schemes. While limited institutional infrastructure and financial capacity remains an important barrier in many countries, experience across the world shows that it is feasible to start creating social protection systems, even in low-income countries.

Total family policy generosity and child poverty in 20 countries, circa 2000.



Net benefit generosity of transfers as a percentage of an average net production worker's wage. The poverty line is 50% of median equivalized disposable income.  
 AUS = Australia; AUT = Austria; BEL = Belgium; CAN = Canada; FIN = Finland; FRA = France;  
 GER = Germany; IRE = Ireland; ITA = Italy; NET = the Netherlands; NOR = Norway;  
 SWE = Sweden; SWI = Switzerland; UK = the United Kingdom; USA = the United States  
 of America. Reprinted, with permission of the publisher, from Lundberg et al. (2007).



# Universal Health Care

## What must be done

### Build health-care systems based on principles of equity, disease prevention, and health promotion.

- Build quality health-care services with universal coverage, focusing on Primary Health Care.
- Strengthen public sector leadership in equitable health-care systems financing, ensuring universal access to care regardless of ability to pay.

### Build and strengthen the health workforce, and expand capabilities to act on the social determinants of health.

- Invest in national health workforces, balancing rural and urban health-worker density.
- Act to redress the health brain drain, focusing on investment in increased health human resources and training and bilateral agreements to regulate gains and losses.

Access to and utilization of health care is vital to good and equitable health. The health-care system is itself a social determinant of health, influenced by and influencing the effect of other social determinants. Gender, education, occupation, income, ethnicity, and place of residence are all closely linked to people's access to, experiences of, and benefits from health care. Leaders in health care have an important stewardship role across all branches of society to ensure that policies and actions in other sectors improve health equity.

### Evidence for action

Without health care, many of the opportunities for fundamental health improvement are lost. With partial health-care systems, or systems with inequitable provision, opportunities for universal health as a matter of social justice are lost. These are core issues for all countries. More pressingly, for low-income countries, accessible and appropriately designed and managed health-care systems will contribute significantly to the achievement of the Millennium Development Goals (MDGs). Without them, the chances of meeting the MDGs are greatly weakened. Yet health-care systems are appallingly weak in many countries, with massive inequity in provision, access, and use between rich and poor.

The Commission considers health care a common good, not a market commodity. Virtually all high-income countries organize their health-care systems around the principle of universal coverage (combining health financing and provision). Universal coverage requires that everyone within a country can access the same range of (good quality) services according to needs and preferences, regardless of income level, social status, or residency, and that people are empowered to use these services. It extends the same scope of benefits to the whole population. There is no sound argument that other countries, including the poorest, should not aspire to universal health-care coverage, given adequate support over the long term.

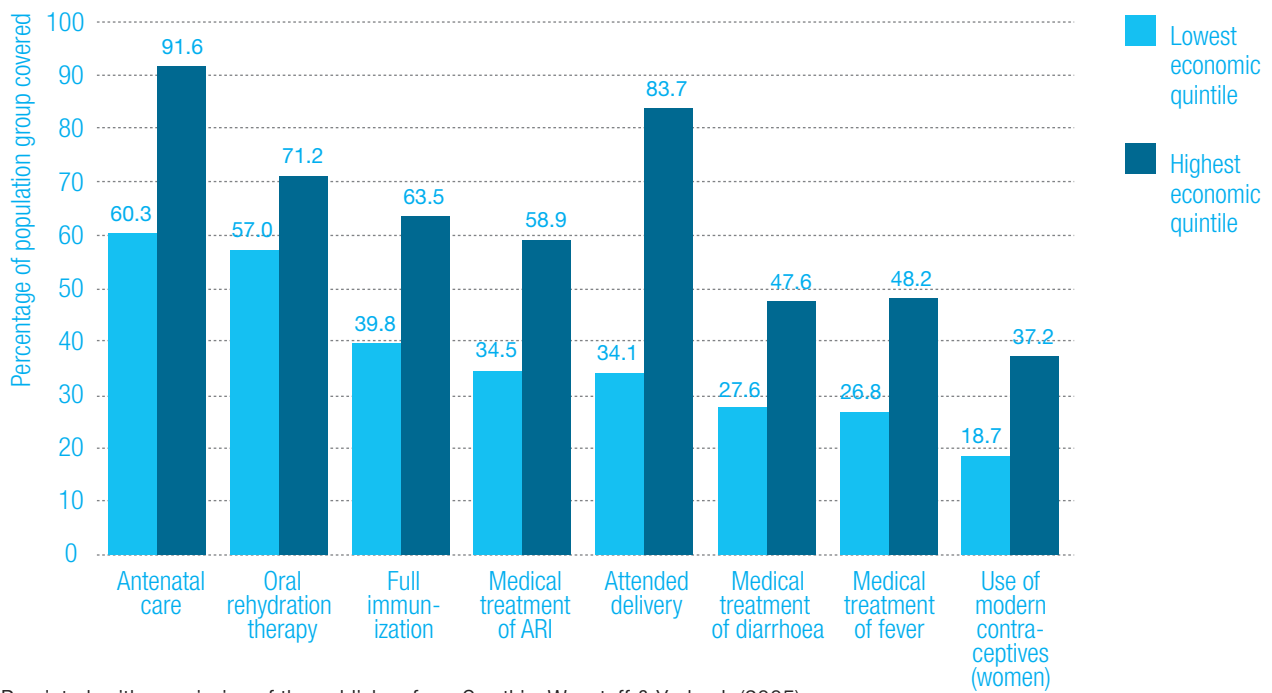
The Commission advocates financing the health-care system through general taxation and/or mandatory universal insurance. Public health-care spending has been found to be redistributive in country after country. The evidence is compellingly in favour of a publicly funded health-care system. In particular, it is vital to minimize out-of-pocket spending on health care. The policy imposition of user fees for health care in low- and middle-income countries has led to an overall reduction in utilization and worsening health outcomes. Upwards of 100 million people are pushed into poverty each year through catastrophic household health costs. This is unacceptable.

Health-care systems have better health outcomes when built on Primary Health Care (PHC) – that is, both the PHC model that emphasizes locally appropriate action across the range of social determinants, where prevention and promotion are in balance with investment in curative interventions, and an emphasis on the primary level of care with adequate referral to higher levels of care.

In all countries, but most pressingly in the poorest and those experiencing brain-drain losses, adequate numbers of appropriately skilled health workers at the local level are fundamental to extending coverage and improving the quality of care. Investment in training and retaining health-care workers is vital to the required growth of health-care systems. This involves global attention to the flows of health personnel as much as national and local attention to investment and skills development. Medical and health practitioners – from WHO to the local clinic – have powerful voices in society's ideas of and decisions about health. They bear witness to the ethical imperative, just as much as the efficiency value, of acting more coherently through the health-care system on the social causes of poor health.



Use of basic maternal and child health services by lowest and highest economic quintiles, 50+ countries.



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## 2. Tackle the Inequitable Distribution of Power, Money, and Resources

Inequity in the conditions of daily living is shaped by deeper social structures and processes. The inequity is systematic, produced by social norms, policies, and practices that tolerate or actually promote unfair distribution of and access to power, wealth, and other necessary social resources.







# Health Equity in All Policies, Systems, and Programmes

## What must be done

### Place responsibility for action on health and health equity at the highest level of government, and ensure its coherent consideration across all policies.

- Make health and health equity corporate issues for the whole of government, supported by the head of state, by establishing health equity as a marker of government performance.
- Assess the impact of all policies and programmes on health and health equity, building towards coherence in all government action.

### Adopt a social determinants framework across the policy and programmatic functions of the ministry of health and strengthen its stewardship role in supporting a social determinants approach across government.

- The health sector itself is a good place to start building supports and structures that encourage action on the social determinants of health and health equity. This requires strong leadership from the minister of health, with support from WHO.

Every aspect of government and the economy has the potential to affect health and health equity – finance, education, housing, employment, transport, and health, just to name six. Coherent action across government, at all levels, is essential for improvement of health equity.

### Evidence for action

Different government policies, depending on their nature, can either improve or worsen health and health equity. Urban planning, for example, that produces sprawling neighbourhoods with little affordable housing, few local amenities, and irregular unaffordable public transport does little to promote good health for all. Good public policy can provide health benefits immediately and in the future.

Policy coherence is crucial – this means that different government departments' policies complement rather than contradict each other in relation to the production of health and health equity. For example, trade policy that actively encourages the unfettered production, trade, and consumption

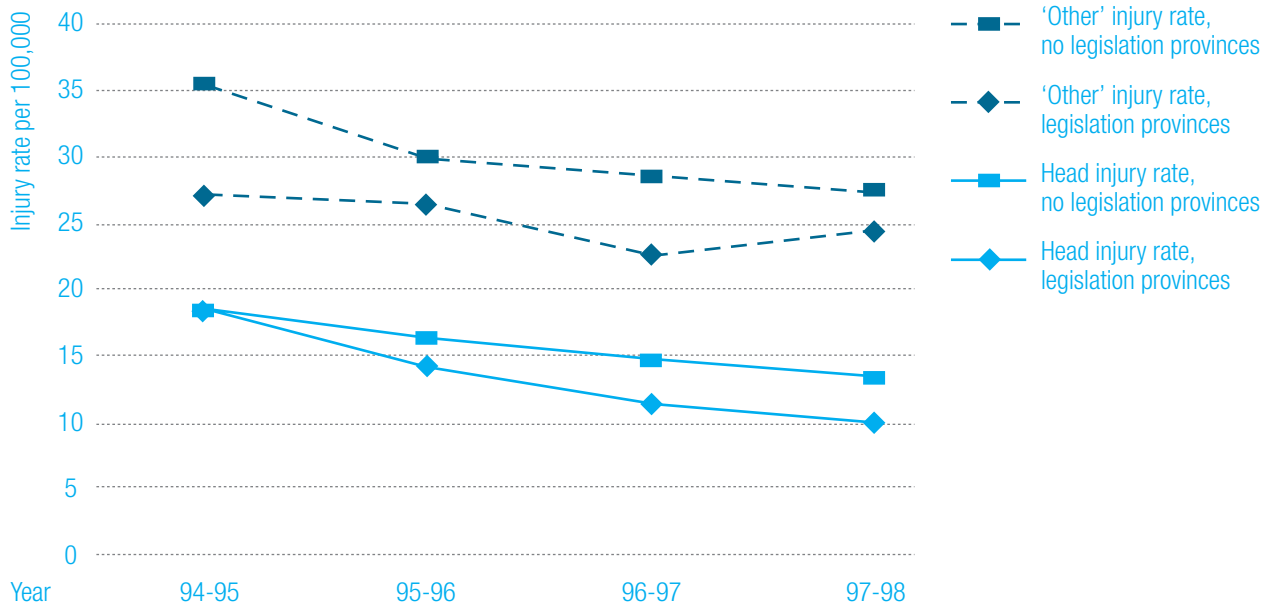
of foods high in fats and sugars to the detriment of fruit and vegetable production is contradictory to health policy, which recommends relatively little consumption of high-fat, high-sugar foods and increased consumption of fruit and vegetables. Intersectoral action (ISA) for health – coordinated policy and action among health and non-health sectors – can be a key strategy to achieve this.

Reaching beyond government to involve civil society and the voluntary and private sectors is a vital step towards action for health equity. The increased incorporation of community engagement and social participation in policy processes helps to ensure fair decision-making on health equity issues. And health is a rallying point for different sectors and actors – whether it is a local community designing a health plan for themselves (Dar es Salaam, United Republic of Tanzania's Healthy City Programme) or involving the entire community including local government in designing spaces that encourage walking and cycling (Healthy by Design, Victoria, Australia).

Making health and health equity a shared value across sectors is a politically challenging strategy but one that is needed globally.



Changes in bicycle-related head and other injuries in Canadian provinces with and without mandatory helmet legislation.



Legislation introduced across provinces between 1995 and 1997.  
 Reprinted, with permission of the publisher, from Macpherson et al. (2002).



# Fair Financing

## What must be done

### Strengthen public finance for action on the social determinants of health.

- Build national capacity for progressive taxation and assess potential for new national and global public finance mechanisms.

### Increase international finance for health equity, and coordinate increased finance through a social determinants of health action framework.

- Honour existing commitments by increasing global aid to the 0.7% of GDP commitment, and expand the Multilateral Debt Relief Initiative; enhance action on health equity by developing a coherent social determinants of health focus in existing frameworks such as the Poverty Reduction Strategy Paper.

### Fairly allocate government resources for action on the social determinants of health.

- Establish mechanisms to finance cross-government action on social determinants of health, and to allocate finance fairly between geographical regions and social groups.

Public finance to fund action across the social determinants of health is fundamental to welfare and to health equity.

### Evidence for action

For countries at all levels of economic development, increasing public finance to fund action across the social determinants of health – from child development and education, through living and working conditions, to health care – is fundamental to welfare and health equity. Evidence shows that the socioeconomic development of rich countries was strongly supported by publicly financed infrastructure and progressively universal public services. The emphasis on public finance, given the marked failure of markets to supply vital goods and services equitably, implies strong public sector leadership and adequate public expenditure. This in turn implies progressive taxation – evidence shows that modest levels of redistribution have considerably greater impact on poverty reduction than economic growth alone. And, in the case of poorer countries, it implies much greater international financial assistance.

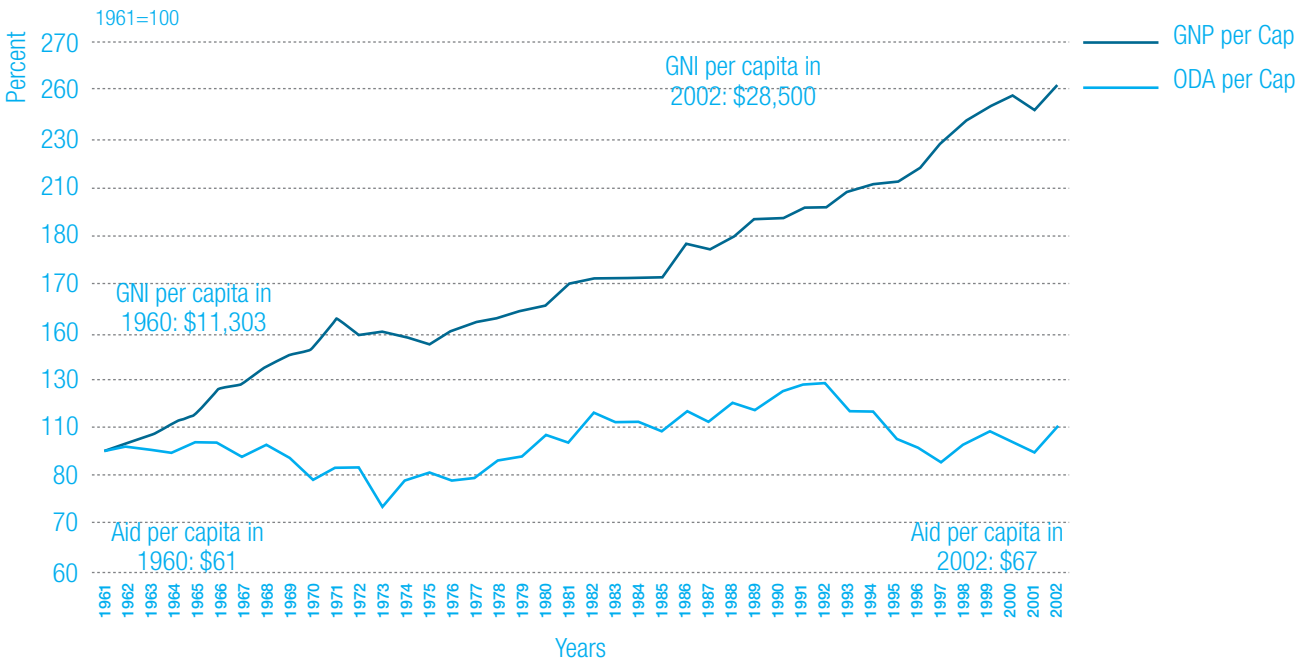
Low-income countries often have relatively weak direct tax institutions and mechanisms and a majority of the workforce operating in the informal sector. They have relied in many cases on indirect taxes such as trade tariffs for government income. Economic agreements between rich and poor countries that require tariff reduction can reduce available domestic revenue in low-income countries before alternative streams of finance have been established. Strengthened progressive tax capacity is an important source of public finance and a necessary prerequisite of any further tariff-cutting agreements. At the same time, measures to combat the use of offshore financial centres to reduce unethical avoidance of national tax regimes could provide resources for development at least comparable to those made available through new taxes. As globalization increases interdependence among countries, the argument for global approaches to taxation becomes stronger.

Aid is important. While the evidence suggests that it can and does promote economic growth, and can contribute more directly to better health, the view of the Commission is that aid's primary value is as a mechanism for the reasonable distribution of resources in the common endeavour of social development. But the volume of aid is appallingly low. It is low in absolute terms (both generic and health specific); relative to wealth in donor countries; relative to the commitment to a level of aid approximating 0.7% of their gross domestic product (GDP) made by donors in 1969; and relative to the amounts required for sustainable impact on the MDGs. A step-shift increase is required. Independent of increased aid, the Commission urges wider and deeper debt relief.

The quality of aid must be improved too – following the Paris agreement – focusing on better coordination among donors and stronger alignment with recipient development plans. Donors should consider channelling most of their aid through a single multilateral mechanism, while poverty reduction planning at the national and local levels in recipient countries would benefit from adopting a social determinants of health framework to create coherent, cross-sectoral financing. Such a framework could help to improve the accountability of recipient countries in demonstrating how aid is allocated, and what impact it has. In particular, recipient governments should strengthen their capacity and accountability to allocate available public finance equitably across regions and among population groups.



The growing gap: per capita aid from donor countries relative to per capita wealth, 1960–2000.



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# Market Responsibility

## What must be done

### **Institutionalize consideration of health and health equity impact in national and international economic agreements and policy-making.**

- Institutionalize and strengthen technical capacities in health equity impact assessment of all international and national economic agreements.
- Strengthen representation of health actors in domestic and international economic policy negotiations.

### **Reinforce the primary role of the state in the provision of basic services essential to health (such as water/sanitation) and the regulation of goods and services with a major impact on health (such as tobacco, alcohol, and food).**

Markets bring health benefits in the form of new technologies, goods and services, and improved standard of living. But the marketplace can also generate negative conditions for health in the form of economic inequalities, resource depletion, environmental pollution, unhealthy working conditions, and the circulation of dangerous and unhealthy goods.

### **Evidence for action**

Health is not a tradable commodity. It is a matter of rights and a public sector duty. As such, resources for health must be equitable and universal. There are three linked issues. First, experience shows that commercialization of vital social goods such as education and health care produces health inequity. Provision of such vital social goods must be governed by the public sector, rather than being left to markets. Second, there needs to be public sector leadership in effective national and international regulation of products, activities, and conditions that damage health or lead to health inequities. These together mean that, third, competent, regular health equity impact assessment of all policy-making and market regulation should be institutionalized nationally and internationally.

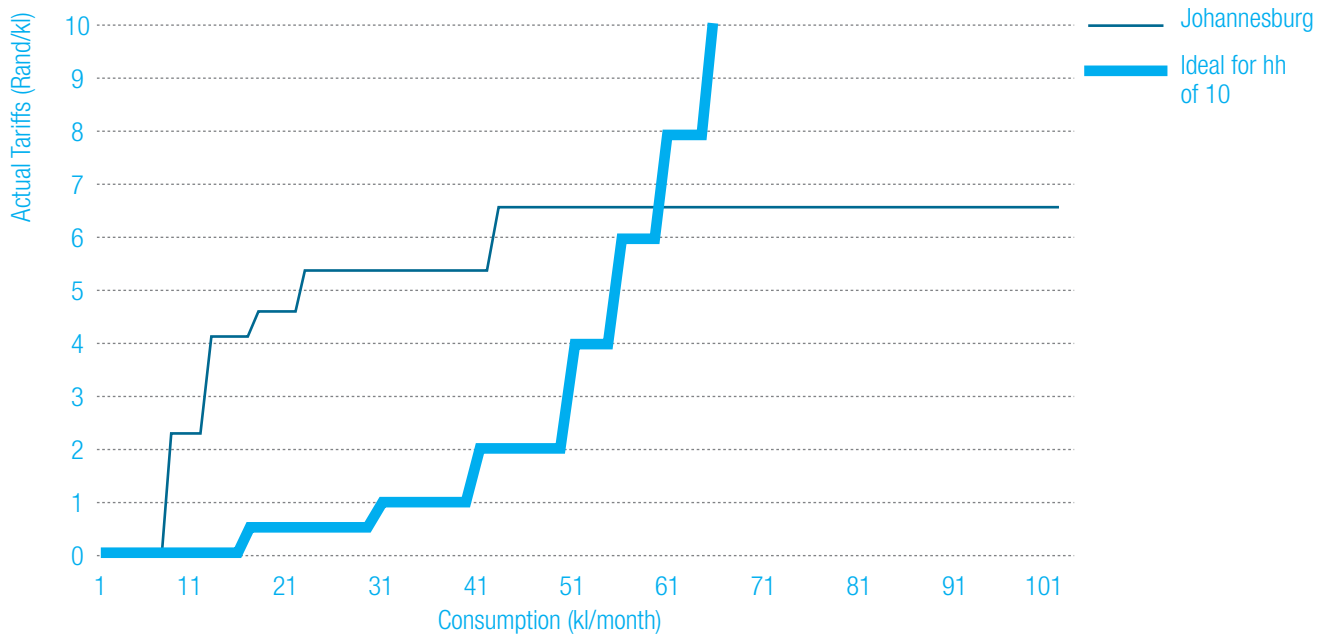
The Commission views certain goods and services as basic human and societal needs – access to clean water, for example, and health care. Such goods and services must be made available universally regardless of ability to pay. In such instances, therefore, it is the public sector rather than the marketplace that underwrites adequate supply and access.

With respect both to ensuring the provision of goods and services vital to health and well-being – for example, water, health care, and decent working conditions – and controlling the circulation of health-damaging commodities (for example, tobacco and alcohol), public sector leadership needs to be robust. Conditions of labour and working conditions are – in many countries, rich and poor – all too often inequitable, exploitative, unhealthy, and dangerous. The vital importance of good labour and work to a healthy population and a healthy economy demands public sector leadership in ensuring progressive fulfilment of global labour standards while also ensuring support to the growth of micro-level enterprises. Global governance mechanisms – such as the Framework Convention on Tobacco Control – are required with increasing urgency as market integration expands and accelerates circulation of and access to health-damaging commodities. Processed foods and alcohol are two prime candidates for stronger global, regional, and national regulatory controls.

In recent decades, under globalization, market integration has increased. This is manifested in new production arrangements, including significant changes in labour, employment, and working conditions, expanding areas of international and global economic agreements, and accelerating commercialization of goods and services – some of them undoubtedly beneficial for health, some of them disastrous. The Commission urges that caution be applied by participating countries in the consideration of new global, regional, and bilateral economic – trade and investment – policy commitments. Before such



Johannesburg water pricing. The existing subsidy structure (thin line) favours richer consumers (and allows over-use), while the ideal tariff structure (thick line) favours adequate subsidized supply to poorer consumers with disincentives for higher use.



hh = households.

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commitments are made, understanding the impact of the existing framework of agreements on health, the social determinants of health, and health equity is vital. Further, assessment of health impacts over time suggests strongly that flexibility, allowing signatory countries to modify their commitment to international agreements if there is adverse impact on health or health equity, should be established at the outset, with transparent criteria for triggering modification.

Public sector leadership does not displace the responsibilities and capacities of other actors: civil society and the private sector. Private sector actors are influential, and have the power to do much for global health equity. To date, though, initiatives such as those under corporate social responsibility have shown limited evidence of real impact. Corporate social responsibility may be a valuable way forward, but evidence is needed to demonstrate this. Corporate accountability may well be a stronger basis on which to build a responsible and collaborative relationship between the private sector and public interest.

# Gender Equity

## What must be done

Gender inequities are unfair; they are also ineffective and inefficient. By supporting gender equity, governments, donors, international organizations, and civil society can improve the lives of millions of girls and women and their families.

**Address gender biases in the structures of society – in laws and their enforcement, in the way organizations are run and interventions designed, and the way in which a country’s economic performance is measured.**

- Create and enforce legislation that promotes gender equity and makes discrimination on the basis of sex illegal.
- Strengthen gender mainstreaming by creating and financing a gender equity unit within the central administration of governments and international institutions.

- Include the economic contribution of housework, care work, and voluntary work in national accounts.

**Develop and finance policies and programmes that close gaps in education and skills, and that support female economic participation.**

- Invest in formal and vocational education and training, guarantee pay-equity by law, ensure equal opportunity for employment at all levels, and set up family-friendly policies.

**Increase investment in sexual and reproductive health services and programmes, building to universal coverage and rights.**

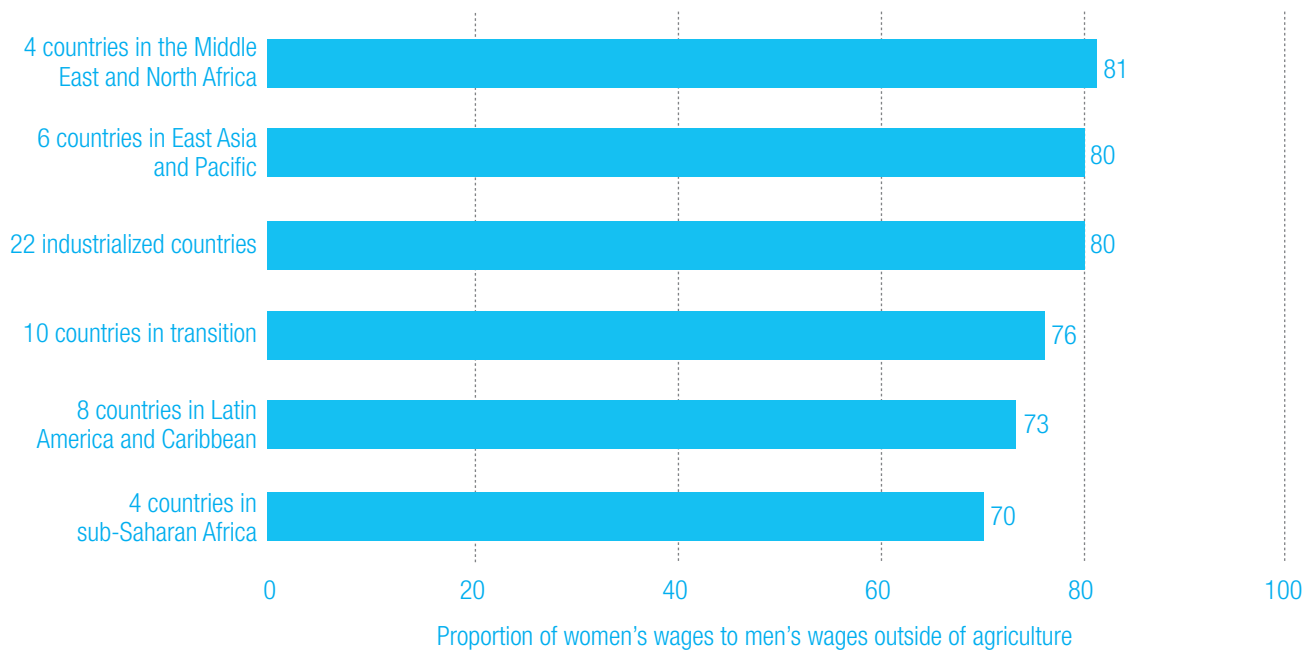
Reducing the health gap in a generation is only possible if the lives of girls and women – about half of humanity – are improved and gender inequities are addressed. Empowerment of women is key to achieving fair distribution of health.

### Evidence for action

Gender inequities are pervasive in all societies. Gender biases in power, resources, entitlements, norms and values, and the way in which organizations are structured and programmes are run damage the health of millions of girls and women. The position of women in society is also associated with child health and survival – of boys and girls. Gender inequities influence health through, among other routes, discriminatory feeding patterns, violence against women, lack of decision-making power, and unfair divisions of work, leisure, and possibilities of improving one’s life.

Gender inequities are socially generated and therefore can be changed. While the position of women has improved dramatically over the last century in many countries, progress has been uneven and many challenges remain. Women earn less than men, even for equivalent work; girls and women lag behind in education and employment opportunities. Maternal mortality and morbidity remain high in many countries, and reproductive health services remain hugely inequitably distributed within and between countries. The intergenerational effects of gender inequity make the imperative to act even stronger. Acting now, to improve gender equity and empower women, is critical for reducing the health gap in a generation.

Nominal wages for women are significantly lower than for men.



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# Political Empowerment – Inclusion and Voice

## What must be done

**Empower all groups in society through fair representation in decision-making about how society operates, particularly in relation to its effect on health equity, and create and maintain a socially inclusive framework for policy-making.**

- Strengthen political and legal systems to protect human rights, assure legal identity and support the needs and claims of marginalized groups, particularly Indigenous Peoples.

- Ensure the fair representation and participation of individuals and communities in health decision-making as an integral feature of the right to health.

**Enable civil society to organize and act in a manner that promotes and realizes the political and social rights affecting health equity.**

Being included in the society in which one lives is vital to the material, psychosocial, and political empowerment that underpins social well-being and equitable health.

### Evidence for action

The right to the conditions necessary to achieve the highest attainable standard of health is universal. The risk of these rights being violated is the result of entrenched structural inequities.

Social inequity manifests across various intersecting social categories such as class, education, gender, age, ethnicity, disability, and geography. It signals not simply difference but hierarchy, and reflects deep inequities in the wealth, power, and prestige of different people and communities. People who are already disenfranchised are further disadvantaged with respect to their health – having the freedom to participate in economic, social, political, and cultural relationships has intrinsic value. Inclusion, agency, and control are each important for social development, health, and well-being. And restricted participation results in deprivation of human capabilities, setting the context for inequities in, for example, education, employment, and access to biomedical and technical advances.

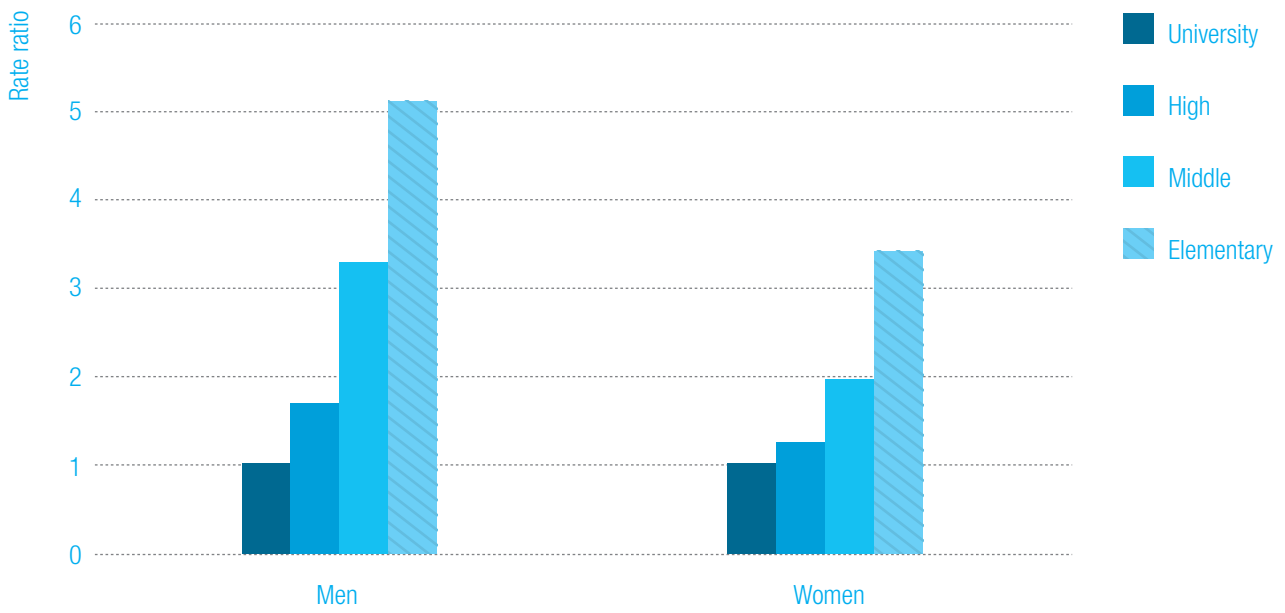
Any serious effort to reduce health inequities will involve changing the distribution of power within society and global regions, empowering individuals and groups to represent strongly and effectively their needs and interests and, in so doing, to challenge and change the unfair and steeply graded distribution of social resources (the conditions for health) to which all, as citizens, have claims and rights.

Changes in power relationships can take place at various levels, from the ‘micro’ level of individuals, households, or communities to the ‘macro’ sphere of structural relations among economic, social, and political actors and institutions. While the empowerment of social groups through their representation in policy-related agenda-setting and decision-making is critical to realize a comprehensive set of rights and ensure the fair distribution of essential material and social goods among population groups, so too is empowerment for action through bottom-up, grassroots approaches. Struggles against the injustices encountered by the most disadvantaged in society, and the process of organizing these people, builds local people’s leadership. It can be empowering. It gives people a greater sense of control over their lives and future.

Community or civil society action on health inequities cannot be separated from the responsibility of the state to guarantee a comprehensive set of rights and ensure the fair distribution of essential material and social goods among population groups. Top-down and bottom-up approaches are equally vital.



Age-adjusted mortality among men and women of the Republic of Korea by educational attainment, 1993–1997.



Source: Son et al., 2002



# Good Global Governance

## What must be done

### **Make health equity a global development goal, and adopt a social determinants of health framework to strengthen multilateral action on development.**

- The United Nations, through WHO and the Economic and Social Council, to adopt health equity as a core global development goal and use a social determinants of health indicators framework to monitor progress.

- The United Nations to establish multilateral working groups on thematic social determinants of health – initially early child development, gender equity, employment and working conditions, health-care systems, and participatory governance.

### **Strengthen WHO leadership in global action on the social determinants of health, institutionalizing social determinants of health as a guiding principle across WHO departments and country programmes.**

Dramatic differences in the health and life chances of peoples around the world reflect imbalance in the power and prosperity of nations. The undoubted benefits of globalization remain profoundly unequally distributed.

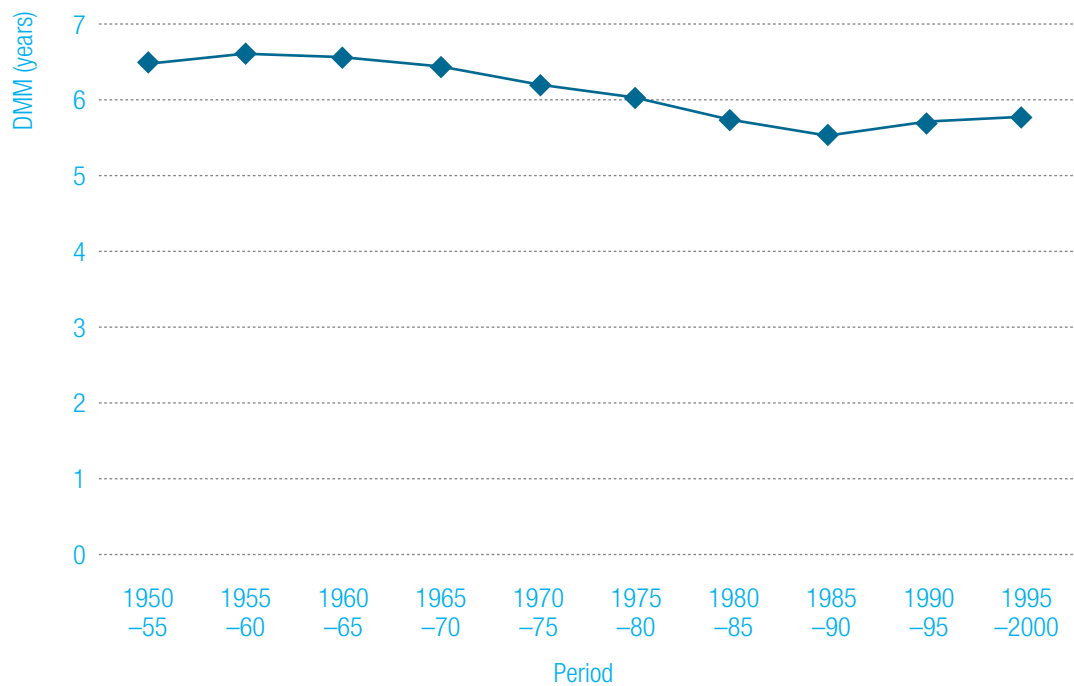
### **Evidence for action**

The post-war period has seen massive growth. But growth in global wealth and knowledge has not translated into increased global health equity. Rather than convergence, with poorer countries catching up to the Organisation for Economic Cooperation and Development, the latter period of globalization (after 1980) has seen winners and losers among the world's countries, with particularly alarming stagnation and reversal in life expectancy at birth in sub-Saharan Africa and some of the former Soviet Union countries. Progress in global economic growth and health equity made between 1960 and 1980 has been significantly dampened in the subsequent

period (1980–2005), as global economic policy influence hit hard at social sector spending and social development. Also associated with the second (post-1980) phase of globalization, the world has seen significant increase in, and regularity of, financial crises, proliferating conflicts, and forced and voluntary migration.

Through the recognition, under globalization, of common interests and interdependent futures, it is imperative that the international community re-commits to a multilateral system in which all countries, rich and poor, engage with an equitable voice. It is only through such a system of global governance, placing fairness in health at the heart of the development agenda and genuine equality of influence at the heart of its decision-making, that coherent attention to global health equity is possible.

Trend in the dispersion measure of mortality (DMM) for life expectancy at birth, 1950–2000.



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# 3. Measure and Understand the Problem and Assess the Impact of Action

The world is changing fast and often it is unclear the impact that social, economic, and political change will have on health in general and on health inequities within countries or across the globe in particular. Action on the social determinants of health will be more effective if basic data systems, including vital registration and routine monitoring of health inequity and the social determinants of health, are in place and there are mechanisms to ensure that the data can be understood and applied to develop more effective policies, systems, and programmes. Education and training in social determinants of health are vital.





# The Social Determinants of Health: Monitoring, Research, and Training

## What must be done

There is enough evidence on the social determinants of health to act now. Governments, supported by international organizations, can make action on the social determinants of health even more effective by improving local, national, and international monitoring, research, and training infrastructures.

### **Ensure that routine monitoring systems for health equity and the social determinants of health are in place, locally, nationally, and internationally.**

- Ensure that all children are registered at birth without financial cost to the household.
- Establish national and global health equity surveillance systems with routine collection of data on social determinants and health inequity.

### **Invest in generating and sharing new evidence on the ways in which social determinants influence population health and health equity and on the effectiveness of measures to reduce health inequities through action on social determinants.**

- Create a dedicated budget for generation and global sharing of evidence on social determinants of health and health equity.

### **Provide training on the social determinants of health to policy actors, stakeholders, and practitioners and invest in raising public awareness.**

- Incorporate the social determinants of health into medical and health training, and improve social determinants of health literacy more widely. Train policy-makers and planners in the use of health equity impact assessment.
- Strengthen capacity within WHO to support action on the social determinants of health.

No data often means no recognition of the problem. Good evidence on levels of health and its distribution, and on the social determinants of health, is essential for understanding the scale of the problem, assessing the effects of actions, and monitoring progress.

### **Evidence for action**

Experience shows that countries without basic data on mortality and morbidity by socioeconomic indicators have difficulties moving forward on the health equity agenda. Countries with the worst health problems, including countries in conflict, have the least good data. Many countries do not even have basic systems to register all births and deaths. Failing birth registration systems have major implications for child health and developmental outcomes.

The evidence base on health inequity, the social determinants of health, and what works to improve them needs further strengthening. Unfortunately, most health research funding remains overwhelmingly biomedically focused. Also, much

research remains gender biased. Traditional hierarchies of evidence (which put randomized controlled trials and laboratory experiments at the top) generally do not work for research on the social determinants of health. Rather, evidence needs to be judged on fitness for purpose – that is, does it convincingly answer the question asked.

Evidence is only one part of what swings policy decisions – political will and institutional capacity are important too. Policy actors need to understand what affects population health and how the gradient operates. Action on the social determinants of health also requires capacity building among practitioners, including the incorporation of teaching on social determinants of health into the curricula of health and medical personnel.



## Unregistered births (in thousands) in 2003 by region and level of development.

Region	Births	Unregistered children, n (%)
World	133 028	48 276 (36%)
Sub-Saharan Africa	26 879	14 751 (55%)
Middle East and North Africa	9790	1543 (16%)
South Asia	37 099	23 395 (63%)
East Asia and Pacific	31 616	5901 (19%)
Latin America and Caribbean	11 567	1787 (15%)
CEE/CIS and Baltic States	5250	1218 (23%)
Industrialized countries	10 827	218 (2%)
Developing countries	119 973	48 147 (40%)
Least developed countries	27 819	19 682 (71%)

CEE = Central and Eastern Europe; CIS = Commonwealth of Independent States.

Source: UNICEF, 2005



# Actors

Above, we set out the key actions called for in the recommendations. Here, we describe those on whom effective action depends. The role of governments through public sector action is fundamental to health equity. But the role is not government's alone. Rather, it is through the democratic processes of civil society participation and public policy-making, supported at the regional and global levels, backed by the research on what works for health equity, and with the collaboration of private actors, that real action for health equity is possible.

## Multilateral agencies

An overarching Commission recommendation is the need for intersectoral coherence – in policy-making and action – to enhance effective action on the social determinants of health and achieve improvements in health equity. Multilateral specialist and financing agencies can do much to strengthen their collective impact on the social determinants of health and health equity, including:

- *Coherence in global monitoring and action:* Adopt health equity as a fundamental shared goal, and use a common global framework of indicators to monitor development progress; and collaborate in multi-agency thematic working groups for coherent social determinants of health action.
- *Coherent and accountable financing:* Ensure that increases in aid and debt relief support coherent social determinants of health policy-making and action among recipient governments, using health equity and social determinants of health performance indicators as core conditions of recipient accountability.
- *Improved participation of UN Member States in global governance:* Support equitable participation of Member States and other stakeholders in global policy-making fora.

## WHO

WHO is the mandated leader in global health. It is time to enhance WHO's leadership role through the agenda for action on the social determinants of health and global health equity. This involves a range of actions, including:

- *Policy coherence globally and nationally:* Adopt a stewardship role supporting social determinants of health capacity-building and policy coherence across partner agencies in the multilateral system; strengthen technical capacity globally and among Member States for representation of public health in all major multilateral fora; and support Member States in developing mechanisms for coherent policy and ISA for social determinants of health.
- *Measurement and evaluation:* Support goal-setting on health equity and monitoring progress on health equity between and within countries as a core developmental objective; support the establishment of national health equity surveillance systems in Member States, and build necessary technical capacities in countries; support Member States in development and use of health equity impact assessment tools and other health equity-related tools such as a national equity gauge; and convene a regular global meeting as part of a periodic review of the global situation.
- *Enhancing WHO capacity:* Build internal social determinants of health capacity across the WHO, from headquarters, through the Regional Offices, to Country Programmes.

## National and local government

Underpinning action on the social determinants of health and health equity is an empowered public sector, based on principles of justice, participation, and intersectoral collaboration. This will require strengthening of the core functions of government and public institutions, nationally and sub-nationally, particularly in relation to policy coherence, participatory governance, planning, regulation development and enforcement, and standard-setting. It also depends on strong leadership and stewardship from the ministry of health, supported by WHO. Government actions include:

- *Policy coherence across government:* Place responsibility for action on health and health equity at the highest level of government, and ensure its coherent consideration across all ministerial and departmental policy-making. Ministers of health can help bring about global change – they will be pivotal in helping to create buy-in by the head of state and from other ministries.
- *Strengthening action for equity:* Commit to progressive building of universal health-care services; establish a central gender unit to promote gender equity across government policy-making; improve rural livelihoods, infrastructure investment, and services; upgrade slums and strengthen locally participatory health urban planning; invest in full employment and decent labour policy and programmes; invest in ECD; build towards universal provision in vital social determinants of health services and programmes regardless of ability to pay, supported by a universal programme of social protection; and establish a national framework for regulatory control over health-damaging commodities.

- *Finance*: Streamline incoming international finance (aid, debt relief) through a social determinants of health action framework, with transparent accountability; strengthen revenue through improved progressive domestic taxation; and collaborate with other Member States in the development of regional and/or global proposals for new sources of international public finance.
- *Measurement, evaluation, and training*: Build towards universal birth registration; set cross-government performance indicators for health equity through the establishment of a national health equity surveillance system; build capacity to use health equity impact assessment as a standard protocol in all major policy-making; ensure training of practitioners and policy-makers on the social determinants of health; and raise public awareness of the social determinants of health.

### Civil society

Being included in the society in which one lives is vital to the material, psychosocial, and political aspects of empowerment that underpin social well-being and equitable health. As community members, grassroots advocates, service and programme providers, and performance monitors, civil society actors from the global to the local level constitute a vital bridge between policies and plans and the reality of change and improvement in the lives of all. Helping to organize and promote diverse voices across different communities, civil society can be a powerful champion of health equity. Many of the actions listed above will be, at least in part, the result of pressure and encouragement from civil society; many of the milestones towards health equity in a generation will be marked – achieved or missed – by the attentive observation of civil society actors. Civil society can play an important role in actions on the social determinants of health through:

- *Participation in policy, planning, programmes, and evaluation*: Participate in social determinants of health policy-making, planning, programme delivery, and evaluation from the global level, through national intersectoral fora, to the local level of needs assessments, service delivery, and support; and monitor service quality, equity, and impact.
- *Monitoring performance*: Monitor, and report and campaign on, specific social determinants of health, such as upgrading of and services in slums, formal and non-formal employment conditions, child labour, indigenous rights, gender equity, health and education services, corporate activities, trade agreements, and environmental protection.

### Private sector

The private sector has a profound impact on health and well-being. Where the Commission reasserts the vital role of public sector leadership in acting for health equity, this does not imply a relegation of the importance of private sector activities. It does, though, imply the need for recognition of potentially adverse impacts, and the need for responsibility in regulation with regard to those impacts. Alongside controlling undesirable effects on health and health equity, the vitality of the private sector has much to offer that could enhance health and well-being. Actions include:

- *Strengthening accountability*: Recognize and respond accountably to international agreements, standards, and codes of employment practice; ensure employment and working conditions are fair for men and women; reduce and eradicate child labour, and ensure compliance with occupational health and safety standards; support educational and vocational training opportunities as part of employment conditions, with special emphasis on opportunities for women; and ensure private sector activities and services (such as production and patenting of life-saving medicines, provision of health insurance schemes) contribute to and do not undermine health equity.
- *Investing in research*: Commit to research and development in treatment for neglected diseases and diseases of poverty, and share knowledge in areas (such as pharmaceutical patents) with life-saving potential.

### Research institutions

Knowledge – of what the health situation is, globally, regionally, nationally, and locally; of what can be done about that situation; and of what works effectively to alter health inequity through the social determinants of health – is at the heart of the Commission and underpins all its recommendations. Research is needed. But more than simply academic exercises, research is needed to generate new understanding and to disseminate that understanding in practical accessible ways to all the partners listed above. Research on and knowledge of the social determinants of health and ways to act for health equity will rely on continuing commitments among academics and practitioners, but it will rely on new methodologies too – recognizing and utilizing a range of types of evidence, recognizing gender bias in research processes, and recognizing the added value of globally expanded Knowledge Networks and communities. Actions in this field of actors include:

- *Generating and disseminating social determinants of health knowledge*: Ensure research funding is allocated to social determinants of health work; support the global health observatory and multilateral, national, and local cross-sectoral working through development and testing of social determinants of health indicators and intervention impact evaluation; establish and expand virtual networks and clearing houses organized on the principles of open access, managed to enhance accessibility from sites in all high-, middle-, and low-income settings; contribute to reversal of the brain drain from low- and middle-income countries; and address and remove gender biases in research teams, proposals, designs, practices, and reports.



# Is closing the health gap in a generation feasible?

This question – is closing the health gap in a generation feasible – has two clear answers. If we continue as we are, there is no chance at all. If there is a genuine desire to change, if there is a vision to create a better and fairer world where people's life chances and their health will no longer be blighted by the accident of where they happen to be born, the colour of their skin, or the lack of opportunities afforded to their parents, then the answer is: we could go a long way towards it.

Action can be taken, as we show throughout the report. But coherent action must be fashioned across the determinants – across the fields of action set out above – rooting out structural inequity as much as ensuring more immediate well-being. To achieve this will take changes starting at the beginning of life and acting through the whole lifecourse. In calling to close the gap in a generation we do not imagine that the social gradient in health within countries, or the dramatic differences between countries, will be abolished in 30 years. But the evidence, produced in the Final Report, both on the speed with which health can improve and the means needed to achieve change, encourage us that significant closing of the gap is indeed achievable.

This is a long-term agenda, requiring investment starting now, with major changes in social policies, economic arrangements, and political action. At the centre of this action should be the empowerment of people, communities, and countries that currently do not have their fair share. The knowledge and the means to change are at hand and are brought together in this report. What is needed now is the political will to implement these eminently difficult but feasible changes. Not to act will be seen, in decades to come, as failure on a grand scale to accept the responsibility that rests on all our shoulders.





Reducing health inequities is, for the Commission on Social Determinants of Health, an ethical imperative. Social injustice is killing people on a grand scale.