

Policies for health: Why a social determinants framework is needed now

Ruth Bell and Michael Marmot

Social justice and two principles

The World Health Organization (WHO) Commission on Social Determinants of Health (CSDH), in the spirit of social justice, had achievement of health equity as its mission. It defined health inequities as those systematic inequalities in health outcomes between social groups judged to be avoidable by reasonable means. Two key principles underpinned its recommendations.

One is that all sectors of government impact on health. For a country to improve health and achieve a fairer distribution of health, it needs not only to work within the Ministry of Health towards universal health coverage, but also across government and society to improve the conditions in which people are born, grow, live, work and age, and the distribution of power, money and resources that shape these conditions – collectively known as the social determinants of health.

The second principle is empowerment in three dimensions: material – having the material conditions necessary to live a healthy life;

psychosocial – having control over one's life; and political – having a voice and fair representation in decision-making. These dimensions of empowerment operate at the individual level, within communities and at the level of countries.

These two principles apply just as much to high-income countries as to middle- and low-income countries. Within countries at all levels of development there is recognition that action on the wider social determinants of health is necessary to tackle health inequities and improve overall population health. Progress toward health equity will not be achieved by universal health coverage alone, important as that is.

Social determinants approach and UHC both needed

Within low- and middle-income countries, the Millennium Development Goals (MDGs) have provided a framework and indicators to measure progress in the conditions in which people live – progress in poverty reduction; elimination of hunger; universal access to primary education; women's empowerment; reductions in child and maternal mortality; combating HIV/AIDS, malaria and other infectious diseases; environmental sustainability (including clean water and sanitation); and global partnerships for development. With the notable exception of gender, the MDGs do not focus on inequities within countries; hence a country's overall progress may mask large within-country inequity.

As Commonwealth countries and countries globally consider how to shape the future development agenda post-2015, it is time to reflect on progress towards these goals and the implications for health and the distribution of health.

The United Nations' Millennium Development Goals report of 2013 gives the most recent assessment of progress towards the goals. The number of people in extreme poverty has been halved and the proportion of undernourished people in developing countries has decreased from 23 per cent in 1990–92 to 15 per cent in 2010–12 (MDG 1). The geography of extreme poverty has changed. Most of the reduction in the proportion of people living under US\$1.25 a day is accounted for by China. A quarter of the world's poorest now live in low-income countries, half of the world's poor live in India and China (classified by the World Bank as lower middle-income and upper middle-income countries, respectively) and a quarter live in other middle-income countries.

Three points are relevant here. First, more needs to be done to reduce poverty in countries where progress has been slower.

Box 1 The Marmot Review

The UK has done much in recent years to develop a strategic approach to tackling health inequalities through action on the social determinants, following the Marmot Review's report in 2010. The Health and Social Care Act 2012 adopted the Marmot Review's call for progress on health equity and gave the reorganised health care system the statutory duty to have regard to reduction of health inequalities. The government's Public Health White Paper was its response to the Marmot Review, declaring that reduction of health inequalities had to be at the centre of its public health strategies and action should be through adopting the Marmot recommendations on social determinants of health. The Marmot Review's six recommended areas for action (early child development, education and lifelong learning, employment and working conditions, healthy standard of living, healthy and sustainable places and communities, and strengthening the role of ill health prevention) have been adopted as priorities by 49 out of 65 health and well-being boards in local government authorities in England. Regional and local governments frequently have considerable autonomy in setting their own priorities, as do non-governmental organisations. Such organisations can do much within their own spheres of influence to tackle the causes of health inequalities.



EL-HANAN VENTURES LIMITED

**EL-HANAN VENTURES LIMITED
(RC 275169)**

Our mission is to be a world class Company with an uncompromised quality for goods and services.

We continually aim at:

- understanding what clients need
- offering the best solutions for clients' services
- competitive pricing for goods and services
- uncompromised quality for goods and services
- timely response and prompt delivery.

Our services

EL-HANAN VENTURES LIMITED has over the years grown from a modest beginning into a premier company that gives excellent services in:

- Healthcare
- Construction
- IT (Information Technology) solutions

Second, even individuals not living under the international poverty line may suffer inequity and disadvantages. Third, poverty is not just about lack of income. Other deprivations such as lack of good education, health, housing or employment matter because they may prevent an individual participating in society and taking control over their life. But if society provides good quality education, universal health coverage, social protection and good public services, individual income matters less. It is increasingly recognised that, in order to enable all households and individuals to benefit from economic development, an inclusive, equity-focused approach is needed across government.

The number of out of school children worldwide declined from 102 million in 2000 to 57 million in 2011. This indicates progress, but the global goal of universal primary education (MDG 2) is unlikely to be achieved. Access to education is an equity issue. Children out of school are from the poorest families, often in rural areas, and in some areas girls are less likely than boys to attend school.

Progress in empowering women (MDG 3) has been mixed. Gender inequities persist not only in school enrolment, but in wage employment and in government decision-making. Remarkably, Rwanda is head of the league table in percentage of women in parliament, having 63.8 per cent (51 out of 80) seats in its lower house held by women in 2013. Rwanda has held that position since elections in 2003, the first parliamentary elections since the genocide. Efforts to increase women's political participation in Rwanda were purposefully achieved through the new constitution of 2003, which enshrined gender equality, a parliamentary quota system (24 seats reserved for women) and novel electoral structures.

Women's empowerment is associated with better maternal and child health. Higher educational attainment among mothers is associated with lower child mortality. Across low- and middle-income countries, a higher gender empowerment index (measured by the proportion of seats held by women in national parliaments, percentage of women in economic decision-making positions and earned incomes of females versus males) is associated with lower child mortality.

Child mortality (under five years) continues to decline in many countries. Globally, under-five mortality dropped by 41 per cent: from 87 per 1,000 live births in 1990 to 51 per 1,000 in 2011, again falling short of the target of a two-thirds reduction. The reality is that some countries have reached the target of a two-thirds reduction since 1990, others are on track and others are making slower progress. Forty-one per cent of child deaths globally occur in three Commonwealth countries (India: 22 per cent, Nigeria: 13 per cent and Pakistan: six per cent).

Globally, maternal mortality (MDG 5) has dropped by 47 per cent, from 400 per 100,000 live births in 1990 to 210 per 100,000 live births in 2010, short of the two-thirds reduction goal. Progress in maternal outcomes is still hampered by inequalities in services for sexual and reproductive health as well as wider social inequality and lack of women's empowerment.

The third health MDG, to combat HIV/AIDS, malaria and other infectious diseases, has also seen unprecedented progress: malaria rates have fallen by over 25 per cent between 2000 and 2010, and death rates from tuberculosis globally are likely to be halved between 1990 and 2015. HIV infections are declining, but in 2011



Fibre Optics Network Backbone Solution at FMC Asaba, Delta State



Administrative Building for NSCDC at Katsina State

Healthcare unit

Our healthcare unit specialises in the sourcing and supply of medical/laboratory equipment and hospital consumables.



Our partners



CONTACT

EL-HANAN VENTURES LIMITED
No.3 Malcom Frazer Street
Plot 1753 Cadastral Zone AO4
Asokoro, Abuja
Nigeria

Tel: +234 817 205 2114 • +234 09 290 7839
Email: info@el-hanan.com

there were estimated to be 2.5 million new infections, of which 1.8 million were in Sub-Saharan Africa. There has been a remarkable increase in survival with HIV/AIDS because of the increased access to antiretroviral therapy. Taking a social determinants of health approach to AIDS has been key to the AIDS response. Health sector responses are vital, but to achieve 'zero inequity' HIV/AIDS responses must focus also on tackling stigma, discrimination, criminalisation, gender inequality and other social determinants that affect exposure and vulnerability to HIV/AIDS and access to prevention and treatment services. Action on social determinants and universal health coverage are complementary.

MDG 7 – environmental sustainability – is an increasing global concern. But while all populations are affected by environmental degradation, it is the poor and disadvantaged who suffer most egregiously. Progress towards the current targets is hampered by inequities; for example, while there has been progress in provision of clean water and sanitation, there are persistent rural-urban and

socioeconomic inequalities in improved water sources. In areas of Sub-Saharan Africa, collection of water is usually women's work and may take up several hours of the day, limiting their opportunities in life.

Continued challenges

Global partnerships for development, the eighth MDG, are of vital importance. The UN reports that the debt burden of developing countries has been lowered and trade tariffs paid by developing countries have declined. However, there has also been a decline in Official Development Assistance for Aid (ODA) in recent years. Where international development spending and national economic and social interests are seen to be competing agendas, rather than complementary and mutually supportive, then there may be limited public or political support for expanding or even maintaining budgets for ODA.

In a world where the wealthiest 20 per cent of the global population enjoys 83 per cent of total global income (2007 estimates) and the poorest 20 per cent have one per cent, and where the poorest 40 per cent of global population increased its share of total income by less than one per cent between 1990 and 2007, it is evident that ambitions for global partnerships for development need to be expanded post 2015 to ensure economic inclusion.

Clearly, some drivers of health and health inequity, including the global economic system and environmental degradation, operate across national boundaries and cannot be controlled by one country acting alone. The CSDH emphasised how global imbalances of power drive and perpetuate inequalities within and between countries. The recent analysis by *The Lancet*–University of Oslo Commission on Global Governance for Health identified political and economic injustices that affect population health and how dysfunctions of the current system of global governance hamper progress in tackling these injustices. It argues that current mechanisms for global decision-making are weak and ineffective, and proposes reforms. The appetite of countries to develop such reforms has not yet been tested, but the current negotiations for the post-2015 development agenda do provide a platform for such discussions.

The unprecedented global consultations that have been taking place about the post-2015 development agenda have brought forward many suggestions and identified many important global issues that are not currently within the MDG framework, including universal health coverage, non-communicable diseases and mental health, migration, conflict, informal employment, infrastructure, ageing, human rights, and sexual and reproductive rights. The consultations have also reasserted the need to build on the existing MDGs and pay attention not only to quantitative measures but also to the quality of experiences, for example, not only the number of children enrolled in school but also the quality of education.

A monitoring framework

Growing concern with inequities requires a framework of indicators that enables progress in reducing inequities to be monitored. A social determinants framework, advocated by the CSDH and the Marmot Review in England, provides a basis for the development of an equity-monitoring framework. Indicators and data would

Box 2 Child mortality

In Rwanda, under-five mortality increased from 151 per 1,000 live births in 1990 to 182 per 1,000 live births in 2000 following the genocide in 1994. Since 2000, Rwanda has reduced under-five mortality to 55 per 1,000 in 2012 (64 per cent reduction since 1990).

Bangladesh has reduced under-five mortality by 72 per cent from 144 per 1,000 live births in 1990 to 41 per 1,000 live births in 2012. UNICEF highlights contributory factors including expanding health care coverage (including immunisation, oral rehydration therapy and vitamin A supplementation for children), a growing network of community health workers and the role of non-governmental organisations in implementing child survival strategies, but also points to wider determinants, including women's empowerment and education for mothers and girls, poverty reduction strategies that improve living conditions, public awareness and high-level political commitments. Progress in child survival in Bangladesh has been characterised by greater improvements among the most disadvantaged. Analysis of these equity gains in child survival identifies an explicit focus on health and social and economic empowerment of women, girls and the rural poor as an essential driver of progress to date.

A number of Commonwealth countries, including Bangladesh, India, Nigeria and Zambia, have renewed their commitment to reducing child deaths following an initiative by the governments of Ethiopia, India and the USA. A particular focus of the initiative is on disadvantaged children and families, aiming to narrow the gap in child survival between rich and poor. This requires a focus on equity and action both to scale up access to effective health care interventions and to empower poorer groups through education and inclusive development.

Zambia is taking an explicit equity focus to tackling inequalities in under-five mortality. The Government of Zambia carried out a national analysis to identify inequalities in child survival and essential services, identifying actions needed in the most deprived regions of the country and bringing together partners to create a new national agenda to achieve equity in child survival.

need to be disaggregated by gender, location (rural/urban), ethnicity, socioeconomic position and any other dimension of inequity that is relevant in a particular society. While the demands of building such a comprehensive data collection and monitoring system are great, there is no reason why countries should not build progressively from a set of minimum indicators disaggregated by gender and a minimum of nationally agreed dimensions of inequity towards a nationally appropriate comprehensive monitoring system.

The time to start is now

Governments are increasingly aware of the need to focus on equity in order to achieve health equity and inclusive development across society. To restate the phrase from the WHO Review of Social Determinants of Health and the Health Divide, countries should 'do something, do more, do better'. By this we mean that 'if countries have very little in place in terms of policies on social determinants of health, some action matters'. Where policies do exist, they 'can be improved to deal with large and persistent health inequities'. Finally, there is 'scope to do better on inequities' in the richest countries in the Commonwealth.

References

- Adams, A. M., Rabbani, A., Ahmed, S. et al., 2013. 'Explaining equity gains in child survival in Bangladesh: Scale, speed, and selectivity in health and development'. *The Lancet*, 382(9909), pp. 2027–2037.
- Commission on the Social Determinants of Health, 2008. 'Closing the gap in a generation: Health equity through action on the social determinants of health'. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization.
- Humphries, R. and Galea, A., 2013. *Health and wellbeing boards one year on*. London: The King's Fund.
- IPU (Inter-Parliamentary Union), 2013. *Women in National Parliaments* [webpage] IPU. Available at: www.ipu.org/wmn-e/arc/classif011213.htm [Accessed 27 February 2014].
- Marmot, M., 2013. 'Universal health coverage and social determinants of health'. *The Lancet*, 382(9900), pp. 1227–1228.
- Marmot, M., Allen, J., Bell, R. and Goldblatt, P., 2012. 'Building of the global movement for health equity: from Santiago to Rio and beyond'. *The Lancet*, 379(9811), pp. 181–188.
- Ortiz, I. and Cummins, M., 2011. *Global inequality: Beyond the bottom billion*. New York: UNICEF.
- Ottersen, O. P., Dasgupta, J., Blouin, C. et al. 2014. 'The Lancet–University of Oslo Commission on Global Governance for Health: The political origins of health inequity: Prospects for change'. *The Lancet*, 383(9917), pp. 630–667.
- Powley, E., 2005. *Case study Rwanda: Women hold up half the parliament* [PDF], Institute for Democracy and Electoral Assistance. Available at: www.idea.int/publications/wip2/upload/Rwanda.pdf [Accessed 27 February 2014].
- Save the Children, 2010. *A Fair Chance at Life: Why equity matters for child mortality*. London: Save the Children.
- The Marmot Review Team, 2010. *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*. London: Marmot Review Team.
- UN (United Nations), 2013. *The Millennium Development Goals Report*. New York: UN.
- UNAIDS (the Joint United Nations Programme on HIV/AIDS), 2011. *Getting to Zero Inequity: Building bridges between AIDS and the social determinants of health*. New York: UNAIDS.
- UNICEF (United Nations Children's Fund), 2012. *Annual report for Bangladesh 2012*. Available at: www.unicef.org/about/annualreport/files/Bangladesh_COAR_2012.pdf [Accessed 27 February 2014].
- UNICEF (United Nations Children's Fund), 2013. *Bangladesh exceeds Millennium Development Goals* [webpage] UNICEF. Available at: www.unicef.org.au/Discover/News/September-2013/Bangladesh-exceeds-Millennium-Development-Goals-in.aspx [Accessed 27 February 2014].
- UNICEF (United Nations Children's Fund), 2013. *Committing to Child Survival: A promise renewed*. New York: UNICEF.
- United Nations, 2013. *Millennium Development Goals and post-2015 Development Agenda* [webpage], United Nations. Available at: www.un.org/en/ecosoc/about/mdg.shtml [Accessed 27 February 2014].
- United Nations, 2014. *Open Working Group on Sustainable Development Goals*, United Nations. Available at: <http://sustainabledevelopment.un.org/index.php?menu=1549> [Accessed 27 February 2014].
- Vasquez, S. T. and Sumner, A., 2012. 'Beyond low- and middle-income countries: What if there were five clusters of developing countries', IDS working paper 404.
- WHO (World Health Organization), 2011. *Global Health Sector Strategy on HIV/AIDS 2011–15*. Geneva: WHO.
- World Health Organization (WHO) Regional Office for Europe, 2013. *Review of social determinants and the health divide in the WHO European Region: Final report*. Copenhagen: WHO.

PROFESSOR SIR MICHAEL MARMOT is director of the UCL Institute of Health Equity (Marmot Institute) and has led research groups on health inequalities for over 35 years. At the international level he is a foreign associate member of the Institute of Medicine, a former vice president of the Academia Europaea and a member of *The Lancet*–University of Oslo Commission on Global Governance for Health. He was chair of the Commission on Social Determinants of Health, which was set up by the World Health Organization in 2005, and produced a report entitled Closing the Gap in a Generation in August 2008. At national level he has led studies on breast cancer screening, ageing and the Whitehall II Studies of British Civil Servants; he served as president of the British Medical Association in 2010–11 and is now the president of the British Lung Foundation. He was a member of the Royal Commission on Environmental Pollution for six years and in 2000 he was knighted for services to epidemiology and the understanding of health inequalities. Among other prizes and distinctions, Marmot has been awarded a Harvard Lowens Professorship for 2014–17.

DR RUTH BELL is senior research fellow at the UCL Institute of Health Equity. She is active in research and advisory roles to advocate and implement the global health agenda for health equity, and co-ordinates advocacy for health equity to national and international policy and research forums.