

Taking action on the social determinants of health to improve population health

Ruth Bell and Sir Michael Marmot

Substantial differences in health and life expectancy exist between countries in the Commonwealth: some countries are among those with the highest life expectancy in the world, some countries among the lowest. But it is not enough to look at average life expectancy of countries. A deeper understanding of population health requires knowledge about the distribution of health across society – according to gender, ethnicity/race and socioeconomic disadvantage/advantage.

Social inequalities in health exist in all those Commonwealth countries from which we have data, and constitute a large part of the burden of poor health in all these countries. This means that within each country, if everyone's health were brought up to the level of those with the most social advantage, there would be a significant improvement in overall population health.

These differences in health within countries are not just a matter of poor health for the poor and good health for the wealthy; the pattern of population health is often observed as a gradient between the two extremes (Figures 1 and 2).

Health indicators of Indigenous peoples are consistently worse than average population health. Information from the Australian Bureau of Statistics for 2005-2007 estimates that life expectancy at birth for Indigenous men (67.2 years) was 11.5 years less than for non-Indigenous men, and for Indigenous women (72.9 years) 9.7 years

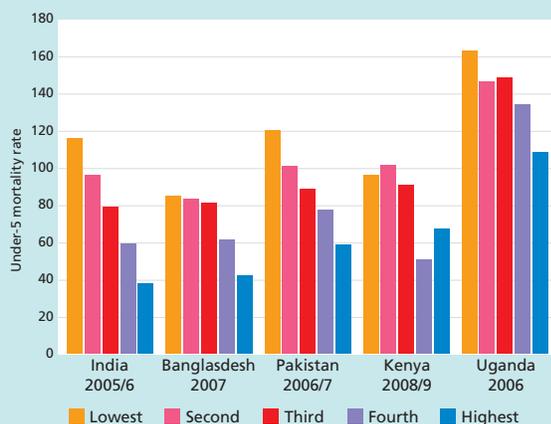
less than for non-Indigenous women (Australian Bureau of Standards, 2010).¹ In Canada and New Zealand Indigenous people also experience lower life expectancy than the non-Indigenous population, although the life expectancy gap for Indigenous people in Canada and in New Zealand is less than in Australia (Australian Institute of Health and Welfare, 2011). A study of changing trends in mortality inequalities between Indigenous and non-Indigenous populations in New Zealand found that health inequalities between Maoris and non-Maoris narrowed between 1996 and 2006 following the introduction of pro-equity health and social policies (Tobias et al., 2009).

The shape of the gradient in health varies within countries by region and over time and is not fixed or immutable. Much can be done to improve health across the gradient. In order to reduce health inequalities, the aim should be to level the gradient by bringing the health of everyone up to the health of those with most social advantage.

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Figure 1

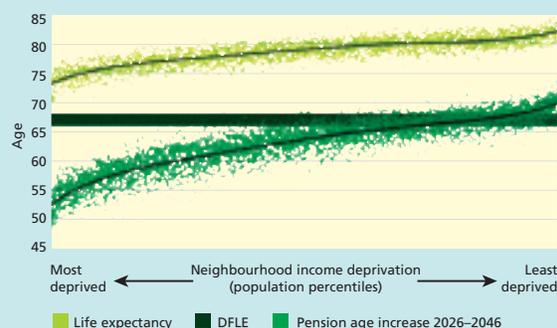
Probability of dying (per 1,000) under age five years (under-5 mortality rate) by wealth quintile in India, Bangladesh, Pakistan, Kenya and Uganda



Source: Graph prepared by the author and Sir Michael Marmot from data sourced from Measure DHS (ICF Macro, 2011).

Figure 2

Life expectancy and disability-free life expectancy (DFLE) at birth by neighbourhood income deprivation, 1999-2003



Source: Marmot Review, 2010

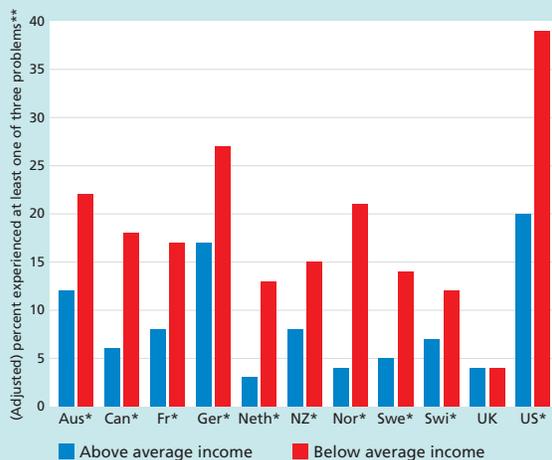
In 2005, the World Health Organization (WHO) convened the Commission on Social Determinants of Health (CSDH) to gather global evidence and provide recommendations on improving health and the distribution of health within and between countries worldwide (CSDH, 2008). The CSDH described the social determinants of health as the conditions in which people are born, grow, live, work and age, and the structural drivers of these conditions as the inequitable distribution of power, money and resources (ibid).

Systematic differences in health between social groups that are avoidable by reasonable means are unfair. Taking action to reduce health inequities is a matter of social justice (ibid). Underpinning the social determinants of health approach is the concept of empowerment, understood across three intersecting dimensions: material (having the material conditions necessary for health), psychosocial (having control over one's life) and political (having political voice and participating in decision-making) (ibid).

The health-care system is an important social determinant of health, but health inequalities are not predominantly caused by inequitable access to health care. Health inequalities persist in the United Kingdom despite an excellent health-care system that is available to all free of charge at the point of use and appears to be one of the most equitable by international comparisons. In a comparative survey of cost-related access to health care among health-care users across 11 countries (Figure 3) only 4 per cent of respondents in the UK reported experiencing at least one of three cost-related access problems and there was no difference in access problems by income (Schoen et al., 2010).

Figure 3

Cost-related access problems in the past year, by income



Note: Percentages adjusted based on logistic regression to control for health status, age, and (in the U.S.) insurance status.

* Indicates significant in-country differences with below-average income ($p < 0.05$).

** Did not fill/skipped prescription, did not visit doctor with medical problem and/or did not get recommended care.

Source: Schoen et al., 2010.

The health system acting alone cannot tackle health inequalities. Partnerships are needed to develop a comprehensive set of approaches and policies that cut across sectors and act at multiple levels – community, parish, city, national, regional and global. The CSDH organised its recommendations for actions to tackle health inequities under three overarching principles and gave examples of policies and programmes for action in each of these areas (Box 1). The recommendations were necessarily broad because of the global remit of the CSDH. No one set of recommendations would suit every context. The intention was that national governments and other stakeholders would take the CSDH recommendations and examine what they could do in their own operating environment. A number of countries in the Commonwealth have done so, or are in the process of doing so, at different levels of government.

In England in 2008, the Labour government commissioned the Strategic Review of Health Inequalities post 2010 (Marmot Review, 2010). This review, chaired by Professor Sir Michael Marmot, took the CSDH recommendations and applied them to the context in England. The Marmot Review reported to the Conservative/Liberal Democrat Coalition government in 2010 and made recommendations across six areas (ibid):

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

The new government welcomed the Marmot Review and in its Public Health White Paper accepted five of its recommendations. The organisations representing health professionals have enthusiastically welcomed the Marmot Review's recommendations. In addition, the recommendations are in line with the experiences, activities and aims of local authorities and many are using them to develop local strategies across areas such as education, local environment, housing, transport and planning.

The CSDH emphasised the importance of monitoring to assess the impact of strategies (CSDH, 2008). Importantly, the Marmot Review (2010) proposed a range of indicators for monitoring progress, including life expectancy and health expectancy across the social gradient, child development across the social gradient, and income sufficient for healthy living.

By global standards England is a rich country with good population health. But countries do not need to be rich to tackle the social determinants of health. Action is possible in countries at all levels of development. For example, comparison of health and social indicators in the Indian state of Kerala with indicators for India as a whole shows that in Kerala women are more likely to be educated and less likely to be underweight, and children are less likely to die in infancy and be stunted (International Institute for Population Health, 2012).

In many countries, community-based action makes a difference in people's lives. This is evident, for example, in community-based

projects to reduce stigma associated with HIV/AIDS in the informal settlements of Nairobi in Kenya, in a combined micro-credit and gender training programme in South Africa to empower women (Pronyk et al., 2006), and in the communities of Ahmedabad, India, where the Self-Employed Women's Association works with women to improve the lives of their families (SEWA, 2008). Much more can be done in Commonwealth countries, and there is much they can learn from Brazil, Chile and other countries with governments that have developed strategies based on the social determinants of health.

Box 1

CSDH principles of action and areas for action

The CSDH's recommendations are based on three principles:

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.

Within these overarching recommendations, the CSDH made the following recommendations for action:

Improve the conditions of daily life

- Equity from the start (early child development and education)
- Employment and working conditions
- Social protection
- Healthy and sustainable places
- Universal health care

Tackle the inequitable distribution of power, money and resources

- Health equity in all policies, systems and programmes
- Fair financing
- Market responsibility
- Gender equity
- Political empowerment (inclusion and voice)
- Good global governance

Monitoring, research and training

Measure and understand the problem and assess the impact of action through monitoring, training and research, including:

- Routine monitoring of health equity and the social determinants of health
- Invest in generating and sharing new evidence on the ways in which social determinants influence health and health equity
- Provide training on the social determinants of health and invest in raising public awareness

What then is the role of Ministers of Health in tackling health inequalities? There is much that can be done to ensure the development of equitable access to health-care systems but it cannot be achieved in isolation (WHO, 2008). Ministers of Health have a clear role as advocates in government for working across sectors to tackle health inequalities, to be the conscience of government and to put mechanisms in place to monitor progress.

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Endnote

¹ These figures are derived from new methodology and are not comparable with previous data (Australian Bureau of Statistics, 2010).

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