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ACTION ON THE SOCIAL DETERMINANTS OF HEALTH: LEARNING FROM PREVIOUS EXPERIENCES

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This paper was prepared for the launch of the Commission on Social Determinants of Health (CSDH) by its secretariat based at WHO in Geneva. It was discussed by the Commissioners and then revised considering their input. It was written by Alec Irwin and Elena Scali.

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Executive summary

Today an unprecedented opportunity exists to improve health in some of the world's poorest and most vulnerable communities by tackling the root causes of disease and health inequalities. The most powerful of these causes are the social conditions in which people live and work, referred to as the social determinants of health (SDH). The Millennium Development Goals (MDGs) shape the current global development agenda. The MDGs recognize the interdependence of health and social conditions and present an opportunity to promote health policies that tackle the social roots of unfair and avoidable human suffering.

The Commission on Social Determinants of Health (CSDH) is poised for leadership in this process. To reach its objectives, however, the CSDH must learn from the history of previous attempts to spur action on SDH. This paper pursues three questions: (1) Why didn't previous efforts to promote health policies on social determinants succeed? (2) Why do we think the CSDH can do better? (3) What can the Commission learn from previous experiences – negative and positive – that can increase its chances for success?

Strongly affirmed in the 1948 WHO Constitution, the social dimensions of health were eclipsed during the subsequent public health era dominated by technology-based vertical programmes. The social determinants of health and the need for intersectoral action to address them re-emerged strongly in the Health for All movement under the leadership of Halfdan Mahler. Intersectoral action on SDH was central to the model of comprehensive primary health care proposed to drive the Health for All agenda following the 1978 Alma-Ata conference. During this period, some low-income countries made important strides in improving population health statistics through approaches involving action on key social determinants. Rapidly, however, a scaled-back version of primary health care, "selective primary health care", gained influence. Selective primary health care focused on a small number of cost-effective interventions and downplayed the social dimension. The most important example of selective primary health care was the GOBI strategy (growth monitoring, oral rehydration, breastfeeding and immunization) promoted by UNICEF in its "child survival revolution". The contrast in approaches between comprehensive and selective PHC raises strategic questions for the CSDH.

Like other aspects of comprehensive primary health care, action on determinants was weakened by the neoliberal economic and political consensus dominant in the 1980s and beyond, with its focus on privatization, deregulation, shrinking states and freeing markets. Under the prolonged ascendancy of variants of neoliberalism, state-led action to improve health by addressing underlying social inequities appeared unfeasible in many contexts. The 1990s saw an increasing influence of the World Bank in global health policy, with mixed messages from WHO. During this period, however, important scientific advances emerged in the understanding of SDH, and in the late 1990s several countries, particularly in Europe, began to design and implement innovative health policies to improve health and reduce health inequalities through action on SDH. These policies targeted different entry points. The more ambitious aimed to alter patterns of inequality in society through far-reaching redistributive mechanisms. Less radical, palliative programmes sought to protect disadvantaged populations against specific forms of exposure and vulnerability linked to their lower socioeconomic status.

The 2000s have seen a pendulum swing in global health politics. Health stands higher than ever on the international development agenda, and stakeholders increasingly acknowledge the inadequacy of health strategies that fail to address the social roots of illness and well-being. Momentum for action on the social dimensions of health is building. The Millennium Development Goals were adopted by 189 countries at the United Nations Millennium Summit in 2000. They set ambitious targets in poverty and hunger reduction; education; women's empowerment; child health; maternal health; control of epidemic diseases; environmental protection; and the development of a fair global trading system, to be reached by 2015. The MDGs have created a favourable climate for multisectoral action and underscored connections between health and social factors. An increasing number of countries are implementing SDH policies, but there is an urgent need to expand this momentum to developing countries where the effects of SDH are most damaging for human welfare. This is the context in which the CSDH will begin its work.

Based on the historical survey, four key issue areas are highlighted, in which the members of the CSDH must take strategic decisions early in their process.

1. The first concerns the scope of change the Commission will seek to promote and appropriate policy entry points. Here the CSDH will face its own version of the choice between comprehensive and selective primary health care that confronted public health leaders in the 1980s. **The CSDH will need evaluation criteria for identifying appropriate policy entry points for different countries/ jurisdictions.**

2. Potential resistance to CSDH messages can be anticipated from several constituencies, which the Commission should seek to engage proactively. **The Commission will want to identify a set of potential "quick wins" for itself and for national political leaders taking up an SDH agenda.** Commissioners will want to develop a strategy for dialogue with the international financial institutions, in particular the World Bank.

3. The CSDH will also benefit from exceptional political opportunities. It will effectively position itself within the global and national processes connected to the MDGs. **Alliances with both the business community and civil society are possible, but competing interests will need to be managed.** The opportunity and limits of economic arguments for SDH policies remain to be clarified, and such arguments raise deeper ethical questions.

4. In addition to robust evidence, **the Commission needs a compelling, collectively owned "story line" about the social determinants of health,** in which the evidence can be embedded and communicated. What story does the CSDH want to tell about social conditions and human well-being?

With answer to these questions in place, the Commission will lead a global effort to protect vulnerable families and secure the health of future generations by tackling disease and suffering at their roots.

1 Introduction

Today health stands higher than ever on the international development agenda, and health inequalities between and within countries have emerged as a central concern for the global community[1,2,3,4]. An unprecedented opportunity exists to improve health in some of the world's poorest and most vulnerable communities – if approaches are chosen that tackle the real causes of health problems. The most powerful of these causes are the social conditions in which people live and work, referred to as the social determinants of health (SDH). Social determinants reflect people's different positions in the social "ladder" of status, power and resources. Evidence shows that most of the global burden of disease and the bulk of health inequalities are caused by social determinants[5,6].

The Millennium Development Goals (MDGs) recognize this interdependence between health and social conditions. The MDG framework shows that without significant gains in poverty reduction, food security, education, women's empowerment and improved living conditions in slums, many countries will not attain health targets[7,8]. And without progress in health, other MDG objectives will also remain beyond reach. Today, an

these recommendations were rarely translated into effective policies. Strong messages on SDH emerged again in the mid-1990s, but once more policy implementation made little headway in the developing countries where needs are greatest. Understanding the reasons for these frustrations is fundamental to planning an effective strategy for the CSDH.

As an input to the strategy process, this paper seeks to shed light on three related questions:

1. Why didn't previous efforts to promote health policies on social determinants succeed?
2. Why do we think the CSDH can do better?
3. What can the Commission learn from previous experiences – negative and positive – that can increase its chances for success?

The first part of this study reviews previous major efforts to address social determinants with attention to these efforts' political contexts. The second part identifies a series of key strategic issues based on the historical record and outlines factors that should enable the CSDH to catalyse effective action.

An issue of vocabulary requires preliminary