
Commission on Social Determinants of Health

Report by the Secretariat

1. In his address to the Fifty-seventh World Health Assembly,¹ the late Director-General, Dr Lee Jong-wook, announced the creation of the Commission on Social Determinants of Health. The Commission, launched in March 2005, aimed to provide guidance to Member States and WHO's programmes by gathering evidence on social determinants and ways to overcome health inequities. This report outlines the recommendations of the Commission in its final report.²

2. The social determinants of health are defined as the structural determinants and conditions of daily life responsible for a major part of health inequities between and within countries. They include the distribution of power, income, goods and services, and the circumstances of people's lives, such as their access to health care, schools and education; their conditions of work and leisure; and the state of their housing and environment. The term "social determinants" is thus shorthand for the social, political, economic, environmental and cultural factors that greatly affect health status.

3. The Commission consisted of 19 members, chaired by Professor Sir Michael Marmot of University College, London.³ Supported by the Secretariat, it convened four working groups on: work with Member States, work with civil society, global knowledge networks and work within WHO. Many Member States contributed to the work of the Commission with the aim of learning from and sharing experiences.

4. The Commission consulted with numerous civil society bodies in all regions, which contributed case studies and evidence for all the Commission's areas of work. A separate civil society report was also produced.⁴ The Commission convened international experts on early child development, employment conditions, globalization, health systems, measurement and evidence, priority public health conditions, social exclusion, urban settings, and women and gender equity in nine global

¹ Document A57/3.

² Commission on Social Determinants of Health. *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, 2008.

³ The other members were: Professor Frances Baum (Australia), Dr Monique Bégin (Canada), Dr Giovanni Berlinguer (Italy), Ms Mirai Chatterjee (India), Dr William Foege (United States of America), Professor Yan Guo (China), Professor Kiyoshi Kurokawa (Japan), Dr Ricardo Lagos (Chile), Professor Alireza Marandi (Islamic Republic of Iran), Dr Pascoal Mocumbi (Mozambique), Dr Ndioro Ndiaye (Senegal), Ms Charity Ngilu (Kenya), Professor Hoda Rashad (Egypt), Professor Amartya Sen (India), Dr David Satcher (United States of America), Dr Anna Tibaijuka (United Republic of Tanzania), Professor Denny Vågerö (Sweden), Dr Gail Wilensky (United States of America).

⁴ Civil Society Report to the Commission on Social Determinants of Health. Submitted to the Commission on Social Determinants of Health at its Ninth Meeting, Beijing, October 2007.

knowledge networks. The Secretariat was more directly involved in two of these knowledge networks. The WHO Kobe Centre hosted the Urban Settings Knowledge Network. The Secretariat also hosted the Priority Public Health Conditions Knowledge Network, which coordinated analyses of social determinants of major public health conditions.

5. The Commission met 10 times, in Brazil, Canada, Chile, China, Egypt, India, Islamic Republic of Iran, Japan, Kenya and Switzerland. Regional consultations also took place in each of the WHO regions. In addition, each working group convened numerous meetings and consultations.

6. The Executive Board was briefed at its 115th and 120th sessions,¹ and at its 124th session considered the matter in the light of the Commission's final report.²

KEY FINDINGS AND RECOMMENDATIONS

7. Health inequities are increasing both within and between countries. A gap in life expectancy of more than 40 years exists between the richest and poorest countries. Moreover, gross inequities in health status divide different groups of people within all countries, regardless of income. In high-income countries, life expectancy gaps of more than a decade exist between different groups according to such factors as ethnicity, gender, socioeconomic status and geographical area. Low-income countries in all regions show marked differences in child mortality according to level of household wealth.

8. Such health inequities are not inevitable. Instead, they mostly point to policy failure, reflecting inequities in daily living conditions and in access to power, resources, and participation in society.

9. Social determinants must be addressed in order to achieve many disease-specific targets, including the health-related Millennium Development Goals, and to control and eliminate epidemics endangering entire populations. Most priority public health conditions share key social determinants, including determinants of exposure to risks, disease vulnerability, access to care, and the consequences of disease. Ample opportunities exist to deal with these determinants collectively, both within and outside the health system. Coordinated action on public health conditions within strong systems based on primary health care is therefore needed to achieve the Millennium Development Goals and reduce health inequities, in addition to improving the population's overall health.

10. The Commission makes three main recommendations:

- (a) improve daily living conditions
- (b) tackle the inequitable distribution of power, money and resources
- (c) measure and understand the problem and assess the impact of action.

¹ Documents EB115/35 and EB120/35, section B.

² Document EB124/2009/REC/2, summary record of the fifth meeting.

Under these main recommendations, the Commission presents action areas and specific recommendations aimed at all parties, including WHO, other multilateral agencies, national and local governments, civil society, the private sector and research institutions.

11. For the first recommendation, the Commission identifies the following action areas:
 - (a) a comprehensive approach to early child development, building on existing child-survival programmes and extending interventions in early life to include social/emotional and language/cognitive development;
 - (b) sustained investment in rural development, addressing policies of exclusion that lead to rural poverty, landlessness and displacement of people from their homes; urban governance and planning;
 - (c) economic and social policy responses to climate change and other environmental degradation take into account health equity;
 - (d) full and fair employment and decent work as a central aim of national and international social and economic policy-making; safe, secure and fairly-paid work, year-round work opportunities, and a healthy work-life balance for all; and improved working conditions for all workers in order to reduce exposure to material hazards, work-related stress, and health-damaging behaviours;
 - (e) comprehensive social-protection policies that support an income level conducive to healthy living for all;
 - (f) specifically with regard to the health sector, the Commission calls for the building of universal health-care systems oriented around primary health care.

12. For the second recommendation, the Commission identifies the following action areas:
 - (a) place responsibility for action on health and health equity at the highest level of government, and ensure its coherent consideration in all policies;
 - (b) adjust the health sector as appropriate – include social determinants in the policy and programmatic functions of health ministries and strengthen such ministries’ stewardship role in supporting a social determinants approach throughout government;
 - (c) strengthen public financing for action on social determinants; increase international financing for health equity, and coordinate increased finance by means of a framework for acting on social determinants;
 - (d) reinforce the primary role of the State in providing basic services essential to health (such as water and sanitation) and regulating goods and services with a major impact on health (such as tobacco, alcohol and food);
 - (e) address gender bias in the structures of society – in laws and their enforcement, in the way organizations are run and interventions designed, and in how a country’s economic performance is measured;

- (f) reaffirm commitment to addressing sexual and reproductive health and rights universally;
 - (g) 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;
 - (h) enable civil society to organize and act in a manner that promotes and realizes the political and social rights affecting health equity.
13. For the third recommendation, the Commission identifies the following actions:
- (a) ensure that routine monitoring systems for health equity and social determinants are in place locally, nationally and internationally;
 - (b) invest in generating and sharing new evidence on how social determinants influence population health and health equity, and on the effectiveness or otherwise of measures to reduce health inequities through action on social determinants;
 - (c) provide information about social determinants to policy actors, stakeholders and practitioners, and invest in raising public awareness.

ANALYSIS AND FUTURE ACTION

14. The concern for equity central to the Commission's call to address social determinants is in keeping with the values of primary health care. The Commission's recommendations complement the call for action in *The world health report 2008*.¹ Both reports emphasize the need for action beyond the health sector by considering "health in all policies". The Commission's report can be seen as an exhaustive review of the range of policies that require consideration in implementing multisectoral action for health, as part of a revitalization of primary health care.

15. Similarly, within the health sector, the Commission aligns itself with *The world health report's* call for health systems to be based on the principles of primary health care and in particular to provide universal coverage. The Commission also identifies how addressing social determinants within the health sector can make health systems more inclusive, accessible and sensitive to disadvantaged communities, and make health promotion more effective.

16. Making progress towards all the Millennium Development Goals requires, among other measures, addressing health inequities – particularly within countries, strengthening health systems based on primary health care, and action on social determinants. The Commission's recommendations thus represent important areas where concerted action could speed progress.

17. The continuing financial, food, fuel and environmental crises reinforce the importance of addressing social determinants since poorer people are more likely to suffer disproportionately. Minimizing such inequities during these crises requires preserving levels of health and social expenditure, in addition to using it better. Revitalizing primary health care and addressing social

¹ World Health Organization. *The world health report 2008: primary health care – now more than ever*. Geneva, World Health Organization, 2008.

determinants become more important than ever if progress is to be hastened towards reducing health inequities and achieving health targets such as the Millennium Development Goals.

18. Significant work on rectifying health inequities and addressing social determinants is already under way within the Secretariat and in Member States, as agreed in the Eleventh General Programme of Work and the Medium-term strategic plan 2008–2013 under strategic objective 7.

19. The Commission asks WHO to build on this work. For the Secretariat, the Commission recommends work in three specific domains. First, the Secretariat should strengthen global and national capacities in order to address social determinants by (a) providing support to Member States in implementing a “health in all policies” approach throughout government and to reorient their health sectors to work on social determinants; (b) making Member States better able to consider the impacts of global policies on health inequities in their countries; and (c) working with partner agencies in the multilateral system to build capacity for considering responses to social determinants and health inequities.

20. Secondly, the Secretariat should strengthen existing efforts on measurement and evaluation of the social determinants and health inequities by (a) facilitating target-setting and monitoring progress towards health equity between and within countries; (b) supporting the establishment of national health-equity surveillance systems in Member States; and (c) supporting Member States in development and use of tools for assessing impact on health equity.

21. Thirdly, the Secretariat should build internal capacity for addressing social determinants in all areas of its work by (a) enhancing staff competencies and setting standards for mainstreaming work on social determinants; and (b) evaluating programmes against these benchmarks.

22. The Executive Board considered the above report at its 124th session and adopted resolution EB124.R6 which had been proposed by several Member States.

ACTION BY THE HEALTH ASSEMBLY

23. The Health Assembly is invited to consider the draft resolution contained in resolution EB124.R6.

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