References


2. The speech was made in late 1997 and was to launch the Social Exclusion Unit. Various other people subsequently claimed to have coined the phrase—though in every case they appeared to do so later than this.


5. See http://www.nao.gov.uk/publications/workinprogress/joinedup1.htm


Social determinants of health: The key to closing the health equity gap

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Introduction

The Commission on the Social Determinants of Health (CSDH; the Commission) was launched by the World Health Organization in March 2005 to report on what actions on the social determinants of health (SDH) need to be taken by governments and others in order to realise the goal of health equity between and within countries. The intent of the Commission has always been to both provide evidence on what actions work and to make practical recommendations about which policies will work in particular circumstances. The Commission's report, due to be launched in September 2008, is expected to bring an impetus to national, regional and international efforts to act on SDH in order to improve health equity. The Commission is paying particular attention to what we can learn from:

- identifying existing programs, policies and initiatives that improve health equity
- enabling factors that will result in change at the upstream level
- how to move from theory to practice—collecting knowledge that is relevant to policy and advocacy.

The publication of the Commission's report will prove particularly opportune for Australia because it will follow a change of national government in Australia to one which has an overt commitment to working for health equity. Thus, the focus of this paper is the current and future implications of the Commission's work for Australia, especially in terms of action to improve health equity, and the importance of all sectors taking action on social determinants to reduce health inequity. The work of the Commission has focused on contributions from 19 Commissioners (including its Chair Sir Professor Michael Marmot, the Nobel Laureate Professor Amartya Sen and the previous President of Chile Ricardo Lagos) and the following five streams of action:

- identifying existing programs, policies and initiatives that improve health equity
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Knowledge networks—the organisation of knowledge to inform health policy proposals and action on SDH. Nine knowledge networks (KNs) have each produced a substantive report on knowledge in their area and recommendations for action. The KNs are gender equity, evidence and knowledge, social exclusion, priority public health conditions, early childhood development, employment conditions, globalisation, health systems and urban settings.

Country action—demonstration and highlighting of the opportunities and possibilities of action, as formalised in country partnership agreements and action plans. The country work stream partners at the time of writing include Sri Lanka, Chile, Iran, Canada, England, Sweden, Kenya and Brazil.

Civil society—whereby the social mobilisation and long-term political sustainability of the SDH agenda is being organised through an extensive civil society process.

Reform of global institutions—including action on SDH and health equity in the policies and investment strategies of global institutions (including the G8, World Bank and global funds) through engagement of the institutions around key thematic issues emerging from KNs and of relevance to countries.

Reform at the World Health Organization—developing the plan for institutional change at WHO so that it can also provide long-term support to countries in advancing the SDH agenda after the Commission has ended.

Potential for reducing health equity gap
While Australia has one of the highest life expectancies internationally, there is still considerable scope to reduce health inequities in this country. There is a 17-year difference in life expectancy between Indigenous and other Australians. Seventy per cent of Indigenous peoples die before they are 65 years of age, while only 21% of other Australians do. Significant differences also exist between people of different socioeconomic status in Australia. In 2000–01 a boy born in the most disadvantaged area had a life expectancy 3.6 years less than a boy born in the area of most advantage.

The Commission’s final report will make it clear that inequities can be dramatically reduced through action on SDH if there is political and social will to do so. The report will suggest that there is a strong motivation for governments to take action on health equity because the distribution of health is a marker of sustainable social and economic development. The extent to which wellbeing is distributed fairly reflects the performance of not just the health sector but all sectors—hence the importance of the Health in All Policies approach. Ensuring action on SDH is emphatically a whole-of-government issue.

Implications for Australian governments from the Commission’s report
The Commission’s report will speak to multiple players including governments in countries at all levels of development, international bodies such as the World Health Organization, the World Bank, and donor bodies including the Gates Foundation and the Global Fund. Australian governments will need to study the report and determine areas for action. This process is illustrated in Tables 1–3, which provide summaries of the main areas of recommendation from the Commission and suggests the implications for Australia.

Structural drivers for health equity
Structural drivers for health equity (Table 1) are those factors that set the context for reducing health inequities. Australia is well positioned in this regard compared to many other countries.

For example, our taxation system remains somewhat progressive despite the GST and other changes introduced by the Howard Government. There have been some successes in restricting market activity in favour of public health, with good examples being Australia’s lead in tobacco control and the success, using policies across a number of sectors, in reducing road traffic accident deaths. These examples offer important lessons for how chronic disease could be reduced through structural changes to our living environments to encourage healthy eating and exercise.

While some countries out rank Australia in terms of gender equity, advances have been made in recent years, especially in terms of government action on gender violence. However, further changes can still contribute to increasing the empowerment of both men and women to live equitable lives free of violence and the abuse of power.

Participation is widely recognised as an essential component of a healthy society. There is much that can be done by Australian governments to ensure that citizen voices can be heard in public debates on a wide range of topics relevant to health. The absence of meaningful participation and consultation with Aboriginal communities was one of the most common criticisms of the Howard Government’s Northern Territory intervention. The power of an informed and interested citizenry has been shown in a number of forums, including in health policy. Examples include citizen juries and the use of the internet, during the November 2007 election campaign, by the social movement Get Up to mobilise many citizens, particularly young people, to use their vote strategically. The Commission’s report will make it very clear that these underpinning drivers of health equity are essential steps in closing the equity gap.
### Table 1: Main steps for reducing health inequity—structural drivers

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<th>Structural driver</th>
<th>Possible Australian action</th>
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| Fair financing—increasing proportion of national budget spent on human welfare and development, and ensuring allocation is fair and reflects needs | • Taking advantage of the current budget surplus to increase investment in education and preventive health care  
• Ensuring income tax is more progressive  
• Increasing the amount of GDP Australia spends on aid to low-income countries |
| Market regulation—markets are not good at ensuring good distribution so governments need to intervene to balance public and private activity | • Considering the role of government regulation in promotion of public health. Current examples are regulation of food advertising on children’s prime television time, distribution of primary medical services, collapse of public housing, and increasing unaffordability of private housing |
| Gender equity—tackling gender bias in institutions      | • Ensuring gender bias is tackled in all areas of life including parliamentary representation, private and public sector management positions, and access to employment and education  
• Continuing and intensifying actions to reduce gender-based violence |
| Fair decision making and participation—participation in decision making to reduce exclusion and promote equity | • Working to improve operation of parliamentary democracy  
• Encouraging genuine rather than token participation in government decision making  
• Funding independent bodies to support citizen participation  
• Supporting recipients of government funding to participate in critiques of government policy |
| Ensuring action on health equity in all policy areas—this responsibility needs to be shared across government portfolio areas | • Implementing Federal government-led efforts to improve coordination across sectors between federal, states and territory governments and in all jurisdictions  
• Implementing Health in all Policies approach as a major COAG goal |

Source: based on draft report from the Commission on the Social Determinants of Health

### Table 2: Main steps for reducing health inequity—conditions of everyday life

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<th>Conditions of everyday life</th>
<th>Possible Australian action</th>
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| Universal early childhood development—a focus on physical, social, emotional, language and cognitive development is a great investment in health equity | • Ensuring the provision of publicly funded and affordable child care that pays attention to child development  
• Ensuring each jurisdiction has integrated services for young children that work across welfare, health, education, employment sectors  
• Ensuring workplaces are family friendly |
| Healthy places—communities and neighbourhoods can promote health and shape the behaviour of individuals | • Funding health promotion initiatives that aim to create healthy places and ensuring these involve multiple sectors and community involvement, and help to make healthy choices the easy choices.  
A national network of Healthy Communities initiatives would enable synergy and learning between projects  
• Focusing on environmental causes of illness rather than directly trying to change behaviours |
| Fair employment and decent work—will provide a sound basis for health equity | • Amending the work choices legislation to ensure workers have decent working conditions that balance their needs with those of employers, and restoring crucial collective bargaining rights  
• Ensuring a balance between work and life as a major aim of government policies |
| Universal health care—access to healthcare is a crucial social determinant of health | • Maintaining and extending Medicare and its universality  
• Ensuring there is universal access to dental care |
| Universal social protection across the life course—recognising the benefits of universal rather than targeted approaches | • Aiming for universality rather than targeting as the basis for social policies |
Table 3: Main steps for reducing health inequity—capacity for analysis, monitoring and action

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<th>Capacity and motivation to understand and act on social determinants</th>
<th>Possible Australian action</th>
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| Social determinant literacy | • Recognising the need for professional development across sectors to generate an understanding of what works to bring about change in population (as opposed to individual) health  
• Including a segment in all professional training on the importance of social and economic determinants of health and wellbeing and the limitation of direct behaviour change |
| Civil society | • Funding NGOs such as Public Health Association of Australia which have been defunded in past 10 years to ensure independent citizen voice on social determinants and health equity, which will assist in reinforcing a social movement |
| Research | • More NHMRC funding of research and capacity building on research on the social determinants of health |

Source: based on final report from the Commission on the Social Determinants of Health

**Capacity for analysis, monitoring and action**

Action to close the health equity gap is most likely to happen when there is broad understanding of what factors improve population health (as distinct from the health of individuals) and how policy can be used as a powerful lever (Table 3). Professionals in many sectors need to understand the differences between population health and clinical medicine. Civil society is crucial in creating a constituency for action on social determinants. International movements such as the People’s Health Movement have been influential, and within this country professional associations such as the Public Health Association of Australia and the Australian Health Promotion Association have advocated for the importance of social determinants.

Finally, there is an urgent need for vastly increased investment in research on social determinants. Australia has been a trailblazer in producing information to support a focus on SDH. Since the first Social Health Atlas was published in 1990, atlases have been published for Australia as a whole and for individual states and territories. They include a broad range of data on social inequity in general and, specifically, on health inequity. Data on health inequities has also been produced by Turrell, Oldenburg et al. and the Australian Institute of Health and Welfare. Australia, therefore, has a sound knowledge base from which to act and is ahead of many other nations, some of which may not even have vital registration systems let alone data on the extent of inequity.

The vast majority of the National Health and Medical Research Council’s budget is devoted to its medical brief and very little is invested in the public health aspect. Research is needed to understand the social processes underpinning inequity and to evaluate interventions designed to address social determinants. Australia has been particularly poor in investing in such research, and very few policies are thoroughly evaluated in terms of their health and equity impact. Thus, a central task for the new Australian Federal Government is to increase investment in long-term research to monitor health inequities and to evaluate policy interventions to reduce them.

**Conditions of daily life that support health equity**

The Commission recognises that it is the conditions of everyday life that determine whether people are healthy or unhealthy. Each of the areas listed in Table 2 require actions from a government that is not focused entirely on the needs of economic growth but, rather, argues for policies which balance economic, social, cultural and environmental concerns (for detailed discussion see Baum 2008). Good conditions of daily life reflect living environments that encourage and support healthy behaviours. This is made possible when we invest in our children’s education, make living environments healthy and sustainable, promote fair and decent workplaces, and provide universal access to health care and a measure of universal social protection across the life course.
**Conclusion**

Sixty years ago the World Health Organization was founded and 30 years ago the Alma Ata Declaration on Health for All was written. It is fitting that the Commission on the Social Determinants of Health will report in the year of these anniversaries. The central messages about how we achieve health equity haven’t changed even though the threats to health that we now face may have. The power of citizen participation, ensuring a health perspective in policies in all sectors, and nominating health and wellbeing as key aims of government decision making all remain central.

South Australia has already picked up the Health in All Policies agenda from Europe and this could now form the basis of concerted action on the social determinants of health through the Council of Australian Governments (COAG). This is a golden opportunity to take the Commission’s report and develop a national plan of action to advance health equity and close the gaps in health status between different groups of Australians.

**References**


3. For more information about the Commission’s work streams and, in particular, details of the scope of the 9 KNs, see the CSDH website at: http://www.who.int/social_determinants/en/


13. People’s Health Movement website http://phmovement.org/


18. NHMRC is Australia’s peak body for supporting health and medical research. For details see http://www.nhmrc.gov.au/