



Commission on  
**Social Determinants of Health**

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The conditions in which people live and work can help to create or destroy their health – lack of income, inappropriate housing, unsafe workplaces, and lack of access to health systems are some of the social determinants of health leading to inequalities within and between countries.





“Interventions aimed at reducing disease and saving lives succeed only when they take the social determinants of health adequately into account.”

Dr LEE Jong-wook, Director-General,  
World Health Organization,  
The Lancet, 19 March 2005

**In both rich and poor countries, people’s health largely depends on the social conditions in which they live and work – the social determinants of health.**

The link between people’s health and their surroundings can no longer be ignored. Health inequities continue to grow across social classes, occupations, and ethnic groups within countries, even where more resources are made available and in spite of applying “the best” evidence-based interventions. Faced with this challenge, health policy-makers are seeking ways to shift from disease-focused solutions to people-focused solutions, taking into account the

realities of people’s daily lives and the societies in which they live. Such an approach requires incorporating health equity into all policies. The Commission on Social Determinants of Health (CSDH) recognizes health is a social goal and a responsibility across the whole of society. There is increasing evidence that better coordination and leadership to address the social dimensions of health across all governmental policy-making is possible, and results in improved health and access to health care. By acting on the social causes of ill-health, governments are poised to meet their development goals, reduce health disparities, promote population health, and create and sustain economically-viable societies.

*Act on inequalities,  
create fair health opportunities*



“At the core of the Commission’s work is the belief that a society that has organized its social conditions so that its population has better health is a better society. Health is a measure of the degree to which the society delivers a good life to its citizens.”

Sir Prof. Michael Marmot

Chair, Commission on

Social Determinants of Health

## Leading action on health inequities

The Commission on Social Determinants of Health (CSDH) created by the World Health Organization draws the attention of governments, civil society, international organizations, and donors to pragmatic ways of creating better social conditions for health, especially for the world’s most vulnerable people. WHO Director-General Dr LEE Jong-wook launched the Commission in March 2005. It will operate until May 2008.

### **The goals of the Commission are:**

- to support health policy change in countries by assembling and promoting effective, evidence-based models and practices that address the social determinants of health;
- to support countries in placing health equity as a shared goal to which many government departments and sectors of society contribute;

- to help build a sustainable global movement for action on health equity and social determinants, linking governments, international organizations, research institutions, civil society and communities.

### **The Commission’s approach allows it to:**

#### *Re-dress major gaps in evidence*

CSDH collects state-of-the-art information on major social determinants of health on a global scale which will improve the performance of health policy, its targeting and monitoring.

#### *Promote learning by doing*

Countries advancing action on social determinants are contributing their learning to the evidence-gathering work of the Commission, while learning from the experts and evidence assembled by the Commission.

#### *Create new alliances*

Action and knowledge agendas are being developed with the simultaneous involvement of leading scientists, practitioners, civil society organizations, government officials and global initiatives, creating new networks of advocates to tackle the social determinants of health.

#### *Set the foundation for a new health agenda*

The innovative global, regional and national networks being created by the CSDH enable it to create the foundations for a new and sustainable global agenda, which promotes a comprehensive approach to health and health equity.



## A key to achieving development targets

CSDH works with countries to develop more efficient health policies that lead to health equity. Its main focus is on:

- improving the performance of health policy by tackling the social determinants of health in all policies affecting health outcomes across government;
- increasing the capacity to design, implement and monitor interventions and address the social gradient of health; and
- placing equity at the centre of all government planning, policy and decision-making.

In partnering with countries from both the developing and developed world, CSDH creates a learning platform through which countries, already advanced or beginning to act on social determinants of health, share their experiences and build support mechanisms. Examples from countries as diverse as Brazil, Chile, and Sweden show how improving one area of development can snowball into other areas and promote the well-being of society.

## Country example: Chile

CSDH is supporting Chile to analyse health equity gaps in infant mortality and life expectancy. Chile is forging ahead with the social determinants of health agenda and launched the Health Reform and Chile Solidario (Chile in Solidarity Programme) to address health inequalities and improve health opportunities for the most vulnerable communities.

The Ministry of Planning and Cooperation was tasked to coordinate different social sectors, with equity as the goal. Through the Ministry's Solidarity and Social Investment Fund, the innovative Programa Puente (Bridge Programme) was established to:

- target families in extreme poverty, making them priority subjects of public policy;
- traverse government departments and use selective interventions to tackle inequities;
- include all sectors of policy-making that influence health.

Families covered under Chile Solidario are provided with a counsellor who facilitates access to a variety of social services including programmes that offer occupational skills, support for the disabled, and facilities for health and child development. Incentives have been created for employers who hire unemployed heads of households covered by the Solidario programme. Between 2002 and 2005, the number of families covered increased from 56 000 to 225 000.



*Opportunities early in life  
make for a brighter future.*

## Reaching beyond national borders

Regional-based strategies to address the social determinants of health provide opportunities for exchange and collaboration among countries, both within the same region and across regions, while ensuring the sustainability of the CSDH process beyond its tenure.

The Commission is playing a key role in promoting cooperation and support between countries through regional and international bodies. Through its work with civil society organizations, it is already witnessing a dynamic process in which organizations from different regions are beginning to identify common areas of interest and are developing ways to synchronize their actions on the social determinants of health.

In formulating its regional strategies, CSDH emphasizes:

- **The dissemination and use of existing knowledge in the region**, including the compilation of country-specific information on studies, policies and interventions on social determinants of health.
- **Advocacy through regional forums** to all the countries in the region to incorporate social determinants of health into public policies, with an emphasis on intersectoral action in the health policies of governments.
- **Strengthening institutions and regional networks** monitoring health inequities, promoting interventions, and assisting countries to address the social determinants of health and health inequities.
- **Strengthening and promoting the participation** of civil society organizations in regional work.

## Civil society participation redefined

An innovative approach has been developed to work with civil society representatives from across the globe to gather knowledge from different levels of society outside formal structures. Instead of merely “rubber-stamping” decisions made by others, civil society organizations working with CSDH have developed their own strategies through national and regional consultative processes. Thus, their knowledge and concerns contribute collaboratively to the process.

This approach seeks to respect civil society's critical autonomy and regional specificities, while empowering civil society partners and reinforcing their capacity for action on social determinants of health and health equity.

The active participation of civil society organizations in the work of the Commission aims to:

- provide a global platform for the civil society voice;
- strengthen capacities among participating civil society organizations;
- advance civil society agendas in relation to social determinants;
- broaden the political uptake of the Commission's messages;
- provide social monitoring of system failures and inequities; moreover, participating social groups can lead the action to correct such failures.





## Knowledge for action

Countries are often aware of the social causes of ill health, but few are successful in sustaining the implementation of actions to reduce inequities in health. Knowledge of how to act is still fragmented and not always useful for different stakeholders.

### **The CSDH aims to evaluate on a global scale:**

- the situation and evidence base in relation to health inequities and social determinants, including evidence of interventions, and
- policies and programmes tackling social determinants that have proven effective in helping to reduce health inequities.

Working through **nine specific themes**, the objectives include:

### **Collecting best practices on a global scale:**

the focus is on “what works” and providing policy-makers with interventions/ actions that can be used to improve health and reduce inequities.

### **Using an innovative process for**

**knowledge collection:** not only through research institutions but also from governments, communities, civil society organizations and international institutions.

### **Providing an interface between know-how and policy-making**

**processes:** through its approach to knowledge collection, changing the way all types of knowledge are valued and used by key stakeholders to improve health and health equity.

The nine specific themes are:

### **Early child development:**

Well-established evidence illustrates that opportunities provided to young children are crucial in shaping their lifelong health and development status. Evidence of successful models, and challenges to implementing early child development (pre-natal - 8 years) programmes, will be collected from countries, international agencies, nongovernmental organizations and civil society. Criteria will be developed for successful implementation in a range of country contexts with particular focus on low-income countries, and an easily-accessible database of successful programme models will be created.

**Globalization:** The scope is to examine how the dynamics and processes of globalization affect health outcomes. Trade liberalization, integration of production of goods, consumption and lifestyle patterns, and household-level income are among the aspects under study. The uneven distribution of gains and losses resulting from globalization, and its impact on inequities will be analysed to inform policies aimed at mitigating the actual and potentially harmful effects of globalization on health.

**Health systems:** The way health systems are designed, operate and financed acts as a powerful determinant of health. The effectiveness of different models of health systems in improving health equity outcomes will be reviewed. In an effort to gather and mainstream knowledge and action on how to overcome social barriers to health, the focus is on innovative approaches that incorporate effective action on social determinants of health. The recommendations from this work will be particularly relevant for resource-poor countries.

**Urban settings:** The focus is on urbanization, particularly broad policy interventions related to “healthy urbanization”. The Network will closely examine slum upgrading as an entry point for other possible interventions. The upstream determinants of healthy urbanization will also be analysed including stimulation of job creation, land tenure and land use policy, transportation, sustainable urban development, social protection, settlement policies and strategies, community empowerment, vulnerability reduction and better security, among others.



**Women and gender equity:** The aim is to define mechanisms and actions to reduce gender-based inequities in health by examining: (1) factors affecting social stratification and how to improve women's status relative to men; (2) differential exposures to health-damaging factors; (3) differential vulnerabilities leading to inequitable health outcomes; (4) differential economic and social consequences of illness and reproductive health needs; and, (5) factors which promote issues related to women in health systems and health research. In addition, women and gender equity will feature in each of the other themes.

**Social exclusion:** The relational processes that exclude particular groups of people from full engagement in community life may operate at the macro-level (access to affordable education, equal employment opportunity legislation, cultural and gender norms) and/or at micro-levels (income, occupational status, social networks around race, gender, and religion). The linkages between social exclusion and concepts such as social capital, social networks and social integration will be examined. The nature and operation of such processes and their association with population health status and health inequalities will be analysed in various country contexts selected to reflect the impact of differing structural (political, economic and social) constraints.

**Employment conditions:** Fresh insight will be sought on approaches to address employment conditions at the level of comprehensive policy, rather than interventions in specific workplaces. Evidence of the effectiveness on health equity of existing policies and programmes which address employment conditions in different countries and different vulnerable and high-risk groups will be gathered. Models and measures to improve the understanding of links between employment conditions and social determinants will be developed for different country contexts and for different vulnerable groups (such as migrants and workers in the informal economy). Ways to translate this knowledge into public and occupational health policy recommendations to improve the health of workers and their families will be elucidated.

**Priority public health conditions:** In the design and implementation of specific priority public health programmes, there are often factors which increase or perpetuate barriers to access to health care for disadvantaged groups and exacerbate inequities in health status. Evidence of these factors will be examined in country settings that vary by level of income and socioeconomic development.

**Measurement and evidence:** The aim of this cross-cutting theme is to develop methodologies and tools for measuring the causes, pathways and health outcomes of policy interventions to tackle the social determinants of health and health inequities. The focus is on approaches to document processes of change and to attribute improvements in health outcomes to programmes and policies. The group will produce guidelines for designing evaluations, including recommendations on appropriate quantitative and qualitative evidence, selection of indicators and variables, and development of measurement tools. These will also serve as a resource for the other specific themes and for the evaluation of CSDH as a whole.

*Don't get used to inequalities*





## Country example: Brazil

In March 2006, Brazil launched a national Commission to participate officially in the CSDH process and to address the needs of a large portion of the Brazilian population still suffering from social conditions that produce inequities in health. The national Commission has initiated a process to monitor these inequities and is emphasizing the expansion of existing knowledge. It aims to make a systematic study of the leading determinants of national health inequities, and the interventions that have been, and are being, used to address them. It will then facilitate the incorporation of this knowledge into the development and implementation of public policies. The national commissioners are drawn from many spheres including academic, political, media and business, and social leaders.

To interface with the national Commission, an intersectoral committee has also been established, bringing together the social ministries (education, labour, health, women's affairs, etc.), agriculture and development ministries, and other government bodies such as the national secretariat of municipal health councils. These councils are connected with the provision of primary health care and directly manage social and health action at the district level. Thus, the Brazil Commission and its linked bodies aim to achieve intersectoral action, social participation and the inclusion of areas responsible for managing and implementing public policy from local to national levels of governance.

## Country example: Sweden

In the late 1990s, Sweden launched an innovative public health strategy and national equity targets across government sectors. Based on a comprehensive review of health indicators across the social gradient, the government established eleven targets for improving health outcomes.

The new national agenda for improving health was established through an extensive consultation and consensus-building process involving different political constituents, civil society, technical and scientific stakeholders. In

late 1999, following an intersectoral steering mechanism, a national strategy for equity in health was proposed to the government. This culminated in a health system that promotes fair health opportunities for all social strata. The new health strategy and targets reflect a commitment, at the highest political levels, to an equity-orientated and intersectoral approach which delivers real improvements in health.

“Pressure from below has been useful in ensuring that health concerns are incorporated. For instance, one of the targets which refers to “Better health in working life” is the result of active pressure and support from employees and trade unions.” Swedish Commissioner Denny Vågerö.

## Commissioners – leading voices on health inequities

**Michael Marmot – Commission Chair** is Director of the International Centre for Health and Society, and Professor of Epidemiology and Public Health, University College London, United Kingdom. Professor Marmot has been at the forefront of research into health inequalities for the past 20 years, as principal investigator of the Whitehall studies of British civil servants, investigating explanations for the striking inverse social gradient in morbidity and mortality.

**Frances Baum** is Head of Department and Professor of Public Health at Flinders University and Foundation Director of the South Australian Community Health Research Unit. Professor Baum is one of Australia's leading researchers on the social and economic determinants of health.

**Monique Bégin** is a sociologist and the first woman from Québec elected to the House of Commons, Canada. She was twice appointed Minister of National Health and Welfare and remains best known for the Canada Health Act

(1984). An academic since leaving politics, Dr Bégin has taught Women's Studies at Ottawa and Carleton Universities, Canada.

**Giovanni Berlinguer** is a member of the European Parliament where he serves in two Commissions: "Environment and Health" and "Culture, Education and Information". Dr Berlinguer was responsible for Italy's first National Health Plan approved by Parliament (1968). He is a member of the International Bioethics Committee of UNESCO (2001–2007) and rapporteur on the project "Universal Declaration on Bioethics".

**Mirai Chatterjee** is Coordinator of Social Security for India's Self-Employed Women's Association (SEWA) - a trade union of over 200 000 self-employed women. She is responsible for SEWA's Health Care, Child Care and Insurance programmes. She has been a member of national task forces on social security, health and poverty reduction. Most recently, she was appointed to the National Advisory Council and the National Commission for the Unorganised Sector.

**William H. Foege** is Emeritus Presidential Distinguished Professor of International Health, Emory University (USA), and a Gates Fellow. An epidemiologist, Dr Foege worked in the successful campaign to eradicate smallpox in the 1970s. He was appointed Director of the United States Centers for Disease Control and Prevention in 1977. In 1984, he co-founded the Task Force for Child Survival, a working group for WHO, UNICEF, The World Bank, UNDP, and the Rockefeller Foundation. From 1999–2001, Dr Foege served as Senior Medical Adviser for the Bill and Melinda Gates Foundation.

**Yan Guo** is Professor of Public Health and Vice President of the Beijing University Health Science Centre, China. She is also Vice Chairman of the Chinese Rural Health Association and Vice Director of the China Academy of Health Policy. Professor Guo is an active advocate in promoting health policy, primary health care, rural health services management, maternal and child health care, and health education and promotion in China.

**Kiyoshi Kurokawa** is President of the Science Council of Japan and the Pacific Science Association. He is also Adjunct Professor, Research Center for Advanced Science and Technology of the University of Tokyo, Adjunct Professor of the Institute of Medical Sciences of Tokai University, and Professor Emeritus of the University of Tokyo. Dr Kurokawa has served in many ministerial committees in Japan and is currently Member of the Science and Technology Policy Committee of the Cabinet Office.

**Ricardo Lagos Escobar** is the former President of Chile. An economist and lawyer by qualification, he worked as an economist for the United Nations from 1976–1984. In the 1990s Lagos served in Chile under President Aylwin and his successor, President Eduardo Frei, as Education Minister and from 1994–1999, he was Minister of Public Works.

**Stephen Lewis** was Canadian Ambassador to the United Nations from 1984–1988. In this capacity, he chaired the Committee that drafted the Five-Year UN Programme on African Economic Recovery. From 1995–1999, Mr Lewis was Deputy Executive Director of UNICEF in New York, USA. He is currently UN Special Envoy for HIV/AIDS in Africa, appointed by UN Secretary-General Kofi Annan in 2001.



**Alireza Marandi** is Professor of Pediatrics at Shaheed Beheshti University, Islamic Republic of Iran. Dr Marandi is former Minister of Health and Medical Education. He is Chairman of the Iranian Society of Neonatologists, the Board of Directors of the Islamic Republic of Iran Breastfeeding Promotion Society, and the National Committee for the Reduction of Perinatal Mortality and Morbidity.

**Pascoal Mocumbi** was Prime Minister of the Republic of Mozambique from 1994–2004. Prior to that, he headed the Ministry of Foreign Affairs for eight years and the Ministry of Health for six years. He has been the High Representative of the European and Developing Countries Clinical Trials Partnership (EDCTP) since March 2004. Dr Mocumbi also has an active role in global health initiatives, serving on the board of the International Women's Health Coalition and the Medicines for Malaria Venture.

**Ndiro Ndiaye** is Deputy Director-General of the International Organization for Migration. In 1988, she was appointed by the President of the Republic of Senegal to the post of Minister for Social Development. From 1990 to 1995, Professor Ndiaye was Minister for Women's, Children's and Family Affairs.

**Charity Kaluki Ngilu** is the Minister of Health of Kenya. Since 1989, she has been a leader of the Maenbeleo ya Wanawake organization, the national women's movement. Before entering politics, Mrs Ngilu was Managing-Director of a food-manufacturing company in Nairobi, Kenya.

**Hoda Rashad** is Director and Research Professor of the Social Research Center of the American University in Cairo, Egypt. She is member of the Senate (El Shoura Council), one of the two parliamentary bodies in Egypt and she serves on the National Council for Women. She is currently a Vice-Chairman of the Dutch Development Assistance Research Council. In the past, Dr Rashad has served as a member of the Scientific and Technical Advisory Group of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.

**David Satcher** is Interim President of Morehouse School of Medicine, National Centre for Primary Care, USA. Dr Satcher served simultaneously as United States Surgeon General and Assistant Secretary for Health from February 1998 to January 2001. From 1993–1998, he served as Director of the United States Centers for Disease Control and Prevention and Administrator of the Agency for Toxic Substances and Disease Registry.

**Amartya Sen** is Lamont University Professor and Professor of Economics and Philosophy at Harvard University, USA. Dr Sen has served as President of the Econometric Society, the Indian Economic Association, the American Economic Association and the International Economic Association. In 1998, Dr Sen was awarded the Nobel Prize in Economics.

**Anna Tibaijuka** is Executive Director of the United Nations Human Settlements Programme (UN-HABITAT). Mrs Tibaijuka has spearheaded UN-HABITAT's main objective of improving the lives of slum dwellers in line with the Millennium Development Goals. She is also the founding Chairperson of the independent Tanzanian National Women's Council, and of the Barbro Johansson Girls Education Trust dedicated to promoting high standards of education for girls in Africa.

**Denny Vågerö** is Professor of Medical Sociology and Director of the Centre for Health Equity Studies, Sweden. He is a member of the Royal Swedish Academy of Sciences, and of its Standing Committee on Health. Dr Vågerö has been a key figure in European health inequalities research and is presently Vice-President of the European Society of Health and Medical Sociology. He was involved in the Swedish Government's Commission on Work, Environment, and Health.

**Gail Wilensky** is a Senior Fellow at Project Health Opportunities for People Everywhere, an international health education foundation. From 1990–1992, she was Administrator of the United States Health Care Financing Administration, overseeing the Medicare and Medicaid programmes and from 1997–2001, she chaired the Medicare Payment Advisory Commission. From 2001–2003, she co-chaired the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, which covered health care for both veterans and military retirees .

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