Achieving health equity: from root causes to fair outcomes

Michael Marmot, on behalf of the Commission on Social Determinants of Health

Health is a universal human aspiration and a basic human need. The development of society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage due to ill-health. Health equity is central to this premise and to the work of the Commission on Social Determinants of Health. Strengthening health equity—globally and within countries—means going beyond contemporary concentration on the immediate causes of disease. More than any other global health endeavour, the Commission focuses on the "causes of the causes"—the fundamental structures of social hierarchy and the socially determined conditions these create in which people grow, live, work, and age. The time for action is now, not just because better health makes economic sense, but because it is right and just. The outcry against inequity has been intensifying for many years from country to country around the world. These cries are forming a global movement. The Commission on Social Determinants of Health places action to ensure fair health at the head and the heart of that movement.

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Health inequality, inequity, and social determinants of health

Consider three children: one African, one south Asian, and one European. At birth each, representing the average for their country, has life expectancy of less than 50 years. The African and south Asian figures come from 1970, the European figure from 1901. Over the past century, life expectancy for the European child increased by about 30 years, and is still rising.[1] Between 1970 and 2000, the south Asian child's life expectancy rose by 13 years, whereas for the child in sub-Saharan Africa, during the same period, life expectancy rose by 4 months.[2]

The improvement in health in 20th century Europe, North America, and the other countries that now make up the Organisation for Economic Cooperation and Development, is a major societal achievement. Although there is no certainty as to what accounted for the improvement in Europe, it is most likely a combination of improvement in the conditions in which people live and work and, more recently, advances in medical care.

The health achievements that Europe has enjoyed have already started happening in south Asia and other regions (figure 1)—but have considerable distance still to go—and could happen in sub-Saharan Africa. No country or region should have to live with levels of ill-health that are avoidable. The lack of improvement in health in the countries of central and eastern Europe and the former Soviet Union is of concern, as are the other differences shown in figure 1. Improvements in living and working conditions, and finding a way to deliver known medical solutions, would lead to dramatic reductions in these global inequalities in health.

Such inequalities in health should not be tolerated. In many poor countries, maternal mortality ratios exceed 500 per 100 000 livebirths. In Sweden the ratio is two per 100 000.

Inequalities within countries and the social gradient

There is a second problem of inequalities in health: the dramatic differences within countries. These differences in health occur along several axes of social stratification including socioeconomic, political, ethnic, and cultural. One way of describing the magnitude of inequalities is the gap between top and bottom socioeconomic groups. In El Salvador, for example, if mothers have no education their babies have a one in ten chance of dying in the first year of life; if mothers have at least secondary education the infant death rate is a quarter of that.[3]

Such striking inequalities in health within countries are seen in rich countries, too. In Glasgow, UK, life expectancy of men in one of the most deprived areas was 54 years, compared with 82 years in the most affluent.[4] Thus the poorest men in Glasgow have lower life expectancy than the Indian average. Men with the lowest life expectancy in the USA (1997–2001)[5] had lower life expectancy than the Pakistan average (1995–2000).[6] In every instance, indigenous peoples of the world have life expectancies lower than the national average.[7]

But focusing on the gap between top and bottom fails to draw attention to a pervasive finding: the social gradient in health (figure 2).[8] With few exceptions, the evidence shows that the lower an individual's socioeconomic position the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic range. The gradient can be obvious or subtle. In general,

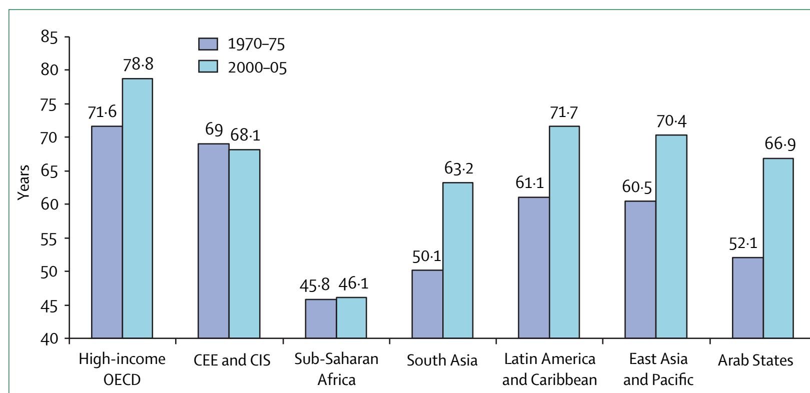

***Figure* 1: Life expectancy at birth by region, 1970–75 and 2000–05**
Source: Human Development Report 2005.[2]

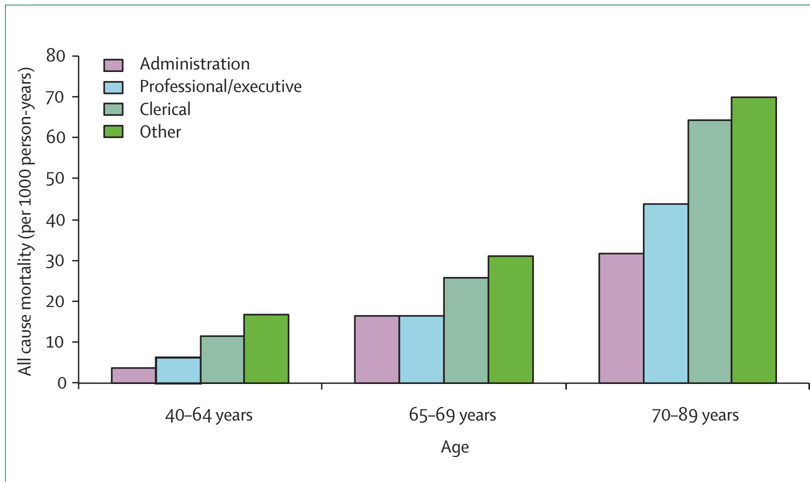

***Figure* 2: Mortality over 25 years according to level in the occupational hierarchy, Whitehall**
Source: Marmot and Shipley, 1996.[9]

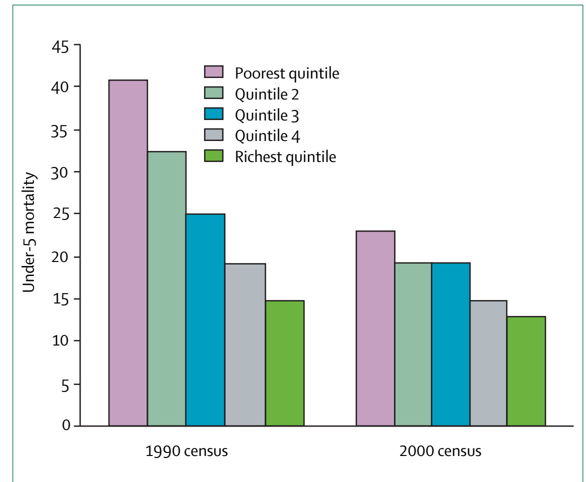

***Figure* 4: Under-5 mortality rates by wealth quintile, 1990 and 2000, Thailand**
Source: Vapattanawong and colleagues, 2007.[13]

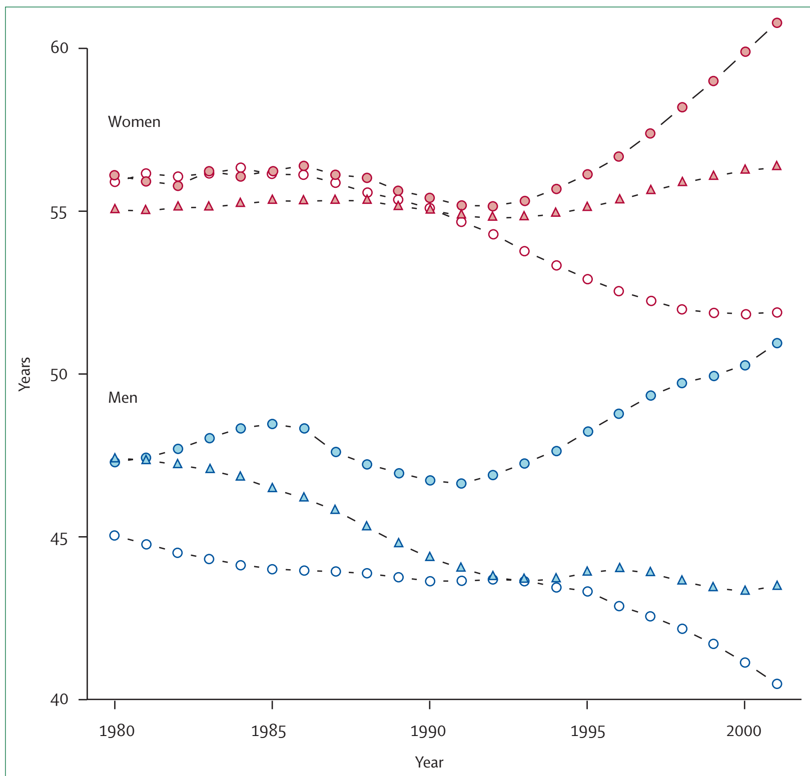

***Figure* 3: Trends in male and female life expectancy at age 20, by educational attainment, Russia**
Figure shows values for educational levels: elementary (open circles), intermediate (triangles), and university (filled circles). Source: Murphy and colleagues, 2006. [12] Reproduced with permission.

people second from the bottom have worse health than those above them but better health than those below. In Sweden, adults with a PhD have lower mortality than those with a professional qualification or Master's degree.[10] The gradient is a worldwide occurrence, seen in low-income, middle-income, and high-income countries.[11]

The gradient in health should not deflect attention from the plight of people at the bottom of the gradient, the poorest of the poor. Rather, the social gradient in health means that we are all implicated.

Inequalities in health within and between countries arise from inequalities within and between societies: in social and economic conditions and their effects on people's lives that determine their risk of illness, and the actions taken to prevent or treat illness when it occurs. Such inequalities are not inevitable or immutable. For example, we see increasing differences in Russia in life expectancy by level of education among both men and women (figure 3). There is also evidence that conditions can be changed for the better (figure 4). A central aim of the Commission on Social Determinants of Health is to assemble the evidence, particularly of what will make a difference, to lay the basis for action to reduce inequalities in health within and between countries. Where such evidence is lacking the Commission will make recommendations on how to redress the gaps.

Justice, inequality, and inequity

All societies have social hierarchies in which economic and social resources, including power and prestige, are distributed unequally. The unequal distribution of resources affects people's freedom to lead lives they have reason to value,[14] which in turn has a powerful effect on health and its distribution in society. The Commission takes issue with the unequal distribution of social conditions when health suffers as a consequence

Not all health inequalities are unjust or inequitable. If good health were simply unattainable, this would be unfortunate but not unjust. Where inequalities in health are avoidable, yet are not avoided, they are inequitable. This distinction can be illustrated by the difference in

men's and women's health. Women, in general, live longer than men. This difference is likely due to biological sex differences, and is not, therefore, inequitable. However, in cases where women have the same or lower life expectancy as men—that is, where social conditions act to reduce their apparently natural longevity advantage—inequality is a mark of inequity.[15] The injustice that the Commission seeks to address comes from failure to achieve levels of health that, but for lack of action, should be attainable.

The right to the highest attainable level of health is enshrined in the charter of WHO and many international treaties.[16] This right obliges governments and others to act—to take steps that increase all individuals' chances of obtaining good health. The realisation of this right, however, will take not just access to health care but action on the social determinants of health.

Although we see health as having intrinsic value—health as an end in itself—the Commission also recognises its instrumentality. Good health enables people to participate in society, with potentially positive consequences for economic performance.[17,18] Addressing the social determinants of health will yield greater, and sustainable, returns to existing efforts to improve global health.

Empowerment and freedom

At the heart of the concern with social determinants of health, and health inequity, is concern for people without the freedom to lead flourishing lives.[14] To make a fundamental improvement in health equity, technical and medical solutions such as disease control and medical care are, without doubt, necessary. But they are insufficient. There will need to be empowerment of individuals, communities, and whole countries.

We see empowerment operating along three interconnected dimensions: material, psychosocial, and political. People need the basic material requisites for a decent life, they need to have control over their lives, and they need political voice and participation in decision making processes. Although individuals are at the heart of empowerment, achieving a fairer distribution of power requires collective social action—the empowerment of nations, institutions, and communities.

The differential status of men and women in almost every society is perhaps the most pervasive and entrenched inequity. As such, the relation between the sexes represents as pressing a societal issue for health as the social gradient itself. Indeed the feminisation of the catastrophic AIDS epidemic in southern Africa clearly shows the lack of power of women to enjoy fundamental social freedoms.[19] This marked health inequity encapsulates disempowerment at many levels—government and institutional incapacity to act on evidence of gender effect, and the unequal participation of women in political institutions from village to international levels; unequal access to and control over property, economic assets, and inheritance; unequal restrictions on physical mobility, reproduction, and sexuality; sanctioned violation of women's and girls' bodily integrity; and accepted codes of social conduct that condone and even reward sexual violence against women. It is not enough to focus on delivering antiretrovirals to women with AIDS in southern Africa while doing little to deal with their profound disempowerment.

Panel 1: SEWA, the Self-Employed Women's Association, India

Many Indians, both urban and rural, experience severe disadvantage as a result of low social status: the combined effect of caste, education, and income. They have poor housing, with restricted access to clean water and sanitary facilities. They have had little in the way of financial resources and have difficulty pursuing their rightful livelihoods. Their children have had little opportunity for development and education, especially where they forego schooling to work with their parents. When ill, they have little access to health care, frequently only available for a fee.

In Ahmedabad, there are around 100 000 street vendors, forming a sizable proportion of the informal employment sector in the city. They sell fruit, vegetables, flowers, fish, clothes, vessels, toys, footwear, and many other items for daily and household use. Most vendors have been selling in the city's markets and streets for generations.

Like other poor self-employed women, the vegetable sellers of Ahmedabad live in poor parts of the city. They start work at dawn, buying their wares from merchants in the wholesale markets. They frequently need to borrow money, incurring very high rates of interest, and routinely face harassment and eviction from their vending sites by local authorities. The Self-Employed Women's Association (SEWA) is a striking example of collective action by these women and others like them, to challenge and change these conditions.

To strengthen control over their livelihoods, vegetable sellers and growers (all SEWA members) linked together to set up their own wholesale vegetable shop, cutting out exploitative middlemen. As a result, both growers and sellers have seen improved incomes through better prices for their produce. SEWA also organises child care, running centres for infants and young children, and campaigns at the state and national level for child care as an entitlement for all women workers. And SEWA members are improving their living conditions through slum upgrading programmes to provide basic infrastructure such as water and sanitation. This happens in partnerships with government, people's organisations, and the corporate sector.

To address the problem of access to credit, the SEWA Bank provides small loans and banking facilities to poor self-employed women, like the vegetable sellers, avoiding the interest rates demanded by private loan agents. The Bank is owned by its members, and its policies are formulated by an elected Board of women workers.

In times of health crisis, poor families not only lose work and income, but often also have to sell assets to secure the wherewithal to pay for treatment. Poor informal sector workers and their families are pushed further into the cycle of poverty and indebtedness. With SEWA, however, when the vegetable sellers or their family members fall ill, collectively organised health insurance can be used to pay for health care costs. SEWA has started an integrated insurance scheme for women in times of crisis.

Frequently harassed by local authorities, the vegetable sellers campaigned with SEWA to strengthen their status, through formal recognition in the form of licenses and identity cards, and representation on the urban Boards which govern market activities and urban development. That campaign, started within Gujarat, subsequently went all the way to the India Supreme Court, and inspired international attention and alliances.

Source: SEWA website http://www.sewa.org/services/bank.asp

Panel 2: Conditional Income Transfer (*Bolsa Familia*), Brazil

In many ways, Brazil of recent years is a good example of managed growth and commitment to poverty reduction. However, even though the government of President Lula Da Silva has set a course to address the high rates of inequality in the country, chronic poverty in parts of Brazil mean that the poorest households continue to suffer from multiple forms of disadvantage. They are frequently unable to secure adequate nutrition for the family, and in rural areas can be highly vulnerable to environmental hazards such as drought and flood. The poorest urban households are connected neither to the water nor the sewage system, and poor communities have no trash collection services. Poor access to education leads to relatively high rates of illiteracy, compromising employment opportunities for young men and women.

The period of so-called redemocratisation from the mid-1980s brought with it important changes in Brazil's approach to governance, social policies, and poverty reduction. A key component of this new policy environment is the Family Stipend Programme, or *Bolsa Familia*, a form of conditional cash transfer targeted at poor and extremely poor families to address key aspects of extreme poverty and reduce inequality.

The *Bolsa Familia*, launched in October, 2003, unified four federal programmes designed to address key aspects of household well being among the poorest families. These were: the school stipend, food stipend, food card, and fuel support programmes. Conditionalities stipulated that children between 7 and 15 years should be regularly attending school, and that growth, nutrition, development and immunisation status of children from 0 to 6 years should be regularly monitored. The programme also included prenatal care for pregnant women.

Complementary interventions, designed to safeguard household income and promote further poverty reduction, included adult literacy classes, aid to family-based agriculture, access to micro-credit, and professional or vocational training. At the federal level, the programme was coordinated through an Inter-Ministerial Management Committee. Originally, the *Bolsa Familia* secretariat was directly linked to the President's office. While municipalities were responsible for registering eligible families, the legislation enacting *Bolsa Familia* established local councils, including the participation of civil society organisations, to monitor interventions.[28]

The *Bolsa Familia* represents a holistic approach to social welfare, poverty reduction and addressing the interconnected conditions that lead to poor and inequitable health. Coordinated cross-sectorally, through inter-ministerial management, the programme acts on key aspects of wellbeing at the family and household level—from child development through stimulating uptake of health and education services, through nutrition for children and mothers, to living conditions with the fuel subsidy, and employment through vocational training, support to family agriculture, and micro-credit.

Although the share of total income represented by the conditional cash transfers has been relatively small, the programme's outstanding targeting (using a unified registry) has resulted in an impressive equalising effect, responsible for about 21% of the fall in the Brazilian Gini index (a measure of inequality of income distribution).[29]

The effect of these processes of disempowerment is most pronounced in indigenous populations,[1] among the most marginalised and disenfranchised peoples in the world, many of whom have experienced profound dispossession of land and erosion of culture. Their crisis is reflected in "wide disparities between the health status of indigenous peoples and non-indigenous peoples within the same country".[20]

In emphasising the need for both empowerment and technical solutions, we draw the parallel with contemporary models of development.[21] An increase in national income, by itself, does not capture development in its fullest sense. At the least, education and health should be included.[2] To achieve development in this fuller sense, economic growth is insufficient—it needs to proceed hand in hand with empowerment.[22]

A social determinants of health approach has several advantages. It bridges the artificial distinction between technical and social interventions, and shows how both are necessary aspects of action. It seeks to redress the imbalance between curative and preventive action and individualised and population-based interventions. And, by acting on structural conditions in society, a social determinants approach offers a better hope for sustainable and equitable outcomes.[23]

Social determinants of health and health equity

There is not a great deal of mystery as to why poor people in low-income countries suffer from high rates of illness, particularly infectious disease and malnutrition: little food, unclean water, low levels of sanitation and shelter, failure to deal with the environments that lead to high exposure to infectious agents, and lack of appropriate medical care. Similarly, we have a great deal of knowledge of the causes of non-communicable diseases that represent the major burden of disease for people at the lower end of the social gradient in middle-income and high-income countries. The WHO Global Burden of Disease study[24] identified underweight, overweight, smoking, alcohol, hypertension, and sexual behaviour as major causes of morbidity and mortality. For both groups of causes the question is how they and their inequitable distribution come about. That is, what are the causes of the causes?

The Commission believes that these health inequities are the result of a complex system operating at global, national, and local levels which shapes the way society, at national and local level, organises its affairs and embodies different forms of social position and hierarchy. The place people occupy on the social hierarchy affects their level of exposure to health-damaging factors, their vulnerability to ill health, and the consequences of ill health.[25]

Putting all these levels in context is the natural environment, and the macro-level to micro-level effects of environmental change. Risks to health include heatwaves and other extreme weather events, changes in infectious disease patterns, effects on local food yields and freshwater supplies, impaired vitality of ecosystems, and loss of livelihoods. If present trends continue the adverse health effects from human-induced environmental changes will be distributed unequally. The poor, the geographically vulnerable, the politically weak, and other disadvantaged groups will be most affected.[26] Addressing the intersection between social determinants of environmental change and the effect of environmental change on health inequities will benefit sustainable ecological and population health alike.[27]

To translate this conceptual understanding into action on the social determinants of health, the Commission convened nine thematic knowledge networks: globalisation, health systems, urban settings, employment conditions, early child development, social exclusion, women and gender equity, measurement and evidence, and priority public health conditions. Each network is reviewing evidence of what is likely to work and why. Other key factors such as violence and conflict, food and nutrition, and the environment were investigated. Special consideration is being given to the increase in the world's ageing population and its implications. Recommendations based on a comprehensive analysis of this work will be reported in the Commission's Final Report in 2008.

Case studies from low-income, middle-income, and high-income countries are described in panels 1–3. These case studies show the range of social determinants of health, the causes of the causes, and illustrate types of action that can be taken to tackle health determinants—from structural conditions of society to more immediate influences, at all levels from worldwide to local, across government.

The Commission sees action as a truly multi-stakeholder process, including government and non-government organisations, civil society more broadly, including trades unions, political parties, popular movements and alliances, private sector organisations and, crucially, health practitioners themselves. Key to multilevel, multisector action is coherence.

The three panels indicate how a combination of environments—home, school, work, neighbourhood, and health-care system—can unequally expose different groups to factors that damage health. None of them captures all elements of the ideal comprehensive strategy necessary to tackle health inequities. Rather, they illustrate various approaches and show how action on the conditions within the environments can improve people's material conditions, psychosocial resources, and behavioural opportunities.

Growing, living, and working

The tragedy of infant and child deaths in poor countries is that most are preventable. Child mortality shows a clear social gradient (figure 5).[36] Child survival is crucial. But so is the quality of children's development. More than 200 million children worldwide are not reaching their development potential.[37]

The Commission's Early Child Development knowledge network stresses the need for a balanced approach to children's development, consisting of physical, cognitive and language, and social and emotional components. In addition to economic circumstance, each component of child development is dependent on the nature of the environments in which children exist. A child's early environment has a vital effect on the way their brain develops. The more stimulating the environment the more connections are formed in the brain and the better the

Panel 3: Multilevel intersectoral action for health—Sweden

Sweden is, in general, a healthy place to live; life expectancy is among the highest in the world and infant mortality among the lowest.[30] Comparing absolute levels of mortality for manual and non-manual workers, Sweden has lower health inequities than other European countries.[31] Health in Sweden is contextualised by a stable, wealthy democracy with strongly developed social welfare policies broadly based on equal treatment.[32] The changing global context, in combination with an economic recession in the early 1990s, is, however, affecting the way work and life are organised. Although health is improving for all groups, health inequalities are growing.

Structural intervention

Norrbotten, an area in the north of Sweden, is characterised by traditional livelihoods in logging and mining. The region has started to see effects of globalisation in the increasing segmentation of traditional sectors, and increasingly precarious forms of employment—indicated by high and rising rates of sickness absence. The region has among the lowest rates of disposable income per person in the country. There are higher rates of death by cardiovascular diseases, suicide and alcohol-related diseases, especially among men. Norrbotten's unemployment rates are higher and education levels are lower than the national averages. The FRISK Initiative by the governor of Norrbotten is aimed at structural drivers in the field of employment and working conditions. Although concerned initially with sickness absence it now takes an integrated approach to (1) management training with a focus on positive health effects and health promotion; (2) improving the work environment and increasing worker safety; (3) providing information resources for the expansion of professional networks; and (4) supporting the rehabilitation of individuals who have been long-term unemployed.[33]

Community intervention

A more disease-oriented approach, combining individual and population-level efforts involving multiple sectors, is the Västerbotten Intervention Program. Västerbotten, a county in northern Sweden, had the highest cardiovascular mortality in Sweden. A long-term prevention programme was initiated in 1985 to address this problem. Especially the community intervention in Norsjö has been followed carefully and offers valuable experience for other communities. Contrary to other models, the health sector and its primary health care providers took an active role in the work, including health counselling and food labelling. In the 10-year assessment, the intervention area had a significantly larger decline in cholesterol, systolic blood pressure, and predicted coronary disease mortality.[34,35] People with low education seemed to benefit the most from the prevention programme, suggesting that the reduction of health inequity is possible through this type of programme.

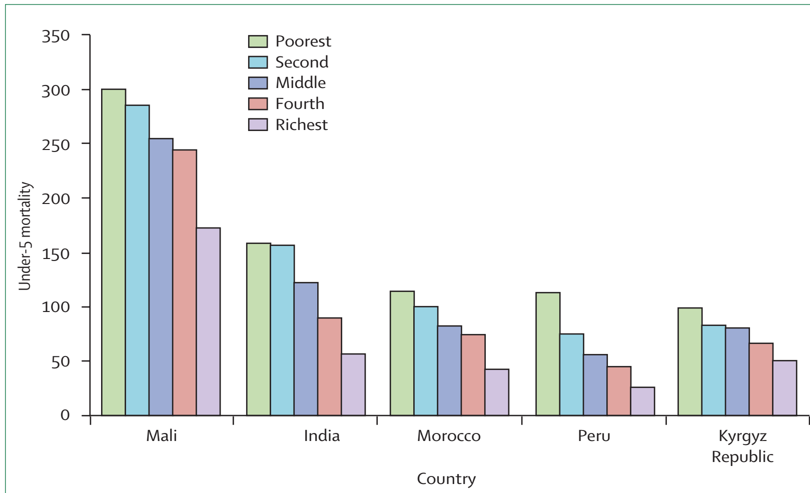

Figure 5: **Under-5 mortality (per 1000 livebirths) by wealth group**
Source: Gwatkin and colleagues, 2000.[36]

child thrives in all aspects of their life: physical development, emotional and social development, and their ability to express themselves and acquire knowledge. Although fundamentally important for childhood health, early child development also has far-reaching societal effects, with implications for health inequities in adult life.

In both India and Brazil, the approach of the Self-Employed Women's Association (SEWA, panel 1) and the policy orientation of the *Bolsa Familia* (panel 2) empower households to break intergenerational poverty through enhanced and more equitable support in childhood.

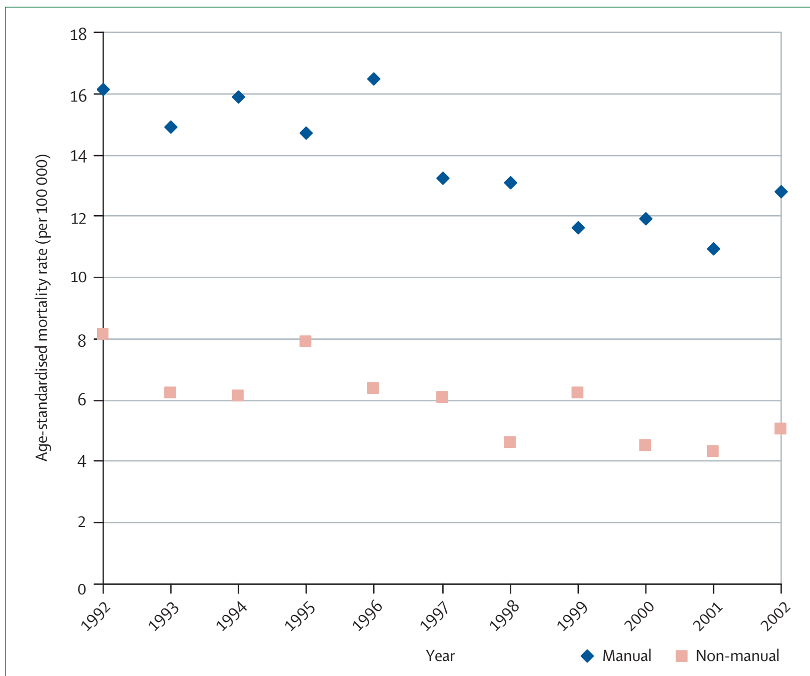

Figure 6: **Socioeconomic inequalities in male cirrhosis of the liver mortality, Australian manual and non-manual workers**
Source: Najman and colleagues, 2007.[42]

Brazil and India, like much of the developing world, are undergoing rapid urbanisation. In 2007, 1 billion of the 3 billion people who live in urban settings live in slums.[38] The scale of the urban problem might seem vast and unmanageable. However, urban areas can provide a healthy living environment. Better housing and living conditions, access to safe water and good sanitation, efficient waste management systems, safer neighbourhoods, food security, and access to services such as education, health, welfare, public transportation, and child care are social determinants of health that can be addressed through good urban local governance. SEWA, supported by the World Bank, shows the value of community-driven improvements to the living environment of the urban poor.

For most people in the world, living conditions are largely determined by economic opportunity afforded through the labour market. A major challenge to health is the conditions under which people work. This challenge applies both to working conditions and to the nature of employment contracts and the availability of work itself. In high-income countries, much action has been taken on physical and chemical hazards in the work place. But with greater segmentation of the labour market precarious employment has become more prevalent.[39–41] The example from Sweden (panel 3) shows how changing employment conditions towards less job security and control, are affecting people's wellbeing and health in a high-income country.

In low-income countries, persistent physical and chemical hazards are compounded by high rates of informal employment with negligible labour protection. Employment conditions provide a fertile area for major improvements in conditions of the physical and social environment. In India more than 80% of workers are outside the formal employment sector, excluded both from the protection afforded by labour standards and from whatever social security provisions are linked to formal employment. SEWA represents a good example of collective action among informal workers including collective bargaining and health and social insurance schemes. Producing goods for export, for example in textiles and clothing, provides employment for people in low-income countries. This benefit should not be at the cost of substandard employment conditions that damage health. The price of apparently cheap consumer goods for people in high-income countries should not be poor health in low-income countries.

Contextualising behaviour

Contemporary public-health interventions have often given primary emphasis to the role of individuals and their behaviours. The Commission recognises the important role of these factors, but sets them in the wider social context to illustrate that behaviour and its social

patterning, as shown in figures 6 and 7, is largely determined by social factors. Figure 6 shows how cirrhosis associated with heavy drinking is more common in lower socioeconomic groups. Countries with more restrictive alcohol policies tend to have lower levels of alcohol consumption, lower levels of mortality from liver cirrhosis, lower levels of other alcohol-related mortality, and fewer social problems due to alcohol.[44] National tobacco control efforts show the responsiveness of health-damaging behaviours to intersectoral action.

We believe that unless action also addresses the structural drivers of inequity in behaviour, it will not tackle the contribution of these behaviours to health inequities.

A new global trend is the so-called nutrition transition[45]—increasing consumption of fats, sweeteners, energy-dense foods, and highly processed foods. The world now faces a double burden of malnutrition—under-nutrition and over-nutrition, both of which are socially patterned.[46] Addressing nutrition inequities requires action on the structural drivers of food availability, accessibility, and acceptability at the global and national levels.[47]

Health systems

Although inequities in health result from the social conditions that lead to illness, the high burden of illness particularly among socially disadvantaged populations, creates a pressing need to make health systems responsive to population needs. International, national, and local systems of disease control and health services provision are both a determinant of health inequities and a powerful mechanism for empowerment. Central within these systems is the role of primary health care, as indicated by the community-based programme in Sweden (panel 3).

In some instances, health systems perpetuate injustice and social stratification. In low-income and middle-income countries, public money for health-care tends to go to services that wealthy people use more than poor people.[48] Reforms that lead to charging at the point of use are a disincentive to use of health care. Out of pocket expenditures for health care deter poorer people from using services, leading to untreated morbidity.[49] Such expenditures can also lead to further impoverishment[50] or bankruptcy.[51] The larger the proportion of health care that is paid out of pocket, the larger the proportion of households that are faced with catastrophic health expenditures.[52]

SEWA illustrates an organisational model that provides a safety net for some groups unable to meet acute health-care costs. The conditional cash transfer model of *Bolsa Familia* (panel 2) stimulates uptake of health services that typically do not get to poor communities. While financial support to improve access to and use of health services among the poor is crucial in the short term, the underlying issue for policy intervention is the need to reduce and remove financial barriers to

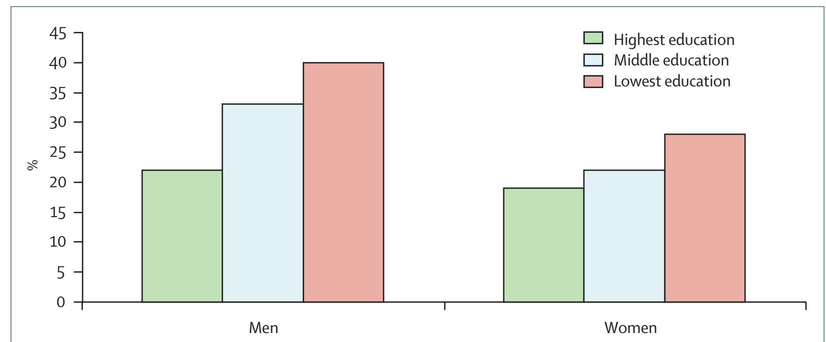

Figure 7: **Smoking prevalence (%) and inequalities in smoking by education level, Europe**
Source: Huisman and colleagues, 2005.[43]

such services. National health systems are pivotal in addressing health inequities; they need to be adequately resourced, function well, and be accessible to all. Appropriately configured and managed health systems provide a vehicle to improve people's lives, protecting them from the vulnerability of sickness, generating a sense of security, and building social cohesion within society; they can ensure that all groups benefit from socioeconomic development and they can generate the political support needed to sustain them.

Current efforts to revitalise primary health care worldwide[53] should go hand-in-hand with attention to the social determinants of health. Just as a social determinants approach to improving health equity must involve health care so must programmes to control priority public health conditions include attention to the social determinants of health. Such action has to involve multiple sectors in addition to the health-care sector. It is not sufficient, for example, to provide treatment for people with diabetes in middle-income countries and not deal with the drivers of the obesity epidemic; to be concerned with childhood illness and not education of women who will become mothers; to deliver health education to individuals and not be concerned with their poverty; to deal with stress-related illness and ignore the conditions in which people live and work that gave rise to it. Lasting control of tuberculosis requires the combination of treatment and preventive action taking into account biological, health-behavioural, and socioeconomic factors.

The shape of society

All societies are stratified along lines of ethnicity, race, gender, education, occupation, income, and class. Health inequities result from unequal distribution of power, prestige, and resources among groups in society. We see this very clearly in each of the case studies from India, Brazil, and Sweden. Although at very different stages of economic development, the differentiation of certain groups—be it by gender, caste, education, place, or income—is key to the way health inequity is generated.

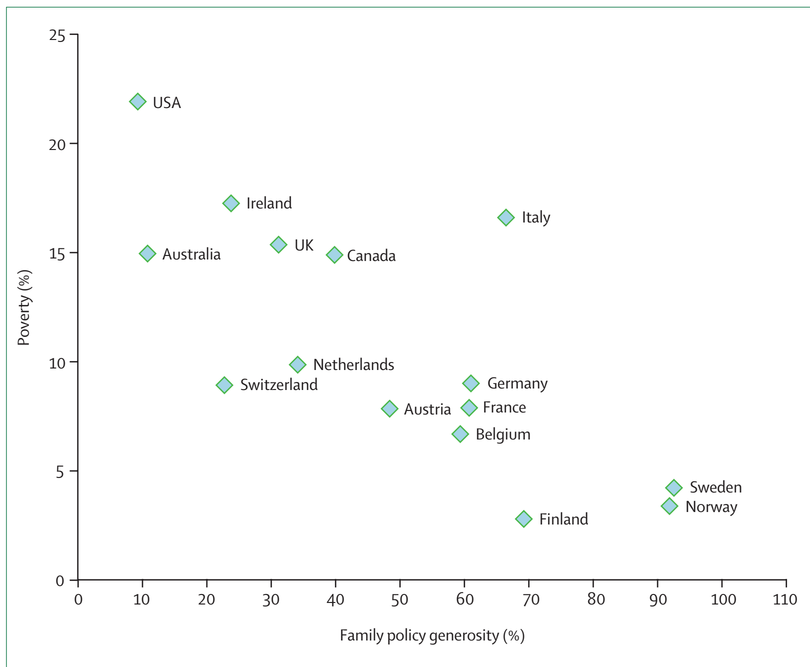

Figure 8: **Total family policy generosity and child poverty in 20 countries around 2000**
Net benefit generosity of transfers as a percentage of an average net production workers' wage. Poverty line 50 percent of median equivalised disposable income. Source: Lundberg and colleagues, 2007.[55] Reproduced with permission.

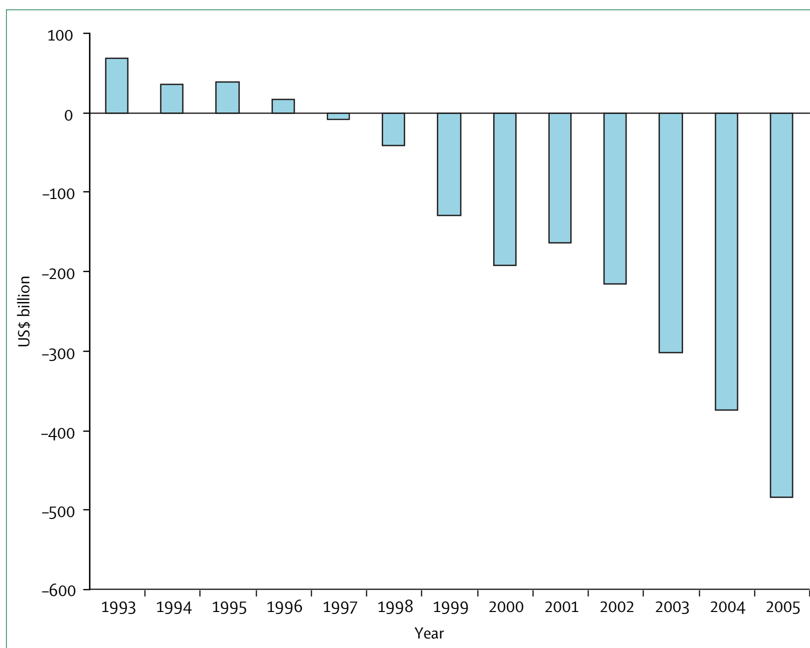

Figure 9: **Net financial flows: developing economies, 1993–2005**
Source: UNDESA, 2006.[59]

At the core of gender health inequity are social norms and structures which support and perpetuate bias. Women account for only 17% of parliamentarians worldwide.[54] The marginalisation of working women in India is substantial. While supporting its members' material circumstances and working arrangements, SEWA also takes action to challenge the Indian legal system. The emphasis in conditional cash transfer programmes, such as that in Brazil and Mexico, on channelling resources through female household members shows the importance policy places on supporting their role in protecting children's development and promoting family health.

The social context

Economic and social policies affect the distribution of the social determinants of health, including resources for education, health, and financial security. It is clear therefore why the relation between the Ministries of Health and Finance is so crucial to a social determinants view of health. Indeed, recognition of the importance of social determinants of health means that government social policy, not just health policy, is fundamentally important for health equity.

Pro-health equity policies seem to rely in many cases on the State in providing security via welfare programmes and a universal social safety net (figure 8). Sweden has, for much of the post-war period, maintained very strong State-led welfare policies. Redemocratisation in Brazil is associated with a strong commitment to address both poverty and inequity. In India, the material conditions of the vegetable sellers of Ahmedabad can be improved in the short term through local forms of collective action and empowerment. But a more sustained empowerment for workers comes from action at the structural level: through the state and national legislature, and improved access to credit.

Globalisation, with its remarkable acceleration of trade, knowledge, and resource flow, offers unprecedented promise for improving human health. Yet, to date, many feel that this promise has been disappointing.

The emphasis placed on globalisation as an engine of economic growth has overlooked or under-estimated the initial conditions of inequality between rich and poor countries, and within them. Where the social institutions through which people share resources are relatively strong and fair, moderate inequality can be constructive, driving the efforts and risk-taking at the micro level that underpin economic success. But where institutions governing the distribution of societal resources are weak, corrupted or structurally inequitable, as they are both within many countries and between the rich and poor regions, inequality can act destructively, suppressing local enterprise and perpetuating impoverishment.[56] So far, the benefits of globalisation have been largely asymmetrical, creating among countries and within populations winners and losers, with knock-on effects on health.

There is great benefit from increased trade openness, increasing inter-dependence among nations, and from an ability to deal with the major issues—environment,

health, security—at a global level.[57] But there is something profoundly wrong in the assumption that all countries come to these new global fora equally equipped.[58] Long historical trajectories bring countries together under globalisation at dramatically differing levels of institutional capacity and strength. A globalisation that does not provide for institutional capacity building among the developing nations is liable to foster and even increase inequity.

The poorest countries of the world, notably in sub-Saharan Africa, receive only small portions of global financial flows. In fact, net flows are increasingly from developing economies to high-income countries (figure 9). As a result, low-income countries rely heavily on official development assistance to finance their health systems and investments in social determinants of health and require more extensive forms of debt cancellation. Official development assistance continues to be important as a source of financing, complemented by more extensive forms of debt cancellation. Aid has the potential to lift as many as 30 million people out of absolute poverty each year, although its effectiveness is undoubtedly affected by issues of delivery. Strengthened social security systems would in the longer term act as a buffer against detrimental health effects of those benefiting less from trade liberalisation.[60]

Although the Commission recognises the contribution that economic growth can make to the availability of resources for reducing health inequities, growth per se is not a sufficient prescription for equitable improvements in population health. Nor is growth with inequality a simple or automatic trade-off. Rather, action within and between countries to mitigate and remove structural, destructive inequality is the necessary counterpart to worldwide growth itself and the policies that aim to support it.

Time for action

We are at a turning point. 60 years ago, in 1948, the establishment of WHO embodied a new global vision, emerging from the ashes of conflict, of universal health at the highest attainable level. 30 years later, in 1978, the community of nations came together again in Alma Ata to call for a new approach to health, founded on a holistic understanding of local primary health-care needs, across the social determinants, and of people-centred action.[61] In 2008, the end of the Commission as a formal entity will, we believe, be the launch of a global movement, one that perceives equitable health as a societal good, at the heart of which lies social action, and a field in which countries and people, rich and poor, can unite in common cause.

Proponents of health for all have been numerous and vocal around the world. The primary health care movement, though sometimes overshadowed by disease-specific concerns, never died. Indeed primary health care, once again has a central role in WHO's current agenda. The 1986 Ottawa Charter on Health Promotion, and its renewal in Bangkok, embraced a truly global vision of public-health action.[62,63] The Latin American social medicine movement and the People's Health Movement, the General Comment on the Right to Health, and the broad social vision of the Millennium Development Goals, all reaffirm the central importance of health, the need for social and participatory action on health, and the core human value of equity in health.[16,64–66]

Building on these efforts, the Commission represents a unique opportunity for action. Whereas in the past, efforts have been fragmented, the Commission for the first time brings together at a global scale actors, experiences, and evidence concerned with social determinants of health and health equity. At the global level, we now understand, better than ever before, how social factors affect health and health equity. And although the need for better evidence remains, we have the knowledge to guide effective action. By linking our understanding of poverty and the social gradient, we now assert the common issues underlying health inequity. By recognising the nature and scale of both non-communicable and communicable diseases, we show the inextricable linkages between countries, rich and poor.

As processes of globalisation bring us closer together as peoples and nations, we begin to see the interdependence of our aspirations: for human security, including protection against poverty and exclusion; and for human freedom, not just to grow and flourish as individuals but to grow and flourish together. And in these aspirations, we recognise the interconnectedness of the causes of health inequity, and the imperative of action which is global, social, and collective.

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Conflict of interest statement

I declare that I have no conflict of interest

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References

1 Willets RC, Gallop AP, Leandro PA, et al. Longevity in the 21st Century London. Presented to Institute of Actuaries and Faculty of Actuaries, 2004. http: //www.actuaries.org.uk/files/pdf/sessional/sm20040426_longevity.pdf (accessed Sept 4, 2007).
2 UNDP. Human Development Report 2005: International cooperation at a crossroads. Aid, trade and security in an unequal world. United Nations Development Programme, 2005.
3 World Bank. World Development Report 2006. Equity and development. New York: World Bank; OUP, 2006.
4 Hanlon P, Walsh D, Whyte B. Let Glasgow flourish. Glasgow: Glasgow Centre for Population Health, 2006.
5 Murray CJ, Kulkarni SC, Michaud C, et al. Eight Americas: investigating mortality disparities across races, counties, and race-counties in the United States. *PLoS Med* 2006; **3:** e260.
6 UNDESA. World Population Prospects: The 2006 Revision and World Urbanization Prospects: The 2005 Revision. United Nations: Population Division of the Department of Ecomonic and Social Affairs, 2006.
7 CSDH (Commission on Social Determinants of Health). Social determinants and Indigenous health: The International experience and its policy implications. CSDH. Report on specially prepared documents, presentations and discussion at the International Symposium on the Social Determinants of Indigenous Health, Adelaide, 29–30 April, 2007 for the Commission on Social Determinants of Health (CSDH), 2007.
8 Marmot M. Status syndrome. London: Bloomsbury, 2004.
9 Marmot MG, Shipley MJ. Do socioeconomic differences in mortality persist after retirement? 25 year follow up of civil servants from the first Whitehall study. *BMJ* 1996; **313:** 1177–80.
10 Erikson R. Why do graduates live longer? In: Jonsson JO, Mills C, eds. Cradle to grave: life-course change in modern Sweden. Durham: Sociology Press, 2001.
11 Victora CG, Wagstaff A, Schellenberg JA, Gwatkin D, Claeson M, Habicht JP. Applying an equity lens to child health and mortality: more of the same is not enough. *Lancet* 2003; **362:** 233–41.
12 Murphy M, Bobak M, Nicholson A, Rose R, Marmot M. The widening gap in mortality by educational level in the Russian Federation, 1980–2001. *Am J Public Health* 2006; **96:** 1293–99.
13 Vapattanawong P, Hogan MC, Hanvoravongchai P, et al. Reductions in child mortality levels and inequalities in Thailand: analysis of two censuses. *Lancet* 2007; **369:** 850–55.
14 Sen A. Development as freedom. Oxford: Oxford University Press, 1999.
15 Sen A. Missing women—revisited. *BMJ* 2003; **327:** 1297–98.
16 UN. General Comment 14: The right to the highest attainable standard of health. Geneva: Office of the United Nations High Commissioner for Human Rights, 2000.
17 Commission on Macroeconomics and Health. Macroeconomics and health: investing in health for economic development. Geneva: World Health Organization, 2001. Report of the Commission on Macroeconomics and Health.
18 Mackenbach JP, Meerding WJ, Kunst AE. Economic implications of health inequalities in the European Union (unpublished manuscript). Rotterdam: Department of Public Health.
19 Lawn JE, Cousens S, Zupan J. 4 million neonatal deaths: when? Where? Why? *Lancet* 2005; **365:** 891–900.
20 Nettleton C, Napolitano DA, Stephens C. An Overview of Current Knowledge of the Social Determinants of Indigenous Health. Working Paper for the Commission on Social Determinants of Health, 2007.
21 Marmot M. Health in an unequal world. *Lancet* 2006; **368:** 2081–94.
22 Stern N, Dethier J-J, Rogers H. Growth and empowerment: making development happen. Cambridge, MA: MIT Press, 2004.
23 Baum F. The new public health, 2nd edn. Melbourne: Oxford University Press, 2002.
24 Lopez AD, Mathers CD, Ezzati M, Jamison DT, Murray CJL. Global burden of disease and risk factors. New York: The World Bank and Oxford University Press, 2006.
25 Solar O. A conceptual framework for action on the social determinants of health: discussion paper for the Commission on Social Determinants of Health. Commission on Social Determinants of Health, 2007.
26 Stern N. The economics of climate change: the Stern Review. Cambridge: Cambridge University Press, 2007.
27 McMichael AJ, Friel S, Nyong A, Corvalan C. Global environmental change and human health: implications for health inequalities, social policy and the health professions. Commissioned by *BMJ* (in preparation).
28 Magalhaes R, et al. Conditional income transfer and poverty reduction programs: the experience of the Family Stipend Program (Bolsa Familia) in two municipalities of the state of Rio de Janeiro. 2007. CSDH Social Exclusion Knowledge Network.
29 Soares S, Osorio RG, Soares FV, Medeiros M, Zepeda E. Conditional cash transfers in Brazil, Chile and Mexico: impacts upon inequality. International Poverty Centre Working Paper 35, 2007.
30 National Board of Health and Welfare (Sweden). Public Health in Sweden—Status Report 2005. http://www.socialstyrelsen.se/Publicerat/2006/9081/Summary2006–1317.htm (accessed July 16, 2007).
31 Vagero D, Erikson R. Socioeconomic inequalities in morbidity and mortality in western Europe. *Lancet* 1997; **350:** 516–18.
32 Navarro V, Muntaner C, Borrell C, et al. Politics and health outcomes. *Lancet* 2006; **368:** 1033–37.
33 WHO Regional Office for Europe. Socioeconomic determinants of health: FRISK-satsningen, Norrbotten, Sweden. http://www.euro.who.int/socialdeterminants/socmarketing/20070220_3 (accessed Sept 3, 2007).
34 Weinehall L, Westman G, Hellsten G, et al. Shifting the distribution of risk: results of a community intervention in a Swedish programme for the prevention of cardiovascular disease. *J Epidemiol Community Health* 1999; **53:** 243–50.
35 Weinehall L, Hellsten G, Boman K, Hallmans G, Asplund K, Wall S. Can a sustainable community intervention reduce the health gap?—10-year evaluation of a Swedish community intervention program for the prevention of cardiovascular disease. *Scand J Public Health Suppl* 2001; **56:** 59–68.
36 Gwatkin DR, Rutstein S, Johnson K, Suliman E, Wagstaff A. Socio-economic differences in health, nutrition, and population. Washington, DC: The World Bank, 2000.
37 Grantham-McGregor S, Cheung YB, Cueto S, Glewwe P, Richter L, Strupp B. Developmental potential in the first 5 years for children in developing countries. *Lancet* 2007; **369:** 60–70.
38 UN-HABITAT. The Millennium Declaration: an urban perspective. Nairobi: United Nations Human Settlements Programme & World Bank, 2005.
39 Bartley M, Ferrie J, Montgomery SM. Living in a high unemployment economy: understanding the health consequences. In: Marmot M, Wilkinson RG, eds. Social determinants of health. Oxford: Oxford University Press, 2006.
40 Benach J, Muntaner C. Precarious employment and health: developing a research agenda. *J Epidemiol Community Health* 2007; **61:** 276–77.
41 Marmot MG, Siegrist J, Theorell T. Health and the psychosocial environment at work. In: Marmot M, Wilkinson RG, eds. Social determinants of health, 2nd edn. Oxford: Oxford University Press, 2006: 97–130.
42 Najman JM, Williams GM, Room R. Increasing socioeconomic inequalities in male cirrhosis of the liver mortality: Australia 1981–2002. *Drug Alcohol Rev* 2007; **26:** 273–78.
43 Huisman M, Kunst AE, Mackenbach JP. Inequalities in the prevalence of smoking in the European Union: comparing education and income. *Prev Med* 2005; **40:** 756–64.
44 Room R, Babor T, Rehm J. Alcohol and public health. *Lancet* 2005; **365:** 519–30.

45 Popkin BM. Nutritional patterns and transition. *Population and Development Review* 1993; **19:** 139–57.
46 Hawkes C, Chopra M, Friel S, Lang T, Thow A. Globalisation, food and nutrition transitions. WHO Commission on Social Determinants of Health. Working Paper Globalisation Knowledge Network, 2007.
47 Friel S, Chopra M, Satcher D. Unequal weight: equitable policy responses to the global obesity epidemic. Commissioned by *BMJ* (in preparation).
48 Gwatkin DR, Bhuiya A, Victora CG. Making health systems more equitable. *Lancet* 2004; **364:** 1273–80.
49 Palmer N, Mueller DH, Gilson L, Mills A, Haines A. Health financing to promote access in low income settings—how much do we know? *Lancet* 2004; **364:** 1365–70.
50 Whitehead M, Dahlgren G, Evans T. Equity and health sector reforms: can low-income countries escape the medical poverty trap? *Lancet* 2001; **358:** 833–36.
51 Gottlieb S. Medical bills account for 40% of bankruptcies. *BMJ* 2000; **320:** 1295.
52 Xu K, Evans DB, Carrin G, Aguilar-Rivera AM, Musgrove P, Evans T. Protecting households from catastrophic health spending. *Health Aff (Millwood)* 2007; **26:** 972–83.
53 PAHO. Renewing primary health care in the Americas: a position paper of the Pan American Health Organisation/World Health Organisation. Washington, DC: Pan American Health Organisation, 2007.
54 Inter-Parliament Union Database on “women in national parliaments”. http://www.ipu.org/wmn-e/world.htm (accessed June 25, 2007).
55 Lundberg O, Aberg Yngwe M, Kolegard Stjarne M, Bjork L, Fritzell J. The Nordic experience: welfare states and public health. Stockholm: Centre for Health Equity Studies, 2007.
56 Birdsall N. Inequality matters: why globalisation doesn’t lift all boats. *Boston Review* 2007 (March/April).
57 Cline W. Trade policy and global poverty. Washington, DC: Center for Global Development and Institute for International Economics, 2004.
58 Birdsall N. The world is not flat: inequality and injustice in our global economy. WIDER Annual Lecture, 2005. Helsinki: World Institute for Development Economics Research, 2006.
59 UNDESA. World economic situation and prospects, 2006. New York: United Nations Department of Economic and Social Affairs.
60 OECD. Towards Asia’s sustainable development: the role of social protection. France: Organisation for Economic Co-operation and Development, 2002.
61 WHO. Declaration of Alma-Ata. World Health Organization, 1978.
62 Catford J. The Bangkok Conference: steering countries to build national capacity for health promotion. *Health Promot Int* 2005; **20:** 1–6.
63 WHO. Ottawa Charter for Health Promotion. World Health Organization, 1986.
64 People’s Charter for Health. People’s Health Movement, 2000.
65 Tajer D. Latin American social medicine: roots, development during the 1990s, and current challenges. *Am J Public Health* 2003, **93:** 2023–27.
66 UN. Millennium Development Goals. New York: United Nations, 2000.