Health Equity at the Country Level: lessons from the CSDH on translating a complex agenda into action

Based on the Commission on Social Determinants of Health Country Report[1]

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[1] CSDH Country Report (2007). *Translating the social determinants evidence in to a health equity agenda at the country level: a progress report on the country stream of work in the Commission on Social Determinants of Health.* Geneva: World Health Organization. www.who.int/social_determinants/country_work/

Introduction

The Commission on Social Determinants of Health (CSDH) (2005-2008), launched by WHO, provided a unique opportunity to marshal the evidence on what can be done to promote health equity, and to focus global attention on the challenge of achieving greater health equity within and between countries through Action on the Social Determinants of Health. To achieve this, the Commission set up a process involving researchers, policy makers, WHO, and civil society, led by Commissioners with a blend of political, academic and advocacy experience.

CSDH Country Work

The CSDH "Country Work" stream aimed to:

(1) support countries in advancing action on social determinants of health (SDH) and health equity (HE) in their specific contexts, while

(2) enabling the CSDH to incorporate countries' experiences in its learning and recommendations.

A core group of interested governments worked with the CSDH Secretariat to establish foundations for ongoing progress and identify ways WHO can support national action on SDH and HE. Country Partners included Brazil, Canada, Chile, Iran, Kenya, Mozambique, Sri Lanka, Sweden and the UK.

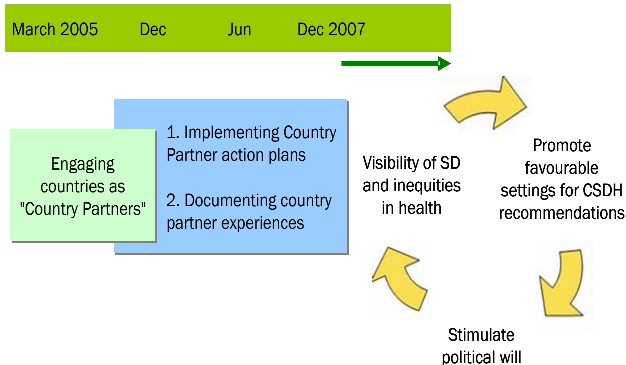

Figure 1 Strategy of the Commission's Country Work Stream (2005-2007)

Country Partners' specific objectives and action plans have shaped the Country Work agenda, while CSDH and WHO have provided technical support and political leverage to Country Partners in strengthening demand for action on SDH and HE; identifying and implementing policy solutions; and documenting results.

This report describes how the Country Work has been conceptualized and organized; how countries joined the process and how their efforts have progressed; how success in the Country Work is being measured; the major questions and challenges Country Partners have faced and the learning that has resulted. The concluding sections of the report outline challenges for strengthening capacities and sustaining the momentum that has been achieved through CSDH Country Partner action.

Five focus areas for action

Country Partners self-selected to use the opportunity for jumpstarting national action

on SDH presented by the Commission. Country Partners have taken their work forward in distinctive ways, reflecting their specific contexts and priorities. The CSDH has, however, highlighted five critical shared areas for national action on social determinants and health equity. Country Partners endorsed this approach.

The five focus areas were:

(1) assessing the national health equity situation (baseline analysis);

(2) 'getting the health sector right', i.e., identifying and using opportunities to strengthen health equity through policy and programme choices internal to the health sector;

(3) spurring intersectoral action on SDH, including through a 'whole-of-government' approach;

(4) social participation in SDH action; and

(5) pursuing 'how to' knowledge to support implementation of SD and HE policies.

Strong overall progress has been registered among Country Partners during their collaboration with the Commission. At this stage, gains are mostly measurable in terms of the political *processes* that have enabled Partners to jumpstart promising national action. Impacts on population health status and equity gaps will be measured over a longer timeframe. Within the short time allotted for formal CSDH Country Work, progress in advancing pro-equity and SDH

policies has been demonstrated on several fronts, including: raising the political and public visibility of SDH/HE issues; improvements in the information environment for an SDH/HE agenda; development of incentive structures to increase accountability on SDH/HE issues; improvements in health sector programming with an SDH approach and capacity building for personnel; creation or strengthening of processes and structures to support intersectoral action for health; and increased incorporation of social participation into policy processes.

Learning from Country Work

This report organizes learning from the Country Work process according to five major questions countries had to face as they advanced national SDH agendas. These questions, and the solutions found by Country Partners, will be relevant to other countries seeking to tackle SDH in the future.

1. How can countries catalyze action at the national level?

Country Partners' experience shows that driving SDH action requires managing several processes, which have tended to unfold through three overlapping phases:

(i) increasing the visibility of SDH and HE issues, for example by using data on existing health inequities to stir public concern and generate political will for action;

(ii) creating an institutional structure to take the SDH agenda forward, for example a national commission on SDH or a national

reference group; for best results, such structures should incorporate spaces for dialogue between government and civil society on SDH/HE issues;

(iii) developing a national action plan—which need not be exhaustive, but can usefully highlight specific opportunities for action in a relatively short time frame (e.g., one year).

Country Partners' action plans have given attention to short-term deliverables and potential 'quick wins', while also looking towards more ambitious horizons of structural change to reduce social inequities. The perspective has generally been incremental and additive, based on the idea that smaller initiatives now will build momentum for systemic change.

2. What can the health sector do to promote an SDH and HE agenda internally?

For countries embarking on SDH work, the health sector is a good place to start, even if their ultimate goal is to employ an approach that involves the whole of government. Country Partners found that 'getting the health sector right' requires priority action in the following areas:

(i) presenting information on the health equity situation strategically, to reinforce political commitment and highlight opportunities for intervention, for example by using statistical decomposition analysis to pinpoint the roots of specific health inequities, as has been done for under-five mortality in Iran;

(ii) ensuring that the health system's design and management contribute to reducing socially determined health inequities, and that health sector programmes are equity-sensitive;

(iii) establishing national health equity goals and plans to achieve them, as Chile and England did prior to beginning Country Work, and as Kenya and Mozambique are now intending;

(iv) strengthening the national health information system to improve ‘health intelligence’ and routine monitoring of social health inequities, as Sri Lanka is now doing through improvements to its national vital registration system and key survey tools, in collaboration with CSDH and WHO.

3. What should the health sector be doing about cross-sectoral action on socially determined health inequalities?

The health sector has responsibility to identify an appropriate role in intersectoral/cross-sectoral action towards health equity goals. Intersectoral action has long been recognized as an essential facet of primary health care (PHC). Historically, however, intersectoral work has been among the most challenging dimensions of PHC to implement.

As part of its work with the CSDH, Canada has sponsored a series of more than 20 country case studies on intersectoral action. These constitute a substantial new body of evidence to inform policy approaches in countries at all income levels. There are several levels of integration within

intersectoral activities, ranging from cooperation to avoid overt programming and policy conflicts among sectors, to coordination, to integrated policy-making. Countries have found that beginning with relatively limited forms of cooperation can be a useful way to build skills, trust and a culture of collaboration, laying groundwork for more ambitious efforts. Many CSDH Country Partners have recognized the goal of moving from a traditional model of intersectoral action towards more comprehensive, cross-sectoral strategies and ultimately a whole-of-government approach.

Country Partners' experiences point to a series of key steps in advancing intersectoral agendas, including:

(i) clearly define the role the Ministry of Health will play;

(ii) engage communication with other Ministries to identify shared concerns and potential areas of action; if ambitious collaborations involving multiple sectors are not immediately feasible, work can begin on priority objectives that may engage only one other ministry, as in Mozambique, where the Ministry of Health plans to develop water and sanitation interventions with the Ministry of Public Works to reduce infant mortality;

(iii) to expand intersectoral buy-in, consider incorporating 'social determinants of health' into a broader, more accessible vocabulary of social justice and wellbeing, as Chile is doing with its national social protection system;

(iv) use tools such as Health Equity Impact Analysis to evaluate policies outside the health sector and show why and how health concerns should be incorporated in these areas;

(v) support innovative government management models and incentive structures that can encourage intersectoral cooperation, such as Chile's new public-sector Management Control System;

Figure 2 From left to right: Lula da Silva (President of Brazil), Michelle Bachelet (President of Chile), Maria Barria (Minister of Health, Chile): **Inter country dialogue on how to work across government sectors and increase social participation to improve health equity**

(vi) line up the support of government and administrative actors with broad mandates: for example the Office of the President, as in the case of Brazil's National Commission, or legislative actors, as when action by Canada's CSDH Reference Group led to a Senate Sub-Committee agreeing to study SDH policy options and report its findings to Parliament.

4. How can Ministries of Health improve social participation on SDH/HE?

Civil society participation can strengthen political will around SDH and HE agendas. Social participation involving vulnerable and excluded groups should seek the empowerment of those groups, increasing their effective control over decisions that influence their health and life quality. All CSDH Country Partners explored ways to build

social participation into SDH processes. However, political structures and institutional cultures often hamper substantive participation. Brazil's model of institutionalizing participatory management in health policy holds promise.

As part of their collaboration with the Commission, WHO Regional Offices, in particular AMRO/PAHO and EMRO, supported work to strengthen regional civil society capacities on SDH. If the work is followed up and existing momentum reinforced, these processes will continue to build informed demand and civil society action on SDH/HE.

5. What kinds of capacities and skills need development to strengthen SDH/HE action, and how can the health sector build capacity?

Workforces in many countries lack training in areas that are important for addressing SDH/HE. While basic skills can be taught relatively quickly, countries need mechanisms to institutionalize ongoing learning and foster the development of new skills. The aim must be to build a cadre of trained experts able not only to adopt and implement an SDH approach but also to develop new techniques and strategies.

Capacity building may be especially urgent in the following areas: SDH monitoring and data analysis; capacity to plan and implement health sector programmes that take on board how the health system itself functions as a social determinant; capacities and mechanisms for cross-government action and social participation; and translating/

communicating evidence to influence policy processes.

Several Country Partners provided or received forms of training during their CSDH work, including Brazil, Chile, Iran, Mozambique, and Sri Lanka.

Early recommendations of work by the Margo Institute are still relevant. They identified the need for two types of training: on the job skills improvement, and the development of new cadres of human resources that were better equipped to deal with health as a broader construct.

Significant progress in 3 years

A key finding of the Country Work is that countries can make significant progress in political action to tackle the social determinants of health inequities in a short time, such as the three-year lifespan of the CSDH. Of course, the nature and scope of a given country's specific advances depend on its context and history.

For *countries with less experience* in formally addressing SDH through intersectoral policy, including most countries in the AFRO region, the CSDH Country Work has generated political interest in SDH and in jumpstarting the process towards policy development by supporting baseline analysis of health equity and relevant social determinants.

For *countries with some experience*, such as Brazil and Chile, the work has generated considerable political support for an SDH focus, and led to the creation of new

mechanisms and institutional structures to promote intersectoral policy development, as well as pro-equity improvements within the health system.

For *countries with significant previous experience*, such as England and Canada, the work has facilitated cross-national sharing of lessons and joint research initiatives. Joint research efforts have surfaced valuable experiences in intersectoral action and integrated policymaking. Collaborative research has also contributed to confirming the economic and equity benefits of tackling upstream health determinants.

Challenging conventional wisdom

Country Partners' experiences encouraged the CSDH to challenge current 'conventional wisdom' in areas such as welfare state policy and state-civil society collaboration.

Role of welfare state

Notably, countries emphasized the importance of robust welfare state protections as an efficient, effective means of improving health and strengthening health equity among social groups—at a time when welfare state mechanisms are under attack in some circles. Research from the Nordic countries has clarified and systematized relevant learning. While the public health effects of any specific redistributive welfare state policy may be best, the combined effect of all such policies and institutions is likely to be substantial. This is especially true from a life-course perspective. People who enjoy access to resources provided by the welfare

state, in addition to the resources of the market and the family, are likely to live longer.

State - civil society collaboration

Some CSDH Country Partners adopted policy approaches that explicitly highlighted social solidarity as a guiding value. Countries also explored different strategies for operationalizing this value in policy and programming. At the same time, Partners' achievements to date necessarily raise additional questions. Areas of active enquiry include how universal health and social protection policy models relate to targeted strategies for the needs of special groups. Similarly, reconciling social participation, inclusiveness and accountability with the imperative for efficient, goal-driven, government action is no simple matter. No uniform solutions exist, and a wide range of strategies may prove useful in specific contexts. These issues point out directions for continued learning in the years ahead.

Sustained effort over time

Improving health equity is a long-term process. Unfair health differences among communities have deep historical roots and are anchored in social and political structures. Partner Countries have shown that change can happen fast; however, 'leveling up' social determinants to substantially reduce inequities demands continuity of effort over time. A crucial objective for the coming years is to sustain and build on the momentum generated by the Country Work. Pathfinder Countries will be leaders in this process. WHO will play an important supporting role.

Moving forward: building capacities and sustaining active learning

Various models exist for understanding how evidence, such as that generated by the CSDH, is translated into political action. The CSDH process has confirmed the importance of negotiating the 'non-linearity' of policy processes. Models for understanding how evidence is translated into action highlight five key elements in an active learning process on supporting action in countries :

(1) disseminating evidence on health equity determinants to create political will for action;

(2) stimulating an increasingly inclusive, informed debate on improving health equity and mobilizing demand for action on social determinants for health equity;

(3) building mechanisms and processes through which pending and new-emerging questions can be addressed and the resulting knowledge shared in an interactive way (between practitioners and between researchers);

(4) supporting country implementation, including pilots, and ensuring active learning from these processes;

(5) supporting 'snowballing' of action across countries, through technical advice and tools for implementation and evaluating their effectiveness.

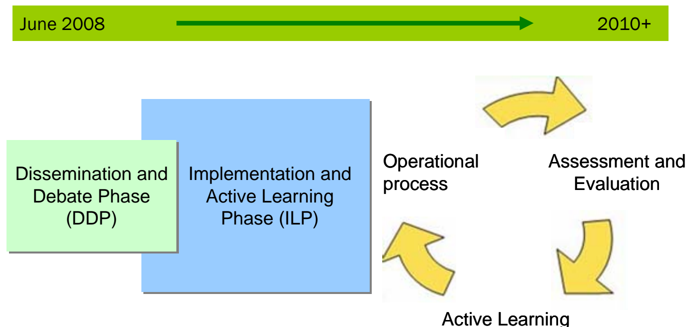

Figure 3 An Implementation and Active learning approach

WHO's Medium-Term Strategic Plan for 2008-2013 establishes a strong organizational mandate for supporting country action on the socio-economic determinants of health equity. WHO needs to reinforce its institutional competencies to meet country demand in this area. WHO Regional Offices will be at the heart of this effort.

As the architects of the Alma-Ata vision saw, delivering Primary Health Care effectively at country level requires an equity-oriented, participatory policy framework and cross-sectoral action on social determinants. Thirty years later, the evidence base has expanded; political and social contexts have evolved; the division of roles and responsibilities among key actors has shifted; and new strategies are required to achieve results.

CSDH Country Partners have charted innovative paths in action on social determinants for health equity. These promising directions must now be pursued to deliver on the promise of improved health for all with accelerated gains for vulnerable and disadvantaged communities.

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