

OVERVIEW OF ACTION ON SOCIAL DETERMINANTS OF HEALTH AT THE GLOBAL AND EUROPEAN LEVEL

Giuseppe Costa
(puzzle di contributi da WHO Venezia e
IHE Londra)

Closing the gap in a generation

Health equity through action on
the social determinants of health

- Social justice
- Empowerment –
material,
psychosocial, political
- Creating the
conditions for people
to take control of their
lives



The WHO Commission on Social Determinants of Health (CSDH) – Overarching recommendations



Improve the conditions in which people are born, grow, live, work, and age

Tackle the Inequitable Distribution of Power, Money, and Resources

Measure and Understand the Problem, Evaluate Action, Expand the Knowledge Base, Develop the Work Force

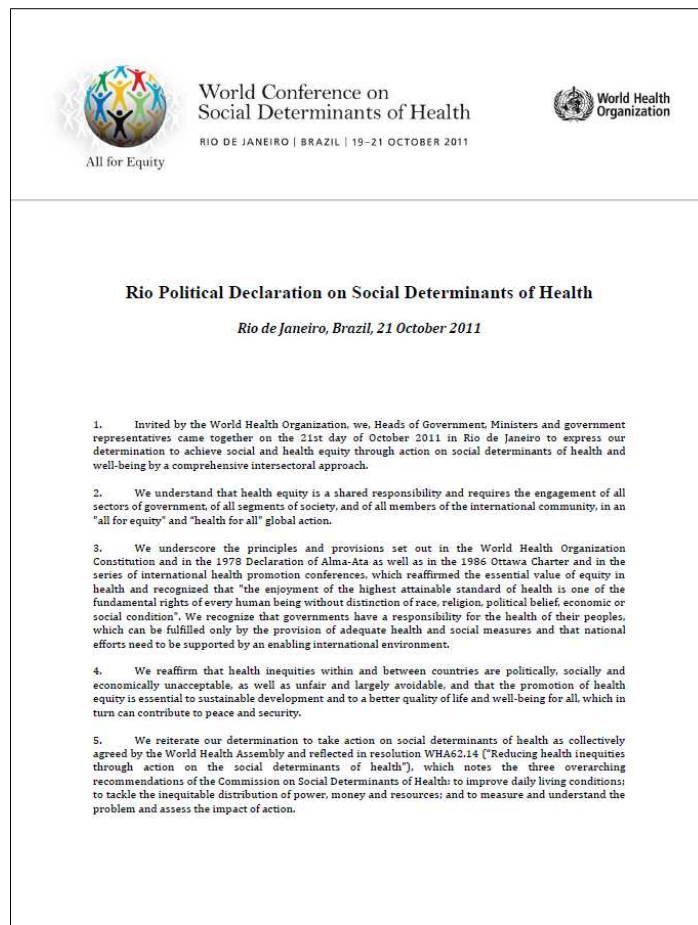
Examples of initiatives, actions and results on SDH: governmental and non-governmental actors

- Global and regional
- National
- Local (municipalities)
- Non-governmental actors
- Health professionals

Background and achievements

- 2008: Final report of CSDH published
- May 2009: WHO Member States endorse report's findings in resolution WHA62.14
- WHO mandated to convene *World Conference on SDH*, 19-21 October 2011, Rio de Janeiro
 - To build support for the implementation of action on SDH
 - Conference attended by over 1000 participants representing 125 Member States and a diverse group of stakeholders
 - Member States adopted the *Rio Political Declaration on SDH*
- May 2012: Rio Political Declaration endorsed in resolution WHA65.8 at the 65th WHA in May 2012.
 - Declaration constitutes WHO's mandate to work on SDH

Rio Political Declaration on SDH



1. To adopt **better governance** for health and development
2. To promote **participation** in policy-making and implementation
3. To further **reorient the health sector** towards reducing health inequities
4. To strengthen **global governance** and collaboration
5. To **monitor progress** and increase accountability

Advancing SDH agenda within WHO

- 12th WHO General Programme of Work for 2014–2019

“Addressing the social, economic and environmental determinants of health as a means of reducing health inequities within and between countries”

identified as 1 of 6 leadership priorities and part of WHO’s fundamental approach to health

- Internal WHO analysis in March 2013 shows that 105 country cooperation strategies include requests for technical support for addressing SDH or implementing a “Health-in-All-Policies” approach.

Advancing SDH agenda for global development

- For the UHC, Post-2015 and sustainable development agendas, the social, economic and environmental determinants of health and health equity are considered integral components
 - *UN General Assembly resolution on Global Health and Foreign Policy*
 - Post-2015 development goals, WHO is proposing:
 - Overarching health goal: *“Ensure healthy lives and universal health coverage at all stages of the life course”*
 - 1 of 4 sub-goals: *“Address the social and environmental determinants of health”*

Examples of joint work with programmes

Global health sector strategy on **HIV/AIDS 2011-2015**

6. Strategic direction 4: Reduce vulnerability and remove structural barriers to accessing services

- 6.1 Promote gender equality and remove harmful gender norms
- 6.2 Advance human rights and promote health equity
- 6.3 Ensure health in all policies, laws and regulations

Multisectoral Action Framework for Malaria



RESEARCH ARTICLE

Open Access

Social determinants of health and seasonal influenza vaccination in adults ≥ 65 years: a systematic review of qualitative and quantitative data

Social Protection Interventions for Tuberculosis Control: The Impact, the Challenges, and the Way Forward

A POLICY GUIDE
for Implementing
Essential Interventions
for Reproductive,
Maternal, Newborn
and Child Health
(RMNCH)

Addressing Ethical Issues in Tuberculosis Programmes with a Special Focus on Social Determinants

Eliminating the Catastrophic Economic Burden of TB:
Universal Health Coverage and Social Protection Opportunities

A consultation to inform the post-2015 TB Strategy and action at national level
Hosted and co-organized by the Ministry of Health of Brazil

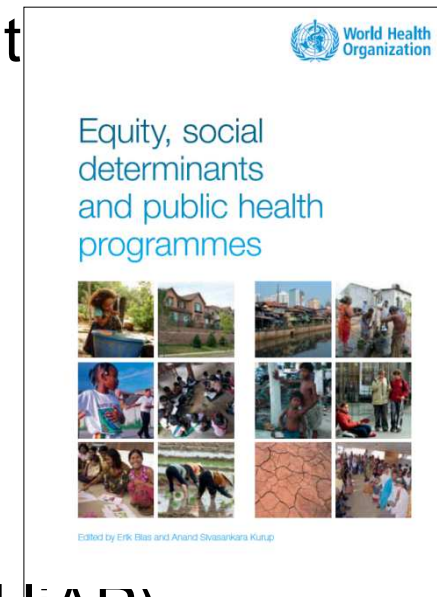
**Strategy Briefs on Cross Sectoral Approaches to
Women's and Children's Health**

Many publications, analyses, case studies, resources...



Supporting integration of social determinants within WHO and national government programmes

- Developing “5-stage and 5-step” tool for re-orienting national health programmes to better account equity, SDH, gender and human rights
- Tool will enable health programmes to
 - better meet their objectives and targets
 - reduce health inequities
 - more strongly contribute to progressive realization of UHC and building health sector’s stewardship role (operationalize HiAP)
- Developing related tools and initiatives to support WHO programmes at country office and headquarters level to similarly re-orient their work plans





Discussion Paper

Addressing the Social Determinants of Noncommunicable Diseases

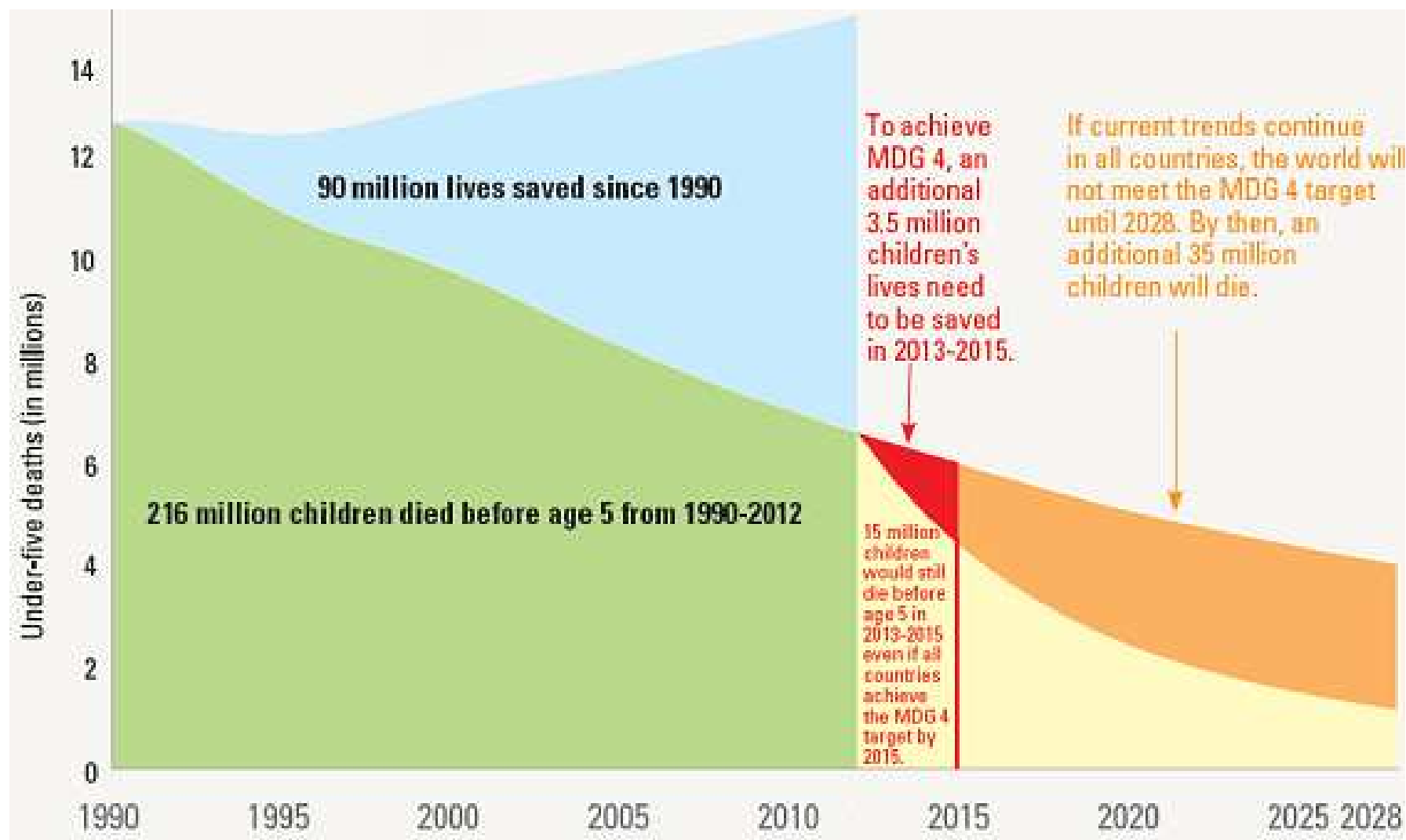
October 2013



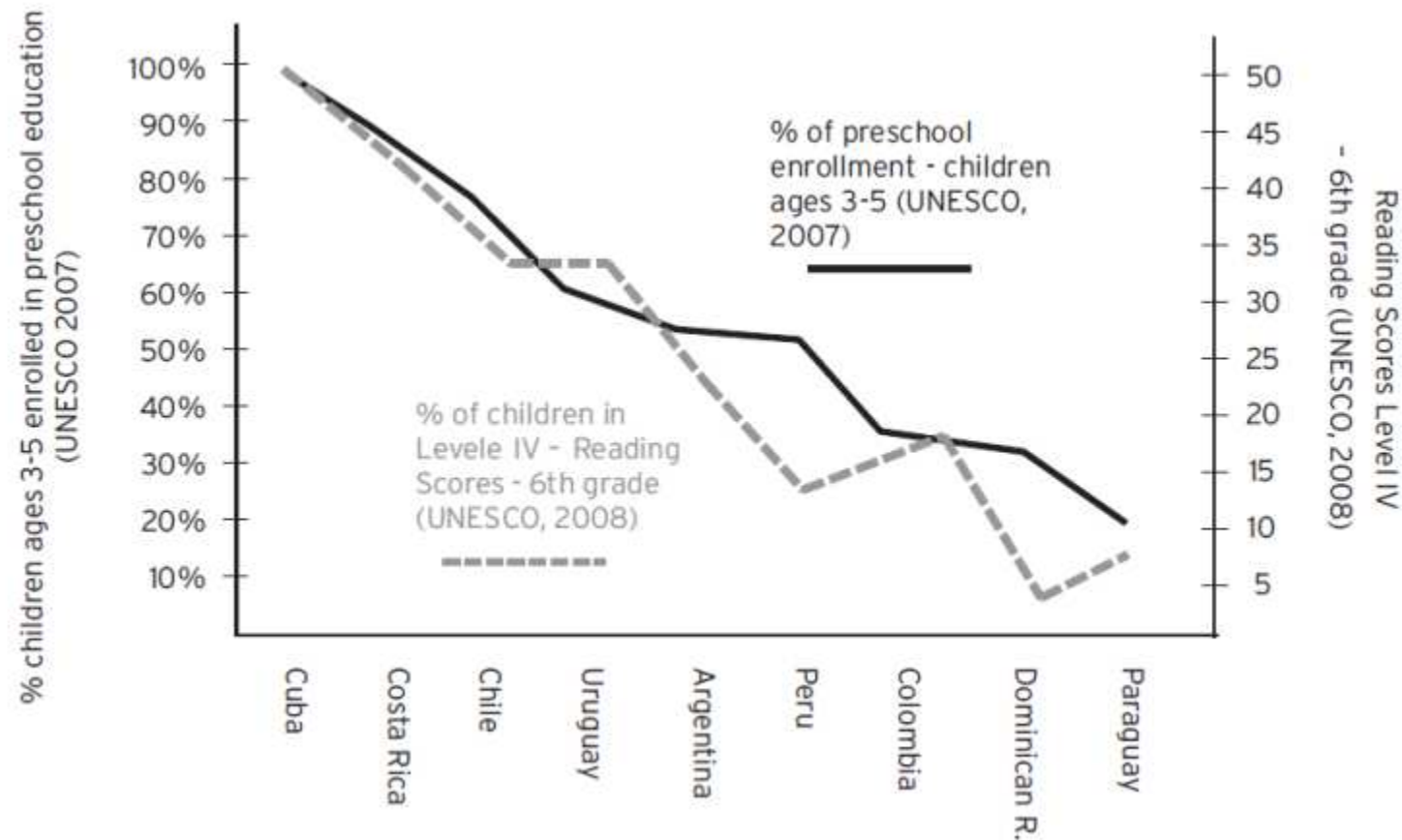
Health and social determinants of health are inextricably linked with sustainable human development

<http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/discussion-paper--addressing-the-social-determinants-of-noncommu/>

PROGRESS ON CHILD SURVIVAL SINCE 1990



Enrolment in preschool (ages 3-5) and reading in 6th grade: selected countries



EMERGING CONSENSUS ON HEALTH IN THE POST-2015 DEVELOPMENT AGENDA/"SDGS"

- Build on the MDGs – with more ambitious targets
- Noncommunicable diseases (NCDs) and their risks
- Strengthening health systems – “universal health coverage” (UHC)
- *Equity and human rights – realizing the right to health for all*
- *Health targets also require actions beyond the health sector – “determinants of health”*

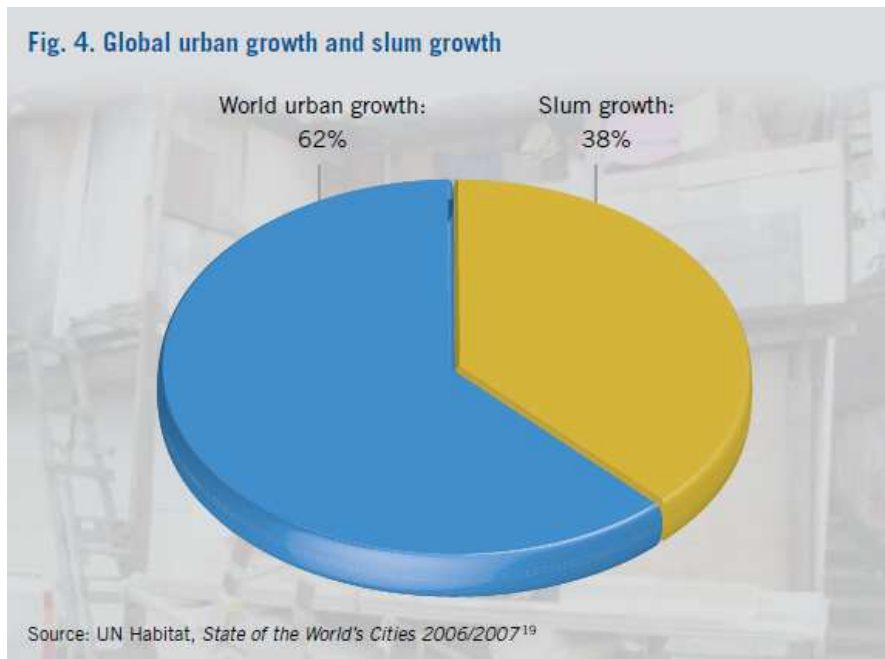
OPEN WORKING GROUP (OWG)

FOCUS AREAS

1. Poverty eradication
2. Sustainable agriculture, food security and nutrition
3. Health and population dynamics
4. Education
5. Gender equality and women's empowerment
6. Water and sanitation
7. Energy
8. Economic growth
9. Industrialization
10. Infrastructure
11. Employment and decent work for all
12. Promote equality
13. Sustainable cities and human settlements
14. Promote Sustainable Consumption and Production
15. Climate
16. Conservation and sustainable use of marine resources, oceans and seas
17. Ecosystems and biodiversity
18. Means of implementation/Global partnership for sustainable development
19. Peaceful and non-violent societies, rule of law and capable institutions

Housing: ideal platform for primary prevention and reduction of health inequalities

- By 2050 the world's urban population will nearly double: 6.4 billion city-dwellers
- Most urban growth occurring in low- and middle-income cities
- The nature of urban housing and/or slum expansion will determine level of many urban health risks



Cost-effective environmental interventions not yet in Health Coverage

Program	Savings for every dollar spent
Lead paint hazard	\$17- \$221
Improved <i>water</i> & sanitation	\$3 - \$34
Sustainable/active transport	\$3 -30
Immunizations (reference value)	\$27



Each of these environmental interventions gives
~ 300% or more return on investment

Tackling health inequalities by improving the quality of housing: *Evidence*

- Vulnerable populations at most risk
- Social gradient for both the housing quality and the housing-related exposure, and for housing-associated health outcomes
- Greatest exposure to indoor hazards due to the time spend inside at home
- Link between housing and urban policies
- Shortage of adequate housing
- Housing and environmental justice compounded by:
 - Lack of access to health care / Housing discrimination that limits choice / Weak tax base / Poor credit / Inadequate public services / Un/underemployment /



→ Housing mediates health inequalities

Tackling health inequalities by improving the quality of housing: *Opportunities*

Low emissions stoves and fuels through cleaner biomass and biogas cookstoves reduce COPDs in poor population and offer gender equity and sustainable



Effective cooling, heating and ventilation, particularly through design measures, in low-income settings reduce respiratory diseases and strokes

Small solar photovoltaic panels and access of poor households to direct-current household appliances offer health equity as well as climate benefits

Healthy and climate resilient housing improve health and health inequalities!

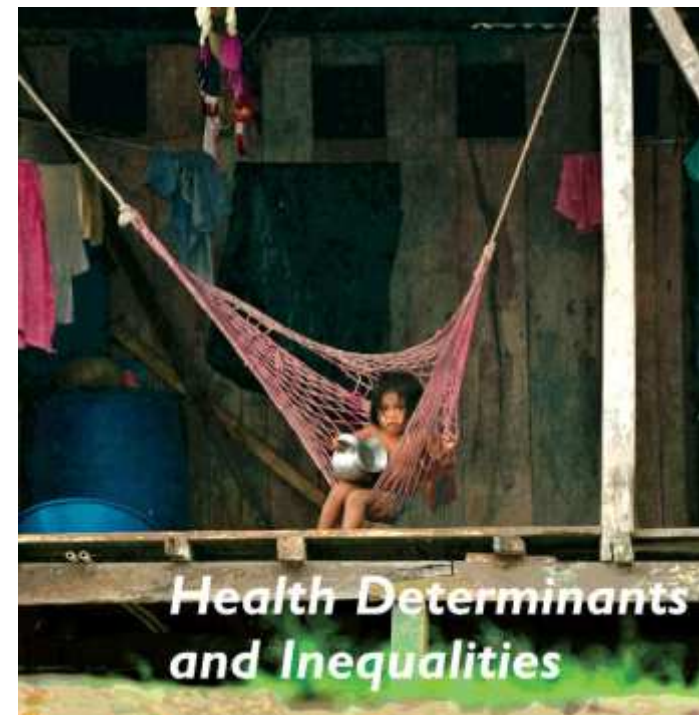
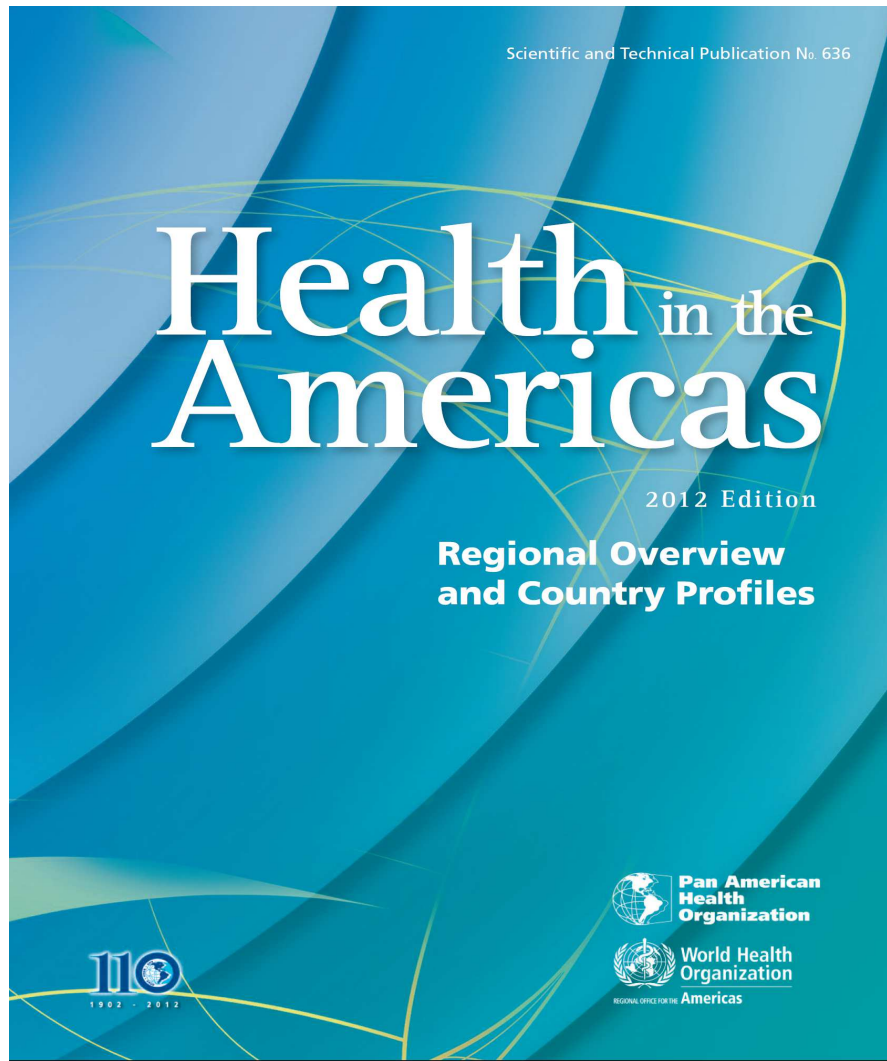
Source: Health in the Green Economy – Housing. WHO 2011.

Tackling health inequalities by improving the quality of housing: *way forward*

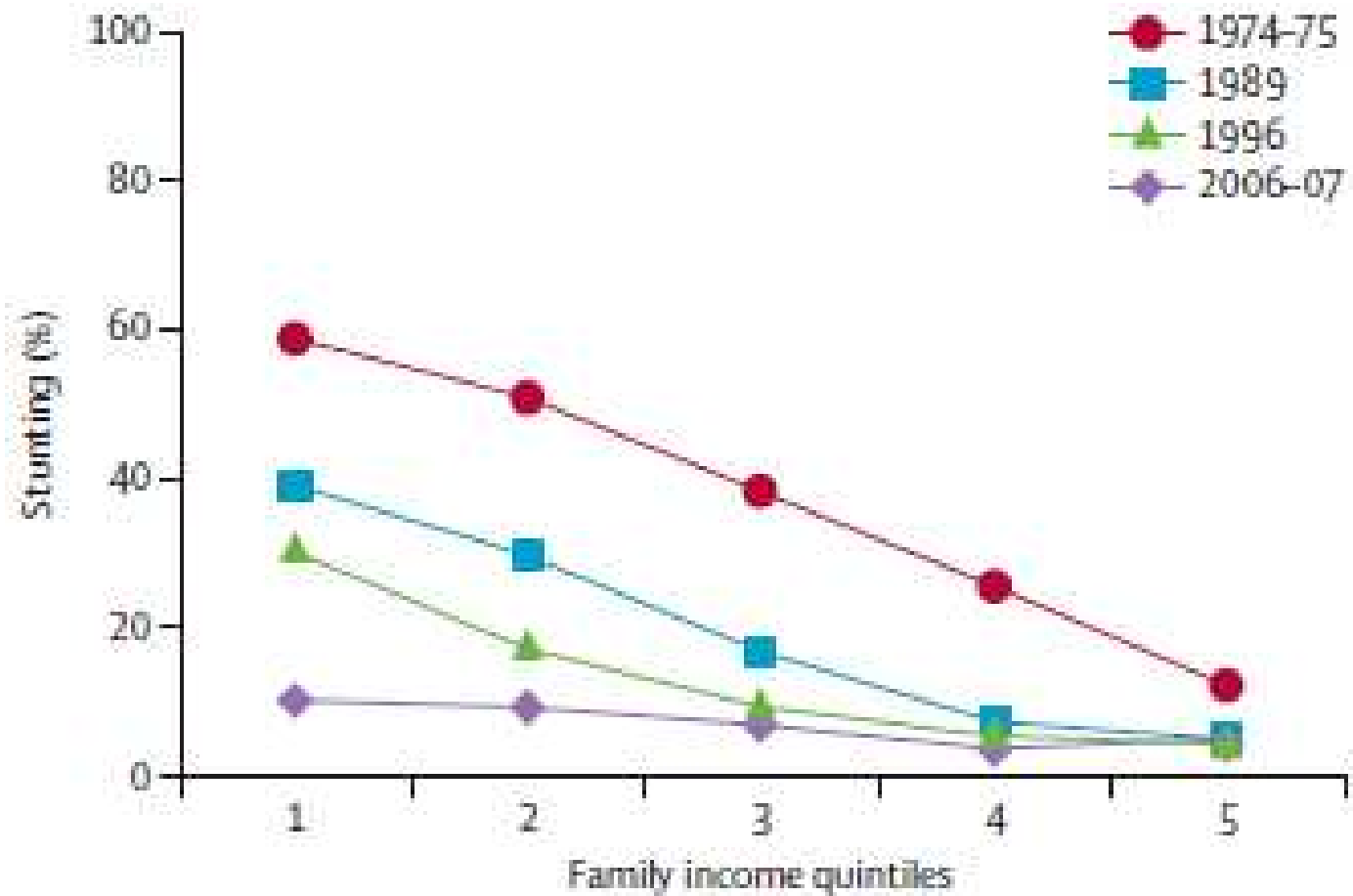
WHO Housing and Health Guidelines

- Guidelines are recommendations to **support informed policy making**
- **Opportunity for health and development** – through management of risks and generation of positive health outcomes
- Knowledge on **health and housing is not presented/framed in an easy way** who can take action
- Many checklists for environmentally sound housing, **few examples of healthy housing criteria**; green labels are not enough
- Need for a **trusted broker** to offer evidence-based information to facilitate action
- **WHO guidelines very influential in setting** the basis for norms and standards, in developed and developing countries.
- **Good timing**: new construction (urbanization), insulation (because of climate change), renovation need of social housing
- Housing and Health Guidelines **will be the first to focus on a sector**

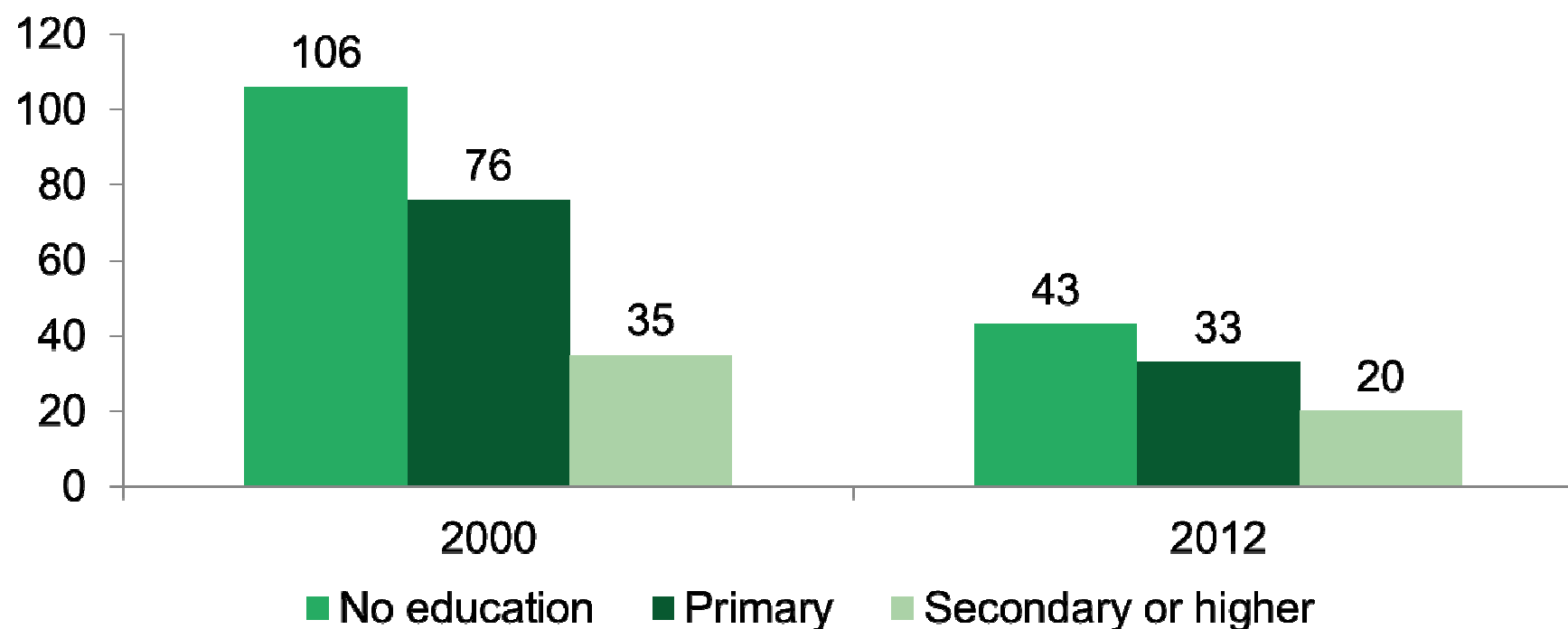
Health in the Americas



Prevalence of stunting by family income and year of survey: Brazil



Under five mortality per 1000 live births by mother's education: Peru 2000 and 2012



(U5M for the ten years preceding the survey)

Source: measuredhs.com

Teheran, January 2006

- Meeting with ayatollah Khamenei



"Serious mental health problems as a result of the war with Iraq"

- War and conflict no 1 public health problem in EMRA region

-Opportunity to connect to the international Red cross/Red crescent movement

31st International Conference of the *Red Cross and Red Crescent Movement* (International Conference), Geneva, Switzerland, 28 November-1 December 2011

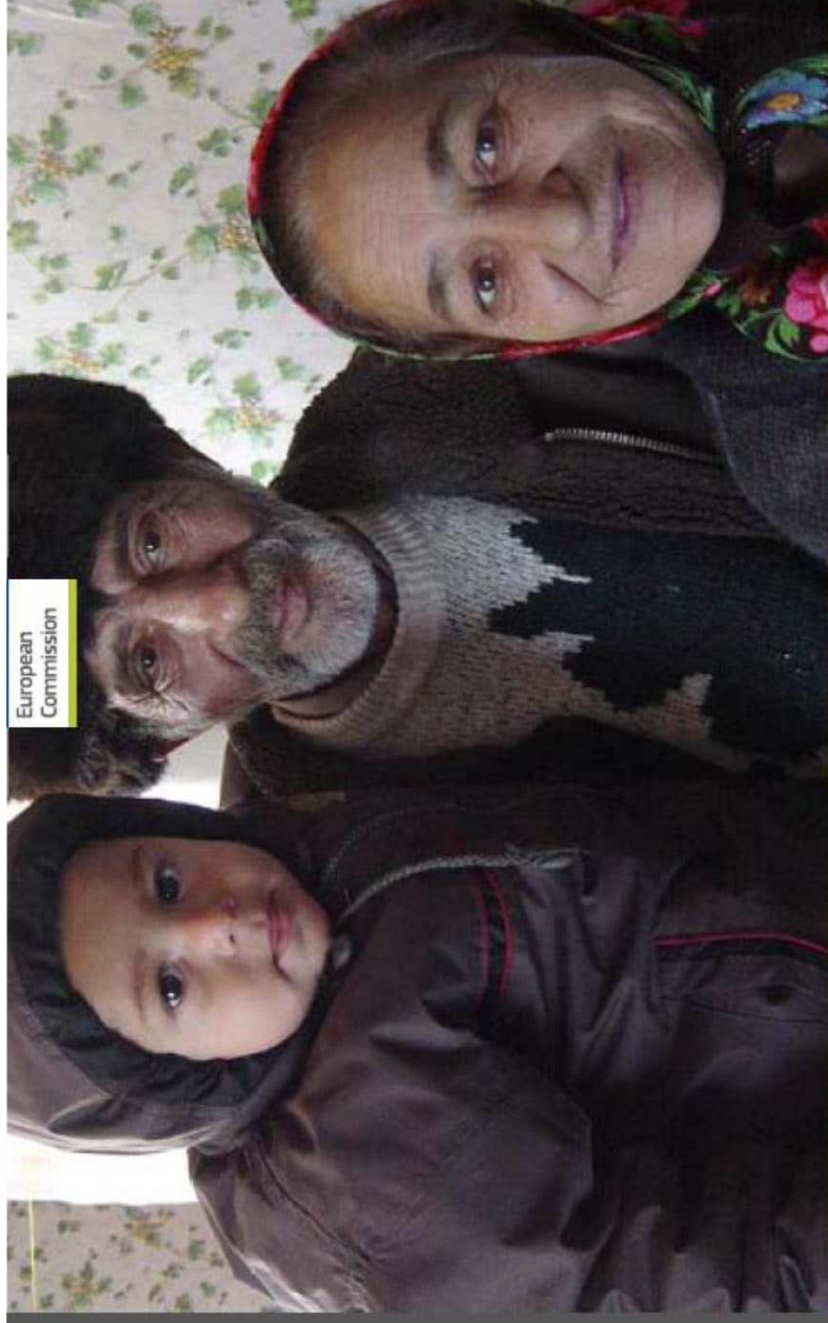
01-12-2011 Resolution 6 - Health inequities with a focus on women and children

- The 31st International Conference of the Red Cross and Red Crescent,
- ***agreeing with the World Health Organization*** that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” and *noting* that according to the World Health Organization: “[w]here systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity. Putting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice. Reducing health inequities is, for **the Commission on Social Determinants of Health** (hereafter, the Commission), an ethical imperative. **Social injustice is killing people on a grand scale.**”

EU Commission

- Solidarity in health (200/567)
- EU Health program (10 yrs)
- 64 actions (70 meuros), 700 organizations (60% public), Italy among the more active
- Results: guidelines, data collection, exchange platforms, training
- Main focus: vulnerable groups, lifestyles
- New actions: JA on Alcohol, nutrition and physical activity, mental health, chronic diseases and healthy ageing , cancer, equity

http://ec.europa.eu/chafea/documents/health/health-inequality-brochure_en.pdf



Action on health inequalities

in the European Union

Graph 16

Health inequalities actions (2003–13) presented in three clusters

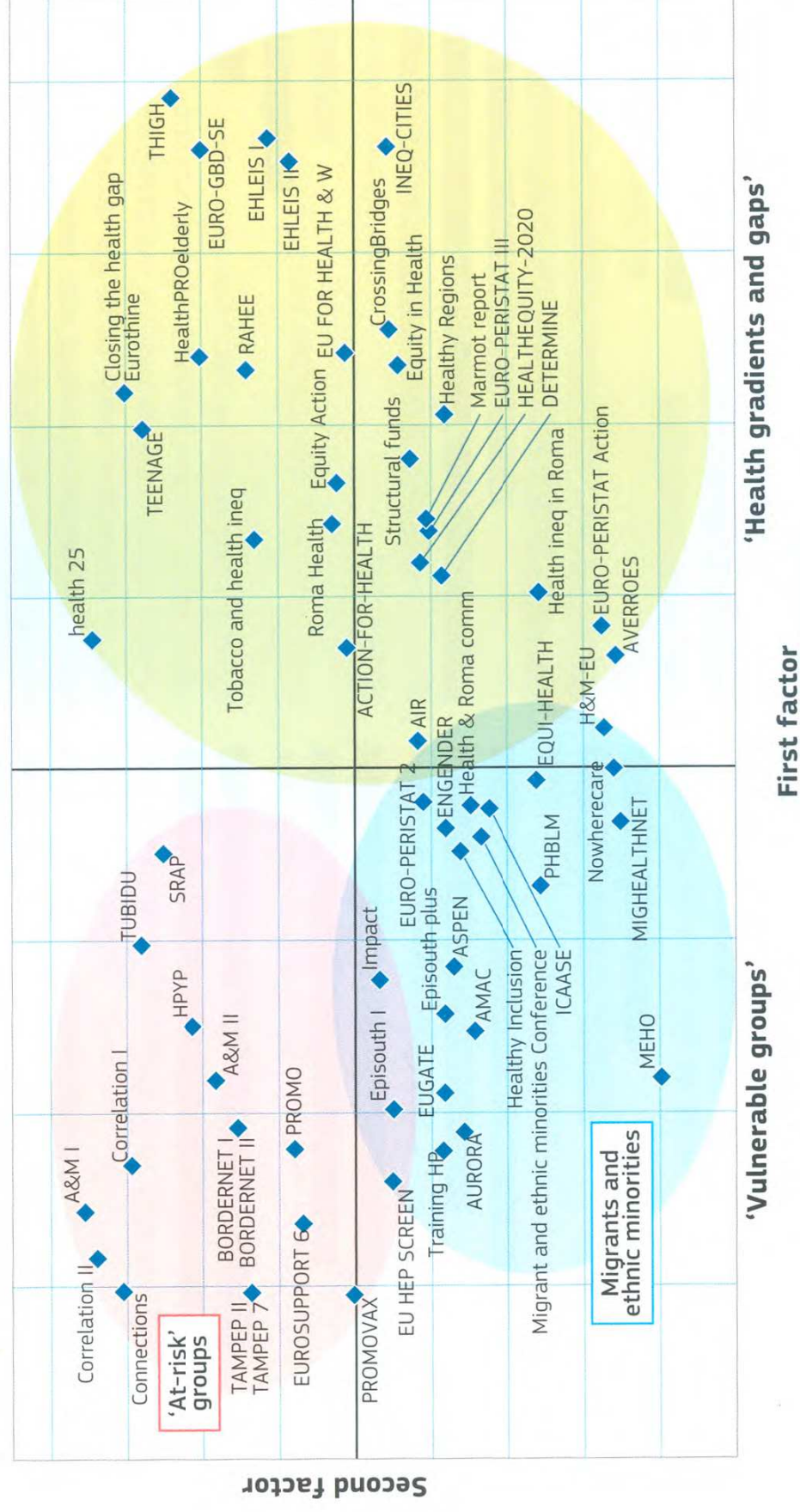


Table 7

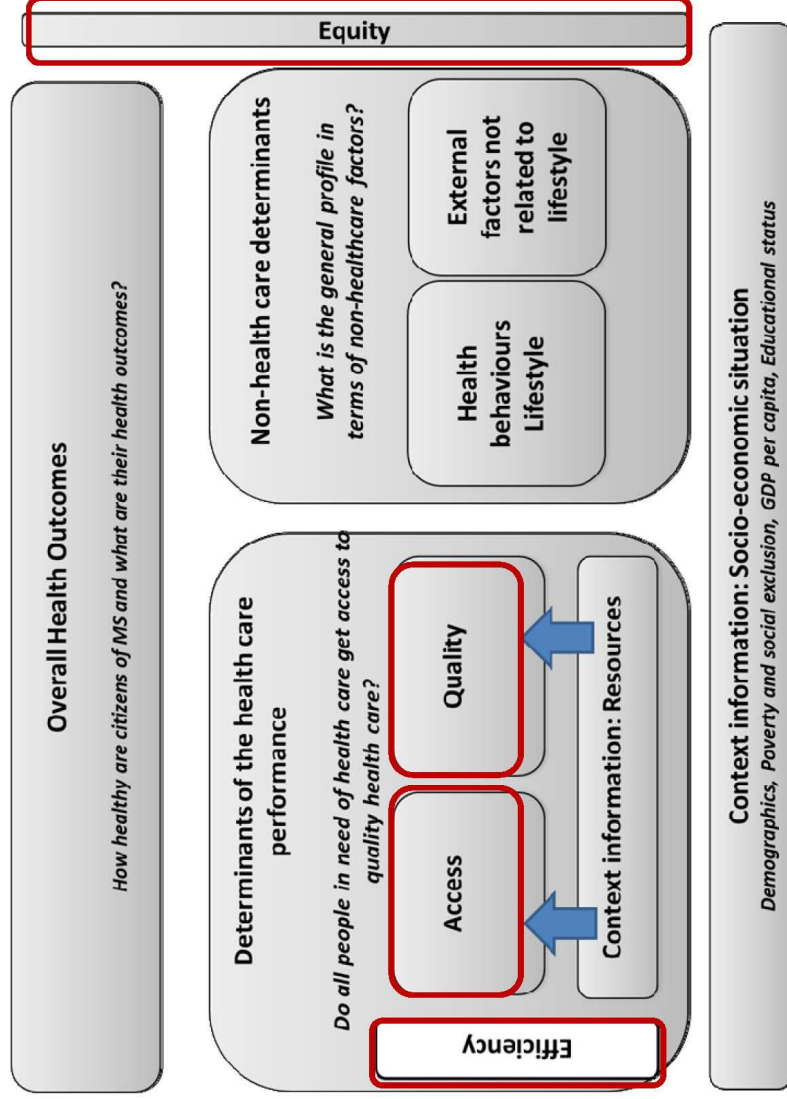
Differences of emphasis between the two main clusters

Type	'Vulnerable groups' cluster	'Health gradients and gaps' cluster
Inequalities targeted	Health problems of migrants, ethnic groups and 'at-risk' groups	Socio-economic differences and effects of sex, age and country of residence
Health problems addressed	Infectious diseases Addictions Non-communicable diseases (for ethnic groups)	Life expectancy Healthy life years Non-communicable diseases
Interventions undertaken or proposed	Improving health care (access, quality, training) Health promotion, harm reduction and prevention via health services	Collecting and analysing data Intersectoral action on social determinants of health

EU Commission

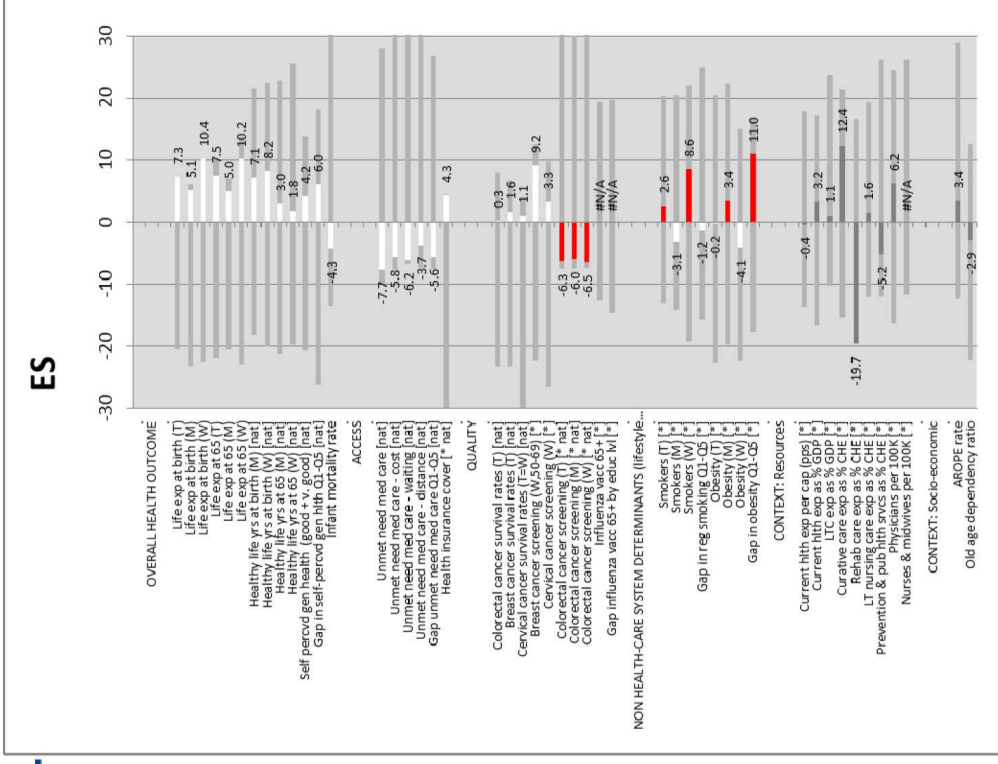
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- Impact on non health policies?

JAF Health Framework



JAF Health country profile charts: an example

- **white** coloured bars indicate better than average results
- **red** coloured bars indicate worse than average results
- **light grey** background bars show min and max values of the indicator in the EU
- Contextual information on resources and socio-economic situation are illustrated by **grey** bars.

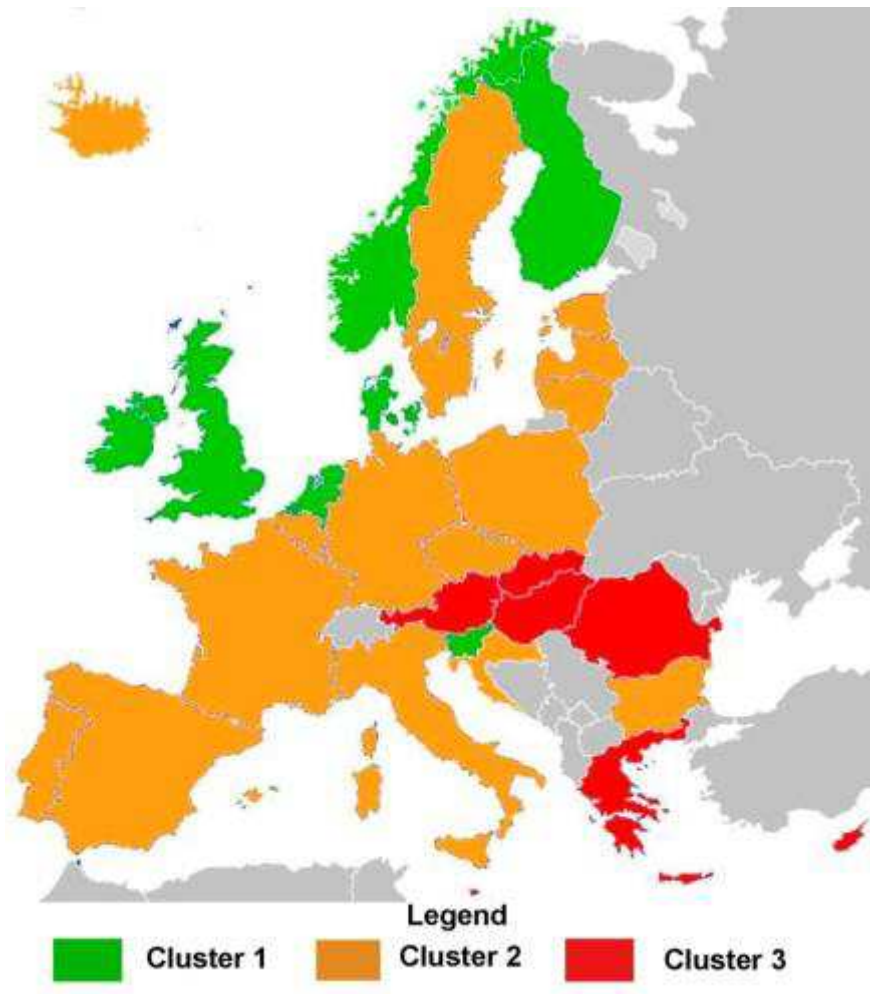


Review of Social Determinants of Health and the Health Divide in the WHO European Region

Review of social determinants and the health divide in the WHO European Region: final report



Country clusters by level of policy response



- **Cluster 1:** *Relatively positive and active response to health inequalities.*

- At least one national response to HIs or comprehensive regional HI policy responses.

- **Cluster 2:** *Variable response to health inequalities.*

- No explicit national policy on HIs, but at least one explicit regional response or a number of other policies with some focus on health inequalities.

- **Cluster 3:** *Relatively undeveloped response to health inequalities.*

- No focused national or regional responses to health inequalities, no explicit health inequality reduction targets (though there may be targeted actions on the social determinants of health).

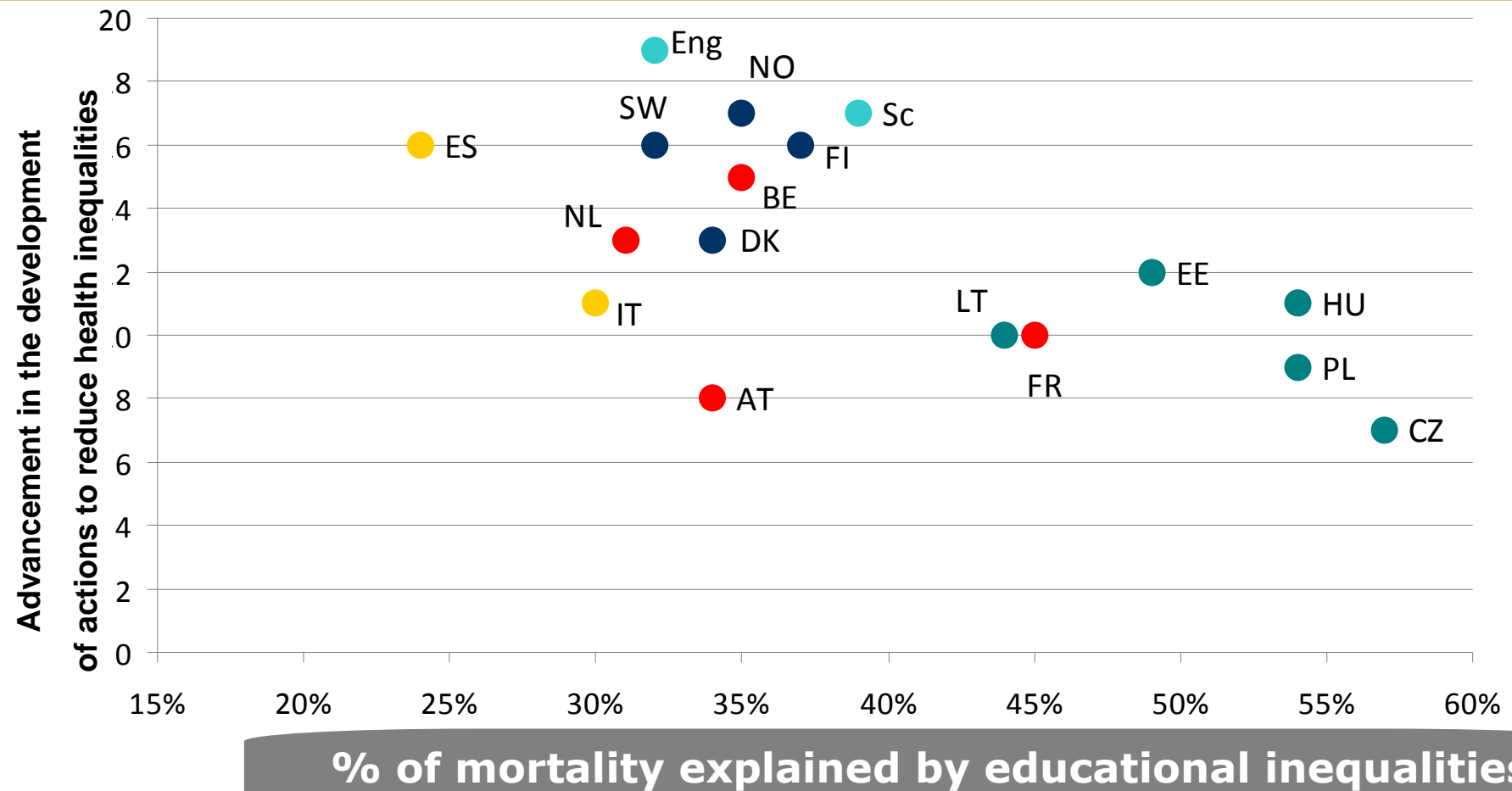
Widening of policy response between member states since 2006

Level of policy response	Countries by Cluster Group
Intensification of policy response	Cluster 1: Denmark, Finland, Norway, United Kingdom*
	Cluster 2: Estonia, Latvia, Spain*, Iceland*
Same level of policy response	Cluster 2: Belgium, France, Germany, Italy, Poland, Sweden
	Cluster 3: Lithuania*
Decrease in intensity of the policy response	Cluster 1: Ireland, Netherlands
	Cluster 2: Czech Republic
	Cluster 3: Cyprus, Greece, Hungary

* Countries where on-going changes to policies (mentioned elsewhere within this report) may affect assessment.

Note: Some countries were not included in the analysis performed in 2006 and are therefore omitted from this table (Austria, Bulgaria, Croatia, Luxembourg, Malta, Portugal, Romania, Slovakia, and Slovenia).

Relative importance of the size of health inequalities matters?



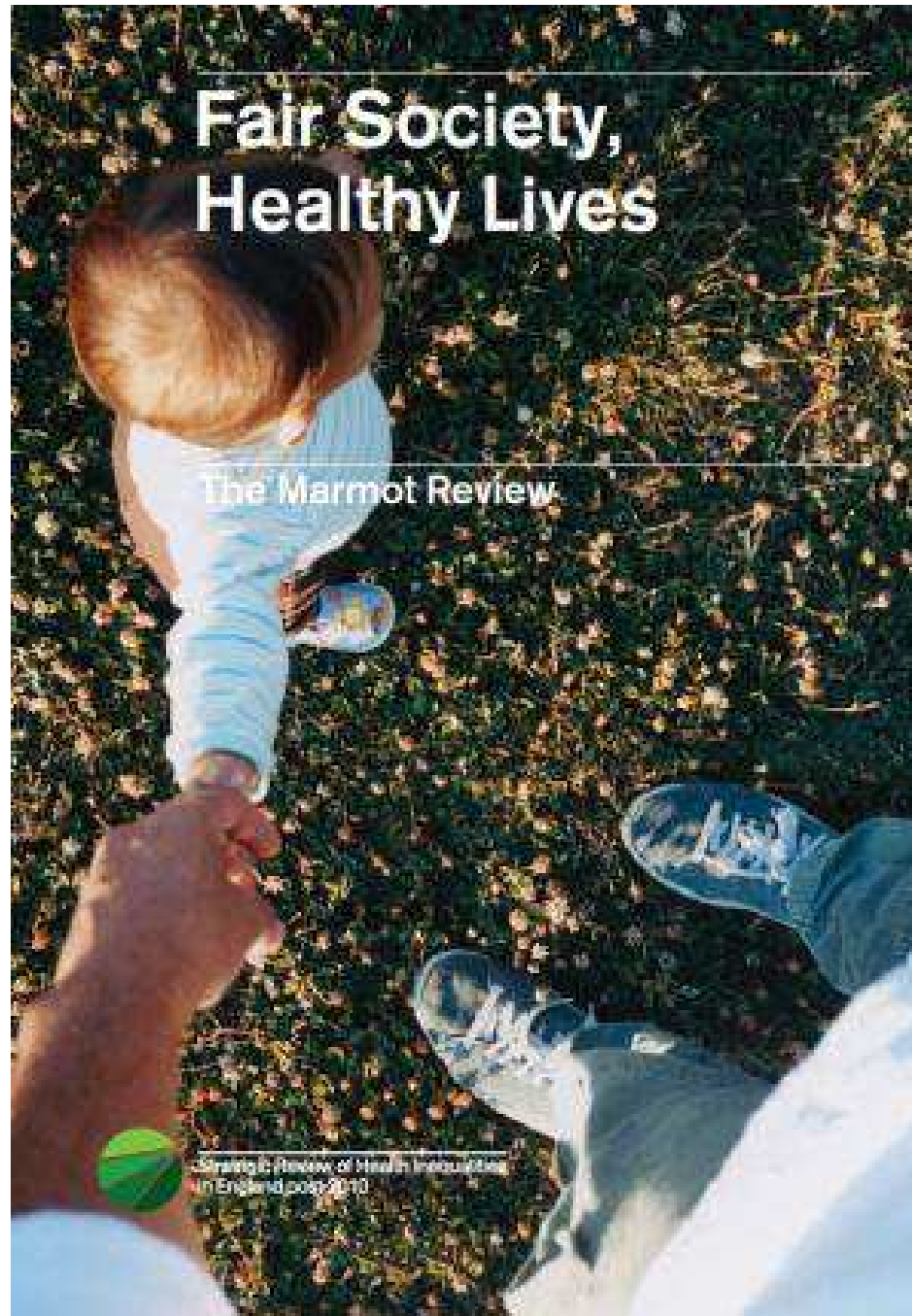
Marra and Zengarini in Eikemo T et al, 2012

A photograph of two children in a slum. A boy in a grey and black patterned jacket is running towards the camera, smiling. A girl in an orange shirt and dark pants is crouching behind him. The background shows a simple building with a red-tiled roof and a dirt ground with a puddle.

**Do something
Do more
Do better**

Strategic Review of Health
Inequalities in England:

The Marmot Review – Fair
Society Healthy Lives



Marmot Review: 6 Policy Objectives

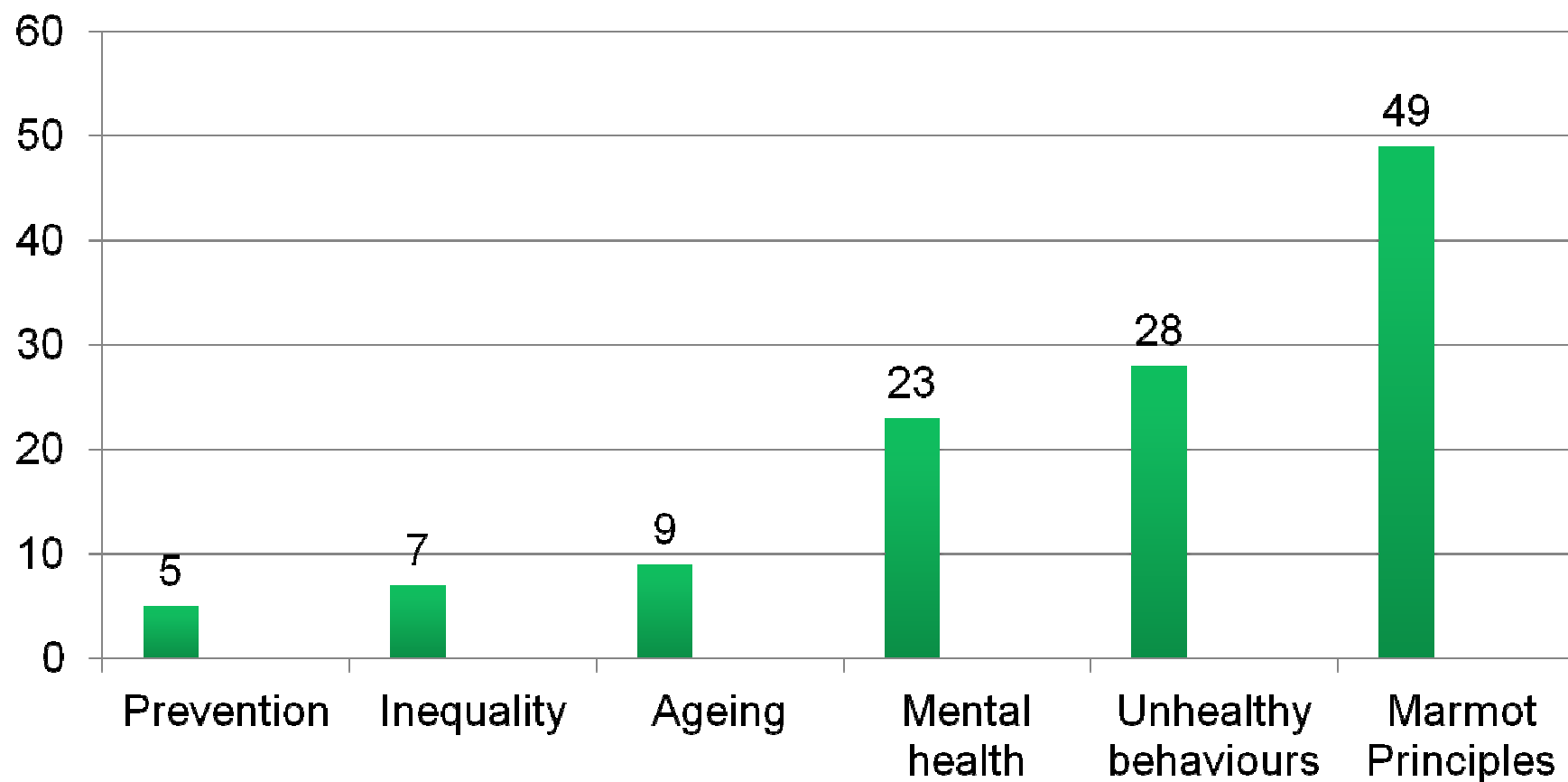
- A. Give every child the best start in life**
- B. Enable all children, young people and adults to maximise their capabilities and have control over their lives**
- C. Create fair employment and good work for all**
- D. Ensure healthy standard of living for all**
- E. Create and develop healthy and sustainable places and communities**
- F. Strengthen the role and impact of ill health prevention**



Post marmot review

- Influenced national policy –
 - public health paper
 - Monitoring
 - Public health agency
- Local governments 75%
- Other sectors – fire fighters, early years, social care
- Third sector a bit
- PUBLIC? EMPLOYERS?

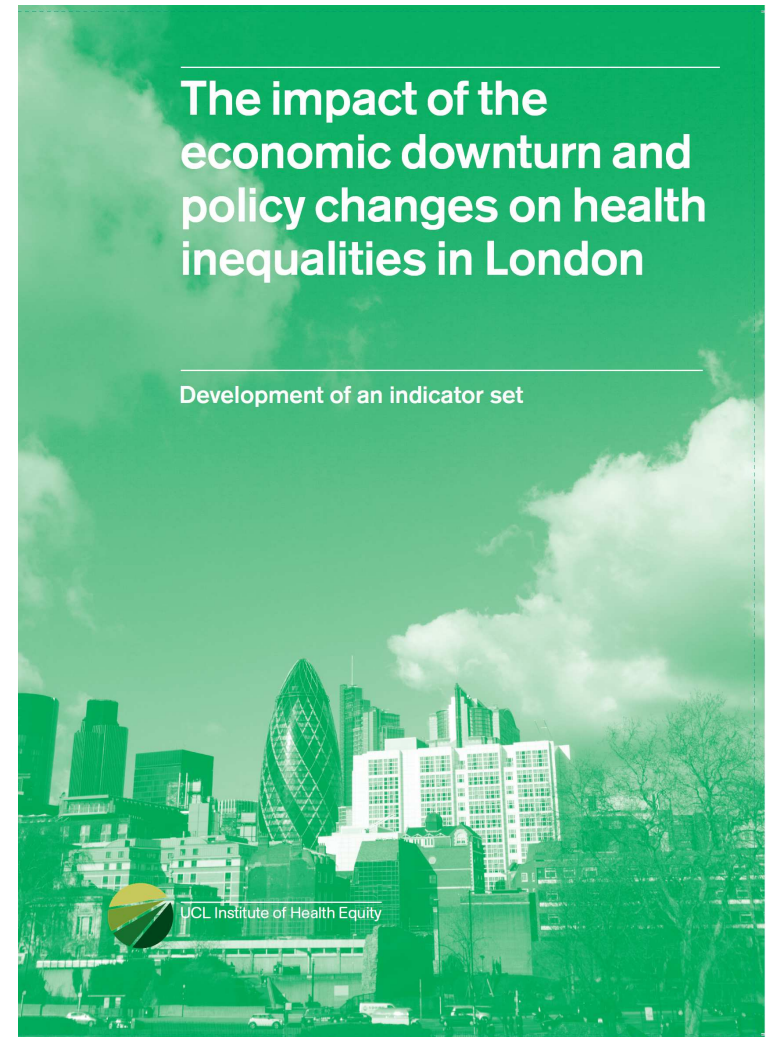
Priorities agreed by 65 Health and Well-being Boards – Local Government England











Implementation

- **Its not our concern** (evidence, description)
- **We don't know what to do** (evidence, links)
- **We don't know how to do it** (delivery, networks)
- **We don't want to** – (levers, incentives, regulations)
- We **really** don't want to - ideology, no pressure
 - - so public pressure
- **We cant afford to** – (cost efficacy, cross sectoral, prevention and other things matter more)

- Report on impact of demographic change, recession and welfare reform on health inequalities in London and production of indicators to monitor and measure impact.



Employment: Lambeth

Indicator	Local Value	London Average	London Worst	London Range	London Best
Unemployment (Jul 2012-Jun 2013)	7.8	9.1	14.9		4.7
Job Seekers Allowance claims (Oct 13)	0.8	0.7	1.0		0.3
Job Seekers Allowance claim duration - 12 months (Oct 13)	1.6	1.0	1.6		0.3
Job Seekers Allowance claim duration - 6 months (Oct 13)	2.3	1.5	2.3		0.5
Employment and Support Allowance claims (May 2013)	0.6	0.6	0.9		0.3
Job Seekers Allowance claimants and job vacancies (Nov 2012)	11.4	6.0	19.6		2.0
Full- and part-time employment (Jul 2012-Jun 2013)	6.1	3.5	2.5		7.3
16-18 year olds not in employment, education or training (2012)	7.5	4.7	10.2		2.0





ULIGHED I SUNDHED —ÅRSAGER OCH INDSATSER

Danish Review 2011-2012

Sosial ulikhet i helse: En norsk kunnskapsoversikt



Espen Dahl, Heidi Bergsli og Kjetil A. van der Wel
Fakultet for samfunnsfag/Sosialforsk



Norwegian Review

presented in
March 2014



Swedish Counties and Municipalities Federation 2009

Vård på
(o)lika
villkor

Cancer in Sweden - incidence and survival by region and socioeconomic group (2011)





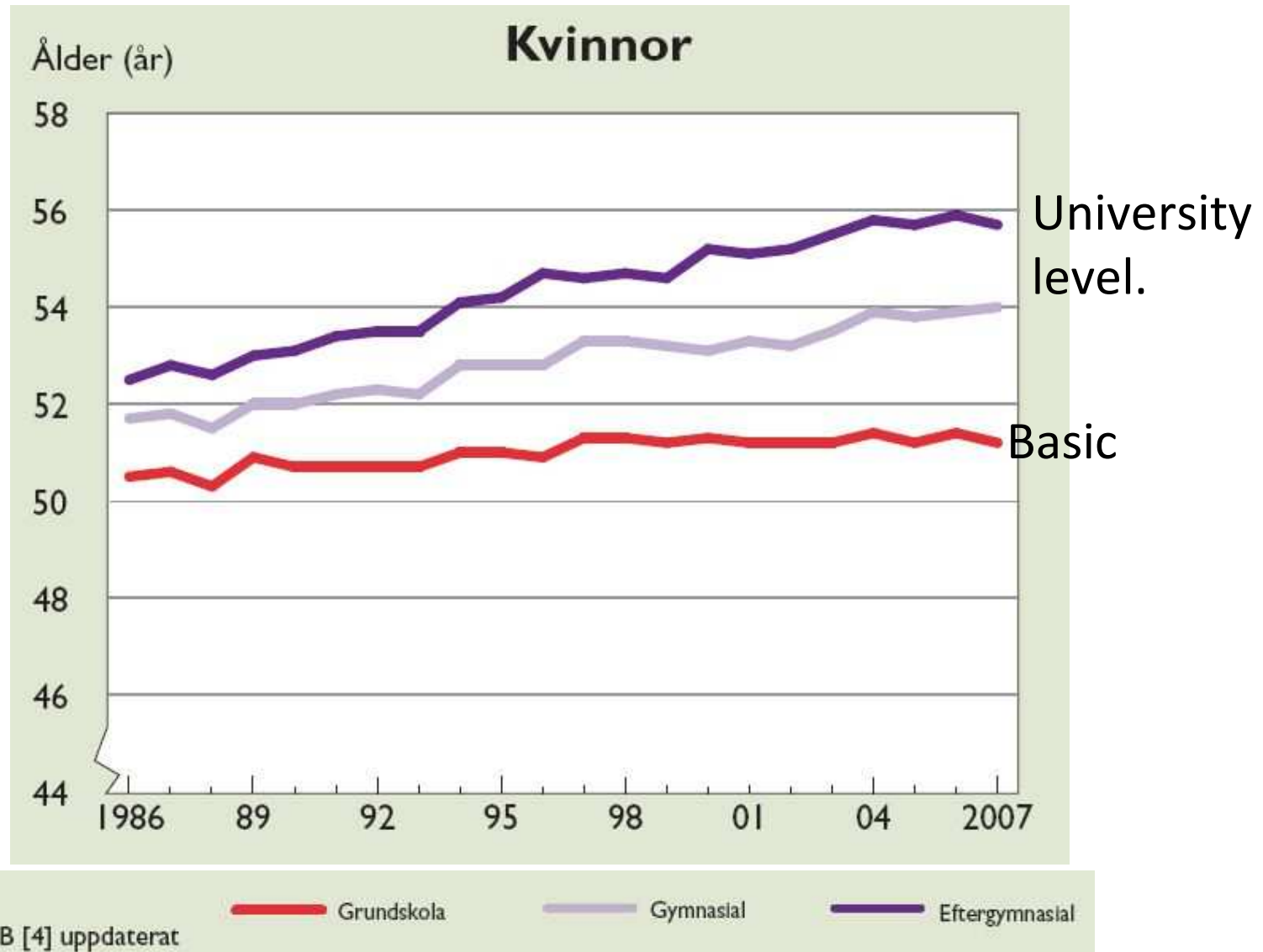
CHES, Centre for Health Equity Studies In Stockholm

- Global health training, Master level
 - Lecturing about the Commission up and down the country

Political Reactions in Sweden

- Mostly very positive
- Minister: Support for the global part – no commitment for policies within Sweden
- "what can Sweden learn from the CSDH" – a review by the Swedish Public Health Institute
- "everything is fine"...expertgroup alienated

Remaining life expectancy at age 30 by educational level. Swedish women 1986-2007



Local Commissions

- City of Malmö, finished
- Gothenburg region, finished
- Linköping region, on-going
- The hesitation of the Swedish government has triggered a large amount of local activities

Commission for a socially sustainable Malmö 2011-2013

- Deputy Mayor had read "Closing the gap"
- Appointment of a politically independent Commission of academics, experts and Malmö civil servants
- Aim: promote health equity and "a socially sustainable Malmö".



Malmö Commission meets the WHO European Review Group



What can a local government do to cope with changes imposed by global trends?

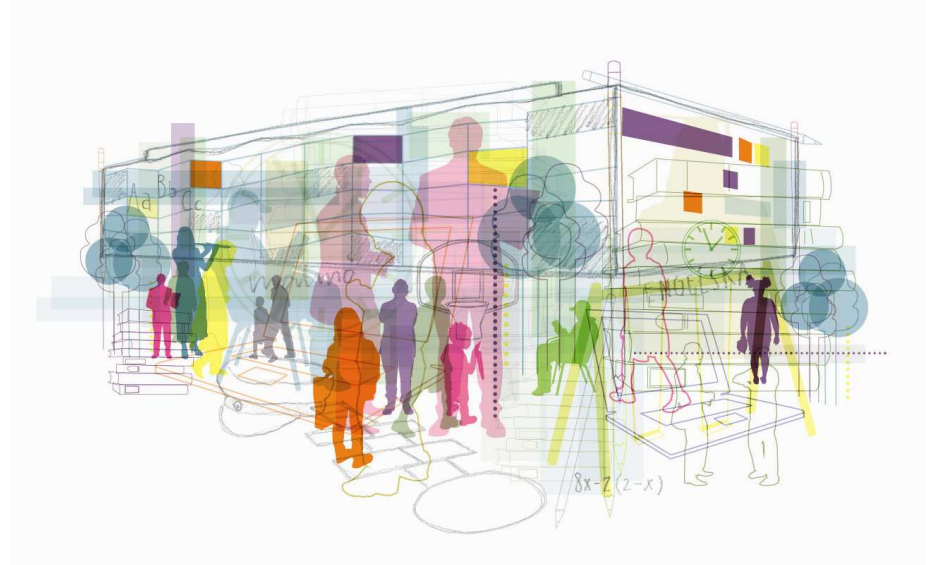
Malmö: strong pressure from global and regional developments



- One of the fastest growing cities in Europe
- Migration: Malmö as a transit city.
- Refugees: for instance, children without parents
- Segregation. Residential, social and ethnic.
- Lively cultural scene, strong civil networks, **strong local government**

Local government to focus on

- Urban planning
- Labour markets
- Schools



- *Massiv investment in social infrastructure*
- *New forms of governance (transparency, dialogue with civil society)*

Commission for a socially sustainable Malmö 2011-2013

**Final report
March 2013**

**Is translated
into English**



Malmö:

Six areas for action

- Children and young people's living conditions
- Living environment and urban planning
- Education
- Income and employment
- Health services'
- Changes in processes for socially sustainable development



Increasing absolute mortality disparities by education in Finland, Norway and Sweden, 1971–2000

Vladimir M Shkolnikov,¹ Evgueni M Andreev,¹ Dmitri A Jdanov,¹ Domantas Jasilionis,¹ Øystein Kravdal,² Denny Vågerö,³ Tapani Valkonen⁴

ABSTRACT

Background and objectives Studies on socioeconomic health disparities often suffer from a lack of uniform data and methodology. Using high quality, census-linked data and sensible inequality measures, this study documents the changes in absolute and relative mortality differences by education in Finland, Norway and Sweden over the period 1971 to 2000.

Methods The age-standardised mortality rates and the

A detailed analysis by Harper and colleagues demonstrated how the observed direction of changes in inter-group health disparities depends on the measure used for quantifying the inequality.¹⁰ It has been suggested that the monitoring of health disparities should be accompanied by an explanation of the meaning and scaling of the inequality measure.^{10 11}

In spite of these methodological deficiencies,

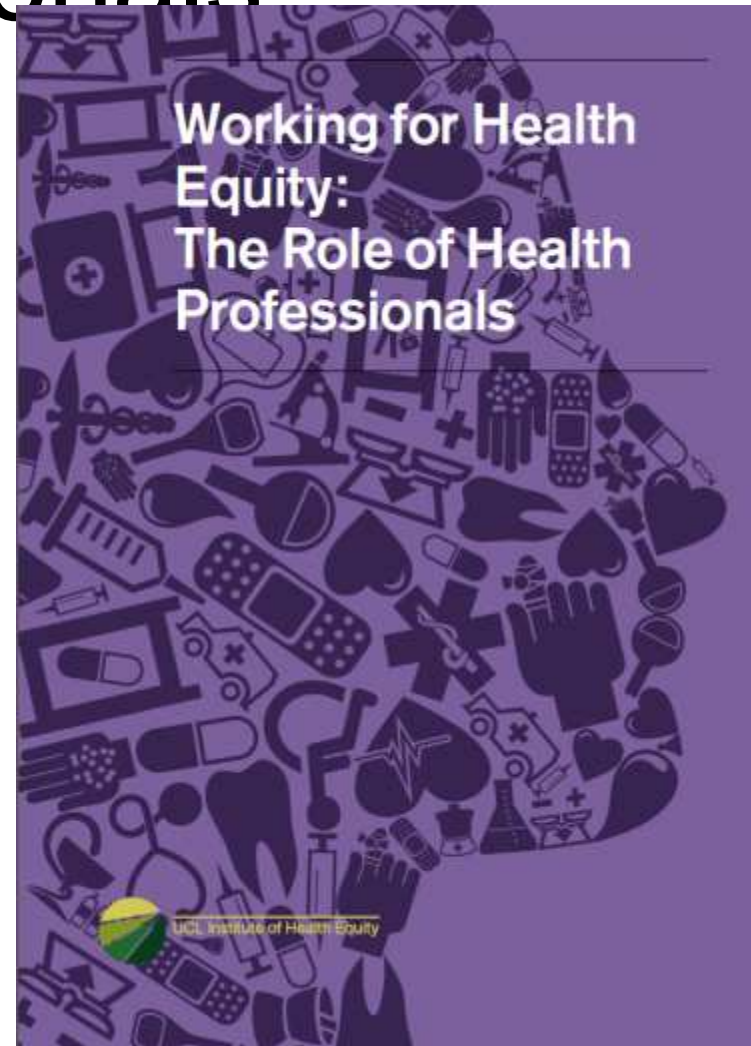
Royal Swedish Academy of Sciences:

"Health inequalities in modern welfare states- do we understand present trends"

- **Good social policies but growing inequalities**
- Explanations
 - new patterns of consumption?
 - erosion of welfare state provisions?
 - global influences on labour markets and incomes?

The Role of Health Professionals

Report and leading programme with Royal Colleges, BMA, WMA, and others to develop more focus on SDH and health inequalities throughout health professionals.



Why we did this

- SDH – NHS workforce underutilised role in SDH and wider inequalities
- NHS 1m employees and reach to wider families – **audit highlights issues around employees and inequalities.**
- And sees 1m people every 36 hours and nearly whole population every year

- WORKFORCE EDUCATION AND TRAINING
- WORKING WITH INDIVIDUALS & COMMUNITIES
- WORKFORCE INSTITUTIONS - the role of the health care sector as an employer
- WORKING IN PARTNERSHIP
- WORKFORCE AS ADVOCATES

Health professionals PRACTICE

- Advocacy and influencing policy
- Community role
- Information about patients
- Practice – primary and secondary

Practice: Examples

- GPs and cold homes
- UCLH – homelessness outreach and care
- Royal Free – HIV – outreach services – debt, homelessness, unemployment – back to work

EDUCATION

- A greater focus on the social determinants of health in under- and post-graduate course curricula
- Dual accreditation in public health.
- More training placements in disadvantaged areas and in a range of sectors e.g. charities, social services
- Continuing Professional Development and education

Organisations

- Action across social class gradient – employees
- Purchasing power – employment and commissioning
- Organisational prioritisation of inequalities.
- Eg audit and Barts and London strategy

Ongoing IHE

- Support to implement the commitments made by royal colleges and BMA and others?
- Royal colleges outlines of practice – what might change
- Set up an education working group
- Will set up a CCG working group
- And explore incentives and system drivers

- WORKFORCE EDUCATION AND TRAINING
- WORKING WITH INDIVIDUALS & COMMUNITIES
- WORKFORCE INSTITUTIONS - the role of the health care sector as an employer
- WORKING IN PARTNERSHIP
- WORKFORCE AS ADVOCATES

News from the EC Expert Group on HIs

- role of the EU Expert Group
 - advising for priority setting in the EC agenda
 - common language and understanding
 - engagement in evaluation processes: i.e validation of health profile in MSs (support and networking)
 - fostering SDH approach in EU Joint Actions (chronic diseases, mental health, cancer, alcohol, nutrition and physical activity)
- Health Policy Forum (by next Autumn): interactive platform for stakeholders and experts (thematic open and restricted networks)
- New JA 2017 on Health Equity:
 - an opportunity for South European Network
 - Sweeden and Italy requested to suggest a preliminary agenda for the new Joint Action for Health Equity



http://ec.europa.eu/health/programme/docs/joint_actions_2008_2011_en.pdf



Towards a proposal for the new JA Equity Action (1)

- Objectives:
 - Improve population health with greater equity across groups
 - Focusing on social determinants across life course and in wider social and economical spheres (HiAP)
- Points of departure
 - Policy and legal context
 - 3EU HP2013-2020 (added European value: coverage and low GNI countries)
 - Europe 2020 strategy (health as a driver for a sustainable and equitable growth)
 - Role of the JA: contributing to EU priority setting, complement and support MSs actions, synergies with other EU actions (H2020, EU HP, EU SF)

Towards a proposal for the new JA Equity Action (2)

- Building on past experience and knowledge
 - Equity action 2011-14 and related tenders
 - WHO and EU projects
 - EU report of assessment “Actions on HIs...”
 - Synergies with EU companion policies and agendas (i.e. platform against poverty and exclusion)
- Guiding principles:
 - EU added value
 - Intersectorality (HiAP)

Towards a proposal for the new JA Equity Action (3)

- Examples of area of interest on SDH (Sweeden)
 - Comparable systems of monitoring and evaluation tools
 - Common set of indicator of the burden
 - Organize knowledge networks to understand mechanisms and choose actions
 - How to influence Structural Funds at the regional level in an equity oriented way
 - Policy development in the HiAP framework (and HIA) equity oriented

Towards a proposal for the new JA Equity Action (3)

- Examples of area of interest (South European Network)
 - Comparable systems of monitoring and evaluation tools
 - Working on the Southern delay in unhealthy transitions among females (smoking and lone motherhood) and in both genders (mediterranean nutrition following EXPO, family support)
 - Vulnerability to crisis

Towards a proposal for the new JA Equity Action (3)

- Other examples of area of interest on SDH (i.e. Norway, strengthen HiAP)
 - Impact of EP policies on lifestyles and consumptions
 - HIA equity focused in parliaments
 - Relationship btw health and wealth
 - Actions on children and poverty
 - Actions on employment
 - Actions on health care at regional level
 - Legal framework and obligations for health across countries
 - HIs in major EU policies: European Semester, TTIP, REFIT...

Barriers

- Austerity measures in response to economic downturn;
- Favourable political rethoric – not translated into action;
- Failure to tackle inequitable distribution of power, money and resources



Global Governance for Health – what needs to happen?

Problem definition: social and economic injustices require global political solutions

- The global financial crisis and ensuing austerity policies
- Knowledge and intellectual property
- Investment treaties
- Food security
- Transnational corporations
- Migration
- Armed violence

(Oslo/Lancet Commission 2014)

Five key 'dysfunctions' of global governance

- Democratic deficits
- Weak accountability
- Institutional "stickiness"
- Inadequate policy space for health
- Absence of international institutions (such as treaties and courts) to protect and promote health.

Four recommendations to improve global governance

- Create a multi-stakeholder platform on governance for health
- Form an independent scientific monitoring panel to measure and track progress in overcoming the political, economic and social determinants of adverse health outcomes
- Health equity impact assessments of all policies and practices
- Strengthening existing mechanisms

(Oslo/Lancet Commission 2014)

Governing for health equity through action on social determinants – what's needed?

- **Conceptual understanding**
- **Construct a 'Delivery-chain'**
- **Accountability**
- **Governance for health**



Focus on the Co-Production of Results

Benefits for health

Benefits for other sectors

Benefits for societal goals

**Equity & Health Equity as common
measures of public policy performance**

**SOCIAL DETERMINANTS OF HEALTH
SECTORAL BRIEFING SERIES 3**



**TRANSPORT (ROAD TRANSPORT): SHARED
INTERESTS IN SUSTAINABLE OUTCOMES**



**SOCIAL DETERMINANTS OF HEALTH
SECTORAL BRIEFING SERIES 1**



**HOUSING: SHARED INTERESTS IN
HEALTH AND DEVELOPMENT**



**SOCIAL PROTECTION:
SHARED INTERESTS IN VULNERABILITY
REDUCTION AND DEVELOPMENT**



**EDUCATION: SHARED INTERESTS IN
WELL-BEING AND DEVELOPMENT**



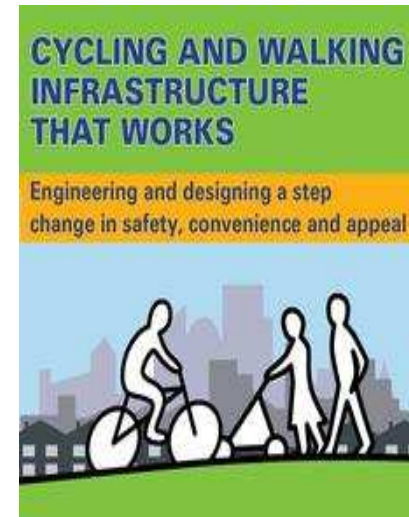
1. Putting (health) Equity 'on' the Agenda

How are other countries doing it....?

- as a matter of fairness and social justice
- as a human right
- for achieving Social Cohesion
- as an approach for managing / reducing social and economic costs
- as an approach to social and economic sustainability
- as an *enabler* of inclusive growth & development

Health and equity as a basis for Innovation, Skills & Job creation

- Cycling and walking infrastructure
- Health Tourism
- Short supply chains and new product development with the agriculture and environment sectors.
- Active free time
- Energy saving projects (energy efficient public buildings including hospitals)



Example

Health investments contributing to new market development and the growth of small & medium enterprises – SMEs

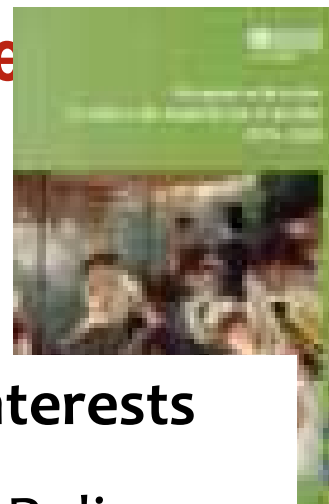
Joining up policy sectors and interests to reduce inequities in risk factors for NCDs

e.g. Fiscal policy to control Harmful use of Alcohol



Alcohol Related Harm

€125 billion annually in the EU, equivalent to 1.3% of GDP



Mapping Allies and Interests

Ministry of Justice & Police

Employers and Development
Sectors

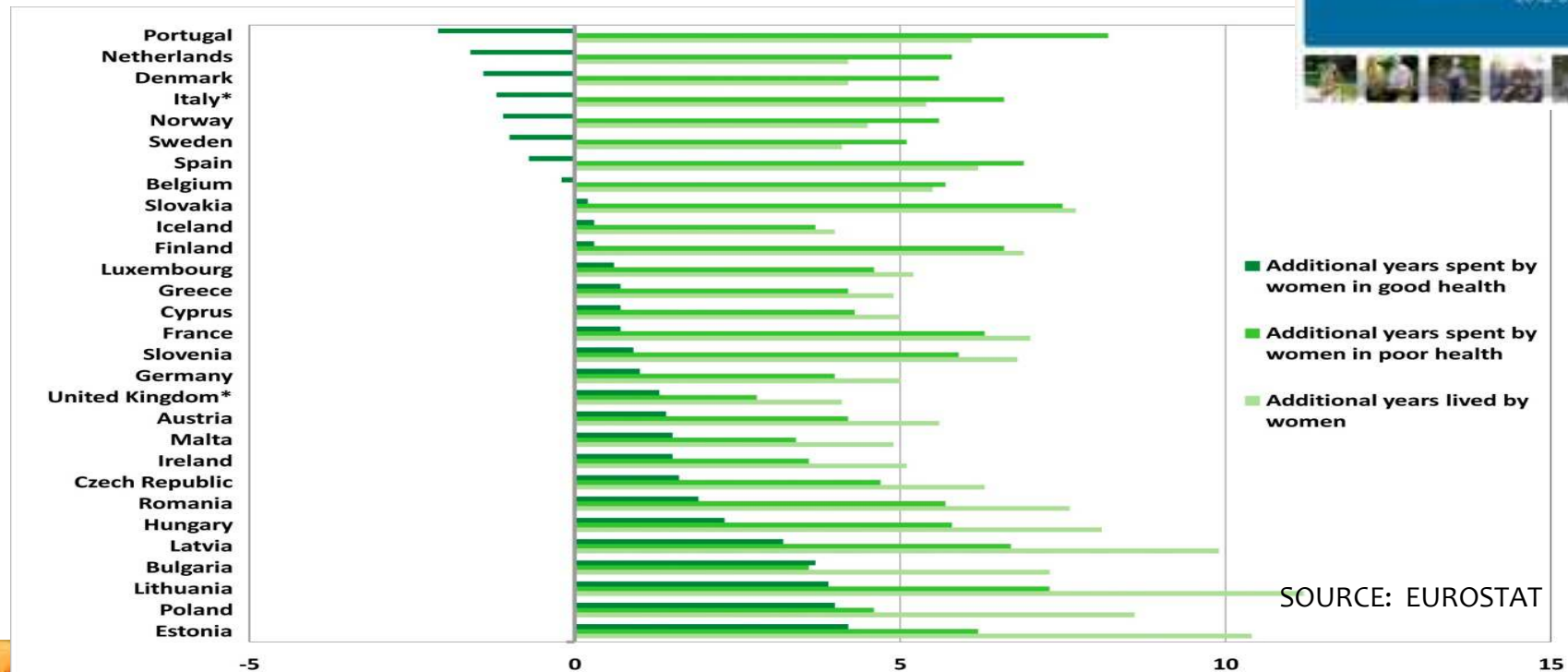
Health

Transport

Local Communities

Source: McDaid, Sassi and Merkur, 2012)

Reducing health inequities in later life and delivering on targets to increase participation of older people in the workforce



requires a healthy population & complimentary policies between health, development and social sectors.

Increasing equity in health and strengthening the social economy

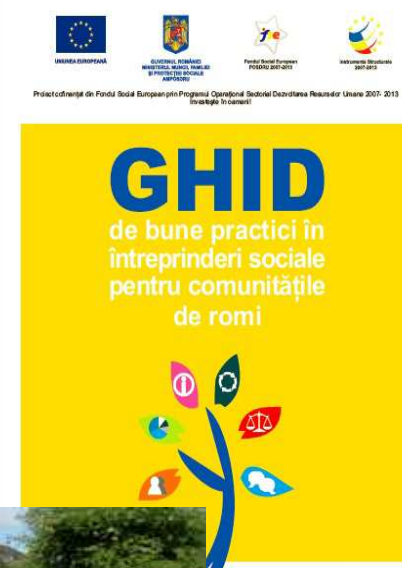
Local people, business & authorities creating solutions



Social mobilisation

Inclusive Decision Making

Shared Accountability



Romania

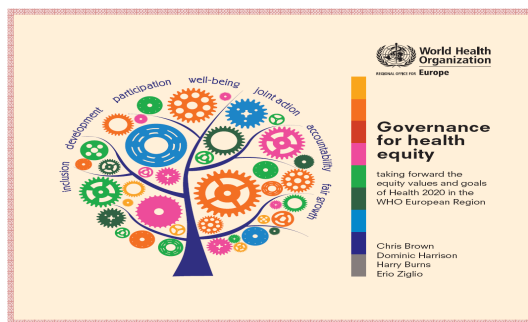
Current European agendas supporting joint investment in health equity

- Inclusive Growth agendas
 - EU Targets
 - Poverty Reduction
 - Participation of Older People in the Workforce
 - CAP Inclusive growth through education & employment
 - EU Social Investment Package
- Costs associated with preventable disease and Inequities
- Well being & Resilience
- Social Sustainability
- WHO Health 2020 Policy Framework

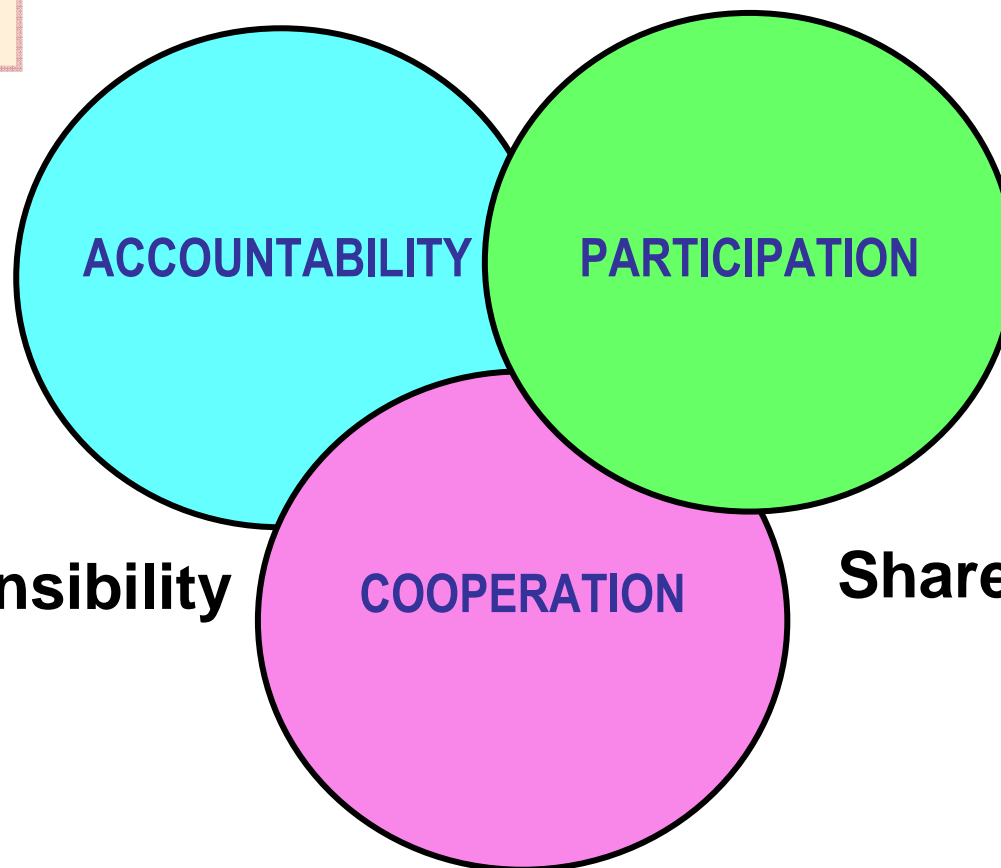
2. Keeping (health) Equity 'in' Policies

A Question of Governance

**How do we make joint investments
for equity in Health work in practice ?**



Co Production



Joint Responsibility

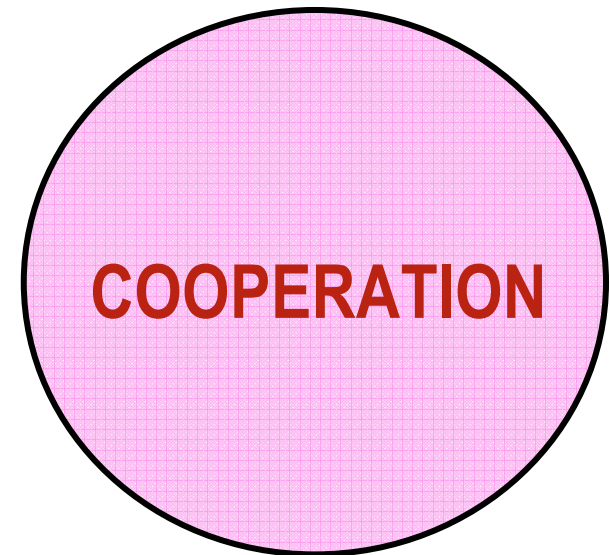
Shared Benefits

Incentivizing cooperation across sectors and stakeholders

Partnership Platforms Formal Intersectoral & Inter-ministerial Working Groups & Task Forces *Slovenia, Estonia, Denmark, Finland,*

Financial & reward systems linked to team results Shared/ Pooled Budgets, common Performance Indicators. *England, Spain, Norway,*

Joint Review of policies and interventions ensure shared understanding of problems & solutions e.g. Impact Assessments, Cross Sectoral Spending Reviews *Slovakia, Lithuania, Latvia, Scotland, EU OMC;*



Hold decision makers to account for health & equity results

Laws, MoUs, Contracts make responsibilities explicit & hold decision makers to account for results.

Guidance, Audit and Regulation support systematic action & remedy poor performance

Rewards & Incentives make pro health action the easy option.

Common Targets Health & Equity as key indicators

Systematic & Transparent Monitoring



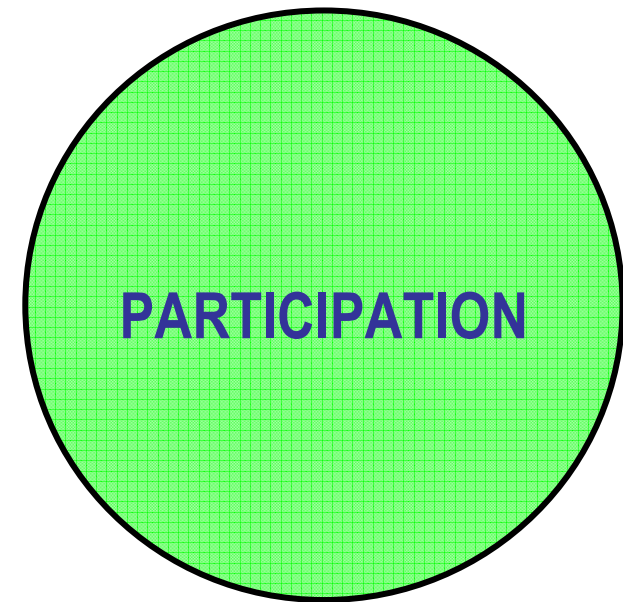
use a mix of *hard* and *soft* instruments

Diversity of voices in decision making and implementation

Bottom Up Planning

Capacity Building for Communities to Participate

Public Reporting of actions and engagement in review of progress e.g. *citizens juries*, *community panels*, social networks and media)



Whole of Government Approach

Example 1. Scotland



Governance Mechanisms used in Scotland . . .

Ministerial Task Force with Clear Values and ToR Reporting to the First Minister (PM)

Decision Support Network - range of Institutions coordinated through PH office of CMO.
Statistics, Policy Analysis, Evidence Synthesis,

Transparent and Inclusive process - expert panels, public consultations/ debates ensured wide range of stakeholders

Legal Agreements and accountability framework for horizontal & vertical integration

Clear & Joint Process for Review and ongoing assessment e.g. Single Outcome Agreements Regular Public Reports & Debates: Independent Reviews to inform policy adaptation

Test Sites Structured approach to building capacity on how to tackle critical problems

Regional Investment Plan to reduce health inequities

Example 2 - Slovak Republic



No National Strategy or targets but wide variations in mortality between regions and within regions

Ethnicity e.g. high % of Roma assumed explanation for differences.

Political Sensitivities,

Economic Pressures

Policies addressing determinants devolved to regional level, health managed centrally.

Instruments for Integrating Health Equity into Regional Investment Plan

A Bottom-up
Approach to
Employment
*An Example of
Good Practice*



Analysis of Health Equity & Identifying Pathways into & out of inequity .

— Education HS & Employment major determinants explaining inequities in adults

Health Equity Impact Assessment of the Regional Investment Plan

Dialogue, Evidence & Capacity Building

Finding common ground for action across political parties, sectors, local communities & the private sector

Implementation linked into mainstream planning and financing instruments.

Ongoing studies, keeping equity on the policy and political agendas & demonstrating impact.

Transfer /Sharing of Learning with other regions

Local Level Implementation

Example 3 Norway

Implementation support

Financing
Auditing

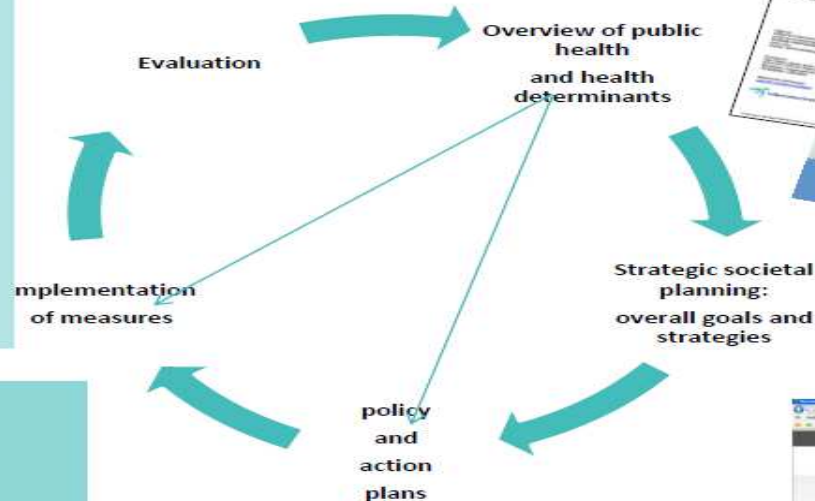
Monitor implementation:

- Baseline
- Indicators in reporting system (Kostra)

Capacity & competence:

- Seminars/courses (KS)
- Workshops
- Networking (KS)
- Collaboration with univ/colleges

Guidance:
Strategies and
interventions



Data support and guidance:



Guidance: «health in planning»



PARTNERSHIP WITH WHO EURO

Strengthening Governance Capacity & Instruments

Appraisals e.g. Migration & Health Assessment.

The Health Equity Appraisal

Building Commitment and Know How

Policy Dialogues

Sub Regional Partnership & Platforms

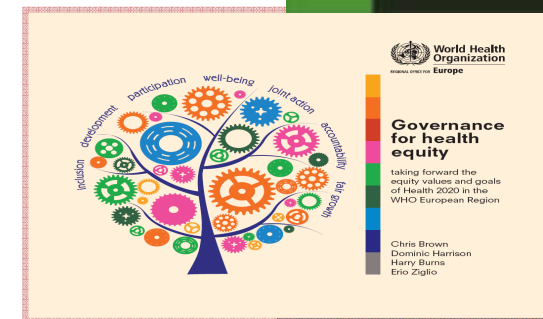
Leadership Programs and Problem Solving Networks.

Documenting Learning

Political Support

External Reviews of Progress

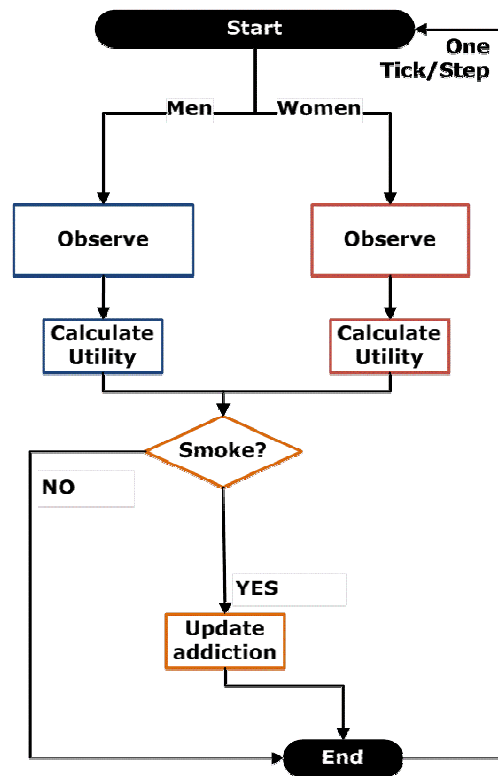
Regional Profile of Italian review and its implementation



Monitoring health and social determinants of health across the lifecourse

- Health and health care measurements by socioeconomic position, sex, geographical distribution
- Early years
 - An indicator of early child development at age 5
- Youth
 - Proportion of young people not in education/training or employment
- An adult poverty measure
- A measure of social isolation and/or poverty at older ages

Application of complex science models



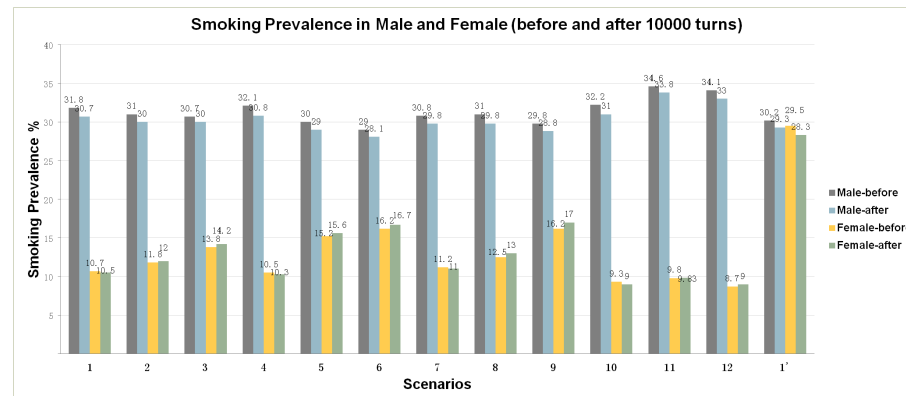
Chao, Hashimoto, Kondo, 2014
Presented in NIH complex science, health disparities, and population health

Several scenarios were prepared under different assumptions within/between genders on

- 1) the magnitude of SES disparity,
- 2) the vulnerability to social influence,
- 3) the chance of staying/moving up SES.

Males benefit from improvement of their SES in terms of decline in smoking prevalence

Females' smoking prevalence persists as long as social stratification within the gender exists due to their susceptibility to social influence.



Policy to tackle SDH

(Exworthy, Health Policy&Planning, 2008)

- Features of SDHs making it resistant to policy translation
 - Multiple causes ~ coordination barrier
 - Life-course perspective ~ misfit policy timetables
 - Inter-sectoral collaboration ~ misfit “modus operandi”
 - Complex causality ~ attribution problems
 - Conflicting priority
 - Globalization ~ multi-level stakeholders hampers governance
 - Data availability

Translation of evidence to policy

- **Policy frame** (Walt ,et al. Health Policy & Planning 2008)
 - Heuristic stages (Agenda setting, Formulation, Implementation, & Evaluation)
 - Policy triangle (Contents, Actors, & Context / Processes)
 - Network frame (clustered actors for collective action)
- Evidence helps problem awareness, causality specification, and monitoring/evaluation

Attribution matters in agenda setting

(Causal stories and the formation of policy agendas. Stone PSQ, 1989)

“Complex causal explanations are not very useful in politics, precisely because they do not offer a single locus of control” (ibid pp289)

“Complex cause is sometimes used as a strategy to avoid blames and the burden of reform” (ibid pp 292)

Attribution “to push a problem into the realm of human purpose” = scientific presentation of risk and causality

What we have/have not?

- ✓ Problem awareness
 - Presentation of “fact” (“Significant” correlation)
- ◆ Causal inference
 - Social experiment ?!
 - Quasi experiment with use of counterfactual modeling (e.g. propensity weighted Dif-in-Dif)
 - Panel data is pre-requisite anyway
- ◆ Evaluation
 - Monitoring (of what, for what depends on politics)
 - formal evaluation of a specific policy (causal model to be specified)

Data for evidence

- Use of existing data (Census, vital statistics)
 - Data confidentiality protection
 - Opt-in linkage of dataset
 - User accountability and training
- Prospective data collection for life-course approach
 - Design (size and sampling method), multi-level data collection, use and misuse of biomarkers, cross-country comparability
- Use of new technology (SNS, mega-data mining)

From “art” to “science”

- Translation knowledge to overcome “conceptual barrier”, or new language
- Scientific approach for conflict resolution e.g. b/w middle class vs. low class
- Countermeasure against opinion control by dominating party for vested interests
- How to share best practices currently available (Network formation!)

Intensified use of political analysis

- Multiple streams theory (Kingdon, 1984)
 - Problem, policy, politics streams
 - Power field model (Reich, et al. 1995)
- Punctuated equilibrium theory (Baumgartner and Jones, 1993)
 - Policy venue of UHC in Japan, Korea, and Taiwan
- Application of sociological theories
- Policy triangle frame (policy contents, actors, context, and processes)

Power of qualitative studies

- To build a “grounded” theory of causal models
- Thick description of champion cases to share lessons
- Narratives to make a “case” for political discussion