The relevance for Europe of the report of the Commission on the Social Determinants of Health

There are few occasions when a serving head of a government commits to tackle the underlying determinants of health. So the excitement was palpable when national Prime Minister Gordon Brown entered the room at the London Conference held in November to discuss outcomes of the study of the Commission on the Social Determinants of Health (CSDH)—‘Closing the gap in a generation: health equity through action on the social determinants of health’ (http://www.who.int/social_determinants/en/).

Then he spoke. ‘To advance the cause of health for all, and to end these inequalities, these injustices, within a generation… that is the task we have set ourselves, and we must not bend in our resolve to see it through. We must take urgent and coordinated action, globally, nationally and locally. . . .’

The UK health minister followed this by announcing that Prof. Sir Michael Marmot, the CSDH Chair, will lead a national review during 2009, in time for whole of government budget and policy reviews. It is hoped other countries will follow suit.

But do we need this in Europe? Are we not well advanced? Is not this mainly aimed at sub-Saharan Africa, as the report cover photograph itself suggests, where need is greatest in terms of morbidity and mortality, let alone the ethical deficits of wealth, quality of life and gender inequities exposed in the report?

Yes, fundamental change in the developing world is at the core of the report. Most recommendations, if implemented, would have greatest impact in parts of the globe most in need, as they should. But almost all apply in some degree to the European context, whether countries still in or emerging from transitional periods, or amongst the still diverse communities of a continent with major inequities.

What are the main messages for Europe?

Its main thrust is that ‘social justice is a matter of life and death’. Avoidable health inequalities arise because of the circumstances in which people grow, live, work and age. They are in turn shaped by political, economic and social forces.

The report calls on all governments to lead action with the aim of achieving health equity within a generation, which it sees as achievable. It recognizes that health equity may not be the aim of all social policies but will be a fundamental result. It cites economic growth as critically important, but without appropriate social measures is of little benefit to health equity.

It notes that traditionally society has looked to the health sector to deal with concerns about health and disease, but concludes that action on social determinants of health (SDH) must involve the whole of government, civil society, business and communities.

What does the report recommend?

The Report has three overarching recommendations:

1. Improve daily living conditions—a whole of life approach, encompassing social protection, community development and decent work.
2. Tackle the inequitable distribution of power, money and resources through financial and systematic reform, governance and market responsibility, gender equity and empowerment.
3. Measure and understand the problem and assess the impact of action through monitoring, training and research.

Extracts from specific recommendations and action areas confirm or identify what Europeans need to do to further tackle underlying health inequalities.

1. Improve living conditions

Equity from the start: the report is unequivocal: investment in early years provides one of the greatest potentials to reduce health inequalities. It stresses universal access and extent of education as crucial factors.

- Provide quality education . . . regardless of ability to pay, identify and address the barriers to . . . staying in school.

Healthy places, healthy people: the daily conditions in which people live have a strong influence on health equity, and provide common cause with European climate change initiatives.

- Establish participatory governance mechanisms that enable communities to partner in building healthier and safer cities.
- Manage urban development to ensure greater availability of affordable quality housing.
- Promote health equity between rural and urban areas through addressing the exclusionary processes that lead from rural poverty.

Fair employment and decent work: working conditions have powerful effects on health equity. This challenges the European trend to reduce health and safety and employment protection in the cause of less regulation or financial measures.

- Strengthen representation of workers in the creation of policy, legislation and programmes.
- Provide secure work and a living wage that takes into account the real costs of living for health.
- Implement regulatory mechanisms to promote and enforce fair employment and decent work standards for all.
- Reduce exposure to material hazards, work related stress and health damaging behaviours.

Social protection across the life course: low living standards—including from European case studies—are a powerful determinant of health inequity. Reducing child poverty and implementing social protection models are key issues for societies across Europe.

- Build universal social protection . . . sufficient for healthy living.
- Use targeting only as a back up for those who slip through the net of universal systems.
- Ensure that social protection systems extend to those who are in precarious work, including informal work and household or care work.
Universal health care: access to and utilization of health care is vital and most of Europe is well advanced. But as EU proposals recently showed, much more can be done to improve the health workforce and patient rights.

- Ensure public sector leadership in health care systems financing, ensuring universal coverage regardless of ability to pay.
- Address the health human resources ‘brain drain’.
- Build and strengthen the health workforce and expand capacities to act on social determinants of health.

(2) Tackle the inequitable distribution of power, money and resources

Health equity in all policies, systems and programmes: the EU health strategy cites equity as a priority for cross sectoral improvement.

- Adopt a goal of achieving health equity as a measure of government performance.
- Establish a whole of government mechanism…at the highest level possible.
- Health equity impact assessment of all government policies, including finance, to be used.
- Health sector should expand... health promotion, disease prevention and health care to include an SDH approach.

Fair financing: this is clearly a potentially controversial section, but financial reform is seen as fundamental to health and welfare objectives.

- Public resources be equitably allocated and monitored between regions and social groups, using an equity gauge.

Market responsibility: there has been criticism that the report describes globalization and other business factors as a problem, but is weak on solutions. In highly developed European trade markets, that is a major issue.

- Strengthen representation of public health in domestic and international economic policy negotiations.
- Strengthen public sector leadership in provision of essential health related goods, services and control of health-damaging commodities.

Gender equity: empowerment of women is key to achieving fair distribution of health. Of 27 EU heads of government, 1 is a woman. The commitment to sexual and reproductive rights is highly sensitive in some European states.

- Set up and fund a gender equity unit to analyse and act on gender equity policy impacts.
- Include the economic contribution of household work, care and voluntary work in national accounts and strengthen the inclusion of voluntary work.
- Invest in expanding women’s capabilities through education and training.
- Set up friendly policies that ensure men and women take on care responsibilities.
- Reaffirm commitment to addressing sexual and reproductive rights universally.

Political empowerment and voice: European debates on migration and rights of ethnic communities, such as Roma peoples, are profoundly linked to this section. In some states a civil society role is not guaranteed.

- Acknowledge, legitimize and support marginalized groups, in particular indigenous people.
- Ensure fair representation in decision making that affects health and in subsequent delivery and evaluation.
- Enable civil society to organise and act.

(3) Measure and understand the problem and assess the impact of action

These objectives are most likely to be grasped by Europeans as being SMART: specific, measurable, attainable, realistic and timely. Health equity impact assessment has a long way to go to become de rigueur, but the case for quality data analysis, stewardship of surveillance systems, dedicated research budgets plus training and capacity building not only in health but also education and other key sectors, is certainly winnable. The knowledge gained can also be transferable elsewhere as a global contribution.

- Establish a national health equity surveillance system.
- Create a dedicated budget for generation and sharing evidence including health equity intervention research.
- Make SDH a compulsory part of training of medical and health professionals.
- Increase understanding of SDH among non medical professionals and raise awareness of the public.
- Build capacity for health equity impact assessments.
- Strengthen capacity for WHO to provide technical support nationally and locally.

Yes, much has been done or started: Nordic and UK countries, in particular, are world class in developing comprehensive approaches. Others such as France, Spain, the Netherlands, Switzerland or Slovenia are equally ambitious. Hungary is using EU structural funds for health innovatively.

Yet, as fine European studies such as the work of the Editor-in-Chief of this journal and his colleagues demonstrate (http://ec.europa.eu/health/ph_determinants/socio_economics/documents/socioeco_inequalities_en.pdf), health inequities remain pervasive and persistent, the gradient is crystal clear in all countries, some economic implications are powerful in terms of potential benefits and savings but more knowledge is needed, and policymakers are puzzled that even when they act on specific lifestyle or environmental determinants the underlying problems largely remain. The need to take up this report is demonstrable.

Several examples have been prominently cited, both within states—the two decade life expectancy gap for men in Glasgow, a decade of difference between communities in north London—or the similar divide across the Baltic between Sweden and Latvia or other states. It applies north and south, east and west. While data are often insufficient, there is not a country in our continent that can claim to have cracked the nut of health inequity.

As Prof. Marmot exclaimed, the CSDH wanted to start a movement for action, a nutcracker comprising policy change and people pressure, and now its beginnings can be seen. A serious political process for health equity is underway.

He also said ‘we know enough already to act’. The WHO Venice office for health and social development (http://www.euro.who.int/tdh) is now producing work itself plus jointly with the European Commission (EC) to apply the recommendations on reorientation of health systems, through performance analysis and tools such as capacity building and policy briefings based on the Tallinn Charter for health systems agreed last June (http://www.euro.who.int/socialdeterminants/systems/20081128_6).

The EC itself is not only facilitating the inter governmental working group mentioned earlier, but also co-funding research and development work in the field, including a web facility offering links to relevant work (http://www.health-inequalities.eu/). The organization coordinating that is EuroHealthNet, via the DETERMINE consortium which has collated examples
of existing activities, but found that policy implementation in Europe is far from systematic. That is a real challenge for the change within a generation which is the ambition of the CSDH.

DETERMINE is also finding, as did the CSDH, that implementation and economic research is difficult both to access and define. A project called ‘Gradient’, due to begin work from 2009 researching child and family social determinants and policy implications, will be co-funded by the 7th EU Research Programme.

The ground on which the report falls in Europe is partially prepared—health, welfare, education and governance systems are largely developed if not well oriented or resourced—but there is recognition that the thorniest areas are well entrenched and need sophisticated arguments.

EuroHealthNet is part of an international collaboration on social determinants to follow up the Report. That will gather ideas from Europe and share new knowledge on how those recommendations can be implemented, some quickly, others further ahead.

Already our team has drafted a dossier cross referencing the EU legislative work programmes with the outputs of the CSDH knowledge networks. Their work gives us the motivation to move on from the areas of public health policy which attract 3% average funding from national health budgets, and into the relevant parts of the highest priorities. The notion that health has nothing to say, no partnerships to build or all is well in Europe with education, housing, transport, community development, justice, markets and trade, migration, environment, industry, energy and technology is simply blinkered and harmful to addressing direct health determinants.

All of those elements are identified, clarified and exemplified in the CSDH Report. Far from flawless, it now needs tough, culturally relevant consideration in all European contexts, for opponents will be fierce or ignorant, as some media comment has shown. But as the British Prime Minister concluded and much of his audience concurred: ‘It is an enormous challenge, but the prize is great: a healthier, more prosperous and fairer world’.

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Report of the WHO commission on social determinants of health: a French perspective

Seen from France, this report underlines how far we still have to go in our country to reduce social inequalities in health. France is not one of the partner countries of the Commission and the conceptions of health determinants which are developed in the report appear far removed from the paradigm which predominates in our country. We can no longer say that France is at the ‘pre-contemplative’ stage: data exist, the phenomenon of social inequalities in health is known and well documented for numerous states of health. But these efforts, which issue largely from the world of research, have not resulted in a system of routine statistical surveillance. Furthermore, at this ‘contemplative’ stage, there is no explicit public policy and no objective written down in law. In the law on public health policy of 2004, objective 34 touches on this question, but restricts it to the state of health of the most precarious populations.

Mobilizing opinion

As stated in the report, reduction of social inequalities in health is above all a political problem, but it is essential to provide evidence. In this respect, the report lends support to those who, in France, think that it is important to continue to increase our knowledge of the subject, but that the most pressing question is how we can move on to the active stage. It is strange to see how our country, always ready to give others lessons on human rights, tolerates a problem as well documented as social inequalities in health. Although the right to optimal health is laid down in a number of texts, this question of social justice and ethics does not mobilize opinion. This is so in France, but also throughout the world. The question thus remains to find out on what basis opinion and the decision makers can be mobilized. Though today it is unfortunately a fragile argument, it seems to us that the ethical imperative put forward in the report must remain central. The fact that the reduction of social inequalities can be a source of economic gain, as shown in a Canadian report, is an argument to be developed in order to remove economic objections, but it cannot be the central argument for mobilization.

WHO reports 2000 and 2008: very different perspectives

This report may well enjoy less popularity in France than a previous WHO report. In its World Health Report 2000, the World Health Organisation had no hesitation in describing the French health system as one of the best in the world. In that report, the conception of health determinants was in line with the prevailing conception in France. The health system was described as being the essential factor of the good health of a country. ‘If Sweden enjoys better health than Uganda—life expectancy is almost exactly twice as long—it is in large part because it spends exactly 3.5 times as much per capita in its health systems.’ On the basis of this analysis, since 1945 France has enjoyed a system of social protection which proclaims, among its objectives, the improvement of the population’s level of health. Within this system of social protection, the general health insurance system, completed by specific schemes for the poorest among the population, should allow widespread access to health care. The number of French people who have the benefit of insurance against ill health has constantly increased over the years and now almost the entire population is covered. In 2002, according to the Health and Social Protection survey, 91% of residents in France also had complementary coverage.

At the same time, the mortality statistics remind us that in this country social inequalities in health are particularly marked in comparison with our European neighbours. This apparent paradox calls into question such a conception of health.

Towards fundamental policy choices

The 2008 report puts the determinants back into perspective in a most useful way. On a world-wide scale, access to drinking water, to a diet which prevents malnutrition, protection against the vagaries of the climate are the major