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How do we move forward on the social determinants of health: The global governance challenges

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Introduction

The WHO Commission on the Social Determinants of Health (CSDH) undertook a gargantuan task in disentangling the complex social forces that affect human health; understanding and explaining their causal connections; and producing a readable report with clear policy measures. The efforts of its Chair, staff, commissioners and nine knowledge networks were impressive in scale, scope and stamina - no exercise to date has made the case so clearly that social inequality and poor health are irrefutably entwined.

While the substantive content of the CSDH's work remains an important focus of discussion, the critical task of putting the findings and conclusions of its Final Report into practice also requires attention. How can the CSDH's recommendations be effectively taken forward? How can an extended process of reviewing evidence be turned into concrete policy action? What political processes need to engaged with to concertedly tackle the social determinants of health?

Improving health equity within a generation: The Commission's political strategy

The Final Report's overall aim is "closing the health gap in one generation" (WHO 2008, p. 32). While a daunting task, historical examples of major social changes (e.g. universal franchise, civil rights movement) show what collective action can achieve. Under the banner of "bringing together global action for health equity under the rubric of social determinants of health" (WHO 2008, p. 33), the CSDH identifies twelve objectives (see Table 1) categorised into three principles ("daily living conditions", "power, money and resources" and "knowledge, monitoring and skills"), and key actions. The result is an agenda that aligns the broad principles of social justice and health equity with specific policy measures.

Armed with this agenda for action, how the CSDH proposes to pursue such broad ranging change is the subject of a chapter entitled "Sustaining Action Beyond the Commission on

Conflicts of interest

KL was lead author of *Globalization, global governance and the social determinants of health: A review of the linkages and agenda for action*, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health.

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the Social Determinants of Health". The chapter focuses on the creation of a "broad partnership of those who do research, those who devise policy, those who implement policy, and those who advocate and act" (WHO 2008, p. 194). As well as embracing these diverse communities, the report calls for a "nutcracker effect" to be achieved by combining "top-down political commitment and policy action", with "bottom-up action from communities and civil society groups" (p. 194). The specific roles of global leaders (including the Commissioners), WHO, country partners, cities, civil society and research community are each discussed briefly. The overarching vision of the CSDH is a broad-based coalition that embeds health equity into global, regional, national and local policy priorities including explicit targets ("mainstreaming health equity across programmes"); creates mechanisms for collaborative efforts across relevant sectors ("cross-cutting functions related to health equity"); and generates and disseminates evidence-based knowledge on the effectiveness of specific interventions and the achievement of concrete goals.

As a broad statement in a Final Report, these intended actions read fine enough, even if the language ("partnerships", "mainstreaming" and "cross cutting") has become somewhat familiar UN-speak. As a political strategy, however, details about what these terms mean in practice and, ultimately, how the ambitions of the CSDH can be achieved, require clarification.

Pushing the "refresh" button: Reframing health equity within the global health agenda

How new are the "big ideas" that the CSDH seek to draw political attention to? Its starting point is that health is determined by social factors, and that "dramatic differences in health… are closely linked with degrees of social disadvantage" (WHO 2008, Preface). At their core, these ideas are not of course new. There has been recognition of this link for decades, if not centuries, harking back to the squalid living and working conditions of industrialising Europe. The establishment of social medicine (as opposed to biomedicine), which locates health within its socioeconomic environment, was prompted by the need to tackle the broader determinants of health. How can the Commission generate new political attention to what is essentially a long recognised, albeit persistent and substantial, problem?

One way the CSDH seeks to renew political interest in the links between health and social inequalities is to show how these links have "gone large" amid globalisation. Today, the world is characterised by social, and by extension health, inequities that are avoidable and inherently unfair. Social injustice has gone global, reinforcing and even worsening existing patterns of inequality, as well as creating new divisions. Thus, while the problems identified by the report may not be entirely new, nor the evidence generated to support such arguments, what might be emphasised is the greater scale of these problems in the context of globalisation.

The importance given to the concept of "global" by the CSDH is suggested by the frequency with which it appears in the Final Report (see Table 1). Unsurprisingly, the core concepts of "health", "social" and "equity" appear most frequently. The fourth most frequently used

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term is “global”, appearing an average of three times per page. In comparison, core terms such as social justice, equality and human rights appear far less frequently.

How the term global is defined and used, as distinct from “international”, is less clear in the report. This remains so within the broader public health community where the term “global health” has become ubiquitous, in many cases, as a contemporary replacement for “international health” or health in the developing world. In the context of political strategy, further attention to the distinct value of the term, in relation to the longstanding problems of health equity and the social determinants of health, could be used to reframe the work of the Commission and give it contemporary relevance. As Gostin and Mok (2009) write, “all countries, rich and poor, are at risk of pronounced health hazards due to growing globalization….[which is] changing the way that states must protect and promote health in response to the growing number of health hazards that increasingly cross national boundaries.” How can the Commission, therefore, reframe the problem of health equity in terms of the contemporary landscape of globalisation to explain its causal factors and define its effective solutions?

There are opportunities to do this, for example, by drawing on the work of the CSDH’s Globalisation Knowledge Network which produced an abundance of analyses on the links between globalisation and the social determinants of health. While selected aspects of this network’s findings is found in the Final Report, the distinct nature of the challenges and opportunities posed by globalisation to health equity need to come through more strongly.

Competing for space on the policy agenda

A related challenge is ensuring the CSDH’s big ideas and agenda for action are given political priority given competing for policy space and resources. The cyclical nature of political timeframes also means the attention of decision makers can tend to focus on: (a) issues perceived as urgent; (b) issues perceived as achievable; and (b) issues that can be addressed within a given mandate. Why should political leaders tackle the social determinants of health “right here, right now” as opposed to perceived terrorist threats, climate change, energy shortages, conflict resolution or financial crises?

As discussed above, the links between health equity and poverty, poor housing and nutrition, and employment insecurity are long recognised. There is thus a risk that health equity remains seen as a chronic rather than acute problem, requiring less immediate attention. Similarly, the range of causal factors contributing to health equity suggests that complex changes to how societies operate individually and collectively are needed. The interrelated nature of the actions proposed suggests the need for highly complex policy interventions across public and private, national and sectoral boundaries. The sheer ambition of the CSDH’s agenda for action, in terms of scope and scale, undermines its political unattractiveness.

To convince policy makers to make health equity a political priority, the strategy of linking to other agendas is one way forward. This approach has been used, for example, to renew commitments to certain infectious diseases. Framing their prevention, control and treatment

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in terms of national and global security, economic development and growth, for example, has led to a proliferation of new initiatives since the late 1990s. The public health effectiveness of these efforts remains subject to debate, but greater political commitment to addressing them has been marked.

Can the CSDH agenda similarly piggyback on other priority agendas? The bulk of the evidence presented in the Final Report considers how other sectors impact on health equity. Health inequities, for example, have worsened as market-driven economic globalisation has spread worldwide. Better management of the globalisation process requires, as one of its core tenets, social protections which include health equity. The global financial crises, and the problems with food and energy prices, for example, should not be considered as issues separate from health equity. The Commission should use this substantial evidence base to demonstrate that efforts to address these problems must be part of the holistic approach to improving the governance of globalisation.

Knowledge and social change: "Too much information"?

The need for improved knowledge and better understanding to guide policy action on the social determinants of health is clear. The monumental task of the Commission, in assembly best evidence across a broad range of health determinants, and conceptualizing their causal links with health equity, has been important for advancing the field. Equally important has been its highlighting of the knowledge gaps within the field including the urgent need to strengthen capacity.

A particular challenge is the development of effective policy interventions to tackle the complex multi-factored problem of health equity. The CSDH calls for "more systematic, shared sets of data" and revision of "existing global development frameworks to incorporate health equity and social determinants of health indicators more coherently" (WHO 2008, p. 171). Irwin et al. (2006, p. e106) write that "The commission aims to lever policy change by turning public health knowledge into pragmatic global and national policy agendas".

There is a clear need too for different kinds of data consistent with the global theme of the report. What data captures the transnational character of global social inequalities? For example, the report's analysis that growth in global wealth and knowledge has not translated into improved health equity, depends on what is being compared and over what time period. If comparing across countries, there are many countries that now have a middle class, but also substantial populations within those countries which have not benefited from economic globalization. The report is hampered by the limitations of national level data. Another gap in knowledge is how political determinants contribute to poverty and, in turn, population health. As Palma-Solis et al. (2008) argue, "[m]ore scientific knowledge must be generated on the political determinants of social factors that contribute to poverty and on how this causal chain affects population health."

While more information and consistent data on key indicators shared across institutions is a good starting point, in terms of political strategy, more information will not necessarily generate political action. Better understanding is clearly a prerequisite for effective decision-

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making but lack of knowledge should not hinder political attention to health equity. The glacial progress of the MDGs suggests lack of knowledge is not the main barrier. More fundamental, perhaps, is the highly contested goal of health equity and the policy measures advocated to achieve it. As described above, there remains a lack of consensus about the relative priority that should be given to health equity. Even more contested are policy measures seeking to redistribute resources from those who have, often powerful vested interests, to those who do not. In short, political ideology than technical knowledge underlies the lack of change.

Despite the strong emphasis by the CSDH on reviewing current knowledge and evidence-based analysis, moving the agenda forward is as much about a battle of values and ideas, as it is about evidence. While the Final Report does much to smooth out these wrinkles of normative disagreement, differing views about social justice and health pose a dilemma. Should the CSDH focus on the evidence and hope that it will lend sufficient weight to move political action forward? Or should it directly engage in open debate about the "elephant in the room", and risk alienating those whose power is needed to enact real change. So far it appears the Commission has taken the former route in the hopes that consensus can still be achieved.

Harnessing the power of ideas: The role of international commissions

International commissions are important diplomatic vehicles in an increasingly globalised world. Since the early 1990s, there has been a proliferation of such commissions: World Commission on the Environment and Development, Commission on Global Governance, World Commission on Dams, International Commission on Intervention and State Sovereignty (ICISS) and the International Commission for the Conservation of Atlantic Tunas, to name but a few. Within the health field, there has been the International Commission on the Biological Effects of Noise, WHO Commission on Macroeconomics and Health and many others.

In their edited volume, *International Commissions and the Power of Ideas* (UN University Press), Thakur et al. (2005) describe international commissions as a key feature of global governance because of their capacity to assert the "power of ideas". They write that their come from "the interaction between ideas as intellectual constructs and as sources of inspiration for the application of policy prescriptions". Such bodies can mobilize, reflect and even generate ideas which can, in turn, influence policy action. Similarly, Ngaire Woods (1995) refers to "ideational factors" which challenges us to understand world politics differently from traditional power politics focused on sovereign states.

The CSDH can be described as such a vehicle, created to generate momentum behind a set of ideas and policy actions. In this sense, its work has been ostensibly a political project with the subtitle of the Final Report, "Closing the health gap in a generation", is an articulation of its ambition. It is perhaps not surprisingly, given this ambitious political task, that the road to this report has at times been bumpy. The real battleground has been ideational – the creation of the CSDH was a direct response to the market-based economism permeating health policy since the 1980s.

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Aware of the sensitivities involved, the seventeen appointed commissioners were carefully selected to represent a broad range of perspectives. The creation of the nine Knowledge Networks is less clear, driven as much by available funding as technical expertise. Indeed, lack of funding for the Commission's intellectual "heavy lifting" contributed to the creation and work of various networks progressing at different rates. However, efforts were also made to ensure network contributors reflected the scholarly, policy and civil society communities. While each network operated independently, a website was created to ensure this worldwide constituency remained informed of processes and outputs.

Thus, Commission's process has formed part of its political strategy from which lessons might be drawn. The boiling down of the rich soup of ideas, produced by the hundreds of contributors to the Commission's work, into one key message – that social justice underpins health equity – was effectively achieved. What institutional form the Commission takes in future will determine how effectively this core idea is taken forward.

Renovation or major building works: What is "good" global health governance?

The longer term status of the Commission relates to wider questions about the state of global health governance (GHG) and indeed, global governance in general. What is the CSDH's political vision of "good" GHG, and how will this contribute to improving health equity? The CSDH describes what "Good global governance" is needed:

> It is imperative that the international community recommits to a multilateral system in which all countries, rich and poor, engage with an equitable voice. It is only through such a system of global governance, placing fairness in health at the heart of the development agenda and genuine equity of influence in the centre of its decision-making, that coherent attention to global health equity, realizing the rights of all people to the conditions that create health, is possible
>
> (WHO 2008, p. 174).

This approach is similar to the UK *Health is Global* strategy (2008–2013) which concludes: "The world needs effective international institutions to provide a stable global order and to maximize the opportunities to improve global health" (UK 2008, p. 25). This strategy looks to the reform of existing international institutions:

> We will work to reform international institutions so that they become representative and effective in the modern world. We want to see them working effectively….WHO is already a major force for good in global public health. We will work across government with WHO and other UN agencies….we will work with the EU
>
> (UK 2008, pp. 25–26).

Given the collective nature of the task, clear recommitment to multilateralism is clearly warranted.

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What is less clear, however, is whether this vision of global governance can be achieved through the existing multilateral system or whether a more radical solution is required. The CSDH calls for the inserting of health equity commitments into existing institution arrangements (e.g. MDGs, Ecosoc, UNGA etc.), focused on a reformed UN:

> closer policy and programme planning between relevant multilateral agencies, strengthening their own collective governance….
>
> Improving global governance for health equity depends on multilateral agencies working more coherently to a common set of overarching objectives, underpinned by a common vision of issues to be addressed and shared indicators by which to measure the impact of their actions
>
> (WHO 2008, p. 171).

It calls for health equity to be a “shared concern and a key indicator of action across the community of multilateral actors”, and a broad constituency of advocates for its achievement. Health equity is seen by the CSDH as resolvable through these global institutions, rather than problematic in themselves (Schofield 2007).

UN reform, of course, has been the subject of perennial debate for many decades. Calls for attention to improved coordination and inefficiency can be found in almost every assessment of UN reform. What is missing is how familiar problems are to be addressed, and indeed, not worsened by the Commission’s recommendations. While better global governance is critical, the challenge is described as technical or operational (i.e. inefficiencies, policy coherence). Improved coordination would likely benefit action on health equity. But why is there poor coordination in the first place?

Thus, the Final Report’s call for improved GHG does not explicitly acknowledge the existence of diverse, and even competing value systems and vested interests. To what extent is the report seeking to find a technical path through a politically-laden minefield? Moreover, critics accuse the CSDH of tinkering around the edges rather than challenging the normative frameworks underpinning contemporary multilateralism. The CSDH’s vision contrasts with calls, largely by civil society organisations, for more radical changes to GHG. Criticising reforms of World Bank governance proposed in October 2008 as “piecemeal change”, critics call for “a fundamental rethink” of existing institutions as part of the problem rather than solution (Bretton Woods Project 2008). The *Global Health Watch 2* (2008), for example, argues for a “new development paradigm”, strongly criticising WHO, the World Bank and Gates Foundation for their role in supporting unfair social and economic policies that harm the health of the poor.

Most importantly, the CSDH’s emphasis on existing multilateral institutions sits uncomfortably against the vision of the emerging global world order described in its Final Report. The report points to the disjuncture between the growth of global markets, and the economic and social institutions necessary “for their smooth equitable functioning”. It also identifies the existence of “winners” and “losers” from globalization “among the world’s countries”, and the “need for new forms of global governance” to “address the risk of inequity in globalization, and to manage the potential of globalization for better and fairer

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health" (WHO 2008, p.166). However, in a world increasingly influenced by non-state actors, and the coagulation of interests and distribution of power, authority and resources in ways that cut across, undermine and even disregard state boundaries, is the strengthening of existing state-based institutions the only way forward? The transition from state-based to global institutions lies at the heart of current debates about GHG – how should political power be organized and exercised in a complex world crisscrossed by new constituencies not necessarily conforming to territorial states? The obsolescence of such statecentrism is illustrated by global financial crises which demonstrate the interconnectedness of national economies, and public and private institutions within and across countries. It also illustrates the shared interest of finding effective and appropriate global institutions to manage and regulate these interconnections better. Where issues emerge that are perceived as urgent (e.g. ozone depletion, whaling moratorium, influenza preparedness), more rapid collective action has been successfully achieved in recent times, often via mechanisms that bypass the existing multilateral system. Should health equity be taken forward in similar ways?

Independent yet dependent: The CSDH and WHO

A final issue, in relation to political strategy, is the CSDH's relationship with WHO. The CSDH was formed in 2005 by the WHO Director-General in direct response to calls, led by civil society, for a high-level body comparable to the Commission on Macroeconomics and Health (CMH), to address concerns about health equity. While convened by WHO, the global network of policy makers, researchers and civil society organizations brought together by Michael Marmot remained independent. Funding for the Commission's work, and its various networks, came from diverse sources, due to necessity or otherwise, which again created a degree of freedom of voice.

While independent, its formation under WHO auspices has linked the three-year work programme, as well as its ultimate fate, to the organisation. How WHO now acts, in support or otherwise, of the CSDH's agenda for action, will be critical. On a positive note, the Final Report is closely aligned with the *World Health Report 2008 Primary Health Care - now more than ever* which marks the thirtieth anniversary of the Alma Ata Conference. Speeches by the Director-General have drawn links between the two reports (Chan 2008).

At the same time, there has been criticism of the failure to allocate WHO resources to follow up the Commission's work, a sign perhaps of a lack of real commitment. Former Director-General Gro Harlem Brundtland identified malaria and tobacco control as cabinet level priorities. Chan has so far not done the same for health equity. Internally, there has also been a lack of clarity about where the crosscutting theme of health equity is located within the organisation. And WHO has long struggled with defining its relationship with CSOs, many of which still feel excluded from the organisation's work. The negotiation of the Framework Convention on Tobacco Control, and revision of the International Health Regulations, demonstrated the potential for non-state actors to support WHO's work.

Most problematically, perhaps, is how far WHO is capable of championing health equity given its diminished status in GHG. Political leverage depends on WHO having a leadership role in global health policy making. This remains so for many technical matters, but

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financial resources and the political clout arising from them remain limited. New players, such as the well-endowed Gates Foundation, have exerted far greater influence in recent years, in some areas, undermining WHO's authority (McCoy et al. 2009). Beyond the health sector, WHO's status is even weaker alongside the World Trade Organisation, World Bank and International Monetary Fund. These latter institutions have the capacity to make the biggest impact on health equity through policies on poverty alleviation, economic development, employment and trade.

Conclusion

The CSDH is laudable, both as an analytical achievement and clear statement of the importance of health equity. It is less clear on the political strategy needed to take forward its critical agenda. Following publication of the CMH report, Jeffrey Sachs persuaded and cajoled world leaders that tackling major diseases is a good economic investment. The CSDH faces the similar task of making health equity relevant to political leaders. Indeed, while the analytical task of the Commission has been Herculean, the real work of harnessing its findings to produce social change has barely begun.

Acknowledgments

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Table 1

The objectives towards “closing the health gap in one generation”

I. Daily Living Conditions

- A more equitable start in life
- A flourishing living environment
- Fair employment and decent work
- Universal social protection
- Universal health care

II. Power, Money and Resources

- Coherent approach to health equity
- Fair financing
- Market responsibility
- Improving gender equity for health
- Fairness in voice and inclusion
- Good global governance

III. Knowledge, Monitoring and Skills

- Enhanced capacity for monitoring, research and intervention

Source: WHO Commission on the Social Determinants of Health. Closing the gap in a generation, Health equity through action on the social determinants of health. Geneva, 2008, Table of Contents.

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TABLE 2

USE OF SELECTED WORDS IN FINAL REPORT

Word	Number of uses
health	3916
social	1557
equity	956
global	721
poor	267
governance	131
*equality	50
human rights	35
social justice	23