The Commission on the Social Determinants of Health: reinventing health promotion for the twenty-first century?

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This paper describes the work of the Commission on the Social Determinants of Health, established by WHO in 2005 and considers the potential for this Commission to contribute to a reinvention of health promotion for the twenty-first century. It argues that the Commission can do this by reinforcing the move that health promotion has been making since the 1980s to be less concerned with behaviour change and more concerned with creating the conditions in which health and well-being flourish. Specific contributions the Commission will make are: providing a vision of the moral importance and feasibility of a more equitable world; positioning health promotion as a task for the whole of the economy through action within the government sector and through assessment of the health equity impact of the corporate sector and neo-liberalism; through its Knowledge Networks, providing a much stronger evidence base than has previously been available on the social determinants of health and health equity including the actions and policies that are most likely to promote health and equity; providing a focus for the further growth of a global social movement advocating for health equity within and between countries; contributing to the reform of WHO and other international health agencies so that all programmes are built to take comprehensive action in communities and nationally to tackle the underlying causes of disease; adding legitimacy to moves to re-orientate health care systems to a focus on health promotion and population health.

Keywords: Health promotion; socio-economic; population health

Introduction

Health promotion does not sing with one tune. In fact the history of the movement demonstrates that it is quite splintered. On the one hand it is concerned with individuals and their behaviours and, on the other hand it draws on social reform movements that focus on societies, and on policies that shape the experiences of individuals. In the first approach it aligns with the health education movement and in the second with the new public health (Ashton and Seymour 1988, Baum 2008). Increasing inequities and the globalisation of economies and markets are bringing rapid changes to the conditions that shape health (Kickbusch 2006) and these have significant implications for the ways in which health promotion is conceived and executed. This paper considers the extent to

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which the Commission on the Social Determinants of Health (the Commission) has the potential to shape the direction of health promotion in the twenty-first century in a manner that will see health promotion more equipped to take action to reduce inequities and ensure that globalisation becomes fairer.

The Commission on the Social Determinants of Health

The Commission was launched by the World Health Organisation in 2005 and its final report released in August 2008 (CSDH 2008). The report makes three overarching recommendations which concern the importance of:

(1) improving daily living conditions in which people are born, grow, live, work and age;
(2) tackling the inequitable distribution of power, money and resources – the structural drivers of daily living conditions – globally, nationally and locally; and
(3) measuring and understanding the problem of health inequities and assessing the impact of action.

The report’s main arguments are supported primarily by the moral case for social justice globally and within countries. The report resulted from the work of 19 Commissioners who were innovators in science, public health, policymaking and social change and the 5 streams of action (see Irwin et al. 2006 for more details) they established.

(1) Organization of knowledge to inform public policy proposals and action on the social determinants of health, through nine knowledge networks (KNs).1
(2) Demonstrations of the opportunities and possibilities for action, which is formalised in country partnership agreements and action plans – the country work stream.
(3) Social mobilisation and long-term political sustainability of the Social Determinants of Health (SDH) agenda, which is being organised through an extensive process of engagement with civil society.
(4) Promoting action, in United Nations institutions and other global players in public health, on equity in health and providing specific policy proposals for improved action on the social determinants of health – global initiatives.
(5) Developing the plan for institutional change at WHO so that it is better placed to provide long-term support to countries in advancing the SDH agenda after the Commission has ended.

Since its formation, the Commission has provided a focus for national and international efforts to act on the social determinants of health in order to increase health equity between and within countries. Its focus was not only on knowledge about the impact of social determinants on health and what can be done to make the health impact more health-promoting (the KNs have developed detailed records of policy and programme actions), but also on taking action through the civil society and country work streams. The country work stream brings together more than 10 countries and includes: Bolivia, Brazil, Canada, Chile, Iran, Kenya, Mozambique, New Zealand, Sri Lanka, Sweden, Thailand, and the UK.

The Commission’s understanding of how social determinants influence health equity is based on an understanding that ill-health (and unequal health outcomes) are produced
through a chain of causation, shaped by broader social context, that starts from the underlying social stratification. There are four main points on this chain where intervention can be useful:

1. Decreasing social stratification (for example, redistributing wealth);
2. Decreasing exposure to factors that threaten health (for example, ensuring socially cohesive and supportive communities);
3. Reducing the vulnerability of people to health damaging conditions and strengthening the community and individual level factors which promote resilience (for example, improving access to education by removing fees); and
4. Providing accessible, equitable and effective health care (for example, universal public health insurance).

The Commission is paying particular attention to learnings from previous experience to improve health equity particularly: (a) the enabling factors that will result in change at the upstream level; (b) identifying existing programmes, policies and initiatives that can, have or are improving health equity; and (c) how to move from theory to practice – collecting knowledge that is policy and advocacy relevant (Irwin and Scali 2005).

Can the Commission contribute to a re-invention of health promotion for the twenty-first century?

Economic globalisation, with its attendant growing inequities, and the pressures of climate change will force health promotion (like other movements and institutions) to confront its position on such major issues affecting the health of all global citizens. This section examines the potential for the Commission to influence the health promotion movement so that it is able to respond to these twenty-first century challenges. It argues that this potential lies in the following.

1. Providing a vision of the feasibility and moral importance of achieving a more equitable distribution of health within and between countries within a generation and emphasising that health is a human right and so legitimates the value base essential for action on the social determinants of health.
2. One of the core messages of the Commission will be that promoting health is a task for the whole of economy and not just the health sector, and should be lead by the head of government.
3. The knowledge networks established by the Commission provide a much stronger evidence base than has previously been available on the social determinants of health and health equity including the actions and policies that are most likely to promote health and equity.
4. Providing a focus for the further growth of a global social movement advocating for health equity within and between countries through action on the social determinants of health.
5. Contribute to the reform of WHO and other international health agencies so that they build all programmes with an understanding that they have to take comprehensive action in communities and nationally which tackle the underlying causes of disease.
6. Add legitimacy to the move to re-orientate health systems to a focus on health promotion and population health.
Providing a vision and view of health as a human right

The most memorable call for social justice by the World Health Organization since its formation was the call for Health for all by the year 2000 made in 1978 in the Alma Ata Declaration (WHO 1978). The power of this vision was very much in the forefront of the Commission’s deliberations from the outset. Dr Halfdan Mahler (who had been Director General of the WHO in 1978) attended the first meeting of the Commission and made it clear that he saw the work of the Commission had the potential to pick up the social justice mantle of Alma Ata. In the 30 years between Alma Ata and the Commission’s report, the language of social justice has been marginal to most health debates. More commonly in this period the pursuit of health has been justified on instrumental ground by being seen good for economic growth (see, for example, World Bank 1993, Commission on Macroeconomics and Health, in Sachs 2001).

Discussions in the Commission also acknowledged the role of health in economic development, but beyond this the Commissioners remained resolute that health was also a human right and the pursuit of its equitable distribution was a matter of social justice. This was not always easy to do. A common criticism of this position was that it was politically naïve. Of course this is the usual cry of perspectives that point to problems that those with most power have no political will to resolve. Thus it was despite such pressure that social justice remained dominant theme in the final report and thus enables the report to provide a strong rallying call for progressive health movements, including health promotion, to work to achieve the vision of health equity in a generation.

Whole of economy focus

The Commission’s Final Report is very clear that the cause of much ill health and inequitable distribution of health is the structural problem of inequitable distribution of power, money and resources. Very few, if any, international Commissions in the era of neo-liberalism have recognised this. The Commission’s report will thus provide a basis for many civil society groups and progressive governments who want to develop policies aimed at a redistribution of power and resources in a way that creates more health equity. The report also links the pursuit of health equity with the movement to combat global warming, and argues that the agendas on these two issues are intertwined and need to be seen in concert.

Increasingly the health promotion movement is recognising that if it is to be relevant to health it must take an approach that recognises the ways in which all sectors have an impact on health outcomes. These sectors are both those within government and the private sector including most crucially the corporate sector. The required intersectoral action within government has been well-recognised by WHO in Alma Ata and the Ottawa Charter for Health Promotion. Yet the history of the Healthy Cities and other projects that work across sector to promote health has taught the lesson that when the health sector takes the lead in such an endeavour this lead may be interpreted as health imperialism and lead to resentment from other sectors (Baum 1993, Boonekamp et al. 1999). The Commission has consistently argued that a focus on the social determinants of health should be led by the head of government. In Europe this has been expressed as ‘health in all policies’ (Stahl et al. 2006). A whole of government approach should (and can) mandate a commitment from all sectors, including, most crucially, ministries of finance. Thus it is important that the Commission’s report speaks to heads of state and convinces them that health equity and overall improved population health is a crucial goal of good governance.
There has been less focus from health promotion on the role of economic policy including the behaviour of the corporate and business sector, other than dabbling with the notion of corporate social responsibility or obtaining sponsorship from business for health promotion activities. Yet there has been a growing critique of neo-liberalism and its impact on health (the People’s Health Movement exemplifies this position). This has included appraisal of the role of international institutions such as the World Bank and International Monetary Fund and the impact of their economic policies and prescriptions on health. Thus in poor countries World Bank economic policies and neo-liberal prescriptions for government policy which have lead to weakening of public sectors (including national health systems) and the health professional brain drain have created the conditions for a perfect storm to ravish the health of their populations – most tragically in Africa (Lewis 2005). Globally, the activities of transnational corporations are increasingly criticised as both giving themselves unprecedented power and economic rewards and as paying scant attention to reducing global warming and other environmental damage (Hamilton 2003, Korten 2006). The Commission’s Report based on the work of its knowledge network on globalisation, documents the ways in which current patterns of globalisation perpetuate and even deepen inequities rather than challenge them. Yet until very recently (apart from a few weak civil society voices) there has been an international consensus that neo-liberal economic and social policy solutions would result in a trickle down that would finally deliver health for all. The Commission is an important ‘establishment’ voice that notes the mistakes of the neo-liberal agenda and calls for the necessary structural changes to the global economic system to make for a fair globalisation in which inequities between and within countries are reduced. My own view (Baum 2008, pp. 371–388) is that, in the interests of human health and well-being, the global community will have to retreat from the model of corporate capitalism supported by a neo-liberal agenda and conduct some serious soul searching about what models of economic organisation and what global and national government regulation will be both sustainable, accountable to local communities and globally equitable. The Commission certainly outlines the problems of our current system and leaves the path clear for the health promotion movement to debate and develop alternative models of health promoting economic development.

**Evidence base**

Most health promotion and public health research has concentrated on studying diseases and behaviours – the proximal causes of morbidity and mortality and unequal health outcomes. It has been noted this is because of the bias of medical research funding bodies and the simpler research designs possible when researching proximal causes (Kavanagh et al. 2002). Research on the causes of health inequities has been funded in recent years, but there has been much less funding on research concerning measures to reduce inequity (Exworthy et al. 2006). The Commission knowledge networks have produced excellent summaries of existing knowledge in each area and made a series of recommendation for action. They have providing a substantial body of knowledge and data for use by health promotion policy makers and researchers. Many of these KNs are expressing the desire to continue the work started under the Commission after the Commission’s report. Thus they will provide, for the first time, an ongoing global network of researchers focusing on the social determinants of health. This should have the effect of increasing the legitimacy of research on this topic, so making it more likely that national and international funding bodies will fund a greater proportion of work on this topic. It will also provide more
nuanced information on what interventions work and on the importance of conducting more intervention research to provide further information on successful interventions. The Evidence and Measurement KN in particular, notes that as interventions on social determinants of health are complex and subject to social and political flux, the research designs have to draw on a broad range of methodologies and cannot be as rigidly designed and implemented as research studying the more proximal causes of ill health (Kelly et al. 2006). The Commission will add legitimacy to this perspective and should create the climate in which more of this complex and somewhat messy policy implementation research is funded and conducted.

Global social movement

Since its outset, the Commission has recognised that it has a limited life and that, if the ideas and values it develops are to take root and be acted on by international agencies and national governments, then a social movement to create the political will is essential. This view drove the importance the Commission has attached to engaging with civil society. Civil society actors have been involved in the Commission’s activities since the outset. Civil society has been contracted to conduct consultations in each region of the world. Representatives of civil society have attended each Commission meeting except one and made presentations to the Commissioners. This means they are both intimately involved with the Commission, able to feed into the thinking of the Commission, but also able to take a critical stance and appraisal of the Commission’s work.

The People’s Health Movement (www.phmovement.org) was formed in 2000, prior to the formation of the Commission. It brought together a coalition of people’s health movements from around the world who were all united in their analysis that the WHO was out of touch with the concerns of grass roots people and their communities. Hence the First and Second People’s Health Assemblies held, respectively, in Savar, Bangladesh in 2000 and Cuenca, Ecuador in 2005 were conceived as an alternative to the World Health Assembly (the governing assembly of the WHO) and designed to give people a voice in the factors affecting their health, primarily the social determinants of health. The People’s Health Movement was critical of the Commission on the Macro-economics of Health for its focus instrumental view of health and from 2000 advocated to WHO for a recognition of the importance of health as an end in itself. PHM was therefore one of the voices that led to the creation of the Commission. Thus prior to the Commission there was a growing global social movement supporting a social view of health. The Commission’s work has the potential to strengthen this movement and provide it with a report that has the legitimacy of WHO behind it. The Commission’s report is should provide a rallying call for the global health promotion community as it works internationally, nationally and in local communities. If the Commission’s report is to lead to more than tinkering around the edges of the social and economic determinants of health it will be civil society that becomes the advocates and lobbyist for the changes to government and international agency policies that will be required to ensure these determinants promote health and health equity.

Reform of WHO and other international health agencies

Since the publication of the World Bank’s Investing in health report (World Bank 1993), WHO has no longer enjoyed the automatic position as the leading global voice on
public health. By 2008 there are a far greater range of players in addition to the World Bank including the Bill and Melinda Gates Foundation (http://www.gatesfoundation.org/default.htm, accessed 9 July 2007), the Global Fund to fight AIDS, Tuberculosis and Malaria (http://www.theglobalfund.org/en/, accessed 9 July 2007) and the GAVI Alliance which focuses on immunization (http://www.gavialliance.org/, accessed 9 July 2007). The focus of most of these international foundations is on disease-specific initiatives. The net results of this activity, when added to the weakening of national health systems under the neo-liberal prescriptions of the World Bank through its Structural Adjustment Strategies (and more recently Poverty Reduction Strategy Papers) (Labonte et al. 2004; Doherty and Gilson 2006, Sanders 2006), have been a nightmare of fragmentation. Each disease strategy requires negotiation and so ties up the time of precious public-sector personnel, a set of accountability mechanisms and poses problems as any externally imposed solution does when it comes to implementation in a particular setting (Sanders 2006). The disease-based strategies crucially either ignore social determinants completely or pay lip service to them. This will have to change if the Commission’s approach is to be implemented.

In the post-Commission era it will be important for WHO to re-establish a position of leadership for global health. WHO is already taking the Commission message seriously by examining the implications of the emerging findings for the operation of WHO. Only time will tell whether this interest translates through the Geneva Head Quarters and through the regions to genuine change in WHO’s style of operation. Revitalised WHO leadership could result in a new era of global governance for health in which the activities of the numerous global health funds and organisations are co-ordinated. It could result in regulations, treaties and agreements to provide the conditions for health equity. Examples of these would be agreements about the marketing of unhealthy products including tobacco and high fat and sugar food, global taxation treaties to provide a global fund to finance a form of global welfare state to guarantee the basic conditions for a healthy life to all citizens. At best history could view the Commission’s report as a crucial milestone on the road to fair globalisation. It would provide a strong mandate for WHO to become a visionary organisation in the movement for global justice and reclaim the moral high ground that has eluded it since the end of Dr Halfdan Mahler’s tenure as Director General.

**Re-orientate health systems**

The final way in which the Commission might contribute to a revitalised health promotion is by offering a vision of how health systems have to re-orientate for the twenty-first century. The dominant themes for contemporary health systems are the strong push to privatise health systems and the dominance of a medical view of the promotion of health (see, for example, Brugha and Zwi 2002, Piel 2005, Talbot-Smith and Pollock 2006). These themes are relevant in both poor and rich countries.

The provision of health and associated services including pharmaceuticals is rapidly becoming one of the largest global industries (Buse et al. 2005) and the push to privatise health systems has been a central plank of neo-liberal economic policies (Piel 2005). The Commission has gathered information (from a variety of sources) about the importance of universal health insurance systems and public provision of health services to health. Evidence from historical studies (for example of the Nordic country experiences) and its Health Service KN indicate the importance of these factors in terms of both overall
population health outcomes and the distribution of health. Thus once again in reporting this evidence the Commission adds legitimacy to calls for strengthening of publicly funded health systems and provides a focus for the evidence base which supports this view.

If health care sectors are to re-orientate towards a focus on health promotion, then there will have to be a re-evaluation of the current preoccupation with medical solutions (Johnson and Paton 2007). Obviously medicine is central to health care, but promoting population health depends on attention to the broader determinants of health. The Commission makes a strong case for this in its report. While much of the action to support the social determinants of health happens in other sectors, health ministries should be prepared to take on a stewardship role for the health of the population they are responsible for (Saltman and Ferroussier-Davis 2000). This means monitoring the state of population health and the extent of equity and being a facilitator and advocate for health to be seen as an outcome of actions in all sectors. Thus, for example, they would ensure the health impact assessments are conducted and encourage intersectoral action to promote health. If the Commission’s message is heard by health care sectors, then instead of just seeing core business as dealing with the people who present at services, they would equally take up this stewardship function and work to encourage all other sectors to put health and well-being at the centre of their endeavours. Taking the social determinants of health approach serious means health care sectors should make determined moves to increase the investment in health promotion and to ensure that barriers to health care access are removed so that the current situation where people who have most need also have least access to health care is reversed.

Conclusion

Health promotion has spent the last 30 years developing from a limited focus on the health-related behaviours of individuals to a far broader focus on the ways in which societies are best arranged in order to promote health and well-being. Major milestones have been the series of WHO health promotion conferences starting with Ottawa which has seen the transformation of health promotion into a socially concerned movement with a focus on equity. As the challenges confronting us in the twenty-first century grow in the face of rapid economic globalisation, climate change and shifting populations and cultures, health promotion needs a new bible that equips it to contribute to these challenges. The Commission on the Social Determinants of Health final report provides such a document by providing a global overview of the importance of the social determinants of health and the centrality of privileging strategies that create fairness both between and within countries. It points clearly to the fact that inequities result, not from misfortune, but from systematic inequitable distribution of power, money and resources. The health promotion movement has the possibility of re-inventing itself in the twenty-first century to offer the holistic understanding of health, the skills, passion and commitment required to be the core of a social movement which advocates for new healthy, equitable and sustainable economic and social structures globally and within countries.

Note

1. For final reports from the Commission’s Knowledge Networks see the CSDH website at http://www.who.int/social_determinants/en/
References

