

Closing the gap in a generation: health equity through action on the social determinants of health

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The Commission on Social Determinants of Health, created to marshal the evidence on what can be done to promote health equity and to foster a global movement to achieve it, is a global collaboration of policy makers, researchers, and civil society, led by commissioners with a unique blend of political, academic, and advocacy experience. The focus of attention is on countries at all levels of income and development. The commission launched its final report on August 28, 2008. This paper summarises the key findings and recommendations; the full list is in the final report.

Introduction

Life chances differ greatly depending on where people are born and raised. A person who has been born and lives in Japan or Sweden can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in several African countries, less than 50 years. Within countries, the differences in life chances are also great. The poorest people have high levels of illness and premature mortality—but poor health is not confined to those who are worst off. At all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

If systematic differences in health for different groups of people are avoidable by reasonable action, their existence is, quite simply, unfair. We call this imbalance health inequity. Social injustice is killing people on a grand scale, and the reduction of health inequities, between and within countries, is an ethical imperative.

Social determinants of health and health equity

The commission took a holistic view of social determinants of health.¹ The poor health of poor people, the social gradient in health within countries, and the substantial health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives—their access to health care and education, their conditions of work and leisure, their homes, communities, towns, or cities—and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a natural phenomenon but is the result of a combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and cause much of the health inequity between and within countries.

A new approach to development

Health and health equity might not be the aim of all social and economic policies, but they will be a fundamental result. For example, economic growth is, without question, important, particularly for poor countries, because it gives the opportunity to provide

resources to invest in improvement of the lives of their populations. But growth by itself, without appropriate social policies to ensure reasonable fairness in the way its benefits are distributed, brings little benefit to health equity.

Society has traditionally looked to the health sector to deal with its concerns about health and disease. Certainly, maldistribution of health care—ie, not delivering care to those who most need it—is one social determinant of health. But much of the high burden of illness leading to appalling premature loss of life arises because of the immediate and structural conditions in which people are born, grow, live, work, and age.

Action on the social determinants of health must involve the whole of government, civil society, local communities, business, and international agencies. Policies and programmes must embrace all sectors of society, not just the health sector. However, ministries of health and their ministers are crucial to the realisation of change. Health ministries that champion approaches based on social determinants of health can demonstrate effectiveness through good practice and support other ministries in creating policies that promote health equity. WHO must do the same, but on an international scale.

Closing the health gap in a generation

The Commission on Social Determinants of Health calls for the closing of the health gap in a generation: this is an aspiration not a prediction. Great improvements in health, worldwide and within countries, have been made in the past 30 years. We are optimistic that the knowledge exists to continue to make a huge difference to people's life chances and hence to provide improved health equity. We are also realistic and know that action must start now.

The commission's analysis leads to three principles of action: improve the conditions of daily life (ie, the circumstances in which people are born, grow, live, work, and age); tackle the inequitable distribution of power, money, and resources (the structural drivers of those conditions of daily life) globally, nationally, and locally; and measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about these determinants. These three

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Panel: The Commission on Social Determinants of Health's overarching recommendations

Improve daily living conditions

Improve the wellbeing of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all, and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments, and global institutions.

Tackle the inequitable distribution of power, money, and resources

To address health inequities and inequitable conditions of daily living it is necessary to address inequities—such as those between men and women—in the way society is organised. A strong, committed, capable, and adequately financed public sector is needed. To achieve that requires more than strengthened government—it requires strengthened governance: legitimacy, space, and support for civil society, for an accountable private sector, and for people across society to agree public interests and reinvest in the value of collective action. In a globalised world, the need for governance dedicated to equity applies equally from the community level to global institutions.

Measure and understand the problem and assess the results of action

Acknowledging that there is a problem and ensuring that health inequity is measured—within countries and globally—are essential for action. National governments and international organisations, supported by WHO, should set up national and global health-equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should assess the health-equity impact of policy and action. Creating the organisational space and capacity to act effectively on health inequity requires investment in training of policy makers and health practitioners, public understanding of social determinants of health, and a stronger focus on social determinants in public health research.

principles of action are embodied in the three overarching recommendations (panel). The recommendations have to be seen in light of the commission's global reach. Recognition of inequities in health is recognition of the plight of people living on US\$1 a day in rural Africa, urban dwellers in shanty towns in low-income and middle-income countries, and the social gradient in health in high-income countries. Although one set of specific recommendations will not apply to all of these particular settings, the general principles will. The recommendations that follow should be seen as principles of action that need to be developed for, and applied in, specific national and local contexts. The full list of recommendations can be found in the final report of the Commission on Social Determinants of Health.¹

Improve daily living conditions Equity from the start

Investment during the early years of life has some of the greatest potential to reduce health inequities within a generation. Child survival, rightly, has been a focus of worldwide interest. The Commission on Social Determinants of Health has gone further and emphasised the importance of early child development, including not only physical and cognitive or linguistic development but also, crucially, social and emotional development. Early

child development affects subsequent life chances through skills development, education, and occupational opportunities;² it also affects the risks of obesity, malnutrition, mental-health problems, heart disease, and criminality in later life. At least 200 million children worldwide are not achieving their full development potential.³

Brain development is highly sensitive to external influences in early childhood that can have lifelong effects. Good nutrition is crucial and begins before birth with adequate nourishment of mothers. Mothers and children need a continuum of care from before pregnancy, through pregnancy and childbirth, to the early days and years of life.⁴ Children need safe, healthy, supporting, nurturing, caring, and responsive living environments. Preschool educational programmes and schools, as part of the wider environment that contributes to development, can play a vital part in building children's capabilities. The combined effects of good nutrition and psychosocial stimulation completely reversed the effects of stunting on intellectual development in a randomised controlled trial in stunted children.⁵

To build equity from the start of life, governments and international agencies need to commit to and implement a comprehensive approach to early life, building on existing child-survival programmes and extending interventions in early life to include social-emotional and language-cognitive development. This approach will require interagency mechanisms to provide a comprehensive package that extends to all children, mothers, and other carers regardless of ability to pay. These principles of early child development should extend to the education system. Key principles for the education system include provision of high-quality compulsory primary and secondary education for all children regardless of ability to pay, abolishing fees for primary school, and identifying barriers to enrolment in school.

Healthy places healthy people

In 2007, for the first time, more people worldwide were living in urban than in rural settings.⁶ Almost 1 billion people live in slums. The proportion of urban residents varies enormously among countries: from less than 10% in Uganda to 100%, or close to it, in Singapore and Belgium. Policies and investment patterns driven by urban needs⁷ lead to underinvestment in infrastructure and amenities for rural communities worldwide, including indigenous people,⁸ creating disproportionate poverty and poor living conditions for these populations.^{9,10}

Infectious diseases and undernutrition will continue to dominate in particular regions and groups around the world. However, urbanisation is reshaping population health problems, particularly among poor people in urban areas, towards non-communicable diseases, accidental and violent injuries, and effects of ecological disaster.^{11,12}

Access to good-quality housing and shelter, clean water, and sanitation are human rights and basic needs for healthy living.^{13,14} Growing dependence on cars, land-use change to facilitate car use, and increased inconvenience of non-motorised modes of travel have knock-on effects on local air quality, greenhouse-gas emission, and physical inactivity.¹⁵ The planning and design of urban environments has a major effect on health equity through its influence on behaviour and safety.

The current model of urbanisation poses substantial environmental challenges, particularly climate change—the effect of which is greater in low-income countries and among vulnerable subpopulations.^{16,17} At present, greenhouse-gas emissions are determined mainly by consumption patterns in cities in developed countries.

Communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological wellbeing, and that are protective of the natural environment are essential for health equity. Therefore, health and health equity need to be at the heart of urban governance and planning. Upgrading of urban slums should be a priority, including provision of water and sanitation, electricity, and paved streets for all households regardless of ability to pay. Affordable housing must be high on any agenda to improve health equity.

Urban planning should promote healthy and safe behaviours equitably, through investment in active transport, through retail planning to manage access to unhealthy foods, and through good environmental design and regulatory controls, including control of the number of alcohol outlets.

The Commission on Social Determinants of Health focused particularly on urban areas, but relief of pressure of migration to urban areas and equity between urban and rural areas requires sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their homes.

Fair employment and decent work

Work is the origin of many important determinants of health.¹⁸ Work can provide financial security, social status, personal development, social relations, and self-esteem and protection from physical and psychosocial hazards. Employment conditions and the nature of work are both important to health. A flexible workforce is seen as good for economic competitiveness but brings with it effects on health.¹⁹ Mortality seems to be significantly higher in temporary workers than in permanent workers.²⁰ Poor mental health outcomes are associated with precarious employment (figure 1).^{21,22}

Adverse working conditions can expose individuals to a range of physical health hazards and cluster in low-status occupations. Improved working conditions in high-income countries, which have been hard won over many years of organised action and regulation, are sorely

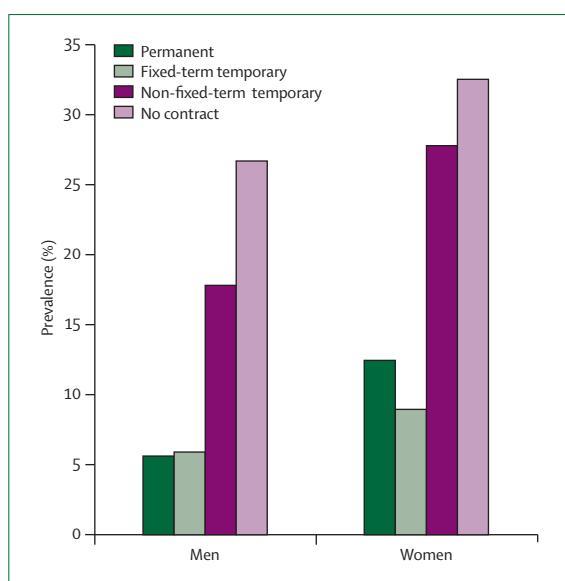


Figure 1: Poor mental health among manual workers in Spain by type of contract²¹

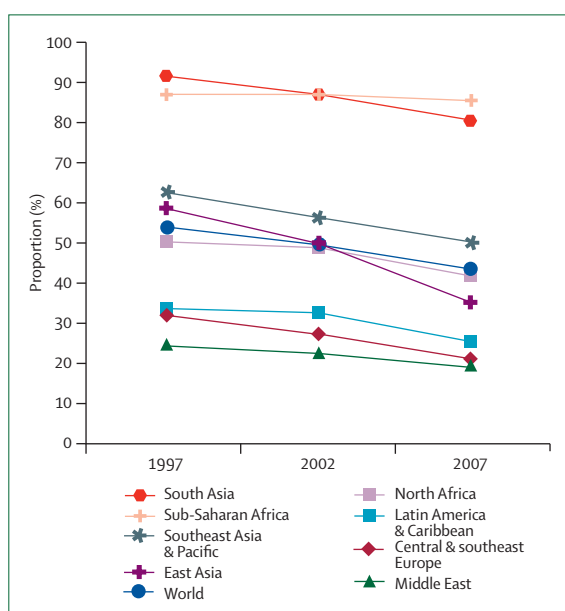


Figure 2: Regional variation in the proportion of people in work living on US\$2 or less a day

2007 figures are preliminary estimates. Reproduced with permission from the International Labour Organization.²⁶

lacking in many middle-income and low-income countries. Stress at work, defined as a combination of high psychological demands and low control or as an imbalance between effort and reward,²³ is associated with a 50% excess risk of coronary heart disease²⁴ and other indicators of mental and physical ill health.²⁵

Although work is seen as a route out of poverty in high-income countries, this is not the case worldwide (figure 2).²⁶ Through fair employment and decent working conditions, government, employers, and

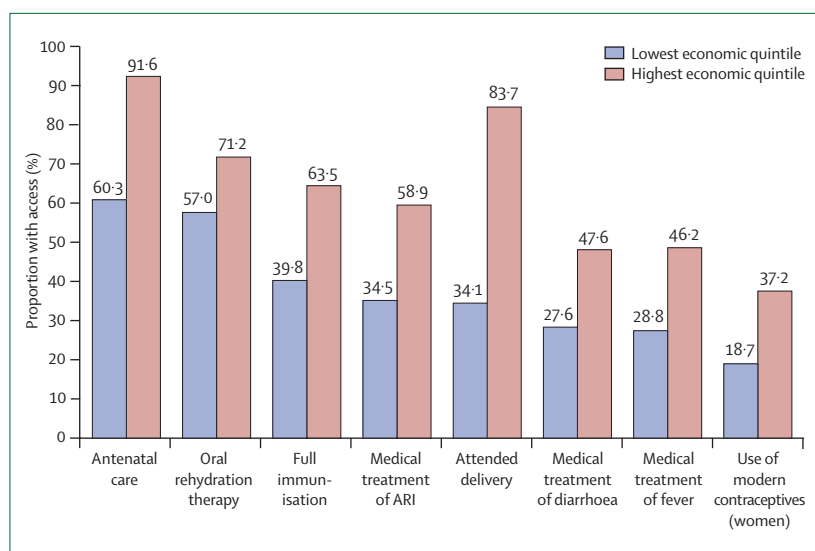


Figure 3: Use of basic maternal and child health services by lowest and highest economic quintiles
Data from more than 50 countries. ARI=acute respiratory infection. Reproduced with permission from The World Bank.²⁹

workers can help eradicate poverty, alleviate social inequities, reduce exposure to physical and psychosocial hazards, and improve opportunities for health and wellbeing. To this end, full and fair employment and decent work must be a central goal of national and international social and economic policy making, and should involve strengthened representation of workers in the creation of policy, legislation, and programmes relating to employment and work.

Employment policy should aim to provide a living wage (that takes into account the real cost of healthy living) and to protect all workers. International agencies should support countries to implement standards of labour for formal and informal workers, to develop policies to ensure balance between work-life and home-life, and to reduce the negative effects of insecurity among workers in precarious work arrangements. Policies that reduce all workers' exposure to material hazards, work-related stress, and health-damaging behaviours are also needed.

Social protection throughout life

Low living standards are a powerful determinant of health inequity. The fundamental principle of social protection is that all people need support at some point in their lives. A feature of all high-income countries is that society provides, to a greater or lesser extent, for vulnerable periods and for protection from specific factors, such as illness, disability, and loss of income or work. However, four in every five people worldwide lack basic social-security coverage.²⁷ Government policies can make a difference—for example, in Sweden and Norway generous transfer payments to socially vulnerable families have been associated with low child poverty.²⁸

Generous universal social protection systems are associated with better population health, including lower excess mortality among elderly people and lower mortality among socially disadvantaged groups. Budgets for social protection are typically larger in countries with universal protection systems and poverty and income inequality tend to be smaller in these countries than in countries with systems that specifically target poor people.

Reduction of the health gap in a generation requires that governments build systems allowing a healthy standard of living below which nobody should fall because of circumstances beyond his or her control. Social protection should be extended to all people, including those in precarious work, informal work, and household or care work.

Although limited institutional infrastructure and financial capacity remains an important barrier in many countries, social protection systems can be initiated, even in low-income countries. Such systems can be instrumental in realising developmental goals rather than being dependent on these goals having been reached. Social protection systems can reduce poverty, and local economies can benefit from them. Therefore, the Commission on Social Determinants of Health recommends that governments establish and strengthen universal comprehensive social protection policies that support a level of income sufficient for healthy living for all.

Universal health care

The health-care system is itself a social determinant of health, influenced by and influencing the effect of other social determinants. Gender, education, occupation, income, ethnicity, and place of residence are all closely linked to access to, experiences of, and benefits from health care (figure 3).²⁹ Leaders in health care have an important stewardship role across all branches of society to ensure that policies and actions in other sectors improve health equity.

Health care is a common good, not a market commodity. Nearly all high-income countries organise their health-care systems around the principle of universal coverage; this approach requires that everyone within a country can access the same range of services according to needs and preferences, regardless of income, social status, or residency, and that people are empowered to use these services.

The commission advocates the financing of health-care systems through general taxation or mandatory universal insurance. The evidence is compellingly in favour of publicly funded health-care systems. In particular, out-of-pocket spending on health care must be kept to a minimum. The policy imposition of user fees for health care in low-income and middle-income countries has led to an overall reduction in use and worsening of health outcomes. Upwards of 100 million people are pushed into poverty each year through catastrophic household health costs.

Health-care systems have the best health outcomes when based in primary health care. The emphasis in the best systems is both on locally appropriate action across the range of social determinants, where prevention and promotion are in balance with investment in curative interventions, and on primary care with adequate referral to higher levels of care.

In all countries, but most pressingly in the poorest and those experiencing brain-drain losses, adequate numbers of appropriately skilled health workers at the local level are fundamental to extending coverage and improving the quality of care. Investment in training and retaining health workers is vital to the strengthening of health-care systems. This strengthening involves global attention to the flows of health personnel as much as national and local attention to investment and skills development. Medical and health practitioners—from those at WHO to those in local clinics—have powerful voices, affecting society's ideas and decisions about health, and bear witness to the ethical imperative and benefit to efficiency of working more coherently through the health-care system to target social causes of poor health.

Tackle inequity of power, money, and resources

Health equity in all policies, systems, and programmes

Every feature of government and the economy has the potential to affect health and health equity. Coherent action across government—including finance, education, housing, employment, transport, and health—at all levels, is essential for improving health equity.³⁰ Traffic injury, a major public-health issue, is an example of where action must come from outside the health sector. Legislation for the mandatory wearing of helmets by cyclists reduced bicycle-related head and other injuries in Canada in the 1990s.³¹

Policy coherence is crucial. For example, trade policy that actively encourages the unfettered production, trade, and consumption of foods high in fats and sugars to the detriment of fruit and vegetable production is contradictory to health policy, which recommends low consumption of high-fat, high-sugar foods and increased consumption of fruit and vegetables.³² Intersectoral action for health—coordinated policy and action among health and non-health sectors—can be a key strategy to achieve policy coherence.³³ Reaching beyond government to involve civil society and the voluntary and private sectors is vital for health equity and can help to ensure fair decision making.

Health, and health equity, should become corporate issues for the whole of government, placing responsibility for action at the highest level and ensuring its coherent consideration across all policies. The results of all policies and programmes on health equity also need to be assessed. Although action across government is required, ministries of health have central roles in stewardship and information. This function requires

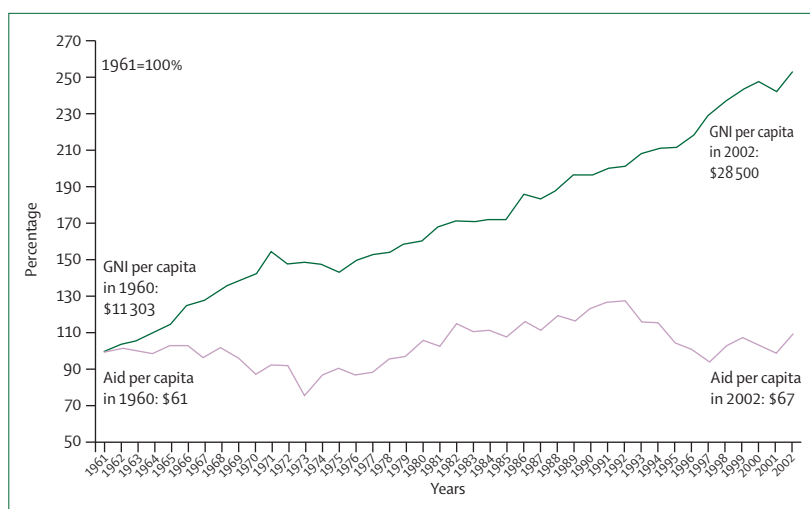


Figure 4: The growing gap: per capita aid from donor countries relative to per capita wealth, 1960–2000
Calculated in US\$ at 1998 prices and exchange rates. GNI=gross national income. Reproduced with permission from IBON Books Manila/Zed Books.³⁴

strong leadership from government ministers of health, with support from WHO.

Fair financing

For countries at all levels of economic development, public financing of action on the social determinants of health is fundamental to welfare and health equity. The socio-economic development of rich countries was strongly supported by publicly financed infrastructure and progressively universal public services. The emphasis on public finance, given the substantial failure of markets to supply vital goods and services equitably, implies strong public-sector leadership and adequate public expenditure.

Many low-income countries have weak direct tax institutions and mechanisms and most of their workforce are employed informally. These countries commonly rely on indirect taxes, such as trade tariffs, for government income. Economic agreements that require tariff reduction can reduce domestic revenue in low-income countries. Strengthened progressive tax capacity is a necessary prerequisite of any further tariff-cutting agreements. At the same time, measures to combat the use of offshore financial centres to reduce unethical avoidance of national tax regimes could provide resources for development at least comparable to those made available through new taxes. As globalisation increases the interdependence among countries, the argument for global approaches to taxation becomes stronger.

Aid is important for social development. But the volume of aid is appallingly low—absolutely, relative to wealth in donor countries (figure 4),³⁴ and relative to the level of aid commitment of about 0·7% of gross domestic product in such countries. Independent of increased aid, the Commission on Social Determinants of Health urges greater debt relief for more countries than currently provided.

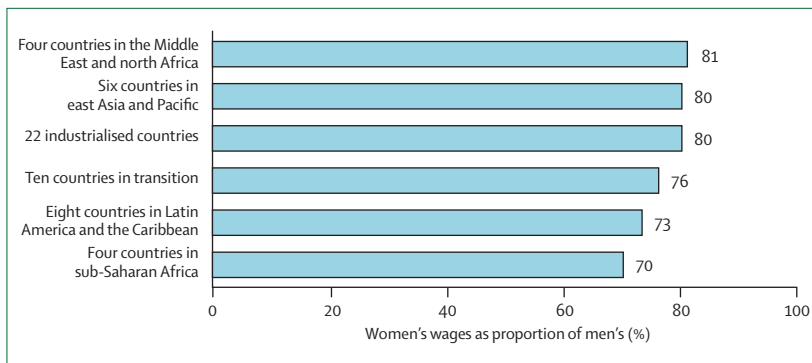


Figure 5: Nominal wages for women are significantly lower than for men
For employment not including agriculture. Reproduced with permission from UNICEF.³⁶

The strengthening of public finance to improve social determinants of health will entail the building of national capacity for progressive taxation and the assessment of potential for new national and global public finance mechanisms; fair allocation between geographical regions and ethnic groups is also necessary.

Increased international finance for health equity and increased finance through a social determinants of health action framework means that existing commitments to increase global aid to the 0.7% of gross domestic product must be honoured and the Multilateral Debt Relief Initiative expanded. The quality of aid must be improved, too, focusing on better coordination among donors and stronger alignment with recipient development plans. Poverty reduction planning at the national and local levels in recipient countries should adopt a framework addressing social determinants of health to create coherent, cross-sectoral financing. This framework must be transparent and accountable.

Market responsibility

Markets can bring health benefits in the form of new technologies, goods, and services and improved standard of living. But the marketplace can also generate negative conditions for health, including economic inequalities, resource depletion, environmental pollution, unhealthy working conditions, and the circulation of dangerous and unhealthy goods.

Health is not a tradeable commodity. It is a matter of rights and a public-sector duty. As such, resources for health must be equitable and universal. Experience shows that commercialisation of vital social goods, such as education and health care, produces health inequity. The Commission on Social Determinants of Health views certain goods and services as basic human and societal needs—access to clean water, for example, and health care. Such goods and services must be made available universally, regardless of ability to pay, with the public sector, rather than the market sector, underwriting adequate supply and access. The unit price of a commodity commonly gets cheaper as consumption goes up, making the first units difficult for people on low

incomes to purchase and encouraging overconsumption by people who can afford the first units, as was the case with water prices in Johannesburg.³⁵ A fairer tariff structure would subsidise the price for poorer consumers and have price disincentives for overconsumption.

Also, public-sector leadership is needed for effective national and international regulation of products, activities, and conditions that damage health or lead to health inequities. Global governance mechanisms—such as the Framework Convention on Tobacco Control—are required with increasing urgency as market integration expands and accelerates circulation of and access to health-damaging commodities. Processed foods and alcohol are two prime candidates for stronger global, regional, and national regulatory controls.

Finally, regular health equity impact assessment of all policy making and market regulation should be institutionalised nationally and internationally. In recent decades, under globalisation, market integration has increased. Some of the effects on employment and distribution of goods and services will be beneficial for health, some of them disastrous. The commission urges that caution be applied in the consideration of new global, regional, and bilateral economic policy commitments. Before such commitments are made, the effect of the existing framework of agreements on health, the social determinants of health, and health equity must be fully understood.

Public-sector leadership does not displace the responsibilities and capacities of the private sector. Stakeholders in the private sector are influential, and have the power to do much for global health equity. Although, to date, initiatives such as those under corporate social responsibility have shown limited evidence of real effect. Corporate social responsibility may be a valuable way forward, but evidence is needed to demonstrate this. Corporate accountability may be a stronger basis on which to build responsible collaborations between private and public interests.

The effect of economic agreements on people's lives should be made obvious. Outcomes of health and health equity must be considered in national and international economic agreements and policy making. The roles of the state as the primary provider of basic services essential to health (eg, water and sanitation) and regulator of goods and services with a major effect on health (eg, tobacco, alcohol, and food) need to be reinforced.

Gender equity

Gender inequities are pervasive in all societies. Biases in power, resources, entitlements, norms and values, and the way in which organisations are structured and programmes are run damage the health of millions of girls and women. The position of women in society is also associated with child health and survival. Gender inequities influence health through, for example, discriminatory feeding patterns, violence against women,

lack of decision-making power, and unfair divisions of work, leisure, and possibilities of improving one's life.

Although the position of women has improved substantially over the past century in many countries, progress has been uneven and many challenges remain. Women earn less than men, even for equivalent work (figure 5);³⁶ girls and women lag behind in education and employment opportunities. Maternal mortality and morbidity remain high in many countries, and reproductive health services remain inequitably distributed within and between countries. The intergenerational effects of inequity between the sexes make the imperative to act even stronger.

There are several ways in which governments, donors, international organisations, and civil society can promote gender equity. First, legislation can promote equity and make discrimination on the basis of sex illegal. Second, gender equity units within central administration of governments and international institutions can strengthen assessments of gender implications of planned actions to ensure that men and women benefit equitably. Third, national accounts can include the economic contribution of housework, care work, and voluntary work. Fourth, finance policies and programmes can close gaps in education and skills and support economic participation by women. Finally, investment in sexual and reproductive health services and programmes leading to universal coverage and rights should be increased.

Political empowerment—inclusion and voice

Empowerment is central to the social determinants of health. Material, psychosocial, and political empowerment comes from inclusion in society and fulfilment of rights to the conditions necessary to achieve the highest attainable standard of health. The risk of these rights being violated is the result of entrenched structural inequities.³⁷ The freedom to participate in economic, social, political, and cultural relationships has intrinsic value.³⁸ Inclusion, agency, and control are each important for social development, health, and wellbeing.

A particularly egregious form of social exclusion is seen among indigenous peoples in many countries. But social inequity is also manifest across various intersecting social categories, such as class, education, gender, age, ethnicity, disability, and geography. Exclusion is a sign of not simple difference but hierarchy and reflects deep inequities in the wealth, power, and prestige of different people and communities.

Serious effort to reduce health inequities will involve changing of the distribution of power within society and global regions and empowerment of individuals and groups to represent effectively their needs and interests. Such changes will challenge the unfair and graded distribution of social resources to which all citizens have claims and rights.

Changes in power relationships can take place at various levels, from the level of individuals, households,

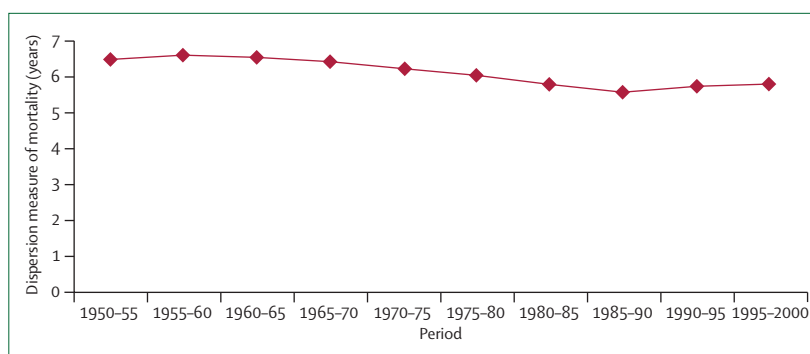


Figure 6: Dispersion measure of mortality for life expectancy at birth

This method measures the global dispersion of life expectancy, calculated as the average absolute difference in life expectancy at birth between each and every pair of countries weighted by population size. Reproduced with permission from WHO.³⁹

or communities to the sphere of structural relations among economic, social, and political stakeholders and institutions. Community or civil society action on health inequities cannot be separated from the responsibility of the state to guarantee a comprehensive set of rights and ensure the fair distribution of essential material and social goods among population groups. Top-down and bottom-up approaches are equally vital.

All groups in society can be empowered through fair representation in decisions about how society operates, particularly in relation to health equity by a socially inclusive framework for policy making. Such inclusion can enable civil society to organise and act in a manner that promotes and realises the political and social rights affecting health equity.

Good global governance

Great differences in the health and life chances of peoples around the world reflect imbalance in the power and prosperity of nations. The benefits of globalisation remain profoundly unequally distributed. Progress in global economic growth and health equity made between 1960 and 1980 has been significantly dampened since (figure 6),³⁹ as global economic policy hit social-sector spending and social development hard. Also associated with the second (post-1980) phase of globalisation, the world has seen significant increase in, and regularity of, financial crises, proliferating conflicts, and forced and voluntary migration.

Through the recognition of common interests and interdependent futures, the international community must commit to a multilateral system in which all countries, rich and poor, engage with an equitable voice. Only through such a system of global governance—that places fairness in health at the heart of the development agenda and genuine equality of influence at the heart of its decision making—will coherent attention to global health equity be possible. Therefore health equity should become a global development goal, and a framework of social determinants of health should be

	Births	Unregistered children
World	133 028	48 276 (36%)
Sub-Saharan Africa	26 879	14 751 (55%)
Middle East and north Africa	9790	1543 (16%)
South Asia	37 099	23 395 (63%)
East Asia and Pacific	31 616	5901 (19%)
Latin America and Caribbean	11 567	1787 (15%)
CEE, CIS, and Baltic states	5250	1218 (23%)
Industrialised countries	10 827	218 (2%)
Developing countries	119 973	48 147 (40%)
Least developed countries	27 819	16 682 (71%)

Data are number (%). CEE=Central and eastern Europe. CIS=Commonwealth of Independent States. Data from UNICEF.⁴¹

Table: Unregistered births (1000s) in 2003 by region and level of development

adopted to strengthen multilateral action on development. The UN, through WHO and the Economic and Social Council, should lead and use indicators of social determinants of health to monitor progress by establishing multilateral working groups on thematic social determinants of health. WHO should lead in global action by enshrining social determinants of health as guiding principles across its departments and country programmes.

Understand the problem and evaluate action

Action on the social determinants of health will be more effective if basic data systems are in place and there are mechanisms to ensure that the data can be understood and applied to develop more effective policies, systems, and programmes. Education and training in social determinants of health are essential.

Lack of data often means that problems are unrecognised. Good evidence on levels of health and its distribution, and on the social determinants of health, is essential for the scale of the problem to be understood, the effects of actions assessed, and progress monitored. Experience shows that countries without basic data on mortality and morbidity stratified by socioeconomic indicators have difficulties in moving forward on health equity.⁴⁰ Countries with the worst health problems have the poorest data. Many countries do not even have basic systems to register all births and deaths (table).⁴¹

The evidence base on health inequity, the social determinants of health, and what works to improve them needs further strengthening. Unfortunately, most health research funding remains overwhelmingly biomedically focused. Also, much research remains gender biased. Traditional hierarchies of evidence (which put randomised controlled trials and laboratory experiments at the top) generally do not work for research on the social determinants of health. Rather, evidence needs to be judged on fitness for purpose—that is, does it convincingly answer the question asked?

Evidence is only one part of what swings policy decisions—political will and institutional capacity are important too. Policy makers need to understand what affects population health and how the gradient operates. Action on the social determinants of health also requires capacity building among practitioners, including the incorporation of teaching on social determinants of health into the curricula of health and medical personnel. In addition, training of policy makers and other stakeholders on social determinants of health and investment in public awareness are needed.

Routine monitoring systems for health equity and the social determinants of health are needed, locally, nationally, and internationally. Combined with investment, such systems will enable generation and sharing of new evidence on the ways in which social determinants influence population health and health equity and on the effectiveness of measures to reduce health inequities through action on social determinants.

Conclusion

Is closing the gap in a generation possible? This question has two clear answers. If we continue as we are, there is no chance at all. If there is a genuine desire to change, if there is a vision to create a better and fairer world where people's life chances and their health will no longer be blighted by the accident of where they happen to be born, the colour of their skin, or the lack of opportunities afforded to their parents, then the answer is: we could go a long way towards it.

Action can be, and is being, taken. But coherent action must be fashioned across the determinants, rooting out structural inequity as much as ensuring more immediate wellbeing. In calling to close the gap in a generation, we do not imagine that the social gradient in health within countries, or the great differences between countries, will be abolished in 30 years. But the evidence, produced in the final report¹ of the Commission on Social Determinants of Health, encourages us that significant closing of the gap is indeed achievable.

This is a long-term agenda, requiring investment starting now, with major changes in social policies, economic arrangements, and political action. At the centre of this action is empowerment of the people, communities, and countries that currently do not have their fair share. The knowledge and the means to change are at hand. What is needed now is the political will to implement these eminently difficult but feasible changes. Not to act will be seen, in decades to come, as failure on a grand scale to accept the responsibility that rests on all our shoulders.

Conflict of interest statement

We declare that we have no conflict of interest.

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