For the agenda, presentations and other background meeting materials, please refer to the WHO website (https://www.who.int/social_determinants стратегический собрание/).
1. Introduction

This report summarises discussions from the WHO Strategic Meeting on Social Determinants of Health (SDH) that took place in Geneva on 12-13 September 2019.

The new General Programme of Work (GPW 2019-2023) of the World Health Organization (WHO) was a key reference point for these discussions (see: Promote health, keep the world safe, and serve the vulnerable https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf). The 13th GPW consolidates the work of WHO around three key goals, the third of which is focussed on disease prevention and promoting good societal conditions for health. In the context of this GPW, a new Department of Social Determinants of Health (SDH), in a new Division of UHC/Healthier Populations (‘the Division’/HEP), was created.

The overall objectives of this meeting were: to review developments in the field of SDH since the Commission on the Social Determinants of Health (CSDH) (see: Closing the gap in a generation: health equity through action on the social determinants of health (2008) https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf); and to identify key areas of work and activities for the new WHO Department of SDH.

2. Developments in the field of SDH

The paragraphs below present a cursory overview of the PowerPoint presentations from the meeting which can be found on the web site: https://www.who.int/social_determinants/strategic-meeting/en/.

Overview of WHO presentations

WHO presentations covered the normative documents and policy tools developed over 2012-2019, following the World Conference on Social Determinants of Health in Rio (2011). Presentations focused on three of the five work streams defined through the 2011 Rio Political Declaration on the SDH (see: https://www.who.int/sdhconference/declaration/en/):

RIO ACTION AREA I. To adopt better governance for health and development (policy coherence), highlighting: Headquarter (HQ)/Regional Office (RO) policy guidance and capacity building on the Health in All Policies (HiAP) approach; Action frameworks and advocacy on SDH and Sustainable Development Goals (SDG) from the WHO offices for the Western Pacific (WPRO)/Africa (AFRO)/Eastern Mediterranean (EMRO)/ Americas (PAHO)/ South-East Asia (SEARO) and Europe (EURO); EURO outreach to other United Nations (UN) agencies through policy dialogues.

RIO ACTION AREA III. To further reorient the health sector towards reducing health inequities, highlighting: HQ mainstreaming in the new GPW through the balanced scorecard; HQ/RO capacity building for addressing barriers to Universal Health Coverage (UHC), in Primary Health Care, Astana, and advocacy as part of the UN initiative on No One
Left Behind (e.g. tools of INNOV8); RO adapted processes and capacity development in countries.

**RIO ACTION AREA V. To monitor progress and increase accountability**, highlighting: HQ health inequalities monitoring manuals (e.g. HEAT) and data (e.g. Health Equity Monitor); EURO Health Equity Status Report Initiative (see thematic presentation below); HQ/RO normative framework for monitoring action according to the Rio Political Declaration; HQ/RO country trainings in inequality data analysis.

**Overview of thematic presentations**

**SDH - Overarching narrative and specific actions - Commission of PAHO on Equity and Health Inequalities in the Americas**: presented by Sir Michael Marmot. Findings from the recently completed PAHO Commission, and its report, *Just societies: health equity and dignified lives*, were presented. The PAHO Commission recommended revising the original CSDH framework for understanding causality. Evidence from the PAHO Commission described the role of history on enduring structural racism and the resultant levels of societal violence, incarceration and the social patterns of communicable and noncommunicable diseases. Building on the CSDH recommendations, the 12 recommendations of the PAHO Commission were reviewed. Suggestions for future WHO work included increasing evidence and advocacy on addressing History and Legacy, Ongoing Colonialism, and Structural Racism through improved governance and advocating for human rights for dignified lives.

**Child health inequalities and the social determinants of health**: presented by Cesar Victora. Alignment of the measurement and monitoring of health inequalities with SDG 17.18 was noted (‘to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location’). On-going work globally of the WHO Collaborating Centre for Health Equity Monitoring at the University of Pelotas in Brazil covers data from 115 countries and 384 surveys over time. Equiplots and other new visualization techniques were developed and are disseminated in WHO’s Health Equity Monitor. New evidence is showing large child health inequalities by ethnicity.

**Basic income, health constitution and governance coherence for human development**: presented by Louise Haagh. Health benefits of economic fluctuations and income security are not well understood by governments/society. Health equity is supported by the good design and high coverage of welfare/economic security/social protection policies. With changed labour markets globally, existing designs are inadequate and Universal Basic Income presents a possible solution. Evidence shows positive impacts of UBI on fertility, nutrition and school enrolment, and mental health and well-being. Building effective economic security systems through UBI and other unconditional measures or services is an opportunity to reinvent health policy and presents a possible role for WHO as an auditor of ‘good’ (health equity) policy design.
Commercial interests and globalization: presented by Sharon Friel. Studies show that public policies and related population health behaviours (e.g. smoking) are influenced by commercial interests through four main channels: marketing, lobbying, corporate social responsibility, and global supply chains. Trade-investment services-intellectual property are strong forces for increasing corporate influence through the removal of obstacles to direct foreign investment and enabling more globally organised commodity supply chains of producers, importers, advertisers, and distributors. Increased corporate influence focused solely on profit interests makes it difficult for government to ensure that standards for safeguarding health are upheld (e.g. labelling, marketing to children). Governments are also reluctant to implement regulatory policies owing to: pervasive beliefs in the paradigm that free markets and education will address population health needs; corruption; strong industry opposition to governments implementing internationally agreed policies; and a lack of demand from civil society and the public. Fit-for-purpose regulatory regimes are required to address negative corporate influence. There was a call for the use of health equity impact assessments of trade/investment/fiscal/monetary policy and to mobilise capacities and resources for this.

Report on Health Prosperous Lives for All in the WHO European Region (2019): presented by Chris Brown. The Health Equity Status Report Initiative of EURO is an example of how to use data in advocacy for political commitment. The data includes inequalities in self-reported health and ‘essential conditions’ for health. Information on evidence-based policies was also included in the report. Domains of essential conditions include: Health Services; Income Security & Social Protection; Living Conditions; Social & Human Capital; and Employment and Working Conditions. Innovative graphics and forecasts of benefits from action on health equity were included e.g., 50% reduction in gaps in life expectancy would provide monetized benefits to countries ranging from 0.3% to 4.3% of GDP within short time intervals. Increased crime and civil unrest affecting the whole-of-society in more unequal societies were other motivational key messages. See: http://www.euro.who.int/en/publications/abstracts/health-equity-status-report-2019

Vulnerable populations in Switzerland: addressing social determinants of health for advancing equity: presented by Patrick Bodenmann. Medical, social and clinical vulnerability was described from the literature. Analysis of cumulative vulnerabilities of frequent users of hospital emergency departments (ED) reveals the need for multilevel interventions. One intervention model is case management by teams of nurses delivering counselling, social support and assistance, and orientation to specialized healthcare. Impacts are: reduced ED visit; improved quality of life; and cost-savings. Another model is a multidisciplinary approach for refugee families centred on maintaining the family. This showed positive impacts on improved schooling, among others. Preventing cumulative vulnerability is an important entry point for action on SDH for equity.

Vulnerable populations and community resilience: urbanization, migration and barriers in health equity in South Africa: presented by Deb Basu. Refugees and migrants are analysed in the context of urbanization. WHO 140th Executive Board (2017) refers to the
Global Compact on Refugees and the Global Compact on Safe, Regular and Orderly Migration and required the WHO Secretariat to develop a Framework of priorities and guiding principles to promote the health of refugees and migrants. The 2017 World Health Assembly (WHA) endorsed the resolution WHA70.15, promoting the health of refugees and migrants. Case studies of Johannesburg, South Africa, were presented. Refugees have the same right to access healthcare as South African citizens yet experience medical xenophobia. Internal and international migrants move to urban areas for reasons other than healthcare but are nonetheless placing pressures on general infrastructure important for SDH. Migrants represent a selection of healthy individuals, with benefits for rural households but poor urban environments can increase illness among migrants. Return migration in times of sickness places significant burden of care on the rural households. Complex relationships between public health, disease, urbanization and migration exist.

Governance and the Global Survey of Health in All Policies Implementation: presented by Lyn Dean. The survey designed by the Global Network for HiAP and led by the Government of South Australia is the first survey assessing the situation of HiAP practice, using the WHO definition, “an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impact in order to improve population health and health equity”. It had 41 responses from jurisdictions at different levels in 22 countries. 98% of survey respondents specified that ‘addressing the SDH’ was a key aspect of their current or intended HiAP approach; 68% of respondents indicated the ‘Delivery of strategic or ‘Big P-policy’ was the most common focus for their HiAP practice. Impacting policy processes is widely considered a key goal of HiAP practice, supporting the ‘systems approach’ for greater long-term impact on SDH, health and health equity.

Overall comments on renewed WHO global leadership on SDH

WHO’s recent initiative to enhance its global leadership on SDH will have a great legitimizing effect for the work of many actors. This will encourage politicians to take political choices for health equity, supporting existing ‘good’ policies (i.e. policies or sets of policies promoting a reduction in health inequities), and make impacts on health equity more visible. To take forward this work, three overarching principles are noted:

- The SDH refer to more than the health and well-being of ‘target’ population groups and their access to health services. Working on SDH includes advocacy for structural drivers, governance and human rights that promote health. Examples of structural drivers include government responses to recessions, policies for urbanization, and broader legislative environments for non-discrimination. The broad scope of SDH as outlined in the CSDH Report should be maintained. The European Health Equity Status Report highlights many of these as domains of essential conditions, and, following the Rio Political Declaration on SDH, refers to policy drivers as the mechanisms and processes for accountability, policy coherence, participation and empowerment.
Recent developments on the scope of the SDH have shed light on new societal determinants that have emerged since the global CSDH (2005-2008). The conceptual framework developed by PAHO and the Institute of Health Equity (2019) highlights Land, the increasing importance of Climate Change, History and Legacy, Ongoing Colonialism, and Structural Racism. There are other new issues, related to the nature and reach of technology, that were less pervasive in shaping society at the time of the CSDH report, that are also potential areas of focus under economic or commercial determinants.

The era of the SDGs requires a new narrative for SDH that articulates a clearer role for WHO and health ministries for engaging across sectors for equity. Capturing the attention of clinicians in this narrative is also valuable, given their relatively stronger societal influence in many developing country settings. However, the messaging needs to reach out to other professionals as well, and to capture the imagination of the general public.

3. Priority cross-cutting areas of focus - functions

1. Provide normative and scientific leadership

- Develop standard concepts and definitions (e.g. vulnerability) and instruments (e.g. data capture) for better communication in WHO and for WHO with other stakeholders.
- Strengthen internal collaboration in WHO including with the Gender, Equity and Human Rights (GER) unit in the Director-General’s office, with the Department of Health Promotion, and with programmes and departments in the HEP and in the other two divisions of WHO.
- Lead developments on the SDH for equity in WHO/the UN system, supported by the scientific community, to align policies for SDH and health equity.
- Provide international evidence related to societal progress, well-being, health and equity and make the case for investment.
- Develop information products to refute the rise of creeping eugenics and flawed scientific studies that refer to genetically, not socially, structured inequities.
- Disseminate recommendations and information on concrete actions to be taken by countries, global actors, etc.

2. Monitor SDH and equity with global reports and promote accountability

- Ensure WHO provides consistent, strong messages on the trends in health equity and their link to the SDH.
- Scan horizons and trends in determinants of health equity: draw attention to both positive and negative societal issues and trends.
• ‘Audit policies’ (i.e. providing detailed case studies of how policies are designed and implemented and their resultant impacts on equity and health); and provide updates on the latest status of actions across countries.

3. **Provide Policy Guidance for Action**

• Develop HiAP, multisectoral action (‘intersectoral’ used interchangeably)/whole-of-government competencies, guides and tools for addressing SDH for health equity.
• Disseminate information on good practice policy design principles and examples in databases, peer review literature and reports.
• Disseminate knowledge on enabling conditions, practices and tools for addressing SDH using clinical health services as one entry point.
• Build networks and network platforms supporting alliances and communities of practice.

4. **Build competencies in people and systems in WHO and in key stakeholder groups**

• Mainstream training across WHO (e.g. WHO Academy) and mainstream standards in data systems (e.g. UHC Inventories).
• In country offices, ministries of health, and government support the development of skills for equity advocacy, working in interdisciplinary environments and for applying SDH policy packages and tools in WHO technical assistance.
• Scale-up technical assistance, supported by scientific networks, the UN and NGOs.

4. **In-depth thematic discussions**

1. ‘Economic’ determinants and commercial/corporate interests/influence

Economic/corporate interests have an important role in shaping population health and health equity, for example through trade and globalization. Evidence suggests that fit-for-purpose regulatory regimes are needed to constrain negative corporate influences on health and to encourage ethical business practices beneficial for population health. WHO has an opportunity to strengthen its role in encouraging positive economic determinants of health.

*To support countries and the international community in creating positive economic/commercial determinants for health and health equity, WHO can:*

• Produce balanced sectoral reports that consider actions to promote a responsible private sector – WHO should explore dynamics at country/regional levels.
• Conduct and provide evidence and tools for health equity impact assessments of trade, investment, fiscal and monetary policies.
• Define models for ethical investment that increase health equity.
• Mobilise resources and capacities for health equity impact assessments of trade/fiscal/economic policies through building up a community of practice across academia and NGOs.
• Improve policy coherence across UN agencies (e.g. with the World Trade Organization).

Specific sectoral focus areas could be:

• Commodity sectors.
• Global food industry, food products (also related to anti-microbial resistance).
• Technology/Digitalization of public health infrastructure.
• Finance and investment sectors and ethical investing.

The new nature and reach of technology was raised:

• Social media and fake news are influencing social norms, attitudes and practices – and through this, public policy-making for health and health equity.
• There is an increase in trade in personal data and information.
• Some population groups are left behind from the positive reach of technology.

2. Urbanization

With one billion people on the move or having moved in 2018, nearly one-seventh of the world’s population is now living in a different location from the one in which they were born. This migration of people, both internal and international, coupled with increasing physical densification of human settlements, are among the driving structural forces impacting the patterns of health equity. Urbanization is occurring most rapidly in low and middle-income countries where people are migrating for work or because of civil strife or war.

Urbanization as a social process of change can be positive but is also stressful. At the individual level stress reduces the capacity to invest in health. At the community level, densification and rapid growth can decrease the quality of the physical environment, places pressure on public resources for health (in addition to health services) and challenges community solidarity. The urbanization process also means that some rural areas and communities are suffering from demographic change, resource and service deprivation, underinvestment, lack of infrastructure, isolation and environmental problems.

To support countries and local communities to develop positive urbanization trajectories for health equity, WHO can:

• Develop a comprehensive checklist for governments as they plan and grow their cities and urban areas.
• Promote use of a policy toolbox that combines policies on income security, healthy commerce, social solidarity (with increasing cultural/ethnic diversity), and on the built environment and climate change.
• Work with other UN agencies on the framing of urban health equity making good use of WHO Collaborating Centres and in collaboration with other WHO departments.
• Develop evidence on how to address SDH in urban contexts of fragile states.
• Identify and disseminate best-practice models on drivers and nudges for how community action can best influence the SDH.
• Describe urban/migrant resettlement policies which are health-protective and related to family well-being.
• Promote the use of tools addressing the cumulation of conditions of vulnerability including through leading hospitals in urban centres.

3. Income security and Universal Basic Income/social protection

Based on the CSDH framework of causation, and several other SDH evidence summaries (e.g. Dahlgren and Whitehead 1991), the impacts that public policies have on health equity is thought to be extensive. Among public policies, the role of the welfare state and social protection systems has a particular status. In the post-2008 financial crisis period, the policies of austerity affected even core welfare states’ governments. Policy reforms motivated by short-term savings focused on income protection for the most vulnerable strata of societies. Punitive income security designs further reinforced poverty traps, deepening moral hazard (as medical services become involved in assessment of income insecurity), and extended informalisation and job insecurity, resulting in worsened physical and mental health.

This period of rapid change without due regard for health implications of the economy underscored how the interlinkages between household income security and health are not well understood by governments or society. This is further evidenced by the absence of representatives of the health sector in economic reform debates or experiments. The evidence shows that income insecurity is a major source of stress. People who are stressed cannot invest in health. Stable economic architecture for income security can abate stresses of the economy which compromise health and result in patterns of health inequities. Social protection policies, including those used in advanced welfare states, as well as newer innovative policies (responding to welfare state weaknesses and globalization), such as Universal Basic Income and Services (UBI) policies, provide the opportunity to build socioeconomic inclusion infrastructure into the modern state. UBI was described as “a monthly income to cover essential living costs that replaced many other social benefits,” whose purpose is “to guarantee everyone a minimum standard of living that everyone receives the same amount regardless of whether or not they are working, and that people also keep the money they earn from work or other sources. The scheme itself is paid for by taxes.”

To support countries and the international community in improving income conditions fundamental for equity and health, WHO can:

• Gather evidence and case studies on different welfare systems and their impacts.
• Promote the auditing of public policies for protecting individual and household income security and disseminate evidence for economic deliberations.
• Convene discussion on and advocate for improving designs of welfare system reforms and social protection policies in response to economic drivers.
• Provide context relevant model examples of legislative models and accountability mechanisms for fulfilling basic needs fundamental to health and well-being (cross-references were made to the circular economy/economy of well-being).

5. Next steps

5.1 Develop the scope of work and align within WHO

• Discuss the summary of the meeting report in the new Division of Healthier Populations and identify areas for cooperation within the SDH Department and across departments.
• Discuss the summary report and next steps with other HQ teams and regional offices.

Figure 1. Preliminary representation of activities on SDH for equity

Priority functions:

1. Normative frameworks, Standardized terminology, Summarize the latest science.
2. Monitoring essential conditions for health equity with global reports, and Audit policies for evidence of health equity impacts.
3. Provide policy options, guidance and tools for action.

4. Build competencies in people and systems within WHO and in key stakeholder groups:
   A. Addressing social determinants of health equity through health services and systems (e.g. surveillance systems being developed by ministries of health/services, including from perspective of emergency hospital departments);
   B. Improving policy coherence in governance for development, health and equity (e.g. through HiAP);
   C. Improving cohesion in WHO-UN on the equity agenda, as part of the Sustainable Development Agenda (Goal 10, e.g. UNDP, OECD, UNICEF, ILO).

5.2 Plan for the 2020-21 Biennium and ensure clarity in alignment across regions

- Follow discussions on WHO restructuring (‘transformation’), ensuring priority given to human resource and budget growth for activities across headquarters and regions.

5.3 Ensure operations of a core team and cross-team functions in the Department

- Ensure that the new unit dealing with SDH and equity is staffed with mission critical positions (at least 4 professionals and 1 administrative staff).

5.4 Convene specific working groups to discuss next steps in each of the areas of focus

- Identify priorities for cross-cutting functions (aligned to global goods for 2020/21).
- Scope the key activities and products for the initial in-depth thematic areas of focus: economic/commercial/private sector determinants; and urbanization.

5.5 Position SDH and equity more clearly internationally

- Consult further within WHO and WHO Collaborating Centres to identify and develop the main elements of the case for addressing SDH (evidence on causation, action, impacts).
- Consult and convene key stakeholders from across WHO to identify audiences and platforms for the SDH and equity evidence and arguments.
- Ensure coherence with the narrative being developed for the Division.
- Consult with other UN agencies.

5.6 Plan for the development of an Action Plan/Strategy/Roadmap on SDH for equity

Any action plan/strategy/roadmap will be an important political signal and mechanism for carrying forward the new leadership role. Such a strategy should be part of a broader initiative on the WHO General Programme of Work outcome for the ‘third billion’ and for the Healthier Populations Division. The strategy/roadmap should combine issues related to SDH for equity and health promotion and have mainstreaming and accountability components. It should build on existing regional processes within WHO based on a country and global needs assessment, identifying a group of leading countries interested in championing SDH for equity and being involved in the development of an action plan/strategy/roadmap.