INTERNATIONAL DISCOURSE ON SOCIAL DETERMINANTS OF HEALTH: A CRITICAL REVIEW

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in partial fulfillment of the requirements for the award of the degree of

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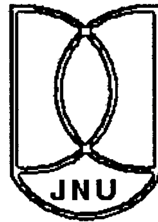

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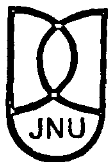

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CERTIFICATE

This dissertation entitled, **International Discourse on Social Determinants of Health: A Critical Review,** is submitted in partial fulfilment of six credits for the degree of Master of Philosophy of the University. This dissertation has not been submitted for any other degree of this university or any other university and is my original work.

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Dedicated to my Inspiration – Papa

Shri Inder Sahni

(22nd July 1950 – 3rd Feb 1997)

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Best Regards

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ABBREVIATIONS

CBHP	-	Community-based health programmes
CCT	-	Conditional Cash Transfers
CMH	-	Commission on Macroeconomics and Health
CSR	-	Corporate Social Responsibility
CSDH	-	Commission on the Social Determinants of health
CSO	-	Civil Society Organisation
ECD	-	Early Child development
GDP	-	Gross Domestic Product
GOBI	-	Growth monitoring, oral rehydration therapy, breast-feeding and immunization
IAH	-	Intersectoral action on health
IDRC	-	Canada's International Development Research Centre
ILO	-	International Labour Organisation
IPR	-	Intellectual Property Rights
KN	-	Knowledge Network
LDC	-	Less Developed Countries
MDG	-	Millennium development goals
NGO	-	Non Government Organisation
PHC	-	Primary Health Care
PRA	-	Participatory Research Appraisal
SAP	-	Structural Adjustment Programme
SDH	-	Social determinants of health
SES	-	Socio Economic Status
SEKN	-	Social Exclusion Knowledge Network
SPHC	-	Selective Primary Health Care
SAPS	-	Structural Adjustment Programme
TRIPS	-	Trade-Related Intellectual Property Rights Agreement
UK	-	United Kingdom
UN	-	United Nation
US	-	United States
WHO	-	World Health Organisation

Chapter 1

Introduction

Health inequalities, between and within countries, span the entire global population. Global processes are generating global, regional, and national inequalities. It has also been described as a ''globalization of inequality''. [1] The Universal Declaration of Human rights states that ' Everyone has the right to a standard of living adequate for the health and well-being for him (her) self and his/her family, including food, clothing, housing and medical care and necessary social service...Everyone has the right to education'. Despite this welcome note, for half the world's population the brutal reality is this: 'you'd be better off as a cow' as the average European cow receives $2.20 a day from the taxpayer in subsidies and other aid while 2.8 million people in developing countries around the world live on less than $2 a day. The health inequality gap between the poorest low-income countries and the rest also has widened over the last 20 years. [2]

The question requiring attention is what impact is the new global order having on the obvious inequalities that exist between people born indifferent parts of the globe? The World Health Organization's (WHO) 1998 annual report, commemorating the organization's fiftieth anniversary, states the many health achievements during the last half-century.

Among them:

- Average worldwide life expectancy increased from 48 years in 1955 to 66 years in 1998.
- In 1995 the worldwide infant mortality rate was 148 per 1000 live births .in 1995 that rate had been reduced to 59 per 1,000 births.
- In 1995 approximately 21 million children died before they reached age five, in 1997 slightly fewer than 11 million children died before their fifth birthday.

Given these trends, the health of the world's population plainly seems getting better. But regrettably, the situation is not so simple; in particular many of the significant gains made over the last 50 years are marred by growing health disparities between

the worlds wealthy and the world's poor. At the close of 1998, the WHO director declared:

Never have so many had such broad and advanced access to healthcare. But never have so many been denied access to health. The developing world carries 90 percent of the disease burden, yet poorer countries have access to only10 percent of the resources to go to health.

While the successes indicated earlier and the many more cited in the "cautiously optimistic" WHO report are encouraging, these gains cannot obscure equally dramatic losses illustrating the negative side:

- More than 50 percent of the people in the world's 46 poorest countries are without access to modern health care
- Approximately three billion people in developing countries do not have access to sanitation facilities
- More than one billion individuals in developing countries do not have access to safe drinking water.
- At least 600 million urban dwellers in Africa, Asia, and Latin America live in what the WHO calls life and health threatening homes and neighborhood
- In 1998, two fifth of all people who died in the world died prematurely

Adding more the UN estimates that in 2004, 17% of the world's population (1.2 billion people) did not have sustainable access to a safe water supply and 41% (2.6 billion people) did not have access to decent standards of sanitation. Worldwide, an estimated 1.3 billion people have no access to effective and affordable healthcare, while annually an additional 150 million people in 44 million households face financial catastrophe as a direct result of having to pay for healthcare. In 2001-2003, 17% of the world's population and 30% of people living in Sub Saharan Africa were undernourished – 830 million people in the developing world. [28]

According to the UN-sponsored World Institute for Development Economic Research in 2000, 1% of adults in the world owned 40% of the world's wealth[1] and the richest

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[1] In this study wealth was defined as what people owned, such as property, land, shares and cash minus their debts or what they owed.

10% owned 85%. In contrast, the bottom 50% of the world's population owned only 1.1% of global wealth. Geographical inequalities in the distribution of wealth are equally striking, with households in North America, Europe, Japan and Australia owning around 90% of global wealth. Sharp inequalities are also apparent within global regions. In Latin America, for example, inequalities in income and wealth have grown dramatically since the 1970s and the continent now has the highest Gini coefficient in the world. In European countries the income of then richest 10% of the population is between 20% and 30% higher than the poorest 10%; in Latin America the incomes of the top 10% are between 200% and 300% higher than those of the bottom 10%. [28]

World Health Organisation's Response to the health inequities

A whole network of international organizations and actors is engaged in monitoring global trends, global problems, and global crises, based on the assumption that problems must be solved by joint action and with the participation of all. The UN system is a key part of this, and needs to be strengthened and reformed. The same is true of the World Health Organization. Indeed, the launch of the Commission on Social Determinants of Health by the late Dr Lee, former head of WHO, was designed to make the WHO more active in the social sphere.

In March 2005, the World Health Organization came up with the idea of setting up a commission, which caters to the social determinants of health. In the opinion of the WHO, the need and demand for clear scientific evidence to inform and support the health policymaking process were the rationale for setting-up such a commission. And the field of the social determinants of health is perhaps the most complex and challenging of all. It is concerned with key aspects of people's living and working circumstances and with their lifestyles. It is concerned with the health implications of economic and social policies, as well as with the benefits that investing in health policies can bring. Thus, with all such efforts, the commission on social determinants of health came in to existence in 2005.

In her acceptance speech Dr Margaret Chan noted that:

Progress in medicine races ahead, yet resources for public health grow more slowly. This leads to further imbalances across the globe – some people leading ever longer and healthier lives, others dying prematurely from preventable causes. This is not a healthy situation – for populations or world security.

Rectifying this imbalance should also be a target for the WHO. The central premise of the commission's work is to achieve and strengthen Health equity both within and across the countries which specifies a movement away from the concentration on the immediate causes of disease to levying focus upon the 'causes of the causes' that is the fundamental structures of the social hierarchy and the socially determined conditions these structures create in which people grow, live and age-the social determinants of health. The commission is being charged with the responsibility to recommend interventions and policies to improve health and to narrow down the health inequalities through action on the social determinants. It places action to ensure fair health as better health, which makes not just economic sense, also a matter of right and justice. In the view of the commission the vast majority of inequalities in health between and within countries are avoidable, and, hence, inequitable. According to the commission, technological solutions are important but not sufficient to counter this, as yielding sustainable returns require action on the societal causes, which helps in empowering people, communities and countries.

About the knowledge networks of the commission

The commission has nine knowledge networks among which six knowledge networks focus on themed areas such as early childhood development, social exclusion, globalization, health system, unemployment, urban setting. The other two women and gender equity knowledge network and measurement and evidence knowledge networks are the cross cutting which also serve as resource for other networks. Each knowledge network is managed by an organized hub or an organized co-hub. There are minimum 10 to 12 members in each knowledge network with experience in science, practitioners, policy, senior decision makers, and representative from civil society organizations, nongovernmental organizations, global institutes etc. The purpose of the knowledge networks is to synthesize knowledge to inform the

commission of opportunities to improve action on social determinants of health.

Purpose of the study

The purpose of the dissertation is to critically review the working of the Knowledge networks of the Commission on Social determinants of health using an analytical framework of health inequities in order to understand how far the knowledge networks synthesized knowledge could help in improving action on social determinants of health.

Objectives

- To critically review the working of the commission's knowledge networks using an analytical framework of inequities in the context of the present global and local contextual realities,
- To study the state of the art on Social determinants of health by exploring its emergence, philosophical basis, conceptualisation, emerging themes and models,
- To study the analytical framework of health inequities and health inequalities in terms of definition, approaches and measurement in order to review the work of the Commission's Knowledge Network,
- To relocate the discourse on Social determinants of health through analysing the salient features, trends, emerging areas, future challenges and recommendations in the area of social determinants of health.

Methodology

The dissertation is a review-based study to critically examine the role of the Commission's knowledge networks. The review of literature includes various commission's report such as the interim report, final reports of the knowledge networks, background and scoping papers of the knowledge networks, and other scholarly articles available on the commission's website. Apart from this, the literature review incorporates various scholarly articles published outside the Commission's domain in various journals and websites to develop a critical understanding about the Social determinants of health.

Chapterization Plan

The *first* chapter is the introduction to the Commission on Social determinants of Health. The *second* chapter is the State of the Art on the Social Determinants of Health, which discusses the historical background of the social determinants, its philosophical basis, conceptual framework of the commission and the emerging themes in area of social determinants. Chapter *three* is Inequalities and Inequities: Developing an Analytical Framework. Building on the health (in) equity and equality analytical framework chapter *four* reviews the work of the Commission's Knowledge networks. Chapter *five* is on Relocating the discourse on the Social Determinants of Health, that provides a discussion on the working of the Commission on the Social determinants of health and recommendations, At the end the concluding *sixth* chapter discusses the salient features of the commission including its strengths, limitations, recommendation, emerging concerns, future challenges etc.

Limitations

- The dissertation holds limitation on the ground of its inability to include the final report of the Commission, which was supposed to be published in May 2008, but till date remains unpublished.
- Secondly much of the work of the commission and knowledge network is on going therefore it was difficult to review them fully during the course of study.

Chapter 2

State of the Art on the Social Determinants of Health

Definition of Social determinants of Health

The draft discussion paper of the Commission on Social determinants of health of 2005 explains that the social determinants of health (SDH) can be understood as the social conditions in which people live and work, or in Tarlov's phrase "the social characteristics within which living takes place". SDH point to both specific features of the social context that affect health and to the pathways by which social conditions translate into health impacts. The SDH that merit attention are those that can potentially be altered by informed action [4]

What are determinants?

'Determinants of health' is a term introduced in the 1970s as part of a wider critique of public health research and policy. It was argued that too much research attention and too much health expenditure were being devoted to individuals and their illnesses, and too little invested in populations and their health. Backing up the critique was evidence that medical care had played a relatively minor role in the dramatic improvements in health through the late 19th and early 20th century. Public health, it was concluded, that work should be more concerned with social policies and social determinants than with health services and disease outcomes. [15]

The concept of Social determinant of health (SDH) originated in a series of influential critiques published in the 1970s and early 1980s, which highlighted the limitations of health interventions oriented to the disease risks of individuals. Critics argued that understanding and enhancing health required a population focus, with research and policy action directed at the societies to which individuals belonged. A case was made for "refocusing upstream" from individual risk factors to the social patterns and structures that shape people's chances to be healthy. Integral to these critiques is the argument that medical care is not the main driver of people's health.

Instead, the concept of social determinants is directed to the "factors which help people stay healthy, rather than the service that help people when they are ill". In

some contexts, health determinants have continued to be conceptualized primarily as characteristics of the individual, such as a person's social support network, income or employment status. Population are not merely collections of individuals, however; the causes of ill health are clustered in systematic patterns, and in addition effects on one individual may depend on the exposure and outcomes experienced by other individuals. This flows from the fact that the determinants of individual differences regarding some characteristic within a population may be different from the determinants of differences between populations.

Historical background of the Social determinants of health

The background paper prepared for the first meeting of the Commission on Social determinants of health in 2005 discusses the historical basis of the social determinants of health. It explains much of the early work could be traced to the prominent works such as the Hippocratic text, *Airs, Waters, Places* [5], likely written in the 4th century BCE, which roundly asserted that Greek democracies had the healthiest populations because democracy spurred individual initiative and an interest in taking care of oneself, whereas despotic rule fostered fatalism and bodily neglect. Another work, *The Yellow Emperor's Classic of Internal Medicine*, compiled in China between the 2nd century BCE and 7th century CE, by contrast stated that proper observance of hierarchy, especially by peasants toward their rulers, was essential for good health – and tellingly framed disease as akin to rebellion

However not until the 17th century CE, did any metaphorical link between the health of our bodies and the body politic became literal. The first text to use data to make this connection was the *Political Anatomy of Ireland*, written in the 1670s by the English physician, anatomist, and economist Sir William Petty (1623-1687). In this provocative treatise, Petty took two unprecedented steps: 1) he provided numerical evidence linking societal resources to health status, and 2) he argued that the body politic could be scientifically studied – just like any other body of the biological sort.

This work helped in setting the basis for systematic investigation of connections between the state and population health. [5]

Moving ahead, with the rise of the modern public health movement in the early 19th century, these statistics were finally brought out into the open and became a focus of public concern and agitation – especially given the all-too-evident wretched physiques of the newly emerging working class, who were crowded into rapidly growing urban slums adjacent to the new factories of the Industrial Revolution. In France, the famed physician and economist Louis-René Villermé (1782-1863) conducted unprecedented empirical research demonstrating that poverty was directly associated not only with elevated mortality rates in Parisian neighborhoods, but also with short stature, illness, and deformities among young military conscripts. His explicit inference was that body size, body proportions, morbidity, and mortality, far from being fixed, bore the imprint of economic conditions and could be affected by government policies. This insight led him, despite his commitment to laissez-faire economics, to advocate the abolition of child labor, resulting in France's becoming the first modern nation to enact such a ban. [50]

Taking this argument a step further, Friedrich Engels (1820-1895) – in one of the era's classic texts, *The Condition of the Working Class in England* –vividly described how the bodies and health of destitute workers and their children were destroyed by horrific living and working conditions. At this time, the emerging liberal sanitary creed held that individual immorality and filth were responsible for the poverty and afflictions of the poor; and it assumed that moral instruction and sewers, in the absence of economic reform, were sufficient to reduce mortality. By contrast, Engels declared that the health crisis reflected the triumph of private profit over social welfare. Indeed, he wrote that the existence of government reports replete with data on societal and environmental determinants of poor health "proves that society is aware of the fact that its policy results" in disparate harm – and that government was thus guilty of "social murder." Not surprisingly, this claim was refuted by those upholding the status quo. Ever since, a fundamental debate has raged over whether social inequalities in health are rooted in individual deficiencies or in societal injustice – with profound implications for apt remedies. [50]

The recognition that social and environmental factors decisively influence people's health is ancient. The sanitary campaigns of the 19th century and much of the work of the founding fathers of modern public health reflected awareness of the powerful

relationship between people's social position, their living conditions and their health outcomes. Rudolf Virchow (1821-1902) asked: "Do we not always find the diseases of the populace traceable to the defects in society? Recent epidemiological research has confirmed the centrality of social and environmental factors in the major population health improvements registered in industrialized countries beginning in the 19th century. McKeown's analyses revealed that most of the substantial modern reduction in mortality from infectious diseases such as tuberculosis took place prior to the development of effective medical therapies. Instead, the main driving forces behind mortality reduction were changes in food supplies and living conditions.

The constitution of the World Health Organization, drafted in 1946, shows that the organization's founders intended for WHO to address the social roots of health problems, as well as the challenges of delivering effective curative medical care. The Constitution famously defines health as "a state of complete physical, mental and social well-being, identifying organization's goal as " the attainment by all peoples of the highest possible level" of this state.

The 1950s: Emphasis on technology and disease specific campaigns

The social model of health propelled by the WHO was hampered in the post World War 2 context of cold war politics and decolonalization. A series of major drug research breakthrough produced an array of new antibiotics, vaccines and other medicines in this period, inspiring health professionals and general public with the essence that technology held the answers to the world's health problems. This boom propelled for the rise of the modern pharmaceutical industries.

At the political level another setback to the social model came with the temporary withdrawal of the Soviet Union and other communist countries from the United Nations and UN agencies in 1949. Following the Soviet pullout, UN agencies, including WHO, came more strongly under the influence of United States. Despite the key US role in shaping the WHO Constitution, US officials were at time reluctant to emphasize a social model of health whose ideological overtones were unwelcome in the cold war settings. During this time colonialism influencing the Afro-Asian countries toned the health model that was vertical, technology driven based on urban-based curative care. These developing countries though in their health agenda had

placed priority to the comprehensive health care but in practice followed the internationally guided vertical programmes ignoring the social context of the disease affected population. [45]

The 1960s and early 70s: the rise of community-based approaches

A renewed concern for the social, economic and political dimensions of health emerged by the mid 1960s when it became clear that in many parts of the world the dominant medical and public health model were not meeting the most urgent needs of poor and disadvantaged population. Out of necessity, local communities and health care workers searched for alternatives to vertical disease campaigns and the emphasis on urban-based curative care. During the 1960 and early 70s, health workers and community organizers in a number of countries joined forces to pioneer what became known as community-based health programmes. Such initiatives emphasized grassroots participation and community empowerment in health decision-making and often situated their efforts within a human rights framework that related health to broader economic, social, political and environmental demands. The importance of high-end medical technology was downplayed, and reliance on highly trained medical professionals was minimized. Instead, it was thought that locally recruited community health workers could, with limited training, assist their neighbors in confronting the majority of common health problems, Health education and disease prevention were at the heart of these strategies.

By the early 70s, awareness was growing that technologically driven approaches to health care had failed to significantly improve population health in many developing countries, while results were being obtained in some very poor settings through community-based programs. Some leading scholars, international public health planners and development experts began to advocate broad adoption of an approach to health informed by the practices and priorities of CBHP.

This included leaders at WHO. In 1975, WHO's Kenneth Newell, Director of the Organization's Division of strengthening Health Services, published" Health by the people", which presented success stories from a series of community-based initiatives in Africa, Asia and Latin America. The book advocated a robust engagement with the social dimensions of health, arguing that:" We have studies demonstrating that many

of the causes of common health problems derive from parts of society itself and that a strict health sectors approach is ineffective, other actions outside the field of health perhaps having greater health effects than strictly health interventions".

In the same year, WHO and UNICEF published a joint report examining Alternative approaches to meeting basic health needs in developing countries. The report underscored the shortcomings of vertical disease programmes that relied on technological fixes and ignored community ownership. It emphasized that social factors such as poverty, inadequate housing and lack of education were the real roots underlying the proximal causes of morbidity in developing countries.

This emerging model of health work found a powerful champion in Halfdan Mahler, Director general of WHO in 1973. He proposed in an initiative to the "Health for all by the year 2000" which implied the removal of the obstacles to health-that is to say, the elimination of malnutrition, ignorance, contaminated drinking water and unhygeinic housing.

The crystallization of a movement: Alma-Ata and primary health care

A new agenda took centre stage at the international Conference on Primary Health Care, sponsored by WHO and UNICEFC at Alma-Ata, Kazakhstan, in September 1978. 3000 delegates from 134 governments and 67 international organisations participated in the Alma-Ata conference, destined to become a milestone in modern public health. The conference declaration embraced Mahler's goal of " Health for All by the Year 2000", with primary health acre as the means.

The PHC model as articulated at Alma-Ata "explicitly stated the need for a comprehensive health strategy that not only provided health service but also addressed the underlying social, economic and political causes of poor health which involves in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication, and other sectors; and demands the coordinated effort of all these sectors".[45]

During the 80s as the drive for Health for All unfolded, the concept of intersectoral action for health took on increasing prominence. In 1986, WHO and the Rockfeller Foundation co-sponsored a major consultation on IAH at the latter's Bellagio conference. From the mid-1980s, Social Determinants of Health were also given prominence in the emerging health promotion movement. The first International Conference on Health Promotion - cosponsored by the Canadian Public Health Association, Canada's Health and Welfare Department and WHO- was held in Ottawa in November 1986. The conference adopted the Ottawa Charter on Health Promotion, which identified eight key determinants of health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. It was understood that this broad range of fundamental enabling factors could not be addressed by the health sector alone, but would require coordinated action among different government departments, as well as among non-governmental and voluntary organizations, the private sector and the media. Following Ottawa, a series of international health promotion conferences developed the message contained the charter and sought to build a sustained movement.

In 1992, Dahlgren and Whitehead formulated their rainbow model of health determinants in which the living and working conditions such as agriculture and food production, education, work environment, water and sanitation, health care services, and housing as contributors to health. The term social determinants of health also appeared in Tarlov's 1996 analysis of how inequalities in the quality of housing, education, social acceptance, employment, and income became translated into disease-related processes. Tarlov saw both material conditions and the cognitive appraisal of these living conditions relative to others as influencing health

The Canadian institute of advanced research outlined various determinants of health (some of which are social determinants): income and social status, social support network, education, employment and working conditions, physical and social environments, biology and genetic endowments, personal health practices and coping skills, healthy child development, and health services. A British working group charged with the specific task of identifying social determinants of health named the social (class health) gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport. The US centers for disease control

highlights socioeconomic status, transportation, housing access to services, discrimination by social groups (e.g., race, gender, or class) and social or environmental stressor.

In the wake of Alma Ata: "Good health at low cost"

The years following the Alma-Ata conference were not generally favorable for health progress among poor and marginalized communities. However, a number of developing countries emerged as models of good practice during this period, They were able to improve their health indicators and strengthen equity, through programmes in which intersectoral determinant of health played an important role. The "Good health at low cost" conference held in 1985 sponsored by the Rockefeller Foundation closely examined the cases of three countries China, Costa Rica and Sri Lanka and one Indian state Kerela that had succeeded in obtaining unusually good health results despite low GDP and modest per capita health expenditure, relative to high-income countries. [45]

The rise of selective primary health care

Selective PHC was rapidly proposed in the wake of the Alma-Ata conference as a more pragmatic, financially palatable and politically unthreatening alternative. Rather than trying to strengthen all aspects of health systems simultaneously or to transform social and political power relations, advocates of selective PHC maintained that, at least in the short term, efforts should concentrate on a small number of cost effective interventions aimed to attack a country's or region's major source of morbidity and mortality. Selective PHC in effect eliminated the social and political dimensions of the original PHC vision. Selective PHC focused particularly on maternal and child health, seen as areas where a few simple interventions could dramatically reduce illness and premature deaths. Jim Grant, head of UNICEF in 1979 believed that international agencies had to do their best with finite resources and short-lived political opportunities working within existing political constrains, rather than succumbing to utopian visions of moral leadership for social justice which Mahler advocated. The Strategy advocated by SPHC was GOBI-short for growth monitoring, oral rehydration, breast-feeding and immunization, which proved effective in reducing child mortality in many countries. However it constituted dramatic retreat

from the original Alma-Ata Declaration vision, particularly regarding intersect oral action on social and environmental health determinants.

The political-economic context of the 1980s: neoliberalism

The 1980s saw the dominance of the economic and political model known as "neoliberalism" or the "Washington consensus"(since its main proponents-- the US government, the World Bank and the International Monetary Fund -- are based in Washington DC). The core of the neoliberal vision was (and is) the conviction that markets freed from government interference " are the best and most efficient alligators of resources in production and distribution" and thus the most effective mechanisms for promoting the common good including health. A key postulate of the neoliberal economic orthodoxy of the 1980s and 90s was that, since economic growth was the key to rapid development and ultimately to a better life for all, countries should rapidly and rigorously implement policies to stimulate growth, with little concern for the social consequences in the near term.

While growth-enhancing policies such as cuts to government social spending might involve "short-term pain" for disadvantaged communities, this would be more than compensated by the "long-term gain" such policies would produce by creating a favorable investment climate and accelerated economic development. As a result of SAP and the global economic malaise, social sector spending in many countries plummeted during the 1980s, with negative effects on the health status of vulnerable communities.

In the poorest 37 countries in the world, public spending on education dropped by 25% in the 1980s, while public spending on health fell 50%. Since SAPs were implemented at the cost of great human suffering, Many of the low-income countries that implemented SAPs, particularly Africa, saw little if any improvement in their GDP growth rate or other core economic indicators following adjustment. Thus the "short term pain" the programmes brought was much worse than the international financial institutions predicted, while the promised "long term gain "failed to materialize in many cases. Overall, the downsizing of the state and the deregulation of markets demanded by the neoliberal development model created conditions unlikely to be propitious for systematic action to improve health through action on social determinants. [5]

The 1990s and beyond: contested paradigms and shifting power relations

The late 1980s and early 90s witnessed a waning of WHO's authority, with de facto leadership in global health seen to shift from WHO to the World Bank. In part this was result of the Bank's vastly greater financial resources; by 1990, Bank lending in the population and health sector had surpassed WHO's total budget. Despite the erosion of WHO's influence during this period, however, the Organization's activities present a complex picture; important and forward looking work was undertaken by many groups within or connected with WHO.

Some efforts gave an important place to social and environmental determinants that are as follows:

1. In certain regions, most clearly Europe, action to address health equity challenges and the social underpinnings of health continued as part of unbroken commitment to the Health for All ideal. The *WHO Equity Initiative* (1995-98) based at Geneva Headquarters clarified the understanding of health equity as primarily related to people's position within social hierarchies, and thus to gradients of social, economic and political power but this initiative got suspended in 1998 due to personality and political struggle.
2. From 1994-97, WHO sponsored the *Task Force on Health in Development* chaired by Branford Taitt to review the global development policies and their health implications. It highlighted upon the effects of social conditions on health arguing that health impact among vulnerable population should be a central criterion in shaping policy choices for economic development.
3. A major WHO effort in the mid-1990s was the attempt to reinterpret and reinvigorate the Health for All strategy under the banner of *Health for All in the 21st Century.* The revitalization of HFA included a renewed effort to promote intersectoral action as a key component of public health strategies .The existence of the IAH initiative attested both to continued recognition of importance of the social and environmental determinants of health and the ongoing difficulties countries experienced in addressing them.
4. The arrival of Gro Harlem Brundtland as Director General in 1998 brought significant changes in WHO's institutional agenda. Brundtland's priorities included a new initiative on malaria, a global campaign against tobacco and a

rethinking of health systems. Brundtland is credited with having restored much of WHOs tarnished credibility in international development debates. However, this renewal came at a price, and the sacrifice-affected areas of importance for the Organization's capacity to promote action on SDH. The ambitions of Health for All in the 21st Century were sharply scaled back. In the area of health and development, Brundtlsand's signature was the *Commission on Macroeconomics and Health (CMH),* chaired by Jeffrey Sachs. The CMH's basic argument was not novel. But by putting number s on the idea that ill health among the poor costs the global economy vast sums of money, the CMH captured the attention of policymakers. Quantifying in dollar terms the potential economic payoff of health improvements in low and middle-income countries, the CMH helped secure fresh prominence for health as a development issue.

The 2000s: growing momentum and new opportunities

The global development agenda is increasingly shaped by the Millennium Development Goals, adopted by 189 countries. The 8 MDGs are linked to quantitative targets and indicators in poverty and hunger reduction; education; women empowerment; child health; maternal health; control of epidemic disease; environmental protection; and the development of a fair global trading system. Three of the eight MDGs are directly focused on health, and several of the other goals have important health components, confirming that, overall, health in the 2000s stands higher on the international development agenda than ever before. [5]

Birth of the Commission on Social Determinants of Health

The 2000s have also seen an evolution in WHO's role in promoting action on health equity and the social determinants of health. In 2003 Lee Jong-wook was elected WHO Director-General on a platform of renewed connection to Health for All values. In a December 2003 article in the Lancet, Lee wrote: "A crucial part of justice in human relations is promotion of equitable access to health-enabling conditions...The Alma-Ata goal of Health for All was right. So were the basic principles of primary health care: equitable access, community participation, and intersectoral approach to health improvement. These principles must be adapted to today's context". In his

address to the 57th World Health Assembly in May 2004, Lee announced WHO's intention to create a global commission on health determinants to advance a pro-equity agenda and strengthen the Organization's support to Member States in implementing comprehensive approaches to health problems, including their social and environmental roots.

Built up on the distal causal thinking in public health, World Health Organization in March 2005 came up with the idea of setting up a commission, which caters to the social determinants of health. In the opinion of the WHO the need and demand for clear scientific evidence to inform and support the health policymaking process are greater than ever. And the field of the social determinants of health is perhaps the most complex and challenging of all. It is concerned with key aspects of people's living and working circumstances and with their lifestyles.

It is concerned with the health implications of economic and social policies, as well as with the benefits that investing in health policies can bring. Thus, with all such efforts, the commission on social determinants of health came in existence in 2005 by the late Dr.Lee Jong, the then the director and is now been headed by Dr.Margret Chan. [3]

The central premise of the commissions work is to achieve and strengthen Health equity both within and across the countries which specifies a movement away from the concentration on the immediate causes of disease to levying focus upon the 'causes of the causes' that is the fundamental structures of the social hierarchy and the socially determined conditions these structures create in which people grow, live and age-the social determinants of health. The commission is being charged with the responsibility to recommend interventions and policies to improve health and to narrow down the health inequalities through action on the social determinants. It places action to ensure fair health as better health, which makes not just economic sense, also a matter of right and justice. In the view of the commission the vast majority of inequalities in health between and within countries are avoidable, and, hence, inequitable. To counter this technological solutions are important but not sufficient, as yielding sustainable returns require action on the societal causes, which helps in empowering people, communities and countries. [6]

The Commission's vision is a world in which all the people have the freedom to lead lives they have reason to value. To realize this, the commission is building upon a global movement for change to improve global health and to rescue health inequity. The objective was to achieve policy change by learning from existing knowledge about the social determinants of health and turning that learning into global and national political and economic action. Further, it aims to level policy change by turning existing public health knowledge into actionable global and national policy agendas. It is expected to achieve the following:(1) compile evidence on successful interventions and formulate policies that address key social determinants of health, particularly for low income countries, (2) raise societal debate and advocate for policies that address social determinants of health, (3) define a medium and long term action agenda for incorporating social determinants of health interventions/approaches into planning, policy, and technical work within the WHO. [6]

The platform of social determinants of health holds importance as it helps to account for (a) general improvement in health among citizens over a period of time (b) health differences observed among populations within nations; (c) differences in population health among citizens in various countries;(d) as a determinants of social costs of poor living and their working condition, degree and quality of social development and social welfare within and among the nations. In the words of the commission a social determinant of health approach has several advantages .It bridges the artificial distinction between technical and social interventions, and demonstrates how both are necessary aspects of action. It seeks to redress the balance between curative and preventive action and individualised and population based interventions. Also by acting on structural conditions in society, a social determinants approach offers a better hope for sustainable and equitable outcomes. [6]

The main expectations from the Commission on social determinants of health are the following: (1) country work will illustrate ways of addressing the social determinants of health in national health policies and programmes related to the commission's theme. Partner countries will document their findings with respect to the policy process and their effects. Their reports will inform the commissioners' recommendations, for national and global policies and for ways of working at the WHO, (2) Knowledge networks comprised of leading scientist and practioners will

compile knowledge on interventions to overcome the social barriers to health, with a focus on low-income countries. The knowledge networks will cover themes that include early child development, health systems, employment conditions, globalisation, priority public health conditions, urban settings, social exclusion, and measurement of the impact of social determinants approaches on health outcomes, (3) commissions report will outline opportunities for action on the social determinants of health for each theme, and recommend specific areas of policy and institutional change to global and member stakeholders, (4) the WHO report will propose concrete mechanisms for incorporating social determinants of health interventions and approaches into WHO programs. [6]

The commissioners comprise 20 leading innovators in science, public health, policymaking and social change to support countries and global health partners to act on social factors leading to ill-health and health inequalities. In addition to the commissioners, there are five streams of action:

1. Organization of knowledge to inform health policy proposals and action on the social determinants of health, through nine knowledge networks (KNs).
2. Demonstrating and highlighting the opportunities and possibilities of action, which is being formalized in country partnership agreements and action plans – the country workstream.
3. Social mobilisation and long-term political sustainability of the social determinants of health (SDH) agenda, which is being organized through an extensive civil society process.
4. Promoting action across United Nations institutions on equity in health and providing specific policy proposals for improved action on health – global initiatives.
5. Developing the plan for institutional change at WHO so that it can also provide long-term support to countries in advancing the SDH agenda after the Commission has ended.

Leading the commission are 19 commissioners who are influential global and national level policy-makers, scientist, practionners and civil society leaders from all over the world. Their diverse backgrounds reflect how health is a concern for all and not just an arena for the health care professionals. Apart from this the commission's global

partners are complementing the expertise of the commission. It is building partnership with government, civil society, and international organisations. It is reviewing the global evidence base on health inequity, harnessing national and local knowledge for action, and advocating for change [6]

Philosophical debates on the Social determinant of health

Alongside the practical debate exists a parallel debate at the philosophical level; one that will in many ways inform the policy choices that societies make to improve the health of their populations. Theories of justice (eg, fair and equitable treatment of people) for social determinants of health are an important topic of philosophical inquiry today. An important starting point for a philosophical discussion of the social determinants of health is the application of John Rawls' theory of justice to such determinants. In A theory of justice, Rawls argued that justice requires the fair distribution of primary goods and that rational people behind a "veil of ignorance" about their personal circumstances would choose principles of justice that maximise the minimum level of primary goods. Primary goods are allocated to individuals on the basis of "fair equality of opportunity", due to the disadvantages that these individuals have accrued through the "natural lottery" and the "social lottery" of life [7]

At a more fundamental level, Amartya Sen, and more recently Michael Marmot, have expressed concerns with the Rawlsian focus on means rather than ends because it does not take account of human diversity. The Rawlsian approach is problematic, they argue, because resources and means cannot be good in their own right--they have no intrinsic value (they cannot be the object of social activity), they are good only insofar as they promote human functioning. As Sen notes, "if the object is to concentrate on the individual's real opportunity to pursue her objectives (as Rawls explicitly recommends), then account would have to be taken not only of the primary goods the persons respectively hold, but also of the relevant personal characteristics that govern the conversion of primary goods into the person's ability to promote her ends. For example, a person who is disabled may have a larger basket of primary goods and yet have less chance to lead a normal life (or to pursue her objectives) than an able-bodied person with a smaller basket of primary goods."

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Ensuring possession of primary goods, therefore, might not address inequalities in health; that reduction of socioeconomic inequality will necessarily lead to reductions in health inequalities should not be assumed. It therefore cannot be said that it is necessarily the case that "health is the by-product of justice", since this "oversimplifies the demands of health equity vis-a-vis the extensive requirements of social justice". This critique throws light on the distinction between a "resource-orientation" (Rawlsian) and a "results-orientation" (capability) in public policy. Thus, although a focus on fair distribution of primary goods and equal opportunity is a useful way of elevating the importance of the social determinants of health, this view has limitations, especially in acknowledging the intrinsic value of health and other capabilities in analysing the relative effectiveness of resources on health and health inequalities, and in understanding public policy more broadly [7]

However the capability approach also faces many limitations. It ignores analysis of the political context of development where the issues of power and how it reproduces are rarely questioned. Here the Individual is the subject and object of analysis collective agents and subjects such as social classes do not appear n or does an analysis of what articulates these collective agents such as exploitation and domination appear. Thus to resolving the differing philosophical ideas on social justice, it is required that the commission contextualize each determinants and deals with the concept of social justice by abiding fairly and justly to its two core components of fairness and redistribution of resources. [7]

Emerging themes in the study of social determinants of health

There exist four emerging themes in social determinants of health research. These concern the explanatory framework, life-course perspective, the role of public policy, and barriers to implementation of health determinants-related public policy. [8]

1. Explanatory framework

Three dominant frameworks have emerged to explain the influence of role of income inequality on health. These are the materialist, neomaterialist, and the psychosocial comparison approaches.

Materialist Approach: Focuses on the conditions of living as determinant of Health. Individuals experience varying degree of positive and negative exposures over their lives that accumulate to produce adult health outcome. Overall wealth of nations is a strong indicator of population health. But within nations, socio-economic position is a powerful predictor of health, as it serves as an indicator of material advantage or disadvantage over the life span. Material conditions reflecting the impact of various social determinant of health-determine health by influencing the quality of individual development, family life and interaction, and community environments. Material conditions predict likelihood of physical (infections, malnutrition, chronic disease and injuries), developmental (delayed or impaired cognitive, personality, and social development), educational (learning disabilities, poor learning, early school leaving), and social (socialization, preparation for work and family life) problems. Material conditions of life lead to differences in psychosocial stress.

The "fight or flight" reaction- chronically elicited in response to threats such as income, housing, and food insecurity, among others weakens the immune system and leads to increased insulin resistance, greater incidence of lipid and clotting disorders, and other biomedical insults that are precursors to adult disease. Individual of lower socio-economic position experience a range of psychosocial states that threatens health. Adoption of health-threatening behaviours is a response to material deprivation and stress. Environments determine whether individual take up tobacco and excessive alcohol use, and carbohydrate-dense diets, are means of coping with difficult circumstances. Materialist arguments outline the source of health inequalities among individuals and nations and the role played by various social determinants of health.

Neomaterialist Approach: Focuses on the conditions of Living and Social Infrastructure as determinants of Health. Differences in health among nations, regions, and cities are related to how economic and other resources are distributed within the population. American states and cities with more unequal distribution of income-as well as poor quality of numerous social determinants of health-have more low-income people and greater income gaps between rich and poor. They invest less in public infrastructure that affects social determinants of health such as education, health and social services, support for the unemployed and those with disabilities.

Such unequal jurisdiction has much poorer health profiles. On the other hand, Canada has a small proportion of lower-income people and a smaller gap between rich and poor, and spends relatively more on public infrastructure than the United States. Not surprisingly, Canadians enjoy better health than Americans as measured by infant mortality, life expectancy, and mortality from childhood-injuries. Neither nation does as well as Sweden, where distribution of resources is much more egalitarian having health indicators among the best in the world. The neomaterialist view directs attention to both the effects of living conditions on individuals' health and the societal factors that determine the quality of the social determinants of health. How a society decides to distribute resources among its citizens is an especially important contributor to the quality of various social determinants of health.

Psychosocial Comparison Approach: Explains Hierarchy and Social Distance as Determinants of Health. Health inequalities in developed nations, it is argued, are strongly influenced by citizens' interpretations of their standing in the social hierarchy. There are two mechanisms by which this occurs. At the individual level, the perception and experience of personal status in unequal societies lead to stress and poor health. Comparing their status, possessions, and other life circumstances with those of others, individuals experience feelings of shame, worthlessness, and envy that have psychobiological effects on health. These comparisons lead to attempts to alleviate such feelings through overspending, taking on additional employment that threatens health, and adopting health-threatening coping behaviour such as overeating and use of alcohol and tobacco. At the community level, widening and strengthening of hierarchy weakens social cohesion-a determinant of health. Individuals become more distrusting and suspicious of others, thereby weakening support for communal structures such as public education, health, and social programs. An exaggerated desire for tax reductions on the part of the public weakens public infrastructure. This approach directs attention to the psychosocial effects of public policies that weaken the social determinants of health

2. The Importance of a Life-Course Perspective

Traditional approaches to health and disease prevention have a contemporaneous emphasize on shifting biomedical risk indicators and changing unhealthy behaviors. In contrast, life-course approaches emphasize the accumulated effect on health of

experiences across the life span. Exposures to adverse economic and social conditions-that is, various social determinants of health-have an important cumulative effect on health. There are three health effects relevant to a life course perspective.

Latent effects: Represents biological or developmental, early life experiences that influence health later in life. Low birth weight, for instance, is a reliable predictor of incidence of adult-onset diabetes and cardiovascular disease in later life. Nutritional deprivation during childhood has lasting health effects.

Pathway effects: Comprise of the experiences that set individuals onto trajectories that influence health, well-being, and competence over the life course. As one example, children who enter school with delayed vocabulary are set upon a path that leads to lower educational expectations, poor employment prospects, and greater likelihood of illness and disease across the life span. Deprivation associated with poor-quality neighborhoods, schools, and housing sets children off on paths leading to poor health status.

Cumulative effects: Represent the accumulation of advantages or disadvantage over time that manifests itself in poor health. These involve the combination of latent and pathway effects. Adopting a life-course perspective directs attention to how social determinants of health operate at every level of development-early childhood, childhood, adolescence, and adulthood- both to immediately influence health and to provide the basis for health or illness later in life

3. The Importance of Policy Environment

The quality of many social determinants of health is determined by approaches to public policy. These public policy decisions are influenced by variety of political, economic and social forces. The organisation of health care is also a direct result of policy decisions made by the governments. These key issues are related to the distribution of societal resources. Policy issues influence the provision of adequate income, family-friendly labour policies, active employment policies involving training and support, provision of social safety nets, and the degree to which health and social services and other resources are available to the citizens. Interestingly, the

role of public policy in the quality of various social determinant of health is neglected by many population health researchers.

Intervention and policy development models for action on Social determinants of health

1. Stronks framework

This model highlights three phases of analysis for the implementation of interventions and policies on SDH. Phase one involves filling in the social background on health inequalities in the specific country or socioeconomic context. The impact of each social determinant on health varies within a given country according to different socioeconomic contexts therefore four intervention areas are identified: [4]

- The first and the most fundamental option is to reduce inequalities in the distribution of socioeconomic factors or *structural determinants*, like income and education. An example would be reducing the prevalence of poverty in the lowest socioeconomic groups.
- The second option relates to the specific or *intermediary determinants* that mediate the effect of socioeconomic position on health, such as smoking or working conditions. Interventions at this level will aim to change the distribution of such specific or intermediary determinants across socioeconomic groups, e.g. by reducing the number of smokers in lower socioeconomic groups, or improving the working conditions of people in lower status job.
- The third option addresses the *reverse effect of health status on socioeconomic position.* If bad health status leads to a worsening of people's socioeconomic position, inequalities in health might partly be diminished by preventing ill people from experiencing a fall in income, e.g., as a consequence of job loss. An example would be strategies to maintain people with chronic illness within the workforce.
- The fourth policy option concerns the delivery of *curative healthcare*. It becomes relevant only after people have fallen ill. One might offer people from lower socioeconomic positions extra healthcare or another type of

healthcare, in other to achieve the same effects as among people in higher socioeconomic positions.

Phase two of the analysis concerns effectiveness. Having identified the possible strategies to tackle health inequalities, one must form an idea of the effectiveness of those strategies. There is clearly a lack of evidence on the effectiveness of interventions to reduce inequities in health. Reviews have shown that many interventions have been undertaken, including health promotion and measures within the healthcare sector. However, only a few them have been evaluated with respect to their effect on the size of socioeconomic inequities in health.[59]

Phase three looks at political feasibility. The question is: can one actually implement a given intervention in daily practice? Could it be scaled up to constitute a realistic policy? Enabling factors, opportunities and potential barriers to a specific policy or intervention must be clearly identified: examples would include legal constraints, norms and values, financial barriers, etc. A certain intervention judged successful in one country might not fit with the cultural norms of other countries, such that its implementation there might not yield the predicted positive effects.

2. Whitehead and Dahlgren framework

The framework proposed by Whitehead and Dahlgren indicates four interrelated levels to which policies can be addressed: strengthening individuals; strengthening communities; improving access to essential facilities and services; encouraging macroeconomic and culture change.

The first level is strengthening individuals. Here, policy responses are aimed at supporting individuals in disadvantaged circumstances, using person-based strategies. These policies adopt the premise that building up a person's knowledge, motivation, competence or skills will enable them to alter their behavior in relation to personal risk factor, or to cope better with the stresses and strains imposed by external health hazard from other layers of influence. Examples would include stress management education for people working in monotonous conditions; counseling service for people who become unemployed to help prevent the associated decline in mental health; and supportive smoking cessation clinics for women with low incomes. The

potential effect of these policies would be more indirect - counseling services for people who are unemployed are not going to reduce the unemployment rate, but may ameliorate the worst health effects of unemployment and prevent further damage.

The second level is concerned with strengthening communities. This is focused on how people in disadvantaged communities can join together for mutual support and in so doing strengthen the whole community's defense against health hazards. The community development strategies at this level recognize the intrinsic strength that families, friends, voluntary organizations and communities can have, over and above the capabilities of individuals working in isolation. These policies recognize the importance to society of social cohesion, as well as the need to create conditions in deprived neighborhoods for communities' dynamics to work.

The third policy level focuses on improving access to essential facilities and services. These policies tackle the physical and psychosocial conditions in which people live and work, ensuring better access clean water, sanitation, adequate housing, safe and fulfilling employment, safe and nutritious, food supplies, essential health care, educational services and welfare in times of need. Such policies are normally the responsibility of separate sectors, often operating independently of each other but with the potential for cooperation. In this point is necessary program or action integrated.

The fourth policy level is aimed at encouraging macroeconomic or cultural changes to reduce poverty and the wider adverse effects of inequality on society. These include macroeconomic and labors market policies, the encouragement of cultural values promoting equal opportunities and environmental hazard control on a national and international scale. [4]

3. Diderichsen framework

Diderichsen model identifies four entry points or levels of action for interventions and policies: influencing social stratification; decreasing differential exposure to health-damaging factors; decreasing vulnerability; and preventing unequal consequences of ill health that can deepen social inequities. [4]

Decreasing social stratification itself- While social stratification is often seen as the responsibility of other policy sectors and not central to health policy per se, Diderichsen and colleagues argue that addressing stratification is in fact "the most critical area in terms of diminishing disparities in health". They propose two general types of policies in this entry point: first the promotion of policies that diminish social inequalities, e.g., labor market, education, and family welfare policies; second a systematic impact assessment of social and economic policies to mitigate their effects on social stratification.

Decreasing the specific exposure to health-damaging factors suffered by people in disadvantaged positions-In general, most health policies do not differentiate exposure or risk reduction strategies according to social position. Earlier anti-tobacco efforts constitute one illustration. Today there is increasing experience, however, with health policies aiming to combat inequities in health that target the specific exposures of people in disadvantaged positions, including aspects such as unhealthy housing, dangerous working conditions and nutritional deficiencies.

Lessening the vulnerability of disadvantaged people to the health-damaging conditions they face-An alternative way of thinking about modifying the effect of exposures is through the concept of differential vulnerability. Intervention in a single exposure may have no effect on the underlying vulnerability of the disadvantaged population. Reduced vulnerability may only be achieved when interacting exposures are diminished or relative social conditions improve significantly. An example would be the benefits of female education as one of the most effective means of mediating women's differential vulnerability.

Intervening through the health system to reduce the *unequal consequences of ill health* and prevent further socioeconomic degradation among disadvantaged people who become ill. Examples would include additional care and support to disadvantaged patients; additional resources for rehabilitation programmes to reduce the effects of illness on people's earning potential; and equitable health care financing.

4. Synthesis: key policy principles

Four policy principles essential from the perspective of the CSDH. The first underscores the need for responsiveness to the socio-political context of each country and region. This is a central element for the development of policies adapted to the real capabilities of developing countries and not shaped according to pre-determined recipes. The second is the principle of community participation in decision-making, underscoring as a central aspect of the CSDH the inclusion and participation of civil society. The third represents intersectoral action, implying not only policies and actions managed from within the health sector, but also the integration of interventions and actions by other sectors that have included contributing to health within their goals. Partner sectors will likely include education, transport and housing, among others. The fourth recalls the need to focus on effective interventions: action based on evidence, evidence for action. [4]

Modeling health determinants and the pathways to inequity

Dahlgren and Whitehead: layered influences

Dahlgren's and Whitehead's frequently cited model explains how social inequalities in health are the results of interactions between different levels of causal conditions, from the individual to communities to the level of national health policies. Individuals are at the centre, endowed with age, sex and genetic factors that undoubtedly influence their final health potential. Moving outward from the centre, the next layer is of personal behaviors and lifestyles. People in disadvantage circumstances tend to exhibit a higher prevalence of behavioral factors such as smoking and poor diet, and will also face greater financial barriers to choosing a healthier lifestyle. Social and community influences represent the next layer. These social interactions and peer pressures influence personal behaviors for better or worse. Indicators of community organization register fewer networks and support systems available to people towards the lower end of the social scale, compounded by the conditions prevalent in area of high deprivation, which have a fewer social services and amenities for community activity and weaker security arrangements. At the next level up, is the factors related to living and working conditions, food supplies and access to essential facilities and services. In this layer, poorer housing conditions, exposure to more dangerous or

stressful working conditions and poorer access to services create differential risks for the socially disadvantaged. Overarching all other levels are the economic, cultural and environmental conditions prevalent in society as a whole. These conditions, such as the country's economic state and labor market conditions, have a bearing on every other layer. The standard of living achieved in a society, for example, can influence an individual's choice of housing, work and social interactions, as well as eating and drinking habits. Similarly, cultural beliefs about the place of women in society or pervasive attitudes to minority ethnic communities can influence their standard of living and socioeconomic position. [4]

Diderichsen: social stratification and disease production

This model emphasizes how social contexts create social stratification and assign individuals to different social positions. People's social position determines their health opportunities. The process of assigning individuals to social positions is four dimnesional (I). The mechanisms involved are "those central engines of society that generate and distribute power, wealth and risk", for example the educational system, labour policies, gender norms and political institutions. Social stratification in turn engenders differential exposure to health-damaging conditions (II) and differential vulnerability (III), as well as differential consequences of ill health for more and less advantaged groups, shown as mechanism (IV). "Social consequences" refers to the impact a certain health event may have on an individual's or a family's socioeconomic circumstances. [4]

Mackenbach: selection and causation

Mackenbach's model emphasizes the mechanisms by which inequities in health are generated: selection vs. causation. The number "1" marks the selection processes represented by an effect of health problems at adult ages on adult socioeconomic position, and by an effect of health in childhood on both adult socioeconomic position and health problems at adult ages. The number "2" is the causation mechanism is represented by the three groups of risk factors which are intermediary between socioeconomic position and health problems (Lifestyle factors, structural/environmental factors, psychosocial stress-related factors). Childhood environment, cultural factors and psychological factors are included in the model,

which acknowledge their contribution to inequalities in health through both selection and causation. [4]

Brunner, Marmot and Wilkinson: multiple influences across the life-course

This model was originally developed to connect clinical (curative) and public health (preventive) perspectives on health. It was subsequently applied to the social process underlying health inequalities as a model of the social factors that both cause ill health and contribute to health inequalities. The model is included in the United Kingdom's Acheson report, introduced explicitly to illustrate how socioeconomic inequalities in health result from differential exposure to risk- environmental, psychological and behavioral- across the life course This model links social structure to health and disease via material, psychosocial and behavioral pathways. Genetic, early life and culture factors are further important influences on population health.

Synthesis

The first stage of synthetic model is the social and political context- (including political institutions and economic processes) giving rise to a set of unequal socioeconomic positions. Groups are stratified according to income levels, education, professional status, gender, race/ethnicity and other factors. The Socioeconomic position locates the underlying mechanisms of social stratification and the creation of social inequities. These socioeconomic stratification mechanisms can be described as *structural determinants* of health or as the social determinants of health inequities. These mechanisms configure the health opportunities of social groups based on their placement within hierarchies of power, prestige and access to resources.

Moving ahead these socioeconomic positions then translate into specific determinants of individual health status reflecting the individual's social location within the stratified system. Based on their respective social status, individuals experience differential exposure and vulnerability to health-compromising factors. The model explains that a person's socioeconomic position affects his/her health, but that this effect is not direct. Socioeconomic position influences health through more specific, intermediary determinants. Those intermediary factors include material conditions, such as working and housing conditions; psychosocial circumstances, such as

psychosocial stressors; and also behavioral factors, such as smoking. The model assumes that members of lower socioeconomic groups live figure in less favorable material circumstances than higher socioeconomic groups, and that people closer to the bottom of the social scale more frequently engage in health-damaging behaviors and less frequently in heath promoting behaviors than do the more privileged. A distinctive element of this model is its explicit incorporation of the health system. [4]

Towards Conceptualization on the social determinants of health

Among the scholars, Solar and Irwin [40] came up with a discussion paper 'Towards a conceptual framework for analysis and action on the social determinants of health' which dealt with drawing a schema whose main focus was on highlighting the mechanisms through which social determinants generates health inequalities, showing how the major determinants related to each other, providing a framework for evaluating which social determinants of health are most important to address, mapping out specific levels of intervention and policy entry points for action.

The paper points over some key issues whose understanding is quite essential in building the conceptual framework. Firstly, it is essential to figure out the distinction between the structural (e.g. income and education) and intermediate (e.g. living and working condition, population behaviour, food availability) determinants of health; secondly to understand and make explicit what is meant by the socio-political context (encompassing a broad set of structural, cultural and functional aspects of the social system which impacts on individual); thirdly to take account of the actions that need to be taken at different levels (macro, meso, micro) in order that inequalities in health can be tackled (i.e. to alter the configuration of underlying social stratification , and those policies and interventions that target intermediate health determinants.

To tackle these stated issues the scholars have considered certain intellectual principles such as a commitment to the value of equity, taking an evidence based approach, methods and epistemology, gradients and gaps, causes: determinants and outcomes, social structure, social dynamics, explicating bias, into action: translating evidence for policy and practice. A review of these specific principles explains the understated, which is as follows:

A commitment to the value of equity

In the context of widening global health inequalities, the commission ensures a commitment of the value of equity as a matter of right and justice as the factors that corresponds to health inequalities are social and they are the products of human agency they are also potentially changeable through human action. But this is complex in nature as upholding one person's rights is to interfere with some other's utilities- and vice versa. To assert the right to health of a group in a society, who experience poor health by virtue of social arrangement, is not only to appeal to argument about social justice, but also to make the case for taking some thing away from other individuals or other social groups who enjoy good health as a consequence of those same social arrangements. Thus the right to health and its equitable distribution comes at the cost of usually borne by others. This social and moral tenants does not receives universal acceptance. The logical fall out from the above notes points out that investing on social determinants of health such as on income, employment, environment, gender etc gives an opportunity to reduce health inequalities.

The paper' The Development of the evidence base about the social determinants of health' (2006) by the measurement and evidence knowledge network draws a framework for describing the causal pathways to health inequity where a strong distinction is being made on the usage of the terms inequity and inequality. In the opinion of Whitehead, health inequality is the measurable differences in health experience and health outcomes between different population groups- according to socio-economic status, geographical area, age, disability, gender or ethnic group'. Inequality is about objective differences between groups and individuals measurable by mortality and morbidity. On the other hand he defines 'health inequity' as differences in opportunity for different population groups which result in for example, unequal life chances, access to health services, nutritious food, adequate housing etc. These differences may be measurable; they are also judged to be unfair and unjust. Thus directing attention over inequities than inequalities is more rational as it offers a ground for immediate action where rectifications are possible. Thus the commitment to the value of equity is to match out ways in overcoming the social determinants causing health inequity

Taking an evidence based approach

The approach aims to find best possible evidence about social determinants of health, which will offer an effective basis for building up effective understanding and strategies for action on reducing health inequities. However gaps in the evidences can provide strength to some unimportant part and leaving the others. Thus the strength of any evidence should not become the basis for any policy recommendation, as it may be possible that sometimes for very important issues evidences are not there or for some unimportant task good evidences exist. So in the process of policy recommendation one needs to carefully define whether the evidences are good, poor, or ineffective. Also the policy making should just not depend on the evidences but should also to be sensitive to local cultural context

Methods and epistemology

All disciplines have something to contribute to the understanding of the social determinants of health. Besides the rich and diverse disciplinary subject matter the subject matter of the social determinants of health has been dealt and interpreted by different people in their own ways leading to methodological complexities, ideological and political biases, differences in understanding and interpretation of diverse disciplines etc. To answer to the 'web of complexities' a pluralistic approach is needed that aims to imbibe a wide range of methodologies to assess the success of interventions and policies which aim to address the social determinants of health. Further attention has been laid on the ways the qualitative evidences through the usage of two suggested models i.e., enhancement model and epistemological model contributes to the evidence base for policymaking[2].

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[2] The enhancement model assumes that qualitative research adds something 'extra' to the findings of quantitative research-by generating hypotheses to be tested, by helping to construct more sophisticated measures of social phenomena, and by explaining unexpected finding generated by the quantitative research.
The epistemological model views qualitative evidence as making an equal and parallel contribution to the evidence base through:(a) focussing on questions that other approaches cannot reach; (b) increasing understanding by adding conceptual and theoretical depth to knowledge; and (c) shifting the balance of power between researcher and the researched.

Gradients and gaps

Conventionally a health inequality is described in three different ways: health disadvantage, health gaps and health gradients. Health disadvantage focuses on the differences, acknowledging that there are differences between different segments of the population, or between societies. The health gap approach focuses on differences between the worst off and everybody else, often assuming that those who are not the worst off enjoy uniformly good health.

The health gradient approach relates to the health differences across the whole spectrum of the population acknowledging a systematically patterned gradient in health inequalities. For policy level intervention focusing on reducing health gap conceptually means improving the health of the poor fist but this is limiting as it doesn't caters to the entire population .on the other hand the health gradient approach explains that health inequalities impact the entire social hierarchy from top to the bottom but mere action on uplifting the bottom may not reduce the inequalities in the entire social hierarchy. Thus reduction of health inequalities and social determinants of health the policy level intervention requires attention on the whole gradient of the social hierarchy.

Causes: determinants and outcomes

Where health equity is the goal, the principle stands for development of model of causes where the evidences should be interrogated to determine what phenomena are attributed to other phenomena to determine patterns which point to strong causal or associated relationship. Further level of analysis will be required to levy to the multi factorial explanations adhering to examining the dynamic plausibility of evidence and the policy level interventions at the individual, organisation, community level etc.

Social structure

Ethnicity, gender, sexuality, age, area, community and religion etc, all are the dimensions of inequalities. The relationship aspect of each variable within itself and its interrelationship with each other is not effectively documented in the literature of the social determinants of health. But these variables in one way or the other leads to

differences the life chances, which are marked by the social differences. Therefore the key principle is to acknowledge and identify the different axes of social difference and that these dimensions overlap. The model of social structure focuses on examining the sensitivity of the evidence to the relations between groups and individuals, social variations and differences in the population.

Social dynamics

Highlights that the social systems and the sub-system which make up societies are not static objects, they are constantly changing and therefore the relationships which gives rise to the outcomes of health inequalities and differences are themselves also changing in terms of their force and in terms of their salience at any given moment.

Explicating bias

The impression of any society is a reflection of its people. The knowledge that prevails in our society is socially constructed and not value free. Knowledge which holds the most vital tool for the tackling of health inequalities requires that it should be acknowledged that because knowledge is socially constructed, bias will be inherent part of any knowledge based activity. Thus the overarching goal in reaching understanding a phenomenon is to make these values explicit that is to uncover bias and manage it.

Into action: translating evidence for policy and practice

This principle explains the prime necessity for getting accountable to the different forms of data and evidences in validating various public health interventions. But besides evidence there are other gradients existing at micro-macro level such as political will, transferability of evidence into appropriate social strategies, and scalability into different context etc which when ignored leaves the canvas of the society half painted without a factual description. [9]

Moving ahead, the draft discussion paper of the Commission on Social determinants of health[4] proposes a conceptual framework for the CSDH, which gives importance to the key issues such as (a) structural vs. intermediate determinants; (b) what is

meant by socio-political context; and (c) levels at which inequities in health can be tackled, whose mention is made below.

Structural and intermediate social determinants

Structural determinants are those that generate social stratification. These include the traditional factors of income and education. Today it is also vital to recognize gender, ethnicity and sexuality as social stratifiers. A central point is the aspect of social cohesion related to social capital. *Intermediate* determinants flow from the configuration of underlying social stratification and, in turn, determine differences in exposure and vulnerability to health compromising conditions: living conditions, working conditions, the availability of food, population behaviours and barriers to adopting healthy lifestyles. Relevant population groupings for analysis and action on intermediate determinants can be defined in various ways like for example (1) by greater vulnerability (children) and (2) by geography (slum dwellers). The *health system* itself should also be understood as an intermediate determinant. The role of the health system becomes particularly relevant through the issue of access, which incorporates differences in exposure and vulnerability. This is closely related to models for the organization of personal and non-personal health service delivery. The health system can directly address differences in exposure and vulnerability not only by improving equitable access to care, but also in the promotion of intersectoral action to improve health status.

A further aspect of great importance is the role the health system plays in mediating the differential consequences of illness in people's lives. The health system is capable of ensuring that health problems do not lead to a further deterioration of people's social status and of facilitating sick people's social reintegration.

Socio-political context

This framework differs from some others in the importance attributed to the *socio-political context*. This is a deliberately broad term that refers to the spectrum of factors in society that cannot be directly measured at the individual level. 'Context' therefore encompasses a broad set of structural, cultural and functional aspects of a social system whose impact on individuals tends to elude quantification but which

exert a powerful formative influence on patterns of social stratification and thus on people's health opportunities.

Within the context in this sense will be found those social and political mechanisms that generate, configure and maintain social hierarchies, such as the labour market, the educational system and political institutions. The most relevant contextual factors, i.e., those that play the greatest role in generating social inequalities, may differ considerably from one country to another. For example, in some countries religion will be a decisive factor, in others less so. Contextual differences militate against "one-size-fits-all" policy approaches to address SDH. Since the mechanisms producing social stratification will be different in different settings, certain interventions or policies are likely to be effective for a given socio-political context but not for others.

Meanwhile, the timing of interventions with respect to local processes must be considered, as well as for example partnerships, availability of resources, and how the intervention and/or policy under discussion is conceptualized and understood by the participants at national and local levels. The specificities required for an appropriate understanding of context may vary with the specific health determinants on which one wishes to act. In general, the construction/mapping of context should include at least four points: (1) political systems and processes, including definition of needs, existing public policies on determinants, patterns of discrimination, civil society participation, and accountability/transparence in public administration; (2) macroeconomic policy, including fiscal, monetary, balance of payments and trade policies; (3) policies affecting factors such as labor, land and housing distribution; (4) public policy in areas such as education, social welfare, medical care, water and sanitation.

To set feasible policy goals, these general considerations should be supplemented with another, more health-specific element of contextual analysis, namely an assessment of the social value placed on health. The value placed on health and the degree to which health is seen as a collective social concern differs greatly across regional and national contexts.

Levels for policy action on SDH

Drawing on Diderichsen et al., a typology or mapping of entry points for policy action on SDH identifies the following major options, marked by darkly shaded boxes within the framework: *social stratification; differential exposure/differential vulnerability; and differential consequences.*

Selection of specific themes for the CSDH

Clearly, the CSDH cannot hope to address the full range of social determinants Reasoned choices must be made regarding specific topics on which the Commission will focus its knowledge-building activities, policy recommendations and advocacy.

The selection of recommended areas of work for the Commission has been strongly shaped by a concern with addressing "orphan" areas, i.e., important areas relatively neglected by previous research and heretofore insufficiently addressed by interventions.

The draft paper presents the following aspects that informed the development of a proposed list of foci for the Commission:

- Themes that impact on the gradient of health inequity, that is, those areas that are closely related to the construction and maintenance of social stratification.
- Themes that incorporate a life course perspective, given the powerful impact of such factors on health inequities, linked to the possibility to address, through a life-course approach, groups facing unusually high health vulnerability.
- Themes particularly closely related to the health system and thus to the special responsibilities and opportunities of the health sector in tackling inequities in health. All themes selected should reflect policy areas in which the health sector can realistically expect to exert influence, favoring the implementation of SDH interventions and scaling up towards more comprehensive equity-oriented policies.
- Themes reflecting fast-growing health problems predominant in developing countries.

- Themes reflecting a strong concern in *all* countries, implying consequences both for developing and developed countries.
- Themes that would engage groups experiencing high exposure and vulnerability to the social determinants of health inequities.
- Themes that are already widely recognized as important SDH, such that from the start the Commission's work could focus, not on trying to convince partners of the theme's relevance, but instead on seeking and promoting effective interventions and policies to respond to the problem.

Focal areas identified as Social determinants

Gender and social exclusion

Gender and social exclusion have been identified as key structural determinants. They point to social forces that directly shape health inequities. As such, they are of central relevance for the Commission. At the same time, gender and social exclusion constitute structural determinants upon which the health system can actually intervene (directly or indirectly) and which can be incorporated into health sector programming, including but not limited to the delivery of clinical health services. [4]

Including a life-course perspective: early child development

A life-course approach focuses on the different elements of the experience of health, from the moment of conception through childhood and adolescence to adulthood and old age. The life-course model describes the causal pathways of health inequalities and links these to broad social and economic factors as well as to studies of child development. It reveals critical points in the transitions from infancy through childhood into adult life, where an individual may move in the direction of advantages or disadvantages in health. This approach shows that mainstream policies in health, education and social welfare do not always provide enough protection for people at these crucial turning points. The patterns are not uniform, varying by social class but also by ethnicity. Social circumstances influence health at all ages, but have particularly strong effects *in utero*, in infancy and in childhood. For many people, physical, emotional and cognitive development patterns are effectively fixed in childhood, with beneficial or harmful effects on subsequent health.

Such findings suggest that, to develop robust strategies for promoting health equity through social determinants policy, the CSDH requires a specific focus on early child development.

Focus on areas closely connected with health systems

The various models that have tried to explain the functioning and impact of SDH have not made sufficiently explicit the role of the health system as a social determinant. In some instances, the relevance of the health system has been seen as limited to its role in giving (or denying) access to preventive and curative services to vulnerable and exposed groups, particularly with regard to financial barriers. On the other hand, intersectoral action for health has at times been promoted as a major axis of health policy, with greater or less emphasis and varying degrees of success. Overall, the orientation of health systems policy has rarely included intervention on SDH. There is ample evidence that SDH dramatically impact health and substantially constrain the health opportunities of vulnerable groups; yet the direct, independent actions that the health system can undertake with respect to SDH are limited. What, then, should health systems do - particularly with regard to SDH and health inequities? Little guidance is currently available on these questions. This gap in knowledge and leadership represents a space in which the Commission to make a significant contribution. [4]

Focus on vulnerability and high exposure: employment conditions

Human production is the basis for both welfare and health. There is a clear correlation between gross national product (GNP), income level, living standards and average life expectancy when nations are compared, but also notable differences in health and life expectancy between socioeconomic strata and occupational groups within nations. Differences in working conditions and work-related health status have been reported for centuries. The spur for improvement has been the often appalling working conditions, especially for manual workers, who are likely to be poorly educated and have low incomes. Even when the health of manual workers improves, health inequalities do not necessarily diminish, as occupational groups with a better education also benefit from welfare improvements and increased economic resources.

For the CSDH employment conditions should include both internal factors (workplace) and external factors (social, economic, governance structure and legal context) related to employment. [4]

Focus on fast-growing problems: urban settlements

Part of the Commission's opportunity to add value will involve engaging themes whose impact on global health is destined to expand rapidly in the coming years, and which have not yet registered sufficiently with the health community. The theme of urban settlements and in particular the health challenges of slum dwellers constitute a vast and growing challenge for developing countries. Interventions in this area imply the integration of actions simultaneously addressing a range of health determinants. [4]

Globalization

Globalization can be regarded as a social macro-determinant. Global processes exert a powerful impact at all levels of the social production of health: on the evolution of sociopolitical contexts in countries; on social stratification; and on the configuration of numerous specific determinants (e.g., working conditions, food availability). Using its health equity framework, the CSDH will identify policies that can foster a more equitable distribution of globalization's benefits and a fairer portioning-out of opportunities for human flourishing. [4]

About the knowledge networks of the commission

The commission has nine knowledge networks among which six knowledge networks focus on themed areas such as early childhood development, social exclusion, globalization, health system, unemployment, urban setting, the other two women and gender equity and measurement and evidence knowledge networks are the cross cutting knowledge networks which also serve as resource for other networks. An organized hub or an organized co-hub manages each knowledge network. There are minimum 10 to 12 members to each knowledge network with experience in science, practioners, policy, senior decision makers, and representative from civil society organizations, nongovernmental organizations, global institutes etc.

The purpose of the knowledge networks is to synthesize knowledge to inform commission of opportunities to improve action on social determinants of health.

A brief sketch over the work of the various networks

1. *Early childhood development knowledge network*

The agony of the infant and child deaths in poor countries is that the majority is preventable. Child mortality shows a clear social gradient. Apart from child survival quality of child development is too essential as the seeds for adult health are sown in early childhood but over 200 million children worldwide are not reaching their development potential this is based on defining poverty at $2 a day. Thus it is essential to prioritize early child interventions. [54]

2. *Women and gender equity knowledge network*

Key work of the women and gender equity network is to focus on mechanisms, processes and actions that can be taken to reduce gender-based inequities in health by examining five areas: factors affecting social stratification and how to improve women's status relative to men, differential exposure to health-damaging factors, differential vulnerabilities leading to inequitable health outcomes.

3. *Globalization knowledge network*

The scope is to examine how globalization's dynamics and processes affect health outcomes. Among the aspects of globalization in focus are trade liberalization, integration of production of goods, consumption and lifestyle patterns, household level income. The uneven distribution of globalization's gains and losses and the impact it has on inequities will be analyzed to inform policies aimed at mitigating the actual and potential harmful effects of globalization on health.

4. *Employment knowledge network*

Works to develop the promotion of knowledge gathering and action on social determinants of health concerned with the importance of work and employment conditions in the structure of our contemporary market oriented society. It will help to

develop models and measures to clarify how different types of jobs, conditions of underemployment, social discrimination at workplace and the threat of becoming unemployed affect workers health. It will identify pathways by which employment and working conditions affect the health of workers and their families. The goal is to show how such knowledge can be translate into labour and health policy measures that can improve the health of workers and their families by strengthening fair access to employment and other dimensions of decent work.

5. *Urban setting knowledge network*

WHO Centre for Health Development in Kobe, Japan, was selected as the hub to manage the Knowledge Network on Urban Settings of the WHO Commission on Social Determinants of Health. It focuses on synthesizing global knowledge on social determinants of health and urbanization. The focus will be on urbañizations, particularly broad policy interventions related to "healthy urbanization", and will closely examine slum upgrading as an entry point among other possible interventions. The upstream determinants of healthy urbanization will include: stimulation of job creation, land tenure and land use policy, transportation, sustainable urban development, social protection, settlement policies and strategies, community empowerment, vulnerability reduction and better security among others.

6. *Health system knowledge network*

The way health systems are designed, operate and financed act as a powerful determinant of health. Evidence on the effectiveness of different models for health systems to improve health equity outcomes will be reviewed. In an effort to gather and subsequently mainstream knowledge and action on how to overcome social barriers to health, the focus will be on innovative approaches that effectively incorporate action on social determinants of health. The recommendations will be highly relevant for countries with tight resources.

7. *Measurement and evidence knowledge network*

This knowledge network works to develop methodologies and tools for measuring the causes, pathways and health outcomes of policy intervention to tackle social

determinants of health and health inequities. The task includes development of measurement tools, guidelines for designing evaluations, selection of indicators and variables, proposing approaches for using the evidence on integrating the social determinants of health and health equity goals into national and global policy planning. it sets forth a cross cutting theme which will serve also as a resource for other specific themes for evaluation of CSDH as a whole.

8. *Social Exclusion knowledge network*

Focal area of work is to examine the relational processes that lead to exclusion of particular groups of people from engaging in community and social life. These processes may operate at macro and micro levels, examining the linkages between social exclusion and proximal concepts such as social capital, networks and integration.

9. *Priority Public Health Conditions knowledge network*

This Knowledge Network has been established to identify barriers and facilitators of access to health care. It aims to introduce pro-equity interventions within health programmes, particularly in low and middle-income countries. The PPHC-KN is different from the other knowledge networks in three distinct ways: Its analysis evolves from specific public health conditions rather than from the determinants. Its organizational hub and most members are located in WHO where the hubs/co hubs for other KNs and most members are in institutions outside WHO. It has started later than the other KNs.

Although the Commission has outlined its essential thematic areas of work, it is important to reflect upon the analytical framework of health (in) inequalities and equities, which has been done in the third chapter.

Chapter 3
Inequalities and Inequities: Developing an Analytical Framework

Researchers and policymakers worldwide have demonstrated longstanding interest in health inequality. Just as in any other scientific pursuit, some of them may simply be interested in describing how health is distributed. Others may be interested in understanding the mechanism of health inequality so they can improve population health. Health distribution is a way in which health is spread among the unit of analysis in the population. Health equality is the health distribution in which health is spread equally to every unit of analysis in the population, and health inequality is all health distributions that are otherwise.

Reducing health inequality is the same as increasing health equality. Kunst and Mackenbach use the following working definition of health inequalities: "Differences in the prevalence or incidence of health problems between individual people of higher and lower socio-economic status". It should be emphasized that although the definition refers to individuals, the crucial characteristic is their membership of a socio economic group. Whilst differences between individuals may well be interesting in themselves, they are only meaningful in terms of inequalities or inequities if those differences are linked to socio-economic status or some other dimension of differentiation (e.g. ethnicity or religion). In the recent times confusion over the terms health equality and health equity exists, due to which these terms are often used interchangeably without knowing the differences. [11]

Equality and inequality are dimensional terms. They are generic measurable concepts descriptively informing the differences not going into the moral dimensions. On the other hand health inequity and equity are normative terms following value judgments based on theories of justice, theories of society, based on reasoning underlying the genesis of health inequities. It is a political concept expressing moral commitment to social justice. Recognizing health inequity involves normative judgment, science alone cannot determine which inequalities are also inequities nor what proportion of an observed inequality is unjust or unfair [10]

The beginning of interest in Equity in health is difficult to pinpoint. Certainly, the issue of social disparities in health has a long history, dating back in modern history at least to the writings of Frederick Engels, who, in 1845 in *The Condition of the Working Class in England*, asked, "How is it possible . . . for the lower class to be healthy and long-lived? What else can be expected than an excessive mortality, an unbroken series of epidemics, a progressive deterioration in the physique of the working population?" Impetus to the policy relevance of social determinants of health was provided by the Black report. The report, titled *Inequalities in Health*, was initiated by the Labour government and published in 1980 in the United Kingdom; it described and analyzed the existing social inequalities and proposed government actions to overcome them.

Usage of the term Equity in health can be dated back to 1983 by Gavin Mooney who addressed the ethical dimensions of the inequalities, using the term "equity" in his discussion of implications for health service resource allocation of equal expenditure per capita, equal resources per capita, equal resources for equal needs, equal opportunity of access for equal needs, equal utilization for equal needs, equal extent of meeting priorities, and equal health outcomes. Following this, the Health sciences researchers have increasingly defined Equity in health in different ways.

For example *Margaret Whitehead* refers as "differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust," assumes that "unfairness" and "unjustness" can be measured. However with an increasing focus on equity in health (rather than on health services), notions of fairness became problematic, as health has no counterpart in anything measurable either in individuals or populations, and fairness in health may differ widely depending on cultural contexts. As a result, the International *Society for Equity in Health* viewed Equity in health is the absence of systematic and potentially remediable differences in one or more aspects of health across socially, demographically, or geographically defined populations or population subgroups. (Conversely, inequity in health is the presence of such differences).

The definition is both consistent with currently accepted notions of social justice (fairness) and stated in terms that facilitate measurement and, thereby, monitoring. It implicitly incorporates the concept of fairness (by speaking to systematic differences);

it meets *Amartya Sen's (1999)* notions of people's capacity to flourish as human beings (since it addresses "one or more aspects of health"); and it meets John Rawls's (1971) notion that it does not require the sacrifice of the worst-off (by implicitly comparing one population group with another and including potential remediability). To this *Paula Braveman (2005)* offers a narrow view as "particular type of difference in health that can be shaped by policies: . . . a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups that have experienced social disadvantage or discrimination in the past) systematically experience worse health or greater health risks than other social groups."

Health sciences researchers have increasingly distinguished health inequity from health inequality. However, confusion over the terminology still persists, especially when researchers with different disciplinary training assemble to collaborate. In addition, words that seem to suggest similar meanings, for example, difference, disparity, heterogeneity, and injustice, aggravate the confusion[11] To cite clarification over health inequalities and inequities, the WHO defined inequity as "differences [in health status], which are unnecessary and avoidable, but in addition, are considered unfair and unjust."

Of the determinants of health differentials between population groups or individuals, those related to biological variation and freely chosen health-damaging behavior are not likely to be considered inequitable because they are either unavoidable or "fair". These differences are referred to as "health inequalities". Differentials due to health damaging behaviors not based on informed choices, exposure to unhealthy living and working conditions, or inadequate access to health and social services are more likely to be judged avoidable and unfair and thus constitute health inequities. Equity in health "is concerned with creating equal opportunities for health, and with bringing health differentials down to the lowest levels possible."[13]

Whitehead and Dahlgren defined health inequities as health inequalities that are avoidable and unfair. This reflects that some health inequalities are of moral concern because of the value we place on health. This moral concern distinguishes health inequality as a topic of both policy and ethical inquiry. The moral or ethical dimension of health inequality is generally termed health inequity, although no consensus on a precise definition of health inequity exists. Thus Equity is a normative

concept linked to social justice that can be defined in many, sometimes-contradictory ways. For example definitions of equity include equal access to healthcare for equal need, equal utilisation for equal need, and equity in final health outcome. Unlike equity, inequality is an empirical concept that can be measured in many ways, linked for instance to income and wealth, gender, ethnicity or geographical location. Actual measures of health status may be assessed objectively or through self-assessment, which might produce very different values. Importantly, not all inequalities in health status may be inequitable as they may occur as a result of individuals making fully informed choices about the way in which they live, or be due to unavoidable biological factors. [49]

According to Whitehead, health inequality refers to the measurable differences in health experience and health outcomes between different population groups according to socio-economic status, geographical area, employment status age, disability, gender or ethnic group'. Inequality is about objective differences between groups individuals measurable by mortality and morbidity. Whitehead defines 'health inequity' as differences in opportunity for different population groups which result in for example, unequal life chances, access to health services, nutritious food, adequate housing etc. these differences may be measurable; they are also judged to be unfair and unjust.

Seven principles of action for addressing global health inequities proposed by the World Health Organisation include: 1) improving living and working conditions; 2) enabling healthier lifestyles; 3) decentralizing power and decision-making and encouraging citizen participation in policy-making; 4) conducting health impact assessments of multisectoral actions; 5) keeping equity on the global health agenda; 6) assuring that health services are of high quality and accessible to all; and 7) basing equity policies on appropriate research, monitoring and evaluation(Whitehead, M.: 1992). [13]

Approaches to tackle health inequality

Tackling health inequalities variously means improving the health of poor groups, reducing the health differences between poorer and better-off groups, and lifting levels of health across the socioeconomic hierarchy closer to those at the top. There

are conventionally three different ways in which health inequities are described: health disadvantage, health gaps and health gradients. [15]

Health disadvantage simply focuses on differences, acknowledging that there are differences between distinct segments of the population, or between societies. Health inequality is the link between social disadvantage and poor health. The health inequality goal is therefore to achieve positive changes in the poorest groups: in their social conditions and life chances, in their risk behaviours and, as the longer-term outcome, in their health. Defining health inequalities as the poor health of poor people has important policy advantages: It directs attention to the groups and communities who have lost out in the general rise in living standards and life expectancy. It sets clear goals and clear criteria for monitoring and evaluation. It aligns health equity policies with policies to promote social inclusion and to regenerate communities, steering them towards interventions to improve the life chances and health opportunities of poor groups.

The targeted groups can be defined in spatial terms, using area-based measures of disadvantage, by their household circumstances (for example, unskilled manual head of households, claimant families) or through markers of individual vulnerability, like being a care leaver or a teenage mother. While offering policy advantages, defining health inequalities as the health penalties of poverty has limitations. It conflates inequality and disadvantage: it turns socioeconomic inequality from a structure, which impacts on everyone into a condition to which only those at the bottom are exposed. This has two important implications: 'The link between poverty and ill health' and 'the health of the worst off' 'The disparity in health status between rich and poor' and 'the health gap between the worst off in society and the better off' 'Exists between social classes' 'right across the spectrum of advantage and disadvantage'.

The health gaps approach focuses on the differences between the worst off and everybody else, often assuming that those who are not the worst off enjoy uniformly good health. Narrowing health gaps means 'raising the health of the poorest, fastest'. It requires both improving the health of the poorest and doing so at a rate which outstrips that of the wider population. Again, it is an important policy goal:• It focuses attention on the fact that overall gains in health have been at the cost of persisting and widening inequalities between socioeconomic groups and areas.• It facilitates target

setting to close the health gap between disadvantaged groups and the population as a whole. It provides clear criteria for monitoring and evaluation. However, focusing on health gaps can limit the policy vision. The problem and the policy response are again confined to a small proportion of the populations as '*the penalties of inequalities in health affect the whole social hierarchy and usually increase from the bottom to the top. Thus, if policies only address those at the bottom of the social hierarchy, inequalities in health will still exist.*' Thus to resolve the stated limitation of the two approaches, the health gradient offers a solution.

The health gradient approach describes the fact that health improves at each step up the socioeconomic ladder. There are gradients in disability and chronic illness self-rated health and psychological wellbeing, and life expectancy and premature mortality – as well as in most major causes of death, such as coronary heart disease and lung cancer. There are also marked gradients with increasing levels of area deprivation in mortality from these major causes. The health gradient approach believes that relates to the health differences across the whole spectrum of the population, acknowledging a systematically patterned gradient in health inequities.

The founding principle of the World Health Organization is that the enjoyment of the highest attainable standard of health is a fundamental human right, and should be within reach of all 'without distinction for race, religion, political belief, economic or social condition'. As this implies, the standards of health enjoyed by the best-off should be attainable by all. It is a way of representing health inequalities that makes clear that the costs are not only borne by those at the bottom. A focus on socioeconomic differentials rather than on social disadvantages widens the frame of health inequality policy: It is an inclusive goal: improving the poor health of poor groups and narrowing health gaps are necessary but not sufficient to level up health across socioeconomic groups. It means that the three policy objectives can and should be pursued in tandem. Tackling health gradients is in line with international health policy. The commission on social determinant of health recommend using the gradient approach because it allows for a focus on all members of society and recognizes the importance of considering and taking a societal wide approach to the issue.

State of affairs on Social determinants of health in different countries

Before the creation of the Commission on the Social determinants of health, the goal tackling inequalities in health has been an overarching goal of the public health policies for most of the countries. As most countries have ambitious goals for reducing inequalities in health: the United States goes so far as to set the goal of eradicating all inequalities in health by 2010. Other countries have goals to reduce the gap in health status between specified groups by amounts ranging from 10% to 50%. There are major differences in policy approaches to health inequalities. Two countries, Sweden and Northern Ireland, have structured their overall public health policy to tackle the underlying determinants of inequalities in health. England is the only country with a separate comprehensive policy on inequalities in health. New Zealand prescribes a framework to ensure that inequalities in health are tackled systematically across all health policies. Other countries address inequalities in health in their overall public health policy and in policies on specific topics.

A description of the different countries efforts in reducing health inequalities can be traced as early as 1986 with Finland's *Health for All Programme, aimed* to reduce disparities between population groups. *Finland*'s public health strategy has a total of eight public health targets. The final one is "to reduce inequality and increase the welfare and relative status of those population groups in the weakest position". The objective is to reduce mortality differentials by gender, education and occupation by 20% by 2015.[16]

The *United States' Healthy People 2010* include a section on disparities in health in all 28 of its focus areas. These sections give details on where the disparities lie within each topic area. The policy, however, does not provide a strategy on how inequalities in health should be tackled within the focus areas. One of the goals of Healthy People 2010 is ''to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation''(1). The U.S. Department of Health and Human Services Strategic Plan includes a goal to eliminate disparities in health care (2) and Congress mandated an annual National Healthcare Disparities Report (NHDR) (3). States have also adopted the Healthy People 2010 goal to eliminate disparities for selected indicators of health (4). Each of these initiatives entails an

obligation to measure disparities in health and to monitor trends in disparities. [16]

Alongside this, *England* has set national health inequalities targets in two areas: infant mortality and life expectancy. The targets aim to reduce the gaps in: infant mortality by at least 10% by 2010 between manual groups and the population as a whole; life expectancy by at least 10% by 2010 between the 20% of areas with the lowest life expectancy and the population as a whole. England is the only country with a comprehensive stand-alone policy on reducing inequalities in health.[16] The strategy has been developing since 1997 when the new Labour Government came into power. Work began with the commissioning of the *Acheson Report* in 1997. This Report confirmed that inequalities in health were increasing and made many recommendations for action. A *Programme for Action* was subsequently published in 2003 following a public consultation and a Treasury led *Cross-Cutting Review* on inequalities in health. The *Cross-Cutting Review* recommended that tackling health inequalities should be incorporated into priority programmes. It identified five areas and named the government departments required to take the lead:

1. *Breaking the cycle of health inequalities:* Examples of suggested actions are: to reduce poverty through measures in the tax and benefit system; to improve educational attainment among disadvantaged children; to reduce teenage pregnancy and improve antenatal, maternal and child health services for disadvantaged and minority ethnic groups; and to promote healthy schools, particularly in disadvantaged areas.
2. *Tackling the major killers:* Promoting smoking cessation; improving screening; improving nutrition; increasing physical activity; and reducing accidents, particularly among disadvantaged groups, are identified as key areas for action.
3. *Improving access to public services and facilities:* Examples include: ensuring services are accessible to all, taking into account cultural and language barriers; improving primary care services in underserved inner city or rural areas; improving access to affordable food; and improving accessibility of disadvantaged groups to core facilities.
4. *Strengthening disadvantaged communities* :Neighbourhood renewal of deprived areas, including action on work and enterprise, crime, education,

health and housing; promoting environments where people feel safe to go out; and improving housing conditions are included as areas for action.

5. *Supporting targeted interventions for specific groups:* Targeted interventions include ensuring that services can meet the complex needs of vulnerable people such as minority ethnic groups, older people, homeless people, prisoners, refugees and asylum seekers and people with long-term medical or mental health problems.

The *Cross-Cutting Review*, like the *Acheson Report* before it, concluded that in order to achieve the targets set, action would be required across government. *Tackling Health Inequalities. The Programme for Action*[48], is therefore backed by 12 government departments. The *Programme* presents a strategy on targeting resources and actions along four themes: supporting families, mothers and children; engaging communities and individuals; preventing illness and providing effective treatment and care; assessing the underlying determinants of health. The themes are underpinned by five principles: preventing health inequalities becoming worse by reducing exposure to risks and addressing the underlying causes of ill-health; working through the mainstream by making services more responsive to the needs of disadvantaged populations; targeting specific interventions through new ways of meeting need, particularly in areas resistant to change; supporting action from the centre by clear policies that are effectively managed; delivering at local level and meeting national standards through diversity of provision.

The *Irish* health strategy, *Quality and Fairness*, gave four targets for 2007. These were developed to reflect the overall goal of the *National Anti-Poverty Strategy* that is to eliminate the impact of deprivation and disadvantage on health status. Ireland seeked a 10% reduction in the gap between groups: the gap in premature mortality between the lowest and highest socioeconomic groups be reduced by at least 10% for circulatory disease, cancers, injuries and poisoning by 2007; the gap in life expectancy between the traveling community and the whole population be reduced by at least 10% by 2007; the gap in low birth weight rates between children from the lowest and highest socioeconomic groups should be reduced by 10% from the current level by 2007. *Northern Ireland's* goal is to reduce inequalities in health between geographic areas, socioeconomic groups and minority groups. This is supported by

two ambitious targets: to reduce the gap in life expectancy by 50% for those living in the 20% most deprived electoral wards and the average life expectancy;to reduce the gap in the proportion of people with long-standing illness between those in the lowest and highest socioeconomic groups by 20% between 2000 and 2010.[16]

Scotland's recently published spending review reveals the Scottish Executive's new target to reduce inequalities in health. Within the area of *Health and Community Care* the first objective is "to reduce the health gap between people living in the most affluent and most deprived communities". The target set is "to reduce health inequalities by increasing the rate of improvement across a range of indicators for the most deprived communities by 15%, by 2008". [16]

Denmark's Programme on Public Health and Health Promotion aims "to reduce social inequality in health to the extent possible above all by strengthening efforts to improve health for the most disadvantaged groups". Thus, actions in the 15 areas identified will be targeted towards the most disadvantaged. The *Programme* therefore calls for the monitoring of morbidity and mortality in various social groups for the duration of the *Programme* period. Denmark's more recent strategy, *Healthy throughout Life,*, endorses the Government's commitment to tackling inequalities in health. It states that the Government believes that social equity in health is one of the fundamental values of a welfare society. The *Finnish Programme reports* that in implementing its public health targets one aim will be to reduce inequality and increase the welfare and relative status of those in the weakest position. [16]

New Zealand- Reducing inequalities in health underpins all of New Zealand's health policies. *The New Zealand Health Strategy,* sets the scene by identifying the priority areas for action, and stipulates that all policies and programmes to be introduced should aim to reduce inequalities in health. To this end a framework to be used in development of policies and programmes has been developed. *Reducing Inequalities in Health*, was produced as a guide for all of those working to reduce inequalities in health. It describes inequalities in health in New Zealand and identifies the scale of the problem. It then sets out a framework that can be used at all levels (national, regional and local) by policy makers, service providers and community groups to develop strategies to reduce inequalities in health. [18]

The framework proposes that interventions should be developed and implemented at four levels:

Level 1 Structural- Social, economic, cultural and historical factors fundamentally determine health. The most basic way to reduce inequalities in health is to tackle these factors. This requires investment in education, and the social security system, and also the development of labour market policies that will favour those most at risk of unemployment. The disadvantage of this approach is that it is not directly within the control of the health system. Health care professionals are encouraged to advocate that other sectors introduce policies that will improve health and reduce inequalities in health.

*Level 2 Intermediary pathways-*The impact of social, economic, cultural and historical factors on health is mediated by a range of other factors such as material, psychological and behavioural factors, all of which may be amenable to intervention. Potential interventions include: improving living conditions through housing policy and community development programmes; improving the physical and social environment at work; and community and school based programmes to help people from disadvantaged groups gain control over their lives and improve their coping skills.

Level 3 Health and disability services- Health care services have an important role to play in reducing inequalities in health. Health and disability services contribute by ensuring equity of access to care by distributing resources in relation to need by and removing barriers, however defined, that prevent the effective use of services for all ethnic groups.

Level 4 Impact- Actions at this level aim to minimize the impact of disability and illness on socioeconomic position. People who are chronically ill, or who have a disability or mental health problem, find it more difficult to gain employment or promotion. Specific actions include: income support; disability allowance; accident compensation; and ant discrimination legislation and education.

More recently the Health Equity Assessment Tool (HEAT) has also been introduced in New Zealand. It is used to review how particular inequalities in health come about

and identify how they may best be tackled. It consists of a set of questions that can be applied to specific areas to be addressed like: (1) What health issue is the policy/programme trying to address? (2) What inequalities exist in this health area? (3)Who is most advantaged and how? (4)How did the inequality occur? (What are the mechanisms by which this inequality was created, is maintained or increased? (5) What are the determinants of this inequality? (6) How will you address the Treaty of Waitangi (the founding document of New Zealand) in the context of the New Zealand Public Health and Disability Act 2000? (7) Where/how will you intervene to tackle this issue? Use the Ministry of Health Intervention Framework to guide your thinking (8) How could this intervention affect health inequalities? (9) Who will benefit most? (10) What might the unintended consequences be? (11) What will you do to make sure it does reduce/eliminate inequalities? (12) How will you know if inequalities have been reduced/eliminated?

Australia signifies to the countries offering notable work already in the field of the social determinants of health. Since the post Second World War, the governments of Menzies, Whitlam and Dunstan signified the periods when the governments were prepared to invest government resources in nation building with measures that tended to have equitable outcomes. This approach to nation building was progressively lost from the 1980s, when a small government and economic rationalist policy direction came to dominate thinking about public policy in Australia. Despite this, there have been some important developments that have attempted to keep a focus on health inequities and the crucial role social determinants have in policies designed at reducing them. A few of these initiatives are described to demonstrate its progressive thinking about the social determinants of health.

For example, Australia has a sound knowledge base from which to act and is ahead of many other nations that may not even have vital registration systems, let alone data on the extent of inequalities. It has been a trailblazer in producing information to support a focus on the social determinants of health. The first Social Health Atlas was published in 1990 and since then atlases have been published for Australia as a whole and for States and Territories. They include a broad range of data on social inequity in general and on health inequity and provide an important policy tool for governments that want to monitor their progress on reducing inequality. Data on health inequities

has also been produced in association with the Australian Institute of Health and Welfare. While these documents do not address social determinants to any significant degree, they are important in documenting the extent of inequities that other evidence indicates is largely a result of the impact of social determinants. At the level of community, the community health sector (started as a result of the Whitlam Government's Community Health Program in 1973) served as innovators in terms of action on the social determinants of health. Since the 1980s, federal and State governments have introduced a series of policies and campaigns designed to reduce domestic or intimate partner violence. These policies, especially at the State level, have had a strong intersectoral flavour and have provided shelters for women and children leaving violent relationships, trained police in appropriate responses, re-educated the judiciary with the message that violence in the home is a crime and should be treated as such, started campaigns to encourage people to disclose sexual abuse, and then increased institutional determination to prosecute perpetrators.

This concerted cross-sector and jurisdiction approach has meant that domestic violence and child sexual abuse are no longer hidden and are widely seen as determinants of health and responded to as such. Apart from this in 2004, New South Wales (NSW) Health released the NSW Health and Equity Statement *In All Fairness*, a policy statement that included actions that could be taken by the health sector within NSW to improve health equity – including working with other sectors. *In All Fairness* provides a framework for NSW Health to build on existing work. A key aim of the policy is to integrate equity into the core business of NSW Health. There are six key focus areas for action, from which strategies have been developed: [17]

1. Investing in the early years of life.
2. Engaging communities for better health outcomes.
3. Developing a strong primary health care system.
4. Regional planning and intersectoral action.
5. Organisational development.
6. Resources for long-term reduction in health inequities.

Measuring inequalities

Across the world, inequalities have been defined and measured differently. In the context of World inequality, it has been differently defined and analyzed by the usage of three different concepts. *Concept one* is defined as a measure of *international* inequality, which focuses country as a unit of observation in which income inequality is used as the basis for calculating inequality between the countries. But this measurement is "unweighted" as each country counts the same and other important aspects like population, its composition and dynamics etc are ignored. Thus it does not holds a proper measure of analyzing inequalities among the citizens of the world; *Concept two* is defined as population weighted international inequality, that offers a mid way solution to the shortcomings of concept one .In this it is assumed that everyone in a country receives the same income but the number of representative individuals from each country reflects its population size. The mean income among nations is weighted by the population of each country. Concept two is based on the assumption that "within-country" distribution is perfectly equal: all Chinese have the same mean income of China, all Americans, the mean income of the United States, etc.

Thus concept two fails to look at the intracountry population dynamics based on income, which leaves Concept two as only a halfway house to the calculation of a true world income distribution; *Concept three* talks about inequality by referring to how individuals in the world are doing. It goes back to the individual as the unit of analysis, ignoring country boundaries. It treats, in principle, everybody the same. It lines up all individuals, regardless of the country, from the poorest to the richest. Now, Chinese individuals will no longer be crowded together: the poor Chinese will mix with poor Africans, the rich Chinese with the middle-class or rich Americans, and a few rich Africans may even mix with the U.S. "top dogs." This is a true basis for analysis of world inequality as it highlights the real differences both within and between nations. This criteria holds the best unit for calculation of world inequalities reflecting the gap of wealth divide between the rich and the poor that is widening tremendously. [12]

Measurement and different schools of thought

The univariate or unconditional approach cited in the article by Gakidou, E., etal (2000) looks only at the health of individuals and views inequalities in health as the dispersion of health status within a population. The measure proposed is individual health expectancy- a measure that combines an individual's risks of being in a state of less than perfect health across his or her lifespan and reflects the expected number of years an individual can be expected to live in full health. Types of health inequality measures follows: 1) the differences between the individual and the mean of the population; and 2) inter-individual differences. [13]

However the second school of thought supported by Lindbladh, E., *etal* (1998)[13] holds criticism to the univariate approach. It explains that the individualism proposed, tends to produce strategies for health behaviour change (such as information provision and taxes on consumption of alcohol or cigarettes) that are consistent with the views of the higher social classes. Increased individualization in society leads to lack of discourse on socioeconomic and structural policy measures to mediate health inequalities. Wolfson, M. *etal* (2001) explain that the *World Health Report* approach has been advocate univariate approaches, that fails to indicate the causes and social patterning of variations in health, even more significant weakness of the WHO approach lies in its proposed data collection strategy based on small area data. Several conceptual and methodological shortcomings limit the use of small area data, including nonrandom migration to or from the area, the small number of events such as deaths likely to be observed, and the likelihood that any specific geographical area may be associated with unique social, economic, or political conditions rendering it non-representative of the general population. [13]

Holding argument against approach to measuring inequalities in health advocated by Gakidou, Murray and Frenk (2000), Braveman, P., *etal:* (2000) places utmost importance to the social determinants of health, it stresses on the ethical considerations at the population level that would favor guiding resources to those with both poorer health and lower social position; supporting current global efforts aimed at the study of the social determinants of health and placing importance to the social determinants of health on the global research and policy agenda. Murray, C., etal: (2000) explain bivariate or conditional approach seeks to establish the distribution of

health within a population, but conditional on another factor – whether those with low income also have poorer health. However, "if health inequality is measured only through social group differences, such as in education, health inequality that is not correlated to the social variable chosen will simply not be measured'. [13] Thus the Univariate School of thought its idea prerequisite for investigating the causes and solutions to health inequalities

Most measurement of health inequality involves the use of indicators or indexes to measure health, but it also requires decisions on what groups or areas to compare and what is the most appropriate form of analysis for the question being investigated. In short, devising a method for measuring inequalities requires answers to three questions: [14]

1. What is the comparator, are inequalities to be measured between groups or populations of small areas, countries or populations to which different socio-economic classification have been applied, similar groups or populations over time?
2. What type of inequality is of interest: relative or absolute inequality, Risk based versus outcome-based measure?
3. What is the intended use for index of inequality: To monitor the impact of policies and practices (often governmental policies and practices) on specific populations?

Measuring health inequities

Measuring health inequalities is not an easy task as it involves moral and ethical considerations. However attempts have been made by health researches in this direction. Amongst which, Yukiko Asada (2005) proposes a framework for measuring health inequity. According to the author measuring health inequity entails three steps: (1) defining when a health distribution becomes inequitable, (2) deciding on measurement strategies to operationalise a chosen concept of equity, and (3) quantifying health inequity information. Steps 1 and 2 extract the information concerning health inequity from the health distribution. Quantifying the extent of health inequity by means of a single number (step 3) is a strategy to facilitate examination, comparison, and understanding of the health inequity in question. All

three steps ask distinct questions, and a decision made at one step does not always guide a decision at another step.[11]

Step 1: Defining health inequity

A variety of perspectives on defining health equity exist. They can be loosely categorised as: health equity as equality in health, and health inequality as an indicator of general injustice in society.

Health equity as equality in health

Perspectives in the first group derive the moral significance of health distributions from the value of health. This simplest view is the perspective on health equity as strict equality of health outcome for all persons. If we believed that health is to some degree special, equality of health outcome among everyone, just as equality of political liberty among everyone, might seem to be the most straightforward criterion for health equity. Strict equality for all, however, is not an attractive view for various reasons. For example, it denies personal choice. It would be unrealistically expensive. Moreover, it would be unachievable because some determinants of health are beyond human control. Unlike political liberty, strict equality in health for all would not be a feasible nor agreeable goal.

Accordingly, popular accounts of health equity relax the strictness in one-way or another. The most common way to depart from strict equality in health outcome is to look at health determinants as inequitable. Inequalities in health associated with socioeconomic status (SES), for example, to many people present an intuitive moral concern. The WHO researchers consider determinants more broadly than SES and propose to view health inequality caused by factors amenable to human interventions as inequitable. Another way to define health equity as equality in health is to focus on the level of health. This approach is based on the idea of the minimally adequate level of health, a multipurpose resource that is useful for any life plan. Society would be concerned about whether each person satisfies the minimally adequate level of health regardless of how each person realizes her health. Society would not be concerned about health above this level as it accepts that people may trade off health with other

goods depending on their preferences and conceptions of good life. In other words, adopting this view we would not measure health inequalities above this level.[11]

Health inequality as an indicator of general injustice in society

It is known that multiple factor directly or in complex combination determines health. The exact mechanism of health production is beyond our understanding. But health is an ultimate outcome of how society distributes multiple determinants of health. Further health inequality is regarded as an indicator of general injustice in society. Many researchers support the primary goods that Rawls suggests in his theory of justice as the important determinants of health. ''Social justice is good for our health'' they therefore claim. In this view, the primary concern is just distribution of social primary goods. Extended, distribution of health may be used as an indicator of a just society.

Step 2: deciding on measurement strategies

To operationalise an equity perspective as a measurement strategy, it involves consideration over issues such as about health, the unit of time, and the unit of analysis. Empirically, these are measurement questions based on data availability. When measuring health inequity, moral considerations should also guide measurement strategy.[11]

Looking at the Issues of health, the author explains, that we cannot measure health equity without measuring health. In deciding the measurement of health in health equity analysis, we must consider a fundamental question: why does health distribution cause moral concern? Two widely shared views exist. Firstly, health in itself is one component of welfare. Secondly, health is a multi-purpose good that is useful for any life plan. These characteristics of health form the fundamental basis for moral interests in health distribution. These fundamental values of health support functionality as the aspect of health to consider, thereby, the use of health related quality of life measures. In the understanding of health as one component of welfare and a multi-purpose resource, what is relevant is what a person can or cannot do or whether a person exhibits general symptoms such as pain or anxiety. A different

disease category in itself does not affect the level of health related welfare or the potential use of health as a multi-purpose resource.

While focusing on the unit of time in health inequity analysis, one must ask: within what time period should health equity be sought? Three approaches exist. The whole life approach looks at the entire health experiences of people from birth to death. The life stage approach compares health experiences of people within the same age group.

The cross sectional approach takes a snapshot of health experiences of people at a certain time all together, irrespective of their life stages. The understanding of health as a multi-purpose resource endorses the life stage approach and rejects the whole life and cross sectional approaches.

Also the unit of analysis relates to distinguish between the individual and group approach. The first and the most fundamental question are among whom—individuals or groups—you wish to seek health equity. The second issue relates to comparability of health inequity analysis. The individual is the ultimate unit of analysis, while an unlimited number of group choices are possible, and group definitions vary. The third issue concerns the use of the average in the group approach. What does the average of a group represent? Should we be worried about the information neglected by the use of the average? Researchers often consider the choice of the unit of analysis as dichotomous. Should both individual and group data be available, however, researchers could examine health equity across individuals as well as groups.

By simultaneously measuring health equity across individuals and groups, researchers can identify what proportion of the overall health inequity is attributable to a particular group characteristic and, among many group characteristics, which one contributes most to the overall health inequity. Recent studies have increasingly used this approach. While this approach is promising, it does not resolve all the three issues mentioned above. Researchers still need to examine the philosophical question of among whom they wish to seek health equity and the issue of comparability. [11]

Step 3: Quantifying health inequity information

There exists various measures to the researchers to quantify for example, the range measures, the concentration index, and the Gini coefficient. But how can researchers choose among the various measures? To this the author stresses that the convenience, rather than principle, often drives this decision. But different measures can conclude different degrees of health inequity even when used for the same health distribution. A mention of six principle questions is made which deserve significant thought when quantifying health inequity information.

1. How many units are to be compared, and what is the basis of comparison?
2. Need to aggregate of differences at the population level?
3. Looking at the absolute or relative differences within the population group compared
4. Assessing health inequity by drawing sensitivity to the population's mean health?
5. Addressing health inequity by drawing sensitivity to population size [11]

Building on this health (in) equity analytical framework the next chapter (*four*) is to review the work of the Commission's Knowledge networks based on Early child development, Women and gender equity, Globalization, Health Systems, Urban Setting, Employment Conditions, Social exclusion, Priority Public Health Condition, Measurement and Evidence Based as its thematic areas.

Chapter 4

An Analytical Review of the Commission's Knowledge Networks

The central premise of the commission's work is to achieve and strengthen health equity both within and across the countries by addressing to the structures of the social hierarchy and the socially determined conditions in which people grow, live and age-the social determinants of health. For the purpose to synthesize knowledge to inform opportunities to improve action on social determinants of health, the commission formed nine knowledge networks, among which six knowledge networks focus on themed areas such as early childhood development, women and gender equity, globalization, health system, unemployment, urban setting, social exclusion, the other two women and gender equity and measurement and evidence knowledge networks are the cross cutting knowledge networks which also serve as resource for other networks.

The core work of the knowledge networks of the Commission on the Social determinants of health is to translate the conceptual understanding into action on the Social determinants of health. The work was to collect, collate and synthesize a diverse range of evidence on: (i) plausible causal relations; (ii) key areas in which action should take place; and (iii) effective practices and interventions for addressing socially determined health inequities globally. Each knowledge network is managed by an organized hub or an organized co-hub. There are minimum 10 to 12 members to each knowledge network with experience in science, practioners, policy, senior decision makers, and representative from civil society organizations, nongovernmental organizations, global institutes etc. The organizational hubs for each knowledge networks have been as follows:

1. Human Early Learning Partnership and the Centre of Excellence in Early Childhood Development as the Early Child Development Knowledge Network hub
2. Karolinska Institute, Sweden, and Indian Institute of Management: as Women and Gender Equity Knowledge Network co-hubs

3. WHO Kobe Centre, Japan: Dr Susy Mercado; and Dr Kirsten Havemann as Urban Settings Knowledge Network hub
4. University of Ottawa as Globalization Knowledge Network hub
5. University del Desarrollo and National Institute for Health Clinical Excellence as Measurement and Evidence Knowledge Network co-hubs
6. Pompeu Fabra University, Spain, and Federal University of Bahia for Employment Conditions Knowledge Network co-hubs
7. University of Witterasand as Health Systems Knowledge Network hub
8. Human Sciences Research Council, South Africa; ICDDR, B and BRAC, Bangladesh; National University and Javeriana University, Colombia; National School of Public Health Sergio Arouca, Oswaldo Cruz Foundation, Brasil; Lancaster University, UK as Social Exclusion Knowldege Network co-hubs
9. Department of Equity, Poverty and Social Determinants of Health, WHO, Geneva as Priority Public Health Conditions Knowledge Network hub

An analysis of the working of the knowledge networks

The Early Child Development Knowledge Network (ECD)

The final report by the Early Child Development (ECD) knowledge network attempts to explain the importance of the early years of life in the development of an individual. It explains the span of early childhood as expanding from prenatal development to eight years forming the foundation for a range of health and social outcomes across the entire life-course. As a cornerstone to human development the two agenda of Child survival and health covered in the early child development form a step forward in the fulfilment of millennium development goal of reducing poverty, providing for education and health. The report explains the principal strategic insight is that the nurturant qualities of the environments where children grow up, live and learn matter the most for their development, yet parents cannot provide strong nurturant environments without help from local, regional, national, and international agencies therefore a fair investment in the early childhood positive development is a step in the improvement of the entire life course, which expands, to the fulfilment of adequate nutrition, physical growth, care, love, and protection in a supportive outside

environment to the child. Further it proposes ways in which government and civil society actors, from local to international, can work in concert with families to provide equitable access to strong nurturant environments for all children globally. [19]

The knowledge network proposes a model that gives an overview of the environments that matter most for children, as well as a sense of how these environments are inter-associated. The Total Environment Assessment Model for Early Child Development proposed to show how environments responsible for fostering nurturant conditions for children range from the intimate realm of the family to the broader socioeconomic context shaped by governments, international agencies, and civil society. These environments and their characteristics, then, are the social determinants of ECD. One guiding principle of the framework is the "equity-based approach" to providing nurturant environment for children everywhere.

The report provide a framework for understanding the environments (and their characteristics) that play a significant role in providing nurturant conditions to all children in an equitable man The environments are not strictly hierarchical, but rather are truly interconnected. At the most intimate level is the family environment. At a broader level are residential communities (such as neighborhoods), relational communities (such as those based on religious or other social bonds), and the ECD service environment. Each of these environments (where the child actually grows up, lives, and learns) is situated in a broad socioeconomic context that is shaped by factors at the regional, national, and global level. The explanation of the model is as follows: [20]

At the individual child level, in keeping with the central importance of biological embedding and the influence of many and varied environmental factors for this process, the network provides a framework that uses a 'cell-to-society' approach to early child development. The basic premise is that the process of biological embedding and of early child development in the physical, language/cognitive, and socio-emotional domains is affected by variations in many aspects of environmental conditions and defined at many levels of societal aggregation. The child as an agent with a voice to contribute is an integral part of this approach. The network informs that children deserve to be considered social actors.

The key messages at this level includes three broad domains of development—physical, social–emotional and language–cognitive—are interconnected and equally important; Children shape their environments as well as being shaped by them; Social determinants shape brain and biological development through their influence on the qualities of stimulation, support, and nurturance available to the child; Health, nutrition, and well-being of the mother are significant for the child's development; Play is critical for a child's overall development.

At the family level, the network highlights the significant role of family as a fundamental source of nurturing for a child. As a first unit of contact, it holds an essential role in early childhood development as the "fundamental group" and the "natural environment" for growth and well-being. Parents and caregivers are identified as principal actors in the construction of identity and the development of skills, knowledge and behaviours, and as duty-bearers in the realization of the young child's rights. Family members provide most environmental stimuli for children, and families largely control a child's contact with the distal environment provide the largest share of human contact with children and because families mediate a child's contact with the broader environment.

Perhaps the most salient features of the family environment are its social and economic resources. Family social resources include parenting skills and education, cultural practices and approaches, intra-familial relations, and the health status of family members. Economic resources include wealth, occupational status, and dwelling conditions. The gradient effect of family resources on early child development is the most powerful explanation for differences in children's well-being across societies. Family socio-economic status has an impact on outcomes as diverse as low birth-weight, risk of dental carries, poorer cognitive test scores, difficulties with behaviour and socialization, and increased odds of disengagement from school.

Within families, gender-based bias has been identified to create inequities in the nurturant conditions afforded to girls compared with boys. Also it suggests giving greater power in decision-making to mothers for alleviating some of this inequity. The network stresses upon the young children need to spend their time in warm responsive environments that protect them from inappropriate disapproval and punishment.

It says that they need opportunities to explore their world, to play, and to learn how to speak and listen to others. Here the role of family is recognized to provide opportunities to the children to explore and experience but this requires support from the government. Thus the government plays a crucial role in helping the families provide appropriate and adequate opportunities for a healthy child development.

At the third level of the analytical framework the role of residential and relational communities is given importance, as it is here that the children and the families are embedded. Residential and relational communities offer families multiple forms of support from tangible goods and services that assist with child rearing, to emotional connections with others that are instrumental in the well-being of children and their caregivers. At the residential/locality level, both governments and grass-roots organizations also play a highly influential role. Alongside this, Relational communities are significant in bringing early child development. According to the report the term relational communities refers to the people, adults and children, who help form a child's social identity: tribal, ethnic, religious, and language/cultural. Often, this is not a geographically clustered community. The Relational communities are a primary source through which families derive values, norms, and social support. It provides a source of social networks and collective efficacy, including instrumental, informational, and emotional forms of support. However, discrimination, social exclusion, and other forms of subjugation are often directed at groups defined by relational communities.

Moving ahead, the network stresses importance of the early child development programmes and services which incorporate and link health-promoting measures (e.g., good nutrition, immunization) with nurturance, participation, care, stimulation, and protection—offer the prospect of sustained improvements in physical, social–emotional, and language–cognitive development, while simultaneously reducing the immediate and future burden of disease, especially for those who are most vulnerable and disadvantaged. Thus Public investment in early childhood programs and services as extremely powerful measure, in bringing far greater returns to society occurring in many areas (education and beyond) and throughout the life course.

Further, the report stresses on the ultimate goal of every society to ensure universal access to quality services and programmes that are built on existing service infrastructure (e.g. health care system). It explains that the Early child development services and programmes would involve multiple entry points, including health care systems, community-based childcare, and preschool education. The role of Health care system being the first system-of contact for children and mothers is uniquely powerful to contribute to early child development in a comprehensive manner, combining health and nutrition. Alongside, partnerships with families and tailor services to the needs of those they serve is important. It implies the central role of the Government to play to ensure that early child development programmes and services are fully integrated into social protection policies.

Moving to the next level of Regional and National level, Monitoring variation in children's developmental outcomes at the regional level provide insights regarding 'nurturant' macro-environmental conditions At the national level a comprehensive, inter-sectoral approach to policy and decision-making work best for early child development. Thus investing in early child development is an integral component of a nation's long-term economic and social strategy. The network explains the responsibility of the National governments for upholding their commitments to the Child Right Convention and the Millennium Development Goals.

At the next level the report highlights the role of global environment in influencing early child development through its effects on the policies of nations as well as through the direct actions of a range of relevant actors, including multilateral economic organizations, industry, multilateral development agencies, non-governmental development agencies, and civil society groups. It explains the element of power in economic, social, and political terms as the major feature of the global environment in relation to children's well-being . Power differentials between types of actors, particularly between nations, have many consequences, including the ability of some nations (mainly resource-rich ones) to influence the policies of other nations (mainly resource-poor ones) to suit their own interests. Although power differentials may have invidious effects on ECD, they can be exploited for the benefit of children, too.

Due to the global responsibility in population health, the network recommends the World Health Organization to strengthen its commitment to early child development as a key social determinant of health. It states the international community must establish a unified mechanism for monitoring child development between communities and societies and over time. It encourages alliances between all individuals and organizations dedicated to child well-being and social welfare. Finally, the network has suggested two primary directions for the future: Continued research to provide a better understanding of the effects of environments on biological embedding and early child development, particularly that of broader environments; the use of available information to inform action to further the goal of a "grass-roots to global" child-centered social investment strategy.

Analysis

The review of the report shows that the network aims to provide an integrated approach involving families, communities and government to address the developmental needs of many through several multiple entry points. These multiple entry points would operate through health care service system, community based childcare and preschool education unit. However the current position of these entry points reveals a dismal status in most of the countries. Therefore for action on the above stated it is required that these entry points get rectified first to perform there routine roles first. The report does not stress on strengthening the dying health service system first but on the contrary puts additional responsibility over it. Further in the era of a globalization the question of who will determine the early child development policies is overlooked .The network does refer about influence of the global players on the national policies but it would have been significant if it stressed upon the need to minimize of the role of the global players in the national policy space.

In another case it is evident that the modal framework drawn above has shown the influence of the environment factors as social determinants of health in early child development. But there are certain ambiguities associated which needs to be answered to make this social determinant help the policy makers in removing health inequities. Like it is known that priorities of the different communities such as residential, relational, national, international and global vary accordingly their specific needs and concerns.

In the light of such complexity how far will the issue of early child development form priority concern against the backdrop of each community's immediate challenges is difficult to answer. In the case of the residential and relational communities, it is to be stated that despite the fact that they play a significant role in shaping life of the individuals, they are not much entertained in the policy discourse. Not many responsibilities are given to them on an account of their patchy, fragmented and uneven existence causing disruptions in the implementation, management and monitoring of any given programme. It is opined that it is often too risky to give responsibility to such communities, but is comparatively much easier to incur participation from them. Even in the case of the developed countries following individualistic ideological framework, the possibility of relational and residential communities playing any key role is uncertain.

The model represents the influence of the micro to the macro reflection of environment factors on the early child development in one way or the other. It is also known that among the various levels of environment, family plays the most essential unit of influence. But after that it is important to rank the communities according to lèvels of influence for the policy makers to plan action. This again raises a query that the influence of these levels is very much known to us, but how far are these different communities aware of their responsibility over early child development is uncertain.

Certain important determinants have not been taken into account by the knowledge network. One such is the role of the school, which helps to build up a healthy base of the individual by in shaping the cognitive, physical, social behaviour. Another influential determinant is the role of the peer group, which plays an important role in moulding the habits, personality and behaviour of an individual. Alongside this, network falls short of addressing the problems and difficulties associated within each level. In addition it significantly incorporates the gender perspective as its unit of analysis at each level but fails to look into issues of caste, race etc.

The study proposes ways in which government and civil society actors, from local to international, can work in concert with families to provide equitable access to strong nurturant environments for all children globally. In order to maintain a social determinant of health perspective on the evidence, the network chose to present generic principles and characteristics that are transferable around the globe.

But on the contrary this approach looses pragmatism in the implementation phase due to its inability to assess the specific context related concerns. In addition to this, the report includes various case studies of different countries about the child development programmes, among them one such example is that of India, where the ECD programme attempts to tie up with the Integrated Child Development Programme, which is problematic. It overlooks ground realities and ignores the factors, which led to the failure of the ICDS scheme in many states.

Women and Gender Equity Knowledge Network

The knowledge network concerned with women and gender equity in its final report [21] addresses to the problem of gender inequality. It states that despite the allocation of power, resource, authority and control by men, the devastating impact of the gender inequality is affecting both the sexes. But with huge magnitude of the implication of the gender inequality, the network report considers taking action to improve gender equity in health and to address women's rights to health as one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources. The report is grounded in the affirmation of equal and universal rights to health for all people, irrespective of economic class, gender, race, ethnicity, caste, sexual orientation, disability, age or location.

The network considers the concern for consistent and smoother implementation of human rights for the cause of mobilizing people especially women, governments etc. It promotes intersectoral coordination, as addressing the problem of gender inequality requires actions both outside and within the health sector because gender power relations operate across such a wide spectrum of human life and in such inter-related ways. It recognizes interplay of gender with society like other social relations, gender relations as experienced in daily life, and in the everyday business of feeling well or ill, are based on core structures that govern how power is embedded in social hierarchy. The structures that govern gender systems have basic commonalities and similarities across different societies, although how they manifest through beliefs, norms, organizations, behaviours and practices can vary.

The report shows that gender inequality and equity in health are socially governed and therefore actionable. Sex and society interact to determine who is well or ill, who is treated or not, who is exposed or vulnerable to ill-health and how, whose behaviour is risk prone or risk-averse, and whose health needs are acknowledged or dismissed. Three sets of actions identified by the network: Creating formal agreements, codes and laws to change norms that violate women's human rights, and then implementing them; Adopting multi-level strategies to change norms including supporting women's organizations; Working with boys and men to transform masculinist values and behaviour that harm women's health and their own.

It mentions seven approaches, which can make difference in reducing health inequality. The *first approach* is to address the essential structural dimensions of gender inequality, *second* to challenge gender stereotypes and adopt multilevel strategies to change the norms and practices that directly harm women's health, *third* is to reduce the health risks of being women and men by tackling gendered exposures and vulnerabilities, *fourth,* to transform the gendered politics of health systems by improving their awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women, *fifth* is to take action to improve the evidence base for policies by changing gender imbalances in both the content and the processes of health research, *sixth* is to take action to make organizations at all levels function more effectively to mainstream gender equality and equity and empower women for health by creating supportive structures, incentives, and accountability mechanisms, *seventh* refers to support women's organizations who are critical to ensuring that women have voice and agency, who are often at the forefront of identifying problems and experimenting with innovative solutions, who prioritise demands for accountability from all actors, both public and private, and whose access to resources has been declining in recent years.

The first approach is addressing the essential structural dimensions of gender inequality approach emphasis to ensure that resources for and attention to access, affordability and availability of health services are not damaged during periods of economic reforms, and that women's entitlements, rights and health, and gender equality are protected and promoted, because of the close connections between

women's rights to health and their economic situation Secondly, it emphasis to support through resources, infrastructure and effective policies/programmes the women and girls who function as the 'shock absorbers' for families, economies and societies through their responsibilities in 'caring' for people, and invest in programmes to transform both male and female attitudes to caring work so that men begin to take an equal responsibility in such work. Further it aims to expand women's capabilities particularly through education, so that there ability to challenge gender inequality individually and collectively is strengthened. Also it focuses on increasing women's participation in political and other decision-making processes from household to national and international levels so as to increase their voice and agency.

The second approach suggests to challenge gender stereotypes and adopt multilevel strategies to change the norms and practices that directly harm women's health through creating implementing and enforcing formal international and regional agreements, codes and laws to change norms that violate women's rights to health. Further it stresses to work with boys and men through innovative programmes for the transformation of harmful masculinist norms, high risk behaviours, and violent practices.

Differential health needs of men and women are mentioned under the third approach which the it aims to meet separately where not only must neglected sex-specific health conditions be addressed, but also sex-specific needs in health conditions that affect both women and men must be considered, so that treatment can be accessed by both women and men without bias. Also it is required to tackle social biases that generate differentials in health related risks and outcomes. Policies and actions to encourage equal outcomes where no plausible biological reason exists for different health outcomes, more comprehensive policies are required that balance working lives with family commitments. Need for recognition of Domestic work, including care for other family members Family leave policies must mandate that men share these responsibilities with women. Social insurance systems to protect even when not working or ill. Addressing to the structural reasons for high-risk behavior. Empower people and communities to take a central role in these actions.

The fourth approach is to transform the gendered politics of health systems by improving their awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women. This requires provision of comprehensive and essential health care which is universally accessible to all in an acceptable and affordable way and with the participation of women: ensure that user fees are not collected at the point of access to the health service, and prevent women's impoverishment by enforcing rules that adjust user fees to women's ability to pay; offer care to women and men according to their needs, their time and other constraints. Development of skills, capacities and capabilities among health professionals at all levels of the health system to understand and apply gender perspectives in their work: recognition to the women's contributions to the health sector, not just in the formal, but also through informal care. Strengthen accountability of health policy makers, health care providers in both private and non-private clinics to gender and health. Incorporate gender into clinical audits and other efforts to monitor quality of care.

The fifth approach is take action to improve the evidence base for policies by changing gender imbalances in both the content and the processes of health research. Ensure this requires collection of data disaggregated by sex, socioeconomic status, and other social stratifies by individual research projects as well as through larger data systems at regional and national levels, and the classification and analysis of such data towards meaningful results and expansion of knowledge for policy, inclusion of women in clinical trials and other health studies in appropriate numbers and the data generated from such research should be analyzed using gender-sensitive tools and methods. Redress the gender imbalances in research committees, funding, publication and advisory bodies by promoting research to broadens the scope of health research and links biomedical and social dimensions, including gender considerations, strengthening women's role in health research.

The sixth approach is to take action to make organizations at all levels function more effectively to mainstream gender equality and equity and empower women for health by creating supportive structures, incentives, and accountability mechanisms. It needs to have Gender mainstreaming in government and non-government organization,

support action-oriented gender unit with strong positioning and authority, and civil society linkages to ensure effectiveness and accountability. Building effective interventions for women's empowerment authentic participation ensuring autonomy in decision-making, sense of community and local bonding. Further integration of the interventions with economic, education, and/or political sectors, for greater psychological empowerment, autonomy and authority

The seventh approach is to Support women's organizations that are critical to ensuring that women have voice and agency, which are often at the forefront of identifying problems and experimenting with innovative solutions, who prioritize demands for accountability from all actors, both public and private, and whose access to resources has been declining in recent years

Analysis

In the first approach the clarity over the type of programmes for the women and girls who function as 'shock absorbers' has not been mentioned which adds to the confusion to the policy makers. Other structural dimensions such as race or caste, class and gradient which play a potent role in influencing gender inequality are left unexplained in this approach. Further the reflections of political economy explain that neoliberal economic reforms have deeply led to acute alterations in the functioning of the health services. This has severely harmed the people with low socio-economic status to gain access to the health services. The recommendation of the network that economic reforms should not impact functioning of health services is welcome. At this current phase when the world is viewing the disastrous impact of these economic reforms, it would have had been beneficial for the developing and under developing countries if the network recommended some positive directions to over come the negativities of neoliberal economic reforms.

Secondly, the network accepts a strong association between the women's right to health and their economic situation, which is true but is equally true for the men folks as well. The assessment report of the millennium development goal on poverty explains 4 million people would miss the target even by 2015. This explains the need to ensure right to health for all. Further the idea of attitudinal change of men towards 'caring' activities could be disseminated through programmes but whether it would

get implemented at the household level is doubted. Also the gendered power relation structured in the social fabric requires just more than a behavioural change.

It is contested that strengthening of women's capabilities to individually as well as collectively challenge gender inequality requires handling of factors beyond education to the structural determinants. It is doubtful whether women's education will increase capability without reflecting upon the macro structural dimensions of society influencing them. In the opinion of Amartya Sen [52], *freedom* is the prerequisite for the enhancement of capabilities. The current global scenario is dominated with neoliberalism, which has widened the gender inequality placing low position to the women both in the public and private spheres especially in the developing and underdeveloped countries.

In the public domain women are unable to find jobs equivalent to men. The growing informal sector has led to casualisation of workers, who work day and night without proper wages, working condition, social protection coverage, time for rest and leisure etc. Besides this, the household also offers as an avenue of torture where the life of women is caught in caring responsibilities for family members, up keeping daily routine household work of cooking, washing, cleaning and other menial tasks etc. All these factors restrict the women's *freedom to gain capabilities.* Further the answer of provision of education is secondary until women meet their survival goals of food, clothing and shelter.

Moving ahead to women's participation in the political activities, the 73rd and 74th amendment to the Indian constitution provide for participation of women through 33% reservation in the panchayats and municipalities. But marked with gendered power relations being enjoyed by men, the ground reality reveal usurping of the real political power of the female candidates by men who just act as nominal dummy representatives while the real power lies with the men.

The second approach talks about creating, implementing and enforcing formal and regional agreements, codes and laws to change norms that violate women's right to health. These laws and codes are influential in maintaining women's right to health only at the workplace level. There role gets restricted in the private sphere of families, where the patriarchal structures and socialization plays an important role in reducing

significant importance to the women and their issues. The subordination of women reduces their ability to keep sound mental, social and physical health. Thus it is required that work done with regard to women health at the international level as recommended should have a trickle down effect to the household level as well to ensure women right to health.

The third approach talks about giving recognition to the domestic work, including care for other family members etc. This forms an important part of our National policy for the Empowerment of women 2001 as well, but over the span of more than six years no significant work has been done in this direction, which also indicates the strong patriarchal structure at the policy making and implementation level.

This approach also states that the social insurance system must ensure that even those who may not have had formally recognized and remunerated occupations are also protected when not working or ill. This implementation of the social insurance coverage system is difficult in the contextual reality of competitive market economy and rising inequalities. Adding more, the approach stresses on empowerment of the individuals to challenge the status quo posed by the gender blind or gender biased attitude. This again is an individualistic approach, which poses responsibility on the individual and not on the government. Thus the notion of empowerment that should have the spirit of social justice actually carries the spirit of de-emphasizing the State.

In the forth approach, the network makes a mention over developing skills, capacities and capabilities among the health professional to understand and apply gender perspective in their work. But the possibility of this recommendation is only possible if specific guidelines are also framed so that the health professions can initiate work in this direction.

In general the recommendations made are ahistorical as they fail to draw lessons from the past experience as most of the above recommendations are already part of the Alma Ata Declaration 1978 and National Health policy 2002 which are now part of history. Thirdly it is discrete in nature as it ignores the current backdrop of political economy of health dominated with neoliberal market-driven insights. Also the report fails to draw relations between gender and contents of other knowledge networks such as globalization, early childhood development, urban setting, health system

knowledge networks. Also it would have been more useful if the network examined the issue of women's health in the developing and developed countries associated with infant mortality ratio, maternal mortality ratio, mortality and morbidity associated with HIV/AIDS, violence against women, nutrition, health seeking behaviour etc.

Urban Setting Knowledge Network

The third knowledge network to submit the final report is the urban setting knowledge network. The knowledge network sees urbanization and urban setting as a health determinant. The global context reveal that the urban population in developing countries is expected to grow from 2 billion in 2000 to 3.9 billion in 2030 (UN, 2006) (while total world population may grow from 6 to 8 billion) with the most rapid pace of growth expected in Asia and Africa. While North America, Latin America and Europe are currently the most urbanized regions, the number of urban dwellers (1.8 billion) in the least urbanized region, Asia, is already greater than that in North America, South America, Japan and Europe combined. [22]

According to the knowledge network, the facts show that one in three of the total urban population of the world live in slums, rising to almost half of all urban dwellers in the developing regions, and to four of five urban dwellers in the LDCs. While developing regions account for about two-thirds of the world's urban populations, these regions account for 85% of the world's slum dwellers. Nonetheless, slums are not only a problem of developing regions; 6% of urban dwellers in developed regions live in slums amounting to 54 million people. The report states that slum formation with rapid urbanization impact cities with increase in urban poverty. According to the 2003 Global Report on Human Settlements (UN-HABITAT, 2003), 43% of the urban population in developing regions lives in "slums". In the least developed countries, 78% of urban residents are slum dwellers. In resolving this the economics of urban health development brings out the crucial role of good governance, supportive public health policies and financing of infrastructure. [29]

A range of social determinants limiting the slum dwellers' ability to take action to improve their health vulnerability, deprived urban living environment have been dealt as the determinants linking to poverty in urban areas.

These factors include poor quality and often insecure, hazardous and overcrowded housing; limited *or no safety net;* inadequate income; high prices paid for many necessities causing health risks; inadequate, unstable or risky asset base; inadequate provision for infrastructure and services (including water and sanitation) causing very large health burden; poorer groups' voiceless ness and powerlessness within political systems and bureaucratic structures, inadequate protection of poorer groups' rights through the operation of the law (including protection from discrimination).

The network suggested an inventory for action to improve the urban setting. The emphasis is on incorporating health in slum-upgrading to strengthen equity focus of healthy settings, target the urban poor through primary health care, putting health equity on the agenda of local governments and metropolitan authorities and to pursue a national agenda for healthy urbanization. According to the report, all these four targets require different action at the physical environment, infrastructure, human, social, economic, governance and political domains.

The component focussed under the physical environment, infrastructure, human and social domains include water and sanitation, waste management and pollution, literacy, women's health, child survival, health and nutrition, safe household fuels, road and workplace safety, youth health, access to primary health care, tobacco control, mental health promotion and community safety. Moving down to the Economic and Governance and political domains, components to form strategies include provision of micro finance in livelihood, housing, health and other community projects; provision of jobs, training opportunities for gainful employment; secure income, securing tenure and property right by empowering communities to negotiate and demand secure tenure and home ownership or by offering the urban poor alternatives to their current shelter location; ensuring voting rights and political participation, keeping vigilance against corruption, getting government budgetary support for health and social protection.[22]

Analysis

The inventory of action has covered the entire sectors of the economy towards the implementation of its inventory of action. However it would need intersectoral coordination, sound participation and a responsible behaviour of all the sectors, which

is quite challenging at the ground level. Secondly the network has ignored on how the inventory of action would be implemented where the role of the state is ignored but which holds importance in many ways such as maintaining intersectoral coordination, law and order, allocating financial resources, surveillance systems.

Globalization Knowledge Network

The globalization knowledge network in its final report to the commission reviews the impact of globalization in the world today, where the neo-liberal forces shape the picture of globalization. Globalisation affects health and social determinants of Health through increasing social stratification, differential exposure or vulnerability, health system differences and its consequences. These changes arise through the impact of globalisation on pathways linking to health viz power, resource, labour, gender, policy, economy, trade, financial flow, health system, water, sanitation, food security. [23]

The network has put forth certain recommendations to improve the existing situation. It states that the Millennium Development Goals (MDGs) should be used as a guide to aid flows and debt cancellation. It recommends that MDGs to be revised to incorporate equity measures and to ensure greater measure is given to the social determinant of health. It recommends structuring of the global governance agenda around 'three R's' to respond to globalization. These R's stand for redistribution, regulation and rights with coordinated action on an international scale by national and multilateral institutions.

In order to serve the Social determinant of health, it is required that the global governance mechanisms strengthen governance through core (regular budget) funding of WHO and other UN agencies with SDH mandates; establishing United Nation's Economic and Social Council, with WHO, as lead institution for coordination of multilateral action on SDH; democratizing international institutions by increasing representation of the developing countries, increasing an dequalising their accountability to members, improving their transparency and increasing their openness to civil society organizations; creating a permanent and sufficient resourced position of UN Special Rapporteur on the Right to Health.

It recommends provision of appropriate national policy space on making decision related to health and social determinants of health and not sacrificing it at the cost of other gains, ensuring that any trade or other economic agreements do not disturb health. Apart from this it emphasizes to increase focus on the creation of an economic environment, which generates livelihood for all people, stable income at level consistent with their physical, mental, social well-being, social protection for those who are unable to sustain livelihood, which in the opinion of the network means bringing back employment as the central concern of the economic and development policies.

For the purpose of reduction in globalization led migration, it suggest that the policy measures need to include programmes to promote return migration, restricted emigration, bi or multi-lateral agreements, improved domestic HHR planning and self-sufficiency, restitution, compensation. Besides this, it says that health concern needs to gain more ground as a concern for trade negotiation. It promotes careful sequencing of liberalization commitment together with expanded social protection policies to buffer liberalisation's health negative consequences. It opines that the social protection policies to be universal and progressively tax-funded wherever possible and not tied to employment since many of the world's poorer people are in the informal economy or have less access to employment based social insurance scheme. The network supports aid effectiveness that is accompanied by a shift from off-budget programme to project-based aid to on-budget programme, which allows the recipient countries greater flexibility in responding to the self-selected development priorities, rather than those of the donors.

In addition to this, it advocates debt cancellation for the less developed/poor countries which do not gain from the global financial flows, supports the need of the high-income countries to assisting low-income countries in developing institutional capacities for progressive forms of revenue collection. It recommends that aid coordination and alignment to be facilitated through global pooled funds, promoting multilateral consensus against collecting odious debt.

To minimize health inequities due to stronger and ever expanding IPR regimes, it recommends developing country government should actively participate in the intergovernmental working groups on Intellectual Property Rights established by the

WHO to ensure that their national legislation allow full use of flexibilities provided for by TRIPS, explore the use of compulsory licenses of patented essential medicines whenever the price can be significantly reduced through competition and avoid concession in bilateral or free trade agreements that increases the level of IPR protection. Adding to this, WHO as a matter of priority, should evaluate mechanisms other than the patent system, such as contests, public-interest research funding and advance purchase agreements to encourage the developmentof drugs for disease that disproportionately affect developing countries.

Besides this, it strongly informs to check that no further reforms based on neoliberal health sector reform should be implemented, at least until and unless evidence of their appropriateness, effectiveness and affordability in low and middle-income countries have been established. Also a comprehensive review of the overall and out-dated system of global governance established after the second world war should be initiated to establish a system conducive to health equity in the context of the conditions, needs and generally accepted principles of governance in the 21st century. It suggests the productive areas for policy innovation that includes international or global taxation, regulating the use of offshore financial centers to avoid existing national tax regime; and assessing tax policy commitment in light of their implication for the right to health.[23]

Analysis

The knowledge network misses out over the linkages of globalisation with gender, social exclusion and environmental dimensions, which is problematic when we analysis it as a social determinant of health. Secondly it advocates appropriate national policy space on making decision related to health and social determinants of health and not sacrificing it on the cost of other gains, ensuring that any trade or other economic agreements does not disturb health. This recommendation is ideal but it lacks pragmatism to help the already debt-ridden poor countries decide ways on which how they can follow an independent national policy in the neo liberal globalized world.

Also as stated in one of the recommendations, it is ideal to include health as a concern in the trade negotiations. But how far these health concerns will be heard at the

dominant profit-based trade negotiators front is doubtful. In another recommendation the network supports aid effectiveness that is accompanied by a shift from off-budget programme to project-based aid to on-budget programme allowing the recipient countries greater flexibility in responding to the self-selected development priorities, rather than those of the donors. This raises an insight into the question of how far the donor agency would work in accordance with the self-selected needs of the recipient countries when their own personal interest gets affected.

Adding to this, it promotes careful sequencing of liberalization commitment together with expanded social protection policies to buffer liberalisation's health negative consequences. It opines that the social protection policies has to be universal and progressively tax-funded wherever possible and not tied to employment, since many of the world's poorer people are in the informal economy or have less access to employment based social insurance scheme. This commitment to a sound coverage of the poor with social protection in the informal economy is highly doubtful in the neoliberal environment. For example, India has approximately 93% of the population engaged in informal economy without social protection coverage. With the overall crippling of the national policy space, the national government is unable to provide social protection coverage owing to meager resource and budgetary allocation for the poor. Also with widening inequalities between the rich and the poor, it is hard to find universal coverage even in the rich countries for example; in USA approximately 47 million people lack insurance coverage.

Another dimension missed by the knowledge network is the question of how globalization may be changing the nature of infectious diseases. The current forms of globalization are weakening the capacity to address infectious diseases in an effective and timely way. Globalization currently places the individual accumulation of wealth above collective goals such as resource redistribution and social justice. The liberalisation of economies worldwide has demanded reduced public expenditure on, for example, health systems and the promotion of a global economy through multilateral trade agreements has, so far, given limited attention to its associated public health risks.

Globalization from the late 20th century has also been distinct in a number of respects. The most obvious perhaps is the people's greater movement: the advent of

affordable air travel means that almost any destination in the world can be reached within 36 hours, less than the incubation period for most infectious diseases. In addition to tourism, business and study travel, migration and displacement are moving people internationally at an unprecedented rate.

A far smaller, yet worrying number of reports of more serious illnesses including cholera (from infected aeroplane food) and TB warn us that our desire to travel far exceeds our readiness to deal with the potential health consequences of a globally mobile population. As well as hyper-mobility, widening inequalities within and across countries are contributing to our vulnerability to infectious diseases. A billion people live in poverty worldwide, with three-fifths of the developing world lacking access to safe sanitation, a third lacking access to clean water and a fifth to health care of any kind. The end of the Cold War has added to these numbers by pressuring former Communist governments to join the global economy at the cost of cutting public spending on health, education and housing. The so-called 'emerging economies' in eastern and central Europe have experienced particularly serious setbacks, as their basic social infrastructures have crumbled amidst political and economic instability. These countries are reporting worrying trends in the spread of infectious diseases among them multidrug resistant TB, HIV/AIDS and syphilis. Apart from this, globalisation impacts health in many other forms such shifting behaviour patterns (diet and smoking), changes in trade laws affecting workers' health and the effects of trade on agriculture and food security etc.[43]

The other aspect left but needing attention is to think of globalisation and health in the context of sustainable development – ensuring the health of people in the future as well as the present. The impact of globalisation is deterimental leading to inequalities and resource control (land, water, utilities and so on), unemployment, poor condition of labour market, income, political and cultural shifts, which affect the control over policy decisions. Globalsiation could come to mean: we are moving into a period where we know that the actions of each of us as individuals and groups have impacts on the environment and health of others.

The president of Cuba had summed up that 'globalisation is an objective reality underlining the fact that we are all passengers on the same vessel, that is, this planet where we all live. But passengers on this vessel are traveling in very different

conditions. Trifling minorities are traveling in luxurious cabins furnished with internet, cell phones and access to global communication networks. They enjoy a nutritional, abundant and balanced diet as well as clean water supplies. They have access to sophisticated medical care and to culture. 'Overwhelming and hurting majorities are traveling in conditions that resemble the terrible slave trade from Africa to America in our colonial past. That is, 85 per cent of the passengers on this ship are crowded together in its dirty hold suffering hunger, diseases and helplessness. Obviously, this vessel is carrying too much injustice to remain afloat and it pursues such an irrational and senseless route that it cannot call on a safe port. This vessel seems destined to clash with an iceberg. If that happened, we would all sink with it.'[42].

The Measurement and Evidence Based Knowledge Network

The Measurement and Evidence based knowledge network in its final report explains that Evidence about the social determinants of health is insufficient to bring about change on its own; political will combined with the evidence offers the most powerful response to the negative effects of the social determinants. This report begins by identifying six problems, which make developing the evidence base on the social determinants of health potentially difficult. [24-25]

These are: lack of precision in specifying causal pathways; merging the causes of health improvement with the causes of health inequities; lack of clarity about health gradients and health gaps; inadequacies in the descriptions of the axes of social differentiation in populations; the impact of context on interpreting evidence and on the concepts used to gather evidence; and the problems of getting knowledge into action.

In order to overcome these difficulties a number of principles are described which help move the measurement of the social determinants forward. These relate to defining equity as a value; taking evidence based approach; being methodologically diverse; differentiating between health differences, health gaps and health gradients; clarifying the causal pathways; taking both a structural and a dynamic approach to understanding social systems; and explicating potential bias.

The report proceeds by describing in detail what the evidence based approach entails including reference to equity proofing. The implications of methodological diversity are also explored.

A framework for developing, implementing, monitoring and evaluating policy is outlined. At the center of the framework is the policy-making process, which is described beginning with a consideration of the challenges of policies relating to the social determinants. These include the multi-causal nature of the social determinants themselves, the fact that social determinants operate over the whole of the life course which is a considerably longer time frame than most political initiatives, the need to work intersect orally, and the removal of the nation state as the major locus of policy-making in many parts of the world. The ways to make the case for policies are described and appropriate entry points and communications strategies are identified. The next four elements of the framework are outlined in turn: (a) evidence generation, (b) evidence synthesis and guidance development, (c) implementation and evaluation, and (d) learning from practice. Finally the report describes the principal ways in which policies relating to the social determinants may be monitored.

Analysis

The knowledge network sheds light on important points, which the other knowledge networks must adhere to such as the following:

- Need for knowledge networks to more accurately abide by methodological pluralism and evidence-based approach in their working.
- There is a need to have synthesis of evidence on the social determinant of concerned which can help the policy makers to find what works for them.
- It is important for the knowledge networks to propose Guidance for action on how to achieve the equity goal.
- Need for 'equity proofing', which can help to identify, assess and address the potential equity impact (positive, negative, unintended) to maximise the potential health equity outcome and minimize any potential harm.
- Need to introduce Quality standards in the working of the knowledge networks for maintaining rigour by explicating baises, transparency, systematicity and relevance of their work on the social determinants of health

- Need for the knowledge networks to have accurate description on the social structure and its dynamics
- Need to have a multidisciplinary approach combining the best several disciplines such as sociological, psychological, anthropological, historical, political, geography, economics, biomedicine, ecology etc to develop holistic disciplinary understanding to the social determinants of health.
- It is important for the Knowledge networks work towards the problem quoted by the Measurement and Evidence based Knowledge network 'that it is possible to have good evidence about unimportant problems and limited or poor evidence about very important ones. The need is therefore for the knowledge networks is to distinguish between absence of evidence, poor evidence and evidence of ineffectiveness which by and large has been missing.
- The network proposes hybrid polices which incorporates both universal and targeted intervention on social determinants of health but unfortunately the analysis of final other knowledge networks have shown that neither the aspect of universality not targeted intervention has been properly dealt as the commission misses to give much importance to the state responsibility in bringing social determinants of health nor the aspect of social justice catering to fairness and redistribution of resources finds justice.[24-25]

Employment Conditions Knowledge Network

The Employment Conditions knowledge network final report explains that despite the abundant literature availability on the specific employment and working conditions and health, the literature, which focuses on the direct, role-played by the employment relations and conditions, as a key social determinant in shaping health inequalities is rarely existent therefore it aims to provide a rigorous analysis on how employment relations affect different population groups, and how this knowledge may help identify and promote worldwide effective policies and institutional changes to reduce health inequalities derived from these employment relations. [26]

The report focuses on the employment relations and employment conditions and working conditions as key social determinant in shaping health inequalities. Thus employment conditions, employment relations and working conditions as three

different but interrelated concepts. Employment relation's concept constitutes the relationship between an employer that hires workers who perform labour to sell a profitable good or service, and an employee who contributes with labour to the enterprise, usually in return for payment of wages. An important component of employment relations are the existence of power relations between the employer and the employee. In the developed world the employment relation are formal due the high governmental backup. On the other hand in the developing countries the employment relations are much in exploitative hands of informal agencies. Classification of the employment conditions is done in five dimensions across the global scope as unemployment, precarious employment, informal employment, slavery or bonded labour, child labour. Finally, Working relations are related to the task performed by workers, the way the work is organized, psychosocial work environment etc. It includes Occupational injuries, Occupational hazards, psychosocial occupational stressors.

The report identifies labour organisation and political parties as key determinant of differences in the impact of welfare state across countries and over time. The network report builds on two main approaches such as theory-building and trans disciplinary knowledge. It is opined that they may help in understanding the complex links between employment relations and conditions and the health of workers and their families; Second, models may help guide further observations and testing of potential social mechanisms linking employment conditions and health inequalities; and third, theoretical frameworks will also help identify the main "entry-points" (i.e., exogenous factors) to implement policies and interventions to reduce health inequalities.

The Knowledge Network has developed two frameworks based on a single theoretical model with the objective of understanding the origins and consequences of different employment relations and relating them to key political and economic variables, working conditions, and health inequalities. The first model is a macro structural framework, which reflects on the notion that employment relations need to be put into their larger institutional context. Here it is the power relations, labour market, and social policies according to their level of social protection, active policies on employment, and general view (i.e., egalitarian, focus on family, individualistic).

Power relations are crucial to redistribute economic resources and thus to determine the level of equality present in a given society.

A first level of this framework refers to power over the labour market, in government and in civil society, its ensuing labour market characteristics such as labour regulations, collective bargaining and the power of trade unions, as well as to the level of development of the welfare state, that is, the extent to which the state exerts its distributive power through the implementation of social policies. Both institutions are fundamental for understanding employment relations, given that workers´ welfare depends on both the functioning of the labour market and the social protection policies implemented by the state, modifying social stratification and therefore social inequalities.

In the framework, labour regulation refers both to the specific regulation of the labour market (employment protection legislation) and to welfare state benefits related to the salaried relationship, such as benefits for those involuntarily leaving the labour market, for example, income security measures for the unemployed. Collective bargaining refers to the various ways in which labour/capital relations can be conducted. Several studies have found that the most important factor in explaining pay dispersion is the level of wage setting, i.e., whether wages are set at the level of the individual, the plant, the industry, or the entire private sector. The concentration of unions and the share of the labour force covered by collective bargaining agreements also matter.

Meanwhile the level of development of the welfare state determines the level of "decommodification", that is, the extent to which workers are able to maintain a livelihood in society without reliance on the market. The social policies implemented by the state through their lack of involvement into the market protect the work force from the insecurities of the labour market. The welfare state and the labour market are two institutions deeply inter-connected and it is not possible to understand the labour market without considering the welfare state institutions that surround it. Examples of welfare state social protection policies are those related to family, children, and people with disabilities. Various forms of welfare state regimes coexist in today's world that typically follows different paths of development.

The second model is the micro conceptual framework in which one can assess the potential links between employment conditions and health inequalities through a number of behavioural, psychosocial, and physiopathological pathways. Potential exposures and risk factors are classified into four main categories: physical, chemical, ergonomic, and psychosocial, which include factors such as exposure to physical or chemical hazards, repetitive movements, work intensification, hard physical labour, shift-work, or lack of control. While each risk factor may lead to different health outcomes through a number of complex pathways and specific mechanisms, some main points need to be emphasised here.

First, axes such as social class, gender, or ethnicity/race are key relational mechanisms that explain why workers, and often their families, will be exposed differently to risk. Second, three of the key specific social mechanisms underlying class, gender, and ethnicity/race are the concepts of exploitation, domination, and discrimination. Third, those cross-cutting axes (i.e., social class, gender, and ethnicity/race but also other related aspects such as age, migrant status, or geographical location) may be linked to multiple disease outcomes through multiple risk factor mechanisms. That means that the key axes generating work-related health inequalities can influence disease even though the profile of risk factors may vary dramatically. Material deprivation and economic inequalities, exposures which are closely related to employment conditions (e.g., nutrition, poverty, housing, income, etc.), may also have an important effect on chronic diseases and mental health via several psychosocial factors life-style behaviours, and physio-pathological changes.

Looking beyond the models proposed, the network also focuses on the political determinants considering the political process underlying social class formations in the labour market impacting the welfare state across countries as an important determinant of population health. At the level of labour market dynamics, employment relations are core of the welfare state designed at the national level, which could be generalised at global level as well. In the opinion of the network strong bargaining power can act as a key in maintaining good population health. The model suits the countries having strong workers bargaining power but workers bargaining power is not a good indicator in the less and middle developed countries which have informal economy. In order to cover the whole world the network

developed a global typology of employment relations. In this the countries are divided into groups according to their position in the world system (core, semi-periphery, and periphery) while three types of employment relations are generated by each position.

The *typology* shows that the clustering of countries according to labour market characteristics varies greatly between peripheral and semi peripheral (low and middle income) countries on one hand and OECD countries, on the other. *Semi peripheral* countries are characterized by growing informality in their labour markets but they maintain some degree of stability and rule of law in labour market transactions, which approximates them to wealthier *OECD* countries. *Peripheral* countries represent another level of labour market instability altogether. They range from high levels of informal work to severe labour market insecurity where the rule of law or labour market protections are sometimes impossible due to wars, political instability, authoritarian regimes and foreign interventions. Health outcomes among peripheral countries, higher labour market inequality results in higher probability of dying for men and women: higher under-5, infant, neonatal, and maternal mortality rates; and more deaths from cancer and injury. Years of life lost by communicable diseases (both sexes) were also highly significantly and positively associated with the labour market inequality. Similar relationships between labour market inequality and health were observed among semi-peripheral countries with a few exceptions. However one shortcomings of this typology is that it fails to deal with the health inequities within the core, semi-peripheral and peripheral countries

At the policy intervention level, the network has put forth policy level entry points at four levels. The framework built classifies the entry points as A, B, C, D. *Policy entry point A* refers to any change in power relations that can occur between the main political and economic actors in society. Political power is understood here in a broad sense, not limited to traditional political actors (for example, political parties) but including any actor that is meaningful for understanding the social context in a country. In contemporary societies, political actors include political parties, trade unions, corporations, transnational companies, banks, employer associations, and civil society organizations. *Policy entry point B* refers specifically to modifications of employment conditions that reduce exposures and increase vulnerability to health-damaging factors; for example, regulating temporary work to promote safety and

health at the workplace and working hours. *Policy entry point C* relates to actions to modify working conditions such as health-related material hazards in the workplace, behaviour changes, and psychosocial factors present in the workplace or living situation. *Policy entry point D* relates to different types of interventions that may reduce the unequal social consequences produced by ill health and psychopathological change.

The network has made the various recommendations out of which some of the major ones have been mentioned below: [26]

The network recognizes the influence of institutions, social relations including power relations on employment relations. In order to improve health inequalities produced by employment relations, the network places importance to take into account the power differences among social actors such as employers (owners of big businesses and micro-entrepreneurs), workers and government. Along this, for a more equitable balance of power in employment relations in most parts of the world, it is needed to create decent job growth and improve health. The quest for economic development in countries must not come at the cost of the health of the people who make that development possible. Alongside this, Social inequalities due to employment relations represent an enormous social and public health burden. Thus full employment policies should be promoted to reduce the health inequalities associated with unemployment. Secondly tailored employment policies must be developed for young workers in developing/poor countries and for both, old and young workers, in developed countries.

The recommendation says that unless guaranteeing fair employment is recognised as a priority by public health agencies and international regulatory institutions, health inequalities at the workplace are unlikely to be reduced. The concept of *fair employmen*t reflects the necessity to understand power relations embedded in employment relations. Employment relations are an antecedent of working conditions that can affect health directly or through working conditions. Fair employment should imply a just relation between employers and employees that requires: freedom from coercion, job security, fair income, job protection and social benefits, respect and dignity at work, workplace participation, and enrichment and lack of alienation. The concept of fair employment encompasses a public health perspective in which just

employment relations are a prerequisite factor to reduce poverty, improve health, and reduce health inequalities. Fair employment relations, including employment and working conditions, are key social determinants of workers' health. However, today fair employment is not acknowledged as a human right. Political and public health international institutions should recognize fair employment and decent working conditions as universal human rights. There is a strong need to develop communication and dissemination campaigns concerning employment and working conditions as social determinants of health inequalities.

For improving employment conditions in case of the precarious employment, the recommendation is based on the belief that regulation of the labour market via protective legislation (wages, benefits and working conditions) and independent strong unions are necessary to reduce the size of the precarious workforce and its determination of health inequalities. For improving the condition of the informal workers, the task requires promotion of economic development policies and programs in middle and low-income countries considering the offer of formal job posts to assure social sustainability and unemployment reduction.

At the policy level, it requires development of policies targeting the reduction of informal business such as special taxation gradients for unregistered small and home-based firms, Supporting the creation of informal workers organizations based on shared relevant features such as occupation (domestic workers, taxi drivers, etc.), workplace location (farmer markets, streets), conditions such as being a migrant worker, and production chains (food industry chain composed of small agricultural farmers to international trade corporations). These organizations, like labour unions, will strengthen and make politically visible informal workers interests and needs.

Analysis

The recommendation made above raises the following doubts to us such as the proliferation of the informal economy voices a feeling of alienation and exploitation for a large chunk of workers without a social protection cover. The creation of the informal workers organization has both merits and demerits. On one hand it can help in getting the interest and needs voiced at the political front and can help in their plea for formal jobs opportunities heard. On the other hand the creation of unions can

invite growth of power politics within the informal sector creating differences in the interest thus harming the principle of solidarity. It can lead to proliferation of different inform workers unions symbolizing different occupations at the cost of one uniform body standing for formalization. The power game can inflate exploitation of the vulnerable group viz women, children and the poor workers at the lower rung. The union leaders if not democratic can bully the needs of the vulnerable group in garb of personal rewards. Secondly the suggestion of the creating of economic polices to secure job opportunities in the formal sector is vague in nature as it ignores to lay set of practical guidelines for the planners to explain how with a range of budget and infrastructure inputs opportunities to work in this direction.

With regard to the Primary Health Care, it views the provision of universal coverage by health care, including occupational health and safety programs integrated to primary health care, especially family health care programs. This is an additional point, not addressed in the Alma Ata declaration. But today, when the PHC philosophy is almost dead, how far this additional provision gets coverage and where (whether in the non-existent PHC in most developing countries or within the highly selective PHC) is uncertain. In addition to this it suggests development of occupational training and empowerment programs, including occupational health and safety contents, targeting informal workers and social movements. It also supports collective arrangements for production based on solidarity as exemplified by the so-called solidarity economy. Also Health and health equity among workers should be a matter of public health, thus they should be guaranteed to working people independent of their conditions of employment. Here the strategy and model of primary health care has a capacity and a responsibility to reach these sectors with preventive and curative interventions and with support for reinsertion into work. But after the complete fall back of the PHC approach of the Alma Ata, the report could have suggested the ways of how despite the complete dominance of capitalist profit-based neoliberal economy, the PHC approach still can become a success.

With regard to improving the employment condition of child labour, it suggests government–led national industrial policies devoted to full employment, universal education and enforcement of fair employment standards are necessary to eliminate child labour. Secondly there should be development of programs to raise parents'

awareness about the social and health problems caused by child labour, and when applicable, conditional cash transfer programs to poor families with school-age children.

Again the recommendation has loopholes as less leverage is given to structural inputs such as availability of adequate infrastructure for ensuring setting up of schools, employment avenues for guaranteeing universal education and full employment. Also, the awareness generation strategy is ineffective as it forgoes the social forces that lead to child labour proliferation. The problem of Child labour is not on an account of parent's ignorance over its health and social ill repercussions on the child. The rising poverty in the families precludes a child from getting healthy childhood development needs over which the parents compromise to earn two square meals for basic survival. Lastly there exists great difficulty in ensuring success to the conditional cash transfer programs to poor families with school-age children in the developing and poor countries as this requires a proper accountability checks for ensuring that cash benefits in curbing child labour over the families whose basic survival is at stake.

In case of another employment condition, slavery, the recommendation say government lead national policies devoted to full employment, and educational opportunities, national and international law enforcement of fair employment standards are necessary to eliminate slavery; secondly there needs to be developments of international campaigns to raise awareness about sex traffic targeting potential victims, and provision of support and protection to those who is seeking for help; thirdly supporting land reforms in developing countries can potentially reduce slavery most common in areas of rural land conflicts

It recommends combining state and community level policies through intersectoral actions. The role of the state should be guarantee health and work as rights, along with access to fair employment and decent work. Also the state must take responsibility to ensure real participation of the less powerful social actors. The recommendation places importance on the role of the state and intersectoral action, but it is not easy to implement in the neoliberal political economy The recommendation includes that the health sector should assume a fundamental role in the achievement of health equity for workers and their families. It can do so by including in discussions about economic development models, the labour market, and

norms and regulations on employment and working conditions, the centrality and importance of the impact of these factors upon the protection and promotion of the health of workers and their families. The principal guarantors of health and health equity for workers are the workers themselves. Health cannot be delegated. For this reason, society as a whole must guarantee to workers the right to know about the health risks generated by employment and working conditions and must provide them with the tools for participation and real influence in the negotiation and modification of employment and working conditions.

The network also sheds light on the existing gaps in knowledge. It suggests promotion of more longitudinal empirical research and reviews in relation to issues such as the mediating mechanisms between employment dimensions, their interrelation one to each other, and several health outcomes. There is also a need to stratify employment dimensions by social class, gender, age, ethnicity/race and migration status. Secondly more research is needed about public health and health inequalities in relation to employment relations in the middle and low-income countries. Most research, concepts and theories are developed within developed countries without taking a multilevel (from social system to individual health) perspective into account. Thirdly there is a lack of theoretical frameworks showing the links and pathways that create employment dimensions leading to poor health outcomes. Fourthly there is a need to generate models that specify how macro-social processes, operating at the country and regional levels, individual employment situations, and health are interrelated. Finally explanatory models are also needed for guiding public health interventions but also for the evaluation of policy interventions at various levels.

Health System Knowledge Network

The final report by the Health system knowledge network explains health system as a social determinant of health. The Health systems are seen as encompassing *'all the activities whose primary purpose is to promote, restore, or maintain health'* (WHO 2000). Health Systems Knowledge Network is involved with the task of synthesizing evidence to inform health system action against the root causes of health inequity. The macro-economic policies and neo-liberal health sector reforms have dominated the system development over the last decades due to which Health systems have failed in many ways. Health system as a social determinant of health equity pertains

to social stratification, differential access and use of health care, differential experiences of health care use, differential consequences, health inequity by health system intervention in the form of intersectoral action for health, social empowerment, primary health care, health care financing and organization, redistribute welfare, financial protection from health care costs, respectful treatment etc. [27]

The recommendations are underpinned by three understandings derived from review of international experience: The experience of health systems is always context-specific; it requires substantial and co-ordinate reorientation through re-framing of policy and institutional transformation; Also despite the increasingly plural nature of health systems (especially with respect to health care provision), the public sector plays the primary role in working towards health equity and should be strengthened to achieve this function.

The recommending section in the report concludes, that Ministers of Health and health officials and civil society organizations must mobilize action towards intersectoral relationships, facilitating social empowerment, gradually building up universal coverage, revitalizing primary health care, also the progressive policy actors working at national level must take action to build coalitions of support for policy change, and finally the International actors must support national led health system transformation and action.

The first recommendation aims to achieve the Intersectoral action for health (IAH), which refers to 'a recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone' (WHO 1997). The definition of IAH is interpreted to include collaborative action between different departments and bodies within government, as well as between actors within and outside government, such as civil society organisations, for-profit private organizations and communities. Further IAH is a complex political process, involving diverse groups in wide-ranging activities.

The second measure suggested is to mobilise Social empowerment, which refers to 'people's ability to act through collective participation by strengthening their organizational capacities, challenging power inequities and achieving outcomes on many reciprocal levels in different domains: including psychological empowerment, household relations... transformed institutions, greater access to resources, open governance and increasingly equitable community conditions'. Social empowerment interventions take many forms but commonly engage people collectively through participatory processes in identifying health needs and strengthening capabilities to address them.

The network recommends Ministers of Health and senior health officials to gradually build up universal coverage which involves reduction in the out-of-pocket payments removal of public sector user fees, developing innovative ways to limit other health care costs (such as drug and transport costs); widening geographical access to comprehensive services by investing in public primary and secondary services in currently under-served areas and strengthening referral linkages (strengthening maternal care will offer particular benefits for women); re-allocate government resources between geographical areas taking account of population health needs and all available funding sources; develop innovative strategies to improve the acceptability and quality of public sector health care; and enhance technical efficiency (especially in relation to pharmaceuticals).

The network recommends that the Ministers of Health and health officials, working with civil society organizations should strive to revitalize PHC. The report provides an evidence base support to PHC in bringing health equity. The PHC approach recognizes that, through intersectoral action and social empowerment, the health system can leverage 'upstream' impacts that influence social stratification and other social determinants of health as well as intervene in the pathways that lead to social inequities and ill-health. PHC integrates the promotion and prevention interventions that act on these determinants, whilst, in terms of the health care delivery system, the primary level of care also plays an important role in promoting health equity.

The key steps involved in all contexts are to: strengthen the local level (sometimes called the District Health System) as the foundation of the health system and the focal point for the wider action needed to address the social determinants of health inequity;

adequately fund the local level and PHC, within the framework of universal coverage; recognize and tap local-level opportunities for partnership between multi-disciplinary teams of local public health professionals, CSOs and local political and community leaders; provide the primary care level with infrastructural and logistical support, especially in terms of drugs, technology and transport systems; ensure the availability of local health personnel with the necessary resources, values base and skills to take action on health inequity and work with disadvantaged and marginalized populations; strengthen local health management by training and motivating managers and by establishing local information systems that support action on health inequity

The network recommends that the progressive policy actors working at national level must take action to strengthen the processes of developing and implementing policies. In says that addressing the social determinants of health inequity is not simply about making appropriate policy choices, as politics always matters. It is important that the progressive policy actors who seek to bring about health system transformation must recognize these challenges and be strategic about the processes of developing and implementing new policies. They must also, sometimes, take action to address contextual factors (such as wider economic and social policy frameworks, features of the governance system or socio-cultural norms) that may block the development of such policies or their likelihood of effective implementation. This would involve building coalitions of support for policy change, where the policy actors seeking equity-promoting health system transformation may engage other potentially powerful actors who have their own circles of influence (such as the wider pool of public sector health managers and professionals and trade unions, other politicians and parliamentarians), as well as take action to offset policy opposition.

The next step would be to strengthen policy implementation to address health inequity through securing the legislative and funding base of new policies, by establishing clear health equity goals to guide implementation and enable an equity-based evaluation; implementing new interventions first in disadvantaged areas and learning through doing by monitoring and evaluating the experiences of implementation. After this it is important to empower public managers to lead sustained institutional change through: mentoring processes that nurture and develop the values and skills for such leadership; policy frameworks that enable a balance of local autonomy and central

direction and enabling supportive leadership from senior officials and Ministers of Health.

The next recommendation is regarding the international actors, who must support national led health system transformation and action. As the international agents and interests have significant influence over the development paths of national health systems. International actors must make the case for providing international assistance to support national health system action on health inequity: for example, by linking such transformation to achieve the Millennium Development Goals. Three other strategies for international action to support the national health system are to: work with and respect national decision-making and institutions; provide support to strengthen the health equity orientation of national health systems; and increase funding flows for health systems (especially to fragile states and low-income countries). [27]

Analysis

The review of recommendations shows that the network has placed the responsibility on the community, national, international players for reducing health inequity, which goes similar to the framework model suggested by the early child development knowledge network as well. The recommendations put forth by both these knowledge networks looks general. The knowledge network has descriptively discussed the ways of achieving the stated goals. But the actual possibility lies in the implementation of these goals, where the political, economic forces play an important role. In this context, it can be stated that the network's report adds on more details on the goals but does not answers to the challenges upfront at political arena. Adding to this, the issues of accessibility, availability, affordability of health services are central to health systems as a social determinant of health are not discussed.

Also it is important for the Knowledge network to adopt a holistic understanding of health system by focusing on systemic interactions between people and the health service system. Distinctions like health system and health service system are essential to be made are Health system is considered as dynamic concept involving biological and social dimensions of the well-being of human beings. Health service system, on the other hand, is an organized complexity involving preventive, promotive and

rehabilitative services and is only one of the many inputs required to improve the health of the people. The two systems are important for understanding social determinants and to grapple with the problem of health of the people. Different approaches are needed for undertaking empirical studies as both systems have distinct social-political-technological subsystems. For instance, an epidemiological and managerial approach is more important for studying the health services system while a predominantly social science and epidemiological approach is needed for the health system. The health of the people is influenced by the interphase between the two systems in all their complexity with epidemiology providing the connecting link. [36]

Priority Public Health Conditions Knowledge Network

The final report of the Priority Public Health Knowledge Network is still unavailable on the commission's website. Therefore the review of the knowledge network has been based on the scoping paper. The Priority Public Health Conditions Knowledge Network has been established to identify barriers and facilitators of access to health care. It aims to introduce pro-equity interventions within health programmes, particularly in low and middle-income countries. The PPHC-KN is different from the other knowledge networks in three distinct ways: Its analysis evolves from specific public health conditions rather than from the determinants. Its organizational hub and most members are located in WHO where the hubs/co hubs for other KNs and most members are in institutions outside WHO. It has started later than the other KNs.Its objectives are: to analyse selected priority public health conditions and identify the social determinants causing inequities in health outcomes; to propose interventions and actions that can be taken to improve the situation, including possible changes to the organization of public health programmes; to mainstream and integrate the outputs of objectives 1 and 2 into WHO's work, and public health policy and programming

The network focuses on priority public health conditions from four perspectives:

1. To represent large aggregate burden of disease
2. To display large disparity across and within population
3. To affect disproportionately certain population or groups within populations;
4. To focus on emerging epidemic prone conditions

It operates as decentralized network with several nodes in the process and output levels. The role of Secretariat is seen important and will be in process-oriented like providing guidance, managing, monitoring specific analysis. It would also maintain relations, and is the guardian of strategic vision ensuring that all nodes are on track. It will act, as a facilitator, communicator of information, will be responsible for overall synthesis, final publication including organizing external peer reviews.

At the implementation level the scooping paper of the PPHC-KN refers to the following questions for consideration:

- What are the need for and characteristics of champions or enablers to drive implementation
- What are the critical resources, paths, timings, and sequencing, and the potential stumbling block
- What are the key stakeholders and their power relations?
- Who are the potential proponents of change and their values, reasons, arguments and power; and who are the potential opponents
- What are the possible adverse effects

Analysis

It is an important knowledge network, which can play a key role in guiding other knowledge networks and the commission on social determinants of health at the level of analysis, intervention and implementation of any programme with its mentioned expert concerns. Further with its location existence in the WHO, it can serve as a link between the WHO and the other knowledge networks

Social Exclusion Knowledge Network

The Social Exclusion Knowledge Network (SEKN) is one of nine such networks set up by the Commission to collate global knowledge on action to address the social determinants of health. Owing to diversity of various social exclusion definitions, the knowledge network has adopted a relational approach to define social exclusion, where exclusion is viewed as a dynamic, multi-dimensional process driven by unequal power relationships. In the SEKN conceptual model exclusionary processes operate

along and interact across four main dimensions - economic, political, social and cultural - and at different levels including individual, household, group, community, country and global regional levels. These exclusionary processes create a continuum of inclusion/exclusion characterized by an unjust distribution of resources and unequal access to the capabilities and rights required to: Create conditions necessary for entire populations to meet and go beyond basic needs, amenable participatory and cohesive social systems, value diversity, guarantee peace and human rights and sustain environmental systems. [28]

The relational approach to social exclusion helps to broaden the global relevance of the concept, provide a wider lens to understand the causes and consequences of unequal power relationships, make explicit the links between exclusion and a 'rights' approach to the social determinants of health, direct analytical attention to interactions between relationships and outcomes at different levels e.g. community, nation state and global regions, highlighting both *active* and *passive* exclusionary processes, recognizing that exclusionary processes will impact in different ways to differing degrees on different groups and/or societies at different times, recognizing an inclusion/exclusion continuum and allowing for the possibility of inequitable inclusion and extreme exclusion as well as the possibility of differential inclusion/exclusion along different dimensions, hence having global relevance, avoiding the stigma of labeling particular groups as 'excluded', acknowledging the potential for groups and/or nations to actively resist exclusionary processes and their ensuing negative consequences.

Pathway link between exclusion and health inequity

Both constitutive and instrumental pathways link exclusion to health inequalities: constitutively restricted participation in economic, social, political and cultural relationships will negatively impact on health and wellbeing; Instrumentally, these restrictions result in other deprivations, for example, poor working conditions or complete exclusion from paid work in the formal or informal economy, leading to low income, poor nutrition, etc., which contribute to ill-health.

The SEKN model on Social Exclusion

In the SEKN model on Social Exclusion, exclusionary processes are located within social systems (e.g. the family, households, nation states, global regions, etc) i.e., the model assumes that these processes and their impact on health inequalities operate in the context of pre-determined biological determinants which suggests the complex interactions between biology and society with powerful influences on health. Within social systems interactions between the four relational dimensions of power – social, political, economic and cultural – generate hierarchical systems of social stratification along lines of gender, ethnicity, class, caste, ability and age. In turn the stratification systems, and the unequal access to power and resources embedded in them, lead to differential exposure to health-damaging circumstances whilst at the same time reducing people's capacity (biological, social, psychological and economic) to protect themselves from such circumstances, and restricts their access to health and other services essential to health protection and promotion. These processes create health inequalities, which lead to further increase inequities in exposures and protective capacities and amplify systems of social stratification.

Typology of actors in the exclusionary process

State led policies/actions: The knowledge network identifies state led policies: where first group proposes *Universalist policies* reflecting theories concerning the value of social solidarity and collectivisation of risk, these policies extend rights to publicly funded services, typically to all citizens with no fee or only a small fee at the time of use. A second group of state-led policies appraised for the SEKN are based on a selective approach, targeting particular population groups. Typically the only eligibility requirements are some form of citizenship or residency status and in most cases these policies involve means-testing, with eligibility dependent on potential recipients being required to demonstrate that their income falls below a specified level. Three types of unconditional means-tested selective policies are described below: cash transfers, services and subsidised insurance for people living on low incomes. The third type of 'state-led' policies appraised by the SEKN is 'Conditional Cash Transfers (CCT), reflecting theories concerning the 'irresponsibility' of poor people and the need for them to be 'incentivised' to adopt socially-valued behaviour; these

policies provide transfers in cash or kind dependent on pre-defined reciprocal behaviour on the part of recipients.

2. Non-governmental Organisations (NGOs) and community action: Three main types of action are included under this heading: autonomous action by communities in pursuit of social, economic, political and/or cultural rights (ranging from small scale action by community groups to large scale social movements); community engagement in policy/action decision-making commonly facilitated by other actors such as the state as known as silver bullet in the 21st century, NGOs or the private sector; and the direct provision of services or other support by NGOs.

3. Private sector action: For the purpose of the SEKN work, private sector action has been divided two types: service provision, such as insurance, health care or education – discussed in this report in the context of state led policies and actions – and actions broadly labelled corporate social responsibilities.

4. Multi-lateral agencies: These include global agencies such as the various UN agencies, the World Bank, and pan-regional agencies such as the Union.

Two types of strategic initiatives are considered, the first involves initiatives by multilateral and pan-regional bodies aiming to promote new directions for policies and actions with the potential to reverse exclusionary processes. The second involves initiatives by national governments or state agencies within countries aiming to promote better co-ordination and integration of existing policies and services, or reform of services to better met the needs of groups most severely affected by exclusionary processes.

The following are the recommendations for action on social exclusion:

Recommendation theme 1: Advantages of the meaning of concept of social exclusion

The knowledge network emphasis that concept of social exclusion provides a unique framework for understanding the social determinants of health inequalities and for developing more appropriate and effective action to address them. In this context, national governments, international agencies, civil society and private sector actors should: Recognise the underlying relationship between social inclusion and human

rights: action to promote and protect human rights will reverse exclusionary processes and promote social cohesion; Be clear about the added value the concept will bring to understanding the problems to be targeted and shaping the actions to be taken; Promote public debate about the potential benefits and dis-benefits of the concept as a framework for policy and action; Only use the term 'social exclusion' when more precise and informative descriptors of the phenomena to be targeted, such as food insecurity or racism, are not available; Focus on the multi-factorial relational processes driving differential inclusion and conditions of extreme exclusion, rather than solely on ameliorating the conditions experienced by groups labelled as 'social excluded'; Attend to all the dimensions of exclusionary processes - social, political, cultural and economic – and the interactions between them when developing, implementing and evaluating policy and action; Consider the value of using the SEKN conceptual model as a tool for developing more comprehensive policy and action to address social exclusion and as a framework for evaluation.

Recommendation theme 2. The primacy of universal rights and full and equal Inclusion

The primary aims of policies/action aimed at reversing exclusionary processes should be to: Promoting full and equal inclusion to social systems; provide universal access to living standards which are socially acceptable to all members of a society, including access to the same level and quality of health and educational services, safe water, sanitation and 'decent work', as defined by ILO; respect and promote cultural diversity; address unequal inclusion as well as situations of extreme exclusion.

Recommendation theme 3: Responsibility of the State

The State must have the primary responsibility for reversing exclusionary processes, and promoting full and equal inclusion for all groups whilst respecting cultural diversity by: Ensuring human rights are met and protected, including at the very least funding and overseeing universal provision of healthcare, education and social protection; establishing and maintaining accountable and transparent political and legal systems; developing conditions which require and support other actors, including public and private sector organisations and non-governmental organisations, to act to reverse exclusionary processes and promote full and equal inclusion for all

groups whilst respecting cultural diversity; resisting the actions and influence of international agencies likely to increase exclusionary processes; promoting and supporting community empowerment.

Recommendation theme 4: Social movements and community empowerment

Social movements and community empowerment are essential if exclusionary processes are to be resisted and reversed and full and equal inclusion is to be achieved. Not all social movements are a positive force and the state has a role in regulating action by civil society in all its forms but state regulation can be actively oppressive, restricting the legitimate voice and action of civil society, or can inadvertently undermine civil society action – as can the action of multilateral agencies, donor organisations and private corporations.

'Community involvement' is too often used as an instrument for delivering policy designed by other actors, rather than as a mechanism for genuine participation and empowerment. If social movements and community empowerment are to fulfil their potential to reverse exclusionary processes and promote full and equal inclusion, then national governments, international agencies, civil society organisations and other actors seeking to address social exclusion must: create and maintain the conditions – including transparent, accountable and participative political and legal systems, mechanisms and institutions – necessary for genuine delegation of power and control over the design, implementation and evaluation of action to the people/groups who are the target of the policy/action.

Further the international agencies and national governments need to recognise the political legitimacy of civil society and 'community voice'; involve civil society in all its forms in policy development, implementation and Monitoring; enact and implement legal protection for civil society organisations within an appropriate regulatory framework; design policies which transfer real power to the people who are targeted; resource policy implementation to support 'community' empowerment; reform professional education to give greater status to lay and indigenous knowledge.

Recommendation theme 5: The role of multilateral agencies and donor agencies

Multilateral agencies and donors have a major contribution to support states in reversing exclusionary processes and promoting full and equal inclusion for all social groups whilst respecting cultural diversity. However, these same actors have also been responsible for driving powerful exclusionary forces. In the future: A minimum requirement from these agencies must be to ensure their policies and actions 'do the poor no harm'. They should build on existing frameworks to develop ways of assessing the exclusionary/inclusionary impact of their own policies and actions, and those of others, and acting on the results; They should take positive action now to reverse exclusionary processes and promote positive inclusion by: Promoting egalitarian relationships between countries and regions; Working to support the extension and protection of human rights; Contributing to the development of conditions which require and support other actors, including public and private sector organisations and NGOs, to act to reverse exclusionary processes and promote positive inclusion, promote and support genuine community empowerment.

Recommendation theme 6: The limitations of targeting and conditionality

Targeted policies and actions, especially those based on conditionality, can be stigmatizing and disempowering, reproducing exclusionary processes and exacerbating inequities. They have high transaction costs, problems with uptake and are subject to 'leakage'. In this context targeted policies and actions should only be implemented within a framework guaranteeing human rights and universal access to essential services and socially acceptable living standards; Conditionality should only be incorporated into policies and actions where there is convincing evidence that it is necessary to achieve the intended outcome. If policies and actions must be based on conditionality, they will be less stigmatizing and more likely to build social cohesion and collective capacity for action if: The conditions are located at the level of communities and/or groups rather than individuals or households; Conditions are prioritized by these communities and/or groups rather than being centrally determined; Policies and actions are administered and monitored locally through participative mechanisms; The services and/or resources necessary for conditions to be met must be available and readily accessible.

Recommendation theme 7: The limitations of insurance-based approaches

In some country contexts, national social insurance systems are an important funding mechanism supporting comprehensive and universalistic welfare systems free at the point of use. These systems are demonstrably powerful drivers of positive inclusion, promoting social solidarity and cohesion across social groups. The insurance principle has also underpinned collective action by disadvantaged groups aimed at reversing exclusionary processes through, for example, labour movement organisations, mutual societies and co-operatives. Increasingly, however, means-tested subsidised insurance, typically involving private sector 'for profit' organisations, is being promoted by national governments, international agencies and/or large scale NGOs as a way of protecting against the risks experienced by people most severely affected by exclusionary processes.

Recommendation theme 8: The need for policy/action co-ordination

The complexity and multidimensional nature of exclusionary processes require policy/action responses, which cut across government departments and sectors. There is therefore a need for initiatives, which aim to support greater co-ordination across sectors and actors.

Recommendation theme 9: The role of the private sector

The SEKN has not looked extensively at the private sector's role in helping to reverse exclusionary processes but it stresses that private sector provision of essential services, notably healthcare, results in two-tier services and undermines the public sector where it exists. In theory at least, the private sector can be a powerful force to reverse exclusionary processes as an employer, by complying with high labour standards and by developing greater social corporate responsibility across a wide spectrum of issues. Also it stresses that increasing evidence that corporate social responsibility can have significant benefits for the companies involved in building labour skills, increasing demand for products and producing reputational gains. To date, however, most social corporate responsibility initiatives are voluntary and their reach is relatively modest and when it is driven only by philanthropic values, it can reinforce exclusionary processes through paternalistic attitudes and discrimination. In

this context social responsibility by corporate bodies and nongovernmental organisations should be an expectation enshrined in national and international legislation, and the benefits of corporate social responsibility should be more carefully analysed and publicized.

Recommendation theme 10: Measurement, monitoring and evaluation

Systems to support policy and action development, implementation and evaluation should: Aim to capture the dynamics of exclusionary processes, not just describe changes in states of exclusion, Combine objective indicators with experiential/subjective understandings i.e. incorporate both quantitative and qualitative data - indicators and stories; Collect and use both qualitative and quantitative data on the experiences of people most severely affected by exclusionary processes; Aim to incorporate data and stories on all dimensions of exclusionary processes – social, economic, economic and cultural; Seek to obtain 'evidence' on the impact of exclusionary processes on health status and health inequalities; Evaluations of policy and action should give equal attention to outcomes and to factors shaping implementation

Recommendation theme 11: Future research

More research is needed on: Understanding the forces driving exclusionary processes in specific societies, linking global, regional, and local levels; Understanding the relationship between processes of exclusion and the creation and maintenance of health inequalities; Describing and evaluating the action of social movements and community groups in addressing exclusionary processes; Funding systems to support universal systems of healthcare, education and social protection in all countries of the world. These systems need to take account of the global nature of corporate enterprises; Evaluating the impact of policies and actions with potential to reverse exclusionary processes, promoting equal and full inclusion and greater social cohesion; Testing the specific contribution of conditionality to the effectiveness of policies and actions aimed at reversing exclusionary processes; Exploring the role of international agencies as drivers of exclusionary processes and/or actors promoting positive inclusion; Developing more robust systems for requiring corporate social responsibility through international and national legislation and regulation.; Extending

methods and tools for policy impact analysis so that policies can be assessed for their potential impact on exclusionary processes and/or their reversal.[28]

Analysis

The strength of the knowledge network lies in its holistic analysis of the concept of social exclusion. It has also been successful in bringing into light the role of state that has been missed by other knowledge networks. It has also been able to incorporate learning's from the other knowledge networks such as globalization and employment Health system knowledge networks in its final report. The model suggested brings out the dynamics of social, cultural, economic and political dimensions with the caste, class, gender, and race variables.

Following are the weakness of the network

The network talks about the positive role of the private sector in dealing with the problem of exclusion. The causal factor bringing marginalisation of the working force in the employment sector is due to redundancy to the public sector by the private sector. The network does not focuses on strengthening the much needed public sector but on the other hand seeks to discover on ways such as privatization causing exclusion can also be useful in some form. Also the knowledge network has restricted to case study as its sole method of getting data which is limiting. On the other hand usage of participatory research appraisal techniques such as focused group discussion, community mapping, resource mapping, Venn diagram etc offers much more vast area of scope and enquiry into the data on social exclusion captured now. All this could have involved the people affected themselves to narrating their stories, which is also one of the suggestion put forth by the network as community action.

Question of redistribution of resources needs more attention from the network and it needs to focus on the prominent role of the state in achieving social justice. There is also a need to form an international declaration to combat exclusion in future towards which the commission on social determinant of health could pay attention.

The network explains about the dynamics of the social, economic, political and cultural dimensions and the impact on the caste, class, gender, race factors leading to

differential consequences and vulnerabilities in the context of health outcomes. What the network misses is a discussion on how the variables like caste, class and gender interact and impact each other with the changes in the outer environment and its resultant impact on health. Also there is a need to focus on the systemic approach to find the linkages between social exclusion and health system. Social exclusion knowledge network does not discuss on the importance of the life course approach in its model. Further the geographical causal factors leading to exclusion are missed out in the model described.

An evaluation of the final reports of the knowledge networks in the context of social inequalities variables is listed below

In terms of social inequalities there exist three broad groups of categorizations in the literature and in the arena of public debate upon social inequalities. The first categorization is social demography referring to the age, sex, and area of residence ethnicity/ race classification. The second categorization is social and economic status is basically classified on the basis of car ownership, employment, income, occupational social class, socio-economic groupings, and tenure status. The third categorization is the social environment assessing through housing conditions social networks, and social support [14].

In the Social demography the demographic categories of age and sex are known to be strongly associated with morbidity and mortality. Age is a clearly defined and easily measured category. In the category of sex variable, nearly all health data are differentiated at origin by sex. The third feature is the area of residence where a group may be defined by the type of place of residence of its members, such as the inhabitants of a particular housing estate, or block of flats. The forth feature is the Ethnicity where identity is formed in relation to a number of dimensions: self-description, being traditional, participation in the ethnic community, and racialisation. Ethnic identity can be seen as influenced by the wider social structure. The relationship between ethnicity and health is also mediated by structural factors, in terms of socio-economic position, and racial harassment and discrimination. Racism and its accompanying social disadvantage are important aspects of the lives of people from ethnic minority groups to address ethnic inequalities in health. The next feature is of the Family structure and marital status in which there is substantial

evidence that adult health status is strongly influenced by childhood experience. Longitudinal studies of birth cohorts such as the 1946, 1958 and 1970 British Birth Cohort Studies show how a wide range of childhood factors are associated with adult health. It is assumed that most of these effects can best be captured by the socio-economic status of the household or parents, but the family or household structure is also important. There are at least three possible structural dimensions: Household size; Number of adults and their age–sex breakdown, number of children and their age–sex breakdown; Relationship between different household members. The urban setting knowledge network has not extensively dealt with this section

The review of the reports of the knowledge network shows the following. In terms of the usage of the social demographic variables, the sex associated demographic classification has not been fairly dealt in case of the Women and Gender Knowledge Network as work report is centric to the women issues owing to their vulnerability, but this equally debars equal focus over the men issues involving sex related attention. Alongside this, the Urban Setting Knowledge Network was unable give significance importance to the demographic factors such as age and sex. In case of the Early Child Knowledge Network, the span of childhood expands from 0 to 8years. The importance of this period is highly acknowledged but it is vague as it fails to look into the age specific developmental needs and hazards within the span of 0-8 years, which play a vital role in healthy child cognitive, physical, social development. In terms of the Globalisation Knowledge Network, it is evident that it has not taken into account differences based on the sex associated demographic factors with importance. In terms of ethnicity it can be said that such important domain has been missed in the networks such as urban setting, women and gender knowledge network etc.

In terms of the determinant of family structure and marital status, examples show that in the west married people generally have lower death rates than single or formerly married persons; Births outside marriage have higher stillbirth, post-neonatal mortality and low birth weight rates; Married people are less likely to report long-standing chronic illness than single or formerly married persons; Rates of psychiatric disorder as detected by community surveys are higher among the separated and divorced than among the married; Blood pressure is higher among the

single; Average height among remarried couples is lower. Powerful associations have been observed between marital status and health, the increasing trend towards cohabitation means that marital status is less used; instead living alone or cohabiting may be used.

In case of India, marriage remains dominant force. In case of women the risk associated with early marriage and early childbirth complications is very much evident in most parts of the country. Marriage involves additional responsibility of caring, cooking, cleaning and all sorts of domestic work along with surviving in the professional world outside. Alongside this, the responsibility of childbirth increases the to cater to the proper care and development of the child. As a result of web of responsibilities, many a times the health of women itself gets ignored. But the women and gender knowledge network does not looks into the dimension of marriage and its association with health.

The second categorization is Social and economic status, which is basically classified on the basis of car ownership, employment, income, occupational social class, socio-economic groupings, tenure status. In this Education is widely seen as a good indicator of social position and a robust indicator of inequalities. The relationship of educational attainment to geographical area may be difficult to map. It is, therefore, probably not advisable to use education as the only classifier. When it is used, one should always control at least for age, reflecting the period during which the individual was in the school system. Also the level of Occupational social class, offers a systematic approach to classifying individuals according to their wealth. There are consistent gradients by occupational class with death ratios increasing from managerial and professional occupations to unskilled labourers for both men and women; Occupational class of father is associated with chances of survival in the perinatal period; there are gradients for both chronic and acute illness by occupational class; Heights of children and of adults vary systematically by class.

The third categorization refers to the Social environment assessing through housing conditions, social networks, and social support. The classifications considered in the previous section are all characteristics of the individual or the household that are portable in the sense that they are independent of the physical and socio-economic

environment (even though the salience or interpretation of, for example, car ownership, may not be). But several aspects of the physical and social environment, such as housing conditions, rural or urban residence, or social capital, can influence health differentially. These are considered together in this section. The relationship between housing and health has long been held important. The mechanisms that link poor housing with ill health is not as clear or straightforward as they seem and a direct causal pathway is hard to demonstrate. Strategies that seek to target health inequalities based upon housing measures alone may not be adequate. It is recommended that additional measures be included to form a more accurate and balanced picture. Here it can be said that the work by the urban setting knowledge network has been commendable in this direction.

Another dimension of social environment refers to social capital. Social capital is a collective dimension of society external to the Individual. Szreter & Woolcock define social capital as 'norms of respect and networks of trusting relationships between people who are interacting across explicit, formal or institutionalised power or authority gradients in society'. [53] Social capital is a feature of the social structure not of the individual actors within the social structure; it is an ecological characteristic.

The next chapter *(five)* is discussion and recommendations based on the analysis of the working of the Commission on the Social determinants of health.

Chapter 5

Relocating the Discourse on the Social Determinants of Health

The discourse in public health shows differences of opinion over the notion of causality. Two schools of thought with distinct ideologies offer solutions to the issues in public health. To one school of thought it is the proximal causes, which mean the near or the biological factors hold prominence, whilst to the other school it is the distal causes, related to the social determinants where importance lies. From a very long time the debate over proximal versus distal causes is evident. But these two schools of thoughts are lacking in their ability to deal with the issues of causality in totality [31]. The commission on social determinants of health views the causality with the framework of focussing just at the distal causes, which undermines the relevance of the proximal factors. The commission on social determinants of health show how different determinants such as early child development, women and gender equity, globalisation, urban setting, health system etc affect health but it has not been able to reflect how the same determinants can be related to causation of disease reflecting on how the peculiar conditions in these areas can interfere biological functioning on an individual causing disease which reduces the commission's credibility to provide a holistic solution.

An associated predicament in the report of the commission is its discrete image. There is lack of synchronization between the different knowledge networks. Also the networks have ignored to draw a relationship between the referred social determinants and other important social determinants. For example, the final report of the Early child development network report has ignored looking into the social determinants such as education, social support or 'racism' or 'caste' (in the context of India), which lead to social exclusion.

Although many knowledge network talk about the need to have intersectoral action as their core suggestions, however at the same time it was found that the knowledge networks themselves were unable to adapt to this principle in their working as they were unable to integrate their respective knowledge and learning with each other (except for the case of social exclusion knowledge network) due to which it is

difficult to find an integrated approach even between the knowledge networks, also the most of knowledge networks have not been able to aptly look into the issues related to the within the countries context. Adding to the discreteness, the life course approach is not given much attention by the knowledge networks. It is true that early child development plays an important role in the life of the individual but it is equally important to involve an understanding of what is happening in the society in which the life course is being lived as socioeconomic conditions are important both because of their early effects (biological, behavioral, psychosocial) and because of their impact on opportunity structures later in life.

It has been found with most of the knowledge networks misses to explain how in the present context of dominant Neoliberalism can the countries initiate the suggested work on social determinants of health

The commission is found to be ahistoric in nature. It revolves around Primary Health Care approach by overlooking the predicaments of the Alma-Ata Declaration. The commission's work seems more generic in its approach. For instance the health inequalities impact both developed and developing countries. The networks fail to deal independently with the social determinants of health causing health inequalities in the developing and developed world. Apart from this, the recommendations of the reports fall short of addressing the health inequities within the countries, which makes the report loose out on contextual validity.

Political and policy discourse

Issue of social justice has not been dealt fairly. The concept of social justice envisages fairness and redistribution of resources, however to this the commission has an altered interpretation. On the context of fairness, the commission has proposed health gradient approach, which relates catering to the health differences across the whole spectrum of the population than merely focussing on the poor disadvantaged, which in its opinion restricts the policy vision. However it has to be found in near future that how far will the gradient approach reduce or worsen the health inequity. Addressing to second variable of social justice, the redistribution of resources, the commission has refrained its much usage and applicability in its reports. Apart from the case of

few knowledge networks, the role of the State has not been given its due importance in addressing to the social determinants of health.

Unnecessary importance is given to the Private sector. The private sector causing inequity and exclusion of most of the workforce has been given a positive role by the social exclusion knowledge network, which aims that through corporate social responsibility (CSR) private sector can reverse its exclusionary impact. But the role of CSR approach is a piecemeal solution that cannot cater to the needs of the actual number of people hit by the coming of the private sector. Adding more, its top to bottom approach leads to lack of sustainability and confidence among the people, who always remain apprehensive over the life of these programmes, which can get changed, delayed or terminate at any point of time depending on the companies funds, profit and priorities than depending on the existing needs of the people.

Further, the different frameworks and models produced have a trend to identify the different spheres like individual, family, community, nation, international as areas where the work for improving the health equity has to be started. Here within the frameworks the role of the state, which is viable for the welfare of the masses, has not been taken into much consideration except by few knowledge networks. It is opined the commission has sidelined the important and key role of state in reducing health inequality and social determinants of health. On the other hand it has placed the responsibility to the different spheres, where lack on accountability to the agency may lead to difficulties in initiating strategies for action.

Thus the reports of the knowledge networks have cited to a paradoxical situation owing to who holds the responsibility of bringing social determinants of health for reducing health inequity. Many knowledge networks have marginalized the much important role of State in addressing to the social determinants of health, whose role has already minimized due to globalisation, privatisation and dominance of market economy. On the other hand, it has been brought out by social exclusion knowledge network that the private sector can play an important role in reversing the exclusionary process by the mode of corporate social responsibility which shows how the commission's functionalist approach of not disturbing or challenging the status quo of the neoliberal framework prevails in its action.

The commission undermines the scope of determinants of health by reducing the goal of equity in health to achievement of nine stated determinants. Now, the question arises over, who decides over, which social determinant of health is important? The list of social determinants of health is long. It includes basic education, adequate nutrition, food security, road accidents, addiction, early childhood development, women and gender, health system peace, urban setting, shelter, income and social status, a stable ecosystem, sustainable resources, social capital and social support network etc. Among these, it is sometimes difficult to decide which determinant is the most significant. Importance over each determinant may vary both within and outside the national boundaries depending on the needs and priorities and resources available. A particular determinant may become vital to one place but not to the other at one point of time or the other. Therefore talking about social determinants of health involves keeping in mind the changing and complex dynamic nature of the determinants and the contexts. In this case the efforts of the commission on a few stated determinant as the most vital social determinants of health may be out of pragmatism but misses the complexity.

While moving ahead, one question strikes, ' Do we really need to have a global commission on social determinants of health?' The creation of a global commission on the social determinants of health gives an impression that all the national government of different countries are unaware of any knowledge over the social determinants of health and the commission is geared with the responsibility of offering solutions to the entire world. As the socio-economic, political needs and priorities of each country differ from other, differences are also evident over the field of social determinants too. Here the question arises as to how will the commission gear the national governments to work on the determinants involved? Where each country has its own socio-economic and political forces that shape its needs and concern, the introduction of a blueprint approach on the social determinants for all the countries may not be of much help.

For the case of developing countries the knowledge network recommends for provision of adequate national policy space with each countries to determine decisions based on their actual needs and priorities. Here for many developing countries certain other social determinants of health may be needed, which then

means that the commission desist from dumping its ideas but to give adequate national policy space to each country to handle its priorities. On the other hand, in the developed world different countries such as UK, New Zealand, and Australia already depict excellent examples in health improvements based on their national priorities and needs. All this reduces the significance of a global commission.

The commission in its effort to assist the world on the social determinant of health has listed certain determinants, which in its opinion are central to tackle health inequalities. The determinants identified are early child development, women and gender, urban setting, health system, globalisation, social exclusion and evidence based. The question arises here is that; will the action on these specified determinants help in uprooting health inequality?

The play of a functionalist approach is very much evident in the work of the commission, which ignores larger structural factors dominant global power relations etc. The dominance of World Bank and other private endowments has led to the marginalisation of the World Health Organisation whose budget is undersized in comparison with the World Bank. The intention to maximise profit is the agenda of the dominant players today. Increasing privatisation of the health services has made the health services beyond the reach of the common man. The introduction of user-fees, growing cost of essential drugs etc has made health sector an arena for commercial activities. In this phase of expanding health inequalities, the creation of a commission to address to the social determinants of health is an encouraging step, but this would require strengthening of the World Heath Organisation whose survival will determine the commission's existence.

Politics within World Health Organization is evident. Although it is known that the World Health Organization is a global organization for improving health. However it is to be mentioned here that it is also not free from the power relations. It will be quite interesting to know how the final report of the commission on social determinants of health will be taken by the members of the WHO and especially of the security council like US, China etc who follow the individualistic ideological backing.

Dynamics of Power relations from global to local context needs attention. The knowledge networks working to initiate actions at different spheres such as

individual, family, community, national, international must take into account the existence of power relations and ideologies at each level within these sphere. Thus it is important to know who favors what and why first? The commission now needs to gear up responsibility of finding out what are the different types of power groups and ideologies existing in the local to global politics, knowing what is their sphere of influence on health and other sectors, knowing the role of state with regard to the existing power relations, what is the impact of power relations on health equity.

Ideology matters, achieving equity in health is the goal of the commission on social determinants of health and for many countries as well. The term equity in health has been differently defined, due to which no one definition persists. In order to implement work on equity in health, the countries have adopted their own frameworks, which represent ideological basis. The examples of US and Canada represent an individualistic ideological basis [8] over notion determinants of health where the component of its social roots is missed. In another case, UK upholds the notion of health promotion, which is being interpreted in various forms and ways so that it upholds to the individualistic ideological basis of the country. Thus it is interesting to know how the global commission formed to do action on the social determinants of health, executes its decision in a conflicting ideological world.

Apart from this, forces of political economy such as liberalism, conservatism or social democratisation predict the national policy behaviour [8]. Nations with what is termed a liberal political economy such as Australia, Canada, New Zealand, the United Kingdom (UK), and the United States (US) see relatively little government action in support of the social determinants of health; nations with social democratic political economies such as Denmark, Finland, Norway, and Sweden much more so. Nations with conservative political economies such as France, Germany and The Netherlands fall in the middle. Australia, for example, spends 18% of its GDP on social expenditures – 4.7% of GDP on pensions, 2.8% on families, and 2.3% on incapacity or disability benefits.18 These figures are high in relation to the US (14.8% of GDP total social expenditure) and Canada (17.8%), but low in relation to the social democratic nations (Denmark 29.2%; Norway 23.9%; Sweden 28.9%, and Finland 24.8%) as well as conservative nations (France 28.5%; Germany 27.4%; Belgium 27.2% and Switzerland 26.4%) – among others. Indeed, Australia is ranked 22nd of

30 OECD nations in social spending. Liberal nations also have higher rates of poverty and greater degrees of income and wealth inequalities. And not surprisingly, indicators of population health tend to parallel these classifications: liberal nations show highest rates of infant and premature mortality; social democratic nations less so. Thus the Government approach to public policy are not preordained or natural processes, but are socially determined by politics and the power of groups that strive to influence decisions by government to achieve policy objectives.

Moving ahead, one question strikes importance, Is the creation of healthly public policy primarily about health? Or is healthy public policy primarily about politics? [8] Social determinants of health continue to be a marginalized approach to developing public policy. Recent analyses indicate that the concept of social determinants of health is absolutely marginalized in different developed countries such as United Sates and Canada. What role the commission on social determinants of health could play in United States, to elevate the miseries of sufferers (approx. 46 million people in United States are without any social security cover) of health inequalities?

In Canada and United States, and probably elsewhere, there is little penetration of these concepts into either public health discourse or government policy-making[8]. This has much to do with dominant public health strategies whose individualist approach, based in biomedical and epidemiological traditions, conflict with a structural approach to understand health and its determinants. The individualist approach [51] to health is consistent with neoliberal governance approaches in Canada and United States and other developed nations. There, the emphasis on the market as the arbiter of societal functioning conflicts with a social determinants of health approach that requires commitment to equitable income distribution, support of public social infrastructure that provides adequate housing, food security, and strong public health and social service. While there is some policymaker awareness of its importance, governments do not institute health promoting social policies.

Vincent Navarro critically discusses some of the major arguments for the growth of inequalities in health in the world today. In his opinion the most significant reason for increased inequalities in health today stem from "public policies that benefit globalization", which have triggered: a) unprecedented growth in wealth and income derived from capital versus labour, b) polarization in wages and an increase in wage

dispersion, and c) diminishing impact of redistributive policies of the welfare state. He questions the "technocratic," "humanistic," and "apolitical" discourse used by international agencies, such as WHO and the IMF, in their analysis of the growing inequalities, claiming that such discourse obscures the actual causes of this growth: the power relations among and within countries [32].

Trends in the social determinants of health and the policy discourse

Social Determinant of Health is multi-faceted phenomena with multiple causes. While conceptual models of SDH are useful, they do not necessarily provide policy-makers with a clear pathway towards policy development and implementation. As specific policy initiatives tend to be targeted to a specific population group in certain circumstances and for prescribed time-periods, they can neglect the wider context within which SDH are generated and re-generated. Some policy-makers believe that the lack of a simple problem hinders the development of simple policy solutions. There is no 'smoking gun', social inequities in health are 'invisible' and so the policy response tends to be diffuse. Thus at this juncture, it is essential to observe how far the frameworks designed of the different knowledge networks offer solutions to the policy maker's predicament. [6]

Second, recent studies of SDH have emphasized the significance of the life course perspective. The health effects starting *in utero* and in early childhood is profoundly entrenched inter-generationally. Such a perspective poses serious challenges to policy-making processes whose timescales are rarely measured over such long periods. The tenure of elected or appointed officials is measured in months and years rather than decades, the electoral cycles in parliamentary or presidential democracies are usually 5 to 7 years, and even reporting cycles (for budgetary purposes, for example) tend to be much shorter (usually annually). Moreover, coalitions of interests in support of the SDH policy may be unsustainable over the time periods necessary to witness significant change. The attention of the public (often supported by the media) has tended to reflect and magnify such short-term timescales. There have been some exceptions to this especially in the field of public pension policies, but the general problem of timescales remains important.

Third, SDH necessarily implies policy action across a range of different sectors. It is increasingly recognized that action beyond healthcare is essential and, as such, intersectoral partnerships are critical to formulating and implementing policy towards SDH. However, there is a significant body of evidence, which shows that partnerships are hampered by cultural, organizational and financial issues. Whether at central, regional or local level or sectorally (say, between the healthcare sector and the education sector), collaborating organizations operate according to different values, have different accountabilities and performance measures/ criteria, and different reasons for collaborating. For instance, government agencies have traditionally been organized vertically according to service delivery however; such 'silo' or 'chimney' approaches are not well equipped to tackle issues that cut across traditional structures and processes. The health agenda may be quite marginal to the activities of some collaborating agencies. Even in organizations with apparently similar interests, this is further complicated by conflicting performance regimes (indicators, timeframes, incentives, etc). There is also an argument that SDH action is required beyond the state or government, in civil society including voluntary or even private sector agencies. Given the differences between these and state agencies, policy collaboration on SDH can be highly problematic.

Fourth, policy towards SDH must be viewed as one of several competing priorities for policy-makers' attention and resources. Economic policy or foreign policy might at different times take precedence over SDH. More specifically, SDH may be overshadowed in the policy-making process by healthcare itself. However, this *healthcare* focus is often to the neglect of *health* and *SDH per se*. This focus reflects the medicalization of (western) society with its emphasis on the medical model of care, heroic interventions, and the application of the rescue principle. As a result, attention tends to be on the short-term rather than the long–term and on discrete interventions rather than coordinated, collaborative ones.

Fifth, the cause-effect relationships within some aspects of SDH are not readily apparent. Knowing and understanding causal pathways is a first step in devising appropriate policies but the question of attribution remains. In circumstances where a clear cause-effect relationship cannot be linked with a discrete policy intervention, there may be a case for relying more heavily on a value-based approach.

Sixth, in order to identify, monitor and analyze epidemiological changes over time, routine data needs to be available. In many countries, these data are not available, of poor quality or have been collected over insufficient periods to aid policy-making with sufficient sensitivity. Just as one cannot fly a modern aeroplane without a large number of sensors and measurements (dials and meters), one should not expect to manage a nation's population health, including the variety of disparities therein, without a comprehensive health information system.

Seventh, processes of globalization have been undermining the role of the nation state in policy-making. Powers have been relocated to supranational organizations such as the European Union, World Trade Organization, International Monetary Fund and World Bank. In particular, some of the supranational institutions have promoted a neo-liberal agenda. Raphael argues: 'The decline of the social welfare state is driving neo-liberal approaches to policy-making that fundamentally conflict with strengthening the social determinants of health'.

Eighthly, Governments' ability to shape and mould the SDH with the goal of improving their population's health is becoming limited as many of the 'causes of the causes' no longer fall within their responsibility. They therefore need to rely on influence and leverage in multinational networks. There is a parallel argument that decentralization processes to regions and cities have had a similar effect on the policy-making capacity of national governments. [6]

Conceptual models for policy making

It is important the Commission takes into account some of the conceptual models for policy making into consideration which the Measurement and Evidence based Knowledge networks has also cited: [24]

'Policy streams' model

Policy stream model while taking into account the policy making issues: The policy streams model proposed by Kingdon (1995) is concerned with how issues get onto the policy agenda and how proposals are translated into policy. This is the prelude to implementation. Kingdon uses the notion of policy streams to explore the ways in which opportunities for implementation are created. He argues that policy 'windows'

open (and close) by the coupling (or de-coupling) of three 'streams': problems, policies and politics.

- *Problem stream:* Conditions or issues only become defined as problems when they are perceived as such. Often, only problems which are amenable to policy remedies are recognized
- *Policy stream*: Insofar as there are multiple potential issues (which may or may not become defined as policy problems), there are also multiple strategies and policies proposed not just by civil servants or professionals but also by interest groups
- *Politics stream:* This stream refers to the lobbying, negotiation, coalition building and compromise of local, national and international interest groups and power bases.

These three streams may remain separate until they are coupled by chance factors, political (e.g. elections) or organizational cycles (e.g. staff turnover), or by the actions of a policy entrepreneur. The policy entrepreneur facilitates the coupling process by investing their own personal resources (namely reputation, status and time). A successful policy therefore is likely to comprise clear objectives, a mechanism that achieves those objectives and the resources to facilitate the process. Failure to connect these streams will lead to failure of the policy.

Network models

Given that the policy process is a pluralistic activity which involves multiple stakeholders, each with their own interests and motivation, it is recognized that policy development rarely operates in isolation but in networks of these stakeholders. These networks involve interactions between communities of interest. Whilst networks might develop high degrees of trust and dependence, they can equally exclude others from the decision-making process. Close network relations can also foster learning and development as they are grounded in practical experience. As such, networks can foster bottom-up policy developments. [24]

Policy failure model

Wolman (1981) seeks to explain why policies might fail. Rather than assuming that implementation is the most likely outcome, he argues that policy failure is common and needs to be analyzed. His work is useful in highlighting the multiple locations of policy process and the potential causes of failure.Dahlgren and Whitehead (2006) offer an account of potential policy failure in relation to SDH. They argue that there is often a significant gap between policy statements to reduce social inequities in health and the actions needed to reach this objective. Very few in-depth analyses have been carried out to identify the main reasons for this gap.

Social level

The objective measurement of the state of health may be biological, but its definition, perception, and understanding are all rooted in a person's social milieu. People are social beings; they exist in social groups (race, age, sex, caste, social class). Each group has its own social environment and culture that affect people's perception and behaviour towards various issues of which health is one. The social structure determines the ways in which the individuals perceive the situation in which he/she is placed and determines the alternative course of action that appear feasible.

In the international arena the class issue is loosing its prominence, the famous thesis of Amartya Sen work on 'Development as Freedom' [52] ignores the class aspect. Much on the similar philosophical basis the Commission on the Social determinants of health also misses on giving importance to the class context. According to Navarro [32] sources of power in the societies are multiple such as class power, gender power, race power, national and regional power, and so forth. This multiple focus of power does not mean that structurally, under capitalism, some powers are not important than others. According to Navarro class power is the frame within which the power matrices operate. And the class power is based on ownership of resources, be they means of production, knowledge or organization. Also as the class power is reproduced in many different spheres, the public sphere that is, the state plays a critical role. Since the state is the synthesis of power relations, understanding class power relations is essential to the understanding of the nature of the state. And the state plays a critical role in reproducing class relations in any society. State power and

class power are not unrelated both are marginalized in the commission's discourse on social determinant of health.

In the context of India, class as a determinant of health plays an important role. The classification of the class of an individual could depend on the occupation, ownership over land or other possession. In India it is difficult to classify people on pure white collar or blue-collar jobs due to the prevalence of unorganised sector. It is a fact that the people belonging to upper caste also hold a higher class position in the society, which means that the caste affiliation plays an important role in determines the occupational, educational, housing status. The people who are at the lowest rung in the class hierarchy are also the ones who are lowest category in the caste classification.

Another dimension related is gender. The patriarchal structures favours men's dominance due to which the women find themselves in a deplorable condition at the household and the occupational level. Now among women those women who belong to the lower caste would face more hardships in the occupation given to them than the women of the upper caste. They are more exploited in terms of lowest wage, comparatively long working hours, risky environment conditions, less or no resting time etc. This makes the lower caste women also the one in the lowest class section of the society. Therefore the interaction of the class, caste, and gender is related with each other, which the knowledge network should contextualize which at present have been missed out.

Thus in the near future, it is important for the commission examines the collective agents and subjects such as states, social classes and the manifested exploitation and domination as the social determinants of health

Moving ahead it is important to know whether there exists any difference between the terms social determinants of health and health inequality. [15] The concept of determinants of health refers to reducing overall exposure to health-damaging factors along the causal pathway, which involves the working at the range of current national and local targets: for example, to raise educational standards and living standards (important constituents of socioeconomic position) and to reduce rates of smoking (a major intermediary risk factor). On the other hand tackling the determinants of health

inequalities refers to tackling the *unequal distribution* of health determinants. The objectives for health inequality determinants are likely to focus on leveling up the distribution of major health determinants.

Focusing on the unequal distribution of determinants is important for thinking about policy. This is because policies that have achieved overall improvements in key determinants such as living standards and smoking have not reduced inequalities in these major influences on health. Positive trends in health determinants can go hand-in-hand with widening inequalities in their social distribution. Thus distinguishing between the overall level and the social distribution of health determinants is essential for policy development. When health equity is the goal, the priority of a determinants-oriented strategy is to reduce inequalities in the major influences on people's health. Tackling inequalities in social position is likely to be at the heart of such a strategy. It is the pivotal point in the causal chain linking broad ('wider') determinants to the risk factors that directly damage people's health. The role of the commission has neither addressed to the determinants of health or health inequality in totality. In case of determinants of health, by listing nine areas of focus it is not sure whether we can achieve equity in health or even after listing nine target areas the networks have not been able to focus on reducing overall exposure to health-damaging factors along the causal pathway. Apart from this, in the case of determinants of health inequality the commission has not dealt with the aspect of redistribution of resource distribution due to which the aspects of social justice as health as a right are left unheard.

The networks have suggested different models as framework for action on social determinants of health. Unfortunately such Given that the recommendations are fruitful in determining what needs to be done to establish equity in health, it fails to explain how the policy makers needs to take steps to implement these recommendations in the in- egalitarian world order. The work of the knowledge network is a blue print solution in the form of model and frameworks to the societal human problems. It offers mechanical solutions to the structural problems despite knowing that each individual is unique and complex and the political, socioeconomic, cultural environment around him influences. Given this, the 'model approach' may not be of any help until the structural issues rooted intrinsically in the social fabric of specific societies are dealt and also until the national governments are given a chance

to themselves inform about their priorities and choices on the social determinant of health.

Cultural level

Culture is commonly denoted as 'a way of life' along with which social, economic, political, education, religious, health factor are shaped. Culture is the shared, learned knowledge that people in a society hold. The realm of culture has not been given importance by many knowledge networks in their work on social determinant of health. However in the area of health care provision, cultural diversity and the experiences of contrast is increasing. What illness is to one person, or one culture, may be no problem to another, and visa versa. Further ideas about the visible signs of health also differs; for example, many mainstream U.S. women strive for thinness, while in impoverished Jamaica, a plump female body is much more appealing. The people of Fiji also like fat bodies, as these signify a wealth of social connection and financial resources and thus, "health". To keep fit a white American might go for a daily walk or join health club to work out, while an African American might, in addition or as an alternate, take a laxative purge in the spring and several other times throughout the year. All this affects the relationship between patients and providers and the outcome of their interactions, as well as the relationship between and among providers themselves. In an increasingly multicultural society, it thus becomes essential for effective and humane health to learn more about culture. [33]

Geographical level

At the geographical level place plays an important part in influencing health, which has been largely overlooked by the commission. However the aspect of Geography explains how the magnitude of inequities in health not only varies within each society over time but also varies between societies. For example, socio-economic differences in mortality appear to be larger in northern than in southern European countries. This might be due to a varying socio-economic gradient in ischemic heart disease. In England, people living in the south of England are taller than those living in the north. There is a gradient in mortality from low in the south and east of the country to high in the north and west. These are found for most causes of death and for all the major

causes, e.g. circulatory disease, malignant neoplasms, respiratory disease, and accidents, poisonings and violence.

Thus, the existence of disease-specific disparities, along with the prevalence of the disease (and, hence, its importance in the population), provides important clues about the genesis of disease and its distribution in the population. At least in some countries, for example, Canada, the health of socially disadvantaged people who live in generally wealthier areas is better than the health of the similarly disadvantaged who live in poor areas (There is mixed evidence, however, of how the health of advantaged populations is affected by the local presence of disadvantaged groups). The extent to which the health of the more advantaged is influenced is likely to determine the strength of the consensus for or against policy changes to decrease inequity.

Another area requiring attention is the accessibility over the health services determined by the spatial factors in shaping the equity in health. Kinman, E. L. (1999) [13] in the study on 'Evaluating health service equity at a primary care clinic in Chilimarca, Bolivia', attempted to link equity with a temporal and spatial analysis of clinic users, supplemented by a community survey. During the first 25 months of operation, the utilization of the primary care clinic in Chilimarca, Bolivia varied considerably. Spatially, utilization was shifted away from the targeted service area. Within the targeted service area, usage was concentrated in a few blocks of the community and generally diminished with increasing distance from the clinic. The community survey revealed that place of origin, length of residence, and language spoken at home differentiated clinic users from non-users. Failure to include the spatial dimension of utilization would lead to different access and equity conclusions if data had not been decomposed by area.

For example, over the period of the study, patients from the core catchment area declined by as much as 90 percent, to be replaced by clients from other areas. This resulted in changes in the average patient socio- demographic characteristics. The author concludes, "spatial analysis of output measures is imperfect and does not necessarily deal with all of the access issues related to acceptability. They do, however, begin to isolate areas of a defined geographic area where further

investigation would assist in ascertaining, and subsequently addressing, potential problems related to equal access."

Another example drawing importance of the spatial factors, Cox. H. etal: J. and M. Pringle (2000) [13] , in their study on 'Inequalities in access to coronary angiography and revascularisation: the association of deprivation and location of primary care services', attempts to examines inequality in relation to primary care services, particularly access to coronary angiography and revascularisation. (Coronary artery surgery reduces re-infarction rates and mortality in patients with ischaemic heart disease). A cross-sectional survey was conducted in all 180 Nottinghamshire practices in the Trent region between 1993 and 1997.

The numbers of coronary bypass grafts, angioplasties, and angiographies were determined from the regional National Health Service database and linked to a database of general practice characteristics. Poisson regression analysis was used to determine the relationship between the angiography and revascularisation rates and the following practice characteristics: deprivation score, distance from nearest secondary or tertiary referral centre, medical cardiology admission rate for ischaemic heart disease, fund holding status, and partnership size. Multiple linear regression analysis was used to determine the relationship between practice characteristics and the waiting times for revascularisation and angiography. Practices with high deprivation scores had significantly lower rates of utilisation of angiography and revascularisation procedures. Their patients also waited longer for angiography. Practices that were 20 km or further from a revascularisation centre had significantly lower angiography and revascularisation rates. On average, their patients had to wait more than twice as long for an angiography compared with patients from nearer practices. The results suggest that there may be some under-investigation and/or treatment of patients with ischaemic heart disease from 'deprived' practices and for those from practices far from a secondary or tertiary referral center.

Economic level

Material conditions are important social determinant of health, which determine health by influencing the quality of individual development, family life and interaction, and community environments. Material conditions predict likelihood of

physical (infections, malnutrition, chronic disease and injuries), developmental (delayed or impaired cognitive, personality, and social development), educational (learning disabilities, poor learning, early school leaving), and social (socialization, preparation for work and family life) problems. Material conditions of life lead to differences in psychosocial stress. [6] Disadvantages in the material conditions arise due to inequities of socio economic structure, power relations, and its related dynamics leading to income inequality, poverty, Social exclusion based on race, caste, class, gender division. However the concern for improving the material conditions finds a shift to improvement of capabilities and opportunity by the commission.

The commission supports the gradient approach, which moves from addressing to the bottom level in social hierarchy. It explains that penalties of inequalities in health affect the whole social hierarchy; therefore there is a need to improve health at each step up the socio-economic ladder. [46] It contradicts the health gap approach for restricting the policy vision for the reason that the problem and the policy response get again confined to a small proportion of the populations. Consequent response of the adoption of the gradient approach has led the Commission to refrain usage of the class determinant in its discourse

Arguments are cited over whether we need population-based approach or a vulnerable population based approach to reduce health inequality. To this Peter Allebeck (2008)[34] in his article cites the debate where Potvin and colleague (2008) questioned the key messages of Geoffrey Rose quoted in the classical book Strategy of Preventive Medicine with a commentary by Kay-Tee Khaw and Michael Marmot. The message may be summarized as follows: the distribution of risk levels for major determinants of disease follows a continuum in which the high-risk persons are at the extreme end. A large number of persons with moderately increased risk levels contribute more cases than a small number with extreme risk levels. Thus, interventions targeting the general population, aiming at shifting the risk curve to the left, are more effective than interventions targeting high-risk groups.

This latter is called the prevention paradox, since it is not the individuals with moderately elevated risk that have the greatest benefit from such interventions. To this Frolich and Potvin , while acknowledging the important public health impact of Rose's principles, mean that Rose did not address the underlying mechanisms that led

to different distribution of risk in different social groups. They suggest that focus on vulnerable populations, as target for public-health interventions should be a complement to the population-based approach. The concept 'vulnerable groups' denotes subgroups in society characterized by 'shared social characteristics that put them at higher risk of risks' and should thus be distinguished from high-risk groups according to the Rose risk distribution.

But a re-reading of Rose, together with the commentary by Khaw and Marmot, and the paper by Frolich and Potvin, helps us stimulate thinking about theoretical as well as empirical grounds for public-health intervention and their socio-economic consequences. It is easy to make the case that there can be no harm in adding a 'vulnerable populations approach' as a complement to the population approach. But Khaw and Marmot give an example in their commentary showing that while interventions targeted to poorer groups might seem sensible, this is not without problems since i) one would have to set an arbitrary cut-off point for defining the vulnerable group and ii) the appropriate level of intervention may well be the whole of society.

Thus the question arises 'Are the population-based approach and the vulnerable populations approach complementary or contradictory?' [34] It depends, is probably the most appropriate answer. On circumstances, type of population, type of risk factor, etc. A clear policy implication is the need for careful monitoring and follow-up of public-health intervention, with focus on effects—intended or not—in different socio-economic groups

The above-cited answer over the debate finds a push towards the population-based approach in the work Commission on Social determinants of health. However here it should be learnt that the health related targets of the MDGs do not target the least affluent, as the most health targets are stated in terms of improvements in societal averages rather than in terms of gains within poor populations. To this, Gwatkin (2002b)[34] looked at the potential consequence of this by comparing two possible implementation scenarios one without targeting where the richest group benefit first in a low income country (top down) and a second where the poor are targeted (bottom up). Large variations were observed between the top and bottom population quintiles. Inequalities in child under fives mortality rates would be ten times as high using the

top-down approach compared with the bottom-up approach. He argues that the drive for rapid improvements in global average ignoring targeting may undermine the principle of helping the poor, and it might be better to focus on more challenging efforts targeting the poor, even though it may take longer to reach the MDGs.[35]

Recommendations

Trends towards a Holistic framework on Social determinants of Health

The Commission on the Social determinants of Heath needs to move towards a holistic approach that offers solution to the social determinants of health in a fuller manner. Many prominent efforts are highlighted to explain the trends towards the need to bridge the casual divide in the public heath thinking for the commission on the social determinants of health to revisit its thought of 'distal' importance.

The first is the attempt towards building **Holistic epidemiology** [36], which emphasis to focus at different levels. In this first is the issue of perspective, where support epidemiology and system approach are important in building holistic epidemiology. As epidemiology explains the extent, distribution and determinants on health and health related aspects and application of them for the improvement of the population on one hand, the System approach on the other hand reflects an understanding of the Health System in the larger context, which explicate the interrelationship between the sub parts, influence of power relations and resultant disparity at each level. In the present understanding of social determinants of health, holistic views are based on a systemic understanding especially with regard to interactions between people and health service system. The second level is the operational and empirical level, where the identification of the pathways that result in ill-health become important in order arrive at determine policy-decisions. Moving ahead the third level focuses on rectifying the health services where the access to health care has been problematic to large section of population especially due to globalisation by rejuvenating the focus of the primary health care approach to refocus the issue of universal access to the poor and disadvantaged.

The next approach is the **Social-ecological** system perspective invoked by Anthony McMicheal in 1999, depicting a cube, representing the past/present, whose three axes

extend from individual-to population, proximal-to-distal, static/modular to life course and which is projected forward to future [37].

Another is the **Eco-epidemiology** [37] proposed by Mervyn Susser in 1996, with its image of 'Chinese boxes' referring to nested interactive systems each with its localized structures and relationships. According to Susser, 'States of health exist in people; people form societies; any study of the attributes of people in relation to health outcomes is also one of the manifestations of the form, structure and processes of social forces.' [37]

Subsequently the **Ecosocial theory** [37-38] clarifies more on the dialectics of causality in public health. Ecosocial theory is one of the contemporary theories in the field of Social epidemiology that offers solution to the proximal versus distal divide. Social epidemiology actually refers to the study of the role of social factors in the etiology of disease' or better understood as calling for a marriage of sociological frameworks to epidemiological enquiry. Focused on the guiding question of 'who and what drives current and changing patterns of social inequalities in health', the ecosocial approach fully embraces a social production of disease perspective while aiming to bring in a comparable rich biological and ecological analysis.

There exist four major core constructs of ecosocial approach. This includes embodiment, pathways [47] as pathways of embodiment, cumulative interplay between exposure, susceptibility and resistance, accountability and agency. Here, the notion of 'embodiment', is central to the construct of the ecosocial approach, it recognizes that we as humans, are simultaneously social beings and biological organisms. Understanding probable pathways of embodiment thus requires clarity about what it is that bodies do, as jointly biological organisms and social beings. Minimally, this includes: (a) For biological organism: reproduce; develop; grow; interact; exist in time and space; and evolve; (b) For social being: societal context; social position; social production; social consumption; and social reproduction. Consideration of these integral aspects of bodily existence is key for understanding both population health and social inequalities in health.

Connecting to this is the second core construct related to the trajectories of biological and social development covered in the pathways of embodiment, which includes (a)

social arrangement of power and property and contingent patterns of production, consumption and reproduction, and (b) constrains and possibilities of our biology, as shaped by our species' evolutionary history, our ecological context, and individual histories.

The third construct focuses on the cumulative interplay between exposure, susceptibility and resistance, expressed in pathways of embodiment, with each factor and its distribution conceptualized at multiple levels (individual, neighborhood, regional or political jurisdiction, national, inter-or supra –national) and in multiple domains (e.g. home, work, school, other public settings), in relation to relevant ecological niches, and manifested in processes at multiple scales of time and space.

The fourth construct refers to accountability and agency, that is related to pathways of knowledge about embodiment, this involves accountability towards the agencies involved such as institutions, government, business and public sector, households and individuals and also towards the epidemiologists and other scientist for theories used and ignored to explain social inequalities in health; a corollary is that, given likely complementary causal explanations at different scales and levels, epidemiological studies should explicitly name and consider the benefits and limitations of their particular scale and level of analysis.

Thus ecosocial approach explain that societal patterns of disease represent the biological consequences of the ways of living and working differentially afforded to the social groups produced by each society's economy and political priorities. Class and racial inequality, for example, differentially affect the living standards, working conditions, and environmental exposures of the dominant and subordinated classes and racial/ethnic groups, thereby creating class and racial/ethnic health disparities. Stated more generally, a society's economic, political, and social relationships affect both how people live and their ecologic context, and, in doing so, shape patterns of disease distribution.

Given the complexity of the Social determinants framework, there is no doubt that we need to relocate the existing framework of the Commission. The following concluding chapter attempts to discuss the salient features of the Commission followed by its strengths, limitations. It also tries to outline the trends and challenges.

Chapter-6

Conclusions

The chapter attempts to put forth an over view of the discourse on the Commission on Social determinants of health which includes the salient features, strengths, weakness, trends, policy level challenges, emerging areas, future challenges on Social determinants of health to revisit in the near future.

Salient features of the Commission on Social determinants of health

The commission on social determinants of health has nine knowledge networks. The review of final reports of the Knowledge Networks (KN) on Early child development, Globalisation, Employment, Women and gender, Social exclusion, Priority public health condition (scoping paper), Health system knowledge, Urban setting knowledge and Measurement and Evidence based knowledge network shows how the different knowledge networks addresses to the specified social determinants of health and proposes analytical frameworks and models for action based on certain accepted principles and norms. In terms of the inventory of actions suggested, most of the general recommendations refer to the need for intersectoral coordination, primary health care, social empowerment, community participation, involvement at the national and international level etc. Apart from this, specific recommendations have been made related to the concerned social determinant of health by the knowledge network

The strength of the Commission on Social determinants of health lies in its ability to bring to light the issue of social determinants of health after the Alma Ata Declaration. With rise in world inequities and its consequent health inequity today in the neoliberal world order, the commission brings to the forefront of the concern for reducing health inequities and it opens a much needed forum for discussion reflecting debates, concerns, criticism, analysis, work on the social determinants of health and reduction in health inequities which can help in formulation policy agenda towards social determinants of health.

The Commission on the Social determinants of health faces certain limitations: the notion of social justice is not adequately dealt by the commission; the aspect of fairness faces altered interpretation which moves from class based approach to gradient approach. On the other hand, the other key dimension of social justice, which is the redistribution of resources, has been completely missed out. Secondly the commission poses a paradoxical and unclear note on the responsibility of catering to the social determinants of health where different spheres like individual, family, relational, residential, community, national and global etc are identified for action but the much needed role of the State in bringing social determinants of health is not given its much due importance while it gives the private sector responsible for bringing health equities through corporate social responsibility which reflects a paradox over welfare versus market driven State. Thirdly, the commission has given models and frameworks for action but it refrains from explaining how the countries facing the challenges of neoliberalism in the present context can move into the models suggested. Therefore commission does not challenges the neoliberal world order but adopts a functionalist approach by proposing work on a few social determinants of health. Here again, the question arises how far the commission will be able to reduce health inequities through its proposed nine social determinants?

Also question arises over whether we need to have a global commission on the social determinants of health, which is based on the assumption that inaction on social determinants of health is on account of lack of knowledge regarding them. This masks the real issue of power relations precluding the national governments not able to take actions on the social determinants. It is also important to know who decides which social determinant is important as the list of social determinants of health is long and each determinant holds its importance depending on the contextual realities. Therefore how far the stated determinants would reduce health inequity?

Also important is to know how the commission mobilizes different countries to adopt its frameworks on social determinants as each country's contextual realties varies and any force from commission can become a sign of encroachment on the national policy space which the commission itself propagates to not to violate? The commission's knowledge networks fails to address the existence of power relations at each realm of the social, structure and its dynamics. An issue that remains largely hidden in these

discussions of the social determinants of health is that of social class and its meaning within capitalist society. The literature usually refers to income, social status, or socio-economic positions as primary social determinants of health, which serves to depoliticise much of the discussion about stratification within societies. Introducing the class into the debate begs the question of how the organisation of capitalist societies both creates and maintains inequalities in economic, social, and political power, thereby shaping booth the determinants of population health and population health itself. [8]

Further there exists a causal divide in the thinking on public health between the proximal versus the distal causes [31]] and in the case of the Commission the distal causes are given more importance, which lacks a holistic understanding of health. The other weaknesses of the commission are its discreteness, it's ahistorical approach, mechanistic approach to the structural problems, inability to take into account culture, geographical issue as important components impacting on health.

Emerging areas for the Commission on Social Determinants of health

It is important that the Commission on Social determinants of health takes into account the emerging and significant threats to health that require global action if they are to be tackled effectively. These include aspects related to climate change, environmental degradation in the context of sustainable development, growth in infectious and non-communicable diseases, and causes related to international conflict and terrorism. [35] In the case of infectious diseases HIV/AID is seen as the first widespread emergent infection of global interconnected era; the transmission of infectious diseases generally is a critical issue for global health in the twenty-first century and an obvious example of the health interaction between countries regardless of their geospatial boundaries. There is emergence of new infectious diseases which require attention of the commission such as SARS virus, bird flu, mad cow disease, hantavirus, monkeypox etc which manifestly demonstrates that geographical boundaries are highly permeable to communicable diseases, helped in part by the increase in international travel and the effects of global change. Such examples illustrate that the nature of health problems have become globalised, with the need for a global view and a global approach to public health imperative, which the commission should also observe. However, more importantly, the commission needs

to focus on the various staggering problems being faced by the developing countries related to causes of mortality and morbidity in terms of infant mortality, female feticide, and maternal mortality, nutritional deprivation, hunger etc.

It is well established that social determinants of health are excellent predictors of illness and disease but we know little about how these same health determinants lead to recovery from illness. This is an emerging area of enquiry. [8]

Trends

Tackling social inequities has been approached in different ways. Today the discourse on social inequities has moved from improving the much-needed material conditions, provision of basic amenities, strengthening public sector to what Simon Szreter calls as economic growth and empowerment, to community empowerment in Nicholas Stern's opinion [7], to increasing freedom, opportunities, capabilities in Amartya Sen's view. [44] Adding to this Support led model, control, autonomy, social engagement in the form of social network and social capital, are the dominant buzz ideas. All these views are very much guiding the discourse of the Commission on Social determinants of Health. However we need to find out in the near future how far are these actually the real solutions to poverty? How far the solutions like gradient approach, capability approach, empowerment, freedom fit in and offer help to the developing countries? Also it is interesting to find a lot of reliance on Social engagement but very less is known on how will it operate and deliver?

Adding to this the issue of class has been marginalized and is replaced with gradients favouring Weber's notion of status. Today the role of the State, public sector is replaced with corporate social responsibility of private sector, formation of alliances and network, role of technology, media, community-based health promotion, addressing to complexity of human behaviour, capacity building etc. Reflecting upon the other trends in working on social determinants of health, it is opined that different countries follow their ideological framework when it come to implementation. For example the expression of individualised ideological basis is evident in the Health promotion policy of United Kingdom.

Future Challenges

Whether health policy is about health or politics is the question, which will determine the future of the commission. The interim report makes a mention that the final report of the Commission would be published in May 2008[3] but its delay is evident which probably indicates the bureaucratisation and priorities of WHO. Thus it would be interesting to know when the final report comes out, how the different countries react to the final report of the Commission on the social determinants of health in future etc. Also it would be interesting to know which all countries accept or reject the report. Ideally this would shed light on the political ideological backgrounds and socioeconomic circumstances, which would make the countries, assess their programmes with regard to Commission's report to arrive on decision. It would also be interesting to understand the opinion of different countries and their basis and perspectives on the acceptances rejection or marginalization of the final report of the Commission on Social determinants of health.

The commission in its effort to assist the world on the social determinant of health has listed certain determinants, which in its opinion are central to tackle health inequalities. The determinants identified are early child development, women and gender, urban setting, health system, globalisation, social exclusion and measurement and evidence based. The question arises here is that will the action on these specified determinants help in uprooting health inequality?

Achieving equity in health is the goal of the commission on social determinants of health and for many countries as well. The term equity in health has been differently defined due to which no one definition persists. In order to implement work on equity in health, the countries have adopted their own frameworks, which reflect an ideological basis. The examples of US and Canada represent an individualistic ideology over a collectivistic notion. In another case, UK upholds the notion of health promotion, which is being interpreted in various forms and ways reflecting the individualistic ideology. Thus it is interesting to know how the global commission formed mainly to initiate actions on the social determinants of health executes its decision in a conflicting ideological world.

Much of the future challenge for commission rests on its ability to find ways for mobilizing different national countries to work on the social determinants of health who are trapped in the vicious circle of neoliberal dictated national policy space, privatisation, rising debts and liabilities, strong hold of individual market driven structures, rising corruption etc. Further in the near future, it is important for the commission to deeply examine the collective agents and subjects such as role of the States, social classes and the manifested exploitation and domination as the social determinants of health.

Recommendations: What needs to be done?

There is a need to overcome the causal divide and move toward a holistic framework by also considering the embodiment of social and biological factors. It is also important to have a systemic understanding especially with regard to interactions between people and health service system. [36]

The future work of the knowledge network should be based not only on what is ideal to achieve regarding equity in health but to propose the ways by which the poor under developed countries could achieve the ideals. Strengthening of Health System is crucial although this is quite challenging in the current situation increasing international pressure on the national governments in the context of globalization. The work of the commission would be more rewarding if it is able to influence and mould the strategies of the World Bank and other private endowment bodies in this favourable direction although this may be unrealistic to expect given the economic, political and strategic objectives of such organizations.

The commission on social determinants of health must adhere certain principles stated by the Measurement and Evidence based Knowledge network [24] but missed by others such as there is a need for knowledge networks to have accurate description on the social structure and its dynamics, to build more accurately on methodological pluralism and evidence-based approach in there working. There is a need to have synthesis of evidence on the social determinant of concerned, which can help the policy makers to find what works for them by learning from others experiences. It is important for the knowledge networks to propose Guidance for action on how to achieve the equity goal. Further need is to have 'equity proofing', which can help to

identify, assess and address the potential equity impact (positive, negative, unintended) to maximise the potential health equity outcome and minimize any potential harm. Also there is a need to introduce Quality standards in the working of the knowledge networks for maintaining rigour by explicating biases, transparency, systematicity and relevance of their work on the social determinants of health. To this a multidisciplinary approach combining the best several disciplines such as sociological, psychological, anthropological, historical, political, geography, economics, biomedicine, ecology etc can help to develop holistic disciplinary understanding to the social determinants of health.

Beyond that there is a need to contextualize the discourse on social determinant of health, which means that the commission must move from 'we know' to 'they know'. The commission should allow the national governments to put forth country specific social determinants needing attention to the commission. Thus the work on the social determinants of health cannot be a top-down approach as proposed by the commission, which then trickles to the needy countries but on the contrary country-specific and contextual realities need to be given importance.

Evaluation and monitoring of the impact of actions must be an integral part of any intervention or action. As a priority concern in future, it is required to do an enhanced monitoring of social inequalities of health, so that data becomes available –cross stratified –by class, gender, and caste, race/ethnicity and any other social group subject to economic and social deprivation and discrimination, in order to gauge the progress and setbacks in reducing social inequalities in health. Second priority refers to funding interdisciplinary aetiologic research to identify conjoint social and biological determinants of disease at a proper spatiotemporal scales and levels of organization. The third funding priority should be on interventions-based research based on the above research. [37]

It is important for the Knowledge networks to work on the problem quoted by the Measurement and Evidence based Knowledge network,[24] that it is possible to have good evidence about unimportant problems and limited or poor evidence about very important ones. The need is therefore for the knowledge networks to distinguish between absence of evidence, poor evidence and evidence of ineffectiveness, which by and large has been missing.

Another important area of work, which requires attention, is the cross-cultural research comparisons between different country and cultural contexts. Social inequity is itself made up of a number of sub axes related to gender, ethnicity, disability, geography, caste, and social class for example. A programme of research is urgently required to explore the degree to which these axes of social differentiation overlap interact and cluster together, and the impacts of these on heath disparities cross culturally.

To conclude, Professor Sir Micheal Marmot in his paper 'Health In An Unequal World' quotes Chile's Pablo Neruda and invite people to: 'rise up with me ... against the organization of misery.' [39]. Which to me echoes like a revolutionary move but after reviewing the work of the commission, it seems much like a piecemeal move resisting any real challenge to the organization of misery.

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