Social determinants and NCD

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Objectives

By the end of the lecture, the participants will be able to understand the:

- Social determinants of health and CSDH
- Relation between SDH and NCD
- Other “macro” reports: MDG
- Barriers and opportunities for interventions centred on SDH
- Approaches to NCD in the context of global agendas
- Conclusions

Why treat people…

then send them back
to the conditions that made them sick?

The Final Report of the WHO Commission on Social Determinants of Health. 28 August 2008

Commission on
Social Determinants of Health

History: trends and opportunities

From WHO

Social dimensions of health affirmed in **WHO Constitution** (1948), downplayed during 1950s era of disease campaigns.

Determinants re-emerge under Alma Ata **Health for All agenda** (1970s), action falters in 1980s.

1990s: Paradigm of health as private issue dominant; some exceptions.

2000s: “Step-up" and new chance for action. 2001: Commission on macroecon & H

2005 **Commission on social Determinants of Health**

C-PHC

S-PHC

Reforms & Minimum Packages

MDG

Scaling-up

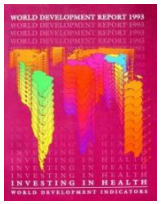
1948

1978

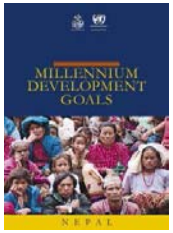
1982

unicef

1993



2000



2001

2002

2005

What are the social determinants of health?

- Greatest share of health problems is attributed to social conditions in which people live and work
- Effective policy to tackle health challenges must address underlying social conditions that make disadvantaged people more vulnerable

- Focus on “causes of the causes”
- MOH cannot address health challenges alone
- MOH can take leadership in advancing actions/policy on SDH across gov. departments and wider society

- **To clarify these processes, WHO set Commission on SDDH & turn PH knowledge into pragmatic policy agendas**

What are the social determinants of health?

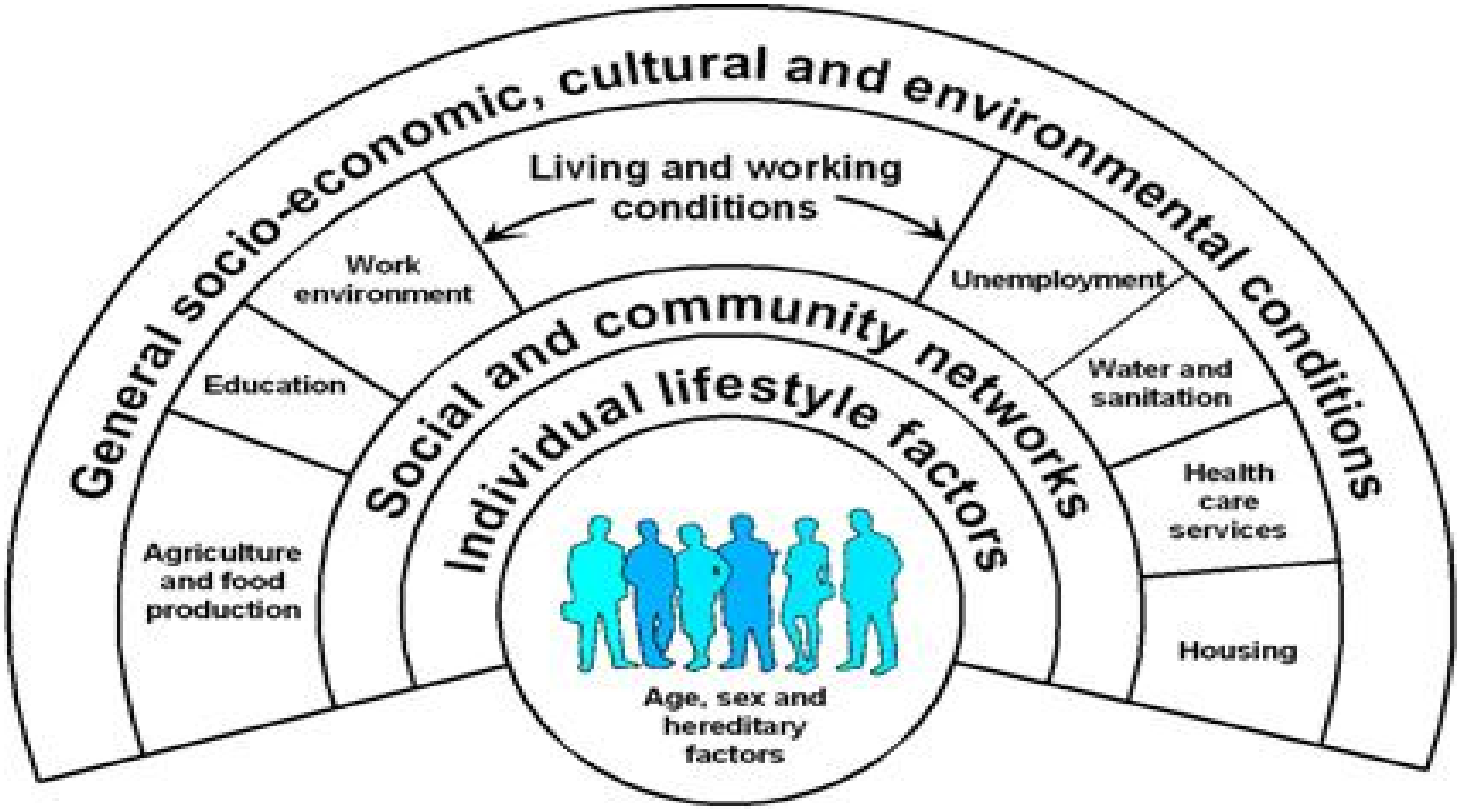
The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by:

- **(Structural factors): Unequal distribution of power, income, goods, and services**, globally and nationally,
- **(Individual level): Consequent unfairness in the immediate, visible circumstances of peoples lives** –their access to health care, schools, education, conditions of work/leisure, homes, communities, towns, or cities– and their chances of leading a flourishing life.
- Unequal distribution of health-damaging experiences is **not in any sense a 'natural' phenomenon....**

Together, **the structural determinants and conditions of daily life constitute the social determinants of health.**

WHO Commission on Social Determinants of Health, August 28 2008

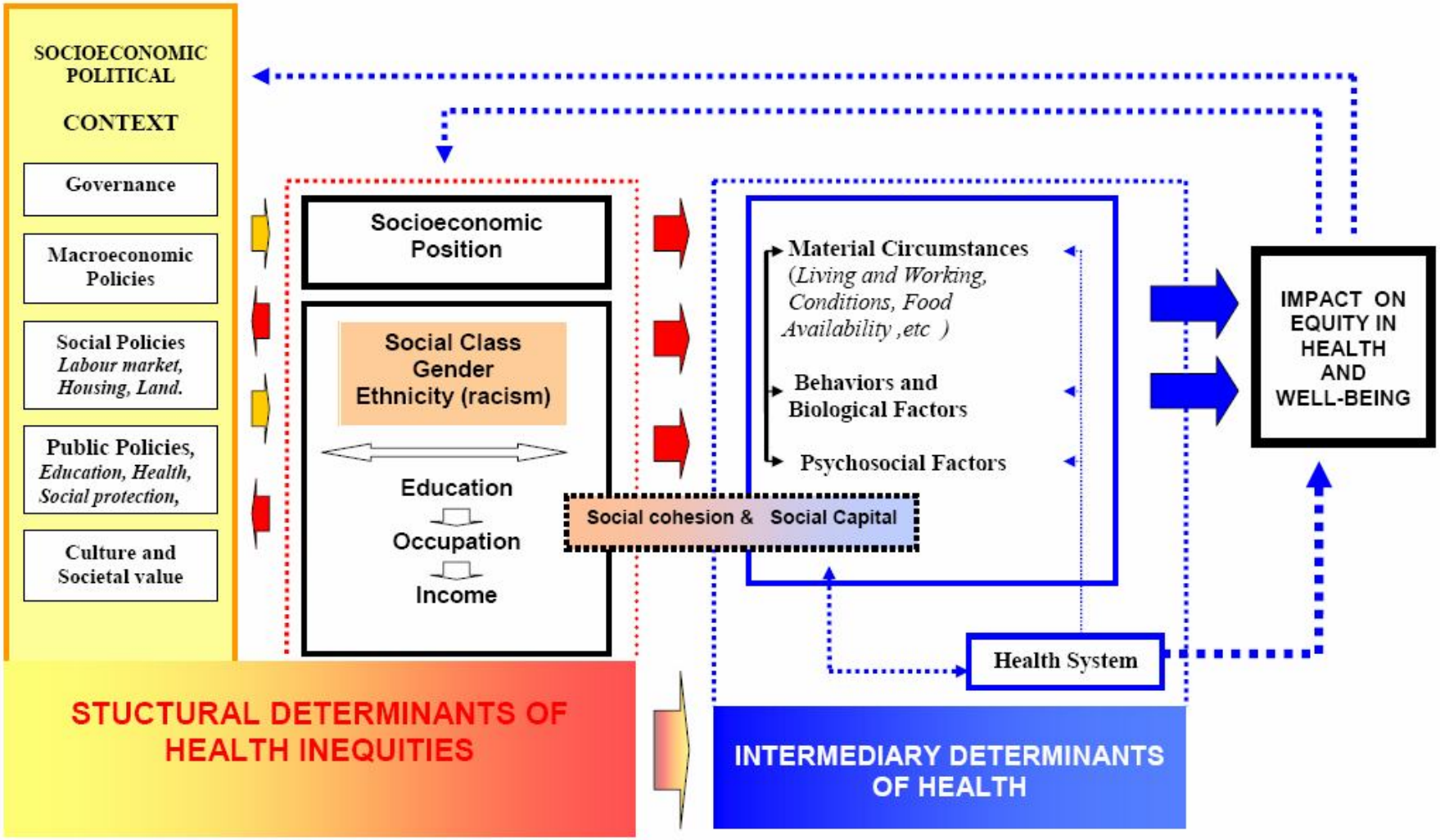
What are the social determinants of health?



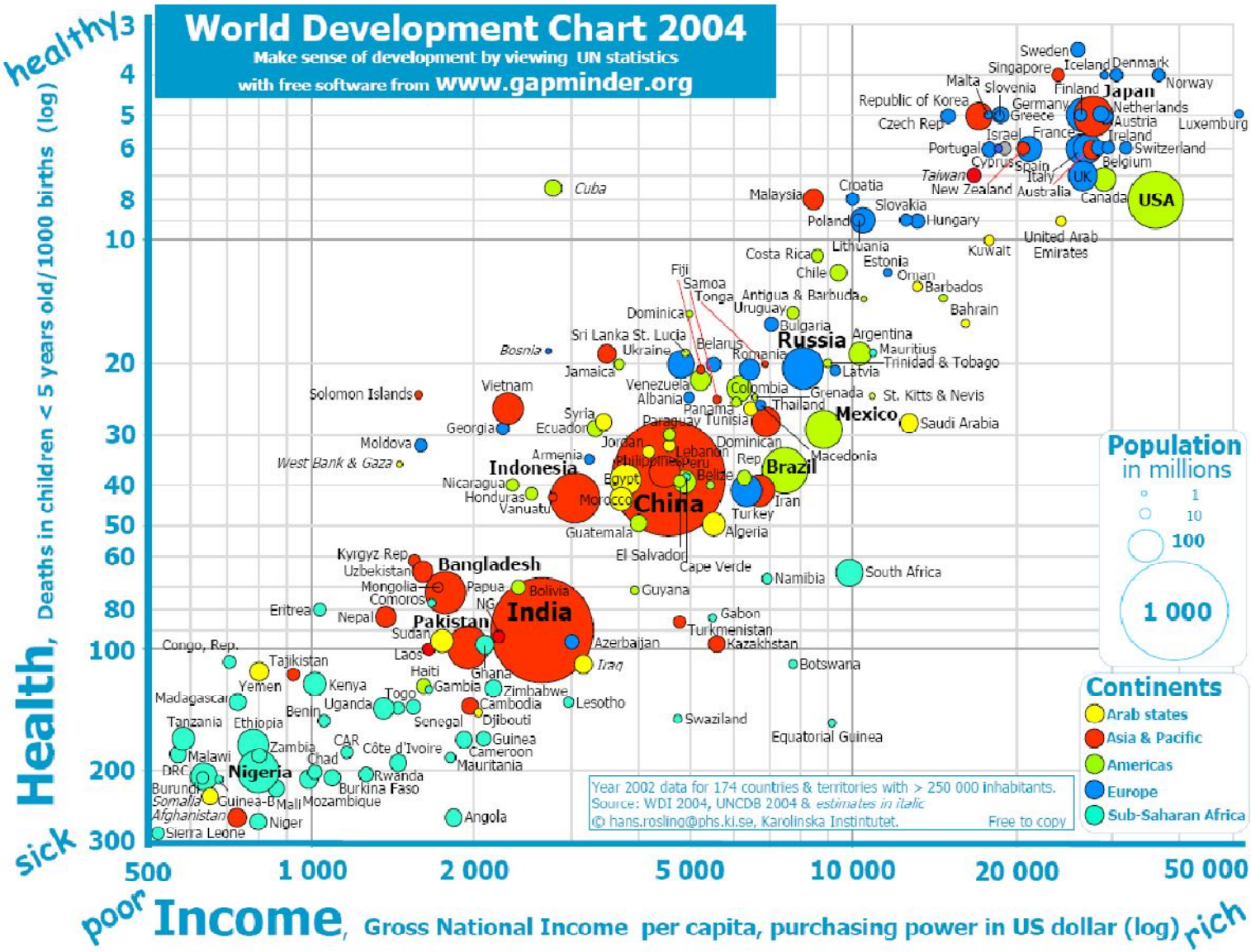
- Highlights the role of health across all government sectors and the need for policies to protect health (health in all policies)
- Calls for an “open” health sector: environment, water, sanitation, education, trade, transport housing, social policy, etc

The Final Report of the WHO Commission on Social Determinants of Health. 28 August 2008

Framework of the major categories and pathways of determinants of health inequities and well-being



WHO Commission on Social Determinants of Health, August 28 2008



Gapminder www

Findings of CSDH: social determinants of health

- **Toxic combination of bad policies, economics, and politics** explains bad health in the world. "Social injustice is killing people on a grand scale".
- Slope linking income and health is the social gradient, **exists in all countries**
- **Health systems will not naturally gravitate towards equity**: need for leadership to compel all actors to examine impact on health. PHC, which integrates health in all of government's policies, is best framework for doing so.
- **Wealth not sufficient** for improving health, need for **equitable distribution**.
- Despite secular increase in **wealth and technology**, key question is **how it is used for fair distribution** of services & capacity-building, esp in LIC.
- Much of the work to redress health inequities lies **beyond the health sector** (e.g. relation to infectious diseases with clean water).
- Excessive reliance on medical interventions for increasing LE.
- **Need to assess impact on health/equity for every government policy.**

http://www.who.int/social_determinants/final_report/en/index.html **(WHO, 2008)**

Example: Poverty and inequities

- Poverty, unemployment and homelessness continue to be the most important constraints to development in Africa - almost 50% of Africans live in extreme poverty (in Kenya 56% of the people live under the poverty line)

- Inequality is a big problem: 10% of Kenyans controlling 42% of the wealth - Poverty amidst plenty

Urban settings as a determinant of health

- In Nairobi, where 60% of the city's population lives in slums, child mortality in the slums is 2.5 times greater than in other areas of the city.

Photo: WHO/B.Peguillan

- In Kumasi, Ghana, a country which privatized public toilets in the 1990s, private toilet use per day for a family costs 10% of the basic wage.

Photo: WHO/P.Virot

Findings of CSDH: recommendations (1)

- The Commission makes three overarching recommendations to tackle the "corrosive effects of inequality of life chances":
  - Improve daily living conditions, including the circumstances in which people are born, grow, live, work and age.
  - Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions – globally, nationally and locally
  - Measure and understand the problem and assess the impact of action
  - And 50 policy recommendations

http://www.who.int/social_determinants/final_report/en/index.html **(WHO, 2008)**

CSDH recommendations (2)

1. Equity since early life.
2. Healthful surroundings for healthy population.
3. Right practices in employment and worthy work.
4. Social protection throughout the life.
5. Health universal attention.
6. Equity in policies, systems and programs.
7. Equitable financing.

CSDH recommendations (3)

1. Market responsibility.
2. Gender equity.
3. Political emancipation.
4. Effective world-wide government.
5. Need to measure problem magnitude, analyze it and evaluate the interventions effects.
6. Goal: eliminate inequalities in a generation and reach equity in health acting on the SDH

Challenges

- **Lack of systemic research in effective policy to reduce health inequalities** (≠policy on some RF)
  - Assess causality (SES ⇨ H, H ⇨SES, X ⇨ SES & H)
  - Assess and test feasibility, implementation, enforcement, etc
- **Lack of economic evaluation (acknowledged by CSDH)**
  - Cost-effectiveness studies: how to prioritise interventions (50 in CSHD)
  - Unintended csq of well-intentioned policy (e.g. impact of redistribution of wealth, failure of rationality in B, etc): extend evaluation to multiple sectors
  - Internal vs. external validity ("commissions" in various countries)

Challenges (2)

- **Even if policy is identified, how to “sell” it politically**
  - Limited resources with financial crisis
  - Positioning health as cross-gov. policy was historically difficult to achieve
  - Even if political will exists, broad policy will raise a number of opposing forces
  - Challenges to raise support for interventions targeting minorities

Opportunities

- Awareness of the role of SDH on health disparities increasingly recognized
- Highest political process of CSDH (science or opportunities to tap on new funding sources?)
- These issues are brought at highest-level policy agendas: UN-MDG (underscores role of health in development), World Economic Forum, WB, etc

Millennium Development Goals

Underscores centrality of health in development agenda

1. Eradicate poverty and hunger
2. Achieve primary universal education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

www.developmentgoals.org

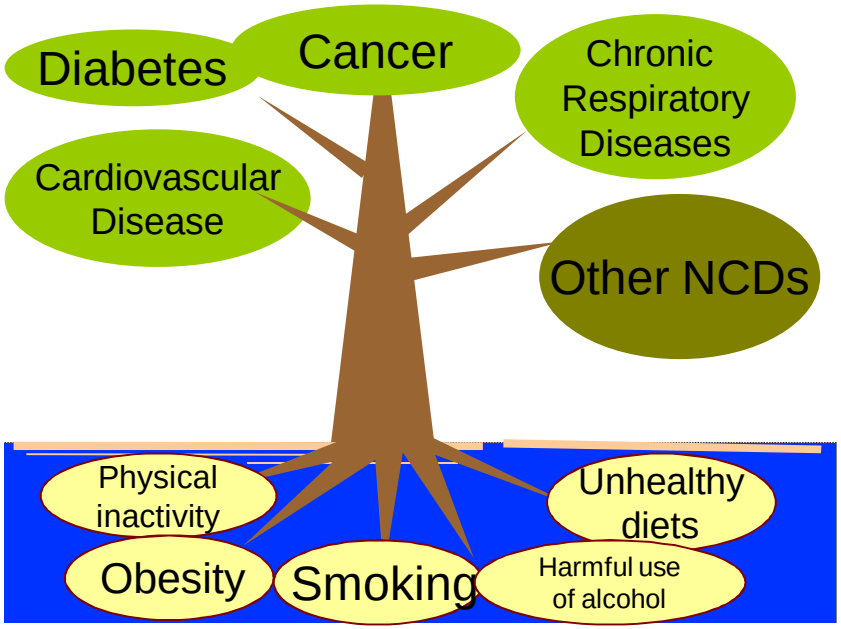
Relation of SDH with NCD

NCD: Huge burden, largely preventable, effective interventions

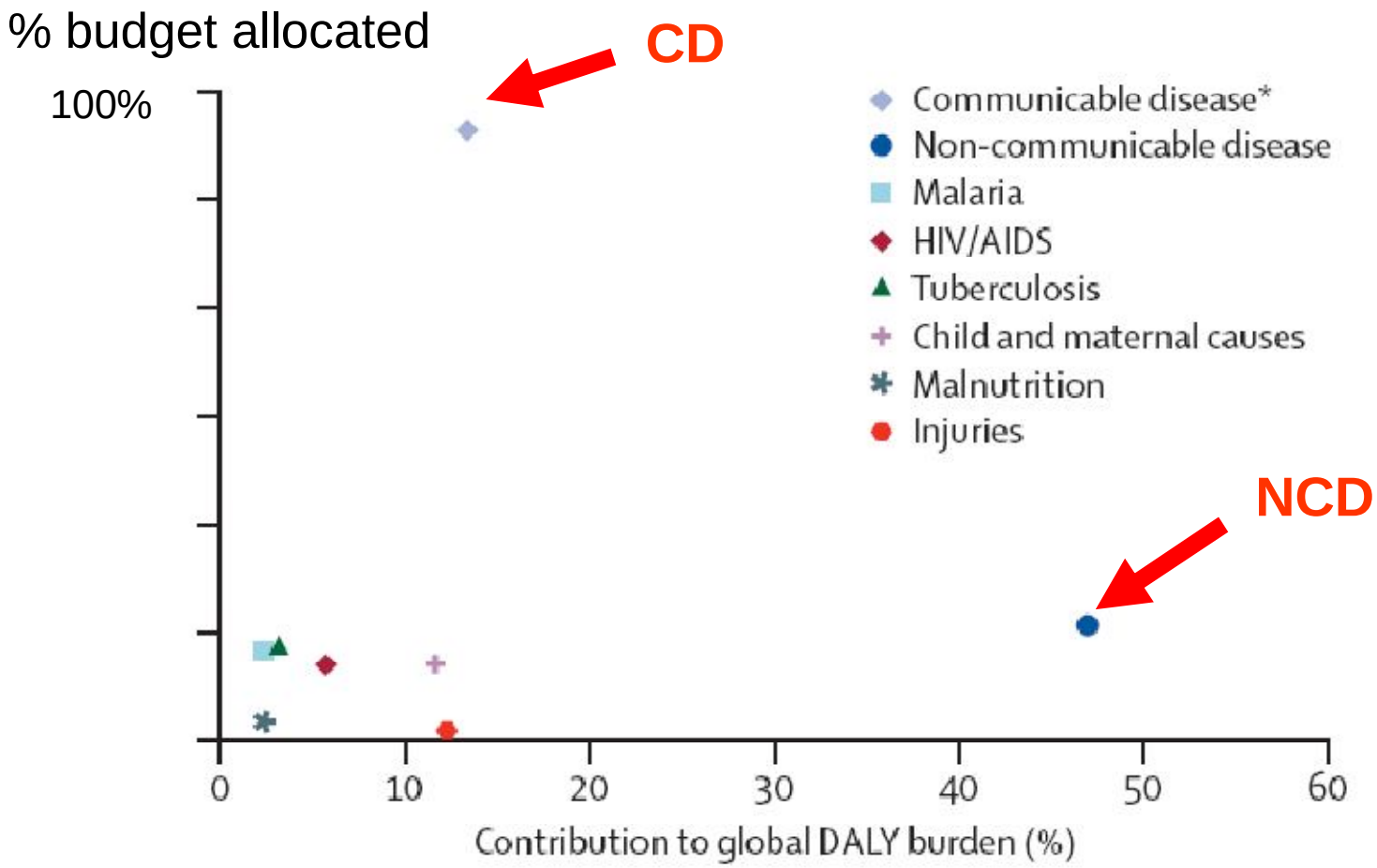
NCD are responsible for up to 60% of all deaths, 80% in LIC/MIC
>80% of CVD, strokes and DM and >40% of cancers are preventable

- Major NCDs:
  - Cardiovascular disease
  - Cancer
  - Chronic Respiratory disease
  - Diabetes

- Shared preventable risk factors:
  - Tobacco use
  - Unhealthy diet
  - Physical inactivity
  - Harmful use of alcohol



Minor part of WHO budget allocated to NCD



Stuckler D, McKee M et al. WHO's budgetary allocations and burden of disease: a comparative analysis. Lancet 2008; 372: 1563–69

Findings of CSDH linking SDH and NCD

- Heart disease is caused by how people live, which is shaped by environments in which they live; e.g. obesity and excess availability of high-fat and high-sugar foods
  - recognition that lifestyle are not only individual choices
- Solutions should come from beyond the health sector.
- Addressing inequity in Health is a means to tackle NCD.
- The health sector needs to focus attention on addressing the root causes of inequities in health.

http://www.who.int/social_determinants/final_report/en/index.html **(WHO, 2008)**

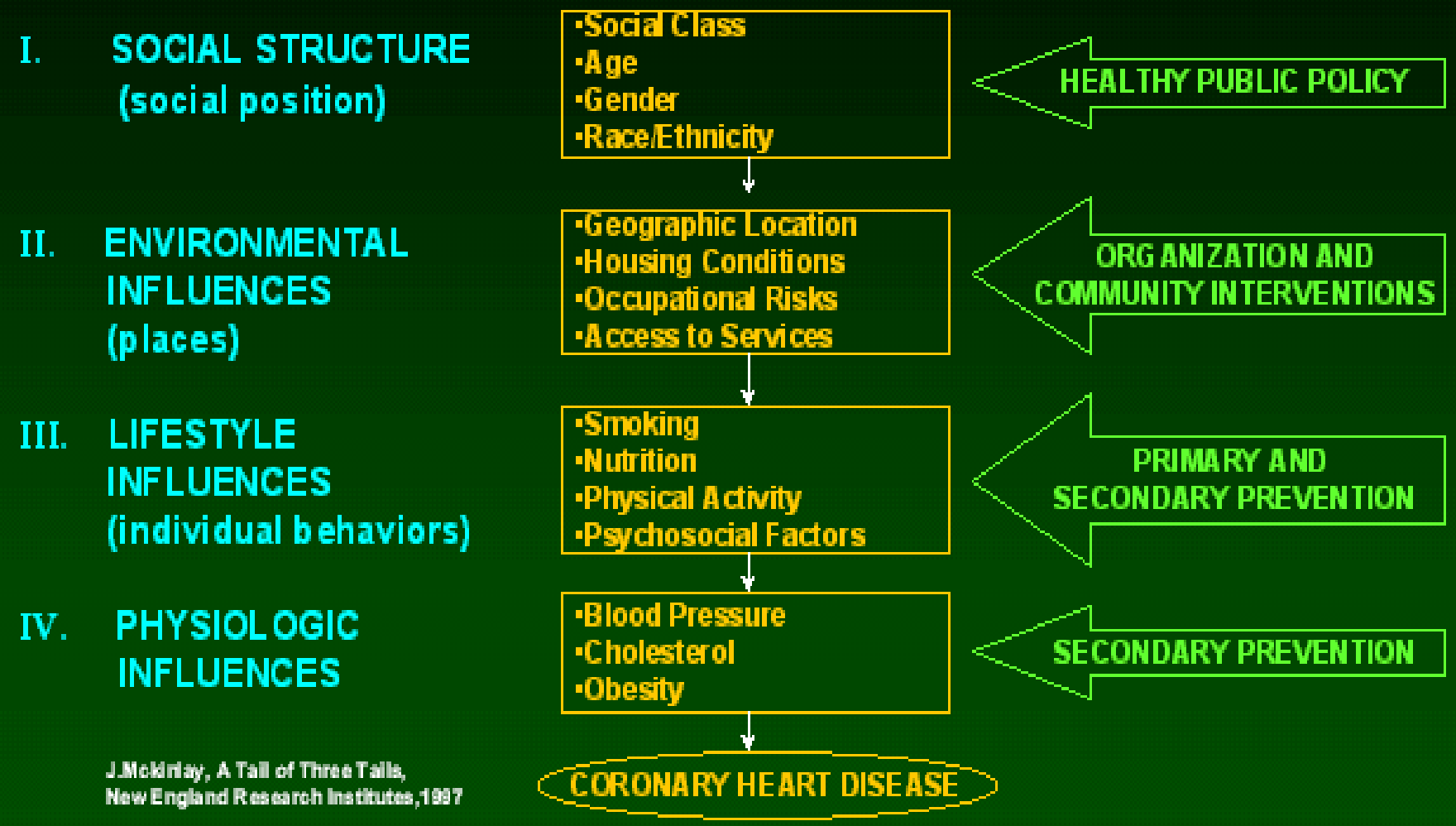
Arguments for including CVD & NCD in the MDG

- MDG to be reviewed in Sep 2010.
- Predominance of CVD and other NCD in global burden of disease.
- CVD affects people of working age at higher rates in LIC/MIC than HIC, affecting economic growth.
- Health systems cannot be built vertically disease by disease; need to integrate NCD within existing health systems -skewed to CD- and strengthen them altogether.
- Cost-effective policy, program, and treatment initiatives exist for NCD (e.g. Lancet series): apply now to improve health & reduce poverty.

Low priority of cardiovascular and chronic disease on the global health agenda“. Circulation 2007; 116: 1966-1970.

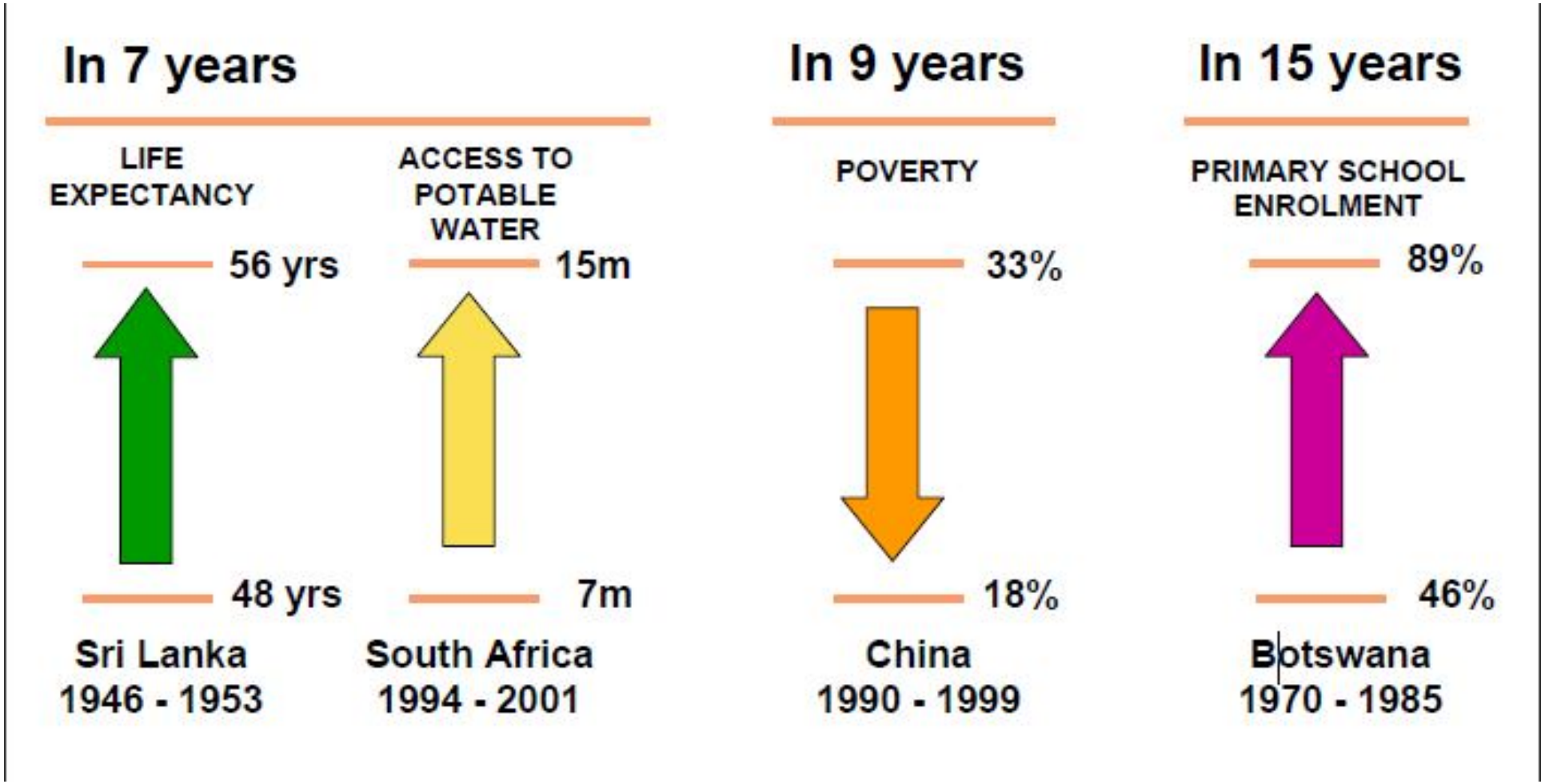
Which level of policy to tackle NCD: global, population, focused?

Levels of Causation and Corresponding Types of Health Intervention

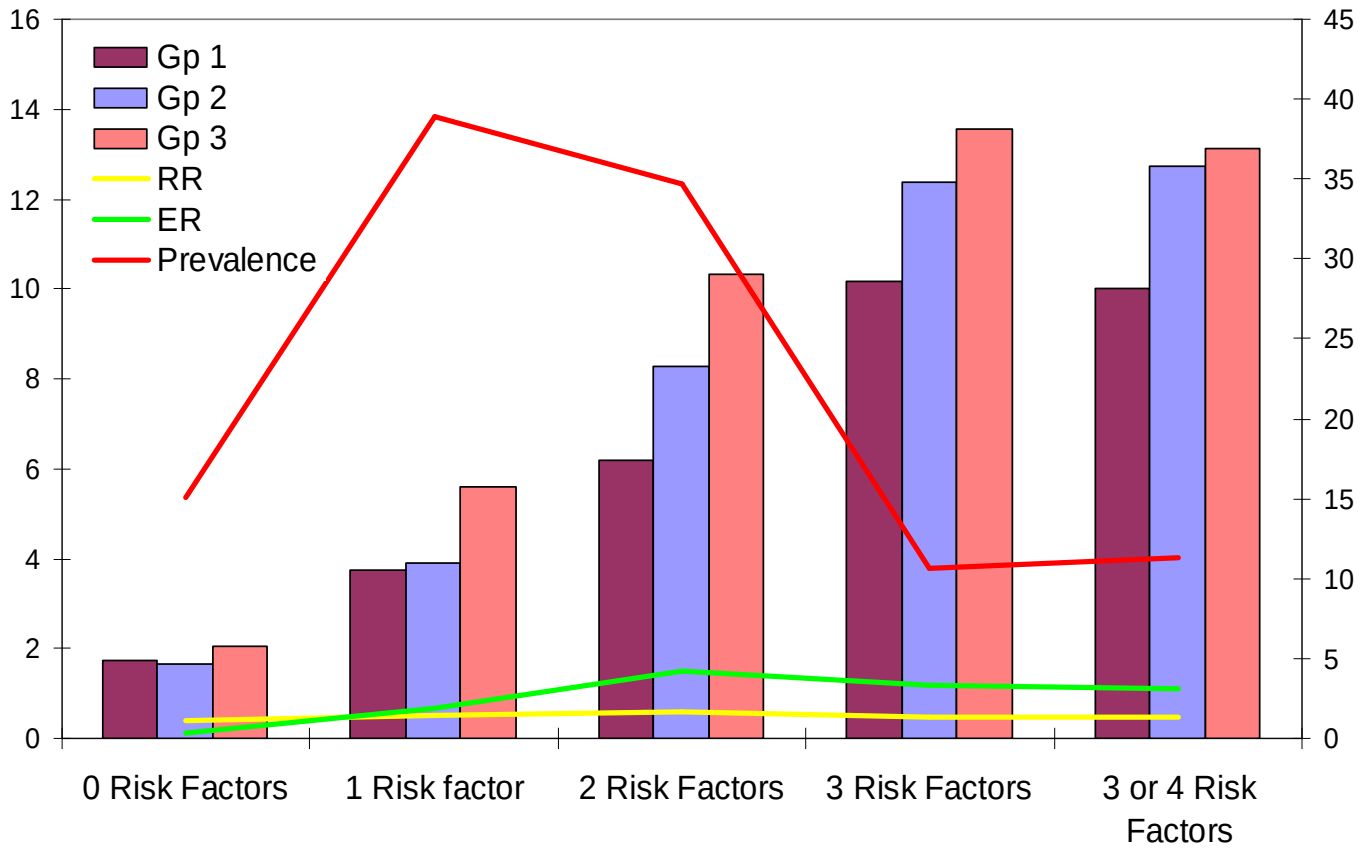


J.Mckinlay, A Tall of Three Tails,
New England Research Institutes,1997

Progress in implementing policy targeting SDH can be achieved in short time periods

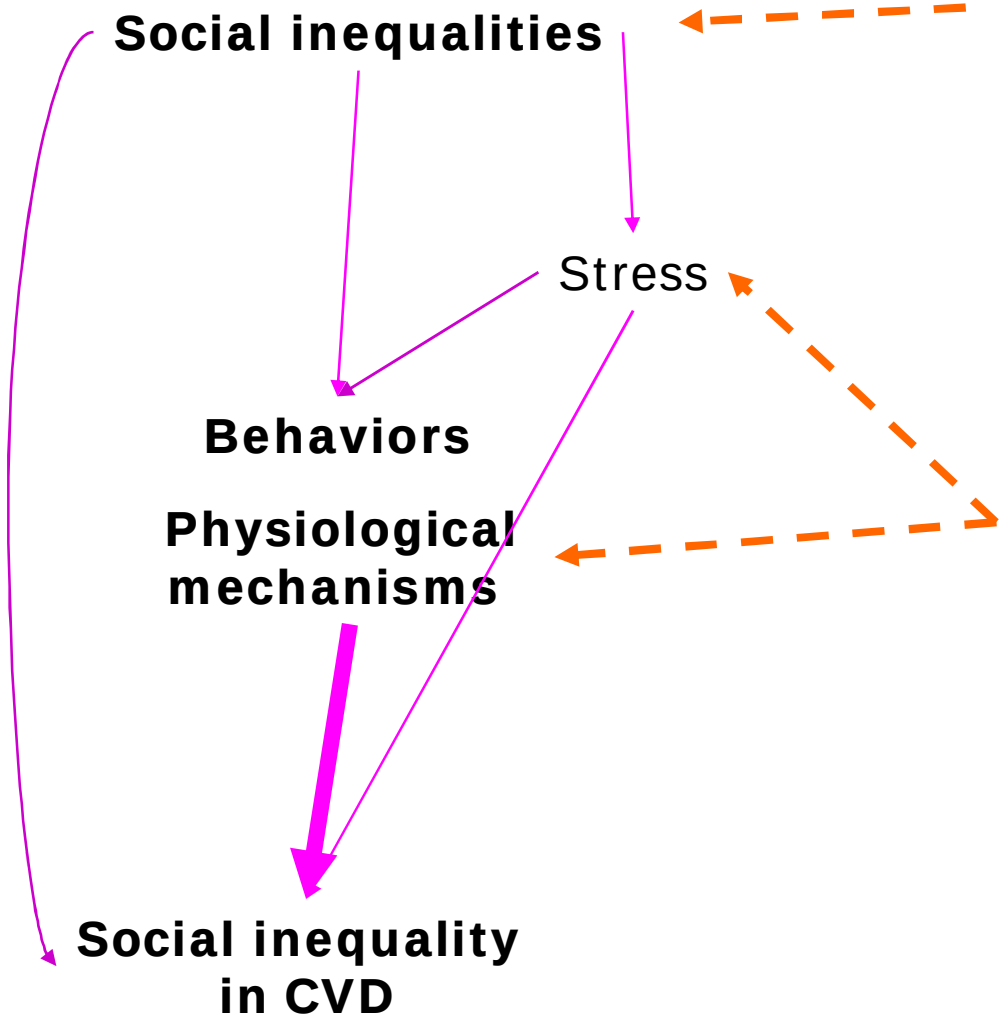


Social group, CHD and combinations of risk factors



Risk factors = Blood pressure, Cholesterol, Smoking, Diabetes

Lynch, Davey Smith, Harper, Bainbridge. *JECH* 2006



Fundamental intervention

1. **Reduce social inequality**

   ("Ideological Orientation")

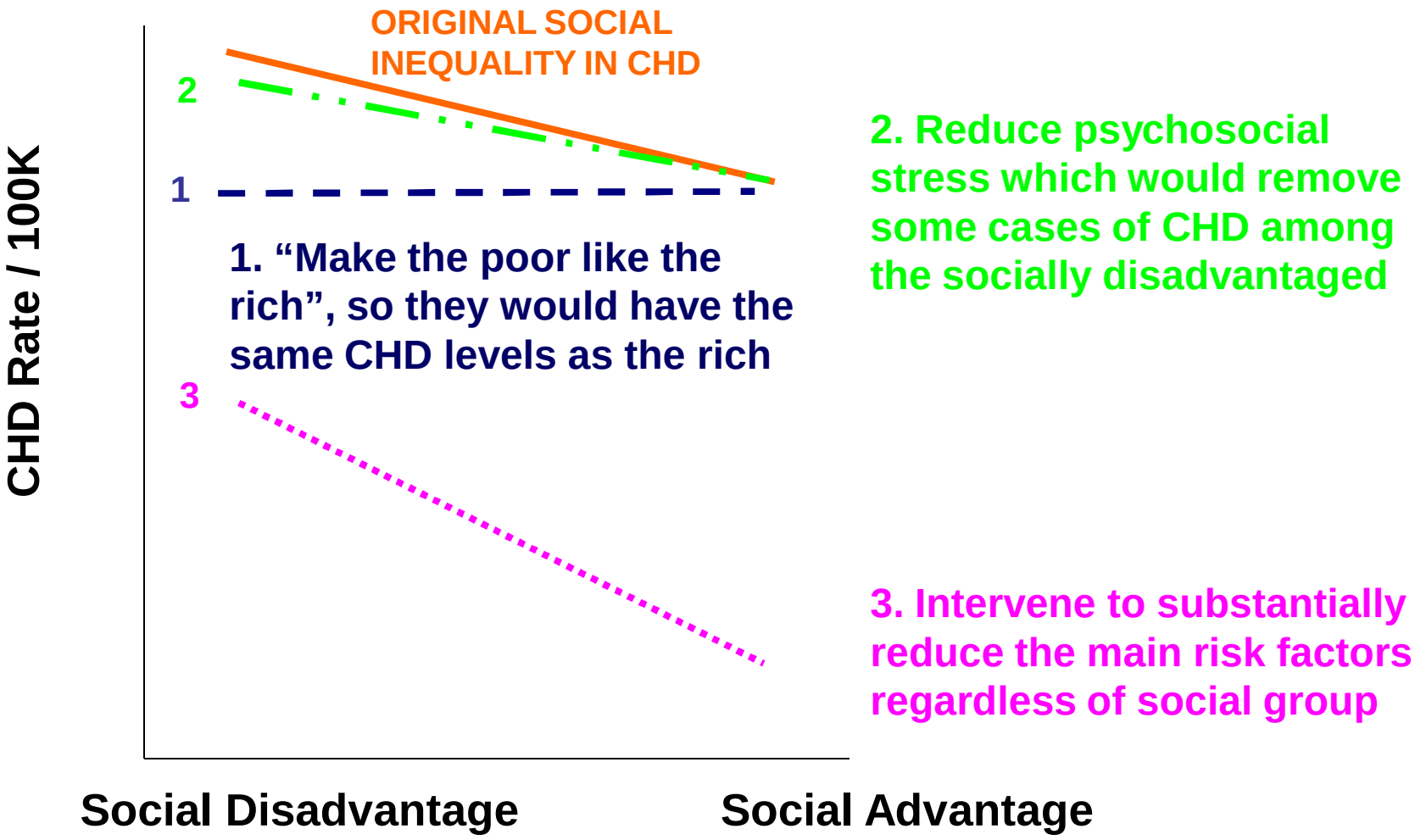
Mechanistic intervention

2. Reduce stress

3. **Reduce the main risk factors population wide**

   ("Pragmatic" Public Health orientation)

Hypothesized effects of different interventions to reduce social inequalities in CHD – which is more "effective"?



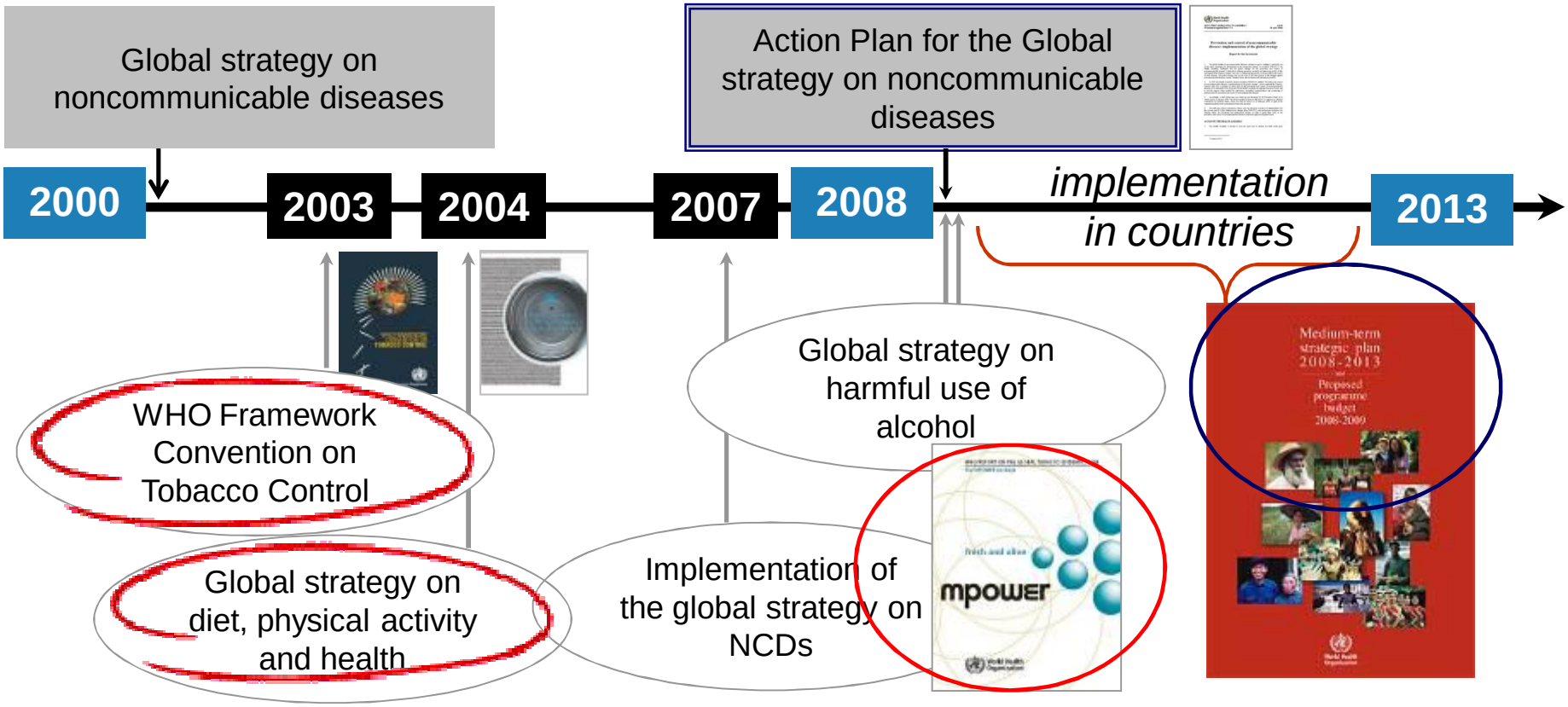
Politics of prevention

- **Risk factor vs. population approaches**
  - Global policy (population): might better address equity issues
  - RF: often simpler (tobacco, salt) and broader beneficiaries

- **Population/RF approaches ⇔ multiple/single sectors/actors**

- **Who benefits the intervention: need to reach most vs. those most in need**

The global response to address NCDs



A six-year Global Action Plan to address cardiovascular disease, cancer, respiratory disease and diabetes was endorsed by the WHO World Health Assembly on 24 May 2008.

Conclusions

- Relation between SDH and NCD largely recognized
- Approach on global “causes of the causes” is highly desirable but complex and involves many actors: hard to materialize
- However, need to test processes, cost-effectiveness & prioritize
- Much of the social gradient in NCD is related to few RF
- Population interventions on RF (tobacco, salt) are cost effective and benefit all (can perpetuate inequity gradient at lower level)
- Health care: need to facilitate access by the disadvantaged
- Need for funds to NCD (or advocacy at economic forums)

- Need to tackle NCD beyond health sector
- Need to include NCD in global development/social agendas
- This is needed to heighten political commitment and because multisectoral interventions are key for HP and NCD prevention

Thank you