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06 June 2009

The Report of

the APA Secretary-General

on

Achieving Health Equity in Asia

Background:

The Executive Council of APA met on 8-9 October 2008 in Tehran and approved the suggestion made by the Islamic Consultative Assembly of Iran to include Achieving Health Equity in Asia in the agenda of the Plenary. The third APA plenary met on 27-29 November 2008 in Jakarta and adopted the resolution on Achieving Health Equity in Asia. (APA/Res/2008/20) According to this resolution the plenary decided to establish a Sub-Committee under the Standing Committee on Social and Cultural Issues.

The mandate of the Sub-Committee was defined “to review the situation with regard to SDH in Asian countries, and identify the main social determinants of health inequities and provide relevant recommendations to the Asian Parliamentary Assembly”. By the same resolutions, the plenary further requested the Secretary General to prepare a report for consideration of the Sub-Committee.

Introduction:

In light of the above and based on the text of the resolution, the Secretary General submits the present report to the Sub-Committee on Achieving Health Equity in Asia. This report is prepared mainly in accordance with the latest findings of World Health Organization as well as the Report of the Commission on Social Determinant of Health. The report reviews the main social determinants of health in Asia, and focuses on the role of parliaments in promoting policies on health to address the problem of socio- economic inequalities at the global, - regional and national levels. The result of the Sub-Committee deliberations will be forwarded to the first Executive Council meeting in 2009 to be referred to APA Plenary for further consideration and action.

Social differences and inequality in health:

Inequalities in health, both within and between countries, are the result of social differences in economic status, wealth, education, occupation, and place of residence. These inequalities are defined as inequities when there are systematic differences between more and less advantaged groups and geographical areas; and as such, they are unjust and unfair. Getting rid of these health inequalities, that is achieving health equity in Asia as elsewhere,

means addressing these systematic disparities in health (or its social determinants) through social action. They can best be addressed through action on social determinants of health, moving beyond areas traditionally addressed in the health sector in collaboration with other sectors and interested parties. Priority social determinants to achieve greater health equity, especially in poorer countries, could most effectively focus on the next generation, on the health of mothers and children. The achievement of health equity requires commitment, advocacy, and legislative action that are carried through into practice. This concern points to a major role for parliamentarians in advocating for, and supporting legislations that seek to achieve health equity. Parliamentarians can play a great role in advocating for health equity, referring to the UN and WHO Charters and international agreements that uphold health as a human right, with the ultimate goal and ideal of achieving greater health and social equity.

Many of the inequalities in health, both within and between countries, can be understood as originating in social inequalities between individuals, populations and geographical areas. Inequalities in health can be identified by the health conditions of a population or a social group – how long people live, what makes them ill and causes their death, and what kind of facilities are available to treat illnesses and ensure that they maintain, as far as possible, a state of good health. These inequalities in health are considered as inequities, in so far as they are rooted in poverty and its deprivations, which make it so difficult for people to enjoy good health and the sense of well being associated with good health. Inequities are defined as remediable differences in health status between more and less advantaged groups and geographical areas. The achievement of health equity thus requires commitment, advocacy, and legislative action that are carried through into practice. In this context, the parliamentarians can play a major role in formulating and adopting legislations.

Evidence for persistent inequalities in health, both between and within countries prompted the establishment by the World Health Organization of the Commission on the Social Determinants of Health (CSDH) in 2005, which was given the task of identifying and suggesting solutions to address inequalities in health caused by social disparities in wealth, education, occupation and social status, and social disadvantage related to gender discrimination, social, ethnic and religious identity. The title of the final

Commission Report, launched in August 2008, firmly states the Commission's priorities: *Closing the gap in a generation: Health equity through action on the social determinants of health.*ⁱ

Inequality is a measurable concept, in contrast to equity, which is a value, a shared perception of how things ought to be, or should not be. In the UN as a whole, as in WHO, Charters and international agreements uphold health as a human right, with the ultimate goal and ideal of eliminating health inequities. In the global arena, and in Asia in particular, there is a growing concern for the values of health equity and fairness, for an equal opportunity for everyone to enjoy the "highest attainable standard of health [which] is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (as stated in the constitution of the WHO in 1946). Article 25 of the Universal Declaration of Human Rights 1948, Article 25 states that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." Other human rights instruments, to which many Asian countries are also signatories, protect the rights of women, children, the disabled, and other socially marginalized and excluded groups.

Some health inequities originate within the health sector, and can be traced to the ways health services are financed, organized and staffed. Within the framework of international conventions mentioned above, the health sector has an obligation to provide equitable services and to advocate for greater health and social equity. However, action to promote health equity also requires action by related governmental sectors and other stakeholders, which have a more direct responsibility for dealing with social conditions which cause poor health.

A brief perspective on the range of social determinants that affect people in Asian countries can help to identify major challenges for achieving health equity, and pave the way for advocacy on the part of interested parties, such as parliamentarians, who wish to act on these issues. These social determinants provide a thematic framework for identifying and tackling health inequities. The social determinants are multi-dimensional and interrelated clusters of themes that influence health outcomes, especially inequities in health.

At the global level, it is not often recognized that the net flow of development aid to poorer countries, especially in Asia and Latin America, may be less than the return flow of debt repayment, demanded by major global financial institutions, which, at the same time insisted on restricting government expenditure on health and social services, thus depriving the most disadvantaged sectors of society access to health care and social welfare support. In times of financial crisis it is the poor people, in poor countries, who suffer most.

SDH and health equity in Asia

SDH can be considered at different scales, in a global, regional, country and local setting. In terms of policies and actions it is important to distinguish between **structural** determinants, the overall structures of political, economic and social power at the various levels, which drive the **intermediate** or proximal determinants that are associated with differences in individual life style factors, social community networks and general socio-economic, cultural and environmental conditions. It is not surprising that policy makers and researchers have paid more attention to these circumstances of daily life as they are seen as more immediate and feasible targets for action than the more overarching structural determinants.

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Differences in health and wellbeing that are inequitable exist at the country level. A key indicator of health, life expectancy, shows that wealthier countries have higher life expectancies for both males and females; life expectancies for women and for men in Japan are among the highest in the world, 86 for females and 79 for males in 2006. Japan is also marked by a relatively equitable distribution of health and well-being among different sectors of the population, compared with some other wealthy countries in Asia. Within countries there are considerable inequalities in health status, well-being and social practices. Country level information on inequities in

health status and wellbeing is more likely to be available for administrative divisions such as states, governorates or districts, than for inequities between the various groups identified on the basis of disadvantages.

Identifying the conditions of daily life resulting in health inequities is a useful guide in priority areas for action. Broadly speaking, the themes identified by the Commission on Social Determinants of Health are similar to those in Asia. However, the determinants identified for Asia should be analysed in their local context, using local statistical information (where available) and detailed community studies which are able to explore the “black box” through which social conditions affect health outcomes, and hence provide more detailed local context within which policies should be developed. These social determinants, rephrased slightly to make them more relevant for Asia, and focusing on conditions that are likely to produce health inequities include:

- Gender inequity: low levels of women’s empowerment, to be addressed through education for girls and women, and employment generation;
- Poor conditions for early child development, including child labor and street children;
- Insecure employment conditions, especially informal, low wage employment;
- Unhealthy environment of expanding urban slums;
- Unhealthy socially determined lifestyle and behaviors, such as smoking, drinking alcohol, using unhealthy diets;
- Inequitable health systems as a barrier to accessing essential health care: social discrimination and inequity associated with health programs (public and private), especially those delivering care for HIV/AIDS and malaria;
- Armed conflicts and crises resulting in health inequities.

Issues such as “globalization” and the concerns expressed in the final CSDH report, in August 2008, on the inequitable distribution of power, money and resources at the global, national and local levels, are cross cutting, affecting other determinants in a number of ways. In the Region, as elsewhere, the Commission report, issued in August 2008, identifies inequities as the result of “poor social policies and programs, unfair economic arrangements, and bad politics”. These overarching conditions constitute a global, national and local framework which places severe limits on the extent to which the daily conditions of life can be improved. As the global economic crisis affects the

Region, it is likely to make worse existing problems of poverty, water scarcity and the emerging threat of climate change.

In summary, the possible list of social determinants that can foster, or hinder, the achievement of health equity in Asia is a long one. However, for most countries, especially poorer countries with fewer resources, one can identify social actions affecting maternal and child health as a priority area. Less educated, malnourished mothers living in poor households are more likely to give birth to small babies, who have a slender chance of survival during the first few years of life and/or of life time good health. The household conditions in which these families live – crowding, lack of access to safe water and sanitation, environmental pollution, lack of skills and opportunities for gainful work, and absence of access to health and social services, condemn parents and children and coming generations to continued disadvantage.

Achieving health equity through action on the social determinants of health

Achieving health equity requires deliberate action on many fronts; health and social systems do not, of their own accord, produce equitable health and social conditions. Deliberate action is required to do so. The question which must engage parliamentarians, and others, is how to do this. Here some general policy and action guidelines are useful, suggesting a phased approach to achieving health equity; through:

- **Collecting evidence** on social determinants of health and health inequities and successful actions to achieve health equity; including data bases, published and unpublished research and reports, and using it for advocacy;
- **Advocating** for the inclusion of social determinants of health in national policies and programs;
- **Improving health systems and health financing** so that they are more equitable, with resources distributed according to need, and achieving full coverage;
- **Fostering inter-sectoral collaboration**, as solutions to health equity are largely to be found beyond the health sector;

- **Expanding partnerships** with other institutions and individuals with a concern for health equity, such as academic institutions, non-governmental organizations and the media.

The role of parliamentarians

Based on these suggested strategies for achieving health equity, it is recommended that parliamentarians review their roles and concerns, in order to identify ways to forward the agenda of health equity. The following activities might be thought relevant:

- **Advocating, promoting, and drafting legislations** designed to achieve health equity, The parliamentarians can be actively involved in drafting legislations that will promote health and social equity in practice, such as equitable social protection policies for health care, long term disability, and protection during unemployment, old age, etc. An example of powerful legislative change for health equity in India, widely supported by advocacy groups and parliamentarians, is the passage of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, which has been credited with a marked decline in the imbalance between male and female births.
- **Keeping informed about health equity issues** through the following sources:
 - Country data on health and social conditions, on disadvantaged groups and geographical areas – provinces, states and districts
 - *World Health Statistics 2008* and *2009* for detailed country level data on health and socio-economic status, especially on inequities in health care and health outcomes (inequities in access to skilled birth attendance, immunization coverage and deaths of children under 5), and demographic and socioeconomic statistics.
 - Activities on health equity and social determinants by WHO, and reported by regional offices, South East Asian Region, and Western Pacific Region: accessed through: http://www.who.int/social_determinants/en/

http://www.wpro.who.int/health_topics/equity/policy_documents.htm

- **Best practices to achieve health equity** should be identified and recorded, for example:
 - Social protection in the form of income support for those who are disabled, ill, elderly or otherwise unable to access resources for their basic development needs,
 - Cash for work and training in work skills could provide a sustainable pathway out of poverty, as in programs in India, Ethiopia which guarantee a basic minimum of resources for living a decent life.
 - Community Based Initiatives, pioneered in the Eastern Mediterranean Region, especially the Basic Development Needs component:
<http://www.emro.who.int/cbi/>

- **Primary health care**, as a key to achieving health equity, should be a focal point for advocacy and legislation. Keep up to date on Primary Health Care issues from WHO *World Health Report: Primary Health Care, now more than ever* and from relevant WHO sources. The 2009 World Health Statistics and the World Health Report was issued May 2009.

- **Globalization issues** increasingly affect health and well being at the country level. The following issues have been identified as having an impact on the achievement of health equity:
 - **Access to affordable essential drugs** requires complex negotiation with multinational pharmaceutical companies which hold the patents.
 - **Employment** has failed to accompany globalization and economic growth. Much of the employment growth is in the low paid and insecure informal economy. Globally, during the 1990s, there was a widening inequality between high and low wage workers.ⁱⁱ
 - **Food security** has been threatened by flooding poor countries with food in the name of “free trade”, thus undermining local food production.

- **Multinational corporations** promote “junk food”, infant formula and cigarettes which undermine health; these activities are difficult to regulate in many countries.
- **Support activities of civil society organizations** which advocate for disadvantaged groups suffering from health and social inequities, and/or provide examples of equitable health services in areas of acute need. The People’s Health Movement is a good place to start.

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