



All for Equity



**SUMMARY OF
KEY RATIONALES,
EVIDENCE AND
STUDIES SUPPORTING
THE WORLD HEALTH
ORGANIZATION'S
WORLD REPORT ON
SOCIAL DETERMINANTS
OF HEALTH EQUITY**

BACKGROUND

The World Report on Social Determinants of Health Equity was called for through World Health Assembly Resolution WHA74.16 in 2021. It will be a landmark for the field, as the first of its kind since the launch of the final report of the World Health Organization (WHO) Commission on the Social Determinants of Health in 2008.

The 2025 World Report highlights insufficient progress on meeting the Commission's targets on achieving health equity. The World Report's 14 specific recommendations for action were adopted by the World Health Assembly in 2024. Those recommendations lie within four action areas:

- Addressing economic inequality and investing in universal public services.
- Tackling structural discrimination and the determinants and impacts of conflict, emergencies and migration.
- Managing the challenges and opportunities of climate action and the digital transformation.
- Bringing about change through new governance approaches.

This publication lays out the summary of key rationales, evidence and studies supporting the new World Report.

The summary was produced by the UCL Institute of Health Equity

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This research was funded by the World Health Organization's Equity and Health Unit as part of the process of developing and writing the World Report on Social Determinants of Health Equity. We are grateful to Sudhvir Singh and Nicole Valentine in particular.

Table1: Summary of key rationales, evidence and studies

METHODOLOGY

The recommendations are based on the findings from the draft full World Report, which has been informed by policy and scientific advisory groups, focal points across the three levels of WHO, and a series of commissioned background papers including scoping and literature reviews.

The Institute of Health Equity were asked to assess the evidence base relating to the recommendations. To do this IHE utilised the search engines PubMed and Scopus to identify, where possible, systematic reviews or meta-analyses relevant to the area. IHE are experts in health inequalities and have written many reports on the SDH, both for the WHO and individual countries. Where published literature has been weak from these searches, IHE have additionally reviewed previous national and international reports. The searches have focused on evidence since 2008 given that the Commission on the Social Determinants of Health published then.

Please note that the references are examples of the strength of evidence base. There are many references that have not been added and so this should not be seen as a comprehensive list.

1. Address Economic Inequality and Invest in Universal Public Services		
No	Recommendation and strength of evidence	Rational and evidence description
1a	Use progressive taxation to expand fiscal space for income transfers and universal and equitable public services.	<p>Progressive taxation generates additional revenue for governments that can be allocated towards funding universal services and/or social security schemes, such as cash/income transfers to lower income households (1). Research has demonstrated that tax is an effective tool to combat income inequality but only if it is progressive (2) (3), and countries with relatively high levels of progressive tax are able to reduce inequities as a result (4). The redistributive effect of progressive taxation is dependent on the size, mix and the progressivity of each component, for example income tax and means tested cash transfers tend to be more progressive than other options (3). Some countries have adopted flat tax systems for example to increase compliance with tax collection; however, a review of the fiscal, redistributive and macroeconomic impact of flat tax systems in Bulgaria, Estonia, Latvia, Lithuania, Hungary and Romania found that a significant reduction in income inequality could be achieved by moving from a flat to a progressive tax system with positive, albeit negligible, macroeconomic and employment impact (5).</p> <p>The association between social spending and health outcomes is strongest where income inequality is greatest, meaning that countries with higher levels of income inequality gain more from increased social spending (6). In OECD countries, a study utilising national longitudinal data found that some areas of social expenditure, such as old age spending, appear more positively correlated to better health outcomes than others, and the association between social expenditure and health tended to get stronger after a time lag of seven years (6).</p> <p>WHO, 2021; Carbonell-Nicolau & Llavador, 2023; Journard et al., 2012; Abdallah et al., 2015; Barrios et al, 2020; Rubin et al., 2016.</p>
1b	Provide adequate public funding for good quality, equitable infrastructure and services.	<p>Adequate spending and regulatory mechanisms are fundamental to the provision and quality of services. There are many systematic reviews that support this, however the variation in life expectancy between low and middle-income countries (LMICs) and high-income countries (HICs) countries arguably illustrates this best. A recent WHO report sets out that 2 billion people are experiencing catastrophically low levels of health care coverage across the world, and within countries broader social services are most available to those on higher incomes, exacerbating inequalities (7). A systematic review of reviews notes that higher public spending, extensions to compulsory education provision, health and safety policy, improved access to health care, and high-quality affordable housing have positive impacts on population health (8). Sun et al, in a review of health care spending across 172 countries, found a per capita 1% increase in health spending was associated with a 0.59% drop in infant mortality and a 0.62% reduction in under five mortality, but noted diminishing returns to spending, suggesting that higher gains through increased spending will be made in LMICs given the low base they start from and the high impact primary health care services make in the early years; they also found a positive impact of spending on social insurance mechanisms on the effectiveness of health systems. Given large variation in response to spending, improvements to the efficiency of services in many countries is also warranted to improve the impact of spending on outcomes (9).</p> <p>WHO, 2023; McCartney et al., 2019; Sun et al., 2017.</p>

1c	Move towards wellbeing economies and consider wellbeing budgeting.	<p>There has been a discourse for a long period of time about the potential negative impact of measuring the ‘success’ of a budget by GDP growth alone. Focusing just on GDP growth implicitly does not include an equity element, and arguably is unsustainable from a resource perspective; alternative approaches have been suggested (10).</p> <p>We found no systematic reviews on wellbeing budgets in PubMed or Scopus, or articles on the effectiveness of these budgets to improve outcomes. However some higher income countries are creating ‘wellbeing budgets’ that widen the determination of budget setting away simply from a desire to grow GDP, for example New Zealand, Iceland and Wales (11) (12–16). Evidence from these budgets does suggest that resources have been allocated to provide public services that foster wellbeing. In New Zealand, for example, the budget has multiple priorities, including tackling mental health, improving child wellbeing, supporting marginalised populations, fostering an environmentally sustainable economy, and improving employment. These wellbeing priorities were backed with approximately NZ\$26 billion, with 1.1bn diverted from other priorities. To mitigate against changing political objectives countries such as France and Wales have introduced legislation that includes the statutory requirement to report to Parliament regularly on the state of national wellbeing to inform policy (17–19). It is important that the impact of these budgets is evaluated.</p> <p>Kubiszewski et al. 2013; Narayan et al., 2021; WHO Regional Office for Europe, 2023; WEALL, 2022; Welsh Government, 2023; WHO Regional Office for Europe, 2023; UCL, 2021; Anderson & Mossialos, 2019; National Assembly for Wales, 2015; French Government, 2015.</p>
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2. Analyse and Address the Commercial Determinants of Health		
No	Recommendation and strength of evidence	Rational and evidence description
2a	Regulate health-harming commercial activities and maximize health-promoting commercial activities.	<p>The private sector influences health through the provision of goods and services and through their contribution to economic stability. Businesses are fundamental to our society, however, some regulation is needed to prevent harm and promote health. For example, in the last two decades the gap between the average incomes of the top 10% and the bottom 50% of individuals within countries has almost doubled, from 8.5x to 15x (20). Minimum wages are one possible intervention; these have been shown to improve self-reported health and happiness in Europe (21), and a study of 24 OECD countries found that a 10% point increase of the Kaitz index (measuring the generosity of minimum wages) was associated with significant declines in death rates and an increase in life expectancy of 0.44 years (22). A systematic review of “sin taxes” (taxes on tobacco or alcohol consumption for example) in Latin America found a reduction in harmful goods consumption (81% of studies), positive effects on revenue generation (71%) and on health outcomes (82%) (23).</p> <p>The private sector is also a substantial actor in influencing policies, governmental actions, and public health through lobbying, building narratives around positive images of their product(s) and manipulating markets (24,25). Where products are ‘unhealthy’, some commercial actors have reframed the discussion regarding poor health outcomes to be related to individual behaviours and choice rather than commercial influences, shifting the responsibility from producers to consumers (26) (27). Systematic and scoping reviews have recommended new mechanisms to monitor and evaluate the impact of commercial entities on health (28,29) (30), and have made recommendations to businesses on how they can help to reduce health inequalities (31).</p> <p>Chancel et al., 2021; Lebihan, 2023; Lenhart, 2017; Miracolo et al., 2021; Hoe et al., 2022; Lacy-Nichols et al., 2023; Mialon, 2020; Kadandale et al., 2019; Wood et al., 2021; Lacy-Nichols et al., 2023; Mialon et al., 2020, IHE, 2022.</p>

2b	Address and manage conflict of interest to prevent negative impacts on population health and health equity.	<p>Conflict of interest issues arise, for example, when private corporations fund health research or when they use their importance to the economy to influence policies, which in turn affect the health of the population. The food industry has been particularly influential in the development of studies, experiments, and products for which false evidence is produced to market its beneficial effects on health (30). A recent systematic review, for example, has highlighted the concerning conflict of interest in the prescription and use of Vitamin D in the treatment of COVID-19, finding a significant proportion of scientific studies to be funded by producers of Vitamin D but not disclosing their conflict of interest (32). The issue of transparency remains a particularly pressing aspect related to the commercial determinants of health, with different structural frameworks presenting ways to address this problem and monitor transparency in academia, policymaking, and scientific studies (29,30).</p> <p>Mialon et al., 2020; Passini et al., 2022; Lacy-Nichols et al., 2023; Mialon et al., 2020.</p>
2c	Use the public sector to provide incentives for commercial activities that positively affect health and health equity.	<p>The public sector can improve the practices of commercial actors by leading through example and increasing the expectations of workers, or through mandating certain practices through the procurement process. Public procurement accounts for around \$8.5 trillion of annual global expenditure and across all types of countries accounts for about a third of expenditure (33) making it a powerful tool to drive through change. While we did not find any systematic reviews, a review by ACCA (34) found that that national and local government public procurement policies have for example: increased paid labour force participation among women in Kenya (35); reduced carbon emissions and created jobs in South Korea (36); and reduced poverty and hunger among farmers in Brazil (37). Western governments are also pushing through legislation, see for example the UK model which requires contractors to demonstrate social value such as supporting the COVID-19 recovery, fighting climate change and reducing the disability employment gap (38).</p> <p>Martins & Guerry, 2018; ACCA Global, 2020; Mohammed, 2019; OECD, 2015; Cervantes-Zapana et al., 2020; UK Gov, 2020.</p>
2d	Strengthen health equity considerations in global and regional trade processes, including in relation to intellectual property.	<p>Systematic reviews recognise that that fair trade policies are positively associated with improvements in population health (8), and that consequently trade organizations, corporate structures, and regulatory systems which may favour commercial interests need to be closely scrutinized by policymakers interested in improving the health and wellbeing of the population (39). However intellectual property rights and patents put affordable healthcare out of reach for many, as demonstrated with the COVID-19 vaccine rollout when companies and governments stalled efforts to allow for the production on generic vaccines. Many LMICs could not afford the market prices for vaccines and supply was purchased for HICs first (40). In the period between December 2020 and February 2022, several high-income countries achieved vaccination coverage rates close to 90%, while in low-income countries, less than 15% of people received at least one dose (41).</p> <p>There is evidence to support the role that public health sectors can play in controlling the impact of private sector activity on targeted communities, changing the narrative around corporate influence and individual's behaviours, and advocating for legislative changes that restrict the power of private industries (42).</p> <p>De Lacy-Vawdon C, 2020; Freeman et al., 2023; Díaz et al., 2023; Sharpe et al., 2022.</p>

3. Champion development financing and investment that promote health equity

No	Recommendation and strength of evidence	Rational and evidence description
3a	<p>Ensure that the need for funding (fiscal space) to address the social determinants of health is included in approaches to taxation, development financing and debt relief.</p>	<p>Latest figures show that 3.3 billion people now live in countries that spend more on debt interest payments than on education or health. External public and publicly guaranteed (PPG) debt in LMICs has tripled, as a percentage of government revenue, from nearly 6% in 2010 to 16% in 2021, with a third of LMICs on the ‘verge of debt distress’. The prospect of greater spending on programmes that are beneficial for health, under these circumstances is highly unlikely. The latest UNCTAD report says that there is an urgent need to restructure this debt (43). A strong evaluation of the impact of the Highly Indebted Poor Countries (HIPC) initiative which involved debt forgiveness and the redirection of funds that were meant to service external debt towards the provision of social services and poverty reduction in eligible countries found that the programme was associated with statistically significant decreases in the under-five mortality rate in Sub-Saharan Africa (44).</p> <p>A UN panel found major shortcomings in the global finance system and recommended that a UN tax convention be developed, building on the G77 proposal for an intergovernmental tax body at the UN (45). In November 2023, the UN Assembly agreed to this, and the start of an intergovernmental UN process to negotiate a new UN Framework Convention on International Tax Cooperation. An effective organisation would help to reduce corruption and global tax evasion helping to create fiscal space for action on the SDH, and give LMICs more voice (46).</p> <p>UNCTAD, 2023; Oryema et al., 2017; FACTI panel, 2021; UN press, 2023.</p>
3b	<p>Deliver and monitor development financing to support public investment in policies, actions and infrastructure that address social determinants</p>	<p>Clearly additional development financing should have a positive impact if targeted correctly, however one systematic review that looked at ‘Development Assistance for Health’, found a statistically negative effect on subsequent domestic health spending (47). This and another paper provide a rationale for monitoring the fungibility (i.e. where untraceable funds risk substitution) and additionality (the extent to which new inputs add to existing inputs at national and international levels) of any funding (47,48).</p> <p>Lu et al, 2010; Kaddar & Furrer, 2008.</p>

4. Equip local government to reduce health inequities

No	Recommendation and strength of evidence	Rational and evidence description
4a	<p>Strengthen the role of local government to implement community-centred actions for health equity.</p>	<p>In many countries, responsibility for many of the services that affect the social determinants of health lie with local governments. The movement towards the ‘localization’ of the SDGs – which have significant crossovers with the SDH approach – reflects this (50). As the authority that is closest to citizens’ needs and aspirations, the involvement of local governments in the design and delivery of policies is necessary to improve accountability in service provision and facilitate democratic participation. To fulfil their role, local governments need sufficient funds – via taxation or transfers from the national government – and a supportive relationship with other levels of government (51), as well as appropriate approaches to listen to and respond to the needs of communities. However, wide cross-sectoral responsibilities are often not accompanied by sufficient funding (51,52). Although no systematic reviews were found in our search examining the issue of local government capabilities and resources in relation to health equity, there is evidence that cutting funds to local authorities, especially if these cuts are regressive, decimates public services (53). Embedding a social determinants of health approach at the local level can improve key social determinants and health outcomes (54,55), as exemplified by cases such as the UK city of Coventry (56) or the Colombian municipality of Paipa (57). Scoping reviews show that the Health in All Policies (HiAP) approach is increasingly being applied at the local level and that on-going funding can facilitate its successful implementation, together with other factors including leadership, clear objectives, the role of evidence, the framing of health and others (58) (59) (60). A case study from Malmö (Sweden), shows how by prioritising social sustainability and action on several key determinants of health, its local government was able to incorporate this approach into its policies and practices (61).</p> <p>Local2030 (2017); Goldblatt et al., 2023; Schultz et al., 2023; IHE, 2020; de Leeuw, 2009; WHO EURO, 2022; Pearce, 2023; Alcaldia de Paipa, 2019; Guglielmin et al., 2018; Lilly et al., 2023; Van Vliet-Brown et al., 2018; The Health Foundation, 2019.</p>
4b	<p>Ensure healthy housing and built environments, including through universal design principles.</p>	<p>Systematic reviews suggest that better urban and transport planning can lead to carbon neutral, more liveable and healthier cities (62) (63). Transport can impact health directly, through road traffic injuries, insufficient physical activity and pollution, and indirectly, through the built environment, natural ecosystems and climate change (64). There is a limited but consistent body of evidence to suggest that slum upgrading can reduce the incidence of diarrhoeal diseases and water-related expenditure (65). There is an established and strong evidence base that illustrates that housing conditions are an important determinant of health (66). Housing interventions have been found to be effective in: increasing warmth (67); reducing malaria infections and clinical malaria (68); targeting toxins, toxics, structural deficiencies and affordability (69,70); and improving links with health and social services (71). Providing housing to homeless populations is beneficial to their health (72). Interventions promoting housing affordability and stability may need to be paired with other efforts to address the structural determinants of health to be effective (73), with for example sufficient income earning opportunities (74). Promising practices include Bogota’s (Colombia) ‘care blocks’, a land use planning model that integrates care and urban planning with a gender perspective (75). Green space planning is a tool for addressing health in disadvantaged neighbourhoods (76).</p> <p>Nieuwenhuijsen, 2020; Alderton et al., 2019 ; Hosking et al., 2022; Turley et al., 2013; Thomson et al. 2013; Thomson, et al., 2009; Tusting et al., 2015; Jacobs et al., 2010; Finnie et al., 2022; Jackson et al., 2011; Onapa et al., 2022; Chen et al. 2022, Haines et al., 2013; Hernández, 2023 ; Rigolon et al., 2021.</p>

4c	Equip local government to support age-friendly communities and combat social isolation and loneliness.	<p>Systematic reviews and representative population surveys show that social isolation increases the risk of all-cause mortality (77-79) and that it has been associated with a range of negative physical and mental health outcomes, including depression, anxiety, dementia, schizophrenia and suicide, as well as cancer, coronary heart disease and other cardiovascular conditions in older adults (80). Surveys have shown that there is a social gradient in loneliness levels, for example among adolescents in Norway (51) and that social isolation exacerbates the condition of poor persons in places such as South Africa, Mozambique, among the First Nations of Canada and in persons with disability (81). However, most of the existing intervention evaluation studies focus on rich countries and do not address community and societal-level interventions (82) and systematic reviews of effectiveness of interventions in older adults lack equity-relevant data (83). Community-level strategies can include actions on transport, digital inclusion and the built environment, as well as promotion of volunteering and age-friendly communities (84,85). A systematic review supports the use of local community facilities and of active engagement in green spaces in promoting the social connectedness and mental health of specific groups (86).</p> <p>Holt-Lunstad et al., 2015; Gao et al., 2021; Naito et al., 2023; Malcolm et al., 2019; Goldblatt et al., 2023; Samuel et al., 2018; WHO, 2023; Madani et al., 2022; Asian Development Bank, 2019; WHO 2023; Hsueh et al., 2022.</p>
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5. Expand universal social protection coverage throughout life

No	Recommendation and strength of evidence	Rational and evidence description
5a	Ensure adequate income guarantees and care throughout the life course, including for people with disabilities or chronic health conditions.	<p>Adequate incomes are needed for a healthy life. These incomes can come from work or social security policies which aim to alleviate poverty and maintain living standards across the life course. Several international comparative studies indicate that welfare states can be key determinants of population health (87,88) and that higher degrees of social rights in a country are related to better self-rated health (89). Adequate social protection policies foster the long-term resilience of households, facilitate upward social mobility and protect vulnerable individuals from falling into poverty (90). A systematic review found that more comprehensive and gender inclusive welfare states have better mental health outcomes, especially for women, and may decrease inequalities between lone and couple mothers, although they do not provide protection from socioeconomic inequalities in mental health (91). Social expenditure can act as a buffer between socio-economic status and health (92) and protect precarious workers from adverse health outcomes (93). Additionally, a recent umbrella review found that countries with social democratic regimes, higher public spending, and lower income inequalities have populations with better health, although the author's stress that there is a need for higher quality reviews and empirical studies (8). In high income countries, contractionary social security reforms tend to increase mental health inequalities whereas expansionary policies have the opposite effect (94). A review in high-income countries found that they are failing to maintain the health of socioeconomically disadvantaged populations, and that this could be due to residual confounding or to an insufficient scope or generosity of existing programmes (95). Reviews indicate that generous unemployment policies can alleviate poverty and improve psychosocial health, even that of those who are employed (96) and they can also mitigate the relationship between unemployment and suicide (97). While societal level interventions have been identified as crucial (98) there is more to be explored in this area concerning the size of the social protection benefit, e.g. (99) (100). For low- and middle-income countries, evidence on in-kind programmes securing food are promising. School feeding programmes have been shown to provide big returns in terms of benefits to public health, but also to human capital development and the local economy (101). Also in LMICs, a systematic review found unconditional cash transfers to be associated with a 37% reduction in the likelihood of having any illness, reductions in food insecurity, and an increase in the likelihood of going to school (102). Other systematic reviews find a largely positive trend of conditional and unconditional cash transfers on physical and mental health, and the social determinants of health more broadly (103-105)</p> <p>Lundberg et al. 2008; Muntaner et al. 2011; Lundberg et al, 2016; Mergoni et al., 2025; McAllister et al., 2018; Álvarez-Gálvez & Jaime-Castillo, 2018 ; Kim et al, 2012; Simpson et al., 2021; Shahidi et al., 2019; O'Campo, 2015; Shand, 2022; WHO, 2008; Hillier-Brown et al. 2019; Torm & Oehme, 2024; Verguet et al, 2020; Pega et al, 2022; Yoshino et al, 2023; Owusu-Addo et al, 2018; Zimmerman et al, 2021.</p>

<p>5b</p>	<p>Build and expand paid leave benefits for sickness and parental leave, including for the precariously employed and informal workers.</p>	<p>Paid sick leave is important to maintain workers' status and income security in times of illness or injury. Strong empirical evidence from individual studies show that paid sick leave is associated with lower risks of all-cause mortality, and mortality caused by heart disease or non-intentional injuries (106); and is likely to reduce the spread of contagious diseases (107,108) (109). Comparative evidence from European countries suggests that paid sick leave is associated with health and economic gains for employers, workers and the economy (110). Paid parental leave aims to secure parental income and parents' return to work while promoting gender equality and mother and infant wellbeing (111). Several individual studies from high-income countries show that introducing paid maternal or paid parental leave improves maternal physical and mental health outcomes and health-related behaviours (112) and reduces the likelihood of postnatal depression, and that the benefits are greater for low resource and first-time mothers (113). Systematic review evidence finds that longer paid maternity leave is associated with better mental health and longer duration of breastfeeding (111); and evidence from OECD countries finds that more generous paid parental leave is associated with better infant and child health, particularly in terms of lower mortality rates (114).</p> <p>In practice, effective coverage of social protection policies and programmes, such as social insurance, is often limited to those with formal employment contracts or those who can afford voluntary insurance (110,115,116). Given the health benefits there is a strong case to expand coverage.</p> <p>Kim, 2017; Amoranto, 2020; Pichler et al., 2020; Piper et al., 2017; Sandner & Scheil-Adlung, 2010; Borrell et al., 2014; Bütikofer et al, 2021; Bilgrami et al., 2020; Borrell et al., 2024; Nandi et al., 2018; Sandner & Scheil-Adlung, 2010; UNHCR, 2022; ILO, 2021.</p>
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6. Take action against structural discrimination

No	Recommendation and strength of evidence	Rational and evidence description
<p>6a</p>	<p>Recognize and repair discrimination embedded in policies, laws, institutions and social norms.</p>	<p>Racism, gender discrimination and ableism have direct and indirect impacts on health, for instance through stress, or due to barriers to access to services. Structural discrimination can be embedded in laws and policies and is a significant contributor to social and health inequalities. It is therefore important to identify any legal and policy frameworks that are discriminatory and rectify them.</p> <p>Systematic reviews in the US have found that perceived structural racism impacted negatively on the mental health, cardiovascular outcomes, physical function, and cognition of older Black adults (117); and that perceived racism by healthcare workers negatively impacted outcomes for type 2 diabetes in Black adults (118). There are a number of reports that suggests that discrimination of all kinds impacts negatively on productivity/the GDP of economies (119,120).</p> <p>A systematic review of workers and refugees in high income countries found that housing conditions, immigration policies, structural discrimination, and exploitative labour practices were the four major determinants that impacted the health and the access to healthcare services (121). Structural barriers against gender equality in work and employment include gender gaps in labour force participation and pay, occupational segregation, unequal working conditions and women's burden of unpaid domestic and care work (122). Policies supporting women's participation in the labour force and decreasing their burden of care are associated with lower gender inequalities in health in Europe (123). It is important to recognise that while good policies and frameworks may exist, for instance on human rights, adherence to them may be weak, as is the case in the PAHO region, and adequate enforcement is therefore necessary (124).</p> <p>LaFave et al., 2022; Anim et al., 2023; Losavio, 2020; Lamontagne & d'Elbée, 2018; Yang et al, 2023; UN Secretary-General, 2016 ; Palència et al., 2017; PAHO Commission/ Institute of Health Equity, 2019.</p>

6b	Redress the negative impacts of colonization by developing standards for reparative justice that measure impacts on health.	<p>Indigenous peoples across the world have higher rates of physical illness and disease, food insecurity, poor living standards and mental health (125) (126) that have been associated with the negative impacts of colonialism, see for example (127,128). Reparative justice focuses on repairing past harms, stopping present harm, and preventing the reproduction of harm. In terms of repairing past harm, modelling studies in the US have found that reparation payments that would close the mean racial wealth gap would be associated with reductions in the longevity gap by between 65% to 102.5% (129), while another study found that reparation payments would have decreased risk of COVID-19 for recipients and also mitigated effects across racial groups (130). Reparations are being examined as a public health strategy to help eliminate racial inequalities in health in the United States (131). Reparative justice is unfortunately not addressing present harm, such that at the end of 2022 69% of people globally had received a COVID-19 vaccine, but in low and middle-income countries (LMICs) vaccination coverage only reached just under 25% of the population. Further, given the risks of climate change, reparative justice is needed to mitigate negative impacts on the most vulnerable. In response to the COVID-19 pandemic, for example, authors have concluded that engaging countries of all income levels, including both state and non-state actors to co-create a new shared vision of access, equity and justice is an urgent action that must include measurements of success (132).</p> <p>PAHO, 2019; Eni et al., 2021; Rodríguez-Díaz, 2022; Axelsson et al, 2016; Himmelstein, 2022; Richardson et al., 2021; FXB Center for Health and Human Rights at Harvard, 2022; Privor-Dumm et al., 2023.</p>
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7. Support Community Engagement and Civil Society

No	Recommendation and strength of evidence	Rational and evidence description
7a	Create the enabling conditions that maximize the capabilities of independent and inclusive civil society to promote health equity.	<p>The United Nations High Commissioner for Human Rights identified five essential ingredients to optimise civil society's transformative potential: a robust legal framework compliant with international standards that safeguards public freedoms and effective access to justice; a political environment conducive to civil society work; access to information; avenues for participation by civil society in decision-making processes; and long-term support and resources for civil society (133). Civil society has long been recognised as a key actor in the design and implementation of policies for health and wellbeing by the WHO (134), which has recently set up a Civil Society Commission to support WHO in its engagement with civil society to achieve health for all and attainment of SDGs. Civil society can deliver services where governments do not reach and do so at a lower cost; it can be a mediator in difficult policies; it has a strong role in advocacy; and it brings diverse views and expertise to policy-making (135). Case studies from the Eastern Mediterranean region support CSOs' contributions to NCD prevention and control through awareness raising, expanding the reach of services, advocacy activities and a push for accountability (136). Friel, based on her experience, observes that civil society organisations have made improvements in the social determinants of health possible through advocacy, monitoring, mobilisation of communities, technical support and training and, crucially by giving voice to those who are most disadvantaged (137).</p> <p>OHCHR, 2016; WHO Europe, 2013; European Observatory of Health Systems and Policies, 2017; NCD Alliance, 2016; Friel 2017;</p>

<p>7b</p>	<p>Incorporate representative community engagement and social participation in policy processes and delivery.</p>	<p>There are numerous systematic reviews that support the positive impact of community engagement (CE) in public health interventions. In general, CE in health interventions can lead to improved health and health behaviours in disadvantaged groups (138-140), and child health in LMICs (141). Several systematic reviews focus on the positive impact of CE and CE interventions on child immunisation and vaccine equity (142) (143) (144); the prevention and control of COVID-19 (145,146); the delivery of sexual and reproductive health interventions in conflict settings (147); the design, implementation and evaluation of nutrition interventions to reduce chronic diseases in indigenous populations in the U.S. (148), and mosquito-control interventions (149). Whole-of-community interventions represent an effective and equitable approach for the reduction of population weight gain (150), including in children (151).</p> <p>Community engagement and social participation are key for achieving equity in health and the social determinants, as exemplified by several Latin American countries that have used social participation to enhance equity (152). The most illustrative case is perhaps Brazil, where social participation is integral to its health system’s governance (152). Also in Brazil, where participatory budgeting has been in place since 1989, evidence shows that involved municipalities were highly responsive to popular preferences when allocating expenditures and spent more on sanitation and health services, seeing a reduction in infant mortality (153). In relation to other health determinants and outcomes, systematic review evidence from the UK indicates that community engagement can improve housing management, has the potential to increase the quality of local services and improves wellbeing at the community level (154). Community-based participatory research (CBPR) and community-engaged research are widely-used research approaches and numerous systematic reviews have documented positive outcomes (155). Community participation and the sense of empowerment and control that it brings can contribute to psychological wellbeing and other health outcomes (156).</p> <p>O’Mara-Eves et al., 2013; Cyril et al., 2015; O’Mara-Eves A et al. 2015; Farnsworth et al., 2014; Jain et al., 2022; Adeagbo et al., 2022; Kamal et al. 2021; Ha et al., 2021; Loewenson et al., 2021; Munyuzangabo et al., 2020; Banna et al, 2018; Oliver et al., 2021; Boelsen-Robinson et al., 2015; Wolfenden et al., 2014; de Andrade et al., 2015; Gonçalves, 2014; Milton et al., 2012; Wallerstein et al., 2020; Marmot et al., 2010.</p>
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8. Articulate and Accelerate the Health Equity Co-benefits of Climate Action and the Preservation of Biodiversity

No	Recommendation and strength of evidence	Rational and evidence description
8a	<p>Support the development and implementation of climate change mitigation and adaptation policies that maximize health equity benefits.</p>	<p>There is strong evidence that deep rapid cuts to greenhouse gas emissions/CO² are needed to limit global temperature to less than 2°C by the end of the century. At present there are approximately 3.3 to 3.6 billion people living in contexts that are highly vulnerable to climate change (157). Increasing weather and climate extreme events have exposed millions of people to acute food insecurity and reduced water security, with the largest adverse impacts observed in many locations and/or communities in Africa, Asia, Central and South America, least developed countries (LDCs), Small Islands and the Arctic, and globally for Indigenous Peoples, small-scale food producers and low-income households. Between 2010 and 2020, human mortality from floods, droughts and storms was 15 times higher in highly vulnerable regions, compared to regions with very low vulnerability (157). There is a very high confidence in evidence that climate change is going to exacerbate poverty further, through for instance higher crop prices, poorer health and displacement, and with that will come greater health inequity. For example, Hallegatte and Rozenberg (158) report that by 2030 (roughly approximating a 1.5°C warming), 122 million additional people could experience extreme poverty, mainly due to higher food prices and declining health, with substantial income losses for the poorest 20% across 92 countries. Not surprisingly therefore, systematic reviews support the notion that action on climate change will improve health outcomes and reduce inequity. Systematic and scoping reviews support co-benefits to health and the climate of, for example: reducing greenhouse gas emissions; more sustainable diets (161) (162); sustainable soil and land management programmes; afforestation and forest conservation; active transport; waste reduction (162) and green building design to reduce flooding (163) and insulation and ventilation of housing (164)</p> <p>IPCC, 2022; IPCC, 2022; Hallegatte & Rozenberg, 2017; Jarmul et al., 2020; Fernandez-Guzman et al., 2023; Houghton and Castillo-Salgado, 2017; Wang et al, 2022.</p>
8b	<p>Ensure energy and food transitions are able to reduce energy poverty and food insecurity.</p>	<p>Decarbonization is likely to lead to increases in energy prices, at least initially. A review of the literature on energy transition and energy poverty found evidence of greater negative impacts on lower-income households and on Black, Indigenous, and people of colour (BIPOC) households, even controlling for income. But there is also evidence that these impacts can be mitigated through policy choices (165). This and other papers support the premise that those who are vulnerable should be protected, e.g. (166,167). Many recognise current issues with energy transition policy that exacerbate inequality e.g. (168,169). There is scientific literature to support a diet that is less reliant on meat to help meet climate change targets, e.g. (170) but a systematic review found that papers that address the implications of transition in terms of food security and/or nutrition do so on a local scale, for a small number of people or a specific category of food chain actors (e.g. farmers, consumers) and that there is almost a complete lack of studies that address broader implications (171).</p> <p>Benneer, 2022; Streimikiene et al., 2021; Biswas et al., 2022; Hickel and Slamersak, 2022; Vandyck et al., 2023; Kesse-Guyot et al., 2021; El Bilali, 2019.</p>

8c	Strengthen support for Indigenous communities in their stewardship of land and natural resources.	<p>Deforestation, pollution and a loss of land for indigenous people makes it more difficult for those populations to maintain a healthy standard of living, while contributing to climate change and the disastrous health impacts of extreme weather events on health, food production and displacement.</p> <p>The IPCC 22 systematic review reports that small-scale farmers can play a crucial role as agents of change through ecosystem- and community-based practices that combine adaptation, mitigation and sustainable development (172). For instance, in drylands, farmer managed natural regeneration (FMNR) of trees in cropland is practised in 18 countries across sub-Saharan Africa, Southeast Asia, Timor-Leste, India and Haiti and has, for example, permitted the restoration of over five million hectares of land in the Sahel. In Ethiopia, the Managing Environmental Resources to Enable Transitions programme, which entails community-based watershed rehabilitation in rural landscapes, supported around 648,000 people, resulting in the rehabilitation of 25,400,000 hectares of land in 72 severely food-insecure districts across Ethiopia between 2012 and 2015.</p> <p>There is evidence to suggest that climate change is affecting migration within and outside Sub-Saharan Africa (173). There is empirical evidence to illustrate that environmental degradation can have negative health impacts. In a study of malaria in Southern Venezuela, the authors find that mining activity is associated with hotspots of malaria transmission, through increased temperatures (174). Addressing land confiscation through compensation has been found to be positive for the health of indigenous communities. For example, this process has allowed Maori to create their own infrastructure, to begin to develop their own health-care initiatives and to advise health-care authorities and governments on interventions to reduce health disparities between Maori and non-Maori New Zealanders (175).</p> <p>IPCC, 2022; Negev et al., 2019; Voyiatzaki et al., 2022; Koea, 2008.</p>
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9. Promote health equity during emergencies, migration and conflict

No	Recommendation and strength of evidence	Rational and evidence description
9a	Ensure emergency preparedness and response efforts incorporate the social determinants of health equity, including additional social protection measures.	<p>The recent COVID-19 pandemic illustrated the need for rapid roll out of social protection to mitigate the negative impact on inequalities in health and the social determinants (176). As for 5a, guaranteeing income is very important to health, and even more so during emergencies. Experimental or quasi-experimental evidence indicates that Cash transfers were protective against food insecurity during the COVID-19 pandemic in countries with differing levels of income (177-179). Vulnerable groups such as informal workers experienced better psychological wellbeing and food security after receiving a one-off payment (180); cash transfers were positively related with self-reported health status (181); with a higher likelihood of participating in volunteering (important for social cohesion) and with higher investments in children's education (182). In the United States additional unemployment benefits were positively linked to lower food insufficiency, and lower risk of depression and anxiety (183,184). Internationally, cash transfers for child support are linked to better child health, improved school attendance, reduced hunger, increased dietary diversity, reduced poverty and child mortality (185) (186). There is a strong view among experts that a universal health coverage system linked to social protection is key to build preparedness for health emergencies and threats (187,188). In conflict-affected areas, community health worker interventions may be effective and also efficient in circumventing the barriers associated with access to care (189). Additionally, several systematic reviews indicate that it is necessary to address the SDH in conflict zones and during emergencies (190) (191).</p> <p>WHO, 2024; Bryant & Follett, 2022; Makkar et al., 2022; Kumar et al., 2022; Cañedo et al., 2023; Ohrnberger, 2022; Londoño-Vélez & Querubín, 2022; Berkowitz & Basu, 2021; Berkowitz & Basu, 2021; Oekin et al., 2022; UNICEF-IRC, 2020; Barron et al., 2022; Tediosi et al., 2020; Werner et al., 2023; Munezero et al., 2021; Leider et al., 2017;</p>

9b	Ensure displaced people and migrants have access to health and social services.	<p>A number of systematic reviews support action to ensure displaced people have access to health and social services. Living conditions (192,193) – such as homelessness and vulnerable housing – and other social and structural factors (194–197) are important determinants of the health of migrants, refugees and asylum-seekers, and they also influence access to health and social services and unmet health needs (198–200). Refugees and forcibly displaced persons are vulnerable to multiple health risks, but systematic review evidence shows that they face a high level of unmet healthcare need in complex emergencies (201). They are also less likely to be part of prevention approaches such as global surveillance mechanisms (202), have poorer access to health services and diagnosis (203) and also suffer from poor access to essential sexual and reproductive health interventions (204). Systematic review evidence points to the effectiveness of a variety of primary health care interventions for internally-displaced persons in conflict settings (205). An intervention study exemplifies how a network of community health workers provided crucial access to malaria treatment in Central African Republic (206). Religious leaders, faith-based organisations and faith communities can provide health care, education and social support to communities adversely affected by health emergencies where they have existing structures, and WHO has developed guidelines to do this appropriately (207).</p> <p>Ziersch et al., 2018; Brake et al., 2023; Egli-Gany et al., 2021; Koseoglu Ornek et al., 2022; Hargreaves et al., 2019; Wali et al., 2018; Nowak et al., 2022; Kaur et al., 2021; Kusuma & Babu, 2018; Ojeleke et al., 2022; Yusuff et al., 2023; Zumla & Abubakar, 2018; Tunçalp et al., 2015; Ekezie et al., 2020; Ruckstuhl et al., 2017; WHO, 2021.</p>
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10. Steer the Digital Transformation in Favour of Health Equity and the Public Good

No	Recommendation and strength of evidence	Rational and evidence description
10a	Address the digital divide and ensure digital and technological transformations and artificial intelligence promote health for all.	<p>In 2021, 37% of the world’s population did not have digital access and those without access are those on the lowest incomes. With increasing information and services available online, digital access is now seen as a human right (208,209).</p> <p>Digital platforms have facilitated the rapid expansion of the gig economy globally. While allowing work flexibility, many digital platform workers have insecure jobs with low or none social protection, low wages and high algorithmic control and surveillance (210). This control can increase competition between workers and pressure them into working longer or irregular hours, all of which is damaging for health (211).</p> <p>A systematic review of the impact of AI on employment found a mix of positive and negative predictions (212) as the outcome is yet unknown. Individual articles about the pessimistic scenarios suggest for instance that the rapid advance of technological improvement is likely to disrupt labour markets (212,213), may lead to a reduction in the demand for human labour and create increased challenges for those without digital skills or digital access (214); and for those in work it may decrease the quality of work that we do (215). Understandably mitigation action is needed to prevent such pessimistic scenarios from negatively impacting outcomes, for workers, but also to avoid seismic increases in the need for social protection. While there is potential for AI to make a strong positive contribution to our lives, health and health equity related issues have been cited that need to be addressed. An improvement in the data available in LMICs is needed to be able to improve the contextualisation of results. This will allow for a better examination of AIs ability to address health inequalities, to mitigate or exaggerate bias (217) and to outperform current statistical/diagnostic techniques (219).</p> <p>ITU, 2021; UN High-Level Panel on Digital Cooperation, 2019; Alauddin et al., 2025; Vignola et al., 2023; Acypreste & Paran�a., 2022; Frank et al., 2019; Obermayer-Kov�acs et al., 2022; Charlwood et al., 2022; Istasy et al., 2022; Groot, 2020.</p>

11. Strengthen focus on social determinants in health systems and policy platforms

No	Recommendation and strength of evidence	Rational and evidence description
11a	<p>Integrate the social determinants of health equity in all health strategies, policies, emergency preparedness and response plans, and public health laws.</p>	<p>A number of systematic reviews support the integration of social determinants and health equity in health strategies to improve outcomes in health systems and health policies (220) (221), and in emergency preparedness and response plans (191). There are a number of high quality studies that have illustrated the socio-economic divide in adoption of healthy behaviours, and public health policy setting and legislation needs to address the socioeconomic gradients in health behaviours if they are going to see improvements in smoking rates, healthy eating and exercise; see for example (222) for a discussion of this phenomena drawing on evidence from different public health examples. To address the social determinants of health, implementation of Health in All Policies (HiAP) must take place at the national, regional and local levels (58). Legislation can contribute - together with other factors - to the initiation and implementation of a HiAP approach at the local level if accompanied by sufficient funding (223). Integrating the social determinants of health in national public health laws can make the focus on health inequalities less vulnerable to changes in government, according to expert analysis of Scandinavian countries (224).</p> <p>Ghiasvand et al., 2021; Yan et al., 2022; Leider et al., 2017 ; Nettle, 2010; Guglielmin et al., 2018; Lilly et al., 2023; Fosse & Helgesen, 2019.</p>
11b	<p>Establish coordination and accountability mechanisms for intersectoral collaboration and community engagement for health at all levels of government.</p>	<p>When de-centralized and well-grounded in their communities, health systems can communicate efficiently with all branches of local government and remain closer to the population and its need (225,226). A HiAP approach has proven to be successful (227,228) in monitoring the wellbeing of the population from the perspective of the social determinants of health, as well as in improving the impact the health sector can have in policies which go beyond those of the health system (229). A public health approach can give a 'wholesome' perspective to other sectors of government, effectively improving not only the wellbeing of the population, but also making policies more reactive and aware of the needs of individuals (230). Barriers to effective implementation of HiAP approaches identified by an umbrella review include the absence of clear roles and responsibilities as well as separate budgets for corresponding activities, which damages accountability (231). The case of Finland shows that implementation of HiAP also needs permanent structures and processes and legislative support (232).</p> <p>Breton et al., 2023; Wilderink et al., 2023; Hagen et al., 2017; Wilderink et al., 2020; Orton et al., 2011; South et al., 2014; Amri et al., 2022; Ståhl, 2018.</p>

12. Achieve Universal Health Coverage through Progressive Health Financing and Primary Health Care approaches

No	Recommendation and strength of evidence	Rational and evidence description
12a	<p>Improve equitable access to a continuum of quality primary health services addressing both physical and mental health.</p>	<p>Ensuring universal access to healthcare remains a fundamental aspect of health equity. As previously cited, a recent WHO report sets out that 2 billion people are experiencing catastrophically low levels of health care coverage across the world (7). Financing, governance, inequity, weak regulation and supervision mechanisms, and poverty were amongst the most cited political barriers in a systematic review of the universality of universal health care systems (233). However significant progress has been observed in improving access in Africa (234). Quality of care remains a significant concern in most countries. Availability of adequate health care providers, defined financing schemes to ensure universality of services, and engagement of communities in the definition of services are all central actions identified in one systematic review (235). Several systematic reviews exploring the emergence of universal healthcare systems around the globe point out the necessity of a standardised monitoring system focused on the quality of services provided (236,237).</p> <p>Health systems anchored in primary health care (PHC) are associated with better health outcomes, improved equity and better cost efficiency (238). A systematic review found that primary care-focused health initiatives in LMICs have improved access to health care, reduced child mortality and in some cases wealth-based inequalities in mortality (239). Several reviews also report that the adoption of strong primary health care models has improved equity, both in LMICs (240) and in Europe (241). Primary health care organisations can gather data on local social determinants of health to design and deliver new interventions aimed at reducing health inequalities in NCDs and improving population health outcomes (242). Several studies show that the introduction of community health workers in Brazil, who currently cover nearly 67% of the population, produced significant health improvements and a reduction in health inequity (243). Time trend analysis indicates that Canadian communities with better local access to primary care consistently showed lower rates of ambulatory care-sensitive conditions (ACSCs) among First Nations on-reserve populations (244). Moreover, closing the funding gap in primary health care would avoid over 60 million deaths worldwide, and increase global life expectancy by 3.7 years by 2030 (245).</p> <p>WHO, 2023; Endalamaw et al., 2022; Sanogo et al., 2019; Endalamaw et al., 2023; Yanful et al., 2023; Dawkins et al., 2021; UNICEF & WHO, 2019; Kruk, 2010; Bitton et al., 2019; Kringos et al., 2013; Allen et al., 2020; Wadge et al., 2016; Lavoie et al., 2010; Stenberg, 2019.</p>
12b	<p>Use pooled government resources to minimize out-of-pocket costs and finance health services.</p>	<p>Out-of-Pocket (OOP) payments remain a significant barrier for accessing healthcare across the globe, acting as both a determinant of health inequalities as well as an obstacle for the achievement of access to true universal health services to the whole population. The global number of people living in households who experience catastrophic health expenditure (CHE) – spending more than 10% of the household budget on OOP health expenses –, or impoverishing OOP health spending at the relative poverty line was estimated to be 2 billion in 2019 and less well-off households are more likely to experience this financial hardship (246). An independent assessment concluded that after implementing the Universal Coverage Scheme (UCS), Thailand was able to reduce catastrophic health expenditure from 6.8% to 2.8% for those members in the poorest quintile, as well as impoverishment as a result of payment of medicines and health services (247). The Lancet Global Health Commission on financing primary health care asserted that in most LMICs out-of-pocket payments must be reduced to a level that can only be achieved through increasing allocations to primary health care from general taxes, requiring increases in taxation. In LICs, more development assistance is needed to expand resources for primary health care (248). One systematic review found that extension of healthcare coverage and alternative sources of financing are necessary to reduce the burden of OOPs (249). Several new forms of financing primary healthcare have been explored and proposed in the literature with positive effects in Iran (250) and Africa (251,252).</p> <p>WHO/ International Bank for Reconstruction and Development / The World Bank, 2023; Health Systems Research Institute, 2012; Hanson et al., 2022; Kolasa & Kowalczyk, 2016; Darvishi et al., 2021; Odonkor et al., 2023; Anjorin et al., 2022.</p>

12c	<p>Increase the share of health and care sector funding to meet essential needs, to avoid marginalization and discrimination.</p>	<p>Poor-quality care is common across conditions and countries and the most vulnerable populations are the worst affected (253). Low income groups, rural populations and other disadvantaged populations tend to have poor service coverage, poor health or both, and they should be the primary focus when countries look at expanding coverage, while targeting these groups must be an integral part of efforts towards universality (254). There is systematic review evidence that shows that community health workers are an effective intervention in reaching marginalised groups (255).</p> <p>Health systems should redress or at least mitigate health inequities and avoid reinforcing them through sexism, racism, ableism, and other manifestations of discrimination. Evidence from ‘The Lancet series on racism, xenophobia, discrimination, and health’, including systematic reviews, exposes how discrimination based on caste, ethnicity, Indigeneity, migratory status, race, religion and skin colour affects health systems worldwide (256), negatively impacting their availability, acceptability, accessibility and the quality of care (257–266). Gender is another strong determinant of health care access and outcomes (267). Some examples include women still facing barriers in accessing reproductive and maternal care; poor women and those from rural areas being more likely to work in informal employment and thus being excluded from health protection; women being less likely to be diagnosed with cardiovascular disease although as many women as men are affected by it; and gender inequality and discriminatory laws and policies continuing to impede access to sexual health and HIV services in many parts of Africa (267).</p> <p>Kruk et al., 2018; WHO, 2014; Ahmed et al., 2022; Selvarajah et al., 2022; Firdous et al., 2020; Horrill et al., 2019; Castro et al., 2015; Samari et al., 2018; Kita et al., 2015; Daeem et al., 2019; Ben et al., 2017; FitzGerald & Hurst, 2017; Watson & Downe, 2017; Meghani et al., 2012; WHO, 2019.</p>
12d	<p>Facilitate equitable access to health technologies from research and development through to manufacturing and delivery.</p>	<p>New, improved health technologies are continually being developed which improve the quality of care available, but as shown by the COVID-19 pandemic, inequalities in access and rollout of vaccines, therapeutics, diagnostics, and other health technologies exacerbated health inequalities between and within countries (268) (269). The Intellectual Property (IP) System is at the heart of the debate on innovation and access to medical technologies and its global framework, defined by treaties and agreements, has built-in policy options and flexibilities which should be used to respond to countries individual needs and objectives (270). The prioritisation of public health needs; a rapid, open sharing of inputs, processes and outputs and the timely access to health technologies that are safe, efficacious and provide therapeutic advantages are some of the required components set by a recent proposal to ‘reboot biomedical R&D in the global public interest’ (271). The use of digital technologies in healthcare can exacerbate health inequity if efforts are not made to include disadvantaged groups. Different reviews show inequalities in the use and access to digital health such as gender, ethnicity, education, occupation and rurality, among others (272) (273).</p> <p>Gleeson et al., 2023; Watkinson et al., 2022; WHO/WIPO/WTO, 2023; Swaminathan et al., 2022; Woolley et al., 2023; Yao et al., 2022.</p>

13. Build and Retain a Workforce Capable of Delivering Equity

No	Recommendation and strength of evidence	Rational and evidence description
13a	<p>Recognize and reward work in the care economy, including informal care, and demonstrate the role of the health and care sector as a healthy and equitable employer.</p>	<p>Women face staggering and persisting discrimination as workers in the formal health and care economy. While they represent almost 70% of the global health and social workforce, it is estimated that they hold only 25% of senior roles (274) while experiencing a 24 percentage point pay gap compared to men globally, after accounting for age, education and other factors (275). Their role in providing informal care is also often not recognised, despite strong evidence that indicates that informal caregiving has a highly significant economic impact, which different studies have placed between 0.5% and 4.9% of the GDP of several developed economies (276). Also, systematic reviews suggest that informal care and social costs should be incorporated into national accounts to adequately measure the economic impact of diseases (276–285). Informal carers suffer from higher loneliness levels (286), higher cardiovascular disease incidence (287), worse mental health (288), more emotional exhaustion (289), and Burnout Syndrome that negatively affects their quality of life (290). Negative health effects are especially seen in female, and married caregivers, and those providing intensive care (291).</p> <p>The healthcare sector can have a significant role in driving health equity in its role as employer, manager and commissioner of services (292). Case studies from the UK show how health organizations can have a positive impact on the health and wellbeing of their communities by acting on the social determinants of health, including examples of organisations that have increased local employment focusing on young people and local residents; increased the proportion of suppliers who pay a real living wage and supported people with severe mental illness to work via an Individual Placement and Support Service, among other actions (293)</p> <p>WHO, 2021; ILO/WHO, 2022; Oliva-Moreno et al., 2017; Rodriguez-Sanchez et al., 2021; Krol et al., 2015; Rodriguez-Sanchez et al., 2023; Peña-Longobardo et al., 2019; Engel et al., 2021; Marešová et al., 2018; Trapero-Bertran & Oliva-Moreno, 2014; Leniz et al., 2021; Michalowsky et al., 2019; Hajek et al., 2021; Lambrias et al., 2023; Ervin et al., 2022; Gérain & Zech, 2021; Alves et al., 2019; Bom et al., 2019; Tomas, 2016; Allen et al., 2023.</p>
13b	<p>Develop human capacity in health, social protection, education, labour, local government and service organizations, to enhance intersectoral efforts to address the social determinants of health equity.</p>	<p>While there is expanding evidence on the importance of improving the social determinants of health to reduce health inequity, (and inequity more generally), and there have been successes, we know that there has not been the level of change needed and further training and capacity building of diverse workforces in relation to how to improve the SDH is required. No systematic reviews directly relevant to this appeared in our search. There is growing interest in incorporating the SDH in medical education, but there is a need for accepted tools and practices and evaluations (294). Answering to this need, the WHO has recently published guidance on how to integrate the SDH into health workforce education and training, understanding that this must be accompanied by a Health in All Policies interprofessional approach (295). This can therefore be complemented by existing guidance on how to implement Health in All Policies (296) (297). Different professional bodies, including the World Medical Association, have stated their commitment to reducing health inequities by acting on the SDH (292,298,299).</p> <p>Doobay-Persaud et al, 2019; WHO, 2023; WHO, 2014; WHO, 2015; The World Medical Association, 2011; Rosa et al., 2021.</p>

14. Monitor Social Determinants of Health Equity

No	Recommendation and strength of evidence	Rational and evidence description
14a	<p>Strengthen statistical infrastructure and build capacity for the use of disaggregated data to measure progress on health equity.</p>	<p>Monitoring health equity and its determinants is crucial to ensure accountability at the national and subnational level. However data used worldwide has been disproportionately concentrated in high-income countries, improving data availability can lead to significant impact and also identify areas where action has not been taken (300). New standards have been developed by WHO for monitoring the social determinants of health equity (301). Health equity impact assessment methods allow for informed debates on policies and interventions and provide essential information to decision makers about the benefits of interventions and impacts on inequalities (302,303). Moreover, recent systematic reviews have found strong evidence of the importance of intersectional analysis for a better understanding of the “causes of causes” in social and health inequalities (304,305). However, experiences from individual studies in countries like Finland or Mexico indicate that data availability does not ensure usage by decisionmakers or healthcare professionals (306), and that governance and legal mandates and a regulatory evaluation agency can be essential in institutionalising monitoring and evaluation (307).</p> <p>Biermann et al, 2021; WHO, 2024; Schönbach et al.; 2020; Bender et al., 2020; Harari & Lee, 2021; Bauer et al., 2021; Kilpeläinen et al., 2016; Valle, 2016.</p>
14b	<p>Utilise new technologies and novel data sources to fill data gaps and inform action on social determinants.</p>	<p>Innovative tools, methods and data sources can be used to enhance our knowledge and understanding of health inequalities and the social determinants. A data dashboard for urban American Indian/Alaska Native people created by the Urban Indian Health Institute (UIHI) in the US shows how new data sources can include traditionally marginalised groups in data collection (308). User-friendly tools can be valuable in analysing inequalities in health and the social determinants, as shown by the HEAT and HEAT Plus software developed by WHO (309). Additionally, new data sources beyond traditional government-supported ones, including big data, provide new opportunities to capture information on social determinants (310). Community-level data can be attainable from public sources and can be linked to health data on local geographic levels to assess the effect of social and community factors on individual health outcomes (311). A systematic review found that readily available data on health determinants from clinical electronic health records can be extracted using natural language processing tools (312)</p> <p>Urban Indian Health Institute, 2023; Kirkby et al., 2022; Torres et al., 2021; Lindenfeld et al., 2023; Patra et al., 2021.</p>

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