

Making social determinants of health real in one Swedish city

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A strong feature of this Malmo Review is the twin focus on what it is trying to achieve and how it thinks it should be done. One key aim is a social investment strategy; the other aims for an inclusive process. Such a process entails good governance and involvement of civil society and relevant sections of the population. The Malmo report includes detailed and high quality information, which is of the utmost importance. I was particularly pleased to see in the Malmo Review: A society's development can be judged by the general level of health and the degree of inequity in the distribution of health in the population. The substance of its recommendations – everyday conditions of children and young people, residential environment and urban planning, education, income and work, health care, sustainable development – are entirely consistent with those of the CSDH. What is fresh and important is the detailed attention to how these can be made concrete in the specific context of Malmo.

At a meeting in Stockholm in early 2013 a Swedish parliamentarian commented that most Commission reports are forgotten within a few weeks of publication, if not before. The report of the Commission on Social Determinants of Health (CSDH)(1), he said, was still being discussed in the Swedish parliament five years after publication.

When we began the CSDH, set up by the World Health Organisation (WHO), we asked ourselves what would success look like. In the long term success would be a reduction of inequities in health, avoidable inequalities, within countries and between countries, achieved through action on the social determinants of health. Such

a goal is, of course, the reason why the CSDH was initiated, but it is a counsel of perfection. Not only is reduction of health inequities a long term goal, but it would be difficult to say were such reductions in inequality to be achieved, why they came about, whether through action on social determinants of health, or for other reasons.

Having a report discussed in a national parliament five years after its publication is certainly one intermediate marker of success. A set of coherent policies would be another. The CSDH made recommendations for different actors: multilateral agencies, WHO, national and local government, civil society, the private sector, and research institutions.

Although we included local government, our assumption was that national government action was vital. Malmö was a revelation. The city of Malmö, not waiting for national action in Sweden, took the CSDH report, *Closing the Gap in a Generation*, and asked how it could apply its insights and recommendations at local level (2). I venture to suggest that such local commitment is indeed a marker of success.

Does Sweden need this?

One version of this question is: why Sweden, why not Ethiopia? We reported in our Review of health inequalities for the European Commission, that Sweden has among the best life expectancy records in Europe and among the shallowest social gradients (3). Do

parts of Sweden really need concerted action on the social determinants of health? There is really only one answer to this question, and it comes in two parts. First, as the Malmö report lays out, health inequities are very much in evidence in Sweden as a whole and in the city of Malmö, in particular. As one measure, life expectancy has been increasing for people of all socioeconomic positions, measured by education. The increase, though, has been faster for people with high education – the gap between low and high has therefore increased.

An illustration of growing health inequities is provided in the Figure taken from the Malmö report. It shows clearly that the social gradient in self-reported ill-health has grown steeper in the years

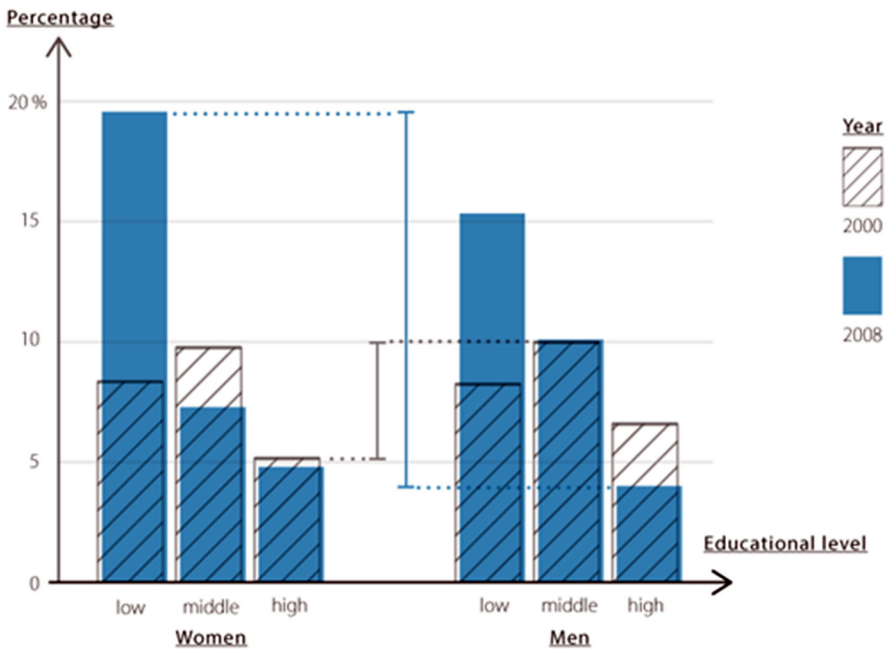


Figure 1. The proportion of men and women in Malmö with self-rated poor health based on education level. Pre-upper secondary school education (low), upper secondary school education (medium), tertiary education (high) Comparison years 2000 and 2008.

between 2000 and 2008. As elsewhere in Europe, although women have longer life expectancy than men they have higher levels of perceived ill-health.

Further, Malmo's need for social action is highlighted by the fact that Malmo is a migrant city with a shifting population.

The second part of the answer to 'why Sweden' is given by the phrase that we adopted in our European Review of Social Determinants and the Health Divide: "Do something, do more, do better."⁴ In fact, the phrase came to us from Sweden – Olle Lundberg chaired the Task Group on Social Protection that gave rise to it – and then returned to Sweden with a ready take-up. If a country is doing very little on social determinants of health, one of the Central Asian countries that are part of the European Region, for example, doing something would make a difference. If a country is taking action, one of the accession countries of the European Region, for example, do more. And, if you are Sweden, do it better. All our countries have health inequities. If they can grow larger in a relatively short time, they can grow narrower, too.

The Malmo report is an acknowledgement that Sweden, and the city of Malmo, can do better.

Where to get and how to get there

A strong feature of this Malmo Review is the twin focus on what it is trying to

achieve and how it thinks it should be done. One key aim is a social investment strategy; the other aims for an inclusive process. Such a process entails good governance and involvement of civil society and relevant sections of the population.

The five perspectives of the Malmo Review are very much in line with those taken by the CSDH, but Malmo takes them to a new level of detail:

- If the judgement is that health inequities are avoidable, it is unethical not to act.
- Sustainability: tackle environmental, social, and economic challenges together – must be done as a whole. The CSDH acknowledged the importance of bringing the social determinants and sustainability agendas together. The Malmo Commission makes this joint perspective integral to their recommendations.
- Societal – action has to be at the societal level. It is insufficient to target individual behaviour. Among the aims should be social integration. Participation is both a means and an end.
- Gender equity. Even in egalitarian Sweden that always scores highly in world rankings on gender equity, social disadvantage and gender inequity interact.
- Social interventions should be seen as investments not costs.

One of the challenges faced by the CSDH derived from its global reach. Early child development and education

are important globally, for example, but the nature of both the problem and solution will differ in Brazil and Belgium, in Somalia and Sweden. We concluded therefore that it was vital that countries, or cities and regions, take action to see how to ‘translate’ our recommendations taking context, socioeconomic circumstances, and culture into account. Malmo shows how this can be done at the city level.

The substance of its recommendations – everyday conditions of children and young people, residential environment and urban planning, education, income and work, health care, sustainable development – are entirely consistent with those of the CSDH. What is fresh and important is the detailed attention to how these can be made concrete in the specific context of Malmo.

In the previous paragraph, I have just listed the six domains of recommendations of the Malmo Commission. In the English Review we also had six domains. Given that social determinants cover the whole of society, it was an effort to make it simple and ‘do-able’. Of course, we had more detailed recommendations within these six. One government official said that he counted 42 – which, in the *Hitchiker’s Guide to the Galaxy*, a satire, is the meaning of life. The Malmo Review had 24 objectives and 74 actions. In my view, having the six domains is a way to simplify the message appropriately, while the 74 provide the needed detail on what should be done.

Proportionate universalism

In the CSDH we were aware of the importance of universalist solutions, rather than confining policies to those targeting the poor. Our perspective was informed, in part, by a specially convened knowledge network, the NEWS group (Nordic Experience of the Welfare State) (5). The question the NEWS group addressed was what the rest of the world could learn from the Nordic experience of the welfare state. Two of the messages were gender equity and universal policies.

The English Review of Health Inequalities, published as *Fair Society Healthy Lives* (6) (known to its friends as the Marmot Review) had this universalist perspective but it came up against the default position of British social policy which is to target those at highest need. Proportionate universalism was a way to resolve this tension. We said that a health system for the poor was a poor health system; an education system for the poor was a poor education system. We called for universalist policies with effort proportional to need, and labelled it proportionate universalism.

Malmo has endorsed this approach and has said that policies and programmes should be universal and adapted both in extent and design to the greatest need. It will be of great interest to watch how this plays out.

High quality data and monitoring

The Malmo report includes detailed

and high quality information, which is of the utmost importance. Monitoring trends both in social determinants and health equity is a way to retain a clear focus on health equity. Monitoring is potentially a radical activity. In countries where evidence is taken seriously, Sweden and the UK among them, keeping track of progress is a way of retaining a commitment to action. In England, for example, since publication of *Fair Society Healthy Lives* in 2010, we have released three sets of data monitoring key social determinants and health inequities at local level (7). These have generated renewed interest and focus on health inequities.

Health as a measure of how we are doing as a society

I have been pushing this argument as a way to engage interest across governments, not only in health departments, in social determinants of health. I was therefore particularly pleased to see in the Malmo Review: A society's development can be judged by the general level of health and the degree of inequity in the distribution of health in the population.

As the Malmo report makes clear it is a response not to a crisis but to an enduring issue, which requires long-term strategic decisions and actions.

We said, when launching the CSDH, that we wanted to create a social movement for health equity. This report from the Malmo Commission will, I judge, not only be beneficial to Malmo

but will be a significant step in furthering that social movement in Sweden and beyond.

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