“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.”\(^1\)

**Introduction**

In 1946, the World Health Organization (WHO) defined health as a “state of complete physical, mental, and social well-being and not just the absence of sickness.”\(^2\) According to the WHO and the Center for Disease Control and Prevention (CDC), social determinants of health (SDH) are identified as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.”\(^3\) These forces include economic policies and systems, development agendas, social norms and policies, and political systems. The WHO aims to improve the disparity caused by SDH through three principles of action: (1) improving the conditions of daily life, (2) identifying conditions that hinder healthy living, and (3) measure the problem, raise awareness, and evaluate action. Because the aim of the WHO is to better the governance for health and development, equity between environmental and health determinants, and progress on SDH and health equity, the WHO’s SDH Unit is responsible for addressing and taking action on health inequalities.

**Historical Context**

Over the past 30 years, international health agendas have wavered “between a focus on technology-based medical care and public health interventions, and an understanding of health as

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a social phenomenon requiring more complex forms of intersectoral policy action.” And while the 1978 Declaration of Alma-Ata and the Health for All movement gave importance to intersectoral action on SDH, the economic policies at the time and until the 1990s prevented any effective policies for any notable improvement SDH to be set in place. Within the late 1990s and into the 2000s, failing health policies – primarily in wealthy countries – created further disparity and prevented healthy equity until the late 2000s.

Founded in March 2005, the Commission on Social Determinants of Health served a vital role in drawing greater attention to previously neglected areas of health provision and access to health services. The Commission on Social Determinants of Health prioritized 3 major areas for recommendations: 1) improving daily living conditions; 2) tackling inequalities in the distribution of power, money, and resources; and 3) measuring and understanding the problem and assessing the impact of the actions being taken to address the problem. The Commission on Social Determinants of Health concluded its work in July 2008 and delegates to the World Health Organization (WHO) may wish to examine the work of the Commission.5

On October 21, 2011 the WHO adopted the Rio Political Declaration on Social Determinants of Health at the World Conference to build support for the implementation of action on SDH and pledging both reduce health inequalities and promoting development across world. This declaration was signed by 125 Member States recognizing that “health was a human right and societal goal.”6 The Declaration endorses the five priority goals of: 1) implementing action on social determinants of health, 2) promoting community leadership for action on social determinants of health, 3) reorient the health sector, including public health programmes, in reducing health inequality through universal health care coverage, 4) taking a global action on social determinants by aligning priorities and stakeholders, and 5) measuring and analyzing progress to build accountability and reform policies on social determinants.7

According to the 2013 World Health Report conducted shortly after the adoption of the Rio Political Declaration, moves toward towards universal health coverage has allowed for an increase of investment in global health research that have allowed nations to identify social health benefits within their borders. It was identified that within 22 African countries, the households that had access to some type of insect repellent – even just a mosquito net – had an average of 31% reduced mortality rate in children.

**Scale of the Problem**

The WHO’s 2010 Ranking of World Health Systems is based off of five index factors: 1) a country’s average life expectancy; 2) the disparity between socioeconomic class in regards to

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life expectancy within the borders; 3) availability of resources; 4) quality of resources; and 5) the contribution made by the state towards health initiatives. Of the 191 member states included in the report, a mere 25% of these nations have adequate available resources for their citizens. According to the WHO, the type and structure of governments and their social and economic policies greatly affect the health of the impoverished populations. People’s access to healthcare, their experiences within their respective health systems, and the benefits they gain are all closely related to other social determinants of health like income, gender, education, ethnicity, and occupation. Additionally, because the impoverished greatly depend on healthcare and other social safety nets, the availability of these greatly determine their health outcomes.

In an annual survey produced by the Commonwealth Fund, “Mirror, Mirror on the Wall” complex and differing health statistics becoming apparent. Currently, Nations with more generous social protection systems have better population health. However, when comparing the Australian, New Zealand, the United Kingdom, Germany, Canada, and the United States, the United States has been consistently outperformed since 2007, even with the most expensive health care system because the U.S. is the only above mentioned country without universal health care. Currently, the estimated annual increase in health expenditure from 2010-2060 in the European Union (EU) will be less than 1% with a continued decrease from that point forward.

As the UN System pivots from the previous Millennium Development Goals (MDGs) to the post-2015 development agenda and the Sustainable Development Goals (SDGs), the World Health Organization (WHO) and health providers all over the world are increasing their emphasis on environmental factors as contributors to public health; indeed, many of the WHO’s resources refer to public health, environmental and social determinants of health. In light of the United Nations Climate Conference (COP21) meetings in Paris in December 2015, delegates to the World Health Organization may wish to incorporate more environmental considerations into their debates and resolutions.

Food & Food Security

In 2004, research into the régime of the people residing in the subtropical islands of Japan identified negative effects of their dietary trends. While Okinawa still has the world’s longest life expectancy, it has been assessed that the average life expectancy has been continuously falling since the 1980s that are associated with the socioeconomic changes that followed WWII. With the introduction of canned meats, the citizens have been consuming less meats and have had a more sedentary lifestyle. This has been linked to the increase of the average body weight of school children and the increase in circulatory disease in general.8

While the Asia Pacific Region has been able to increase food production, the Region has yet to consistently meet nutritional requirements for their people. While these nations are striving for self-sufficiency, they find themselves constrained by rapidly growing populations, traditional farming practices, limited land for agricultural production, and frequent natural disasters. Additionally, the rapid industrialization of this region has led to competition for resources

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between the agricultural and non-agricultural sectors. Furthermore the lack of crop diversification, inadequate irrigation, and the loss of productive assets due to indebtedness has led to localized food insecurities. Although the prevalence of poverty is still high, targeted anti-poverty measures have reduced the vulnerability of famines. Among the poor citizens in this region, the average amount of calories consumed since 2002 has increased by 30%, however micronutrient continue to decrease. This has highlighted the significant differences that remain between the rich and the poor within and between the nations in this region.  

**Poverty and Tuberculosis**

Tuberculosis (TB) is a serious infectious bacterial disease that primarily affects the lungs and is transmitted through airborne respiratory droplets. In order to treat patients with active symptoms of TB, patients require a long course of treatment involving a multitude of antibiotics. Tuberculosis is the single leading cause of death among poor women of reproductive age. In the South-East Asia Region alone there are an approximated 3 million new TB cases and 600,000 deaths each year with 3 million of the people infected having an HIV and TB coinfection. According to the 2005 SDH report, poorer populations are twice as likely to have TB, three times less likely to have access to healthcare to treat TB, four times less likely to complete TB treatment, and five times more likely to incur impoverishing payments for TB care. In an effort to cope with the cost of the disease, people decrease their food intake, sell their assets, take out loans, withdraw their children from school, leave their families so that their family does not feel responsible to care for them, or delay seeking care entirely. Poor housing, overcrowding, malnutrition, and risky behavior all increase a person’s likelihood of getting TB.  

**Addressing the Needs of Less-abled Persons.**

The needs of the disabled, or less able-bodied individuals, are often not at the forefront or readily understood. This realization may be a bit hard to believe, considering WHO estimates upwards of 15 percent of the population – or, roughly, one billion people – is afflicted with some kind of disability. As WHO notes, "Disability is extremely diverse."  

In order to improve access to health services for disabled or less-abled persons, careful observers must first take a broad-based approach to understanding the different types of afflictions that can impact people during their day-to-day lives. Because not every disability can be readily noticed by a layperson, a greater awareness for different types of disabilities and their various manifestations is crucial to improving access to treat these issues; if more people are aware of the problems that can face different members of their community, not only can they

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10. CDC, Tuberculosis, Center for Disease Control and Prevention
work together to improve the treatment thereof, but also work to reduce any and all stigmatization associated with those disabilities.

WHO reported in 2014 that “people with disabilities are more than twice as likely to find healthcare providers' skills and facilities inadequate; nearly three times more likely to be denied health care; and four times more likely to be treated badly.” These disparities in access to health care and in health outcomes are unacceptable, and, in an alarming number of cases, may also be illegal. While it may not always be possible to achieve fully equitable health outcomes, based on a wide variety of factors and intervening variables, it is absolutely essential that equitable access to health care facilities, providers, and services be achieved as quickly as possible.

One area where public attention is sometimes intentionally drawn to the health problems and lack of adequate and appropriate health care facilities for people with disabilities is the treatment of wounded military service personnel. In the United States, recent scrutiny has focused on delays in treating the injuries suffered by military veterans in recent combat operations in Afghanistan and Iraq as well as on non-governmental organizations (NGOs), such as the Wounded Warrior Project, that provide financial and other assistance to wounded and disabled veterans, including for those suffering from post-traumatic stress disorder (PTSD). The United States, the United Kingdom (UK), and other countries have also pointed to serious needs for improving access to mental health care and facilities for wounded and disabled veterans.

Conclusion

SDH refer to social factors that both “promote and undermine the health of individuals and populations.” This distinction allows for the unequal distribution of these factors depending on a person’s socioeconomic position. Currently life expectancies vary greatly between each country a person is born into; in developed countries such as Japan and Sweden, the average life expectancy is more than 80 years, while in developing countries range anywhere between 72 years in Brazil, 63 years in India, and less than 50 years in several African countries. The goal of this assembly is not only to close the gap between and within member nations so that people of all nations have the opportunity to live past 80. To successfully do this, food security and nutrition should have a high priority in national strategies and plans. When nations are deciding whether a determinant is good, it is important to consider if it is good for them.

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Guiding Questions

What are the primary obstacles to equitable access to health services in your country? What steps has your government undertaken in recent years to reduce and/or eliminate these obstacles? What have been the roles and initiatives undertaken by health providers, the private sector, and relevant civil society actors? What have been the results of these various initiatives?

How might the UN System, including the World Health Organization, most effectively reduce and/or eliminate inequities in access to health services? How might the regional offices of the World Health Organization assist in reducing and/or eliminating inequities in access to health services?

What are the differences in access to health services for men and boys and women and girls in your society? What differences exist in terms of ethnic/racial identity, religion, social class, and/or status of disability? What steps have been taken to reduce and/or eliminate these differences in access to health services?

Resolutions and Related Documents


World Health Assembly (WHA), “Progress reports” A68/36 April 24, 2014.


Figure 1.1: 2012 Global Life Expectancy