

**Special Meeting  
of the  
Commission on Social Determinants of Health**



**New Orleans, Louisiana, USA  
November 18-20, 2007**

"The point we're trying to make is that there is the need to target social determinants of health, including housing, education, working and learning conditions, whether people are exposed to toxins. We believe New Orleans illustrates that point better than any place we can think of right now....*While the commission does not have a program to address the constellation of social ills in New Orleans, its members have broad experience from their travels to other countries that they can bring to bear in Louisiana. ....We believe New Orleans provides a tremendous opportunity to invest up front in improving housing conditions, working conditions and living conditions.*"

**Dr. David Satcher, Commissioner, Commission on Social Determinants of Health,  
16<sup>th</sup> US Surgeon General— Excerpted from *The New Orleans Times-Picayune*,  
November 21, 2007**



**Michael Marmot**

**David Satcher**

*"People's health is determined by where they are in social hierarchy and we're trying to make common calls between the problem of inequalities in health in the rich countries and the problems of inequalities among countries....The discussion in the U.S. when we talk about disparities tends to focus on healthcare disparities because of the embarrassingly obvious fact that there is not universal access to healthcare. Addressing healthcare inequalities has to be done. Any civilized country would do it but having addressed inequalities in healthcare, there is still the major issue of inequalities in health that won't be addressed solely by addressing inequalities in access to healthcare."*

**Professor Sir Michael Marmot, Chair, Commission on Social Determinants of Health — New Orleans Workshop**

## **Executive Summary**

The WHO Commission on Social Determinants of Health (CSDH) held its first meeting in Chile in 2005 and has met in more than 10 other countries since then. However, the Commission did not have a meeting planned for the United States of America as it approached the end of its work in 2007.

Thus the meeting in New Orleans, Louisiana during the week of November 18-20, 2007 was a special meeting of the Commission. It was viewed as an opportunity to examine health inequities in the world's wealthiest country but also to examine social determinants of health (SDH) in the context of a major disaster— Hurricane Katrina. Hurricane Katrina also exposed the broader issue of deep seated social inequalities in the USA.

The CSDH was well-represented at the New Orleans meeting despite the difficult timing of the meeting which followed on the heels of a meeting in Beijing, China and occurred during the week of Thanksgiving. It attracted representatives from three major foundations including its sponsor, the Robert Wood Johnson Foundation, and also the MacArthur Foundation and the Kaiser Family Foundation. Each of the foundations participated on the program.

The meeting also attracted several persons who are engaged in scholarly work on SDH. Local leaders including the mayor of New Orleans, the commissioner of health, and academic leaders also attended the meeting. The Commission had an opportunity to revisit the impact of Hurricane Katrina and the role of social determinants before, during and after the storm. Participants were also enlightened by first-hand reports from persons locally and the tour of the Ninth Ward which was hardest hit by the Hurricane.

The Global perspective was added by members of the Commission and others. It was especially interesting to learn how countries such as Sweden had so targeted SDH as to prevent the gradient or the gap in health outcomes between children of the highly educated and children of the poor often lacking high school degrees. This showed that it is possible to prevent health inequities by targeting the SDH.

The Workshop ended with a commitment of the various players, beginning with the local leaders, to partner locally, nationally, and globally in efforts to rebuild the health infrastructure of New Orleans and to learn from it in preparing for future disasters globally.



A special meeting of the Commission on Social Determinants of Health (CSDH) was held in New Orleans, Louisiana, United States of America (USA), November 18-20, 2007. Fifty people attended the meeting which was chaired by Professor Sir Michael Marmot, Chair of the CSDH (See participants list in Appendix A). The primary purpose of the meeting was to assemble key players capable of developing and implementing a blueprint for addressing the social determinants of health (SDH) and health equity internationally and in the United States (US) at local and national levels. The meeting also presented the opportunity to introduce the Robert Wood Johnson Foundation Commission on Health Equity; to highlight and support the sustainability of the work of the global CSDH; and to exchange learning between the US and other countries.

### **Meeting objectives:**

Meeting objectives were to:

- Bring together key persons from academia, research organizations, funders, government policy, and service delivery to examine how social determinants of health played out before, during, and after Katrina.
- Develop the building blocks necessary to eliminate inequalities in health at the global, national and local level including:
  - Fundamental research on the nature and causes of health inequalities.
  - Translation of knowledge into policy and practice.
  - Case studies/demonstration projects.
  - Monitoring and surveillance.
- Use a number of examples from the work of the CSDH, demonstrate the Commission's approach to improving population health and reducing inequalities in health.
- Share findings from the MacArthur Network on Socioeconomic Status and Health on health disparities in the US and the pathways by which they are created.
- Use a number of state and city-level case studies from the USA (e.g. Hurricane Katrina); demonstrate the sort of approaches being employed in bettering population health, ensuring fairer distribution of health and amelioration of disadvantage due to ill health.
- Present and discuss work prepared by the CSDH on the quantification of the impact of a selection of social determinants on health inequalities and the financial costs of such action.

- Develop an understanding of a social determinants of health equity approach as applicable in the USA.
- Further engage with a wider multi-sector audience.

### **Expected Outcomes**

Expected outcomes were:

- A shared understanding of what a social determinants approach to health and health equity looks like.
- Provision of insights from the global CSDH work that are applicable to vulnerable populations in the USA.
- Especially in light of Hurricane Katrina in New Orleans, the CSDH will listen to plans that are being implemented in New Orleans relative to its health and health-related social infrastructure and provide feedback based on the experience in visiting and working with other countries.
- Further development of a social determinants approach to health equity agenda at USA national and state levels.
- Preliminary blueprint for eliminating health inequalities in the USA based on global and USA national and local research and policy experiences.
- Development of a portfolio of contextually relevant approaches to action on health equity using a social determinants framework.
- The creation of an international, and specifically a national USA, network of experts in research, policy and practice relating to social determinants of health and health equity in rich countries.

## The Meeting Agenda

*Session one was designed to lay out the problem, while subsequent sessions addressed how to go about approaching a solution (See agenda in Appendix B).*

### **Session 1: Opening of Meeting**

**Dr. Evangeline Franklin**, New Orleans Director of Clinical Services, representing Mayor Ray Nagin and Dr. Kevin Stephens, New Orleans Commissioner of Health, welcomed the group to what she called "our renewing city." Dr. Franklin was one of the medical directors in the New Orleans Super Dome during the Hurricane Katrina disaster. She encouraged participants to enjoy the food and fun of New Orleans but advised them that when they toured the city, they would also learn how it is a continuing struggle for New Orleans to rebuild, renew, and repair.

**Sir Michael Marmot** welcomed the group on behalf of the CSDH and recognized the Robert Wood Johnson Foundation (RWJF) for sponsoring the meeting. He said the Foundation's support represents a major commitment of a US foundation in the area of health. According to Sir Michael, the overriding aim for the meeting was to share experiences across the various entities represented at the meeting.

**Dr. Risa Lavizzo-Mourey**, RWJF President and CEO said the mission of the RWJF is to improve health and healthcare for all Americans. She said most of the debate in the US around healthcare often centers on affordability of healthcare and not on the social determinants of health. Dr. Lavizzo-Mourey said if the social, educational, and other facets of a person's life could be connected with housing and healthcare, that person could live in a situation that leads to better health. Introducing the RWJF Commission for a Healthier America, which was officially announced in December, she said it would look at how lessons learned at the community level can be turned into actionable steps that the RWJF, as well as other foundations and civic groups can use to make meaningful and enduring differences in the lives of individual people. Dr. Lavizzo-Mourey said there is an obvious link between the work of the CSDH and the work of the RWJF Commission.

**Dr. David Satcher**, CSDH member and 16<sup>th</sup> US Surgeon General, gave the purpose of the meeting. He compared one of the overarching goals of *Healthy People 2010*—to eliminate disparities in health among different racial and ethnic and social economic groups to the mission of the CSDH—the commitment to eliminate health inequities globally. Dr. Satcher cited the Commission's dedication to health equity on a global level as the reason for the New Orleans meeting. He also said the meeting was held in New Orleans because the CSDH was searching for a better understanding of health inequities and how to attack them and how social determinants play out before, during, and after a disaster like Katrina.

Quoting Dr. Satcher, "In case you don't know it, we are here because New Orleans, Louisiana is a unique American city. In many ways, New Orleans represents the best of America. It is rich in history, in diversity, in culture, arts, commerce. But New Orleans also represents America at her worst when it comes to health inequities and America has a major problem with health inequities. But Hurricane Katrina exposed the great health inequities of America and the social determinants that were at the root of those inequities."

## **Session 2: Setting the Scene**

### **Professor Sir Michael Marmot- CSDH- Overview**

Sir Michael related how the CSDH functions, saying it was launched in Santiago, Chile under the former director general of WHO, Dr. Lee John Wook. He said Dr. Wook wanted the Commission to come up with a set of recommendations and to promote action based on evidence. The Commission goal is to marshal scientific evidence as a lever for policy change aiming toward practical uptake among policy makers and stakeholders and countries. According to Sir Michael, the present director general, Dr. Margaret Chan said no one should be denied access to life saving or health promoting interventions for unfair reasons including those with economic or social causes. Sir Michael said, "The reason for doing what we are doing is because it's the right thing to do and if we needed to justify it, I would say that everybody values health. I don't think you need to say 'well in somewhere else land, the people of somewhere else don't value health. They think disease is much better than health.' We don't take that cultural relative position. We say everybody values health."

### **Drs. Robin Mockenhaupt, David Williams, and Paula Braveman - RWJF USA Commission on Health Equity- Overview**

The presenters who are members of the RWJF Commission provided background and gave an overview of the new Commission. Dr. Mockenhaupt said the RWJF has been interested in the area of healthcare disparities for many decades; however, within the last five years it has undertaken a number of different fundraising or grant making efforts in the area of healthcare disparities, focusing primarily on some specific chronic illnesses such as cardiovascular disease and diabetes. The foundation has supported research to document the extent of racial and ethnic healthcare disparities and to look for potential solutions.

The RWJF Board approved funding of the RWJF Commission to Build a Healthier America. This national two-year effort will engage both public and private policy makers in a non-partisan discourse or debate about how to promote conditions that can improve the health of all Americans, focusing specifically on social and economic factors.

### **Dr. Nancy Adler-MacArthur SES and Health Research Network-Overview**

Dr. Adler said a group of scientists were brought together to try to understand what it was about socio-economic status (SES) that affected health, but overtime the Network became more and more interested in policy and what their findings could be used for. She gave an overall picture of SES and health in the US saying as SES goes down, the prevalence of various kinds of conditions increases. There is a dynamic relationship between health and SES over the life course that starts with parental SES. This affects the health of children, which in turn affects their educational attainment, which in turn affects their achievement of socio-economic success in adulthood— an intersection back and forth with health over the life course.

#### **Other Discussion Points:**

- In US context, talking about SES differences in health requires talking about racial/ethnic differences in health and the ways in which the two are intertwined.
- Making academic research on social inequalities more accessible to policy makers.
- Being aware of Bills that are up for reauthorization and seeing where linkages can be made in terms of health.
- Tracking what is being done on poverty disparity issues and looking for opportunities.
- The costs and risks of undertaking bold experiments with uncertain knowledge must be weighed against the costs and risks of the status quo, which is very costly in human terms and very costly in economic terms.

### **Session 3: The Extent of the Problem**

#### ***Denny Vagero-Global Health Inequities—Within and Between Countries***

The CSDH Commissioner discussed global health and equalities and focused on differences among countries as well as differences within countries. He addressed the between countries under 5 mortality rates saying there are enormous variations. Fair chances in childhood are fundamental for equal opportunity later in life since social differences in health start early. Dr. Vagero also discussed variations between countries in life expectancy, general mortality, age-specific mortality, alcohol use, HIV/AIDS, and income. Within country differences have been reduced in Thailand. An example was the under 5 mortality rate which was reduced not only on average but for all lower income groups. He said economic growth, shared by all groups, even by the poorest, and universe health insurance coverage contributed to the reduction. Another example was the use of interventions in Sweden to reduce the impact of differences in parental education on the health outcomes of children.

**Dr. David Williams- *The MacArthur Foundation Network- USA Social Patterning in Health***

Since its inception, the Network has done research, within the US, in the area of race/ethnicity and its intersection with SES. Dr. Williams used national data to illustrate some of the patterns and complexities. He said data show that most Americans of all racial groups are unaware that racial/ethnic disparities exist in the US. Among other statistics, he compared African American, Native American and white mortality rates which show markedly higher death rates for African Americans and American Indians. He discussed the role of the added effects of racism on health.

**Dr. Gary Evans**, Cornell University, discussed the relationship between SES or income and children's health; why there is an apparent link; and the present approach to the question. Dr. Evans said that not only are there morbidity and mortality outcomes related in children to SES or income, but that there is evidence of physiological processes which in some cases are well-documented precursors to the development of morbidity and eventually mortality.

**Dr. Diane Rowland, Kaiser Family Foundation (KFF)-*Local USA-New Orleans***

Dr. Rowland discussed healthcare in New Orleans before and following Hurricane Katrina. She said Louisiana is one of the poorest states in the US and has continued to be one of the states with the poorest health statistics. Louisiana ranks 50<sup>th</sup> on infant mortality; 46<sup>th</sup> in rate of AIDS cases; and 51<sup>st</sup> in diabetes mortalities. The KFF conducts surveys, analyzes the data, and makes a national case for keeping public policy makers aware, so that they can assist when needed. For example, in New Orleans, a year after the hurricane, KFF surveyed 1500 individuals in four parishes to find out about their healthcare; where they had gotten care before; where they were getting care now; their attitudes; and what was happening in their lives.

Other Discussion Points:

- Effects of social hierarchy on health outcomes
- Disparities in life expectancy; but if it is about choice, do Americans choose to live 10 years less than Japanese?
- Global prevalence of rising obesity
- Creating conditions in which people can be empowered
- Individual action and responsibility
- The role of economics
- Issues globally around men, particularly men who are poor and men of color
- Social exclusion and social action.

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- Inspire to act rather than shock to act.
- US has a history and culture of fairness, equality and individualism. If somebody has a health problem, people think about individual responsibility and choice.
- Need for global social movement.

#### **Session 4: Key Issues/ What's Causing the Health Inequities?**

##### **Dr. Sharon Friel, CSDH Secretariat- *Key Findings From CSDH Knowledge Streams***

Dr. Friel summarized the work of the Commission's nine knowledge Networks. She talked about structural issues that have been identified within the knowledge networks that drive health inequities and health equity. Among those mentioned are: issues of governance, issues to do with power relations, gender equity and gender inequities, social exclusion, the market place, and trade commodities. Having mechanisms that are crucial for everybody within society, in particular for those that are most vulnerable, has been identified as a key driver of health inequities and as such a major way of overcoming health inequities. She mentioned urbanization and how sustainable urbanization or lack of sustainable urbanization is helping to drive inequitable experiences from a physical perspective within the living environment and also from a social perspective. Other examples include the double burden of under and over nutrition in many countries around the world; the role that urban design plays in physical energy expenditure; and the intersection between social determinants and environmental change.

##### **Dr. Theresa Seeman, The MacArthur Network- *Drivers of Health Inequalities in USA***

Dr. Seeman addressed the state of health and health inequalities in the US—how SES relates to some of the range of different health outcomes in terms of mental health, cognizant and physical functioning, various aspects of physical health and mortality. Findings indicate that there are consistent gradients in cumulative biological risk by SES. Lower socio-economic groups exhibited greater disregulations in multiple major bioregulatory systems. SES influences health and the influences on health risks appear to operate through multiple biological pathways resulting in significant differences in cumulative biological risk profiles. These profiles are related to significant differences in risks for multiple outcomes including a range of different morbidity and mortality. Individual SES is not the sole SES-related factor of significance as macro level environmental characteristics such as neighborhood SES appear to have significant independent affects.

**Dr. Ayana Buckner, Director of the Regional Coordinating Center for Hurricane Response at the Morehouse School of Medicine in Atlanta, Georgia- *Hurricane Katrina Illustrative Example***

A native of New Orleans, Dr. Buckner said racial and ethnic minorities and poor people bore the brunt of the devastation in New Orleans for many reasons including living in low-lying areas that were flood prone—many being homeowners who over the years were only allowed to live in the Lower Ninth Ward; no free transportation for people to leave the city; and some people staying because they underestimated the impact of the storm. Dr. Buckner said the storm caused a large strain on family relationships, exacerbating stressors that were in some cases already affecting families before the storm. Prior to Katrina, there was already a lack of adequate funding and a shortage of providers to address mental health needs. She predicted Katrina survivors will experience clinically significant mental health problems and more than 30 percent will experience moderate depression or both. Dr. Buckner challenged the group to help the city find a common ground through solidarity, defining it as, “a union of interest, purposes or sympathies among members of a group, a fellowship of responsibilities and interests.”

Other Discussion Points:

- The problems that existed before Hurricanes Katrina (chronic diseases – obesity, hypertension and diabetes, poverty, violence, drug abuse, teenaged parents, premature death) were brought into sharp focus by the hurricane.
- The effects of Hurricane Katrina on people affected – geographic separation, strained family relationships, divorce, stress and mental health problems, substance abuse.

**Dr. David Satcher-*Social Movement for Action on the Social Determinants of Health.***

Dr. Satcher talked about the growth of the civil rights movement and how it started in the community. He drew lessons from the movement for the CSDH.

Other Discussion Points:

- A social movement is needed now to act on the causes of health disparities.
- Need for families and individuals to commit to change.
- Need for media to play a role.
- Many stakeholders can bring something to the table – faith community, media, and business community.

**Dr. Benjamin Springgate**, REACH-NOLA Partnership, RWJF Clinical Scholars Program made the suggestion that developing a strong statement about putting a movement together that reflects the principles of the Commission, would help the people working on the ground in New Orleans. The statement would include action items and would also be a meeting outcome that supports the CDSH vision.

**Dr. Neal Halfon, UCLA Blue Sky Group- *Role of Health care—US Healthcare system with a Population Health and Disparities Perspective***

Dr. Halfon discussed the work of the Blue Sky Initiative which began with the idea that health reform in the US was really focusing on incremental kinds of changes. The Initiative considered how health inequities develop in individuals and populations across the lifespan. He said eliminating health inequities will require significant transformation of the US health and healthcare system. Dr. Halfon concluded that the current health and healthcare system is not engineered to effectively and efficiently address health disparities; it was not designed to do that. Using a computer- operating- system metaphor, he said we need to move from version 2.0 to 3.0 and to change the operating system. This will require a new and integrated policy framework that is capable of supporting a new and more integrated service delivery platform. He said we can reframe the solution from a life course approach— change the operating system and create new tools; focus on population curve shifting strategies, not just identifying individuals who already have problems; and create new policy opportunities and move health reform from one that is incremental to one that is transformative of the system that we have.

Other discussion points:

- Operationalize the model by recommending a series of demonstration sites with New Orleans as the US site.

**Session 5: What Action Looks Like**

**Dr. Michael Marmot** presented a global perspective on thoughts about restructuring the healthcare system. He said one of the challenges for the Commission is its concern with the problem of inequity— health inequity in high income, middle income, and lower income countries. Getting a set of recommendations that applies to all is very difficult.

**Dr. David Williams** made the point that conversations about inequalities in health in the US are heavily driven by a focus on racial/ethnic differences in health and not on SES differences in health. The central focus on race is an important part of the US context.

### **Drs. Evangeline Franklin and Benjamin Springgate- *New Orleans Case Study***

They addressed historical problems in New Orleans; the problems faced in the aftermath of Hurricane Katrina; the problems faced now; and why they think things are getting better. Participants were cautioned to remember that a lot of hard work had already been done in New Orleans at the level of the mayor's office, the office of recovery management, and the economy. They expressed a desire to see New Orleans advance as the flagship community for the CSDH and for leading stakeholders to comprehensively address social determinants to improve health.

#### Other Discussion Points:

- It is important to set goals that are measurable. How not to demoralize, given that this is a long term effort. Set goals that are achievable.
- Some goals are aspirational, others realistic. Healthy people 2010: eliminate health disparities was the goal. But also need objectives with specific timeline.
- Need for quick wins. Perhaps in settings where we know SDH play important role, such as Detroit, Southeast Washington, and parts of LA.
- Health reform in Chile in 2000: after visit to Spain, the original proposal for targeting specific groups was changed.
- What can be done so that policy makers get to understand the SDH? It is something that is completely foreign to most, even for the very educated.
- Important for CSDH and RWJF Commission not to forget mental health issues. Mental health is underfunded. Yet also look at resilience of communities. Mental health paradox: most indicators of physical health are worse for blacks in the US, but for mental health they are better. Identity and building on resources in the community.
- Try to understand how to change paradigms after disaster – how to change for the common good. Do we have case studies?
- Link between criminal justice system and mental health of children is important.
- Need to permeate the education and training of future (health) professionals that deliver at the frontline. CSDH has to focus on education and training across the spectrum: the public, the media, business, inspirational community and health community
- Suggestion to use slides of presentations at this meeting in educational programs in schools.

- Not just involving 'the people', but how to involve the boardrooms, the researchers etc. It has to be a dialogue from both sides.

## **Session 6: Policy Implications**

### **Dr. David Satcher- *USA Policy and Practice—Reflections From the Former US Surgeon General***

Dr. Satcher said you must go outside of the Department of Health and Human Services and involve education, agriculture, health, etc.; all of the departments working together to have a health system focused on eliminating disparities in health.

#### **Other Discussion Points:**

- Need to focus on changing 'norms' (cultural aspects below grass roots)
- The SDH framework is a long-term endeavor, but there is a need to frame SDH messages around current thinking – that is, currently available evidence, visibility of scale of suffering and unsustainable systems, the scale of popular concern; question: where is the tipping point, and how to move towards it?
- Selling the SDH 'viewpoint' or philosophy makes subsequent selling of implementable policies easier
- If we are talking about engendering a 'social movement' (comparable to, e.g. the civil rights movement), does such a SDH movement come under the title of 'health' or is it broader?
- A number of approaches fit into the longer-term SDH timeframe of action: policy change, social mobilization, ideas and tools for change, research, propaganda.
- Policy change is not so much vertical (policy→action) choice, but rather coordination of multiple policy agendas and actions horizontally.
- CSDH products need to be marketed across the board to WHO, other UN agencies, civil society, the private sector
- One thing that is needed is a new 'collaborative' – a successor to the CSDH; this raises questions about what that entity would look like, who would populate it, and how would it be financed
  - It could focus on forward policy processes – with States, regional bodies, foundations and funders, etc.
  - It might follow the EU open method of coordination (e.g. their work on social exclusion), developing progressive agreement on common objectives and indicators for compliance and reporting

- It could use 'demonstration sites' (such as processes of reconstruction in New Orleans).
- It could work with community service organizations on innovation and dissemination.
- It could work with businesses and development banks on developing regulation and consumer mobilization.
- It could develop the portfolio of country partners, adopting policies whether they come under the rubric of health or other sectors (but with implications for health).
- All of these areas of action could be directed towards the establishment of a Framework Convention on Global Health, with binding norms for State action, perhaps following MDG shortfalls.
- Need to take stock of all existing SDH knowledge and activity, to build on these.
- The New Orleans reconstruction gives examples of things happening on the ground, but also the need for coordination across different areas of action; also, we need to think about how to coordinate the post-CSDH agenda with WHO, and without WHO.
- Communications are important – SDH raises complex causal issues, so we need to think about how the overall SDH message is framed.

### **Session 7: Implementation and Mechanism**

#### **Scott Burris- Professor of Law at Temple University Beasley School of Law- *Models for Implementation of Social Determinants of Health Policy and Practice Recommendations***

Mr. Burris said there were two elements worthy of interrogation if the thought is that social determinants can make a difference: 1) that social determinants is actually a way of thinking that can mobilize real change by influencing and changing underlying values and expectations about what is possible and 2) the task of assuming that social determinants is the right message—the right way of thinking. He asked, "How do we turn these ideas into processes of policy learning and social learning and change?"

**Ray Nagin, Mayor of New Orleans**, was introduced to the group by Dr. David Satcher. After officially welcoming the group to New Orleans, Mayor Nagin gave a brief overview of the recovery effort which after two years has begun to show good signs of recovery. He said the initial focus was on repopulating areas of the city that had two feet of water or less and then to start work on the rest of the city. Saying the work has been hard, he said there is still lots of debris and lots of citizens suffering, many not having had the chance to return to the city. The mayor described the healthcare system as totally shattered.

Mayor Nagin recommended that the CSDH, before doing anything specific, should take time to analyze the work that has already been done because there is a significant amount of work that has been done on the federal level, the state level, and the local level. Mayor Nagin said New Orleans would be happy to partner with the Commission in raising public awareness about the role that social determinants play in health inequities throughout the world. He also volunteered to take the message of the CSDH to the US Conference of Mayors. Mayors are generally on the "frontline" of SDH.

#### Other Discussion Points

- Collaborating to carry on the work of the CSDH.
- Issue of communications challenge.
- Challenge of framing issues that are different in different countries, with different kinds of audiences.
- Joining with people of New Orleans as part of a global movement for social justice.
- Need for the climate change agenda and social determinants agenda to come together.

#### Session 8: Site Visit of New Orleans Ninth Ward

#### Session 9: Monitoring and Evaluation

##### **Dr. Ritu Sandana, WHO Geneva- *CSDH Recommendations for Multilevel SDH Surveillance***

She discussed global monitoring of social determinants of health and health equity and said the distribution of health within any country is on the WHO agenda and that the director general of WHO is increasingly putting it on the international agenda. She made the following recommendations:

- That member states agree to take forward the Commission and be a sub-part of the Commission's agenda in terms of monitoring health equity within and across populations as a fundamental part of our health monitoring function.
- To ensure that leadership is provided in collaboration with other institutions in terms of social determinants:
  - There should be benchmarks for world health progress that actually include equity and a timeframe and process to move in that direction.
  - In terms of increasing sustainability and capacity, the development of a fully integrated system to monitor health equity at the member state level.

**Dr. Camara Phyllis Jones, Research Director on Social Determinants of Health and Equity at the Centers for Disease Control and Prevention - *USA Surveillance and Evaluation***

Dr. Jones said it is very important to name and measure racism in the US context, stressing that it sometimes gets lost from discussions of SDH. She defined racism as “a system of structuring opportunity and assigning value based on the social interpretation of how one looks,” which is called race in the US. According to Dr. Jones, this system unfairly advantages some people and disadvantages others. Racism impacts health on three levels—institutionalized, personally mediated, and internalized.

Dr. Jones used a cliff as a metaphor to demonstrate the need for health interventions that move the center of the population away from the edge. She defined interventions in terms of medical care and tertiary prevention, safety net programs, secondary prevention, and primary prevention which might include in the US, for example, nutrition programs. Dr. Jones said that addressing the SDH is going to involve the medical care and public health systems and that addressing the social determinants of equity involves monitoring for inequities, not only in outcomes, which is the disparities piece in the US, but in terms of exposures and opportunities. It involves looking at structures, policies, practices, and norms as part of the data collection effort and then intervening on societal structures and paying attention to systems of power.

Other Discussion Points

- The power of data and the need for evidence and monitoring to reflect the causal framework.
- Need to discuss poverty as well as SDH.

## **Session 10: Making the Case for Action on Social Determinants of Health**

### **Dr. Nancy Adler- *Highlight on the MacArthur Network Report, "The Facts."***

A ladder was used to illustrate policy implications being too kind—policies that address the structure of the ladder, how steep the ladder is, how large the space is between the rungs, and how you help people move up the ladder. Dr. Adler said there are things that can be done to buffer the effects of being lower on the ladder.

**Larry Adelman of the California Newsreel gave a sneak preview of "*Unnatural Causes: Is Inequality Making Us Sick?*"** which began broadcast on PBS on March 27, 2008. Mr. Adelman said there has been no popular media produced around the issues of health and health inequities and what his series does is frame the nation's debate over health. It asks what can and should we be doing? He showed a four minute overview of the series.

### **Other Discussion Points**

- A study called Compare that compares healthcare reform and the impact it will have on health.
- Involving experts in communication to get messages out to influence health policy.
- Role of cultural specificity in modifying and influencing messages.
- Wealth and power.

## **Session 11: Sustaining Action on Social Determinants of Health and Health Equity**

### **Dr. Paula Braveman - *The Future for Health Equity in the USA/North America.***

She said it is absolutely crucial that both race and class be addressed and that the primary emphasis on class in other-countries, will not work in this country. Dr. Braveman said there are risks in opening up the field since there are fears, among some champions of widening the field, of what is meant by disparities. She said it is not a problem for them to widen it to health, health status as opposed to healthcare, but starting to talk about class as well as race is a little bit risky in at least two ways: 1) It can make things very cloudy if all of a sudden, it's not just socio-economic and race/ethnicity, but you have to address gender and disability and sexual orientation and a whole host of dimensions of injustice that need to be addressed and 2) there is the potential for cloudiness to get even more extensive and no longer even addressing injustice, but defining the concept of health disparities in such a way as to make it virtually meaningless. Dr. Braveman stressed the importance of developing a strategy that includes working at the grass roots level, saying it's not going to be enough to work from the top down. Further she said that stimulating a process of consensus building,

both about values and about policy options, among the public, is one of the most important things they have to do.

**Dr. Gail Wilensky- *Working Together Nationally and Internationally— Opportunities and Mechanisms***

A member of the CSDH, Dr. Wilensky addressed mechanisms for maintaining established relationships and capitalizing on pledges of action. Another concern mentioned was who would take on the country partner role going forward. Dr. Wilensky said the group should think about how to frame and prioritize classes of recommendations/action points and stressed the need to limit them so that they will be more effective. Her fourth area of concern was learning and having some agreement about how to articulate what is meant by "social determinants."

**Dr. David Satcher**, reflecting on the meeting recapped the purpose for the meeting. He said they were there because they cared about issues related to health inequities; that they wanted to know more about them; to understand more about the nature and causes and distribution of these inequities; and that they wanted to know more about how to address them, especially targeting social conditions. He said they were also there because they wanted to do more about inequities and he thought being in New Orleans had been very special, bringing home the message more dramatically than anywhere because of what happened there and how social determinants played out there. He reiterated the need to persist and be committed to persisting if they were going to be successful. Finally, Dr. Satcher said he felt it had been a great meeting and mentioned that the greatest deficiency of the meeting was trying to do too much.

**Professor Michael Marmot** closed the meeting saying it was very important for the Commission to meet in other countries because of its efforts to invite countries to partner with them in making a difference. Secondly, he said they want to get "the tiniest glimpse" of real people dealing with real issues in the countries they visit. Dr. Marmot stressed the need to make common cause between the problems of the gross inequities that exist within rich countries, the problems in middle income countries, and the problems in poor countries. He said action needs to be global; action needs to be national; but clearly also needs to be local because in New Orleans, "We saw signs of local action that I think those of us who are here have been profoundly moved by and will go away and reflect on it."

**Other Meeting Highlights**

- Dinner with New Orleans elected officials and other local stakeholders. Dr. Kevin Stephens, New Orleans Health Commissioner was keynote speaker. He spoke about issues and challenges facing the people and city following Hurricane Katrina.
- Commissioners made appearance on local public interest television program.

- Tour of the ninth ward including visits to a restored community-health clinic and a faith-based community center.
- A statement from the meeting participants, "Building a Movement for Health Equity in New Orleans, the United States, and the World," was released on November 19, 2007. (See Appendix C)
- *The New Orleans Times Picayune* highlighted the Commission's work and the meeting in its November 21, 2007 edition. ( See Appendix D)
- Power point presentations were compiled onto a CD for distribution to participants. Power point presentations were included only with consent of individual presenters.

**APPENDICES**

## Appendix A

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## Appendix B

### Agenda

*Meeting Chair: Professor Sir Michael Marmot, Chair of the Commission on Social Determinants of Health*

09.00 – 12.00	CSDH Final Report – working session of CSDH Commissioners and secretariat
<b>SUN 18 NOV</b>	
11.30 – 13.00	<b>Registration</b>
12.00 - 13.00	<b>Lunch</b>
13.00 - 14.00	<b>Session 1: Opening of meeting</b> <ul style="list-style-type: none"><li>• New Orleans Mayor (5 mins) - invited</li><li>• Louisiana State Official (5 mins) - invited</li><li>• CSDH (Michael Marmot, 10 mins)</li><li>• RWJF Commission (Risa Lavizzo-Mourey, 10 mins)</li><li>• MacArthur Foundation (Julia Stasch, 10 mins) – tbc</li><li>• General introductions (10 mins)</li><li>• Purpose of Meeting (David Satcher 10 mins)</li></ul>
14.00 – 16.00	<b>Session 2: Setting the scene</b> <ul style="list-style-type: none"><li>• Commission on Social Determinants of Health – overview (Michael Marmot, 30 minutes)</li><li>• USA Commission on Health Equity – overview (David Williams, 30 minutes)</li><li>• MacArthur SES and Health Research Network – overview (Nancy Adler, 30 minutes)</li><li>• Discussion (30 minutes)</li></ul>
16.00 – 16.30	<b>Break</b>
16.30 – 18.00	<b>Session 3: The extent of the problem</b> <ul style="list-style-type: none"><li>• Global inequalities in health (CSDH, 20 mins)</li><li>• USA social patterning in health (MacArthur network, 20 mins)</li><li>• Local USA – New Orleans (Diane Rowland, Kaiser Family Foundation 20 mins) - tbc</li><li>• Discussion (30 minutes)</li></ul>
19.00	<b>Reception</b> hosted by Mayor of New Orleans (tbc)

<b>MON 19 NOV</b>	
09.00 – 11.00	<b>Session 4: Key issues / What's causing the health problem</b> <ul style="list-style-type: none"> <li>• Key findings from CSDH knowledge stream (CSDH, 20 mins)</li> <li>• Drivers of health inequalities in USA (MacArthur Network, 20 mins)</li> <li>• Hurricane Katrina illustrative example (David Satcher , 20 mins)</li> <li>• Role of health care - US healthcare system with a population health and disparities perspective (Neal Halfon UCLA Sky Blue group, 20 mins)</li> <li>• Discussion (40 minutes)</li> </ul>
11.00 – 11.30	<b>Break</b>
11.30 – 15.30 11.30- 13.30  13.30 – 14.30 14.30 – 15.30	<b>Session 5: What action looks like</b> <ul style="list-style-type: none"> <li>• CSDH global - approaches to addressing health equity (30 mins)</li> <li>• Discussion (30 mins)</li> <li>• USA national (RWJF Commission, 30 mins)</li> <li>• Discussion (30 mins)</li> </ul> <b>Lunch</b> <ul style="list-style-type: none"> <li>○ USA local <ul style="list-style-type: none"> <li>• Case study New Orleans (Evangeline Franklin, 30 mins)</li> <li>• Case study New York (Tom Frieden, Commissioner of Health, New York , 30 mins) – tbc</li> </ul> </li> <li>• Discussion (30 mins)</li> </ul>
15.30 – 16.30	<b>Session 6: Policy implications</b> <ul style="list-style-type: none"> <li>• Social action internationally (CSDH, 15 mins)</li> <li>• USA policy and practice – Reflections from the former US Surgeon General (David Satcher, 15 mins)</li> <li>• Californian Endowment Strategic Plan (Alonzo Plough/Bob Ross TCE, 15 mins) – tbc</li> <li>• Discussion (15 mins)</li> </ul>
16.30 – 17.00	<b>Break</b>
17.00 – 18.00	<b>Session 7: Implementation mechanisms</b> <ul style="list-style-type: none"> <li>• Models for Implementation of SDH Policy and Practice Recommendations (Scott Burris, 20 mins)</li> <li>• Discussion</li> </ul>

<b>TUE 20 NOV</b>	
08.30 – 11.00	<b>Session 8: Site Visit 'Ninth Ward' New Orleans</b>
11.00 – 12.00 (Tea/Coffee in Room)	<b>Session 9: Monitoring and evaluation</b> <ul style="list-style-type: none"> <li>• CSDH recommendations for multilevel SDH surveillance (CSDH, 20 mins)</li> <li>• Discussion (15 mins)</li> <li>• USA surveillance and evaluation (Camara Phyllis Jones CDC, 20 mins)</li> <li>• Discussion (20 mins)</li> </ul>
12.00 – 12.45	<b>Session 10: Making the case for action on SDH</b> <ul style="list-style-type: none"> <li>• Highlight on the MacArthur Network report 'The Facts' (Nancy Adler, 20 mins)</li> <li>• Sneak preview: "Unnatural Causes: is inequality making us sick" CALIFORNIA NEWSREEL (Larry Adelman, 20 mins)</li> </ul>
12.45 – 13.30	<b>Session 11: Sustaining action on SDH and Health Equity</b> <ul style="list-style-type: none"> <li>• The future for health equity in the USA/North America (Paula Braveman, RWJF Commission, 20 mins)</li> <li>• Working together nationally and internationally – opportunities and mechanisms (Commission on Social Determinants of Health, Gail Wilensky, Michael Marmot, David Satcher, 20 mins)</li> <li>• Discussion</li> </ul>
13.30 – 13.50	Reflection on meeting by Mayor of New Orleans and Dr Kevin Stephens, Commissioner of Health, New Orleans – tbc
13.50 – 14.00	Meeting close (CSDH Chair Michael Marmot)
14.00 – 15.00	<b>Lunch</b>

## Appendix C

FOR IMMEDIATE RELEASE

**Building a Movement for Health Equity in New Orleans, the United States, and the World  
A Statement from Participants of the New Orleans Meeting of the  
Commission on Social Determinants of Health  
New Orleans, Louisiana, USA  
November 19, 2007**

Health is a universal human aspiration and a basic human need. The development of society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health. Health equity is central to this premise and to the work of the Commission on Social Determinants of Health as well as its international, national, and regional partners. The Commission on Social Determinants of Health was set up by the World Health Organization in 2005 and will release its Final Report in 2008.

The people of New Orleans and surrounding regions continue to struggle with the devastation of the 2005 Katrina and Rita disasters and the inequitable social conditions which both preceded and accompanied them. The failure of the flood control systems destroyed many neighborhoods, dispersed the population, left lasting impacts on the availability of safe and affordable housing, undercut the capacities of the public school and public health systems, and revealed significant preexistent and persistent social inequalities based on race, socio-economic status, age, and gender which adversely impact health.

Strengthening health equity - globally and within countries - means going beyond contemporary concentration on the immediate causes of disease. More than any other global health endeavor, the Commission focuses on the "causes of the causes" —the fundamental structures of social hierarchy and the socially determined conditions these structures create in which people grow, live, work and age —the social determinants of health.

The time for action is now; not just because better health makes economic sense, but because it is right and just. The outcry against inequity has been intensifying for many years from country to country around the world. These cries are forming a global movement. The Commission on Social Determinants of Health places action to ensure fair health at the head and the heart of that movement. This global movement will address the social determinants of health on multiple levels in part by enhancing public participation and voice to achieve health equity and social justice. New Orleans is a potential focal point for the start of this global movement.

We announce today an offer on behalf of the Commission on the Social Determinants of Health, to partner with New Orleans residents, stakeholders and leaders; a commitment

to answer the call to action, to address social inequities and to strive to eliminate health disparities in New Orleans during its recovery by addressing the "causes of the causes" of poor health, namely the social determinants of health.

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## Appendix D



### **N.O. suggested as health lab**

#### **Commission looking at poverty, illness**

Wednesday, November 21, 2007

**By Kate Moran**

**Staff writer**

A commission of the World Health Organization could use New Orleans as a laboratory to study whether making exercise paths, playgrounds and fresh fruits and vegetables available in poor neighborhoods might help to alleviate some of the health problems associated with poverty.

Commission members spent three days in New Orleans this week touring damaged areas and meeting with Mayor Ray Nagin and the director of the city health department. While they have made no commitments to the city, members said New Orleans exemplifies the connection between health status and social status they are trying to address.

Dr. David Satcher, a former surgeon general who now heads the World Health Organization's Commission on Social Determinants of Health, said policymakers often equate poor population health in places like Louisiana -- with its high rates of obesity, diabetes and infant mortality -- with lack of access to doctors, nurses and hospital beds.

While those factors are important, Satcher says they are not the whole story. His commission is encouraging lawmakers to address the underlying social factors that predispose many poor people to bad health.

"The point we're trying to make is that the need to target social determinants of health, including housing, education, working and learning conditions, whether people are exposed to toxins," Satcher said. "We believe New Orleans illustrates that point better than any place we can think of right now."

After Katrina, for instance, Satcher said many evacuees did not have a firm grasp of the medications they were taking or their diagnoses. He said this feeble participation in their health care indicated poor health literacy or a limited relationship with family doctors.

While the commission does not have a program to address the constellation of social ills in New Orleans, Satcher said its members have broad experience from their travels to other countries that they can bring to bear in Louisiana. He said Chile, for example, has developed programs in early childhood development that might hold lessons for this area.

"We believe New Orleans provides a tremendous opportunity to invest up front in improving housing conditions, working conditions and living conditions," Satcher said.

Dr. Benjamin Springgate, academic co-chairman of REACH-NOLA, a group trying to improve community health, said the city could use Katrina as an opportunity to address structural factors such as the prevalence of carry-outs and liquor stores in poor neighborhoods that can lead to diabetes and obesity. He said the city could amend zoning laws to discourage such establishments, while promoting the development of farmers markets or grocery stores.

Dr. Kevin Stephens, director of the city health department, said he hoped the World Health Organization might use its contacts at the World Bank or at private foundations to develop programs to improve overall health in New Orleans.

"There is no cookbook. There is no right answer," Stephens said. "We have to work in collaboration with the community to figure out what are the solutions and how do we implement

them."

His deputy at the city health department, Dr. Evangeline Franklin, agreed.

"We see this as an opportunity for partnership with some extremely smart people worldwide who agree that the agenda of community health -- safe neighborhoods, the availability of healthy food, access to good employment -- is key for making this city not just recover, but thrive," Franklin said.

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