



**AP-HealthGAEN Report 2011**

# **An Asia Pacific Spotlight on Health Inequity**

**Taking Action to Address the Social  
and Environmental Determinants  
of Health Inequity in Asia Pacific**





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Taking Action to Address the Social and Environmental  
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2011

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## *PREFACE*

In spite of impressive initiatives and significant improvements, global health issues are constantly in the news: famines, wars, early death and escalating health care costs from obesity, diabetes, cancers and mental illness, deaths and injury from traffic and extreme weather events, and the prevailing communicable disease killers keep the world busy. No country, including in the Asia Pacific region, is immune from these health concerns but such life and death experiences are not distributed evenly across social groups or between countries. Generally, the further down the social pecking order the greater the risk. There is no biological reason for the 23 year difference in life expectancy between countries in Asia Pacific or the 12 year difference in life expectancy between Indigenous and non-Indigenous Australian males. As Asia Pacific is home to over 60% of the world's population, improving the conditions for health and health equity here would improve global health equity.

There is eagerness amongst many politicians, policy makers, researchers, advocacy groups and communities to curtail these health and health equity problems. The Commission on Social Determinants of Health (CSDH) made global recommendations on what could be done to address the avoidable health inequities created by political, economic and social factors. The WHO World Conference on the Social Determinants of Health in October 2011 asks governments of the world to share what they have been doing to address these issues following the CSDH 2008 report. The UN Summit on non-communicable diseases (NCDs) in September 2011 positioned these diseases as matters of concern for the highest level of global governance. As the Millennium Development Goals (MDGs) approach the end of their current form, countries and institutions reflect on the successes, failures and opportunities to improve the lot of the world's poor.

But the nature and drivers of health inequities vary greatly between different social, cultural and geo-political contexts and regions, and effective solutions must take into account the local context. This report takes the CSDH global recommendations and looks at the actions that are taking place to address health inequities through an exclusively Asia Pacific lens. The great contemporary human struggles – achieving health equity, poverty reduction and climate stabilisation – would benefit synergistically from alignment of their policy agendas. This report is also a call to join the determinants, diseases and development agendas together and points to some of the ways that is currently being done across the Asia Pacific region.

In the follow-on to the CSDH, a global alliance of researchers, policymakers and non-government organisations concerned for health equity through action on the social and environmental determinants of health has been established: HealthGAEN, the Global Action for Health Equity Network ([www.healthgaen.org](http://www.healthgaen.org)). AP-HealthGAEN is the Asia Pacific hub of the global network.

HealthGAEN's vision is a world where health equity, environmental sustainability and social justice are realized within and between countries.

*Sharon Friel*  
*Chair, HealthGAEN*



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## AUTHORS OF THIS REPORT

At the start of 2011, AP-HealthGAEN and partner organisations agreed to prepare a report which took the global recommendations from the World Health Organization Commission on Social Determinants of Health report and looked at the actions that have been taking place to address health inequities through an exclusively Asia Pacific lens. The lead writers of the report were Sharon Friel (HealthGAEN Chair) and Belinda Loring (HealthGAEN Senior Policy Officer), with significant input from members of the Asia Pacific HealthGAEN steering group and other collaborators listed below.

The **Executive Summary** of this report is available at [www.healthgaen.org](http://www.healthgaen.org)

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## INTRODUCTION: TRANSLATING A GLOBAL VISION INTO REGIONAL AND LOCAL ACTION

### Global vision

#### The WHO Commission on Social Determinants of Health

The World Health Organization Commission on Social Determinants of Health (CSDH) shone a global spotlight on the inequities in health that exist within and between countries at the start of the 21<sup>st</sup> century. It put health equity, social justice and empowerment of individuals, communities and countries at the heart of its concern. Between 2005 and 2008 the CSDH brought together evidence and made recommendations on what could be done to achieve better and more fairly distributed health worldwide through action specifically in the social determinants (1). The CSDH had three major conclusions and associated recommendations:

- inequities in the daily circumstances in which people are born, grow, live, work and age affect health inequities within and between countries;
- the conditions of daily life are influenced by inequities in ‘structural drivers’ – inequities in power, money and resources;
- there is a need to expand the knowledge base on the social determinants of health, evaluate action taken and develop a workforce that is trained in the social determinants of health.

#### HealthGAEN: A 21<sup>st</sup> century movement for action on the social and environmental determinants of health and health inequity

In its final report in 2008, the CSDH called for a global alliance to build on the momentum, expertise and partnerships generated through its work, and to ensure that the momentum generated is translated into tangible benefits for people around the world. This has led to a number of global partners and networks working to establish an entity called HealthGAEN, the Global Action for Health Equity Network ([www.healthgaen.org](http://www.healthgaen.org)).

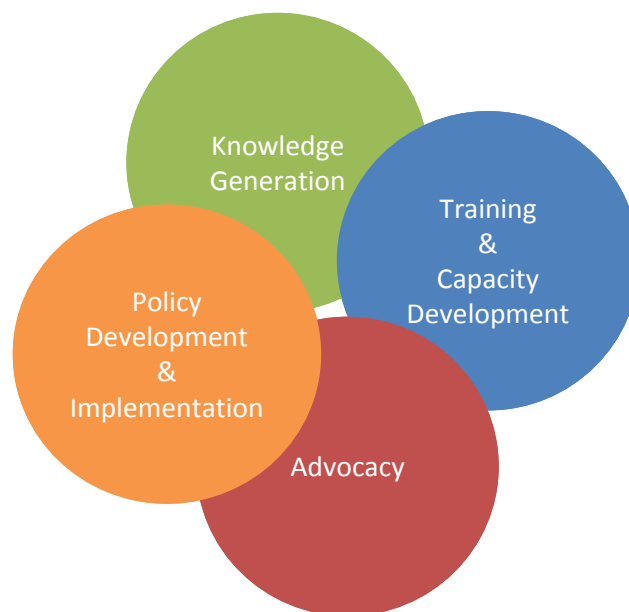
HealthGAEN’s vision is a world where health equity, environmental sustainability and social justice are realized within and between countries.

HealthGAEN is concerned with action to improve health equity. HealthGAEN makes the case for alignment of the social determinants, environmental sustainability and international development policy and practice agendas. HealthGAEN recognises that the health system is a determinant of health inequities – it is therefore inclusive of but not focused on health care concerns. Embracing the social, environmental and development agendas through a complex systems framework is necessary for achieving the vision.

In December 2009 many of the authors of this report met to discuss the nature of the evidence base on the determinants of health inequities throughout the Asia Pacific region, the applicability and transferability of the CSDH policy and practice recommendations to the region and the need for improvement in relevant training and advocacy skills. From those discussions emerged the Asia Pacific arm of the Global Action for Health Equity Network (AP-HealthGAEN), a regional collective of researchers, policy makers and NGOs committed to advancing the health equity agenda through action on the wider determinants of health in the region (2).

AP-HealthGAEN draws on a range of disciplinary expertise and works through collaborative, cross-sectoral and cross border action, through four domains of activity (Figure 1).

**Figure 1- AP-HealthGAEN's domains of activity**



## An Asia Pacific perspective: why this report?

### Aim

In this report we consider how a “globalised concept” such as social determinants and health equity fits in the diverse local contexts of the Asia Pacific region. The way in which the drivers of health inequities play out, and the degree to which action is taken to address health inequities vary greatly between different political, social and cultural contexts and regions. To translate the global momentum in action on the determinants of health inequity, a more nuanced regional and local analysis of the issues and solutions is required.

The Asia Pacific region is home to over 60% of the world’s population, or over 4.1 billion people (3). The region extends from Mongolia in the north to New Zealand in the south and from Kiribati in the east to India in the west (Figure 2). The region encompasses three of the largest and most populous countries in the world (China, India, and Indonesia), several mountainous and landlocked states (e.g. Bhutan and Nepal) and a number of the smallest island countries in the world.

**Figure 2 - Map of the Asia Pacific region**



In a resolution at the 2009 World Health Assembly (4), Member States agreed that there should be a global meeting on the social determinants of health, where governments share what they have been doing in relation to these issues following the CSDH 2008 report. That meeting, hosted by WHO and the Brazilian government takes place in October 2011. AP-HealthGAEN and partner organisations agreed to prepare a report relating to health inequities across Asia Pacific to feed into the global discussions at the meeting.

In this report we take the CSDH global recommendations and look at the causes of health inequities and actions that are taking place to address them through an exclusively Asia Pacific lens.

Specifically, the report aims to:

- shine a spotlight on the extent of inequities in health outcomes across Asia Pacific;
- expand the dominant framing of health equity from a health care issue to a whole-of-society one;
- demonstrate the importance of local context in determining societal and political commitment to improving health equity;
- outline key structural drivers and conditions of daily living that affect health in the region and lay out an argument as to how these contribute to health inequities;
- identify examples of promising policies and programmes that are taking place to address the structural drivers and conditions of daily living that affect health equity;
- incorporate the themes of the WHO World Conference on Social Determinants of Health (WCSDH) to illustrate systems, mechanisms and tools with which to address the social and environmental determinants of health equity in Asia Pacific, and
- provide recommendations about what can be done and what is missing with regards the evidence base; policy and practice; political will, advocacy and training needs.

## Outline of the report

**Section 1** of the report begins by describing the conceptual framework used to understand the causes of health inequities. This is followed by a short chapter which reminds us of the importance of understanding the local context in which health inequities, and action to address them, arise. Finally, we describe the analytical “action” framework that we used to identify the various policies and programs that are taking place across Asia Pacific to improve health equity.

In **Section 2** we describe the ‘problem’, the extent of health inequities between and within countries across the Asia Pacific region.

**Section 3:** A key element of the report is to illustrate a number of promising examples of policy and programs to explain why and how they have made a difference to health and health equity. Section 3 describes what is happening across the region in relation to policy and practice that seeks to improve daily living conditions including urbanisation, work and social protection.

**Section 4** describes what is happening in and across Asia Pacific in relation to policy and practice that seeks to improve the distribution of power money and resources. It looks at issues of trade and macroeconomic policy, environmental policy particularly climate change mitigation and adaption. Approaches to social inclusion are described as well as social participation and intersectoral action – key aspects of governance for health and health equity.

**Section 5** describes approaches to measurement, monitoring and evaluation – the backbone of action in the social and environmental determinants of health and health equity. Using examples from around the region, we illustrate how different countries are approaching these challenges.

**Section 6** of the report highlights the current and future challenges for health equity in Asia Pacific region and outlines some of the ways to overcome these through evidence, training, advocacy and policy formulation and implementation.

The report is based on pre-existing data, policy-mapping, case studies and expert knowledge from across the region. We have drawn upon reports and peer-reviewed publications from a diversity of disciplines such as public health, political science, sociology, economics, and planning. While the scope of the report is Asia Pacific, the evidence does not come equally from all parts of the region, possibly because in some parts the information does not exist or is not published.

## Who is this report for

This report is intended to convey a sense of hope and also the magnitude of the challenge. It is aimed at political leaders, policy makers, practitioners, academics and civil society.

Following the UN Summit on NCDs held in September 2011 and the WHO conference on the social determinants of health in October 2011, ministers and their country delegations are hopefully inspired to implement actions for health equity. This report gives examples of the types of actions that can be adapted locally. The report also advocates for a shift in policy focus. Much of the current action to reduce health inequities in countries across Asia Pacific is through health systems. This report calls for a shift towards a whole-of-government and whole-of-society approach to health and health equity. This report demonstrates through practical examples the many things that can be done when there is political will.

The report is also aimed at researchers and trainers. While much evidence exists, the report has highlighted that there are gaps in the evidence base, particularly on how to intervene effectively to address health inequities. The lack of workforce capacity to understand and act on the issues of social and environmental determinants of health and health equity is highlighted and in the report we outline training models that could inform health and social policy development and implementation in low, middle and high income countries.

The report has also been written for civil society groups and organisations that make major contributions to improving health equity through the services and opportunities they provide and who generate and use evidence to advocate for health equity.

## Key messages

### **1. Health inequity affects everyone in every country**

Health inequity relates to the poor health of the poor, the social gradient in health within low, middle and high income countries and the marked differences in health indicators between countries of Asia Pacific.

### **2. Health inequities across Asia Pacific arise not only from inequities in health care; they are also caused by inequities in environmental, economic and social factors.**

The health sector can go some of the way to reduce health inequities but health inequities are every sector's problem. If done well, trade, urban planning, rural development, employment conditions, social protection, legal systems, climate change policy, to take just a few examples, can meet sectoral goals and improve health and health equity. Inequities in health are avoidable but require political and social commitment to action, across sectors.

**3. Across Asia Pacific there are many policies and programs which are helping to improve health equity.**

Improvements in the distribution of power, money and resources and in daily living conditions are being made through policies and programmes in trade, investment, urban planning, climate change adaptation and mitigation and social services and in the health sector. This report brings them together for the first time through a health equity lens and in a framework that demonstrates how the various policies, programmes and social actions are working to improve the distribution of power, money and resources as well as the conditions of daily living.

**4. Whilst there are signs of hope, significant challenges remain for health equity in Asia Pacific.**

The gains that have been made to date are not inevitable, nor equally distributed, nor is continued progress guaranteed as the world encounters new economic, social and environmental challenges. Tackling health inequities is a political issue that requires leadership, political courage, social struggle and action, a sound evidence base and progressive social policy. These principles play out differently in different socio-cultural contexts.



## **SECTION 1: AN ASIA PACIFIC APPROACH TO INVESTIGATING HEALTH INEQUITY**

### **Chapter 1: Framing the causes of health inequities across Asia Pacific: a social and environmental determinants framework**

There have been improvements in health across Asia Pacific. Since 1950, the average life expectancy at birth rose from 41 years to 67 years and infant mortality has more than halved from 182 to 53 per 1,000 live births (5). However, while there have been major improvements on average, these statistics mask some marked differences in levels of health between sub-regions, countries and among populations within countries. Later in the report we present some evidence that suggests deep-rooted health inequities within countries, both in developing and in developed countries across Asia Pacific.

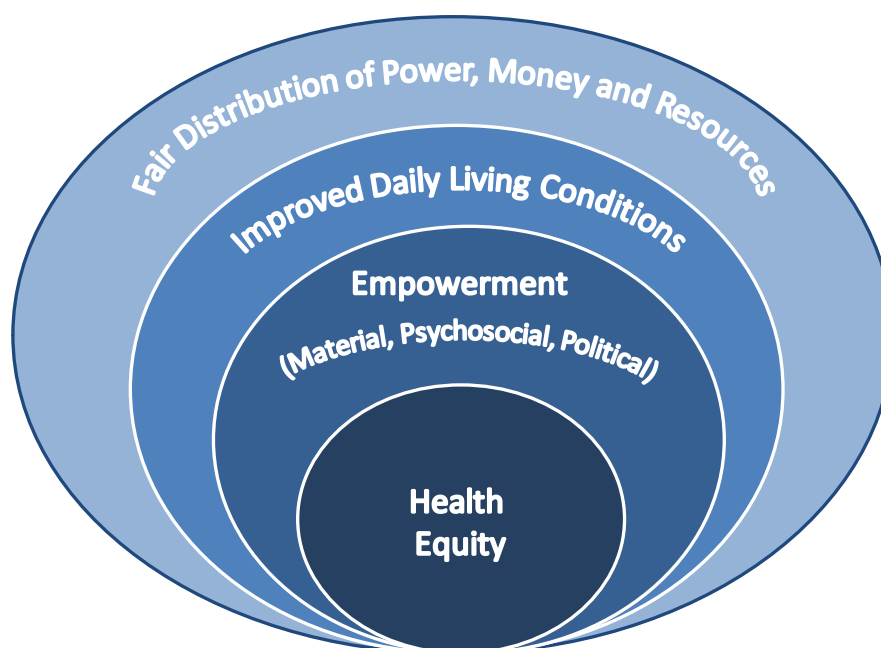
Our starting point is that there is no biological reason for the poor health of the poor, the social gradient in health within countries, and the health inequities between countries. We consider inequalities in health outcomes that are avoidable to be health inequities.

#### **From imbalances in power to empowerment and health equity**

As the CSDH highlighted, the freedom to live a long and healthy life is not equally distributed across social groups or indeed countries (1,6). Most societies are hierarchical, stratified along a range of intersecting social categories – income, education, occupation, gender, age, ethnicity, status within cultural structures and geography - in which power, economic and social resources are distributed unequally. More recently it has been acknowledged that the distribution and degradation of natural environmental resources (e.g. water, air, food, land) are also uneven. This maldistribution of environmental, economic and social resources results in variations in health outcomes. Pursuit of health equity recognises the need to redress the unequal distribution of these resources.

Creating a fairer distribution of resources relates to empowerment of individuals, communities, and whole countries. Empowerment operates along three interconnected dimensions: material, psychosocial, and political. People need the basic material requisites for a decent life, they need to have control over their lives, and they need voice and participation in decision-making processes. The three dimensions of empowerment and their distribution are influenced by the fundamental environmental, socio-political, socio-economic and socio-cultural characteristics of contemporary human societies which shape how people are born, grow, live, work, age and die. Implicit here are two levels of determinants – the structural environmental and social drivers that generate and distribute power, money, goods and services, at global, national and local levels, as well as the more immediate conditions of daily living (Figure 3).

**Figure 3 - Empowerment and health equity**



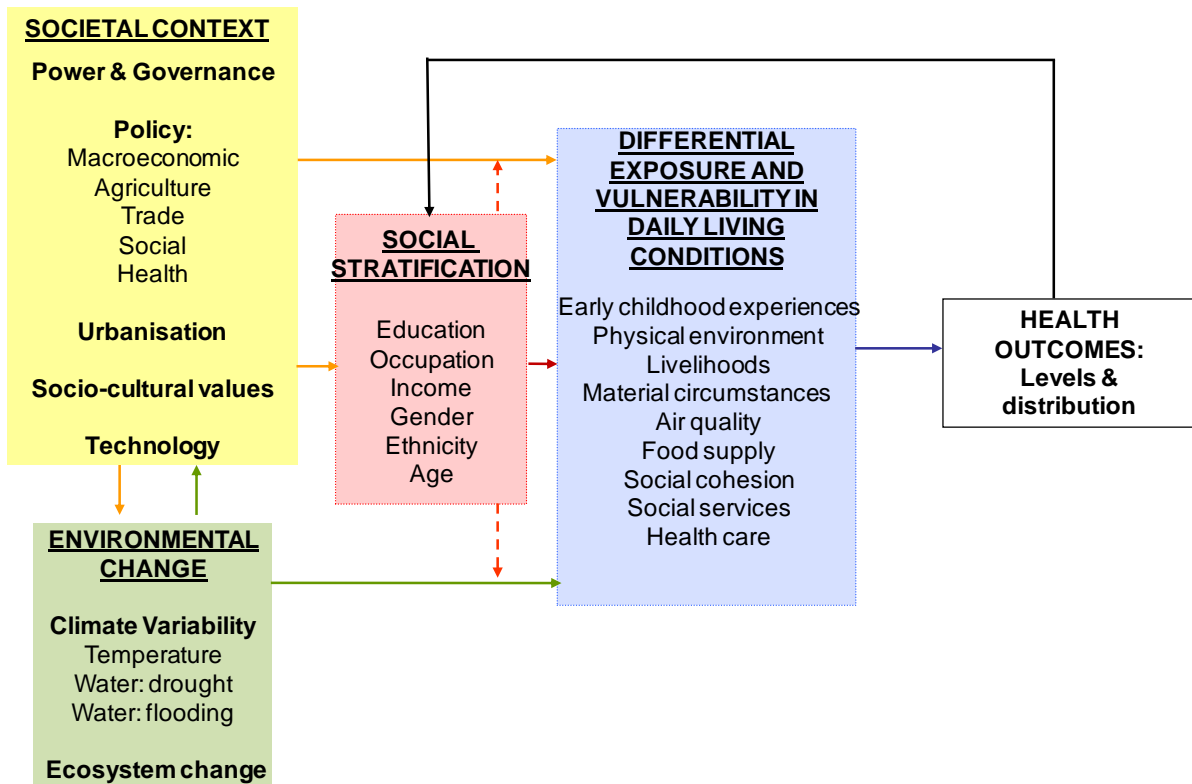
### **The social and environmental determinants of health equity**

There are many social and environmental factors that affect the health of people living across Asia Pacific. We have expanded the CSDH conceptual framework to include environmental factors as structural determinants of health inequities since they affect the distribution of (natural) life-giving resources and affect the conditions of daily living.

*In this report we expand the CSDH conceptual framework to include the natural environment as a structural determinant since it affects the distribution of natural life-giving resources and affects conditions of everyday living.*

The specific plausible causal pathways from the structural drivers to conditions of daily living and health inequities are shown in Figure 4. In summary, the global natural environment affects how societies survive and prosper through its provision of life-sustaining natural resources. The global economic context shapes international relations and domestic norms and policies, which, in turn, shape the way society organizes its affairs, giving rise to forms of social hierarchy. Economic and social policies generate and distribute political power, income, goods and services. These are distributed unequally across the social hierarchy. These, plus environmental pressures, mean that different social groups have different exposure to, for example, quality health care and education, sufficient food and clean drinking water, conditions of work and leisure, and quality of housing and built environment. Together these structural factors and daily living conditions constitute the determinants of health and health inequities.

Figure 4 - Plausible causal pathways to health inequities



Note: Solid lines denote causal pathways, Dotted lines indicate effect modifiers.  
Adapted from (1,7)

## Chapter 2: Contextualising the concepts of health equity and social determinants of health in Asia Pacific

Having a theoretical understanding of the likely causes of health inequities in Asia Pacific is one thing. Effecting healthy social change also requires an understanding of the way a proposed global goal (that society should address health equity through the social determinants of health) resonates with local political systems, especially the political and societal will for change.

### Is health inequity seen as a current and modifiable problem in the countries of the Asia Pacific Region?

The general tenet of this report is that health inequities in the Asia Pacific region are changeable and under the control or able to be influenced by the actions of society in general and government in particular. As we will see later in the report, there is evidence across the region that health inequities are recognized and there are serious attempts to address them. There are also societies in the region, such as Japan, that have led the world in achieving health equity for its citizens (8).

### Is health equity through the social and environmental determinants of health compatible with existing values, beliefs and ideas of the Asia Pacific region?

The Universal Declaration of Human Rights 1948 states that "everyone has the right to a standard of living adequate for the health, and wellbeing of himself and his family ". Countries in the Asia Pacific region have committed to health equity. The important question remains: "to what extent is the goal of health equity embedded in the local Asia Pacific contexts"?

#### **Values**

Language, history, social and political systems strongly shape societal responses to health equity. The acceptance of a societal goal of "health equity through the social determinants of health," requires the society to undergo "a process of [its] translation and adaptation to the [local] dominant value system" (9). This process is more likely to succeed if the goal is compatible with the existing values, beliefs and ideas of the local culture; if it is able to provide answers and solutions to current problems, and if it resonates with culturally deeply rooted local narratives (10). For health equity to be adopted as a goal, the adopting culture must share the assumption that the society sees pursuit or 'striving' for health equity as important.

There is strong evidence in the Asia Pacific region that this is the case. The major religions and traditional cultures in the region promote collectivistic approaches to social arrangements. Seu'ula Johansson's explanation of *Faka'apa'apa* as a Tongan equivalent of social justice is one example of a deeply held value that resonates with health equity as an outcome (11). Another expression of this commitment is the Indonesian constitutional commitment to "social justice for all" (12) and from Papua New Guinea's constitution "equal opportunity to participate in, and benefit from, the development of our country" (13). A review of health policy documents in all jurisdictions in Australia (14) found explicit or implicit recognition of the underlying value of equity within all jurisdictions and some policies designed to increase health equity in all.

### ***Local and timely narrative***

The importance of connecting with local narratives is well illustrated by the case of environmental concern in the Republic of Korea. In a survey conducted in the Republic of Korea in 1982, 93% of respondents preferred economic growth over environmental protection. In the same survey repeated in 1992, that number decreased to 52% (15). It is argued (9) that this change in favour of environmentalism was significantly influenced by a shift in the choice of narratives employed by the major environmental organisations. During the 1970s and 1980s, environmental activists in the Republic of Korea conceptualized nature as a domain of class struggle. They drew on the term *Minjung* which had been used to represent the marginalised in leftist account of economic development. Thus, the environmental organisations framed environmentalism as the struggle of the victims of pollution, the *Minjung*, against the political establishment. As the majority of people in the Republic of Korea identified with the latter, support for environmental protection remained on the fringes. The 1980s saw a change in narrative. A breakaway group of intellectuals reframed environmental protection in the terms and symbols of the Korean religion Donghak, an influential alternative to Christianity. This connected environmentalism with Korean cultural heritage and the religion's philosophy of *Saengmyeong* - life as an interrelationship between humans and nature. This resonated broadly, not only with the victims of pollution but also with the political right, the "perpetrators" in the *Minjung* narrative. The Donghak-inspired narrative was gradually adopted by the major environmental organisations and environmental protection moved from the fringes to the centre of the public discourse (9).

The use of narratives that connect with closely held societal beliefs was also seen in relation to equity in New Zealand. Dating back to the period following the arrival of the first Europeans, New Zealand society has been characterized by strongly egalitarian values, partly driven by a desire to avoid reproducing the rigidly hierarchical class structure of nineteenth century Britain (16). These were then championed by progressive political parties, giving rise to one of the earliest suffrage movements, and social welfare programmes introduced from the 1890s evolved into one of the world's first modern welfare states. However, economic and social reforms in the late 1980s and early 1990s de-emphasized egalitarian values and led to a rapid increase in health inequalities. By the mid-1990s public concern about the growing social inequality and its impact on long-held egalitarian values was widespread. This prompted the government to temper its neoliberal approach from the mid-1990s onwards, and this change was accelerated by the election of a centre-left government in 1999, with an explicit platform of "closing the gaps" between Māori and European ethnic groups and between the privileged and disadvantaged in New Zealand society (17).

### ***It is political***

For a country to act effectively on the goal of health equity, it is not enough for that country to merely state its importance. The goal must occupy a high position in the country's hierarchy of values (10,18), maintain that high position over time through the political process involving a struggle with competing interests, and have the necessary systems and processes to give effect to it. All of these must lead to sustained change in the country's social, economic and political institutions. Thus the pursuit of health equity through the social determinants of health is both a political and a technical process, with both being intertwined.

In summary, the above discussion has considered how societal goals need to find resonance with the local values, problems, narratives and political traditions found in the region. Once connected with local values and beliefs, the global discussion will act as the foundation for health equity policy and practice, which then gets strongly and continuously expressed through political structures. The concept of health equity is not something new for countries in the Asia Pacific region, but partially a rearticulating and re-enforcement of existing principles and beliefs.



Source: lakpuratravels, Sri Lanka, 2011, <http://www.flickr.com/photos/lakpura/5997557648/>

## Chapter 3: An action framework to illustrate what is happening in the social and environmental determinants of health equity in Asia Pacific

Inequities in health are not inevitable. When talking about such health inequities in Asia Pacific one of the first things to come into the conversation is the health system and inequities within it, in terms of availability, access, affordability and quality. In this report we stress that health care is only one of the determinants of health inequities between and within countries in Asia Pacific. There are many others which must be addressed if health equity is to be realised.

A key aim of this report is to describe some of the promising cross-sectoral policies and actions that are currently taking place that address the social and environmental determinants of power, money and resources, and the conditions of daily living in a way that is good for health and health equity.

We have taken the overarching recommendations made by the CSDH in 2008 and illustrated just some of the work that is taking place across sectors in countries in the Asia Pacific region which is in effect implementing the global recommendations (Figure 5).

### How we selected actions across Asia Pacific

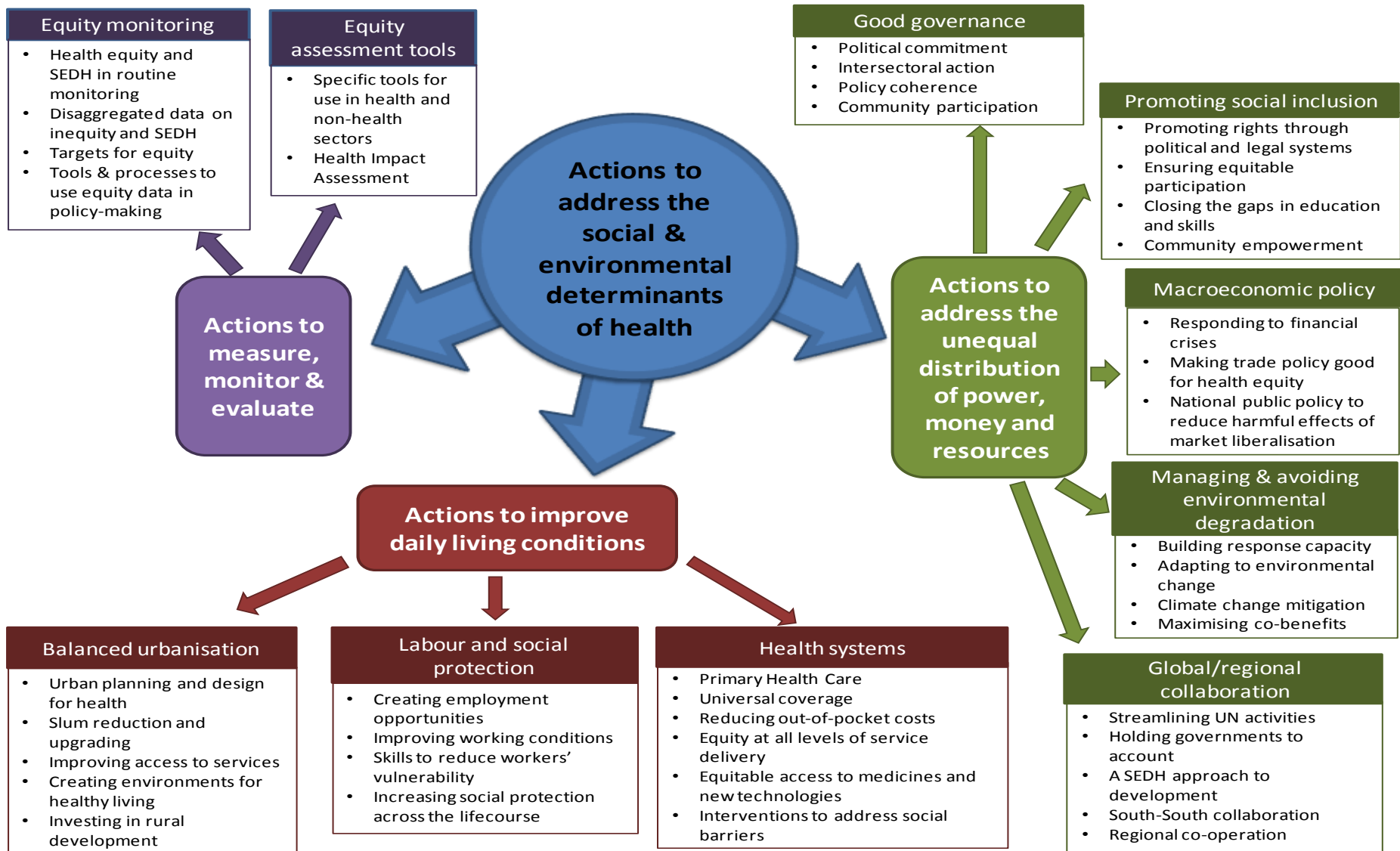
Sections 3-5 describe examples of existing policies and practices from across the diversity of geo-political, socio-economic and socio-cultural contexts in the region. The review is by no means an exhaustive one but is, rather, illustrative of what can be done. There is no “one-size fits all” approach - we would like only to draw attention to the things that can be done in different contexts, and to provide a range of possible actions to fit the diverse situations in the Asia Pacific region.

In our assessment of the evidence interventions to address the social and environmental determinants of health inequities include interventions to improve daily living conditions, and to address the unequal distribution of power, money and resources. Interventions for health equity may have been initiated by government, civil society or other groups. Interventions may equate to everyday government policy or specific programmes or actions. Such interventions may be explicitly about health equity, or health equity may be a secondary consideration.

Two lines of enquiry were used in searching for interventions. First we searched according to five thematic determinants (*Economic globalization; Urbanisation; Environmental change; Health systems; Social in/exclusion*). These areas were identified by AP-HealthGAEN members as being key drivers of health inequities in the region. If activities in each of these areas are done well, they offer great opportunities for human health and health equity. However, if done badly, they can contribute to health inequities across all stages of the life-course, now and in the future, in low, middle and high income countries.

The second line of enquiry related to the five themes of the WHO World Conference on the Social Determinants of Health (WCSDH), which focus on systems, processes and tools to implement action on the social determinants of health and health equity. The WCSDH themes are: governance -role of the health sector; promoting participation - community leadership for action on social determinants; global action on social determinants - aligning priorities and stakeholders, and monitoring progress - measurement and analysis to inform policies on social determinants.

Figure 5 - Action framework



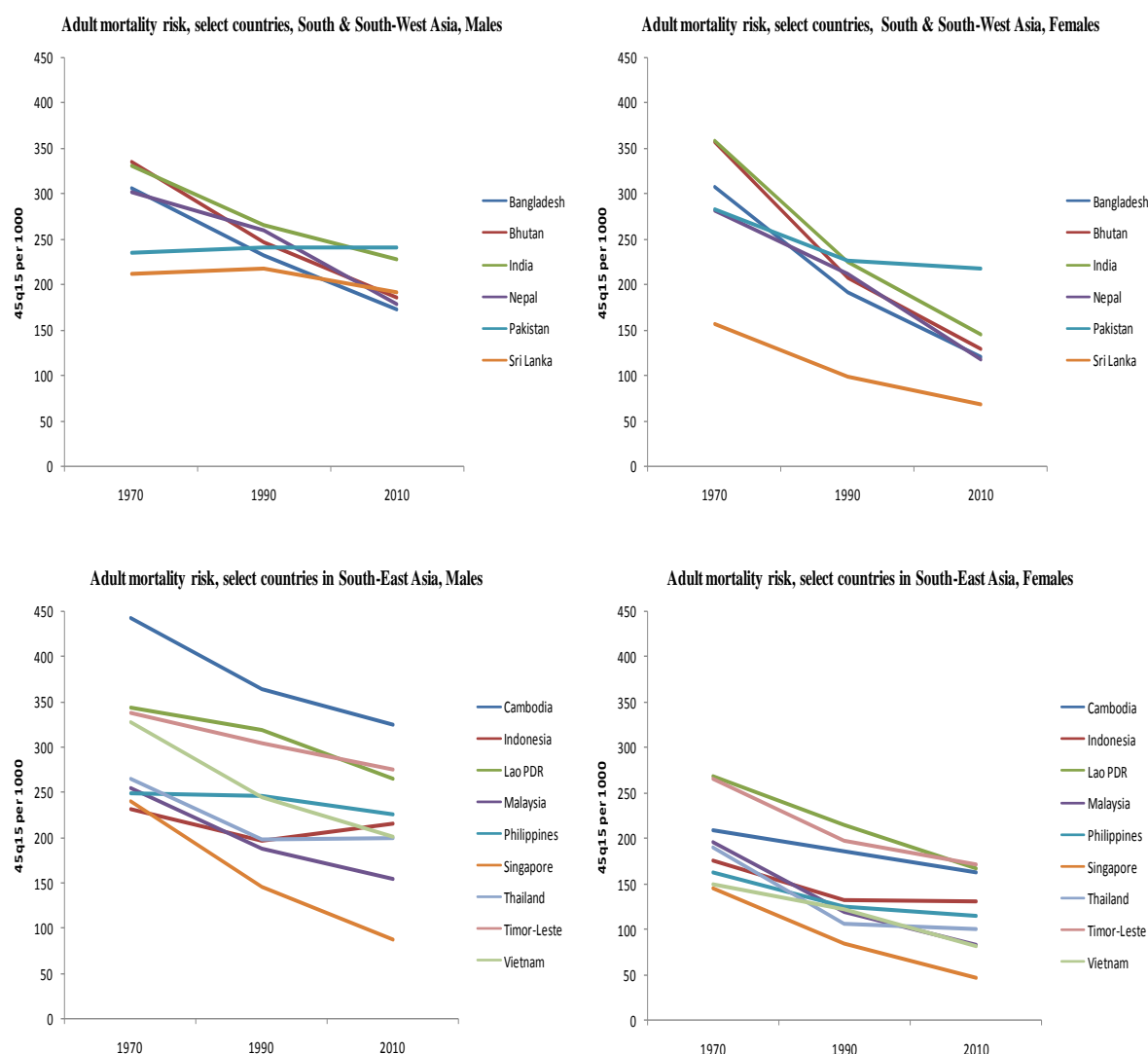


## SECTION 2: THE EXTENT OF HEALTH INEQUITY ACROSS ASIA PACIFIC

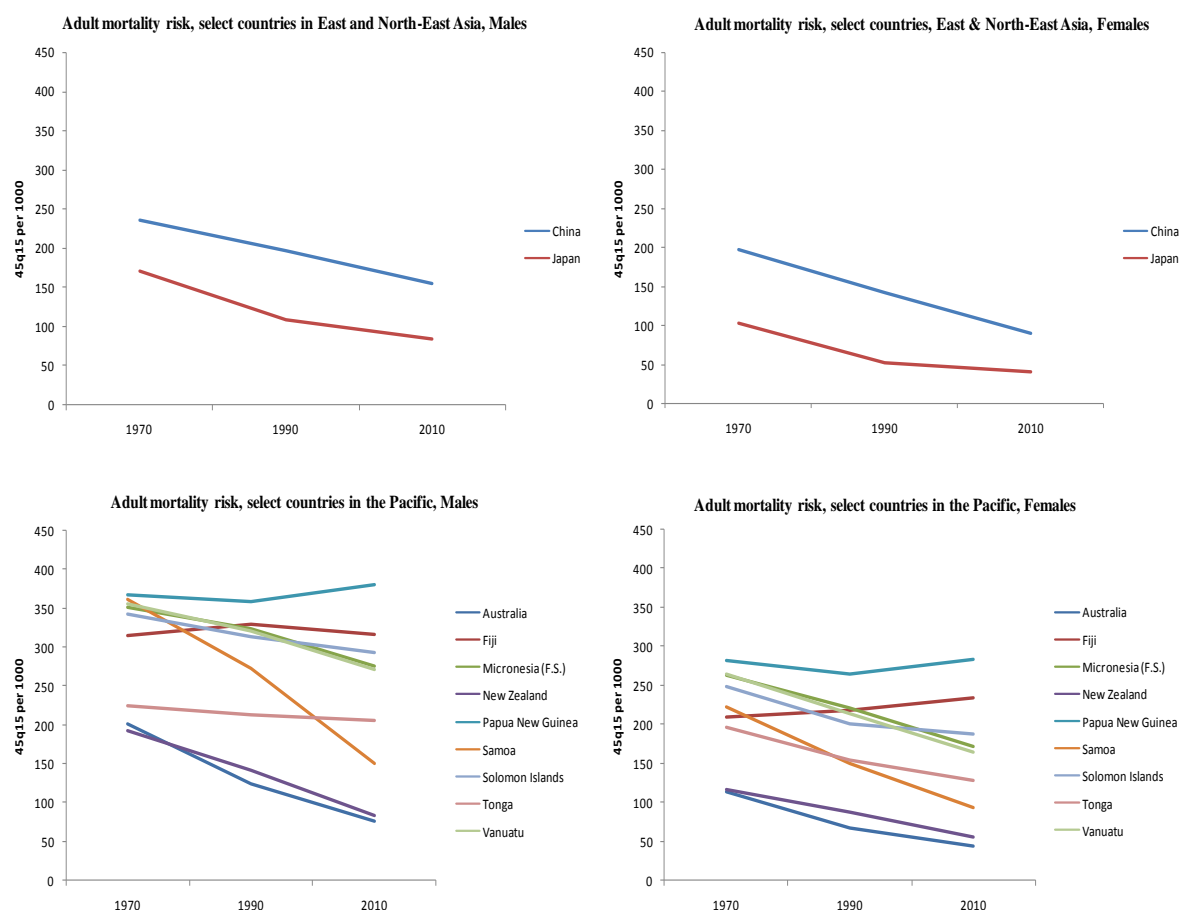
### Overview

Epidemiological data are often used, as we are doing in this report, to illustrate the extent of a problem. However, data can also be powerful messengers of hope. Importantly, time trend data indicate how things can, and have, improved, on average, in health outcomes in many countries in Asia Pacific. While terrible and often widening differences in the levels of premature mortality remain between countries and between males and females in sub regions of Asia Pacific, Figure 6 also tells a story of dramatic improvements, for some, between 1970 and 2010. In the remainder of the report we suggest that a combination of progressive economic, social and health policies have been fundamental to such progress and outline what is currently happening in these policy domains across Asia Pacific.

**Figure 6 - Adult mortality risk among males and females in countries across Asia Pacific, 1970 – 2010**



## THE EXTENT OF HEALTH INEQUITY ACROSS THE ASIA PACIFIC REGION: SECTION 2



Note: 45q15 represents the probability that an individual who has just turned 15 years will die before reaching the age of 60 years, on the assumption that the age-specific mortality conditions of the year are constant throughout life.  
Source data: (19)

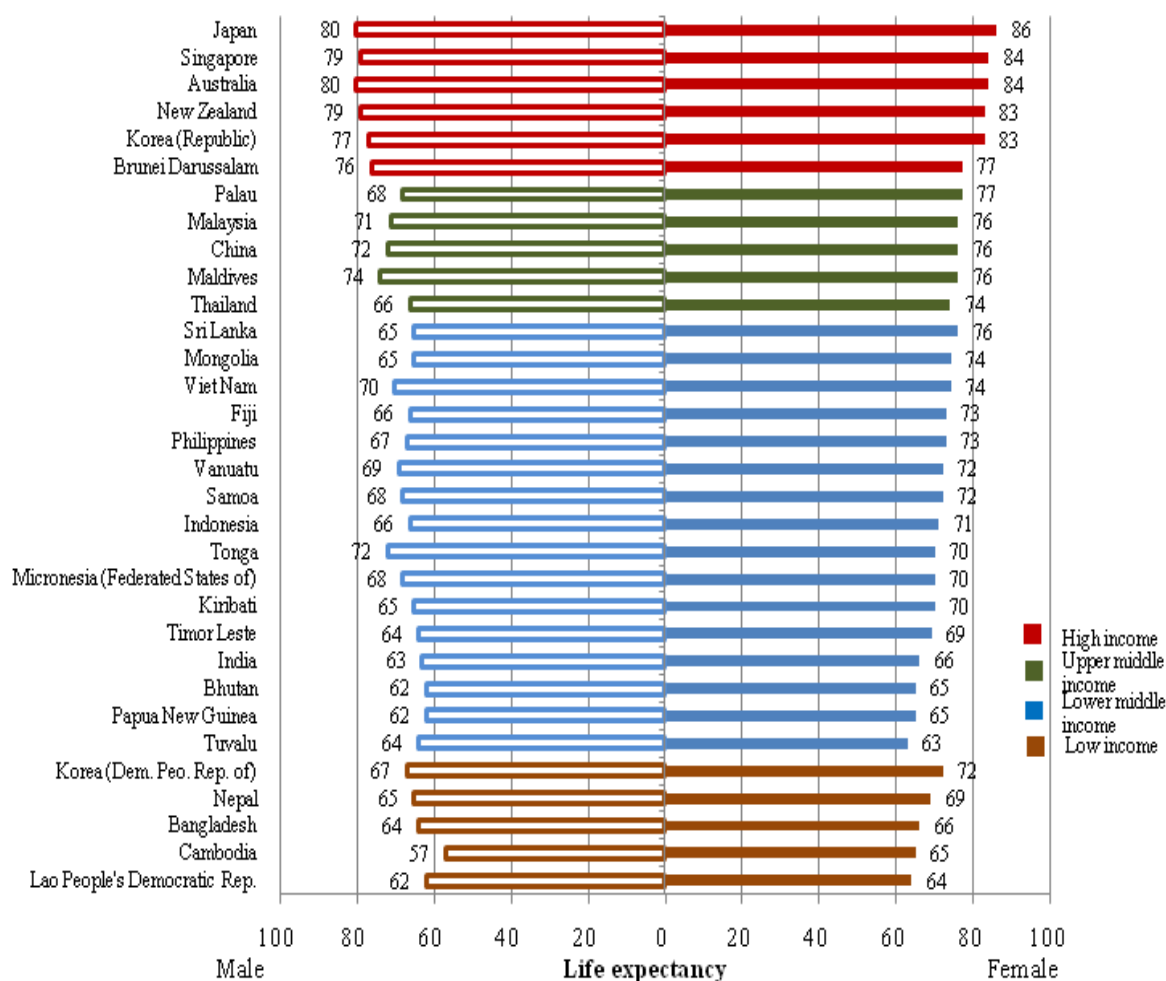
The ultimate goal, of course, is to have improvements in the average plus reductions in the inequities in health outcomes. But it remains clear that there are inequities in health between and within countries. We now present data describing the distribution of a number of health indicators including life expectancy at birth, premature death, maternal and child mortality, communicable and non-communicable diseases and injuries – between and within countries. Between-country inequities in a number of health indicators are described in Chapter 1. Inequities in health within countries are then presented in Chapter 2, using data from selected countries representing different country-level income categories. Within-country health inequities are assessed by stratifying health indicators by measures of social position, including socioeconomic status, sex, ethnicity or geographical area. Some of the health indicators have been stratified using multiple indicators of social position. For example, infant mortality rates are reported according to household income quintile, mother’s level of education, sex, and geographical area.

Although the data reported are reasonably comprehensive, it is not within the scope of this section to provide a completely comprehensive report on all health indicators stratified by all measures of social position, for every country. The data reported have been collected from a number of existing resources, including demographic and health surveys, published journal articles, WHO, UNICEF, and other UN and regional agency reports.

## Chapter 1: Inequities in health between countries

There are large inequities in life expectancy at birth observed between countries in Asia Pacific (Figure 7). Males born in Cambodia can expect to live 23 years less than males born in Japan. Females born in Tuvalu will live 23 years shorter than females in Japan.

Figure 7 - Life expectancy at birth, selected countries categorised by GNI per capita, 2009



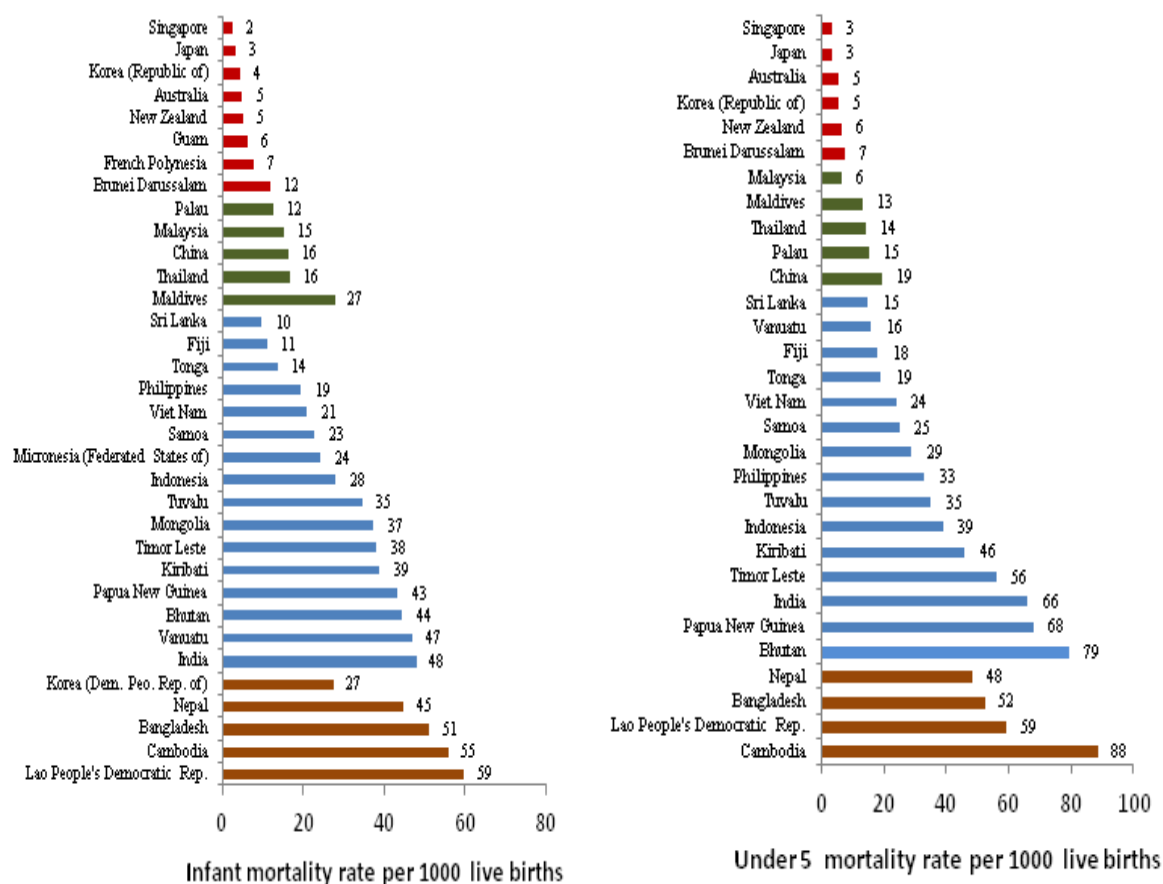
Note: Solid bar shows female life expectancy, bar with no fill shows male life expectancy. Countries are categorised according to the 2010 gross national income (GNI) per capita, which is calculated using the World Bank Atlas method (20). The groups are: low income ( $\leq$ \$1,005); lower middle income (\$1,006 - \$3,975); upper middle income (\$3,976 – \$12,275); and high income ( $\geq$ \$12,276).

### Inequities in maternal and child health in selected countries across Asia Pacific

Maternal and child health indicators follow similar patterns to those of life expectancy and show stark differences. Poorer countries tend to do worse than richer countries (

Figure 8). Bangladesh, Cambodia, and the Lao People’s Democratic Republic have the three highest infant mortality rates in the region, all of which exceed 50 deaths per 1,000 live births. The rates in these countries are more than double those of many lower middle income countries and at least three times the rates in countries belonging to the upper middle (with the exception of Maldives) and high income categories. The under-five mortality rates of lower middle and low income countries are two to 12 times the rates in high income countries (21).

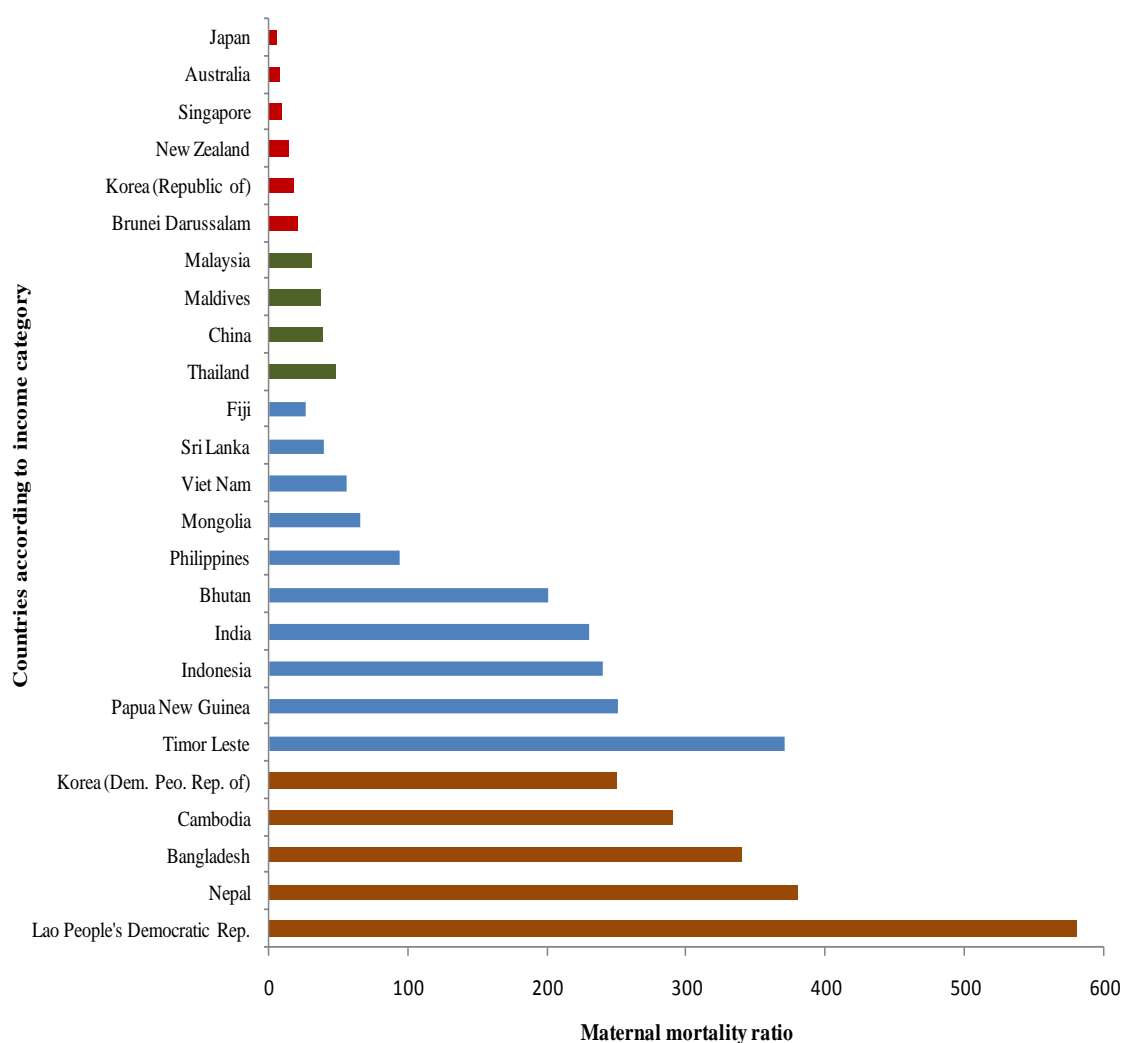
Figure 8 - Under-five and infant mortality, selected countries by income category, 2009



Country income category: High income; Upper middle income; Lower middle income; Low income

Sources: (21,22)

The maternal mortality ratio for low income country the Lao People’s Democratic Republic is much higher than the ratio for any of the other countries reported. Several of the lower middle and low income countries have maternal mortality ratios that are four to 12 times the ratios found in high and upper middle income countries (Figure 9) (23).

**Figure 9 - Maternal mortality ratio by country income classification, 2008**

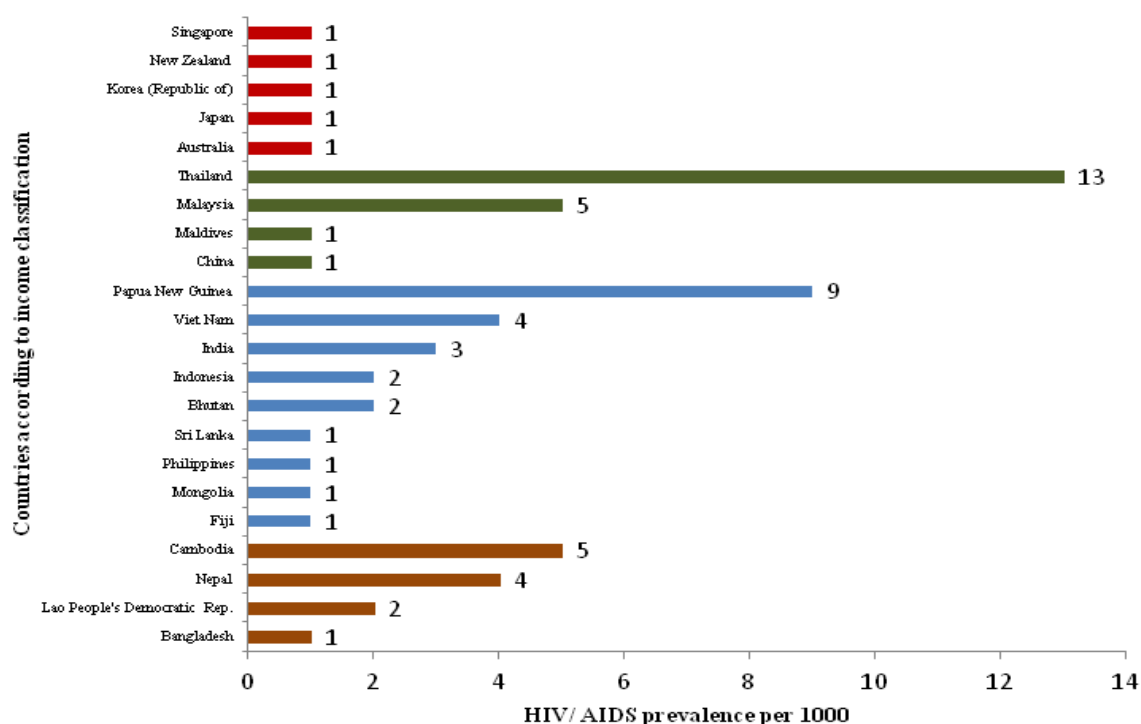
Maternal Mortality Ratio: The annual number of deaths of women from pregnancy-related causes per 100,000 live births.  
Source: (23)

### Inequities in rates of communicable diseases between countries

Communicable diseases continue to affect many people in countries across Asia Pacific but the levels vary markedly. For example, the prevalence rates of HIV/AIDS in Papua New Guinea and Thailand are nine to 13 times, respectively, the rates in the other countries across the region (Figure 10).

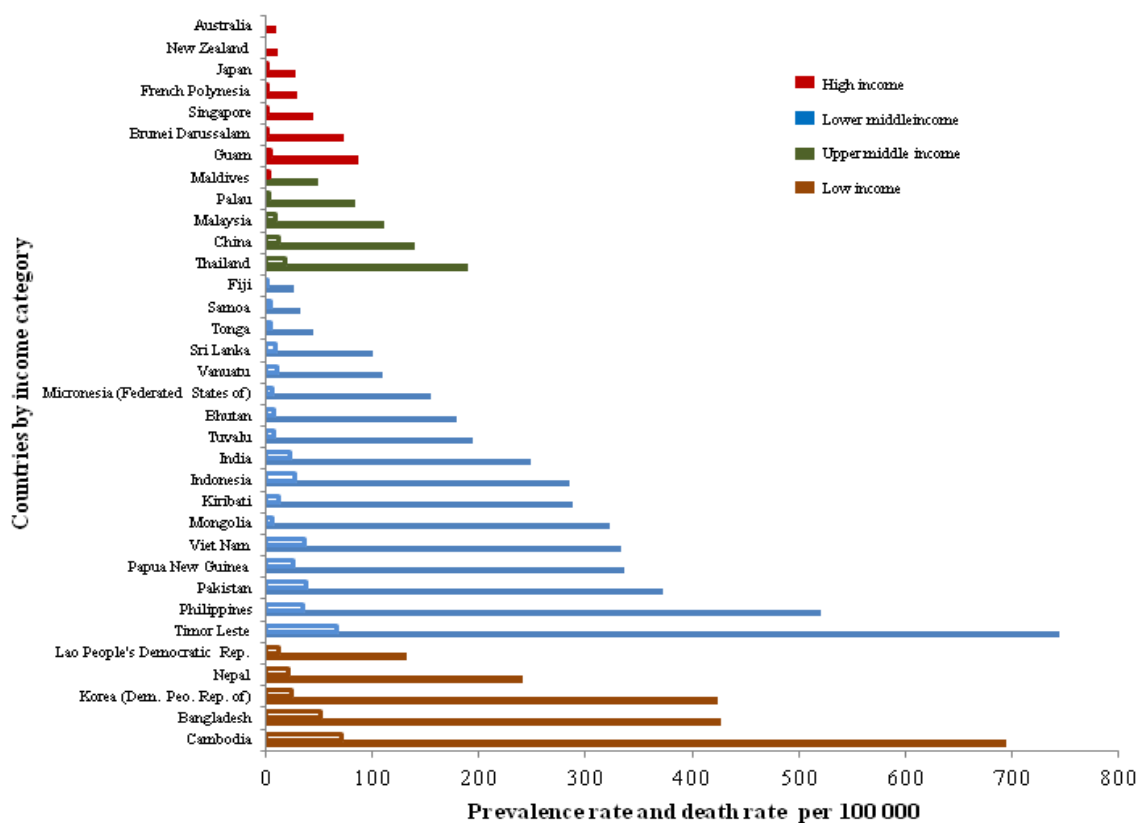
Similarly, the prevalence of tuberculosis (TB) tends to be higher in lower middle and low income countries. The prevalence of TB in the low income countries of the Lao Democratic People's Republic, Bangladesh and Cambodia, and in the Philippines and Timor-Leste is four to seven times the prevalence in the selected high income countries (Figure 11).

Figure 10 - HIV/ AIDS prevalence rate in people aged 15-45 years, by country income classification, selected countries, 2009



Note: HIV/ AIDS prevalence rate per 1000. Data are estimates  
Source: (24)

Figure 11 - Tuberculosis by country income category, 2009, selected countries

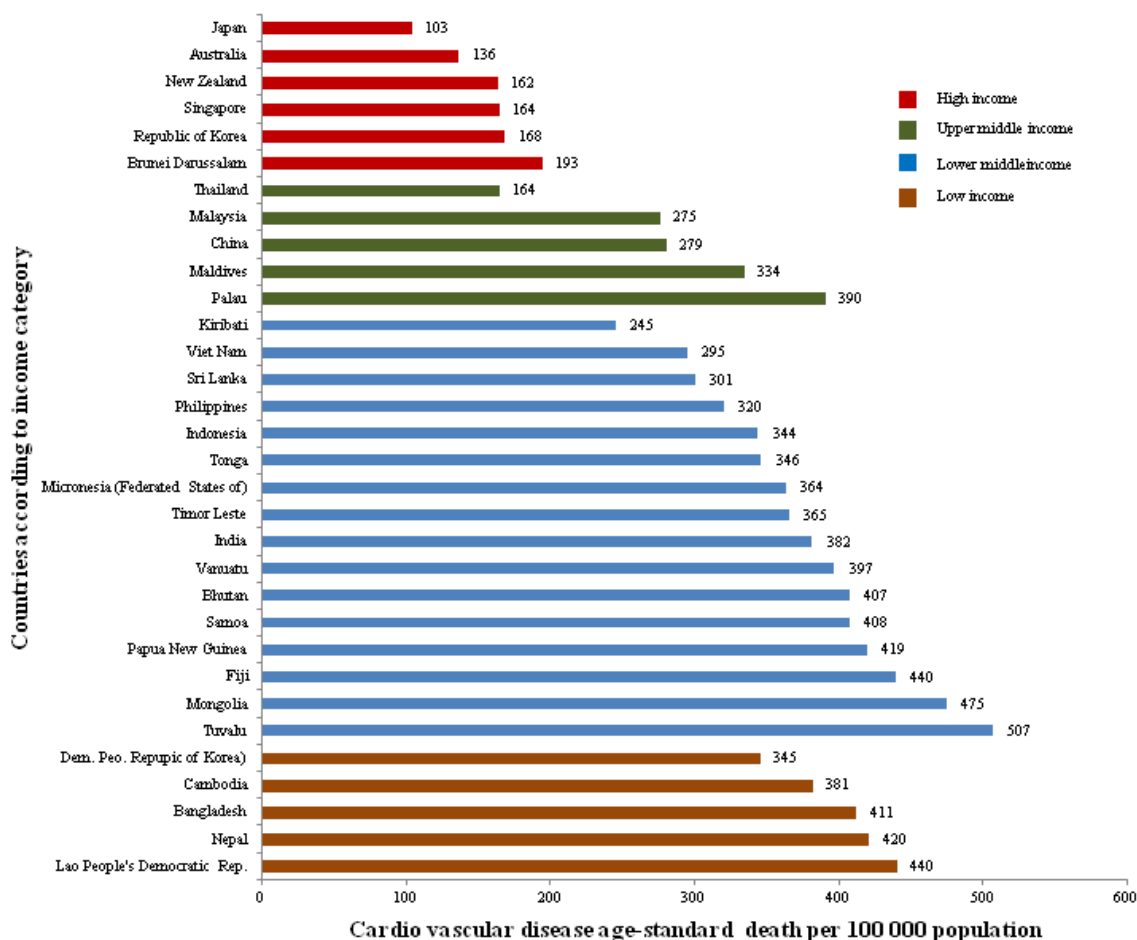


Note: Solid fill shows the TB prevalence rate per 100 000 population in 2009. Outline with no fill shows the TB death rate per 100 000 population in 2009. Data represent the "best estimate" provided by the World Health Organization (25)

### Inequities in rates of non-communicable diseases and injuries

Non-communicable diseases and injuries now play a major part in the overall disease burden and mortality rates in many countries in Asia Pacific. Figure 12 illustrates how death rates from cardiovascular diseases are higher in lower income countries compared to high income countries. This is partly explained by high income countries having better treatment regimens and therefore less people dying but more people living with the disease.

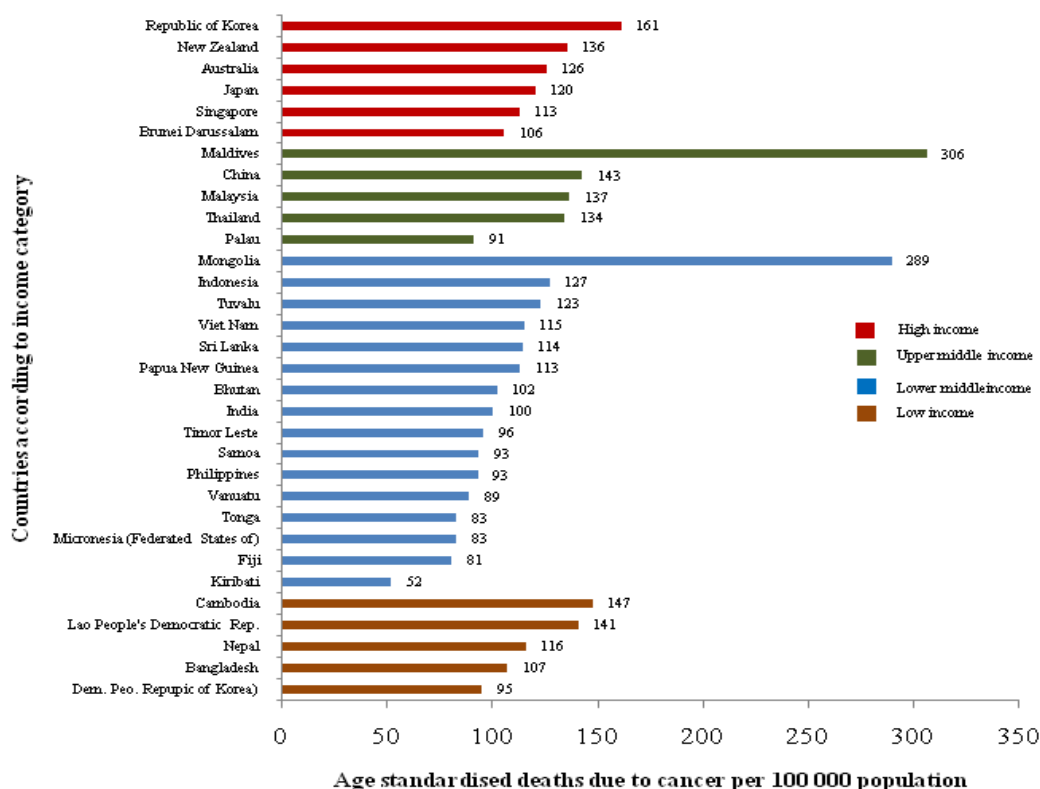
**Figure 12 - Age-standardised mortality rate for cardiovascular disease, selected countries by income category, 2004**



Source: (26)

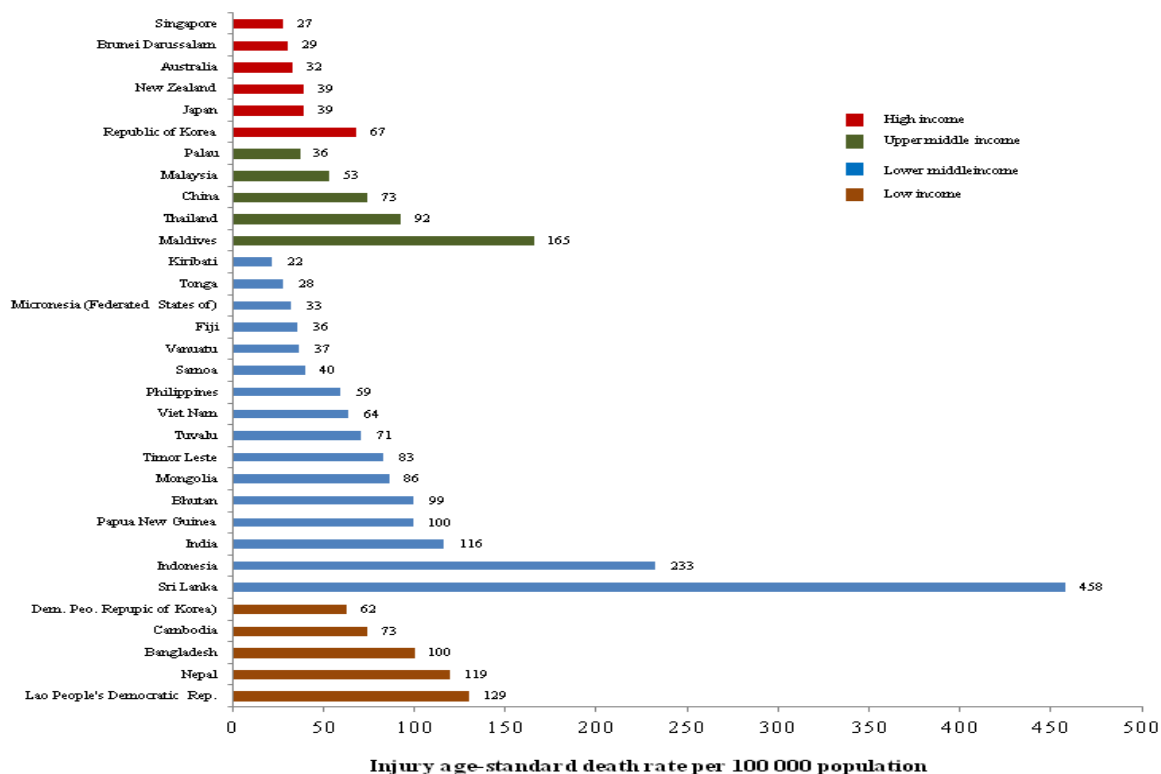
The relationship between death from cancer and country income is not straightforward. As Figure 13 shows, all-cause cancer death rates can be similar in low, middle and high income countries, although a growing problem is observed in the middle income countries (26). There are marked inequities in injury mortality rates between countries (Figure 14). The highest rates of injury mortality are in upper middle income country Maldives and lower middle income countries Indonesia and Sri Lanka (26).

Figure 13 - Cancer age-standardised death rate, by country income category 2004



Source: (26)

Figure 14 - Injury age standardised mortality rate by country income classification, 2011



Source: (26)



## Chapter 2: Inequities in health within countries

Within countries in Asia Pacific, there are marked differences between those at the top and bottom of the social hierarchy (the gap), but health also varies across the whole socio-economic spectrum (the social gradient). The inequities are not just in relation to socio-economic position - health varies enormously by, for example, gender and ethnicity. In this chapter we illustrate some of the within-country inequities in maternal and child health, communicable and non-communicable diseases. Socially stratified health data are much less readily available in many of the countries in Asia Pacific compared to average figures, hence only a few countries are represented below and only a few health indicators.

### Inequities in maternal and child health within countries

Rates of maternal and child health vary markedly by socio-economic position. For example, among the countries reported in Figure 15 and Figure 16, under-five mortality rates decreased progressively with increasing household income and education respectively. In each of these countries, except the Maldives, the rate in the lowest income quintile is at least double the rate in the highest income quintile (27–32). Changes in under-five mortality rates in Indonesia between 1997 and 2004 show how things can improve (Figure 17).

**Figure 15 -Under-five mortality rate by household income quintile, selected countries, 2009 or latest available year**

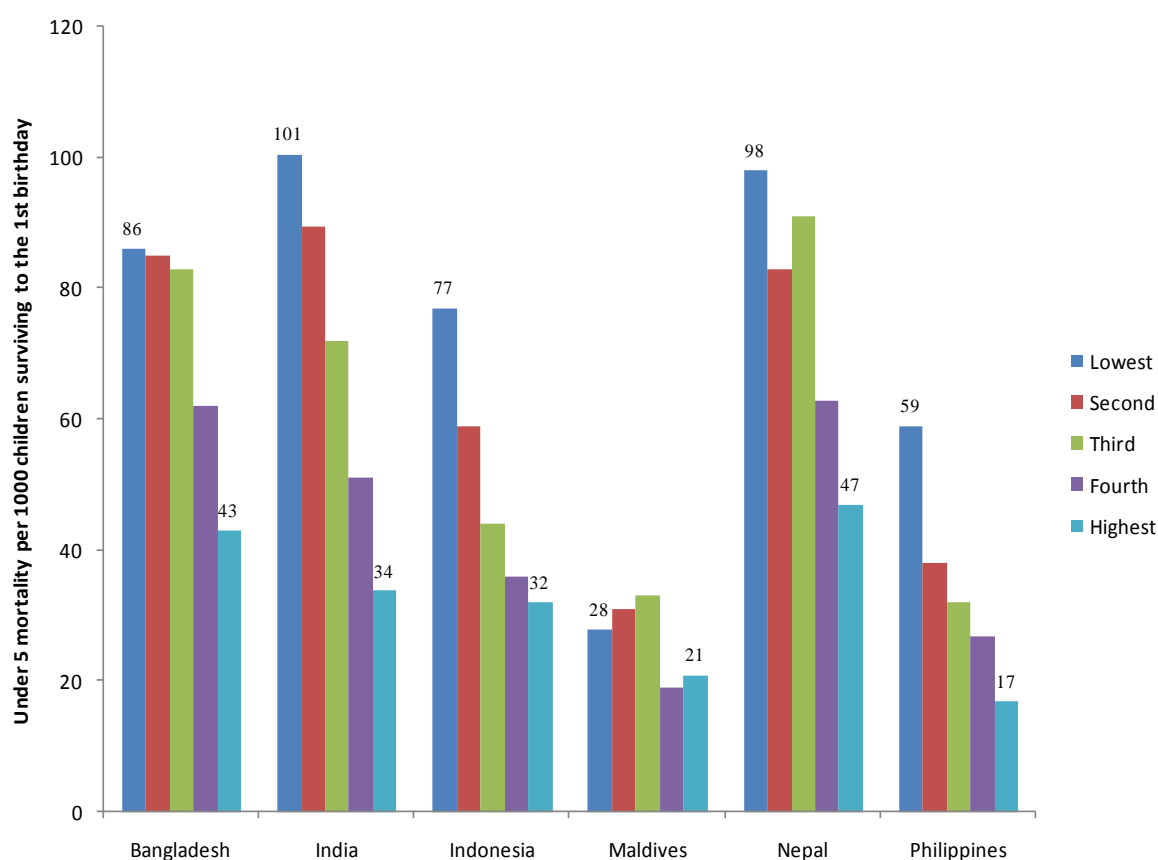


Figure 16 – Under-five mortality rate by the mother's level of education, selected countries, 2009 or latest available year

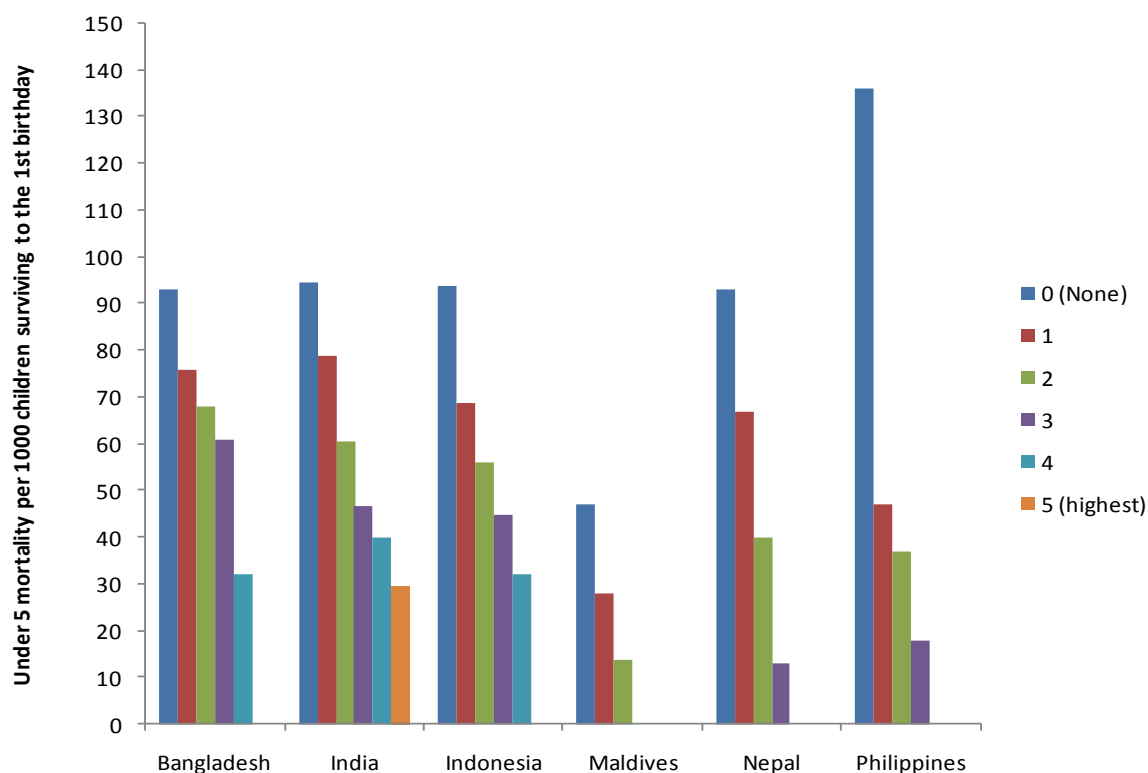
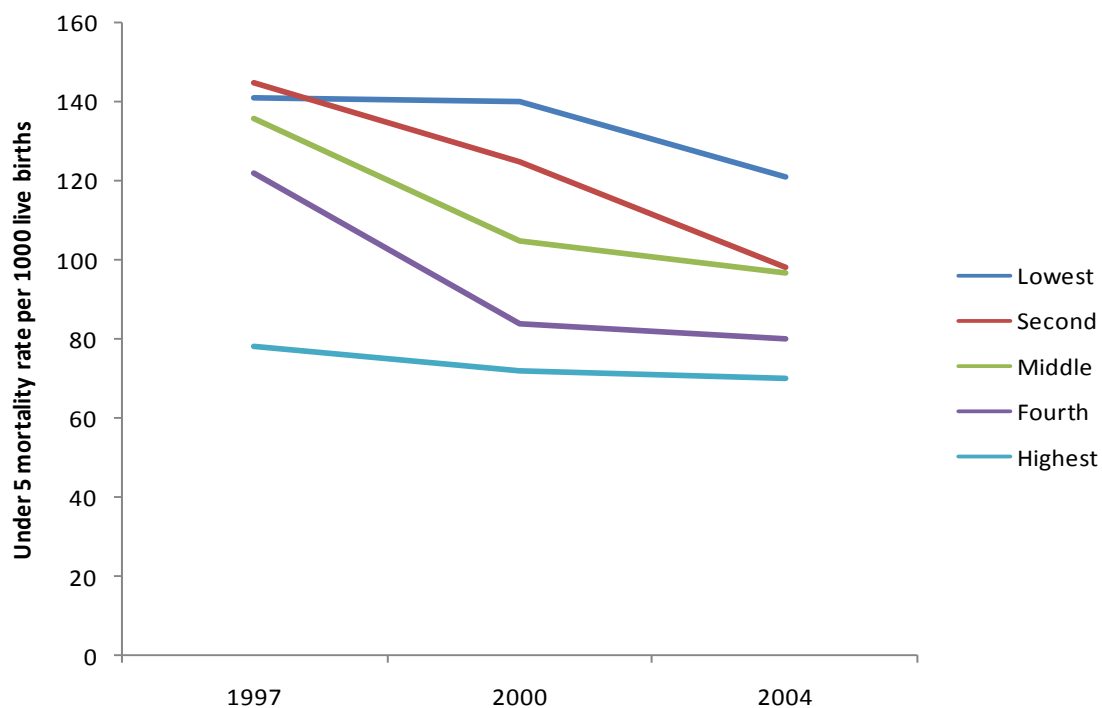


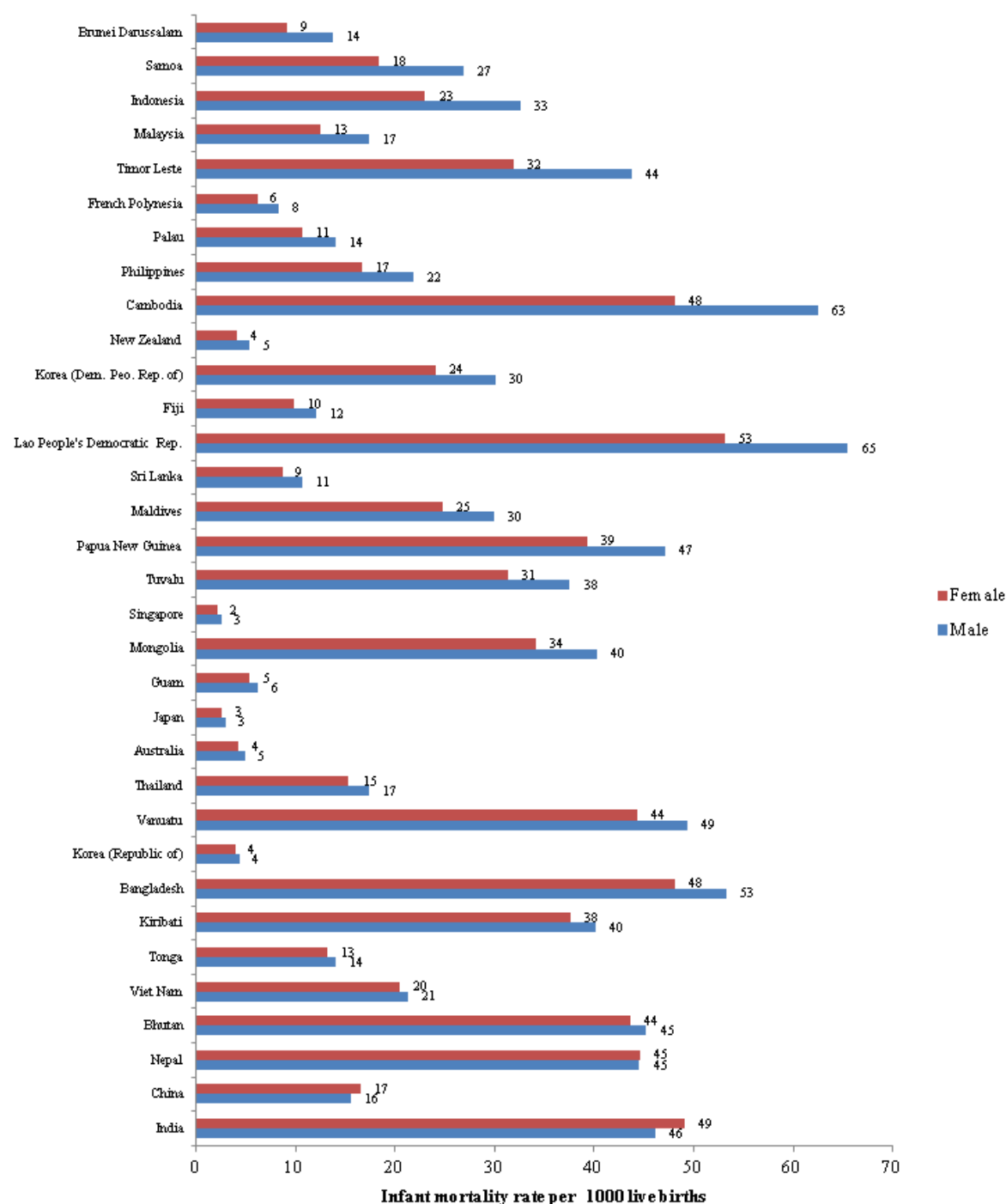
Figure 17 - Trends in under-five mortality rate by household income quintile, Indonesia, 1997 to 2004



Source: (33)

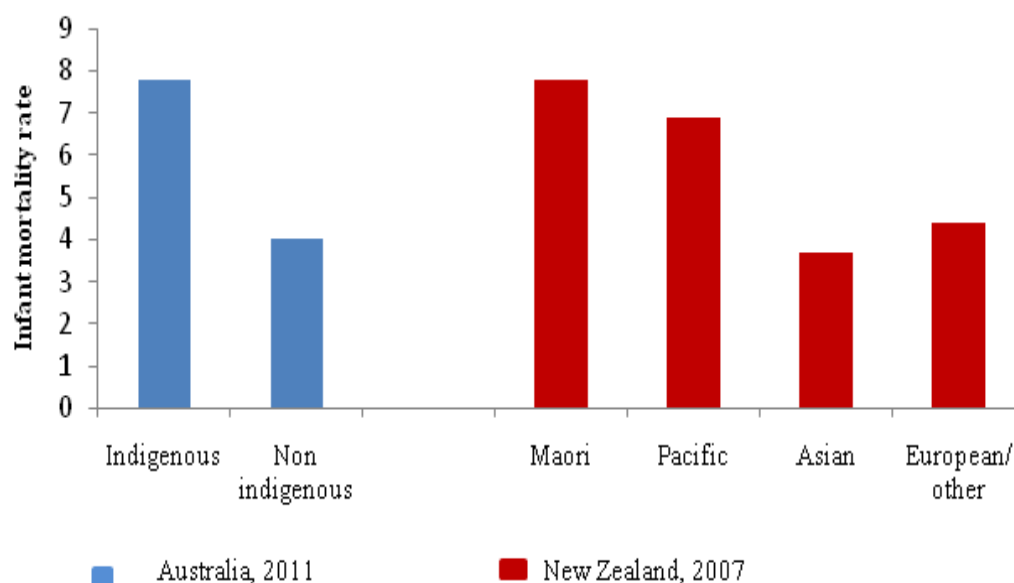
There are very marked gender inequities in child health indicators. In most countries for which data exist, mortality rates tend to be higher for male infants compared with female infants (Figure 18). Exceptions are found in China, Nepal and India, where the infant mortality rate among females is higher than that among males (22).

**Figure 18 - Infant mortality rate by sex, selected countries, 2009 or latest available year**



Child health is also graded by ethnic grouping. For example, in Australia, the infant and under five mortality rates among indigenous groups is nearly twice the rate among non-indigenous (Figure 19). In New Zealand, Māori and Pacific infants have higher mortality rates than infants of Asian or European/other ethnicity (34,35).

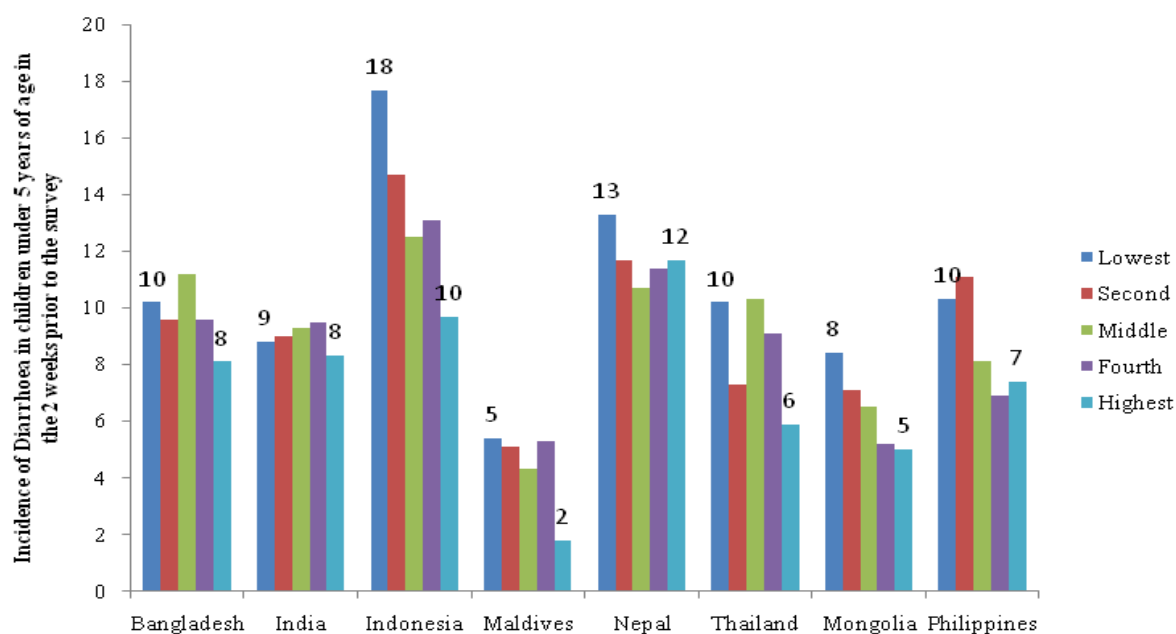
Figure 19 - Infant mortality rate by ethnicity, Australia and New Zealand



**Inequities in rates of communicable diseases within countries**

Diarrhoea is a major contributor to children deaths in many developing countries across Asia Pacific. The relationship between the incidence of diarrhoea and income quintile is not straightforward in the selected countries (Figure 20). In Indonesia, Maldives and Mongolia, the incidence of diarrhoea is highest among those in the lowest income quintile and lowest among those from the highest income quintile, but there is a lack of a clear gradient in incidence across income quintiles in these and the rest of the selected countries (36,37).

Figure 20 - Incidence of diarrhoea by household income quintile, selected countries



Sources: (36,37).

HIV/AIDS is highly gendered in many countries. In most of the selected countries, the majority of adults living with HIV/AIDS are male (Table 1). The highest percentage of males living with HIV/AIDS is found in Malaysia, where 90% of the adults living with HIV/AIDS are male. In Cambodia and Papua New Guinea, 62% and 58% of adults living with HIV/AIDS are female (24).

**Table 1 - Distribution of people living with HIV/AIDS, by sex, selected countries**

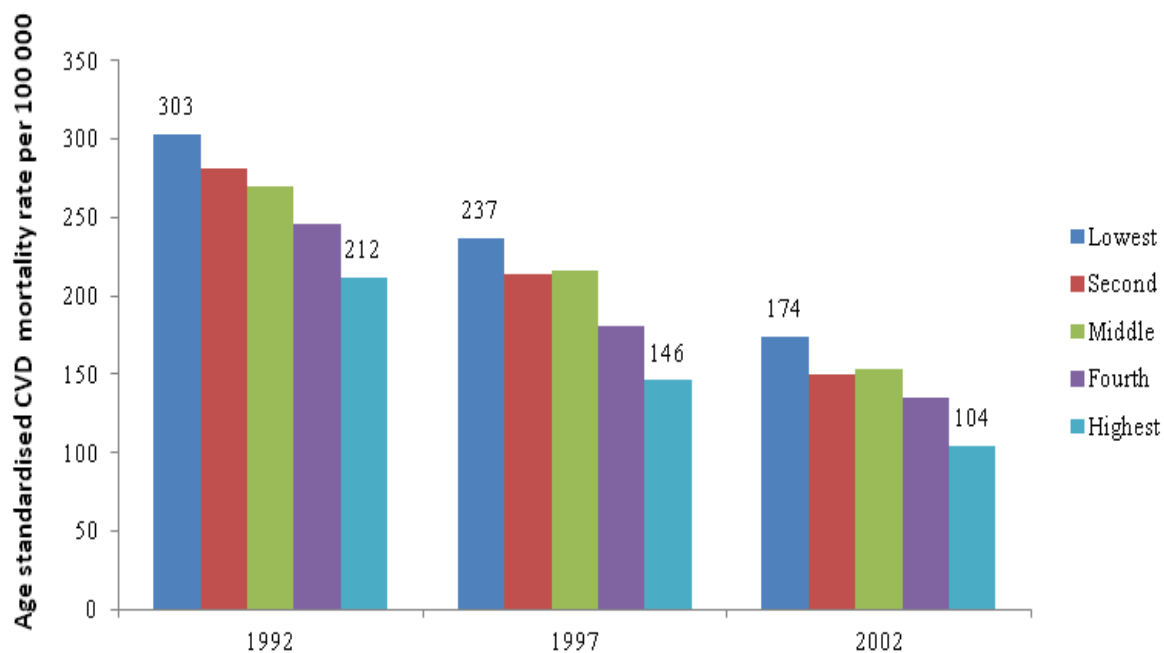
Country	% Male	% Female
Bangladesh	71	29
Lao People's Democratic Republic	58	42
Nepal	67	33
Cambodia	38	62
Philippines	70	30
Indonesia	70	30
India	61	39
Viet Nam	70	30
Papua New Guinea	42	58
Malaysia	90	10
Thailand	60	40
Australia	70	30
Japan	65	35
Republic of Korea	68	32
Singapore	70	30

Source: UNAIDS (24)

### The social distribution of non-communicable diseases

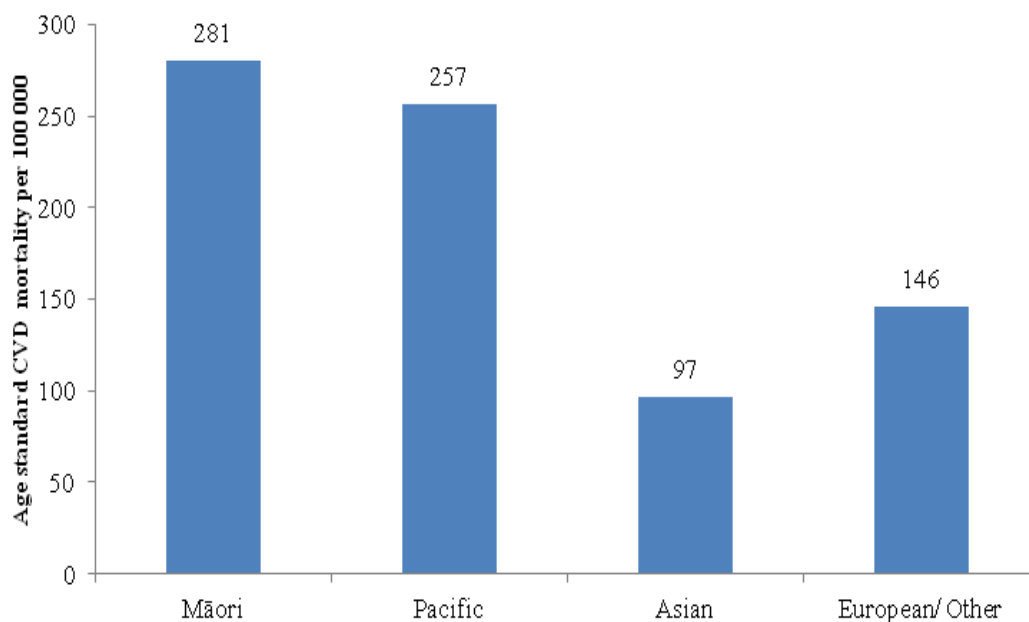
There are even fewer data publically available that relate to the social distribution of non-communicable diseases in countries across Asia Pacific. Using data from Australia and New Zealand to illustrate some of the inequities, we see differences in cancer and cardiovascular rates by income, education, sex and ethnicity. Between 1992 and 2002, cardiovascular mortality rates decreased in each household income quintile but in each year, the poorer groups generally have higher cardiovascular mortality rates compared with the wealthier groups (Figure 21). In New Zealand, cardiovascular disease mortality varies markedly by ethnicity (Figure 22). For example, Māori or Pacific people have cardiovascular disease mortality rates that are two and half times the rate found among those of Asian ethnicity.

**Figure 21 - Cardiovascular disease mortality by household income quintile, male 25–74 year olds, Australia, 1992, 1997 and 2002**



Source: AIHW (38)

**Figure 22 - Cardiovascular disease mortality rate by ethnicity, New Zealand, 2002-03**



Source: Ministry of Health (35)

In Australia, age standardised incidence of cancer and mortality from cancer are higher among males compared with females (Table 2). While non-Indigenous Australians have a higher incidence of cancer compared with Indigenous Australians, mortality from cancer is higher among Indigenous Australians.

**Table 2 – Age standardised cancer incidence and mortality rates by sex and indigeneity, 2007, Australia**

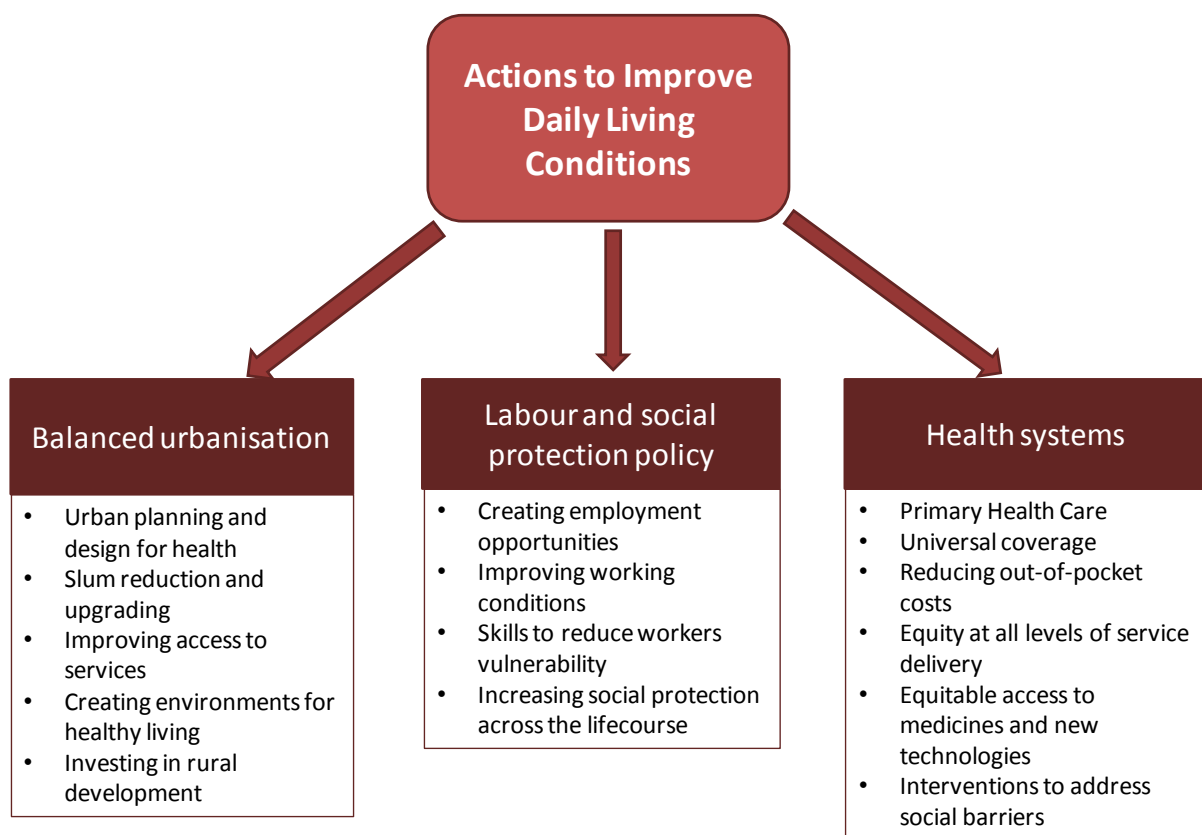
		<b>Incidence (ASR per 100 000)</b>	<b>Mortality (ASR per 100 000)</b>
<b>Sex</b>	Male	595	225
	Female	394	139
<b>Indigenous status</b>	Indigenous	385	230
	Non-indigenous	433	178

Source: (39)

## SECTION 3: TAKING ACTION TO IMPROVE DAILY LIVING CONDITIONS

### Overview

Inequities in health are not inevitable. There are many points of entry within society through which health equity can be achieved. In this report we highlight some of the promising cross-sectoral policies and actions, found in our review, that are currently taking place in the Asia Pacific region to address the social and environmental determinants of health and health equity. Section 3 provides an overview of policies and practices that are taking place in Asia Pacific which address the conditions of daily living including the urbanisation, labour arrangements and working conditions, social protection and health systems.





## Chapter 1: Action to ensure healthy and equitable urbanisation across Asia Pacific

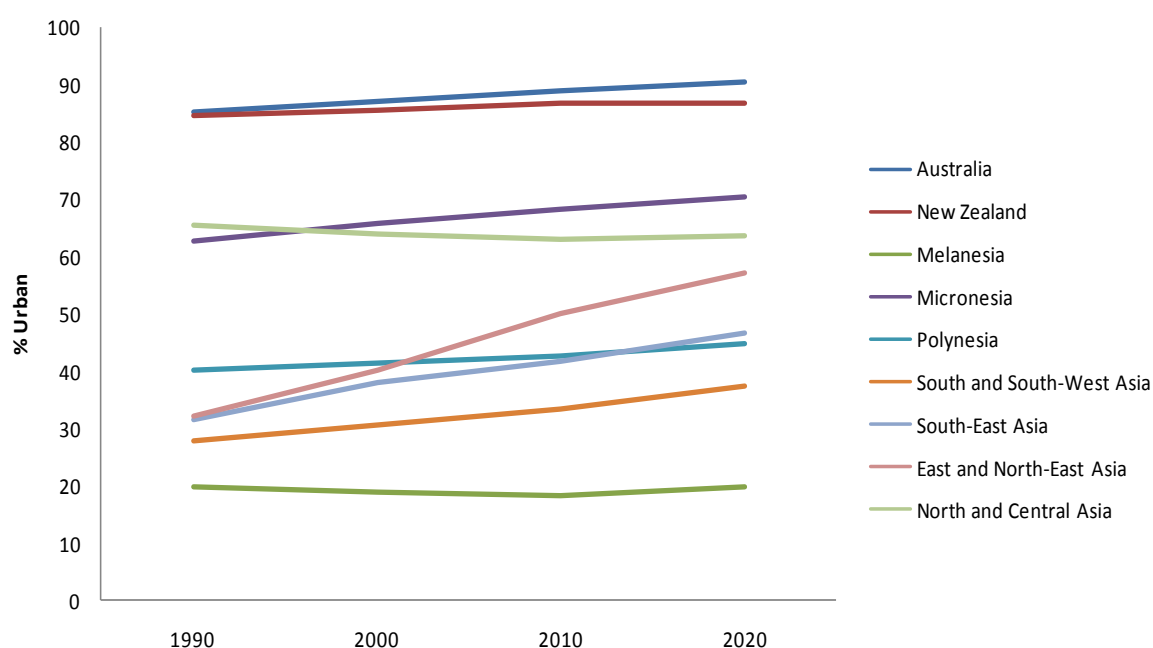
### CSDH Recommendations:

- Place health and health equity at the heart of urban governance and planning
- Promote health equity between rural and urban areas through sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their homes

### Introduction

In 2008, globally, more people started living in urban areas than rural ones. Asia experienced the highest urban population increase (31.5% in 1990 to 42.2 % in 2010) among all regions in the world. Of the expected 5.3 billion urban population living in the developing world by 2050, Asia will host over 60%. In India alone an extra 400 million people will be added by 2020 to already overburdened Indian cities (40,41). Although half of the world's population now live in Asia Pacific cities, the balance of rural and urban dwelling varies enormously within different countries across Asia Pacific (Figure 23) (40).

**Figure 23 - Percentage of population in urban areas, across Asia Pacific sub regions**



Data from: (40)

In low, middle and high income countries across Asia Pacific, urbanization is associated with the growth of urban corridors and urban slums. The urban corridors can lead to what is termed the “urban divide”. The urban divide is the condition where cities are divided into certain areas such as rich and poor areas, illegal area, slums area and central business area. A slum, as defined by UN

HABITAT, is a densely populated area with substandard housing and a low standard of living as depicted by the absence of one or more of the following: improved water supply, improved sanitation, sufficient living area, durability of construction, and security of tenure. In the year 2010 UN HABITAT estimated that 505 million slum people or over half of the world slum population is in the Asia Pacific region. The numbers of people living in urban areas, and in urban slum areas differs between the sub-regions of Asia Pacific (Table 3). Slums have received significant global attention, as indicated by the formulation of one of the three targets of the MDG goal 7 (which stated achieve significant improvement in the lives of at least 100 million slum dwellers by 2020).

**Table 3- Numbers of urban and urban slum dwellers, Asia Pacific sub regions, 2010**

Region	Urban Population (1000s)	Slum Population (1000s)	Urban Population Living in Slums (%)
Eastern Asia	671 795	189 621	28
Southern Asia	545 766	190 748	35
South Eastern Asia	286 579	88 912	31
Western Asia	145 164	35 713	25
Oceania/Pacific	2 306	556	24
<b>Asia Pacific (total)</b>	<b>1651 610</b>	<b>505 550</b>	<b>31</b>

Source: (42)

### From urbanisation to health inequities

The trajectory is for greater urbanisation across many Asia Pacific countries. Done well, urbanisation can be good for health and development. Indeed, to date, the global movement towards urban living has brought a number of social, economic and health benefits (43). However, some aspects of rapid urban growth, particularly the growth observed in developing countries across Asia Pacific, has resulted in a range of negative consequences for social and health equity within cities and between urban and rural communities.

In all countries, rich and poor, urbanisation is re-shaping population health problems towards a triple threat of infectious, NCDs and injuries (43). Infectious diseases remain a major threat, particularly among the urban poor, across Asia Pacific. For example, infectious diseases account for 21% of deaths in Asia with most deaths caused by respiratory infections (34.6%), tuberculosis (16.9%), acute diarrhoeal diseases (13.3%), HIV/AIDS (8.7%), vaccine-preventable childhood diseases (7.6%), and malaria (1.3%) (44).

As the degree of urbanisation and national income increase so too do the rates of NCDs such as diabetes, heart disease and obesity, mental health problems, alcohol and drug abuse and violence (45,46) (47). Work by Allender and colleagues in India demonstrated how NCD risks - body mass index, physical inactivity, smoking, and high blood pressure – increase with increasing urbanicity (48).

In reality, the restructuring of countries - low, middle and high income - by the global marketplace has led to rapid, often unplanned, urbanization and outpaced the ability of governments to build

essential infrastructure and services and provide needs for quality living in cities, while at the same time maintain quality infrastructure and services in rural locations. This has contributed to a growing gap between social groups in terms of adequate housing, employment opportunities, transportation, levels of pollution and sanitary conditions – each of which increases the risk of communicable and non-communicable diseases and their widening inequities (49).

### ***Urban planning and design and health inequities***

Done well, urban planning and design can reduce health inequities by creating cities in which all residents have access to good quality living environments and adequate housing. Done badly it can increase health inequities.

Health risks can arise from spatial inequities and their impact on disposable income, for example, where low-income residential areas are located far from concentrations of employment, resulting in transportation costs and transportation time being a high burden for poor households. Similarly, the uneven distribution of community facilities (such as schools, libraries, clinics) can also result in residents of deprived areas having poorer access to many of the benefits of urban life. Socially disadvantaged groups consistently have poorer access to quality education and display lower levels of education and poorer health outcomes than their non-poor urban counterparts (41) as illustrated by the example from Bangladesh (Box 1).



Source: etravel guide, Dhaka, Bangladesh, 2010  
<http://www.flickr.com/photos/eguidetravel/6060664147/>

**Box 1- Bangladesh: Education in slums of Dhaka**

Education figures for Dhaka's slums are among the worst in Bangladesh. One study of four slums found that just 70% of children were enrolled at the primary level, many of them in schools run by non-government organizations. The children of better-off families were far more likely to not just be in school, but in government or private schools. Children from the poorest households were less likely to be in school, and if they were, almost half those enrolled relied on schooling supplied by non-government organizations, churches or private entrepreneurs, with little government support or regulation (Figure 24).

**Figure 24 - Percentage of children 6-11 years enrolled, by type of school and wealth, selected slums of Dhaka, 2008**



Only a quarter of Dhaka's slums have a government school. Most of these schools are in well-established slum areas, while newer, less formal settlements are left to fend for themselves. Lacking tenancy rights, slum dwellers are in a weak position to demand education and public finance. Moreover, as many city authorities periodically bulldoze informal settlements, some non-government providers are loath to invest in school buildings.

Source: UNESCO (50)

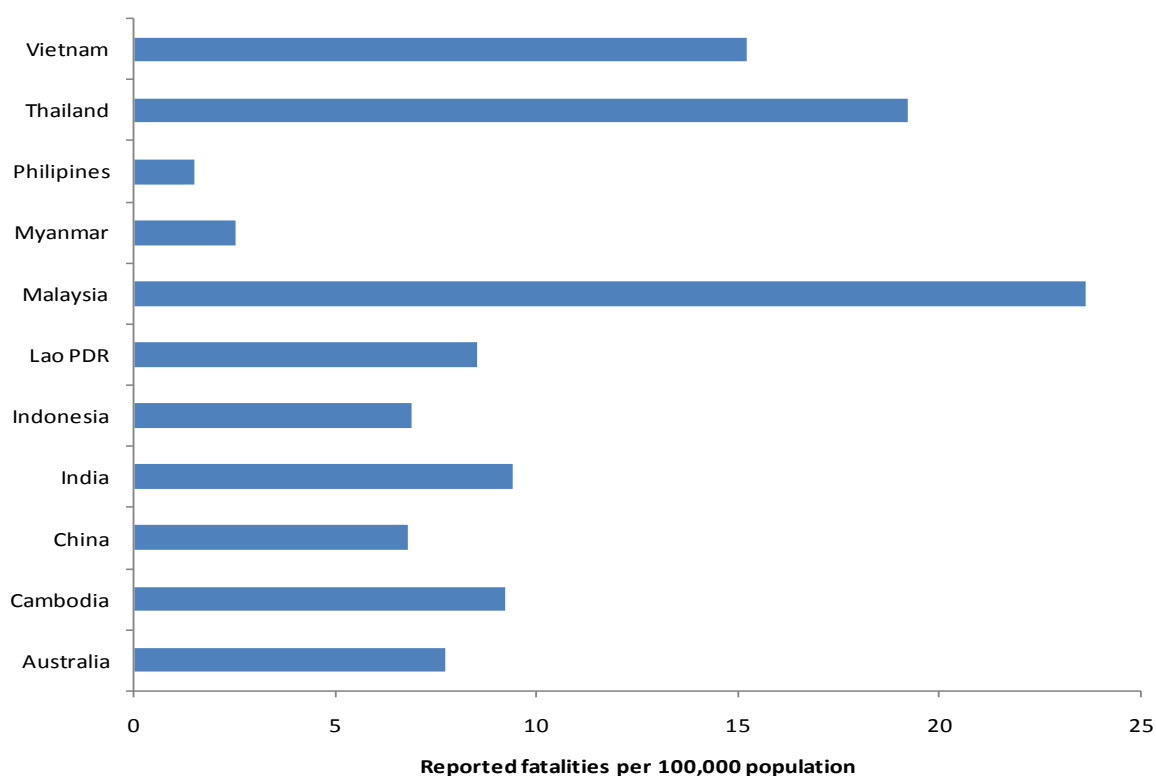
Evidence internationally suggests that sprawling neighbourhoods are not the best design for health (51,52). When done well, high density, mixed land use can result in neighbourhoods that are more conducive to outdoor activities and thus potentially reduce obesity levels and non-communicable diseases. 'Congestion, traffic jams, car costs, air pollution, ugly freeways and bare car parking areas waste time and money, cause daily irritations, and limit the pleasures of living in cities' (53).

In Australia, living in the most socioeconomically disadvantaged areas, with low population density and unpleasant, human-scaled streets was associated with a decreased likelihood of having overall physical activity levels that were sufficiently active for health (54). A recent study on urban violence from three regions of the world including Asia concluded that the built environment has an important relationship with urban violence. The study identified inadequate infrastructure, narrow alleyways or lack of street lighting and limited services as risk factors for increasing violence in cities. In addition, there is a strong perception that unemployment, especially in youth is driving violence (55).



Source: Lingaraj GJ, India 2008,  
<http://www.flickr.com/photos/lingaraj/2415084235/sizes/z/in/photostream/>

In many countries across Asia Pacific, urbanization, urban sprawl and the increased number of motorised vehicles have not been accompanied by adequate transport infrastructure, enforcement of traffic regulations or implementation of measures to ensure improved road safety (56). Of the estimated 5 million injury deaths that occur worldwide each year, more than half involve people in the Asia Pacific region.(57) (Figure 25). Ninety percent of deaths due to road traffic injuries in rapidly motorising countries in the region are not car occupants, but vulnerable road users who cannot afford cars i.e. pedestrians, bicyclists and motorcyclists. Once injured, the loss of breadwinners, out of pocket expenses for treatment, inadequate rehabilitation and difficulties accessing support for survivors, put many people and their families into what is referred to as the ‘injury poverty trap’ (58–60). In rich countries, children from poor socioeconomic classes suffer more injuries and deaths from road crashes than their counterparts from high income groups (61).

**Figure 25 - Risk of death from road traffic accidents, selected countries across Asia Pacific, 2006**

Note: Data systems differ in terms of quality and comprehensiveness, and some do not count pedestrians and cyclists struck by cars, while others count deaths occurring within seven days of an accident, and others include deaths occurring within a month.

Source: (57)

### ***Inequities in access to adequate housing***

Adequate housing is a broad concept that includes a range of issues but in terms of health inequities the key housing issues are:

- Location (presence or absence of hazards, e.g. pollution or risk of flooding);
- Access to basic services such as water, sanitation and refuse removal, and access to an energy source;
- The quality of the shelter itself – protection from the elements, and sufficient living space.

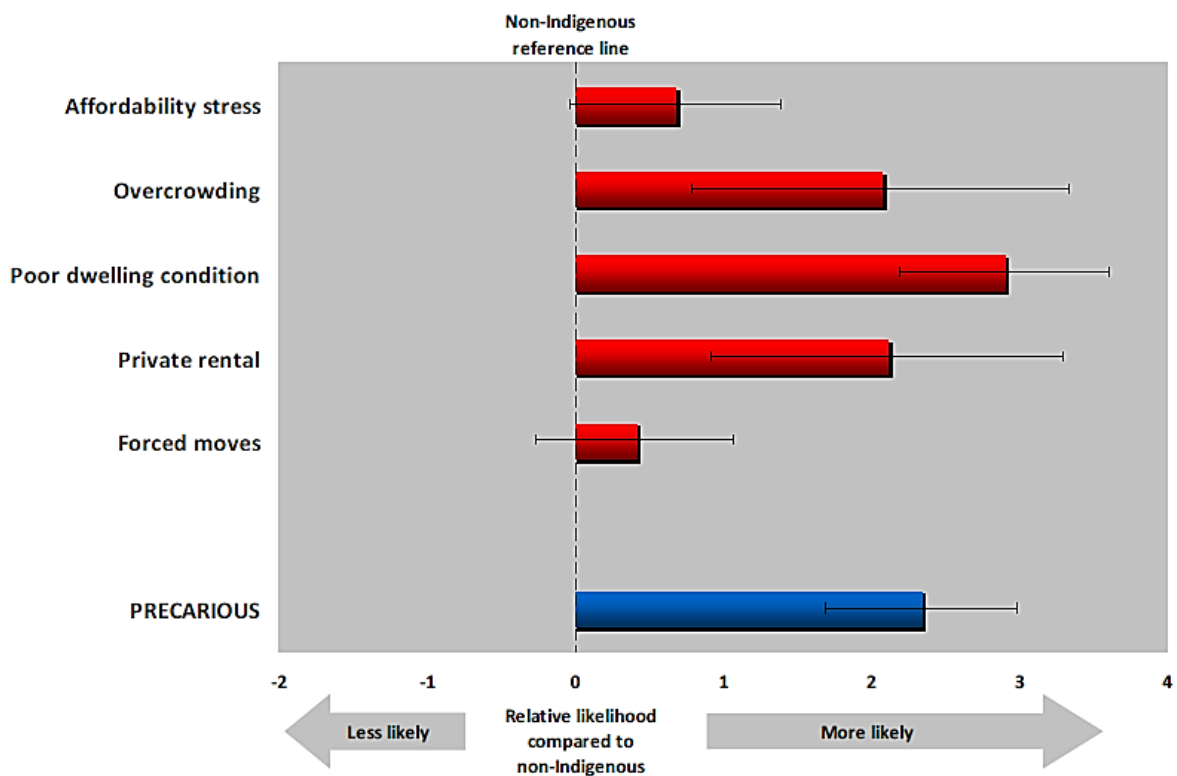
A key health concern across the region is the development and nature of urban slums. Slums pose significant health hazards due to population density, overcrowding, lack of safe water and sanitation systems, and lack of health care services provision and access. In efforts to have access to water and sanitation the urban poor can pay 15 to 20 times more to have drinking water and have to allocate some expense for defecation at public toilet, while at the same time are more at risk of diseases due to unsafe micro environment such as faeces contamination surrounding the public toilet and contaminated drinking water (62). In India for example, access to piped water and sanitary disposal of excreta is significantly lower among urban slum dwellers compared to urban non-slum (63).

The village to city transition and associated changes in physical and social conditions is also occurring across the Pacific islands. Overcrowded housing and inadequate sanitation are causing environmental contamination and degradation and illness (64).

In many cities across Asia Pacific much larger numbers of people are without any form of secure tenure than with secure land titles. The poor are priced out of formal land markets, on top of which the opportunities for them to squat on unused public land are declining (40). In-house crowding in a low-income settlement in developing countries increases the risk and severity of ill-health from transmission of communicable diseases in a household, as indicated by the study in a low income community in Jakarta, which found a significant association between crowding expressed as persons per room or area per person and diarrhoea or respiratory diseases among children under the age of three years (65).

These issues are not confined to low and middle income countries. In Australia, for example, Indigenous people are more likely than other Australians to experience housing precariousness on a number of measures including overcrowding (eight times more likely) and poor dwelling condition (18 times more likely) (Figure 26). In the same study, of those who rated their health as poor: 19% of people were in housing stress compared with 9% of people who rated their health as excellent, and 13% people reported that their dwelling was in poor condition compared with 3% who rated their health as excellent (66).

**Figure 26 - Likelihood of Indigenous Australians being in precarious housing (compared to non-Indigenous)**



Source: (66)

***Rural under-development and the implications for health inequities***

The push from rural dwelling towards urban living in Asia Pacific has resulted partly because of the decline in agriculture and related employment opportunities in rural areas. These declines, which vary in size between countries, are possibly due to conditions of global agri-trade favouring larger developed economies, mechanisation of agriculture and therefore reduced need and cost of labour, and lack of national government investment in balanced rural development (67–69). However, for many people across Asia Pacific, land and agriculture remain the primary means for generating a livelihood. These changes in rural locations therefore seriously threaten food and livelihood security, especially for the poor living in rural (70).

Rural communities' health and wellbeing are also affected by the encroachment of cities (see Box 2 for example). It is estimated that by 2030 Asian cities will consume an extra 175,000 km<sup>2</sup> of land, almost tripling the current amount of urban land in Asia. More than 12 km<sup>2</sup> of mainly productive agricultural land and foreshores are lost daily to mostly poor-quality urban development (71).

The shift in social makeup associated with the rural-urban migration also has implications for health and health inequities. For example, in the Pacific, traditional social systems that continue to work well in rural areas are breaking down in urban settings. The division of families between urban and rural areas means a loss of traditional "safety nets" contributing to higher levels of divorce, single parent families, domestic violence and depression. A strong rural economy, built on improved agricultural productivity and rural livelihoods, with provision of infrastructure and access to quality support services is necessary to boost national economic growth, reduce poverty, and improve rural health.

**Box 2 - Viet Nam: expansion of Hanoi and implications for housing affordability**

In Viet Nam, economic development, industrialization and urbanization have been rapidly expanding Hanoi city. Between 2000 and 2004, 5,496 hectares of land, mostly annual cropland in rural Hanoi, was converted into industrial and urban land for 957 projects, impacting critically on the life and work of 138,291 households, 41,000 of whom were classified as agricultural households. Phú Điền is a peri-urban village in the South-West of Hanoi, which since the late 1990s experienced a large-scale conversion of agricultural land for industrial and urbanization purposes. As a consequence, the price of residential land has soared. The most expensive plots of residential land in the village in 2007 cost 60 million đồng per square metre, equal to around US\$3,750 per square metre; the cheapest plots range from 13 to 15 million đồng per square metre. This makes Phú Điền one of the hottest locations for land buying and selling in Viet Nam.

Source: Nguyen Van Suu (72)

**Taking action to improve health through urbanisation**

There is much happening across Asia Pacific to help urbanisation occur in a way that is good for health and social equity, as the recent publications from WHO SEARO and WPRO on integrated frameworks for action on healthy and equitable urbanisation across Asia Pacific illustrate (41,73). Capital investment along with improved city planning and management are key to improving the



health, transport, shelter and water/sanitation needs of people. In this section we layout some examples of good practice in cities, illustrating policies and programs that address urban planning and design, infrastructure and services, social and environmental sustainability and aspects of governance. Practically, we were not able to review policies and programs relating to rural development although we note it as a key part of the continuum of healthy urbanisation and vitally important for health equity.

### Urban planning and design

Urban planning is being used as a mechanism for creating safer, healthier and more equitable cities. The physical urban environment is being shaped to improve the quality of life of citizens through various planning and design processes: urban planning (integrated city-wide planning/spatial planning/ land use management); urban design/landscape architecture (design of public spaces); civil engineering (planning and design of infrastructure, e.g., roads and sanitation); architecture (building design); and transport planning.

A number of countries in the region have used integrated land-use planning and zoning techniques to address adverse impacts of urbanization, including environmental and health problems. For example the Western Australia State Government introduced the 'Liveable Neighbourhood Community Design Code' in 1998 to facilitate improved access to services, more efficient use of land, less car use, and more walking, cycling and public transport use (74). New urban developments were created according to this code. In South Australia, the Transit

Oriented Development Health Lens project is a collaboration between the Department of Planning and Local Government, the Department of Transport, Energy and Infrastructure, Land Management Corporation and SA Health. Working towards the transport targets, the collaboration aims to bring together higher density, world class design, commercial precincts and mass transit systems and examine the complex interplay between these factors and health and wellbeing and hence the 'liveability' and desirability of these developments (75).

India introduced a National Policy for Urban Street Vendors in 2004 to provide a supportive environment for street vendors and to control congestion and hygiene in public spaces (76). Specific objectives of the policy are to give vendors legal status; to facilitate hawking zones in the urban development/zoning plans; instead of imposing numerical limits on access to public spaces, to provide nominal fee-based regulation of access; to treat them as an integral and legitimate part of the urban distribution system (76).



Source: motiqua, Singapore, 2010,  
<http://www.flickr.com/photos/motiqua/4530456606/>

### Box 3 – China: Integrated Approaches towards a Sustainable and Energy-Efficient Urban Development in Shanghai: Urban Form, Mobility, Housing, and Living

Between 2000 and 2008 Shanghai increased its population by almost 2 million, to a population of approximately 19 million. This hyper-growth has been fuelled by mass production and rapid industrialization. The complex mix of low wages, high technology and a service economy has led to an influx of up to 2 million work migrants from rural areas. The city of Shanghai expanded rapidly to create workplaces, residential space and infrastructure – however sustainability, energy efficiency and the reduction of environmentally harmful CO<sub>2</sub> emissions did not initially play a role. The *Integrated Approaches towards a Sustainable and Energy-Efficient Urban Development* project explores the potential for limiting energy consumption, in urban form and structure, mobility, building technology and living – intervening in both the planning stage and implementation stage. The project seeks to promote the sustainable development of Shanghai as an "emerging megacity", at the same time as improving quality of life, including better residential quality and healthier living conditions, and access to good public mass transit. Using an integrated approach during the planning stage, it aims to significantly increase energy efficiency when developing new urban quarters and districts, including reducing traffic and to influence the behaviour of the inhabitants.

Source: Federal Ministry of Education and Research (77)

### Slum reduction and upgrading

Countries that have experienced success with slum reduction and upgrading in Asia Pacific have used five specific complementary approaches: i) awareness and advocacy from active civil society, (ii) long-term political commitment, (iii) policy reforms and institutional strengthening, (iv) proper implementation and monitoring, and (v) scaling up of successful local projects (40).

India and China have both demonstrated long-term political commitment to slum reduction. India (Box 4) and Indonesia have implemented a wide range of policy reforms, on land tenure, housing and infrastructure to integrate large numbers of urban



Source: mckaysavage, India, 2008  
<http://www.flickr.com/photos/mckaysavage/2832914746/sizes/z/in/photostream/>

poor into cities' legal and social fabrics. Indonesia and Viet Nam have shown the importance of proper monitoring systems and indicators to collect information and analyse trends within slums.

**Box 4 – India: A comprehensive packages of interventions**

Slum upgrading, an intervention currently being implemented in several cities across India, entails basic infrastructure improvements for residents and guaranteed freedom from eviction for ten years (78). This urban improvement strategy provides a set of seven interventions: connections to a water supply for individual households; underground sewage for individual households; toilets for individual households; storm water drainage; stone paving of internal and approach roads; solid waste management; and street lighting. This strategy provides services at the household level while many slum improvements in the past have provided such upgrades on a neighbourhood level through shared facilities which often do not reduce transmission of communicable disease. Slum upgrading carried out in this way in Ahmedabad, India, led to a significant decline in waterborne illness incidence (78).

Looking beyond the housing sector, the Philippines and Indonesia (Box 5) have fought slums with broad-ranging poverty reduction strategies, with policies shifting from entitlement to co-participation (40). Policies must be backed up by adequate human and technical resources, as demonstrated in Indonesia and the Republic of Korea. Slum improvement policy implementation must involve close coordination between central, regional and municipal authorities and the private sector and local communities, as happened in China, Viet Nam and Sri Lanka (40). Cambodia and Thailand set themselves clear targets and benchmarks, and Indonesia used results-based monitoring. Pilot slum-upgrading projects have been successfully scaled-up in Sri Lanka and Indonesia. In China, large public subsidies went into housing projects for the poorest (40).

**Box 5 - Indonesia: Community involvement in slum upgrading**

In central Java in Indonesia, communities were actively involved in a collaborative partnership when implementing community-based sanitation facilities. Community involvement was from the beginning of the process throughout its implementation. This is believed to have contributed to a strong impact on users' receptivity and acceptance of the new technology, and also their willingness to maintain and invest in the facilities on an ongoing basis (79).

**Box 6 - Bangladesh: Community-led Water Management Committees**

An NGO model involving community Water Management Committees in informal settlements prompted the water authority to allow communities to apply for water connections on their own behalf without the need for a guarantor (80). Eighty-eight water-points have been established in 70 slum-settlement areas since 1996, benefiting more than 200,000 people. The committees manage and maintain the water-point, pay bills to the water authority, and instalment repayments back to the NGO. The success of the project shows the potential for residents of informal communities to be reliable clients, responsible, and willing to pay for services.

### Improving access to services and creating physical environments for healthy living

Urban environments can be modified to create liveable spaces and promote healthier behaviours – such as active forms of transport, reducing crime, and limiting smoking. Japan has successfully promoted increased bicycle use, despite increasing car ownership, through a combination of policies providing extensive bicycle paths, bicycle parking at all rail stations, and high fees for car use (81). China has explicitly promoted bicycle use for decades, for example through employee commuter subsidies for bicycle use, cultivating a domestic bicycle manufacturing industry and allocating substantial protected urban space to non-motorised transport (81). In Australia, closing Melbourne’s central business area to cars in 1993 produced a 360% increase in the number of cyclists using this route (82).



Source: Ding Yuin Shan, Hong Kong, 2011  
<http://www.flickr.com/photos/90461913@N00/6214066661/sizes/z/in/photostream/>

#### Box 7 - Nepal: Kathmandu Sustainable Urban Transport Project

Population growth, rapid urbanization, and the increasing number of vehicles have led to traffic congestion, road accidents, environmental degradation, and poor public transport operation and services in Kathmandu. The Kathmandu Sustainable Urban Transport Project, a co-operation between Nepal’s Department of Transport Management and the Asian Development Bank, aims to improve the urban transport system, reduce congestion and air pollution, and promote active transport. The project includes reorganizing the public transport network system in Kathmandu, and establishing a government-managed Town Development Fund, to fund project activities. Activities include promoting electric or low-emission vehicles, making heritage routes pedestrian-only, improving facilities and sidewalks to make Kathmandu city-centre more pedestrian-friendly. Traffic management works and measures, such as junctions’ improvement and monitoring, is also being undertaken to solve congestion and improve safety.

Source: Asian Development Bank (83) and Ministry of Physical Planning and Works (84)

Davao, in the Philippines, implemented a city ordinance prohibiting smoking in indoor and some outdoor public places before a national tobacco control law was adopted. Its legislation process greatly benefited from support of a local political leader, participation of wide range of local stakeholders, and long-term awareness campaigns. Although it allowed designated smoking areas

with certification, Davao demonstrated that local smoke-free legislation can work in the Philippines and facilitated other jurisdictions' action. India adopted a comprehensive tobacco control law in 2003; however, its enforcement responsibility was given to each municipality and it was hardly implemented before 2007. While there is a lack of governmental commitment to the law, a local NGO in Chandigarh initiated campaigns to promote enforcement of the law in the city, including litigation and awareness-raising. Their effort led to the official announcement of smoke-free Chandigarh in 2008, and full enforcement of the law finally began. The experience of Chandigarh illustrates the role of civil society in helping to ensure municipal action is taken to make a city smoke-free. In Shanghai, China, in-door smoke control legislation was passed on 1 March 2010, and the recent World Expo held there was largely smoke free by banning smoking in all restaurants and prohibiting tobacco sales and advertising (85).

#### **Box 8 - Papua New Guinea: Yumi Lukautim Mosbi Project**

The Yumi Lukautim Mosbi Project (YLMP) took a community partnership approach to addressing urban crime in Port Moresby. Seeking 'a just, safe and secure society for all', the project involved crime prevention but also urban safety through linkages between provincial government, law and justice agencies, the private sector and communities most affected by crime. Supported by AusAID and is run under the Law and Justice Sector Program, the YLMP was managed by the Urban Safety Advisory Committee of the National Capital District Commission (NCDC) which consisted of representatives from the corporate sector, donors, women and youth councils, the church, media, police, local government and community representatives.

Programmes were explicitly directed at enhancing safety for individuals (especially women) and communities that felt most vulnerable. Opportunities were created for youth involved in criminal activities, through job creation, community development projects. Some of the strategies developed in collaboration between community and other partners, include:

- Promotion of sport and youth engagement, particularly through schools and informal settlements
- Reintegration and skills development, which specifically targets the inclusion of private sector involvement, skills development and employment creation
- Awareness of urban safety through positive stories, use of media and examples of community initiatives
- Community engagement (where communities are encouraged to develop forums which build consensus on needs and seek funding for these initiatives)
- Residents from a number of communities have been encouraged to engage in community policing and patrols.

To a great extent the success of YLMP has highlighted the limitations of institution-based urban safety approaches in favour of community-focused innovations which build partnerships around meeting needs, as defined by those affected by crime as well as perpetrators. In the past there has been a lack of traction in projects which have been wholly 'owned' by government or donors.

Source: Storey (86)

**Box 9 - Philippines: Parañaque City, identifying community needs with Urban HEART**

Parañaque is a city which situated in the southern part of metropolitan Manila, is home to almost 600 000 people and is growing rapidly. It is divided into 16 barangays or administrative areas. Its Urban HEART team, constituted in 2008, was multisectoral and included municipal representatives from the health, housing, planning, budgetary and engineering sectors. Civil society and community groups also participated, and national- and regional-level health representatives joined during the implementation phase. The mayor of Parañaque City played a central role, both in providing leadership and in liaising with a range of sectors and stakeholders. Urban HEART's assessment component was used to identify the city's most pressing health inequities. Results revealed that the city had overall shortcomings and substantial inequities between barangays on access to safe water, crime and the percentage of pregnant women giving birth in health facilities. Citywide, almost half of all births were happening at home without a skilled birth attendant. And, among the city's 16 barangays, one of the poorest San Martin de Porres, has 92% of all deliveries happening at home. Based on this information, it was decided to establish a birthing facility in San Martin de Porres. Following approval of the San Martin de Porres council, the facility was opened at the end of 2008.

An awareness-raising and advocacy campaign complemented the building's renovation. Information about the new birthing facility was posted in all deprived areas of San Martin de Porres, and media outreach resulted in wide coverage of the facility's opening in local and national news outlets. A series of community outreach efforts informed women about the complications and risks of home deliveries, and motivated them to use the new birthing facility. Following the opening of the birthing facility, the number of women using the facility increased in the subsequent months. A decrease in the proportion of home deliveries was also witnessed in 2009. Encouraged by the success of San Martin de Porres, leaders in five other barangays established birthing facilities in 2010.

Source: World Health Organization et al (87)

A 2006 review of good practice for sustainable urban development by Roberts and Kanaley (71) helpfully summarises what has been put in place in 12 cities across Asia according to seven elements of good practice (Table 4). Good governance, urban management and infrastructure and service provision, each vital for health, were recurring themes in these examples of good urban development.

**Table 4 - Summary of Asian Cities Good Practice Case Studies**

	Good Governance	Improved urban management	Effective and efficient infrastructure and service provision	Financing and cost recovery	Social and environmental sustainability	Innovation and change	Leveraging international development assistance
Bangladesh							
Chittagong: Dynamic and Innovative Leadership	✓	✓	✓				
Shakti Foundation: Microcredit Program	✓			✓		✓	
Bangladesh Environment Movement		✓				✓	✓
Cambodia							
Phnom Penh: Planning for All	✓	✓		✓	✓		
Battambang Town Study	✓	✓			✓		
Growth Pole Strategy for Kratie						✓	✓
People's Republic of China							
Nanjing: Revitalizing the Inner City	✓	✓	✓		✓		
Shenzhen: Building a City from Scratch	✓	✓	✓		✓	✓	
Liaodong Peninsula: Reviving Rustbelt Industries		✓			✓	✓	
India							
Ahmedabad: Issuance of Municipal Bonds	✓	✓		✓			
Andhra Pradesh: Reform of Property Taxation	✓	✓		✓			
The National Urban Renewal Mission (NURM)		✓				✓	
Indonesia							
Tarakan: East Kalimantan: Balanced Development	✓				✓		
Sleman: Managing Rapid Urbanization	✓	✓		✓		✓	✓
Jembrana, Bali: Community Improvement Program					✓		

Lao People's Democratic Republic							
Vientiane: Urban Region Village Area Improvements	✓	✓	✓	✓			
Luang Prabang: Urban Improvements and Heritage Conservation		✓	✓			✓	✓
Savannakhet: East-West Economic Corridor	✓		✓			✓	✓
Malaysia							
Petaling Jaya: Local Agenda 21 Implementation		✓			✓	✓	
Putrajaya: Model City	✓	✓	✓		✓		
Cyberjaya: Multimedia Super Corridor		✓	✓			✓	
Philippines							
Bacolod City Study	✓	✓	✓		✓		
Naga City Study	✓	✓	✓	✓	✓	✓	✓
Iloilo City Study	✓	✓	✓		✓		
Sri Lanka							
Colombo: Community-based Solid Waste Management	✓	✓	✓		✓	✓	
Colombo: Health and Environment Management	✓	✓	✓		✓		
Colombo: Clean Settlements Program	✓	✓	✓	✓			
Thailand							
Muang Klaeng Municipality: Sustainable City Initiative	✓	✓			✓		
Phichit Municipality: Waste Recycling	✓	✓			✓	✓	
Songkhla Municipality: Waste Management and Education	✓	✓			✓		
Viet Nam							
Phu Thuong, Hanoi: Institutional Building in Urban Upgrading	✓	✓	✓		✓		✓
Nhieu Loc-Thi Nghe Basin: Environmental Improvement	✓	✓	✓		✓		✓
Nam Dinh City: Urban Upgrading	✓	✓	✓		✓		

Source: (71)



## Chapter 2: Improving working conditions and social protection across Asia Pacific

### CSDH Recommendations:

- Make full and fair employment and decent work a central goal of national and international social and economic policy-making.
- Achieving health equity requires safe, secure, and fairly paid work, year-round work opportunities, and healthy work–life balance for all.
- Improve working conditions for all workers to reduce exposure to material hazards, work-related stress, and health-damaging behaviours.
- Establish and strengthen universal comprehensive social protection policies that support a level of income sufficient for healthy living for all.
- Extend social protection systems to those normally excluded.
- Make sure that all children, mothers, and other caregivers are covered by a comprehensive package of quality early child development programmes and services, regardless of ability to pay.

### Introduction

Paid work conveys many benefits for health and well-being. It can provide financial security, social status, personal development, social relations and self-esteem: material and psychosocial empowerment (88). The combination of employment and working arrangements and the actual conditions in which people work, together contribute to physical and mental health risks.

For many years concerns have been raised about the effects of economic globalization on the types and quality of work, wages, and job insecurity (89). While initially the effects of the economic crisis were felt more slowly in Asia Pacific than some other regions, its impact has become unavoidable. In this chapter we focus on how economic globalisation and the recent global financial crisis have affected work and its health-related benefits and risk in countries across Asia Pacific.

### Pathways from economic globalisation via work to health and health inequity in the Asia Pacific region

#### *Unemployment*

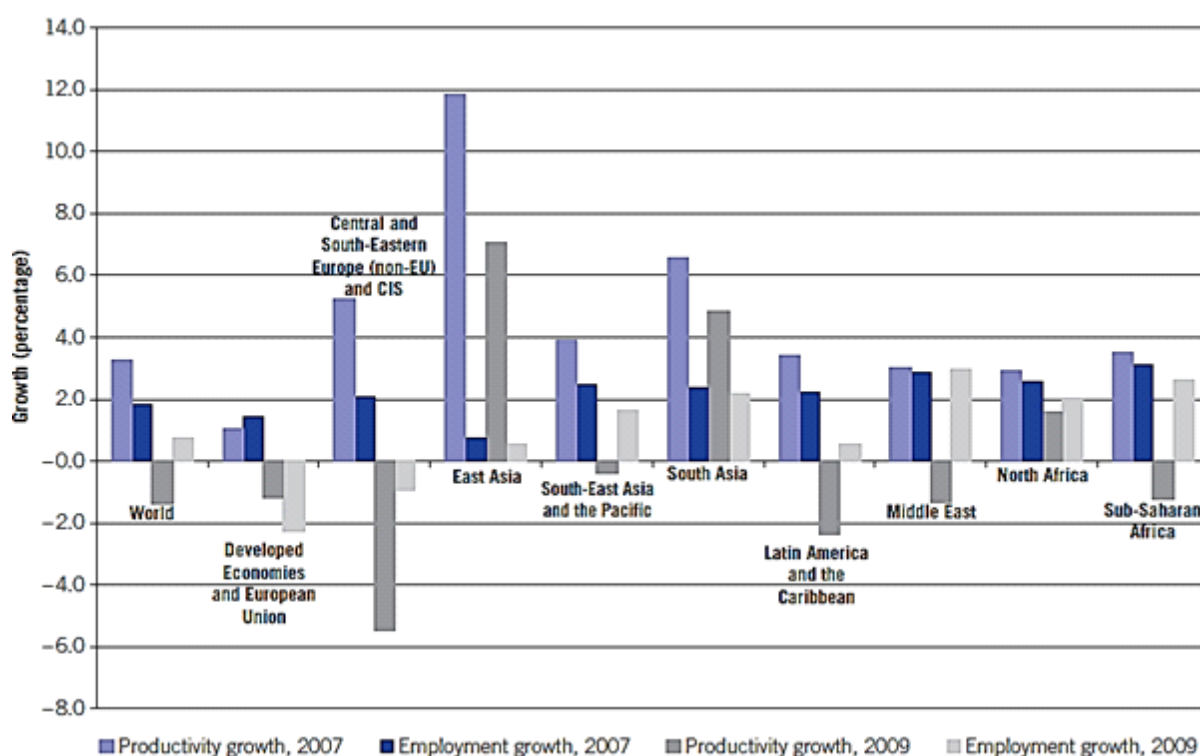
Unemployment is known to be a health and health equity hazard, exposing people to social stigma as well as isolating them and reducing their income (90). Countries across Asia Pacific have not been as badly affected by the global financial crisis (GFC) as countries across Europe or the USA. However, as world trade contracted when the economy entered into a rapid phase of global recession in late 2008, these shocks eventually led to job losses and unemployment in export-led enterprises, particularly concentrated in regions supplying these firms. China, for instance, saw large scale job losses of rural–urban migrants in manufacturing, construction, and wholesale and retail services when export demand collapsed (91).

Despite the strong recovery in economic output in East Asia (Figure 27), regional unemployment remains higher than it was in 2007 although it has declined to 4.1% in 2010. In South-East Asia and the Pacific the crisis affected the quality of employment more than the quantity in some economies, although unemployment remains at 5.1% in 2010. In South Asia, rapid economic growth has

resumed and the region's unemployment rate has been fairly stable, running between 4.3 and 4.5% between 2007 and 2010 (92).

The young, the poorly educated and ethnic minorities have borne a disproportionate share of the increase in unemployment, especially in developed countries. Evidence indicates that the young have been particularly affected through: a) higher unemployment rates, b) higher levels of underemployment, c) increased willingness to accept lower-quality jobs. Youth unemployment is particularly likely to lead to “scarring” effects, referring to the phenomenon that adverse labour market experiences when young lead to further negative market outcomes well into the future. In South Asia young women and men are particularly vulnerable, being 3.2 times more likely than adults to be unemployed. In South-East Asia and the Pacific that ratio rises to 4.7 times, the highest among the world's sub-regions (93).

**Figure 27 - Labour productivity growth and employment growth, world and regions, 2007 and 2009**



Source: (92)

An analysis of the effects of the global financial crisis on health and health inequities, albeit in Europe, finds that rises in unemployment are associated with significant short-term increases in premature deaths from intentional violence (94). The effects on health inequities of financial crises in high income countries in Asia were observed previously in countries such as Japan (Box 10).

**Box 10 – Japan: economic recession, widening inequities in health status**

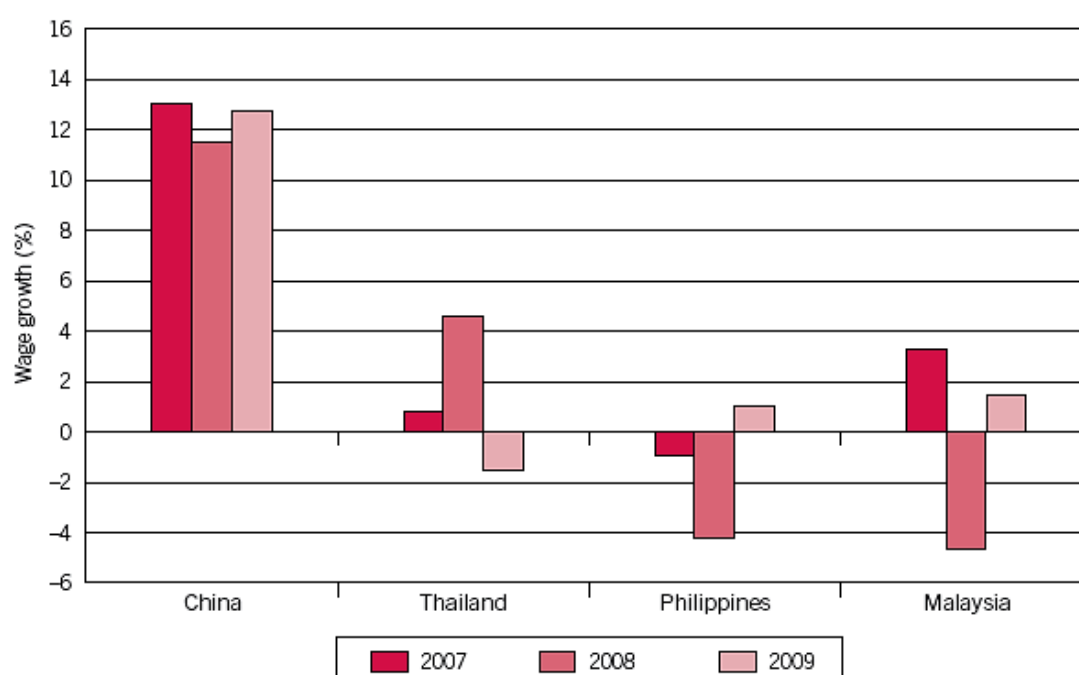
Japan underwent a prolonged economic recession in the 1990s. Self-rated health improved throughout the period for Japanese men and women. However, occupational class-based inequalities in poor health widened during the same period. Middle-class male workers and female homemakers were particularly adversely affected by the crisis, compared with the highest class workers, while unemployed people had persistently poor health throughout the period.

Source: Kondo et al (95)

**Work-related income**

Paid work is the key mechanism through which people obtain resources important to health, especially income. Wages have been affected by the economic crisis. Wage earners account for about 86% of the employed population in developed countries, but this proportion falls to about 35% in Asia. Between 2007 and 2009, New Zealand maintained positive real wage growth, whereas in Japan, a fall in real wages of nearly 2% in both 2008 and 2009 renewed concerns about wage and price deflation. In Asia, on average, real wages have grown in excess of 7% but as Figure 28 shows, this is heavily influenced by China, which accounts for more than half of total wage employment in the region. Countries such as Thailand, Malaysia and the Philippines have been much more adversely affected by the global economic crisis and show real declines in wages.

**Figure 28 - Wage growth in selected countries in Asia, 2007–09**

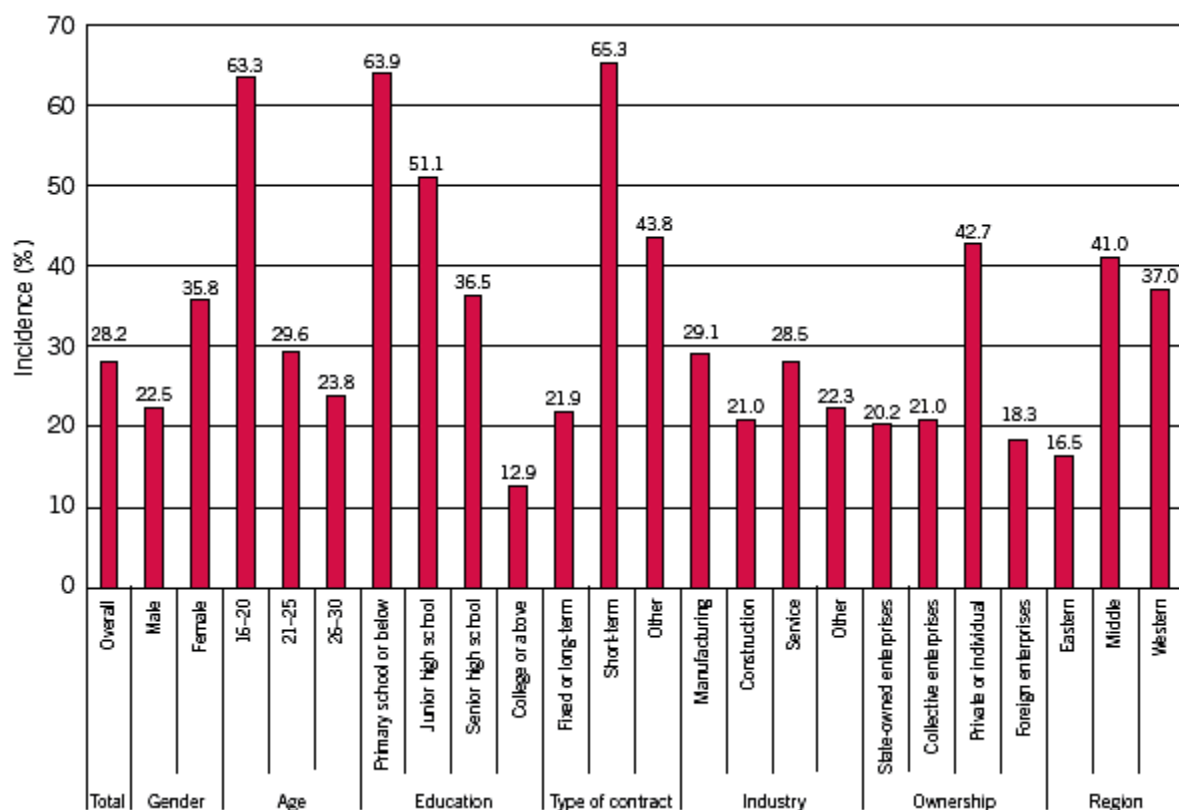


Source: (96)

The level of wages/income actually received has been affected badly by the recession. Twenty-nine % of workers in East Asia, over 50% in South East Asia and around 80% in South Asia live on less than US\$2 per day (96). The recent wages report from the International Labour Organization (ILO) shows a concerning picture of marked inequalities in the incidence of low wage earners (96). As the

example from China illustrates (Figure 29) females, young employees, people with low levels of education, in short term contracts and working in private companies are more likely to receive low wages.

**Figure 29 - Incidence of low-wage employment by major demographic characteristics: China, local workers, 2008**



Source: (96)

Low-income countries have faced a dramatic deterioration in capital inflows – from reduced exports earnings, foreign direct investment, and remittances, each with significant economic and health consequences. Informal workers have been profoundly affected by the drop in demand, fall in prices and exchange rate fluctuations associated with economic crises. Data from the Self-Employed Women’s Association in Ahmedabad, India show how prices (and therefore income) in waste recycling had dropped by one-third to one-half across most materials in the four months from October 2008 to January 2009 (Table 5). Many of the waste pickers are women and children.

**Table 5 - Price of recycling materials collected mainly by women, Ahmedabad, India**

	<i>Category of waste</i>	<i>Price/kg (Indian rupees)</i>	
		<i>October 2008</i>	<i>January 2009</i>
<b>Steel/iron</b>	Nuts, bolts, screws	25	15
	Sheet metal	10	5
<b>Hard plastic</b>	Grade 1	15	6–8
	Grade 2	13	3–4
	Grade 3	10	3–4
<b>Plastic bags</b>	Grade 1	18	6
	Grade 2	8	5–6
	Grade 3	5	3
<b>Paper</b>	Newspaper	8	4
	Brown paper	3	2
<b>Cloth</b>	White cloth	20	12
	Clean cloth	6	3

Source: (97)

### ***Precarious employment and quality of work***

Economic globalization has been accompanied by a dramatic structural transition to new patterns of employment, with a rapid increase in informal, unregulated and casual work, in developing and developed countries. This has arisen partly through the ‘implicit conditionality’ of placating concerns of international credit rating agencies, international creditors and various other actors in international financial capital markets, who assess macroeconomic environments and pass judgment on labour market flexibility as key indicators of competitiveness and credit worthiness (98). Labour market flexibility has been interpreted as reductions in union and workers’ rights, and increases in ‘precarious’ working arrangements (such as informal work, temporary work, part-time working, and piece work) (99–101). These pose physical and mental health risks from the hazards associated with job and income insecurity, weakening of regulatory protections, and lack of access to paid leave(102–105).

The consequences of the global financial crisis are being felt not only as a rise in unemployment. Just as concerning is the expansion in the informal economy – where workers have little or no social protection. Women, young people, and unskilled migrant workers are among those who are particularly vulnerable. The number of workers in vulnerable employment is estimated to have risen to 173.7 million in 2009, an increase of 5.4 million since 2007 (93). The highest share of vulnerable employment is in South Asia (78% of total employment 2009) (92).

Having work is clearly important for health but a poor quality job can be worse for health than not having one. As data from Australia show (Table 6), adverse working conditions are associated with higher odds of poor health, and people in the worst jobs have higher odds than the unemployed for poor mental health, while the unemployed have the highest odds of poor physical and self-rated health, and higher rates of GP visits (106).

**Table 6 - Adjusted odds ratios (OR) and 95% CI for depression, poor physical health, poor self-rated health and visits to the GP by employment continuum category, Australia**

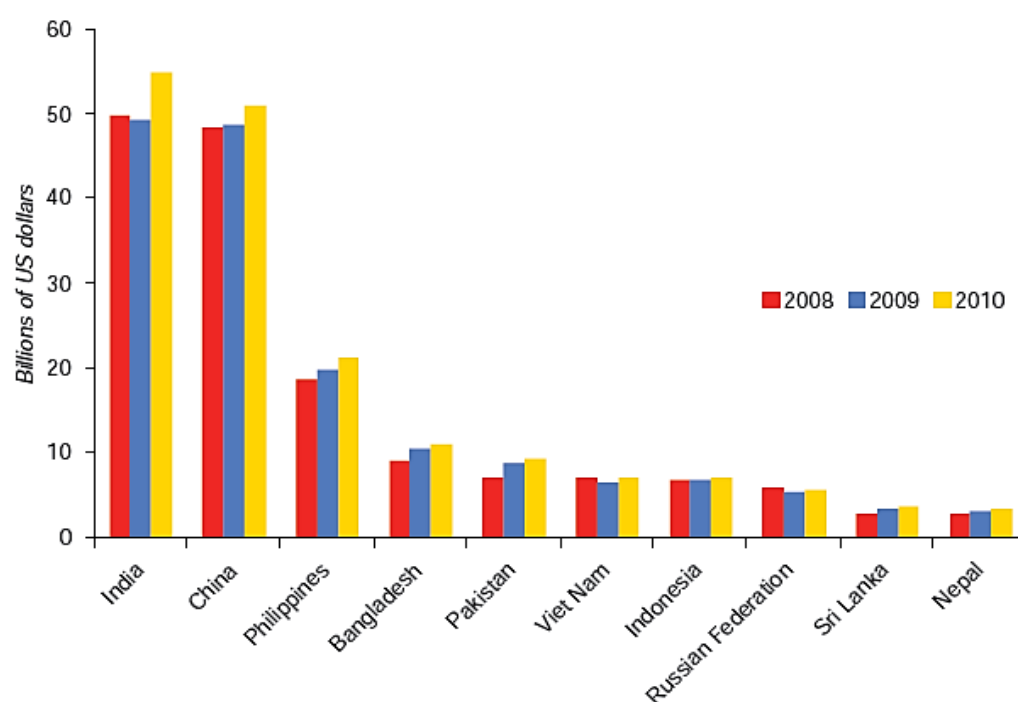
Employment continuum	Depression	Poor physical health	Poor self-rated health	GP visits
	OR (95% CI)	OR (95% CI)	OR (95% CI)	IRR (95% CI)
<b>Optimal working conditions</b>	1.00	1.00	1.00	1.00
<b>1 adverse work condition</b>	1.60 (1.18-2.19)	1.31 (0.99-1.74)	1.58 (1.10-2.28)	1.15 (1.04-1.27)
<b>2 adverse work condition</b>	2.40 (1.64-3.50)	1.84 (1.29-2.64)	2.20 (1.42-3.42)	1.25 (1.09-1.44)
<b>3 adverse work condition</b>	7.27 (3.64-14.51)	2.39 (1.13-5.05)	4.14 (1.89-9.07)	1.30 (0.94-1.79)
<b>Unemployed</b>	4.11 (2.15-7.86)	3.29 (1.77-6.14)	4.81 (2.38-9.73)	1.59 (1.21-2.09)

Source: (106)

### ***International migration***

Facilitated by great economic integration, international migration, both to and from the Asia Pacific region, has been a major driver in social and economic change. International migration in Asia Pacific is on the rise, with 53 million documented migrants in the region in 2010 and a high number of non-recorded migrants. The trend appears to be for relatively poorly skilled workers (e.g. housemaids) to migrate in large numbers to the more affluent countries in the region. Through international migration, societies have become more open and more diverse and in some instances more inequitable.

Remittances have become a crucial source of income for both families and the state. They have contributed to reducing poverty and hence improving resources for health in many countries of the region. In 2010, Asia Pacific remained the world's largest remittance-receiving region. In absolute terms, India and China were the largest remittance-receiving countries in Asia Pacific, followed by the Philippines, Bangladesh, Pakistan, Viet Nam and Indonesia (Figure 30) (93). In the Pacific it has traditionally been Samoa and Tonga which have been the largest recipients of remittances, accounting for about 25% of their GDP. More recently, however, remittances have become increasingly important in Fiji, Kiribati, Solomon Islands, Sri Lanka and Vanuatu. Between 2004 and 2007, the remittance receipts of Fiji accounted for about 6% of its GDP. These figures, however, underestimate the true magnitude of receipts since they represent only those officially recorded.

**Figure 30 - Top 10 remittance-receiving Asia Pacific economies, 2008-2010**

Source: (93)

But migration also has a social cost. Poor working conditions, restricted access to health care, and language barriers make migrant workers more vulnerable to poor health. Human trafficking is a major challenge that needs to be tackled. The increasing scale of female migration is raising concerns about the protection of women migrants as well as the impacts on children and families left behind, and the migration of highly skilled and professional workers, including health-workers, often leaves an unfilled gap in their countries of origin (107).

### Action across Asia Pacific to improve Health Equity through Labour Policy and Social Protection

Quinlan and colleagues (108) remind us of a number of general policy objectives that are important for work-related health equity:

- Discourage or remove incentives for, or eliminate (in the case of child and forced labour), harmful work arrangements.
- Empower workers and communities to better protect their health and wellbeing and to ensure that work quality is a central social policy.
- Overturn the politico-legal privileging of economic/commercial arrangements over social and health regulation.
- Establish enforceable labour standards, universal health care, and a social security safety net to protect workers and communities.
- Ensure that those deriving economic gain from work arrangements are also held accountable for adverse social and health consequences.

Each of these applies within the Asia Pacific context, especially as labour markets grow and re-set after the GFC. It is important that policy makers focus more on quality jobs and incomes. As we show below, there are health equity promoting labour and social protection policies in place in countries across Asia Pacific but, as everywhere, there is room for improvement.

### Creating employment opportunities

A post-crisis macroeconomic framework should seek full employment for men and women as a core policy goal, besides economic growth targets, inflation and sustainable public finances.



Source: Christian Haugen, India 2009.  
<http://www.flickr.com/photos/christianhaugen/3291828637/>

In India, the National Rural Employment Guarantee Act of 2005 obliges the government to provide a social safety net for impoverished rural households, through the guarantee of 100 days of work, at minimum wage, to one family member per household. The National Rural Employment Guarantee Scheme provided employment to 46 million households in 2009, with close to half of those employed women. The implementation of this scheme has provided both lessons e.g. regarding leakages (109), and successes, with half of those employed being women, and more than half from marginalized groups (110).

In 2011, Indonesia became the first Asian country to sign a national “job pact” (111). The Indonesia Job Pact (IJP) is a tripartite agreement between the Government, employers’ representatives and workers unions. The IJP is designed to bring the benefits of economic growth to every citizen through the creation of decent and productive employment, making the Indonesian economy regionally more competitive, while supporting the national policy goals (111). The pact consists of an integrated policy portfolio in four areas:

- Accelerating employment creation, jobs recovery and sustaining enterprises
- Building social protection systems and protecting people
- Strengthening respect for international labour standards
- Social dialogue: bargaining collectively, identifying priorities, stimulating action



**Protecting workers through improved working conditions and social protection schemes**

As highlighted earlier in the chapter, wage levels and the large number of people in low paid jobs is of concern across Asia Pacific. Various countries across the region have introduced new or revised minimum wage policies (see Box 11 to Box 13), which will be important in helping to ensure a healthy standard of living for more people.

**Box 11 - China: improving wage distribution and reforming collective bargaining practices**

Employment and industrial relations in China have undergone tremendous transformation along with China's journey towards a market economy in 1978. After 30 years of economic transition, China has become the 'factory of the world'. In 2008, China introduced a series of high profile labour and social laws, such as the Labour Contract Law, the Employment Promotion Law, and the Labour Dispute Mediation and Arbitration Law. Under the overarching slogans of 'building harmonious society' and 'people centred development', the government set ambitious goals of redirecting China's economic and social development strategies towards more balanced development: balancing rural and urban development through support for rural development; sustainable development through better environmental protection; balance between export and domestic sector development, and; balance between economic efficiency and social equity.

The Chinese government has a number of wage policy instruments designed to influence wage levels, including local minimum wage fixing, the wage information system, and non-binding wage guidelines at the local level. The non-binding wage guidelines were introduced in the 1990s to influence or control wage trends in state-owned enterprises which were gaining their autonomy for wage-setting. They also served as a reference for wage negotiators in all types of enterprises, in parallel with the promotion of wage negotiation in the 2000s.

Collective bargaining also gained crucial momentum in the 2000s, helped by the improved legal framework, tripartite support and expanded union membership in a variety of new forms of trade unions. The creation of diverse forms of trade unions (such as street unions, regional/sectoral unions), was made possible by the revised Trade Union Law and facilitated by the tripartite 'Common Views on Promoting Regional/Sectoral Bargaining'. In 2007, 45.6 million workers were reported to be covered by these agreements. There is growing evidence that trade unions and collective bargaining are starting to impact on labour market outcomes, including less intra-firm wage inequality, better social security provisions at the firm level and better job security.

Source: (112)

**Box 12 - Philippines: adding cost-of living allowance on top of minimum wage**

In May 2011, authorities in Manila decided a cost-of-living allowance should be added to the minimum wage, improving the pay-packets of over 2 million workers in the Philippine's capital city. An extra 22 pesos (US\$0.50) was added to the standard 404-peso daily salary, in recognition of the rising price of food and other essentials in the capital. Although the additional money was welcomed, it fell far short of what many low-earners had been hoping for, with labour unions lobbying for a 75-100 peso wage increase. Unlike a rise in the minimum wage, the new allowance will apply only to basic earnings, not overtime or bonus pay.

Thousands of citizens marched in protest on 1 May, Labour Day, to ask for higher wages in line with rising prices, and President Benigno Aquino vowed to listen seriously to their concerns. Many small businesses have been requesting exemptions from this increase, on the basis that it would make the business unviable. As the director of the National Wages and Productivity Commission, Ciriaco Lagunzad III, explains, these exemptions are not ideal, but sometimes they are better than the alternative: "no company should be exempt from paying the minimum wage, but if this would lead to lay-offs and possible closure of the entire business, then our policy is to preserve employment". This illustrates that setting the minimum legal wage is a delicate balancing act, as Mr Lagunzad warns that raising the minimum wage too high inadvertently pushes more vulnerable workers into the informal sector.

Source: (113)

**Box 13 - India: raising the minimum wage**

The latest employment–unemployment survey undertaken by the National Sample Survey Organisation in 2004–05 indicates that there are approximately 173 million wage earners throughout India, of which 116 million are classified as casual workers. Estimates show that universal and perfectly well-enforced minimum wage coverage could benefit up to 73 million workers, who are currently paid less than the indicative national minimum wage floor. This suggests that extension of minimum wage coverage in India could have a considerable impact. Since 30 to 40% of low-paid wage earners belong to poor families – and because women are paid less than men – the extension of minimum wages could be a useful instrument for reducing both the gender pay gap and the high poverty incidence in India.

Source: (96)

Work-related benefits including social security are also important for workers' health. A few countries such as Australia, New Zealand, and Japan have long-established comprehensive systems, the first two increasingly based on universal and means-tested schemes and the third on traditional social insurance. Other countries, including India, Singapore, Malaysia, and Sri Lanka have systems that are heavily reliant on compulsory personal savings managed by government. Coverage of schemes within countries is highly variable and hence exacerbates the potential for health inequities. Generally, self-employed workers and those in the informal sector are excluded, although

they may be entitled to social assistance. Within the formal sector, protection is often most developed for, and sometimes limited to the public sector, while coverage of the private sector may be restricted to particular industries or groups of employees (114). Countries such as Thailand and the Philippines have begun to construct social insurance schemes covering both public and private-sector employees. As Box 14 illustrates, Thailand has introduced a number of schemes aimed at improving worker's health. The Ministry of Human Resources and Social Security of China, working with UNDP, passed a law in June 2010 requiring private contractors to provide migrant construction workers with disability insurance that would cover treatment and rehabilitation (115). This legislation will benefit the majority of the estimated 175 million migrants working in the Chinese construction sector.



Source: Peter Halling Hilborg, Myanmar, 2011  
<http://www.flickr.com/photos/philborg/6014365066/>

#### **Box 14 - Thailand: protecting workers' health**

The Civil Servants' Medical Benefit Scheme and Government Officials' Pension Act of 1951 provides generous benefits for government workers and their dependants. The Workman's Compensation Scheme is an employer-funded scheme providing benefits for work-related sickness. Thailand's social security system has progressed towards a universal safety net providing free health care to workers and their dependants, thereby greatly reducing inequities in access to health care. Legally registered foreign workers can also be covered by this scheme for a small fee. Although informal workers are still excluded from other social security benefits – e.g. paid sick leave and unemployment benefits – a universal pension of 500 baht per month, also covering informal workers, was recently introduced.

The 1998 Labour Protection Act, required all (formal) workplaces to set up an occupational safety committee, made up of management and worker representatives trained in workplace health and safety. This legislation also established a reporting system for employees to notify suspected breaches of safety rules, which the Ministry is then obliged to investigate, and rendered the general workplace inspection process more rigorous. In addition, the 1998 Act addressed working conditions and conditions of employment (e.g. maximum working hours and minimum wages) and set up a separate reporting process for employees to report breaches of these conditions. Penalties for breaches were increased and independent third parties were allowed to investigate disputes (116).

### Programmes and skills to reduce workers vulnerability

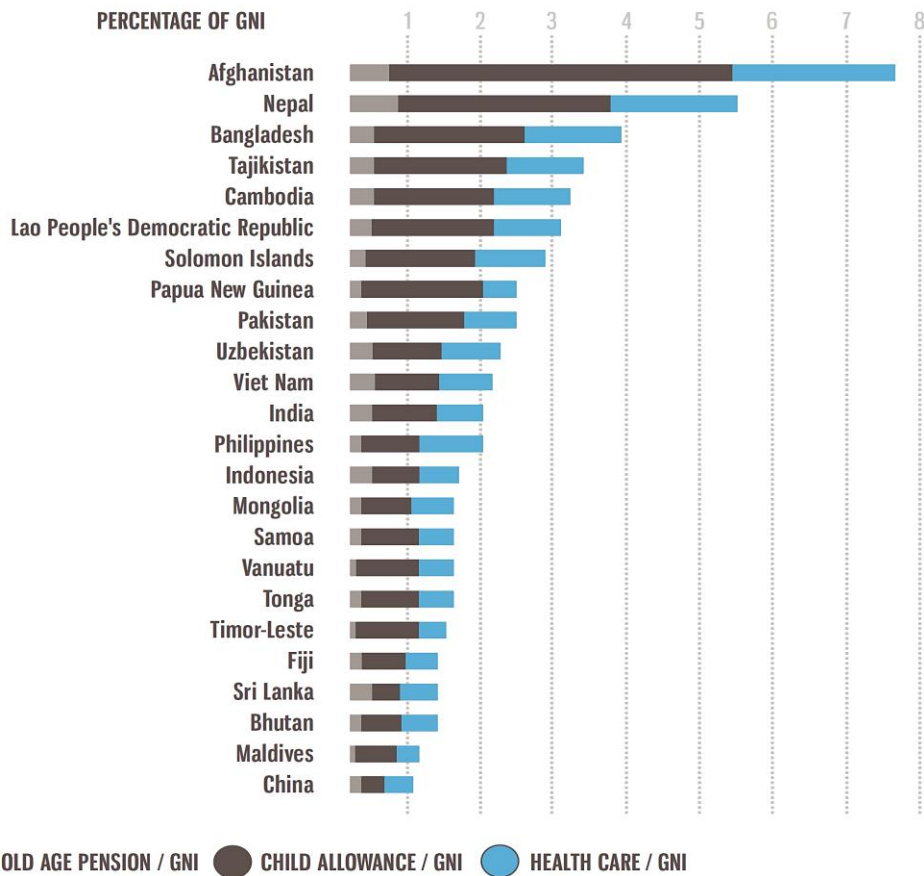
In Asia, only 20% of the unemployed and under-employed have access to labour market programmes such as unemployment benefits, training or public works programmes; and only 20% of the population has access to health care assistance. Initiatives to deliver training to unskilled and workers in precarious employment can offer benefits to employers and employees. The Cambodian NGO SiRCHESI launched a 24-month Hotel Apprenticeship Program in 2006 to provide literacy, English, social skills, health education, hotel skills-training, work experience and a living wage to women formerly selling beer in restaurants, where they had faced workplace risks including HIV/AIDS, alcohol overuse, violence and sexual coercion. This jointly designed partnership between the NGO and private sector was seen by hotel managers as a way to hire additional staff and have minimal employee turnover for two years. For the women, it offered an escape from an unsafe, workplace, a two-year job-training commitment with a living wage, and development of broader knowledge and skills that would improve livelihoods for their families. Quantitative and qualitative analyses indicated changes in health-related knowledge, behaviour, self-image and empowerment (117).

### Increasing social protection to enable healthy living across the life-course

The importance of social protection to health and health equity lies with its potential to provide access to the basic requirements that enable healthy living, particularly to excluded groups. A robust system of social protection not only fulfils people's basic rights, it also establishes a firm platform for both social and economic development and provides a stabilizer for vulnerable groups in times of crisis (118). To be truly effective, and transformative, social protection needs to be institutionalized, based on entitlement, and provide universal access to the services which strengthen people's capacities, such as health, education and nutrition (118). Several recent global initiatives are relevant in this regards. These include the UN's Social Protection Floor Initiative of international organizations such as UNESCO, ILO and WHO, which may open a window of opportunity to establish comprehensive social protection in some countries in the region (119).

Countries across Asia Pacific have been progressively moving towards more inclusive systems of social protection, and even though the amount of investment required to deliver a basic package of old age, early childhood and health support would cost most Asia Pacific countries less than 4% of their GNI (Figure 31), the amount allocated to social protection remains very variable.

Figure 31 - Annual cost of a basic social protection package in selected Asia Pacific countries (as a % of GNI)



Source: (118)

Some developed countries have highly comprehensive schemes, such as Japan (Table 7). Other less wealthy countries have implemented promising social protection measures. Low-income countries in East Asia have only a limited range of social protection programmes. Indonesia however has developed a number of targeted support programmes, including rice and fuel subsidies, as well as introducing a cash transfer programme (118). Some of the poorest countries in the region such as the Lao People’s Democratic Republic and Cambodia – essentially lack formal social security mechanisms.

**Table 7 - Components of Japan's Social Protection System**

Risks covered	Implementation by government	Total cost (Yen, Billions)
Old Age	Basic National Pension Scheme, Employee's Pension Insurance, National Public Service Personnel Mutual Aid, Long-term Care Insurance System	44661
Death	Basic National Pension Scheme, Employee's Pension Insurance, Long-term Care Insurance System	6447
Disability	Basic National Pension Plan, Employee Pension Plan, Pension Plan for Government Officer, Allowance for Disability, Social Services	2561
Work Injury	Industrial Accident Compensation Insurance	982
Sickness	National Health Insurance, Health Insurance Vaccination Program, Public Health Services	27469
Maternity and Family	Child Allowance, Child Rearing Allowance, Child Care Services	3070
Unemployment	Employment Insurance System	1239
Social Assistance	Public Housing Services, Public Assistance System	2675

Source: (118)

### **Early life**

The early years of life lay the foundations for life-long wellbeing. A recent UNESCO review of progress in expanding comprehensive early childhood care and education in the Asia Pacific region (120) found that the well-being of children was improving overall, but there was considerable variation within the region. Relatively few countries across Asia Pacific have established comprehensive national policy frameworks to support the development of children under three. The rapid expansion of some pre-school programmes and the for-profit sector in some parts of the region meant an increase in attendance was sometimes coming with higher teacher-child ratios and a less holistic approach and thus a reduction in quality. In response to deteriorating health of women and children after Mongolia's transition process in 1990, the government introduced a universal scheme, where care for pregnancy, childbirth and post-natal care are provided free of charge, and from the fifth month of pregnancy, all women receive a cash allowance for one year (118). In New Zealand and Australia, the governments provide 14-18 weeks paid parental leave allowance for parents who were self-employed prior to the birth of their child and stop work to care for the child (121). Four other countries meet the standard of ILO Convention No. 183 and provide at least 14 weeks of leave: Bangladesh provides 16 weeks, Mongolia 120 days of leave, Singapore 16 weeks and Viet Nam four months.

### **Unemployment**

The current financial crisis has prompted some countries in the region, including Malaysia and the Philippines, to consider establishing unemployment insurance schemes. With technical support from the Korea Workers' Compensation and Welfare Service and the ILO, unemployment insurance

schemes have been set up in Thailand and Viet Nam in 2004 and 2006–2009, respectively, and an employment injury insurance scheme in Cambodia in 2009–2010 (122).

### **Old age**

Only 30% of older people living in Asia receive pensions. Although Nepal has limited fiscal capacity, it is the only South Asian country with a universal old-age pension scheme. The Government has managed to provide this universal non-contributory pension (the Old Age Allowance Programme) since 1995 (123). Since then, two additional social security programmes, namely the Helpless Widows Allowance for widows above 60 years of age and the disability pension, each paying NPR 500 per month in 2008. At a current cost of 0.23 % of GDP, the scheme has supported older persons and their families to improve food security, access health-care services and invest in their livelihoods. For many older women, particularly widows who live alone and have no children, the pension often provides them with their only source of income. The Cook Islands, Kiribati, Nauru, Niue and Samoa also have non-contributory old age pensions, ranging from US\$40 per month in Kiribati to US\$200 per month in the Cook Islands (118).



Source: Taro Taylor China, 2006,  
<http://www.flickr.com/photos/tjt195/298982355/>

### **Extending social protection to excluded groups**

Additional measures are required to ensure the benefits of economic growth and improved infrastructure do not bypass the very poor. Holistic, multi-sectoral approaches encompassing integrated interventions for ensuring livelihoods, health, education and socio-political capital have been found to be essential to address the problem of extreme poverty (Box 15) (124).

Historically successive governments of Sri Lanka have invested in social development. The continued commitment towards providing free health and free education are testamentary. In fact Sri Lanka has much to attribute to free education that increased female literacy which improved access to health care for pregnant women and children. Presently as Sri Lanka enjoys peace after three decades of civil war, the Governments development focus is for economic development, infrastructure development whereby people have better access to means of social and financial development.

**Box 15 – Bangladesh: A multi-sectoral approach to poverty alleviation through social protection, BRAC**

In Bangladesh in 2002 BRAC introduced the “Challenging the Frontiers of Poverty Reduction - Targeting the Ultra Poor, Targeting Social Constraints” programme to address the multiple dimensions of extreme poverty, through a combination of asset transfer, supplementary feeding, and livelihood support services as well as social awareness and other welfare activities (125). 100,000 ultra-poor households were chosen to participate in a specially designed package of economic, social and healthcare interventions. The strategy also tackles the wider socio-political environment, by increasing awareness and capacity of community members and local government actors to address the problems of extreme poverty. The key features of the programme are:

- Free assets and a subsistence allowance to ultra-poor groups. Employment and enterprise training is also provided to these participants, including micro-finance.
- Provision of health services to the wider village, intensively targeting the ultra-poor participants with free or subsidised treatment and medicines.
- Community institution building for better accessing social safety net services and addressing social injustice and exclusion. It also focuses on strengthening local government towards pro-poor governance, access to information through popular theatre and addressing gender based violence.
- Legal literacy and legal aid services as well as strengthening alternative dispute resolution mechanism.
- Gender Quality Action Learning for improved gender relations within the family and community and women’s equitable access to services and resources.
- Advocacy at grassroots to national level on issues including greater resource allocation by the government for the ultra-poor, access to health services, pro-poor policies, etc.

The programme has demonstrated significant sustained positive impacts on the livelihoods of the participant households (126).

Private-sector initiatives and partnerships have also been used to positively impact social status, earning potential, and access to services and resources for poor and socially excluded groups in Bangladesh (127). These include projects that (a) increase job-skills and employment opportunities for women, disabled women, and rehabilitated drug-users and (b) provide healthcare services to female workers and their communities (Box 16).



**Box 16 – Bangladesh: addressing economic exclusion in a way that is health promoting**

Disabled and divorced women face particular discrimination and exclusion in Bangladesh. Hathay Bunano is a social business enterprise manufacturing handicrafts, toys, and knitwear for the export market. This innovative business model allows export-quality items to be produced in 19 rural centres staffed by 1,800 women throughout Bangladesh. Most employees of Hathay Bunano are female and the company particularly seeks to employ excluded populations, such as divorced, illiterate and disabled women (127). Many disabled women employed by Hathay Bunano are provided with housing where they work because their families are not willing to take them back after rehabilitation.

The company partners with the Centre for Rehabilitation of the Paralyzed (CRP), the premier hospital and rehabilitation centre for the disabled in Bangladesh. The CRP provides therapy, rehabilitation, and vocational training to disabled men, women, and children. Hathay Bunano has integrated their production training with the vocational training at the CRP and has established two production centres staffed entirely by workers who finished the rehabilitation programme at the CRP. The partnership with the CRP enables Hathay Bunano to find good disabled workers and ensures high-quality healthcare and therapy for their disabled workers (127).

Advances in information technology can promote economic inclusion for the poor and excluded, for example using mobile phone banking to enable customers in remote areas to send money, receive remittances and pay for purchases (110). Prepaid smart cards are already used in countries such as Papua New Guinea to pay for such services as electricity. Cocoa farmers in Papua New Guinea receive their payments over mobile phones (115). The Reserve Bank of Fiji is also partnering with mobile phone companies to provide 'mobile money' for all (110). In India, a unique biometric identification enables poor families with no formal documentation to open bank accounts and receive cash transfers (110). Offering financial services to the poor can allow them to participate in the cash economy, and also makes good business sense. In the Philippines, a company, which provides prepaid phone services mainly to low-income consumers, has become the most profitable of the country's largest corporations (110).

## Chapter 3: Health systems to promote health equity

### CSDH Recommendations:

- Build health systems based on principles of equity, disease prevention, and health promotion.
- Ensure that health system financing is equitable.
- Build and strengthen the health workforce, and expand capabilities to act on the social determinants of health.

### Introduction

The health system is influenced by and influences the effect of other social determinants (128). Gender, education, occupation, income, ethnicity, and place of residence are all closely linked to access to, experiences of, and benefits from health care (1). In this sense the health system is capable of both increasing and decreasing health inequities, depending on how it is configured and performs. Health systems can be damaging to health through their impact on wider social determinants, as illustrated by the negative impact on health equity of catastrophic health expenditures that are incurred by many countries in the Asia Pacific region. Health systems can improve the health of some populations while at the same time increase inequities if service provision is not being provided where the needs are greatest. Health systems can positively impact on health inequities. For instance, a well-functioning health system can do much to ameliorate the health inequities arising from other sectors, such as effective treatment of respiratory conditions arising from poor housing. The Asia Pacific Region has made significant progress in developing its health systems, and has often been a global leader in this field. Yet many challenges remain if health systems in the region are to play an effective role in addressing health equity.

### Pathways to health inequity through health systems in Asia Pacific

The World Health Organization (129) describes six “building blocks” that make up health systems:

1. Information
2. Financing
3. Service delivery
4. Health workforce
5. Medical products, vaccines and technologies
6. Leadership and governance (stewardship)

An examination of these health system building blocks in Asia Pacific reveals that large inequities in the levels of resourcing for health services exist between and within countries in the region, as well as the damaging impact on health equity of poorly performing health systems.

### **Information and evidence**

To impact effectively on health inequities, it is important that the health system has identified the populations with health inequities and the evidence of intervention effectiveness. A substantial issue that impacts on the design, delivery and evaluation of interventions is the availability, quality and use of evidence (130). In general, high-income countries in the Asia Pacific region have good epidemiological evidence relating to their population’s health (131). Having this detailed epidemiological profile of a country’s population has led to the general conceptualisation of the

socioeconomic patterning of health outcomes, other health inequalities and of the influences of the wider social determinants such as education, housing, employment and income.

At the other end of the spectrum there is an urgent need for evidence of local epidemiological profiles in some countries (132). Countries without epidemiological evidence of their populations may suffer 'blindness' as to the extent of inequitable access to, and use of, health care. An example from India illustrates this point. The epidemiological evidence indicates that in low or middle-income countries TB is more prevalent among men than women; however studies show that this may be explained by gender differences in the social pattern of interactions (133) rather than a true difference in prevalence. Utilisation data that is not able to be disaggregated by stratifiers, such as sex, ethnicity, place of residence and socioeconomic status can mask major inequities in health systems. For example, the New Zealand National Cervical Screening Programme has exceeded its coverage target of 75%, with 79.7% of women aged 25-69 years screened in the previous three years (134). Should New Zealand not have disaggregated health data to monitor health system access and performance, this screening programme would appear to be a national success. In fact the "target" has only been achieved for New Zealand women of European/Other ethnicity - for Māori, Pacific and Asian women in New Zealand, the programme has only achieved coverage of 57.8%, 64.7%, and 67.8% respectively (134). The second issue is the evidence of intervention effectiveness. Even where there is good epidemiological evidence of the characteristics of populations, countries are still grappling with how to effectively intervene to increase equity in health outcomes (17).

### ***Health financing***

There are two questions we will consider concerning health financing. The first is how much does a country spend on health services? As shown in Table 8, in 2008, total health expenditure per capita in the Asia Pacific region ranged from US\$12 for Myanmar to 348 times more at US\$4,180 for Australia. On average, high-income countries in the region spent about US\$2200 per capita in health care, which was about 19 times higher than middle-income countries (US\$117), and 67 times higher than low-income countries (US\$33).

Health expenditure as percentage of GDP (Table 8) ranged from 2.3% for Myanmar and Indonesia, 3.5% in Tonga to 9.7% for New Zealand. On average, high income countries in the region spent 6.8% of GDP in health services, higher than low- and middle-income countries. Interestingly, the GDP share of health expenditure for low-income countries (4.4%) was higher than that for middle-income countries (3.8%).

A second issue in relation to financing is who pays for health services and what is the impact of that payment mechanism? The sources of health financing can be broadly classified into two categories: public and private. Public sources mainly include tax and social health insurance. In 2008, Myanmar (7.5%) and the Lao People's Democratic Republic (17.6%) had the lowest public share of health expenditure, while Mongolia (81%), Japan (80%), New Zealand (80%), and Papua New Guinea (80%) had the highest public share (Table 8). On average, 60% of health expenditure in high-income countries in Asia Pacific came from public sources, compared with 57% for middle-income countries, and 27% for low-income countries. Importantly, external aid played an important role in some Asia Pacific countries such as Papua New Guinea, Cambodia and the Lao People's Democratic Republic. For a large number of Pacific island countries, donors accounted for 30-40% of health expenditure.

Of the private expenditure, out of pocket payments have the largest potential to impact on health equity.

**Table 8 - Health expenditure, workforce and infrastructure in the Asia Pacific Region, 2008 (or nearest year available)**

Countries/ Economies	Health expenditure per capita (US\$) 2008	GDP share of health expenditure (%), 2008	Public share of health expenditure (%), 2008	Physicians per 10,000 people, 2000-2010	Nurses per 10000 people, 2000-2010	Hospital beds per 10000 people, 2000-2009
Australia	4180	8.5	65.4	48	78	77
Japan	3190	8.3	80.5	21	41	138
Singapore	1404	3.3	34.1	18	59	31
Hong Kong (China)	1351	5.1	52.0	18	55	50
New Zealand	2917	9.7	80.2	24	109	62
Republic of Korea	1245	6.5	53.9	20	53	123
Malaysia	353	4.3	44.1	9	27	18
Fiji	145	3.5	75.3	5	20	21
Thailand	164	4.1	74.3	3	15	22
China	146	4.3	47.3	14	14	41
Indonesia	51	2.3	54.4	3	20	6
Sri Lanka	83	4.1	43.7	5	19	31
Philippines	68	3.7	34.7	12	60	5
Mongolia	73	3.8	81.4	28	35	59
Papua New Guinea	39	3.2	80.1	1	5	-
India	45	4.2	32.4	6	13	9
Viet Nam	76	7.2	38.5	12	10	29
Lao People's Democratic Republic	34	4.0	17.6	3	10	12
Cambodia	43	5.7	23.8	2	8	-
Bangladesh	17	3.3	31.4	3	3	4
Nepal	24	6.0	37.7	2	5	50
Myanmar	12	2.3	7.5	5	8	6
<b>High income</b>	<b>2202</b>	<b>6.8</b>	<b>60.5</b>	<b>23</b>	<b>62</b>	<b>75</b>
<b>Middle income</b>	<b>117</b>	<b>3.8</b>	<b>56.8</b>	<b>8</b>	<b>23</b>	<b>24</b>
<b>Low Income</b>	<b>34</b>	<b>4.8</b>	<b>26.1</b>	<b>4</b>	<b>7</b>	<b>20</b>

Source: Adapted from (26,44,135)

A major health equity issue for the region is the potential of out of pocket payments to health systems to drive families into poverty making inequities worse. Catastrophic health expenditure

occurs when a family spends more than 40% of its income on out of pocket health care costs (136). Based on an analysis of World Health Survey data, Table 9 demonstrates that the proportion of households facing catastrophic healthcare expenditure ranges from a low of 3% to a high of 30% for selected countries of the region (136).

**Table 9- Percentage of households experiencing catastrophic health costs**

Bangladesh	30.0%
India	28.6%
Lao People's Democratic Republic	23.6%
China	14.4%
Nepal	14.2%
Philippines	13.6%
Viet Nam	13.1%
Sri Lanka	12.3%
Myanmar	10.2%
Malaysia	3.4%

Source: (136)

The World Health Assembly stated in 2005 that everyone should be able to access health services and not suffer financially when doing so (137). So far, this goal has not been achieved in Asia Pacific. Currently, certain health delivery systems and health financing mechanisms exacerbate social exclusion – the poor can incur catastrophic out-of-pocket expenditure resulting from the burden of ill-health, pushing them deeper into poverty.

### ***Health workforce and infrastructure***

Health workforce and infrastructure is central to delivering health services equitably and demonstrates a similar disparity as finances. The health workforce can be defined as all people engaged in actions whose primary intent is to enhance health (138), but attention is often focused on physicians, nurses and midwives and there is generally better available data on these groups. Supply of the physician workforce varies widely across countries in the Asia Pacific region. As shown in Table 9, the number of physicians per 10,000 people in 2008 ranged from 0.5 in Papua New Guinea to 47 in Australia. On average, the ratio of physicians to population for high-income economies in the region was 23, followed by 8 for middle-income economies and 5 for low-income economies. Nurses and midwives were also unevenly distributed across the Asia Pacific region. The number of nurses and midwives per 10,000 people ranges from 2.7 in Bangladesh to 109 in New Zealand. On average, the ratio of nurse/midwife to population for high-income economies was 61, compared with 23 and 7 for middle- and low- income economies, respectively.

The health infrastructure consists of hospitals, clinics, health centres, and other facilities where health services are delivered. Hospitals often receive disproportionate attention and account for largest share of health expenditure. The supply of hospital beds across the Asia Pacific region is

dramatically uneven. The number of hospital bed per 10,000 people in 2008 ranged from 4 in Bangladesh to 138 in Japan. On average, the ratio for high-income economies was 75, which was about 3 times higher than middle-income economies and 10 times higher than low-income economies.

### ***Services delivery and access***

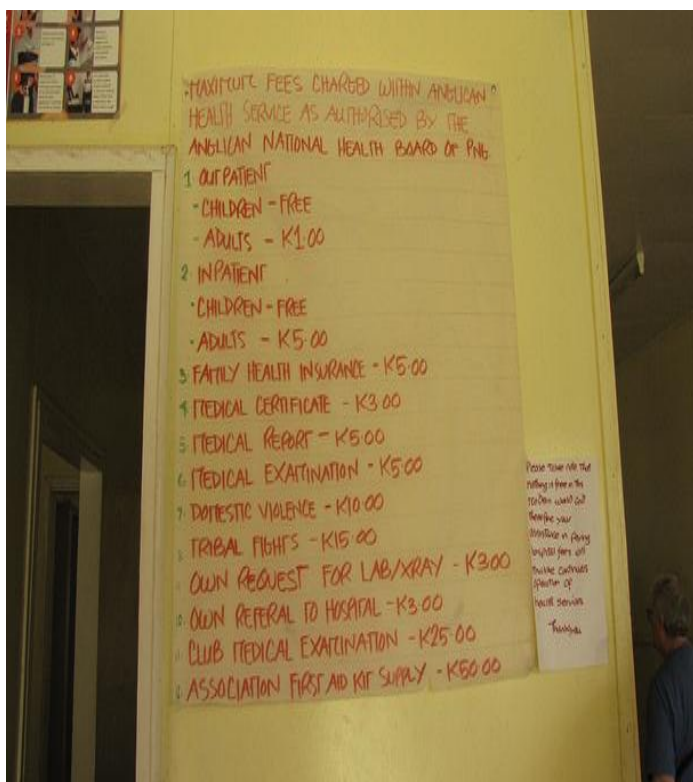
For health services to impact on health equity, the health services need to address the disease burden in the particular population they are serving. Both the range of health services and their accessibility, particularly to the most vulnerable groups in the population, are important.

Access barriers are not limited only to affordability and availability issues, but also to the acceptability of services, and contact coverage - the proportion of the population who actually have had contact with an appropriately skilled and equipped health service provider (139).

When health systems are designed by and for the mainstream, they may not be appropriate or acceptable to the needs or worldviews of many socially excluded groups – further exacerbating the health consequences of social exclusion. Migrants, ethnic minorities, and indigenous people often have different health care needs and preferences, and face additional barriers (e.g. transport, language, education, cultural). The combination of these factors means that health services are often less acceptable, appropriate and accessible for these groups. For example, in Mt Isa in Australia, cultural barriers were considered differently by Aboriginal patients and health practitioners. While Aboriginal patients focused heavily on social relationships and issues of respect and trust, practitioners were more often focused on making Aboriginal people feel comfortable with changes to physical environments and systems, with less emphasis on creating strong interpersonal relationships (140). A “one-size-fits-all” approach to health services provision is not an equitable approach. A more flexible approach to service delivery that is based around the various needs of different communities and groups is needed, if health services are to be equally accessible, appropriate, acceptable and effective (127). Evidence from New Zealand suggests that indigenous groups experience poorer outcomes at all levels of the health care pathway (from screening to diagnosis to treatment and care), resulting in compounding systematic discrimination, and contributing to the marked life expectancy gap between indigenous and non-indigenous New Zealanders (141,142).

Women also suffer from health systems that are not designed to meet their needs. In South Asia there are limited opportunities for women to train as health professionals. This results in both underrepresentation of women’s needs and in girls and women missing out on medical treatment, since they are prevented by custom from seeking treatment from male health professionals. In some areas there is deliberate gender discrimination in healthcare provision. A study in Bangladesh observed that rural girls suffering from diarrhoea were less likely than boys to receive an antibiotic, and urban girls were less likely to be seen by a licensed allopath (143). Moreover, in rural China, women are more likely than men to go blind as a result of cataracts, corneal opacity and glaucoma, all of which are treatable (144). Health systems can block women financially too. Women often face higher healthcare costs than men due to more frequent usage and lacking access to the health benefits associated with a full-time, formal job (145).

Broadly, there are two types of health services: personal health services and public health services. For personal health services, comparative data are often difficult to obtain; Table 10 presents two core indicators: the number of doctor consultations per capita and the number of hospital discharges per 1000 people. On average, low- and middle-income countries have substantially fewer doctor consultations and hospital discharges than high-income countries. Interestingly, some middle-income countries such as Sri Lanka and Mongolia tended to have a higher hospital discharge rate than high-income countries, possibly reflecting the degree that hospitals are providing the primary care function in those countries. Yet, within high-income countries there remained a great



Source: Christopher John, Papua New Guinea, 2010  
<http://www.flickr.com/photos/friarsbalsam/4610955084/in/set-72157623942361121>

variation of health care utilisation. For example, in 2008 the number of doctor consultation per capita ranged from 4.3 in New Zealand and 6.4 in Australia to 13.0 in the Republic of Korea, and 13.4 in Japan. The number of hospital discharges per 1000 population ranged from 102 in Singapore and 107 in Japan to 163 in Australia and 234 in Hong Kong.

The scope of public health services has been growing. This analysis is limited to the following primary health care indicators: percentage of births attended by skilled health personnel, infant immunisation coverage rate for DPT (diphtheria, pertussis & tetanus) and measles, and percentage of population using improved drinking-water sources and sanitation. On average, almost all high-income

countries achieved near-perfect performance in these five indicators, as shown in Table 10. However, the performance of low- and middle-income countries is uneven. Infant immunisation coverage rates for DPT and measles are more than 80% for the majority of countries except India (DPT 66%; measles 71%), Papua New Guinea (64%; 58%), and the Lao People's Democratic Republic (57%; 59%). The percentage of births attended by skilled health personnel ranged from around 20% in the Lao People's Democratic Republic, Nepal, and Bangladesh, to close to 100% in China, Fiji, Malaysia, Mongolia, Sri Lanka, and Thailand. For improved drinking-water sources, the population coverage rate varies from 41% in Papua New Guinea, 57% in the Lao People's Democratic Republic, and 61% in Cambodia to 98% in Thailand and 100% in Malaysia. As for improved sanitation, the population coverage rate ranges from 29% in Cambodia and 31% in India and Nepal, to 96% in Malaysia and Thailand.

Table 10 - Utilisation of personal and public health services in the Asia Pacific Region, 2008 (or nearest year available)

Countries/ Economies	Doctor consults per capita 2008	Hospital discharges per 1000 people 2008	Births attended by skilled health personnel 2000-2010	DPT immunis- -ation coverage (%) 2009	Measles immunis- -ation coverage (%) 2009	Population using improved drinking- water sources (%) 2008	Population using improved sanitation (%) 2008
Australia	6	163	99	92	94	100	100
Japan	13	107	100	98	94	100	100
Singapore	9	102	100	97	95	100	100
Hong Kong (China)	11	234	100	95	95	100	99
New Zealand	4	140	96	92	89	100	-
Republic of Korea	13	162	100	94	94	98	100
Malaysia	4	109	100	95	95	100	96
Fiji	3	89	99	99	94	-	-
Thailand	2	137	99	99	98	98	96
China	2	60	99	99	94	89	55
Indonesia			73	82	82	80	52
Sri Lanka	5	254	99	97	96	90	91
Philippines			62	87	88	91	76
Mongolia	6	228	99	95	94	76	50
Papua New Guinea	1	36	53	64	58	41	45
India			47	66	71	88	31
Viet Nam	2	120	88	96	97	94	75
Lao People's Democratic Republic			20	57	59	57	53
Cambodia			44	94	92	61	29
Bangladesh		38	18	94	89	80	53
Nepal			19	82	79	88	31
Myanmar			37	90	87	71	81
<i>High income</i>	<i>10</i>	<i>147</i>	<i>99</i>	<i>95</i>	<i>94</i>	<i>100</i>	<i>100</i>
<i>Middle income</i>	<i>3</i>	<i>131</i>	<i>83</i>	<i>88</i>	<i>87</i>	<i>84</i>	<i>66</i>
<i>Low Income</i>	<i>-</i>	<i>-</i>	<i>38</i>	<i>86</i>	<i>84</i>	<i>75</i>	<i>54</i>

Source: Adapted from (26,44,135)



One of the major service delivery issues facing Asia Pacific is the rise of NCDs, which are responsible for almost 80% deaths in the region (146). NCDs require a personal and public health response, but so far the public health response is underutilised. Across the region, there has been strong and effective action in developed countries in relation to tobacco (e.g. Australia, New Zealand, the Republic of Korea and Japan) but a weak response in the low and middle income countries. Obesity remains an unmet challenge in both developed and developing countries, with rising rates in some countries despite government control attempts (146,147).

There has also been a development in approaches to intervention that, in some developed countries, has seen a move away from a focus solely on curative and behavioural interventions to a greater focus on prevention that include some of the social determinants of health. These developments have led to intersectoral approaches to intervening to improve health outcomes that go beyond the role of the health system, and are seen in movements active in the region such as “Healthy Islands”, “Healthy Cities” and “Health in All Policies” and a range of other health promotion programs and initiatives (73,148,149) .

### ***Medicines, vaccines and technology***

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use (129). International research (150) on the availability and affordability of selected essential medicines for chronic diseases shows a marked variation between countries, including those in the Asia Pacific region (Sri Lanka, Nepal, Pakistan, Bangladesh).

Access to medicines, vaccines and technology in the Asia Pacific region forms a significant part of the global trading system and is strongly influenced by the 1995 WTO Trade-Related Aspects of Intellectual Property Rights (TRIPS) (151) agreement and the subsequent Doha Declaration (152). This agreement introduced global minimum standards for protecting and enforcing nearly all forms of intellectual property rights, including those for medicines’ patents. The current minimum standards in the TRIPS Agreement — historically derived from those of developed countries — may not necessarily be appropriate for developing countries struggling to meet health and development needs. The new obligations have dramatically changed the legal framework for the production, supply and access to affordable medicines in the region. Although the Doha agreement did make provisions for public health: “the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health” (152). In this regard, the Doha Declaration enshrines the right of WTO Members to make full use of the safeguard provisions of the TRIPS Agreement in order to protect public health and enhance access to medicines for poor countries. However, relatively few countries have the capacity to access these provisions, and the current debate (153) on using these provisions in relation to the NCD burden suggests these provisions are inadequate in practice to ensure universal access to medicines for the major disease burden in the region.

In Sri Lanka, the availability of locally manufactured medicines was generally better than medicines that were not produced domestically, indicating the potentially important role local manufacturing may have in increasing the supply of medicines. It is this ability to find local solutions that is important for improving access, and is hampered by trade agreements.

Pharmaceutical purchasing is particularly vulnerable to corruption, which is a significant issue for the region (154). Where adequate systems, processes and transparency exist, national decision-making and purchasing mechanisms can guide rational, cost-effectiveness-based selection of medicines and reduce costs through bulk purchase.

### ***Leadership and governance***

Pursuit of health equity requires strong government leadership. The dominant provider and funder of health services in the region is the government, and there are compelling reasons for a strong role by government in health systems. However government cannot do it alone, and need effective ways of interacting with other sector players both inside and outside the health sector if equity issues are to be addressed.

This role, described as “stewardship<sup>1</sup>” involves articulating the principles, values and goals of the health system, with an emphasis on universal access, equity, people-centred care, leadership and healthy public policy. This requires the government to differentiate its role in service provision from its role in leading the whole sector. It requires increased recognition by government of the potential actors in the sector, and recognition of the ability of partners inside and outside the health sector to contribute (and detract from) the attainment of the government’s health goals. In summary, the government needs to take into account the pluralistic nature of the health system and move away from a process-based approach to an outcome-oriented approach by actively engaging in setting the ground rules and mediating the social contract for health where it can strategically engage other health system actors. The tools include ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability (129). This review has not documented the extent of the development of stewardship roles across governments in the region, however we have highlighted leading examples (Thailand, Health in All Policies/Adelaide) where this role is being developed, and these examples are discussed in Section 4, Chapter 4.

### ***Community participation & control***

The health system response to address health equity needs to be done with people as active players, not dependent recipients. The concept of community involvement in primary health care (PHC), that views people not only as recipients but as active participants in the planning and implementation of care, was first articulated in the Alma-Ata declaration of 1978 (156):

*“The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.”*

The approach has recently been re-examined and further endorsed by WHO (157). The effectiveness of strong primary health infrastructure on health outcomes has substantial evidential support (158) as does the specific element of community control (159).

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<sup>1</sup> WHO defines stewardship as ‘the careful and responsible management of the wellbeing of the population’(155).

<sup>2</sup> A Gini coefficient of 0 indicates perfect equality, whereas a Gini coefficient of 1 indicates perfect inequality. A

Evidence suggests that health and social outcomes can be improved by empowerment strategies that support community participation in decision making and oversight of healthcare (160). The condition for success is that the strategies are embedded in local contexts and are based on a strong and direct relationship between people and their health workers.

This approach has particular importance for indigenous peoples in the region, who routinely experience worse outcomes than non-indigenous people. The United Nations Declaration on the Rights of Indigenous Peoples (161), adopted by the United Nations General Assembly in 2007 states: “Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.”

Indigenous controlled services have been shown in some settings to out-perform other delivery mechanisms for marginalised communities. A recent study in New Zealand demonstrated a lowering of ambulatory care-sensitive admissions through PHC and that improvements in access to care for Māori were most marked for the population served by Māori controlled providers (162).

### What’s happening in health systems across Asia Pacific?

The Asia Pacific region has world leading examples of health systems directly approaching health equity, including developing universally accessible primary health care systems, strong preventive programs, and direct engagement in the wider social determinants of health. However in the region, there are significant tensions between health services being seen as tradeable commodities and health services as a human right, contributing to health equity.

There are a number of policies and programmes that have been effective in Asia Pacific to reduce inequities in health system access or outcomes. The health sector also has a role in broader action on SEDH, including governance, advocacy, facilitating inter-sectoral collaboration and capacity building. These functions will be discussed under governance approaches in Section 4 Chapter 4. Measures to improve the collection and use of data to monitor health system performance on equity are discussed in Section 5.

#### ***Strengthening Comprehensive Primary Health Care***

A primary health care approach has been embraced in some countries of the region, but not others. Those countries more actively introducing PHC include post-war countries rebuilding their health systems based on a PHC policy (e.g. Cambodia, Lao People’s Democratic Republic, Viet Nam), countries which have systematically developed their health systems based on the PHC policy (e.g. Fiji, Malaysia – see Box 18) and countries which enthusiastically embraced PHC after Alma-Ata in 1978 but are struggling to build upon these gains (Federated States of Micronesia, Kiribati, Marshall Islands, the Philippines, Samoa, the Solomon Islands) (163).

**Box 17 - Australia: Aboriginal Controlled Health Services**

Despite having a universal publically funded health care system (Medicare), in 2001-2 per person Medicare expenditure for Indigenous Australians was only 39% of that for other Australians (164).

The first Aboriginal Community Controlled Health Service (ACCHS) established at Redfern in 1971, was a reflection of the aspirations of Aboriginal people for self-determination (165). It was also a response to the urgent need to provide decent and accessible health services, to address some of the barriers restricting the access of Aboriginal Australians to quality health care in mainstream Australia—including miscommunication and lack of communication between non-Aboriginal providers and Aboriginal patients; mistrust of the mainstream health care system by Aboriginal people; and poor understanding on the part of many non-Aboriginal health professionals of the impact of their own cultures on the way in which they provide health care (166).

An ACCHS is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community that controls it (through a locally elected board of management). There are currently over 130 Aboriginal medical services in Australia, varying greatly in size and staffing levels. ACCHSs exemplify the differences in the style, type and range of care provided when policies and services are designed and delivered by organisations that are a practical expression of Aboriginal self-determination (166).

The Health is Life Inquiry into Indigenous Health (167) listed the benefits a properly resourced community-controlled health service can deliver:

- significantly improved access—because the local community has ownership and control of the service, and because service delivery is flexible and responsive
- the full range of primary health care services available in one place—with service delivery being integrated and holistic
- culturally appropriate care
- value for money, as services can be better targeted because they are based on local knowledge
- a major source of education and training for Aboriginal people
- a pool of knowledge and expertise about Aboriginal health that enables the sector to not only deliver appropriate care but also to advocate effectively for Aboriginal people in health.

ACCHS are represented by a national umbrella organisation, the National Aboriginal Community Controlled Health Organisation (NACCHO), which undertakes activities such as workforce development, national policy advocacy, training and research to improve the effectiveness and cultural validity of national policies, programs and initiatives affecting Aboriginal health, as well as seeking to promote and expand the provision of culturally appropriate primary care(165). NACCHO and the services it represents are prime examples of Aboriginal peoples taking responsibility for their health through: comprehensive primary health care provision, ground-up approach to health policies, strategic partnerships, and the promotion of Aboriginal cultural integrity (165).

Box 17 describes how Aboriginal Controlled Health Services have successfully improved health services access for indigenous Australians. However, mainstream services have also demonstrated success at improving access for marginalised groups. The Inala Indigenous Health Service, a mainstream health service in Queensland, Australia improved Indigenous access from 12 Aboriginal

and Torres Strait Islander patients in 1995 to 4000 patients in 2009 (with a stable Aboriginal population) (168). The health services conducted indigenous community focus group and telephone interviews, revealing barriers such as: few items (e.g. artwork) that Indigenous people could identify with; lack of Indigenous staff; staff perceived as unfriendly; inflexibility regarding time; and intolerance of Indigenous children's behaviour (169). The health service set about addressing these barriers and employed more indigenous staff, culturally friendly waiting room, provided cross-cultural training for all staff and worked with indigenous community to promote awareness about the health centre.

Papua New Guinea is embarking on an ambitious long-term project to re-vitalise rural primary health care in eight provinces serving over one million people (170). The project aims to transform health services for the rural majority through development of community health posts, a primary entry point to the rest of the health system, which provides a basic set of services and houses community health workers. The project will build approximately 32 new facilities and upgrading around 128 existing facilities as well as staff housing. In addition to physical infrastructure, the project addresses the governance/management, funding, workforce, supply, referral and information/communication gaps that contribute to the breakdown in the current system. The aim is to create an adaptive, innovative and learning rural health sector. Specific strategies will include direct-to-facility funding, local health system mentors and supportive supervision, formative evaluation, training (clinical and management) and will utilise advances in geographic information systems and mobile communication technology (170).

**Box 18 – Malaysia: a system based on Primary Health Care**

The thrust of the Malaysian health care system is primary health care, supported by an inclusive referral system to decentralized secondary care and regionalized tertiary care. This model of comprehensive public primary health care delivers promotive, preventive, curative and rehabilitative care across the life course. The network of static health facilities is organized into a two-tier system which includes outreach services for remote areas. Community participation is encouraged through village health promoters, health volunteers and advisory panels. The primary health care approach has delivered increased access to health care at a relatively low-cost. This has translated into health gains for the Malaysian population comparable with countries of similar economic development.

Source: Ministry of Health, Malaysia (174)

**Box 19 – China: primary health care fundamental to health reforms**

Even before the Alma Ata Declaration, China had a health care system providing basic health care to almost all the country's population. However from the 1980's this system deteriorated, but now there is once again a major drive to regain a fair and effective health system (171,172). The economic reforms of the late 1970s brought significant change to the way the system was run. While the government continued to invest in health, market-oriented financing mechanisms were implemented to fund both curative and preventive care, resulting in health services becoming unaffordable and inaccessible for disadvantaged populations. By the late 1980s, the rural health insurance scheme had collapsed. Urban health insurance schemes were also crippled by the rapid rise of medical costs and the inefficiency of state-owned enterprises - their main financiers (173). Since then, the lack of coverage provided by the health insurance system and inadequate government support for essential public health programs have been identified as the main obstacles to universal coverage. Public dissatisfaction with health sector performance along with emerging public health problems, notably SARS in 2003, became driving forces for reform.

In March 2009, China's government announced its blueprint for health system reform with the aim to establish universal coverage that provides "safe, effective, convenient, and affordable basic health services" to all urban and rural residents. This policy is the outcome of protracted discussion and debate regarding the main challenges faced by the domestic health system as well as trends in international health care development. Core government policy regarding the establishment of a harmonious society makes the issue of equity in health and health care of paramount importance. Improving people's access to basic health care has thus become a guiding principle in development policies, and the needs of vulnerable populations have received particular attention. The new round of health sector reform announced in 2009 is backed by strong political and financial support, notably from a high level committee at the central level which is overseeing implementation. In addition to the regular health budget, 850 billion Chinese Yuan (US\$ 126 billion), has been committed for the funding of reform activities between 2009 and 2011. In China, the core issue is to extend coverage to disadvantaged areas and populations, which is anticipated to have a significant impact on health equity.

***Universal coverage & reducing out-of-pocket costs***

Many countries in Asia Pacific have been striving for universal health coverage for some time, including New Zealand (1938), Japan (1961), Australia (1984), Republic of Korea (1989) and Thailand (2002). Successive Governments of Sri Lanka have been committed towards universal health coverage and providing health free of charge. Japan achieved universal health coverage in 1961, through the establishment of employee-based and community-based social health insurance schemes, of which there are now approximately 3500 (175). Enforcing the same fee schedule for all plans and almost all providers has maintained equity and contained costs; and the co-payment rate has become the same for all, except for elderly people and children. This has been achieved by the provision of subsidies from general revenues to plans that enrol people with low incomes, and enforcement of cross-subsidisation among the plans to finance the costs of health care for elderly people. The Palau Health Care Financing Act of 2010 is Palau's first step towards an improved, comprehensive healthcare financing system – under the Act employees contribute 2.5% of their

wages, matched by contributions from their employers, to fund a Medical Savings Account and National Health Insurance scheme (176). Further case-studies of countries' efforts to achieve universal health coverage are described in Box 20 to Box 21.

#### **Box 20 – Republic of Korea: path to universal coverage**

The road of the Republic of Korea to universal coverage began with the enactment of Health Insurance Law in 1963 (177). The Law permitted voluntary health insurance, which virtually proved to be a failure. Accordingly, the Health Insurance Law was revised in 1976 to include the mandatory enrolment of the population, accompanied by the Medical Aid Program to cover the low income, indigent, disabled and elderly in 1977. The compulsory health insurance started from employees in large firms, and expanded to government employees and private school teachers in 1979, to employees of small firms in 1983. By 1989, when all self-employees and residents became mandatory, the Republic of Korea achieved the goal of health care for all. Overall, the Republic of Korea took 12 years to cover the entire population. When the compulsory health insurance was first introduced, the Republic of Korea's per capita GDP was only US\$1,042, compared to US\$5,430 in 1989. Importantly, there was no labour party or social democratic political party at that time, and labour unions became active only in the late 1980s. Thus it was the authoritarian political regime and its motivation for political legitimization that played a key role in the development of universal health coverage. For example, the ruling party made an effort to expand mandatory coverage to self-employees and residents to gain the popularity for the first time presidential election by universal suffrage in 1987. However, the government had incrementally expanded the coverage of population at expense of limited benefit package with a low contribution rate and high cost sharing.



Source: sellyourseoul, Republic of Korea, 2010

<http://www.flickr.com/photos/sellyourseoul/4273474792/sizes/z/in/photostream/>

**Box 21 – Thailand: Universal Coverage Scheme**

Thailand has been approaching universal coverage since 2001. The history of universal coverage in Thailand began from targeting some specific groups of population followed by expanding coverage to other groups until covered all the population. The workers in formal sector were the first group of coverage who were protected from work injury, illnesses, and funeral grants under workmen compensation scheme in 1974 (178) expanding benefit to illness not related to work by introducing social security scheme (SSS) in 1990. The poor, who were exempt from user charges, were another target group by introducing low income card in 1975. This scheme has expanded to elderly, children under 12 years, the disabled, and veterans in the 1990s. The community health base insurance scheme was introduced in 1983 based on maternal and child health which was under the principle of primary health care. This scheme moved to the health card scheme (HCS) in 1991. Government employees and dependents received medical benefit under Civil Servant Medical Benefit Scheme (CSMBS) as fringe benefit from lower salary in 1980. By 2001, Thailand achieved universal coverage by merging almost all schemes (except for the SSS and CSMBS) to be covered by the universal coverage scheme (UCS).

Three main factors accounted for the success of moving to universal coverage in Thailand (179). The first was the knowledge gained from implementation of Thailand's previous health insurance schemes. The second was the civil society movement. In 2001, social movement from NGOs mobilized more than 50,000 people to support the universal health coverage bill and encourage parliament to consider the bill. The third crucial component was political leadership.

The implementation of universal coverage in Thailand was associated with three major reforms. The first reform was a budgeting process which aimed to move from high out of pocket payments to general tax in UCS. This led to an increase in public payment from about 55 % in 2001 to nearly 75 % in 2009 (180). The second reform was promoting the use of primary care by contracting a primary care unit as the main contractor and gatekeeper and making a comprehensive core benefit package by adding prevention and promotion through hospital care and rehabilitation. The third reform was changing the provider payment system from historical allocations to close-ended payments by introducing capitation as a basic payment in ambulatory care, promotion and prevention while using prospective payment by diagnosis related group with a global budget for inpatient service.

Between 2001 and 2005, the UCS substantially reduced Thailand's uninsured population (from 42.5% to 7.0% in urban areas and from 24.9% to 2.7% in rural areas) (181). The implementation of the UCS has also changed patterns of health services use, particularly for rural people and the urban poor, by placing greater emphasis on primary healthcare.

In 2010 WHO released a health-financing strategy for the Asia Pacific region (2010–15), developed jointly by the Southeast Asian and the Western Pacific regions and agreed to by all member states (182). The plan asks member states to reduce out-of-pocket spending to no more than 30–40% of total health expenditure, raise health expenditure per country to at least 4–5% of gross domestic product (GDP), develop systems to cover over 90% of the population by some form of prepayment, and put in place “extensive safety-net provisions” for “especially vulnerable sectors of the population”.



The reforms launched in China in 2009 to improve insurance coverage, build upon their previous rural health cooperative schemes (182). The reimbursement levels for these schemes were initially very low leaving the rural poor heavily indebted. The Chinese Government has set up a 16-city pilot to study the effectiveness of paying the provider directly by the government or the health insurer. The National Pilot Medical Financial Assistance Scheme (MFA) has been implemented in rural and urban areas of China to improve the poorest families' accessibility to health services (183). Local governments formulated various benefit packages, covering varying mixes of inpatient service,



Source: inyuch, China, 2010  
<http://www.flickr.com/photos/inyuch/4370095126/>

preventive and curative health services, some covering out-patient services and reducing co-payment rate. The new extended benefit package reduced poor families' demand of hospitalization services for their chronic diseases, and improved the poor population's utilization of out-patient services to some degree. However, chronic disease and hospitalization were strongly associated with the presence of large amount of medical debt, which indicated that: although establishment of MFA had facilitated accessibility of poor families to this new system, its role in reducing poor families' medical debt resulted from chronic disease and hospitalization was still very limited. To improve MFA benefit package design in the future, out-patient services also need to be covered, as well as reducing co-payment rate to provide more protection to the poor families (183).

### ***Improving performance on equity throughout the health system***

An evaluation of public contracting for health services in Cambodia noted that monitoring was essential to assure quality when contractual payments are linked to performance, and that auditing skills are very important to detect such problems as "ghost patients", excessive charges, and reporting fraud (184).

In New Zealand, there is a legal requirement for District Health Boards (DHBs) to deliver health services equitably and to actively work to remedy current health inequities, particular those faced by Māori. Waitemata DHB developed an Equity Framework (185) to assist staff working in the Planning and Funding team incorporate equity in their day to day work in a practical and systematic way. Developed in conjunction with planning and funding staff, it looked at the major steps in the planning and funding cycle, and developed guidance/templates to help these processes occur in a way conducive to achieving equity. This project noted however that optimising planning and funding processes to consider equity is unlikely to be sufficient on its own. Significant progress towards equity requires a multi-level approach, including commitment at all levels of the

organization, and a dual strategy – both integrating equity into all core business, along with additional equity-specific measures supported by an equity funding stream (185,186).

### ***Equitable access to medicines and new technologies***

A number of countries have used the flexibilities allowed under TRIPs to improve access to medicines. Domestic industries outside the developed countries have been able to develop in places where strong protection for product patents did not exist, such as Bangladesh, and India. The Indian Patents Act of 1970 (amended in 1999, 2002 and 2005 to comply with TRIPs) allowed Indian companies to develop and market generic versions of patented drugs. In Indonesia in 2004, a presidential decree enabled “government use” of certain anti-retroviral drugs that were still protected under patent, on the basis of urgent need in the effort to control HIV/AIDS epidemic (187). This decree authorised the Ministry of Health to appoint a pharmaceutical factory as the manufacturer for and on behalf of the Government. Compulsory licenses, another flexibility permitted under TRIPs, can be granted by the government to permit third parties to use a patented invention without the patent holder's consent. Using such licenses, local pharmaceutical companies may produce generic versions of patented medicines or generic versions of medicines may be imported from foreign manufacturers. Thailand is one such country using domestic compulsory licenses as a policy tool for ensuring public access to affordable medicines (188). When Cambodia joined the WTO in 2004, it had to implement the TRIPs Agreement in its domestic law. However, as a Least Developed Country (LDC) Cambodia had the option of not allowing for patents on medicines till 2016 - so Cambodia enacted a patent law which includes a simple provision withholding patents on pharmaceutical patents until 2016 (187). Centralised oversight of drug purchasing and subsidization in New Zealand has significantly improved access to essential medicines while lowering the average prescription price (157).

**Box 22 – Thailand: Health Intervention and Technology Assessment Program**

Thailand's economic status and health financing reforms, as well as their effects on government budgeting for medical and public health services, played an important role in the increasing needs and demands for health technology assessment information among policy makers. In the midst of substantial economic growth during the years 1982 to 1996, several studies reported the rapid diffusion and poor distribution of health technologies, and inequitable access to high-cost technology in public and private hospitals.

As a result, Thailand established the Health Intervention and Technology Assessment Program (HITAP) in 2007 as a non-profit organization, under Ministry of Public Health. HITAP is set up to assess the health intervention and technology on pharmaceuticals and medical devices and clinical practices for policy advocacy. The assessment is based on cost effectiveness, social impact and ethics.

Examples of their work include assessing the cost-effectiveness of hepatitis B and C treatment, the feasibility and appropriateness of using PET-CT, economic evaluation and feasibility analysis of using three-drug antiretroviral regimens as the standard regimens for the prevention of mother-to-child transmission of HIV. This information helps the government to make a decision on investment and resource allocation for health systems based on the empirical evidence.

HITAP aims to cultivate the public interest and motivate the participation of all sectors in society in order to efficiently distribute and allocate the limited resources to fulfil the public health.

***Targeted interventions to address social barriers***

A government of Viet Nam programme for socio-economic development known as Program 135 (P135) targeted communes known to be relatively poor as priority localities for development resources (189). Under this programme, basic curative and preventive health services, including some prescription drugs, were provided free of charge at commune health centres (CHCs). In an effort to improve the quality of care provided at CHCs, the national Ministry of Health implemented a set of national benchmarks for commune health care, which defined a minimum configuration of equipment, staff, training and other elements of service provision. Communes exposed to the P135 policy did have higher utilization rates, but these effects were conditional upon achievement of benchmark standards. Perceived quality of care is therefore an essential prerequisite for service utilization, even when services are free (189).

**Box 23 - Viet Nam: financial subsidies for health care for the poor and social welfare beneficiaries**

The policy orientations of the Party and the Government have always paid great attention to the goal of ensuring equity in health care. The key documents in health care all affirm the need to ensure state budget support for health care for specific target groups including: people who contributed to the revolution, the poor, ethnic minorities, children under six years and social welfare policy beneficiaries. Health care for the poor and children has continued to be promoted. In 2002, the Prime Minister allocated funding from the central state budget to set up health care funds for the poor in provinces. This was followed by a decree issuing health insurance cards for the poor. The subsidy contributed to the health insurance fund for health insurance cards for the poor was also continuously adjusted upwards. From January 2010 the contribution for health insurance cards for the poor increased to 4.5% of minimum salary.

As for the near poor, starting in 2008, the Prime Minister declared that the state budget would support a minimum of 50% of the health insurance contribution. Also from 2010, the way free health care was delivered for children under six years was changed – instead of issuing free health care cards and direct reimbursement to facilities based on the care provided, health insurance cards were instead given directly at no cost to the family, along with reimbursement of health care costs.

Source: Ministry of Health (190)



Source: Nico Crisafulli, India, 2011  
<http://www.flickr.com/photos/nicocrisafulli/5581527538/>

Micro-insurance schemes have been used to address financial access barriers to health care. Micro-insurance for health in Bangladesh targeted towards the poor and the ultra-poor provides basic healthcare at an affordable rate whereas the Indian micro-insurance schemes for health have been implemented across larger populations and include high-cost and low-frequency events (191).

**Box 24 – Cambodia: health equity funds and vouchers**

In Cambodia, a health equity fund (HEF) scheme started in late 2005 (192) to improve access for the poor to hospital care services. The management of the HEF scheme was entrusted to two non-governmental organisations (NGOs), acting as a third party purchaser. NGO staff interview potentially poor patients at the hospitals to determine their eligibility for HEF assistance, using a questionnaire and eligibility criteria to classify interviewees into three categories of eligibility: very poor, poor and non-poor. The latter category is excluded from HEF assistance. According to the eligibility category, patients receive a full or partial benefit package, including payment for hospital user fees, payment for the cost of transportation to the health centre or hospital, food allowance during the hospitalization, and funeral cost in the event of death. The HEF brought new patients to public facilities, satisfying some unmet health-care needs. There was no perceived stigma for HEF patients but many of them still had to borrow money to access health care (193).

In 2007, the Ministry of Health and the Belgian Technical Cooperation initiated a voucher scheme (192) in to complement the existing HEF scheme for improving access to safe delivery for poor women in three rural health districts. Poor pregnant women are identified, using the same eligibility criteria as for HEF. Each eligible poor woman receives a voucher with five detachable coupons, which entitle her to free services at the health centre (for three antenatal care visits, delivery and one postnatal care visit) and transportation costs for five round trips between her home and the health centre, and for referrals from the health centre to the referral hospital in case of complications. User fees and other related costs at referral hospitals are paid for by the HEF. The percentage births in health facilities rose sharply after the introduction of the vouchers, although there was a steady decline in the number of voucher recipients attending each appointment from the first antenatal visit. A number of barriers remained - although the vouchers covered transportation costs, transport was often not available in the middle of the night, or was much more expensive than the standard rate covered by the voucher. Lack of childcare made it difficult for some poor pregnant women to leave their home for delivery, and some women reported poor staff attitudes and extra payments hinted by midwives. In the Cambodian context, vouchers plus HEFs, if carefully designed and implemented, have a strong potential for reducing financial barriers and hence improving access to skilled birth attendants for poor women. To achieve their full potential, vouchers and HEFs require other interventions to ensure the supply of sufficient quality maternity services and to address other non-financial barriers to demand. If these conditions are met, voucher and HEF schemes can be further scaled up under close monitoring and evaluation (192).

Under Malaysia's new "1Malaysia" government vision, strategies targeting population with lower socioeconomic status in the urban cities were initiated in September 2009. The aim was to make available 50 clinics in 2010 in these localities located within the housing populated low income area. Within 2 months 50 clinics were developed run by nurses and physician assistant and by the end of February 2011, 80 clinics facilities were made available. Almost half the facilities were provided free or at low rental cost by the local housing board or owners. Within 16 months or the end of April 2011, more than 2.4million visits were made to these clinics with overwhelming response.

Programmes "targeted" at those in most need can still offer benefit to the rest of the population. Mass media public awareness campaigns (194) promoting breast and cervical screening in New

Zealand, depicting exclusively Māori and Pacific women (as these groups had much lower rates of screening) were associated with an increase in screening rates for women of all ethnicities (195).

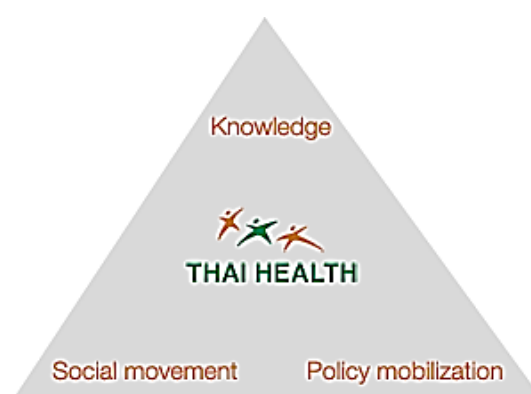
### ***Funding action on the social determinants of health***

The Victorian Tobacco Act, passed in 1987, authorized an additional levy of 5% on tobacco products, to be used to fund VicHealth (196). These funds were used for health promotion, sponsorship of sporting and cultural events and provision of grants for research into health promotion measures and public health research.

The Thai Health Promotion Fund, established in 2002, is funded by a 2% additional levy on excise of tobacco and alcoholic beverages. Recent advocacy achievements include regulations on sugar in infant formula milk powder; television programme ratings; smokefree bars, pubs, open air markets and restaurants; and the Alcohol Control Act 2008. ThaiHealth is moving the delivery of health promotion from service based and health education approaches to focus more on broader social determinants of health and co-ordination of related sectors for healthy behaviours, policies, environments and systems. ThaiHealth uses a concept called "The Triangle that Moves the Mountain" (Figure 32) of health improvement as the key strategy to solve difficult social problems by simultaneously strengthening capacity in the creation of relevant knowledge through research, social mobilisation and advocacy for changes in policy and legislation (179). ThaiHealth is a member of Thailand's Social Inequality Reduction Network (SIRNet) which works at a national level to bring together researchers, government agencies and the health promotion sector to synergistically support intersectoral action on healthy public policies and measures which consider health equity.

Health promotion foundations/ boards modelled on these experiences have been established also in Singapore, Malaysia, the Republic of Korea, Mongolia and Tonga. Australia, the Lao People's Democratic Republic, Samoa, Solomon Islands and Viet Nam are working on developing them.

**Figure 32: The Triangle that Moves the Mountain**

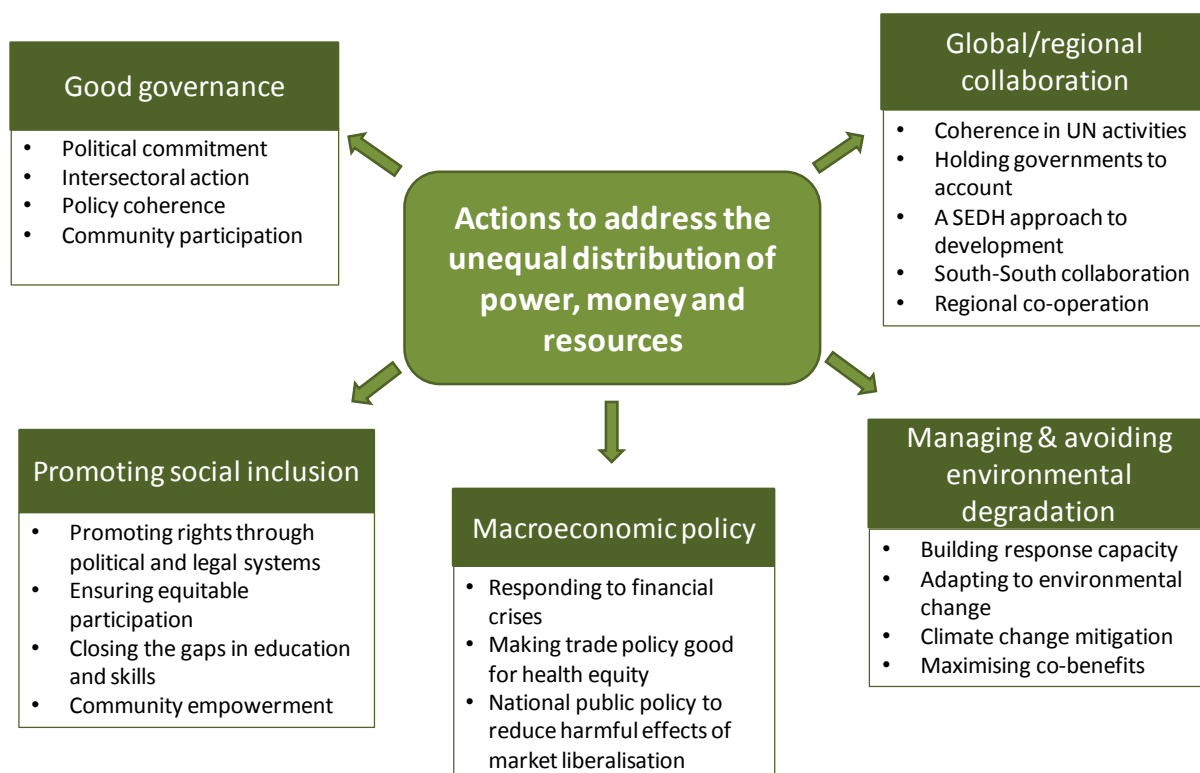


Source: Adapted from (179)

## SECTION 4: ADDRESSING THE UNEQUAL DISTRIBUTION OF POWER, MONEY AND RESOURCES

### Overview

In **Section 4** the policies and practices featured focus on redressing imbalances in power, money and resources. We have highlighted how this is being done through issues of governance, inclusionary systems and processes, macroeconomic and trade policies, and policies to manage existing and prevent further environmental degradation.



## Chapter 1: Fairer distribution of power and resources through systems and processes that promote social inclusion

### CSDH Recommendations:

- Empower all groups in society through fair representation in decision-making about how society operates, particularly in relation to its effect on health equity, and create and maintain a socially inclusive framework for policy-making.
- Enable civil society to organize and act in a manner that promotes and realizes the political and social rights affecting health equity.
- Address gender biases in the structures of society – in laws and their enforcement, in the way organizations are run and interventions designed, and the way in which a country's economic performance is measured.
- Develop and finance policies and programmes that close gaps in education and skills, and that support female economic participation.
- Reaffirm commitment to addressing sexual and reproductive health and rights universally.

### Introduction

Social inclusion is a human right - the right to a fair distribution of resources and equal access to capabilities and liberties (197). Social exclusion is a global problem. It results from a range of dynamic, multi-dimensional processes driven by unequal power relationships, which need to be tackled if people who are excluded by these processes are to be included. Social exclusion encompasses not only low material means but the inability to participate effectively in economic, social, political and cultural life and in some instances alienation and distance from mainstream society. Those who are socially excluded often go unheard, and their needs are ignored or overlooked. Consequently, social exclusion results in a range of practical disadvantages such as poor labour conditions or absence of paid work, limited education, low income and poor nutrition. It is widely recognised that these disadvantages, accompanied often by an 'unhealthy' living environment, are key determinants of health. As a result, social exclusion is strongly linked to health inequity.

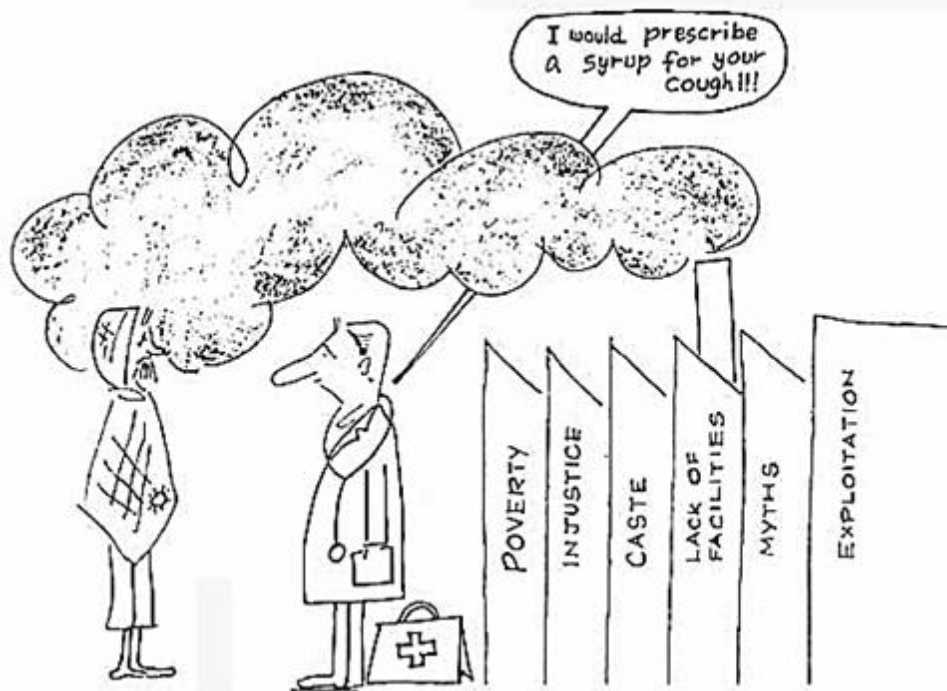
### Social exclusion in the Asia Pacific region

There are many examples across the Asia Pacific region of socially excluded groups that are compelled to endure the multiple deprivations associated with exclusion. These may include, for example, rural populations, children, youth, the elderly, disabled people, refugees, asylum seekers, sexual minorities, and those who experience language barriers or ethnic or religious discrimination. The purpose of this chapter is not to describe all these groups, but to use some of these groups as examples to examine the exclusionary processes which are commonly experienced and which explain how exclusion creates health inequity.

The paucity of data on socially excluded populations in the region, which could itself be a determinant of continuing social exclusion, means as the needs of such groups remain invisible to policy makers. A notable asymmetry of information was found, with a greater volume of published evidence of the impacts of social exclusion in the more developed countries of the Asia Pacific region. All countries are likely to have socially disadvantaged populations, and a key step towards addressing their needs would be to enhance data availability to inform such activities.



Why are some peoples more vulnerable to marginalisation, social exclusion and health inequities than others? Additional to the increasing negative impact of other social determinants on social exclusion are the enduring impacts of deep-seated power imbalances based on discrimination by religion, race/ethnicity, social position, caste and sex. Labonte noted that disadvantage is an 'outcome of social processes, rather than as a group trait' (198). In the Asia Pacific region (and the same is true globally) power imbalances, have shaped social processes for generations, with profound and cumulative ramifications, demonstrated clearly in health outcomes. Individuals and groups marginalised by these social processes are more vulnerable to contemporary challenges such as climate change, urbanisation, economic crises and unfair health systems.



Source: Community Health Cell (199)

### **Women**

Achieving full social, economic and political inclusion for women has historically been a global problem. Women have long faced discrimination in terms of education, employment, and income. The UNDP estimates that women constitute 70% of the world's poor (197). This is partially due to the vicious circle of attitudes prevalent in many societies that restricts their mobility, limits employment choices and hinders control over assets. All of these factors critically affect the health and welfare of girls and women, with those in wealthier households experiencing 'lower levels of mortality and higher use of health services' (145). The correlation between poverty and maternal mortality is striking: 99% of the more than half a million maternal deaths each year occur in developing countries (145).

Women in the Asia Pacific region face perhaps greater disadvantages than anywhere else. Here, unusually, female life expectancy at birth is lower than or equal to that of males; their biological advantage overridden by gender-based discrimination (145), and pre-natal selection results in alarmingly low sex ratios in parts of the region such as India. Wealth is not the only issue, however. Societal failings have also damaged women's health and they are profoundly affected 'by the ways in

which they are treated and the status they are given by society as a whole' (145). Where excluded by law from owning land and property or the right to divorce, women's social and physical vulnerability increases. The male-female gap in secondary education persists and women are less aware of their health needs and tend to rely on faith-based cures (144). Furthermore, globally, women are less protected in the workplace, both in terms of security and working conditions (145).

Women have an extremely limited political voice. Less than 3% of all elected leaders in the Pacific are women, the lowest percentage in the world (200). This exclusion of women from power and decision-making extends to the private sector. Females continue to be under-represented in boards of Asia Pacific companies. A 2011 survey found that more than 70% of boards in five countries – Hong Kong, India, Malaysia, New Zealand and Singapore - have no female independent directors (201).



Source: gautampandey\_2008, 2008  
<http://www.flickr.com/photos/25246216@N06/3316754752/in/photostream>

### ***Indigenous populations***

The Asia Pacific region is home to over 230 million indigenous people. This represents about three quarters of the world's indigenous population (202). Over a third of these people live in China, another third in South Asia, and the remainder live in both developing and developed countries across South East and East Asia, Australia, New Zealand and the Pacific. Indigenous peoples comprise 5% of the world's population (202), but 15% of the world's poor, and up to one-third of the rural poor (203).

Social exclusion in the form of inequities in health has been consistently documented between indigenous peoples and non-indigenous counterparts within the region (142,204,205). Many indigenous peoples have been colonised. Colonisation refers to the policies and practices of acquiring territories and resources, usually for the purpose of exploitation (206). The direct effects of colonisation were usually severe for indigenous peoples, often resulting in very significant mortality, loss of territories and traditional resources as well as disruption of the social order necessary for survival and development. These effects cannot be understated and at their extreme, include attempted extermination and forced confiscations. These historic injustices laid the foundation for the continued marginalisation and social exclusion of indigenous peoples that is evident today.

The processes of colonisation are the manifestation of notions of racial superiority held by colonisers towards indigenous peoples (206). These assumptions are derived from a racist ideology that wrongly assumes that colonisers are advanced genetically, biologically, intellectually, socially, culturally and spiritually. From this ideological standpoint, colonisers believe in their own superior rights to the territories and resources of indigenous peoples. This racist assumption of superiority

becomes embedded into the values and systems of the new order. It is the contemporary arm of colonisation and maintains the marginalisation of indigenous peoples long after the initial historical insult (207). It suggests that where evidence exists of inequity between indigenous and non-indigenous citizens, racism is a key mediator (207–209). Racism towards indigenous populations, both historic and contemporary, can therefore be seen as the ‘cause of the cause’ of current health inequities of indigenous populations in the Asia Pacific region. It underpins the differential distribution of the determinants of health among indigenous and non-indigenous citizens and thus social exclusion.

Perhaps the most fundamental marker of discrimination against indigenous peoples is lack of data. Many states fail to collect comprehensive quality data of their indigenous population. This is a failure on many levels: firstly it fails to acknowledge the rights of indigenous peoples to be counted and counted as indigenous; secondly it fails to give voice to indigenous people; and finally lack of data fails to have inequities identified and monitored. In the Asia Pacific region, many states do not routinely collect quality and comprehensive data of their indigenous peoples (210). In China for example, the State classifies the 55 indigenous minorities or “*minzu*” together as those who are “not Han”, and very little data on health and social or economic characteristics in China is disaggregated by *minzu* (210). In the Philippines data on indigenous peoples are “severely limited” making it hard to set targets for improvement, despite professional consensus that indigenous peoples are at considerably higher risk (211). Furthermore, when data are collected, the analysis is often limited to ‘victim blaming’ rather than structural analysis, which locates the causes of the inequities within the genes, biology, cultural and behaviour of the indigenous peoples (210).

The marginalisation of indigenous peoples through state policies can be both direct and indirect. There are examples of deliberate exclusion of indigenous peoples from public policies and publically funded programmes. Under Section 127 of the Australian Constitution, it was deemed that “aboriginal natives shall not be counted” in any form of population census (212). This explicit exclusion from the fundamental right to be counted was not revoked until a public referendum in 1967 (212). Specific policies in some states excluded Aboriginal children from government-run schools well into the 1950s (213). In the health sector, Australia’s Tuberculosis Act of 1948 specifically excluded aboriginal people, and the Maternity Allowance scheme, barred both Asiatic and indigenous women. The structural and legal disadvantages of being non-white had cumulative consequences, in this example, exclusion from the maternity healthcare systems, led to poor maternal care, support and education which in turn resulted in less healthy children (214). In Indonesia, the Suharto-era policy banning SARA (*Suku, Agama, Ras dan Antar Golongan*, meaning ethnic group, religion, race, and group-based interest) in institutions and socio-political interaction was a move to eliminate ethnic identity from social policies (210).

In addition to this direct exclusion from social policy, health consequences also result indirectly. There are three main ways in which this happens. First, where policies are designed and delivered to non-indigenous norms, access to the benefits of these policies is often uneven. Second, health consequences of social exclusion spring from lack of political power, educational neglect and economic exclusion. This marginalisation is in itself stressful and this stress is embodied by these populations resulting in differential health outcomes (215–217). Third, this environment of uneven protection and higher need is usually coupled with access to health services constrained by socio-

economic barriers and those derived from health service configuration and culture. Furthermore these factors together with the lack of adequate and specific health promotion policies among the indigenous people, has resulted in restricted lifestyle choices. For example, among the Māori population of New Zealand there continue to be high rates of obesity (nearly twice the national rate at 43%), and smoking (more than twice the national rate at 46%). The mortality rate from heart disease and stroke is three times higher among indigenous Australians compared to non-indigenous counterparts.

Dispossession or forced removal from traditional lands and sacred sites erodes the relationship between indigenous peoples and their environment, prevents them from carrying out their cultural activities or using traditional knowledge (210). In Indonesia and the Philippines, the ecosystems that indigenous communities often depend on are rapidly deteriorating through no fault of their own (210). The Bakun Dam in Malaysia is reported to have caused the forced displacement of 5,000-8,000 indigenous persons from 15 communities and indigenous peoples in Manipur, India, suffered a similar fate through the construction of 25 hydroelectric dams (210).

### ***Ethnic minorities***

The Asia Pacific region hosts a wide range of ethnic groups. Minorities have often faced discrimination and social isolation, based on religion, race or caste. In India, excluded groups such as scheduled tribes, religious and ethnic minorities have often suffered from gaps in healthcare provision, especially in tribal areas, in terms of staffing, infrastructure and facilities. Minority group needs have often been overlooked, although the Eleventh Five Year Plan, which set out India's overall strategy for growth for the period 2007-2012, sought to redress these imbalances. The plan acknowledged that many minority communities are self-employed and working in professions such as weaving, spinning and dyeing which lead to occupational ailments (218).

Scheduled castes constitute about 16% of India's population and scheduled tribes about 8%. They are amongst the historically most disadvantaged and vulnerable population groups in the country. Multiple deprivations have resulted in a wide gap between these groups and the general population in terms of political voice, land ownership, employment rates and wages, access to basic amenities such as water and sanitation and social services such as education, health and housing. Not surprisingly, the incidence of childhood mortality and anaemia in women are high. Land is the most important source of



Source: Dr Caleb Otto. Street children sleeping on sidewalk: Manila (2010).

livelihood for the tribal people but this is threatened by globalisation and the increasing demand for natural resources. As a result, ancestral lands have been made available by governments for various commercial developments, leaving many tribal groups suffering from successive, multiple displacements. Tribal communities are isolated, making access to health and education services difficult and contributes to a wide health gap between tribals and the non-tribal populations (218).

### ***Migrants***

The Asia Pacific region is experiencing massive rural-urban migration and some countries are 'struggling to maintain basic services in urban areas, especially for migrants who are particularly vulnerable' (214). In India for example, internal migration is more significant than international migration in terms of the numbers of people involved and is more likely to involve the poor, lower caste, and less educated. This migration makes poverty reduction less likely and the Millennium Development Goals more difficult to meet (219). People displaced from their land by conflict or economic hardship often experience exclusion, plus dramatic deterioration in their resources and capabilities across all dimensions, and their health suffers.

Just as with indigenous populations, migrant groups face both direct and indirect health consequences of social exclusion. In direct terms, migrants are often forced to live in physically high-risk areas, on the fringes of the city in precarious living conditions, and in poverty with very limited access to health facilities. Not all health outcomes are a consequence of physical living conditions however. Health data regarding migrant populations without political power and living on the fringes of society are lacking. As a result, health trends and needs may go unnoticed. In Thailand, 'statelessness' is the primary cause of poverty and poor health (197). Migrant populations also suffer from educational neglect and the resultant vicious circle of consequences (limited economic power, further poverty, unhealthy lifestyle choices). A UNDP report on migration in India highlighted the plight of migrants from Madhya Pradesh. They worked long hours in harsh conditions, injuries were common, and there was inadequate medical assistance or compensation. They faced harassment, theft, forcible eviction, or the demolition of their dwellings by urban authorities or police, and women and children were vulnerable to abuse and sexual exploitation.

### **Promoting rights through political and legal instruments**

Political and legal rights are fundamental to good health. Promoting inclusion through political and legal systems is one way to address the lack of political and social participation for socially excluded groups.

The region has varied models of national mechanisms on gender, from high-level commissions in the Lao People's Democratic Republic and the Philippines to full ministries in Malaysia and the Republic of Korea (144). Political voice at both national and local levels need to be promoted - in Timor-Leste, despite remarkable progress in bringing more women into the national legislature, longstanding conventions about leadership still rule at the local level, where men make the major decisions for their communities (144).

Beginning in 2010, women have been linked for the first time to the Government of India's unique identification number initiative, which aims to provide better access to schemes and pensions (115). After a long advocacy campaign by women's activists in Nepal, women were granted legal rights to

own and inherit property in 2002 (144). Japan enacted the Basic Law for Gender Equal Society in 1999 (144), and has also taken legal measures to mitigate domestic violence and facilitate parental leave. Revisions have been made in existing laws, such as the Equal Employment Opportunity Law and the Act on Improvement of Employment Management for Part-Time Workers, with a stronger encouragement for the private sector to eliminate gender discrimination.

International mechanisms such as the Convention on the Elimination of All Forms of Discrimination against Women, the UN Convention on the Rights of the Child, the UN Declaration on Human Rights, and the UN Declaration on the Rights of Indigenous People have been endorsed across Asia Pacific. In a number of cases, groups have used these instruments to hold their governments to account over circumstances of social exclusion.

Constitutional recognition is an important prerequisite for social inclusion for indigenous peoples.

The Treaty of Waitangi in New Zealand provides formal constitutional recognition for Māori indigenous rights, and underpins the relationship between the government and indigenous people (220). As a result, all government agencies have a constitutional obligation to enter into partnership with Māori, to protect Māori cultural values and ensure Māori experience equal rights and

privileges as other New Zealanders (221). This obligation is variably expressed in reality. However the Treaty has led to a number of concrete mechanisms for Māori (eg the Treaty of Waitangi land claims tribunal) to seek redress over exclusive and discriminative practices (209).

A breakthrough for addressing the social exclusion facing lesbian, gay, bisexual and transgender peoples in Nepal occurred when Nepal's Supreme Court declared that sexual minorities are 'natural persons' deserving protection against discrimination (144). In Papua New Guinea, the Ministry of Community Development and the Ministry of Justice has called for a review of punitive laws relating to same-sex behaviour and sex work (115). In India, a government directive enables marginalized groups, such as the transgender community, to access free legal aid (115).



Skywriting over Sydney, weeks before formal government apology to indigenous Australians, 2008. Source: butupa <http://www.flickr.com/photos/25792994@N04/5424377128/>

**Box 25 - India: PHM's People's Health Tribunals on denial of right to health**

People's Health Movement-India (*Jan Swasthya Abhiyan* or JSA) launched its Right to Health Care Campaign in 2003 and pioneered the strategic use of a right to health and health care framework to fight deterioration of the Indian public health system. The Campaign developed procedures to record "individual denial of health services" and to demonstrate "structural denial" of health care. Ordinary people and local activists — with some orientation and simple tools — documented the denial of services, audited health facilities, and monitored implementation of health system reforms. Documented cases of denial of health care were then presented to panels of "pro-people" experts at People's Health Tribunals held before public audiences of up to 1,000 people.

Documentation from the People's Health Tribunals was then presented to the Indian National Human Rights Commission, leading to a National Public Hearing on Right to Health Care on December 16–17, 2004. Officials present at the public hearing included the Central Health Minister, Health Secretaries or senior health officials from 22 states. JSA representatives made presentations on the scale, depth and range of health rights violations. These included five regional overviews, specific reports on groups facing a high incidence of health rights violations, and a national analysis highlighting the structural and systemic nature of these violations. The hearing concluded with the declaration of a National Action Plan to Operationalise the Right to Health.

Source: Turiano & Smith (222)

**Ensuring equitable participation in parliaments and other governance bodies**

Formal political participation is an important determinant of health. In Papua New Guinea, local communities and women's groups are actively lobbying their Members of Parliament to support more women in Parliament. A year-long campaign to advance women's representation in Parliament, supported by UNDP's Women in Leadership programme, reached almost a million people across 22 provinces (115). Measures such as a separate Māori electoral roll and a minimum number of Māori seats in parliament attempt to address political exclusion for Māori.

Quotas can be an effective way to boost the political participation of excluded groups - about a third of Asia Pacific countries have some kind of quota system for women. In countries with quotas, women's participation rate in elected offices is around 40% higher than in countries in the region without them (144). The Magna Carta for Women of the Philippines calls for a 50-50 gender balance in Government positions to be achieved within five years (144). The French territories in the Pacific have achieved outstanding levels of female participation, because they are subject to the French Law on Parity 2000 which requires all political parties to include women as 50% of their candidates. Women make up 44.4 % of the legislature in New Caledonia and 42.1% in French Polynesia – the highest in the Asia Pacific region (144).

**Closing the gaps in education and skills**

Access to education and educational achievements vary across the Asia Pacific Region, and particular groups experience poorer access and outcomes, including girls, indigenous children and the poor. Initiatives, such as the UN Convention on the Rights of the Child (1989) have aimed to universalize education as a right for all children, yet the realities of social exclusion continue to plague education efforts, with particularly problematic results for children from disadvantaged groups (223). Children who cannot access and complete a quality education are impeded in fulfilling their potential, and experience fewer opportunities to participate actively in social, economic, and political life as adults.

Inequities in literacy and 'health literacy', which assesses the ability of persons to read and understand health related information, reinforce health inequities. Better education leads to higher income and jobs with less physical and mental stress. This has an effect on adult health. People with higher levels of literacy are better equipped to learn about healthy behaviours (e.g. learn the benefits of breast feeding on infant survival), gain knowledge to make healthy decisions (e.g. reading warning labels on tobacco packages), access relevant health information (e.g. drug names, their doses and potential side effects). Higher education levels (especially female education) are also associated with better reproductive health and improved maternal and infant health outcomes. Closing the gap in education is not only fundamental to optimal early childhood development, but also to address the vicious cycle of social exclusion.

The Female Secondary School Stipend Project (FSP) in Bangladesh is an example of a public sector social protection programme, which is targeted to address social exclusion (224). The FSP is a conditional cash-transfer programme originally implemented with the intention of increasing enrolment of girls in secondary schools. It provides parents of female students a portion of tuition, school fees, and monthly stipends up to Class 10 conditional upon their daughter attending a recognized institution, remaining unmarried, having 75% attendance, and securing 45% marks on annual examination. Females as a percentage of secondary school enrollees has increased from 33% in 1991 to 52% in 2005, and it is very likely that the FSP played a key role (225). However, by providing a stipend insufficient to cover the complete costs of education, the FSP has the potential to exclude the poor and ultra-poor and increase the gap in access to education (225).

The successful indigenous-led Kura Kaupapa Māori movement in New Zealand has helped transform education into an empowering rather than disempowering experience for Māori (226). Māori were concerned about the loss of Māori language and the marginalisation of Māori values through mainstream New Zealand education. Parents withdrew their children from state funded schools, to develop and implement schools grounded in Māori language and culture (227). Initially funded solely by parents and Māori communities, these schools are now recognised for government funding and regularly report improved educational performance for indigenous students against national standards compared to the mainstream system (227).

From 2008, Fiji implemented a range of strategies to address its rural/urban, gender and ethnic disparities in educational attendance (228). Specific components included:

- Free primary school education
- Development of a new curriculum framework
- The Compulsory Education Act
- Establishment of new primary and secondary schools in remote and rural areas
- Provision of boarding facilities, scholarships and grants
- Provision of motorboats and outboard motors
- Enhancing multiculturalism by changing the names of schools, which implied ethnic exclusivity.

The Council of Australian Governments reform agenda for school education aims to close the gap between the educational outcomes of Aboriginal and Torres Strait Islander students and their peers. Three targets have been set: 1) ensure all Aboriginal and Torres Strait Islander four year olds in remote communities have access to early childhood education by 2013; 2) halve the gap for



Aboriginal and Torres Strait Islander students in reading, writing and numeracy by 2018, and 3) at least halve the gap in Aboriginal and Torres Strait Islander Year 12 attainment or equivalent attainment rates by 2020 (229).

### Community empowerment

The Baan Mankong ('secure housing') programme in Thailand seeks to organise urban informal settlements to bring about improved shelter, living standards and more secure tenure (230). Initiated by the Thai government in 2003, Baan Mankong is facilitated through the Community Organising Development Initiative (CODI), a unique government-NGO collaborative partnership. CODI's board consists of a balance of government representatives, community organisations and professionals. It was initially to act as a platform for government communication with communities, and administer small loans for infrastructure and housing upgrading, but it has since evolved into an important instigator of community development more generally and thus a 'meeting ground' between the State and the urban/rural poor (86). Communities are expected to manage these funds and also contribute their own, to develop community infrastructure and to use grants to employ people to work with the community, such as architects and engineers. It encourages the development of community 'people's plans' through organising, identifying needs, and addressing priorities, in order to realise goals relating to housing improvement, environmental sustainability, improved services, greater tenure security and improved health outcomes. While ostensibly a housing project Baan Mankong has put urban poverty on the agenda. Baan Mankong offers an alternative vision of urban sustainability which is inclusive of the poor (86).

#### Box 26 - Australia: South Australia's Social Inclusion Initiative

The Social Inclusion Initiative (SII) of the South Australian Government is an example of a government policy designed to tackle social exclusion. It was designed to increase social inclusion by addressing key determinants of health inequity, including education, homelessness and drug use. The SII is a joined-up approach to addressing pressing social problems by implementing concurrently a series of policies, strategies and interventions on the advice of the independent Social Inclusion Board to the Premier of the state government, who is also the Minister for Social Inclusion. The work of the Commissioner for Social Inclusion and the Social Inclusion Board is supported by the Social Inclusion Unit (located within the central government agency of the Department of the Premier and Cabinet). A rapid appraisal to determine whether a social inclusion initiative is a useful aspect of government action to reduce health inequity highlighted four factors central to the successes achieved by the SII. These were the independent authority and influence of the leadership of the SII, the whole of government approach supported by an overarching strategic plan which sets clear goals for government and the clear and unambiguous support from the highest level of government. A social inclusion approach can be valuable in the quest to reduce inequities and further research on innovative social policy approaches is required to examine their likely impact on health equity.

Source: Baum et al (231)

## Chapter 2: Distributing resources for health through macroeconomic and trade policy in Asia Pacific

### CSDH Recommendations:

- Institutionalize consideration of health and health equity impact in national and international economic agreements and policy-making.
- Reinforce the primary role of the state in the provision of basic services essential to health (such as water/sanitation) and the regulation of goods and services with a major impact on health (such as tobacco, alcohol, and food).

### Introduction

The term economic globalisation describes the cumulative and ongoing effects from decisions by many individual countries to increase their integration with the international economy. The nature of economic globalisation has changed significantly since the 1980s when the international financial institutions embraced an economic strategy called “the Washington Consensus”. This strategy extols the role of the free market (entailing greater trade liberalisation, deregulation, privatization of public services, correctives against inflation and stable currencies) in achieving greater global economic integration. Although a combination of improvements in technology and decreased transportation costs have facilitated international economic integration, economic globalisation is firmly a political project, created and reinforced by liberalising economic policy choices by national governments.

### Issues for health equity

While economic integration and associated liberalisation has facilitated greater mobility of capital, technology, knowledge and people, it has also facilitated marketisation and commodification while simultaneously intensifying the uneven development of forms of social protection across people and places. This has resulted in the attendant gains in power, income, goods and services being uneven, each with implications for health inequity via material, psychosocial and behavioural pathways (232).

Processes of economic globalisation have worked on a wide and uneven distribution of starting positions representing different economic histories and colonial legacies; thus the rise of economic power in Asia Pacific is highly uneven. While the Asia Pacific region is increasingly central to economic globalisation, it does not conform neatly to either Anglo-Saxon or European models of capitalism. This is exemplified both before and in the aftermath of the recent global financial crisis (GFC) - developing countries in the region were growing faster than any other region in the world, with an average annual growth of 5.3%



Source: tenaciousme, Tokyo, 2007  
<http://www.flickr.com/photos/tenaciousme/1797368175/>

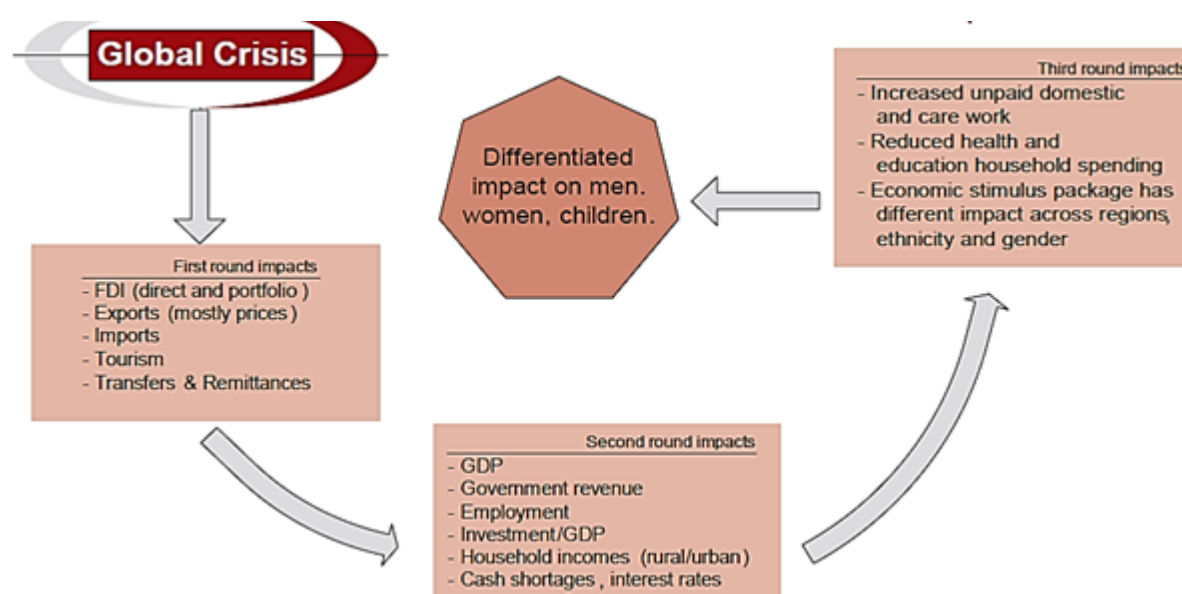
between 1970 and 2008. After the GFC hit, global GDP contracted 1.9% in 2009, with high income countries contracting 3.3% and developing countries expanding 2.7%. East Asia and Pacific grew at 7.4% and South Asia 7% (233). In this regard, the Asia Pacific region is strategically important for both regional and global health equity - trade and other macroeconomic strategies emanating from this region are likely to contribute to the social, economic and health outcomes of domestic, regional and global communities (234). The variegated nature of economic globalisation and its uneven territorial effects helps identify mechanisms that connect liberalising policy choices and potential health inequities.

### An Asia Pacific response to the global financial crisis

Economic globalisation affects inequities in health outcomes through increasing economic insecurity (235–241). A major public health concern at the moment is the acute and long-term effect of the recent GFC. The years 2008–09 were characterized by the deepest economic downturn since the 1930s, with global reductions in economic growth and rising unemployment.

Ironically, global wealth climbed by 8% in 2010 to US\$121.8 trillion, or about US\$20 trillion above where it stood in the depths of the GFC. Wealth grew fastest in Asia Pacific (excluding Japan) (242). Juxtapose that against the 60 million plus people in Asia Pacific in 2009 who would have been lifted above the extreme poverty line of US\$1.25 a day if high growth had continued but will remain in poverty, increasing to 100 million by 2010 (243).

**Figure 33 - Transmission mechanism from GFC to different consequences for women, men, and children**



Adapted from (244)

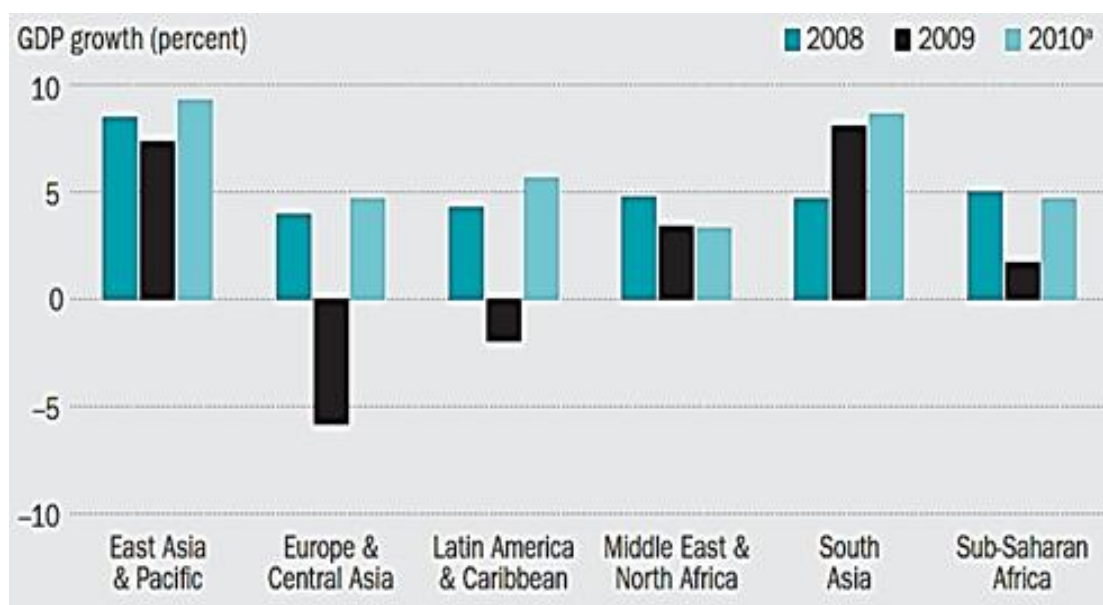
A key response to the GFC by many countries in Asia Pacific was the implementation of economic stimulus packages, involving fiscal and monetary interventions. According to the World Bank, the stimulus packages have had strongly positive results in China, the Republic of Korea, Singapore and

Viet Nam but limited impact in Indonesia, Malaysia and Thailand (243). The most successful interventions are those that targeted infrastructure and social spending, while the least successful were dominated by tax cuts and untargeted social transfers (243). The Australian government pledged the equivalent of 1% of gross domestic product, providing AUD\$4.8 billion for long-term pension reforms, AUD\$3.9 billion for support payments for low and middle-income families, AUD\$1.5 billion towards helping first-time buyers purchase a new home, and AUD\$187 million to create 56,000 new training places, and speed up major infrastructure projects. In writing about his response to the crisis, the Australian Prime Minister at the time, Kevin Rudd, noted the need for strong government to provide public goods and ensure fairness:

*“The intellectual challenge for social democrats is not just to repudiate the neo-liberal extremism that has landed us in this mess, but to advance the case that the social-democratic state offers the best guarantee of preserving the productive capacity of properly regulated competitive markets, while ensuring that government is the regulator, that government is the funder or provider of public goods and that government offsets the inevitable inequalities of the market with a commitment to fairness for all. Social democracy’s continuing philosophical claim to political legitimacy is its capacity to balance the private and the public, profit and wages, the market and the state. That philosophy once again speaks with clarity and cogency to the challenges of our time” (245).*

Although countries across Asia Pacific did experience serious slowdowns on account of the GFC, Asia Pacific is one of the few regions in the world still growing (Figure 34)(233). With stimulus packages starting to kick in, average growth in China is projected to be 8% this year; India between 6-7%; Indonesia between 4-5%; and Asia as a whole at about 5%. Many of the poorer Pacific island economies did not have the same ability to cushion the impacts of the crisis, unlike large parts of Asia and Australasia where many countries have had at least a decade if not more of strong progress in poverty reduction and social protection.

**Figure 34 - Differences in GDP growth among selected developing country regions post-GFC**

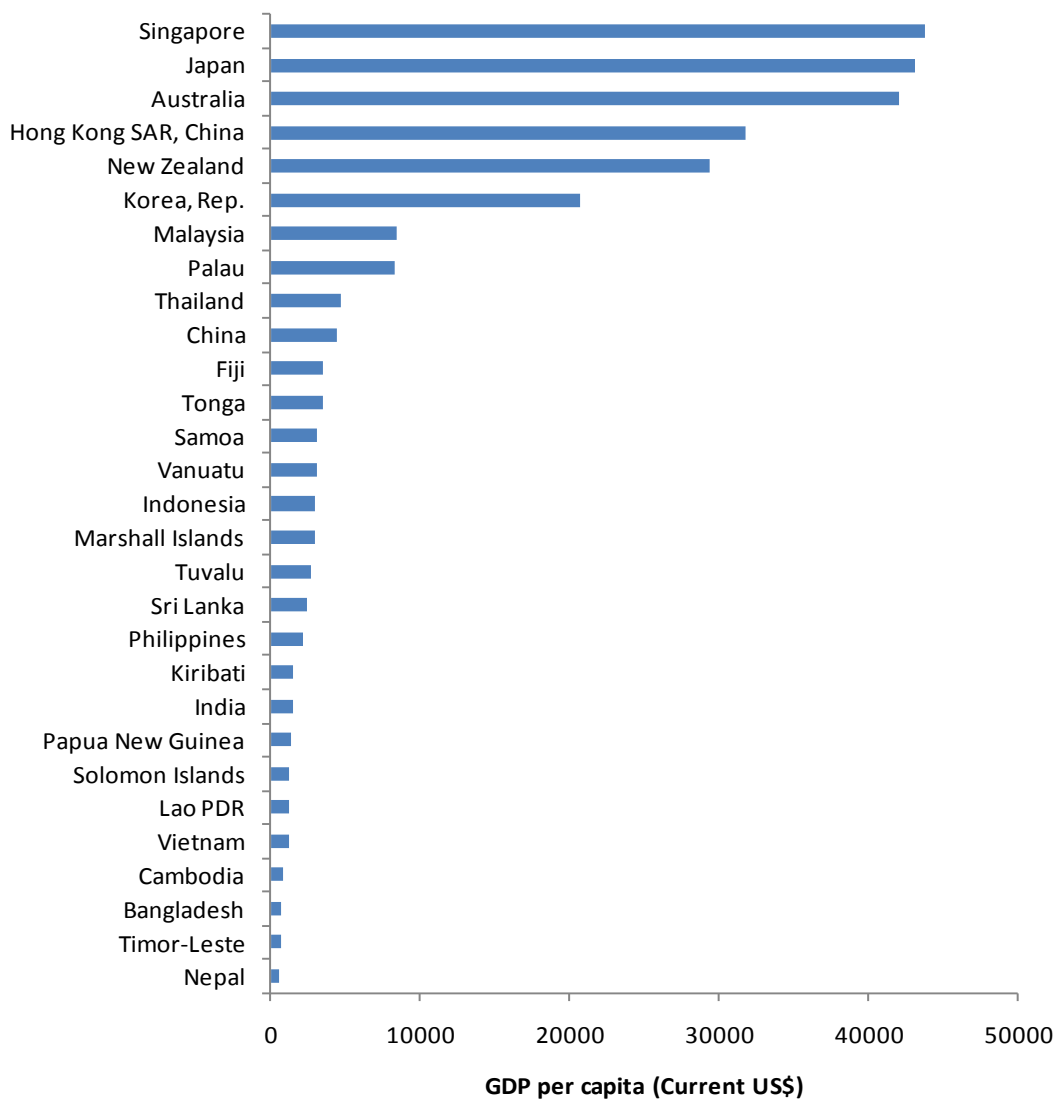


Source: (233)

### Addressing national income inequalities

National wealth is unevenly distributed across countries in the Asia Pacific region. For example, six countries in the region currently have per capita GDP of US\$20,000 or more, but the majority remain economically vulnerable, with per capita incomes below US\$5,000 (233).

**Figure 35 - GDP per capita, selected countries Asia Pacific, 2010**



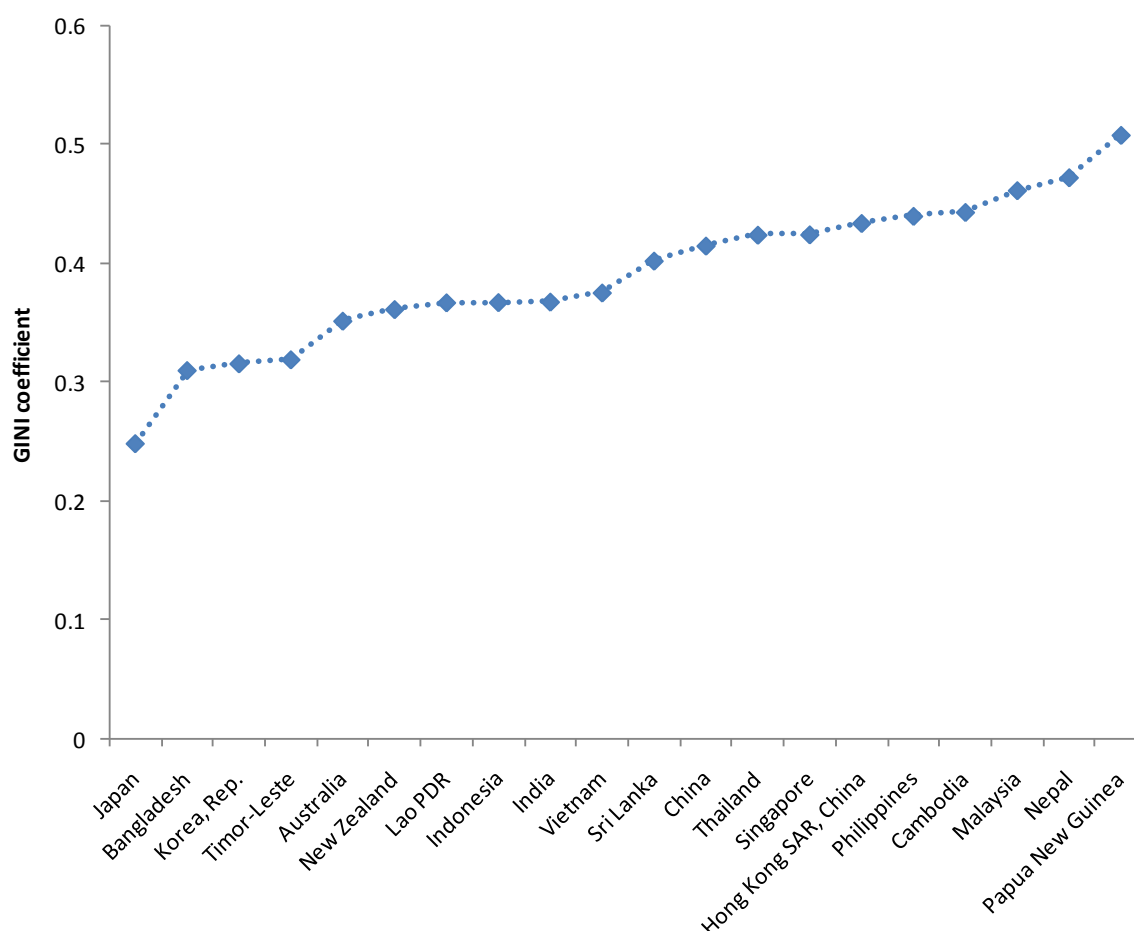
Source data: (233)

Note: Data for Australia and New Zealand are from 2009, all other data are from 2010

How a country uses its economic growth affects levels of poverty and income inequalities. Work by Wilkinson and Pickett (246), although based on data from high income countries, demonstrates a marked correlation between relative income inequality within countries and health inequities. The correlation observed by Wilkinson and Pickett between increasing income inequality and decreasing child well-being would almost certainly apply to countries in Asia Pacific given the degree of income

inequality observed here, ranging from a relatively low level of income inequality in Japan to a Gini coefficient<sup>2</sup> greater than 0.5 in Papua New Guinea (Figure 36).

**Figure 36 – Gini coefficients, selected Asia Pacific countries and territories**



Source data: (233)

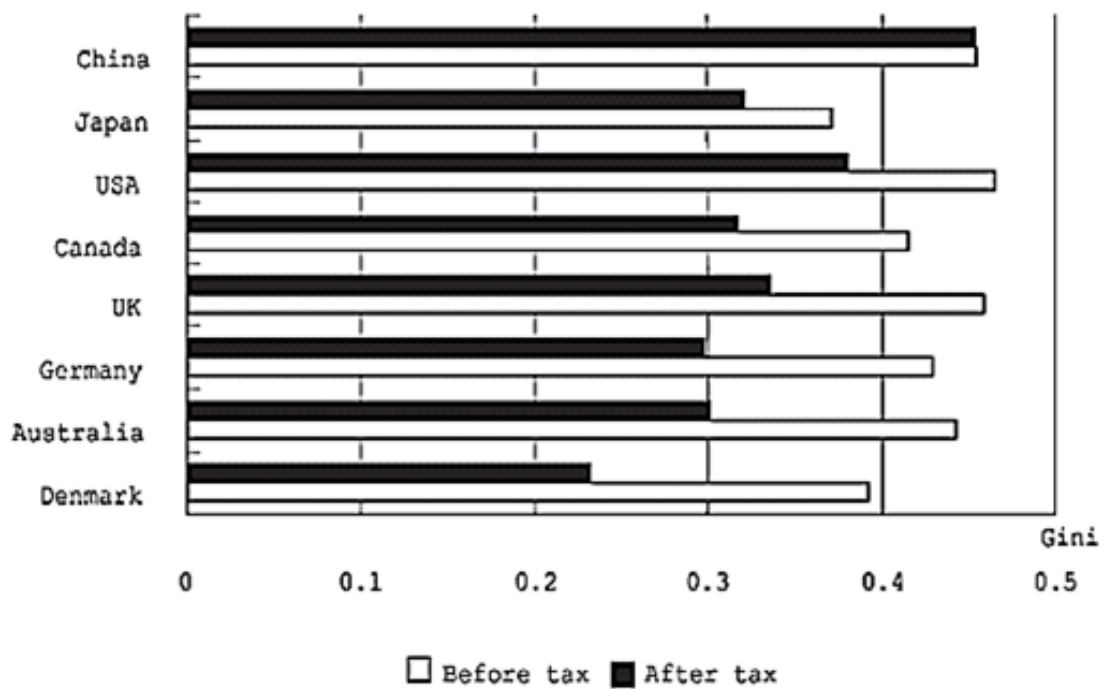
Note: most recent year of data used varies by country

Income inequality can be addressed through a combination of social service provision, social transfers and taxation. Chapter 2 of Section 3 discussed social protection policies. In relation to taxation, generally, personal income taxes and property taxes are progressive (increasing equality), corporate taxes are U-shaped (regressive for small and large companies and progressive for medium-sized companies), and indirect taxes such as Value Added Taxes are regressive. Encouraged by the International Monetary Fund (IMF), indirect taxes are more common in developing countries. In Asia Pacific, indirect taxes grew from 4.6% of GDP in 1990 to 5.4% in 2002 (247). Revenue from personal income taxes still accounts for less than 2% of GDP in low income countries, whereas in high income countries it accounts for about 7% of GDP.

<sup>2</sup> A Gini coefficient of 0 indicates perfect equality, whereas a Gini coefficient of 1 indicates perfect inequality. A Gini coefficient of 0.4 denotes moderately unequal distributions of income or consumption; it is the threshold at which countries should address inequality as a matter of urgency.

The redistribution effect of taxation can be enhanced significantly if a progressive income tax is applied so those with the highest income pay proportionally more of their income in tax, not only absolutely more. The impact of a progressive personal income tax on redistribution can be seen when pre-tax and after-tax Gini coefficients are compared (Figure 37). Using this approach, Australia's taxation system appears to be more progressive compared to countries such as Japan and China (248). Analysis of the Malaysian fiscal policy between 1970s and 1990s highlights some progressive taxation measures taken to explicitly reduce income inequalities between different ethnic groups (Box 27).

**Figure 37 - Pre-tax and post-tax Gini coefficients, selected OECD countries, mid-2000s**



Source: (248)

**Box 27 – Malaysia: progressive fiscal policy**

Malaysia has implemented comprehensive measures, fiscal and non-fiscal, to tackle horizontal inequalities that negatively affect the country's ethnic groups, particularly the inequalities between the bumiputeras (Malays and other indigenous groups) and the Chinese. Between 1970 and 1990, Malaysia's tax policy was established within the framework of the New Economic Policy (NEP). The NEP had two main purposes: 'the eradication of poverty', regardless of ethnic origin, and 'the restructuring of society' in order to eliminate the association between race and economic function within Malaysian society. Although there are doubts about the reliability of the Malaysian government's data, it is likely that poverty fell significantly in the 20 years of the NEP. In 1990, the poverty rate in the peninsula was estimated at 17%. In 1970, 65% of bumiputeras, 26% of ethnic Chinese, and 39% ethnic Indians were poor. By 1990 these figures were 21%, 6%, and 8% respectively. During the NEP period, Malaysia enjoyed high average economic growth rates and a significant reduction in horizontal inequality. In 1970, in Peninsular Malaysia, the monthly income of a Chinese household was 2.29 times that of a bumiputera household. By 1990, this ratio fell to 1.74 times.

The country's fiscal revenue to GDP grew during the period of the NEP from a little over 15% to about 20%. The Malaysian tax system was already progressive when the NEP began (the Chinese contributed proportionately more to total tax revenues). As a result of the improvement in their economic status, bumiputeras contributed a higher proportion of overall tax revenues. However, within the framework of the NEP, some favourable tax reforms were introduced for this group: A reduction in export taxes probably reduced the burden on the bumiputeras, due to the significant presence of Malays in business activities orientated towards exports. Increased tax rates on alcohol have probably been borne by 'non-bumiputeras' because of the Muslim prescription against drinking alcohol. In addition, a tax on trade with China was introduced, a measure that may have affected local Chinese businesses rather than bumiputeras.

Source: (247)

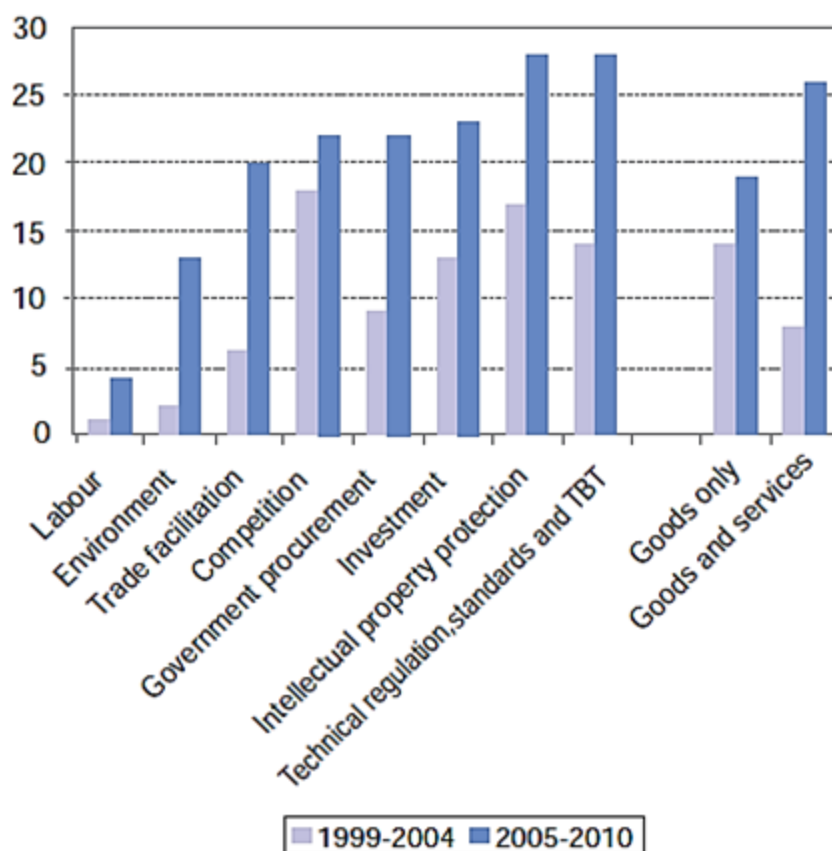
**Making trade and investment policy good for health**

If done fairly, trade can improve health and social equity. However, trading arrangements and foreign investment policy favouring developed economies and powerful transnational corporations often have detrimental consequences for living and working conditions, income security, adequate nutrition and access to education and affordable healthcare for the poor (249).

The Asia Pacific region has made a vigorous comeback from the global economic crisis. Export and import values in the region have already returned to pre-crisis levels, while investment inflows are recovering, albeit at a slower rate. The number and scope of regional and bilateral trade agreements between countries across Asia Pacific and elsewhere are increasing rapidly (Figure 38) (250). Investment provisions have increasingly been included in regional and bilateral trade and economic agreements while the number of international investment agreements, in particular bilateral investment treaties (BITs), has also risen steadily. It is estimated that at the end of May 2010, there were almost 2,800 BITs worldwide and about 50% of these BITs involve countries in Asia Pacific.



**Figure 38 - Recent agreements cover more areas (agreements entering into force in 2005-2010 compared with 1999-2004)**



Source: (250)

The Trans Pacific Partnership Agreement (Box 28) and the PACER Plus (Pacific Agreement on Closer Economic Relations) (Box 29) are currently being negotiated. Depending on the final nature of these agreements, they may pose several threats to public health and health equity across the region. Individual countries and multi-national corporations (MNCs) employ both hard and soft forms of power to position themselves for maximum strategic advantage in relation to trading rules. As a result, much of the present governance arrangements for regulating 'free trade' discriminate in favour of the capital-intensive developed economies. It is essential that governments stand firm, especially now in the TPPA negotiations and reject the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Plus intellectual property provisions and investment provisions that undermine countries abilities to provide equitable access to medicines and regulate health risks. This view is being promoted by the People's Health Movement and Public Health Association of Australia. The Australian Government's Trade Policy Statement released in April 2011 made explicit commitments to rejecting provisions that might constrain the ability of Australian governments to make laws on 'social, environmental and economic matters'. The trade policy statement says: 'The Government has not and will not accept provisions that limit its capacity to put health warnings or plain packaging requirements on tobacco products or its ability to continue the Pharmaceutical Benefits Scheme' (251). See also Chapter 3 of Section 3 for a discussion about the health effects of TRIPS.

**Box 28 - Trans-Pacific Partnership Agreement and implications for health equity**

The Trans-Pacific Partnership Agreement (TPPA) is a regional trade agreement currently being negotiated between Australia, the US, New Zealand, Chile, Singapore, Brunei, Peru, Viet Nam and Malaysia. Proposed intellectual property and investment provisions in the agreement could undermine public health regulation and access to essential medicines in the following ways:

- **Threats to affordability of medicines in Australia and New Zealand**

Under government schemes in Australia (PBS) and New Zealand (Pharmac), the wholesale price of medicines is kept relatively low. Pharmaceutical companies in the US argue that these schemes prevent them from enjoying the full benefits of their intellectual property rights. The TPPA provides an opportunity for big pharma to ask for higher prices and to prevent new policies from being put in place to control prices. These changes could see huge increases in the cost of the medicines, which would undermine the affordability of government medicine subsidisation in both Australia and New Zealand. Excess cost would likely be passed on to consumers, and this would have greatest impact on the most vulnerable population groups.

- **Threats to public health regulation, including tobacco plain packaging**

Proposed expropriation and investor-state dispute settlement provisions in the TPPA could enable foreign corporations to sue governments over legislation that is deemed to reduce the value of their investments. Tobacco companies are likely to take advantage of such provisions, for example to sue the Australian government over their recent tobacco plain packaging legislation.

- **Threats to access to essential medicines in developing countries**

Highly restrictive intellectual property provisions (such as expanded patent protections, elimination of pre-grant opposition and greater rights for pharmaceutical companies in court) could compromise access to essential medicines such as HIV/AIDS drugs in developing countries involved in the TPPA.

Source: adapted from (252,253)

Trade is also related to health and health equity through its potential in reducing the tax-raising capability of governments to fund health and social programs. In many developing countries in Asia and across the Pacific, tariffs provide an important source of taxation. Customs and excise departments can more easily capture revenue than other parts of the tax system in poor economies with large informal and subsistence sectors (248). Taxation is a powerful illustration of how blanket international policy prescriptions for more globalisation as a response to globalisation's contradictions and inherent asymmetries can lead to premature and ill-conceived integration into the global economy. As shown in Table 11, if tariff reductions proposed in the PACER plus agreement are agreed, in Tonga, Kiribati and Vanuatu, the projected loss in government revenue is greater than the total government expenditure on health and education (254).

**Box 29 - PACER-Plus: opportunities and threats to human development in the Pacific**

Pacific Island Countries (PICs) have been struggling to make the most of access to the Australian and New Zealand markets under existing trade agreements. A variety of factors have been blamed for the difficulties, including technical issues that could be resolved in a new or revised trade agreement (such as rules of origin) to more substantial issues, such as distance from markets, poor transport and other infrastructure, a lack of economies of scale, limited skills and experience in most manufacturing and services industries, and a lack of existing supplier base.

Negotiations for a new agreement on economic cooperation (“PACER-Plus”) under the Pacific Agreement on Closer Economic Relations (PACER) between the Pacific Island Countries and Australia and New Zealand have been underway since 2009. The trade conditions being considered in this agreement pose both opportunities and threats to development and health equity in the Pacific. The elimination of PIC tariffs would make Australian and New Zealand exports cheaper than they had been previously. PIC consumers are therefore likely to switch from other import sources, or from domestically produced items, that would now be relatively more expensive. While this represents a gain for Pacific consumers it clearly poses a significant problem for Pacific producers who must either reduce their own costs or go out of business.

One of the key concerns for PIC governments is the potential loss of government revenue as a result of PACER Plus. Australia or New Zealand is the largest source of imports for the majority of the PICs, so eliminating tariffs on those imports will have a large impact on the income of PIC governments.

**Table 11- Government expenditure in health and education as % of total budget, compared to revenue lost from tariff elimination through the proposed PACER-Plus agreement**

	Education	Health	PACER revenue loss
<b>Cook Islands</b>	14	11	6
<b>Fiji</b>	29	14	3
<b>Kiribati</b>	14	9	15
<b>Papua New Guinea</b>	10	6	2
<b>Samoa</b>	22	17	12
<b>Tonga</b>	13	14	19
<b>Vanuatu</b>	23	11	18

Source: (255)

Any decline in national income could reduce investment in social services, already from a low base, undermining the fundamental social determinants of health equity. In order to try to recoup the revenue losses, PICs are likely to introduce new consumption taxes, placing a higher burden of tax on the poor. Beneficial trading arrangements are necessary for PICs to make the most of the opportunities that global trade offers, but not sufficient.

An example from Cambodia illustrates some of the supports available, and necessary, to help low and middle income countries come into the trading system in a way that is good for domestic social

and health equity. In Cambodia, the Trade Integration Strategy focused on 19 products for export with the potential to improve the livelihoods of 2.5 million farmers. UNDP helped the government to refine its economic growth policy agenda to be diversified, inclusive, and pro-poor (115).

### Strengthening national public policy to reduce harmful effects of market liberalisation

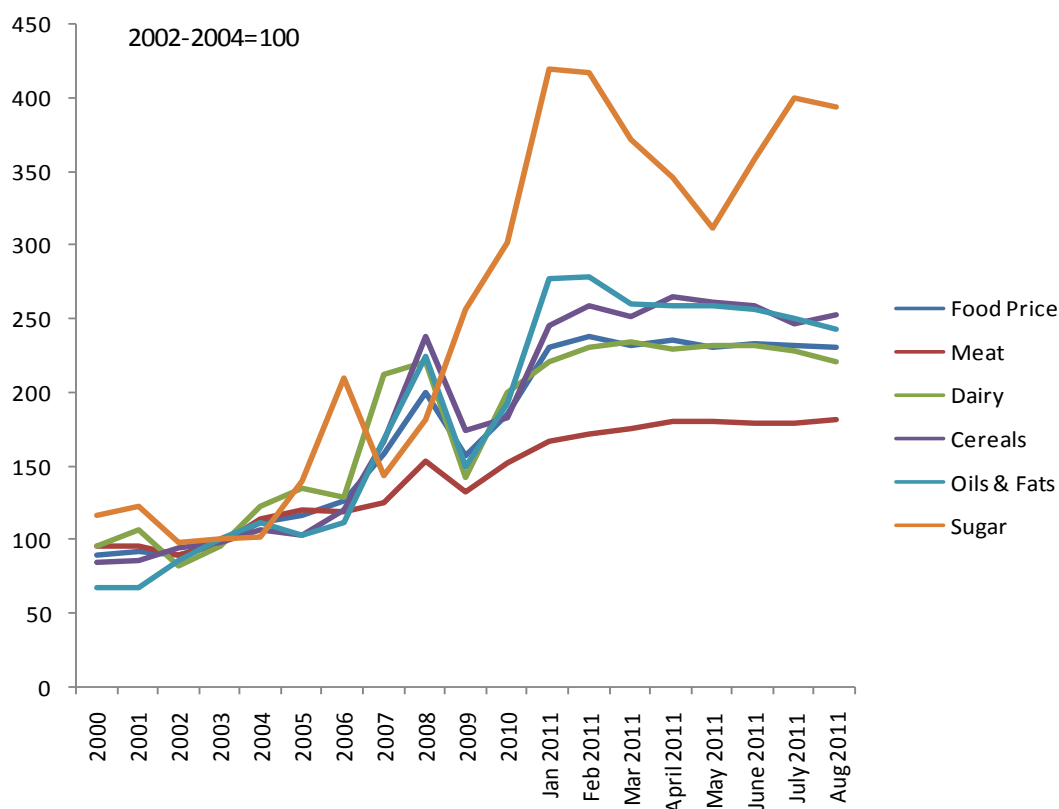
Another way in which trade rules can affect health is by limiting the range of policy instruments available to governments. Under contemporary trading rules, developing countries are required to open their markets to manufactured goods and services but confront substantial protectionism in agricultural markets as well as prominent examples of dumping. The China case is pertinent; it is the paradigm of the successful late industrialiser, exercising trial-and-error in the timing and depth of their trade liberalisation and participation in economic globalisation (256). Chang (257) argues that contemporary trade rules, by shrinking national policy space, will prevent other low- and middle-income countries from adopting at least some of the policies used successfully by China and other emerging market economies at their equivalent stage of development [see also (258)]. The General Agreement on Trade in Services (GATS) is aimed at liberalising trade in services. Public services are included in its ambit, and health care services are the largest unliberalised sector in the international services economy.



Source: yukko\_pp2501, Fiji 2007  
[http://www.flickr.com/photos/yuko\\_ppp/2121820517/sizes/z/in/photostream/](http://www.flickr.com/photos/yuko_ppp/2121820517/sizes/z/in/photostream/)

### *The example of food*

Liberalization of trade in food products and greater foreign direct investment can increase availability and lower retail prices. This is an important positive asset in light of the global food crisis (Figure 39).

**Figure 39 – Global food price index**

Source: (259)

However, there are some features of market liberalisation that raise health and health equity concerns. A recent study by the Food and Agriculture Organization of the United Nations (FAO) examined trade liberalisation and food security in fifteen small and large developing countries (including China and India from Asia Pacific). The study highlighted that trade reforms generally benefit farmers producing exports crops, but have negative impacts on farmers producing import-competing food stuffs, especially those that are highly subsidized by exporting countries (260).

Blouin and colleagues argue that trade liberalisation has distorted the food supply in developing countries in favour of an over-supply, through food imports, of foods that are high in saturated fat, highly processed, calorie-rich and nutrient-poor (249). Imports can alter the type and amount of food available for human consumption and/or prices, thus helping to shape food preferences differently among different social groups (261). In the Asia Pacific region, 25 countries are net food importers, with much of the food trade coming from other countries in the region (262).

Liberalisation of trade has played a substantial part in the nutrition transition in the Pacific Islands, particularly by increasing fat consumption through imports of vegetable oils, margarine, butter, meat and chickens and canned meat (263,264). Between 1963 and 2000, the total fat supply in the Pacific increased by between 5 -80%, the largest increases in the most economically advanced islands (80% in French Polynesia, 65% in Fiji) (264).

**Box 30 - Enhanced and sustainable production, processing and trading of safe and nutritious local food in the Pacific**

In 2007 the Pacific Health Ministers called for a whole-of-society approach to improve food security. They recognised that improvements require multi-disciplinary approaches and multi-sectoral action; a view shared by Pacific Ministers of Trade and Agriculture. A framework for action on food security in the Pacific was endorsed by the Pacific Food Summit in April 2010 and the Pacific Islands Forum Leaders in August 2010. The Framework aims to ensure that all people at all times have physical, social and economic access to sufficient, safe and nutritious food. Development agencies and countries in the region are using the Framework to rationalise, coordinate and plan food security activities and to mobilize resources.

Source: Food Secure Pacific (265)

The Asia Pacific region, and in particular China, was one of the top destinations for foreign direct investment (FDI) during the 2000s. Despite its impact on foreign direct investment flows, the GFC has not halted the growing internationalisation of production. Out of the 102 new national policy measures affecting foreign investment in 2009, 71 of them were in the direction of further liberalisation and promotion of foreign investment. At the same time, governments are increasingly emphasizing regulation. One way to do this is through a health lens having to be applied to all trade and investment agreements (266). This could be applied to food trade and FDI. Transnational food companies, including supermarkets increasingly organize food distribution and marketing on a global scale (267). In 2003 the top thirty global retailers had 19% of the market in Asia and Oceania. In general, food processing is now the most important recipient of foreign direct investment relative to other parts of the food system. There are serious implications for nutrition security in the Asia Pacific region. Trans-national food corporations, specifically supermarkets can be very influential on eating habits through the products they choose to sell, retail price, and the labelling and promotion of particular goods (268). With increasing market penetration by trans-national food corporations there has seen an explosion in the transfer of processed foods, both in terms of variety and quantity, from developed to developing countries, thereby creating national marketplaces crammed with highly refined cheap foods that are now available to more groups and individuals and affecting local markets (267,269,270). Viet Nam, China and Indonesia are expected to be the fastest-growing markets for packaged food retail sales over the coming years, with growth rates forecasted at 11, 10 and 8% respectively. The Republic of Korea, Thailand, India and the Philippines rank among the top 10 growing markets, with total packaged food retail sales expected to grow by 5- 7% annually (267).

***The example of tobacco***

Tobacco market liberalisation can have a profound impact on health. A combination of tariffs reduction, liberalisation in FDI and minimal national tobacco control measures, increases competition in domestic markets, contributes to a reduction in the prices of tobacco products and an increase in advertising and promotion expenditures; all of which lead to increases in tobacco consumption (260). Transnational tobacco companies (TTCs) have played a major role in forcing open previously closed markets, particularly in East Asia. For example, when the Japanese government finally abolished the tariff on US tobacco in April 1987, as a proportion of total US exports, US cigarettes exported to Japan increased from 16% in 1986 to 32% in 1987. This resulted in

a stall in the decline of tobacco consumption among adults and increase in the level of consumption among adolescent girls (271). In 1988 the Republic of Korea opened its cigarette market to foreign companies under the threat of US trade sanctions. Despite strong social stigma against female smoking in the Republic of Korea, smoking rates among young Korean females increased from 1.6% in 1988 to 13% in 1998 (272).



Source: travelmeasia, Viet Nam 2010  
<http://www.flickr.com/photos/travelmeasia/4881148449/sizes/l/in/photostream/>

Fully implementing the Framework Convention for Tobacco Control (FCTC) and addressing state-owned interests in tobacco promotion in the Asia Pacific region would go a long way to reducing the single largest cause of death in the region. Of the members of the Association of Southeast Asian Nations (ASEAN), all but Indonesia has embraced the FCTC and all endorse some form of tobacco control policy. Nevertheless all these states are, to varying degrees, complicit in investing in or promoting the tobacco industry, often using the justification of poverty alleviation (273).

#### **Box 31 – Australia: plain packaging of cigarettes**

Australia's proposed introduction of plain packaging cigarette will be a landmark case, with health implications reaching far beyond Australian borders. While driven by the Minister for Health, the plain packaging policy relates also to trade, foreign affairs and commerce. Australia's draft legislation came under scrutiny at the WTO intellectual property (TRIPS) council meeting in June 2011, with some members concerned it could violate trademark rights (274). The International Chamber of Commerce and other industry groups have voiced strong opposition (275), and the Australian government will need strong resolve to progress this landmark measure to protect public health. When Canada attempted to introduce this measure the threat of being sued by the TTCs meant the reform was dropped.

## Chapter 3: Protecting the natural environment to ensure a public good for everyone

### CSDH Recommendations:

- Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity.

### Introduction

New health equity risks are emerging as a consequence of modern human societies' perturbation and depletion of the planet's biogeophysical systems – Earth's systems that sustain life (276). The increasing scale of environmental change has resulted in dangerous global warming, loss of ecosystem services, desertification and flooding of low-lying river delta regions; loss of land due to sea-level rise, shoreline erosion and coastal flooding; impaired food production and increased severity and frequency of climate-related natural disasters (277). Although most people in all countries are vulnerable to the ramifications of changing global weather patterns, both history and recent experience have shown that when conditions are harsh and resources scarce, the poor and groups marginalised by more than poverty – women, the young, the elderly, indigenous populations and other minorities – are most vulnerable (278). All of these groups, but especially women, face historical disadvantages, including limited access to decision-making and economic assets, that dictate their ability to survive both during, and in the wake of, climate-related events (natural disasters, food insecurity, population displacement, flooding, and storms). The combination of these environmental, economic and social pressures will likely exacerbate existing health risks and inequities within and between countries (7).

### *Climate change*

Recent human activity has increased the levels of natural greenhouse gases to a critical state (276,279). As a consequence, the world is getting hotter, parts of it are getting unusually wetter, and some are getting seriously drier (280,281). Parts of the Asia Pacific region are among the most geographically vulnerable to climate change but the region also faces significant within-country variations in vulnerability, with socio-economically deprived communities most at risk (2).

Temperature increases in the Asia Pacific region are projected to be in the order of 0.5-2°C by 2030 and 1-7°C by 2070 (282). Temperatures are expected to increase more rapidly in the arid areas of northern Pakistan and India and western China. Models indicate greater rainfall is expected during the summer monsoon. Winter rainfall is likely to decline in South and Southeast Asia, suggesting increased aridity from the winter monsoon. The Asia Pacific region is expected to experience an increase in sea level of approximately 3-16 cm by 2030 and 7-50 cm by 2070. The increase in the magnitude, frequency and extent of extreme floods in South Asia is highly problematic, as floods cause damage to main economic sectors in the region, including agriculture, housing and transportation infrastructure (283).

Across the region there is evidence of increases in the intensity and frequency of many extreme weather events such as heat waves, tropical cyclones, tornadoes, snow avalanches, thunderstorms, and storms (282). The Asia Pacific region accounted for 91% of the world's total death and 49% of



the world's total damage due to natural disasters in the last century (284). Furthermore, 70% of natural disasters between 2004 and 2006 occurred in regions where most of the world's most vulnerable populations reside, including the Asia Pacific region (285).

### **Ecosystem changes**

Local human depletion of environmental and biological resources is causing problems for ecosystem services across Asia Pacific, with implications for sustainable production, consumption, and related livelihood activities. Called the “Amazon of the seas”, the Coral Triangle refers to the waters off the coasts of Indonesia, Malaysia, Papua New Guinea, the Philippines, the Solomon Islands and Timor-Leste. An estimated 120 million people live within the Coral Triangle, of which approximately 2.25 million are fishers. 40% of coral reefs and mangroves have been lost over the past 40 years (286). Local degradation including coastal deforestation, wetlands reclamation for urban development, harmful and agriculture practices, declining water quality, pollution, sewage, destructive fishing and over-exploitation of marine life have led to severe impacts on these essential ecosystems. These human induced ecosystem changes are occurring across the Asia Pacific region, from India (diverting river systems for irrigation) to Australia (Murray-Darling Basin) to New Zealand (toxic algal blooms in inland waterways). Rapid climate changes are also beginning to affect the terrestrial and marine ecosystems of the Coral Triangle. Changing weather patterns are increasing the risk of floods, landslides and severe storms in some parts of the Coral Triangle, while causing crippling drought in other areas.

Rising sea levels are putting pressure on coastal communities through storm surge and inundation of fresh water supplies. Damage to coastal vegetation from storms and wildfires are breaking down barriers to erosion (286). The 1997 El Nino event damaged about 18% of the coral ecosystems in South East Asia. In Indonesia, forest productivity is 9-13 m<sup>3</sup> per hectare per year. With the change in rainfall pattern, the productivity of forest in regions with decreased rainfall will have lower productivity by 4 m<sup>3</sup> per hectare per year and those with increased rainfall will have higher forest productivity by about 2 m<sup>3</sup> per hectare per year (287).



Source: go\_greener\_oz AUSTRALIA, 2008  
[http://www.flickr.com/photos/go\\_greener\\_oz/3047060508/](http://www.flickr.com/photos/go_greener_oz/3047060508/)

As pressures on land, water, and forest resources increase, greater variability and extremes will complicate their management, impinge on human wellbeing and affect economic development. For example the region's economies are highly dependent on marine resources—the value of well-managed coral reefs is US\$13 billion in South-East Asia alone (288). Forests provide critical ecosystem services to the agricultural sector, including pollination and watershed protection, and support to fisheries. Millions of poor people and small-

scale enterprises across the region depend on forests for food, fibre, fodder and other materials, but are finding this increasingly hard as the natural forests shrink. Between 1990-2000 and 2000-2005, deforestation accelerated in Cambodia, Papua New Guinea, Viet Nam. Of particular concern are mangrove forests. The Asia Pacific region has around half the world's total area of mangroves, of which most are in South-East Asia. These are under severe strain. In Bangladesh, India, Indonesia and Thailand, mangrove forests are being destroyed as a result of the extraction of timber and the discharge of domestic and industrial waste. But one of the greatest threats to mangrove ecosystems is export-oriented shrimp cultivation – which is degrading water supplies, reducing biodiversity and damaging the common fish stocks on which many communities rely for food and income (262).

### Pathways to health inequity from environmental degradation

Environmental degradation puts additional pressure on human health and health inequities. Here we provide a brief overview of the pathways through which climate change and other ecosystem changes may affect health and contribute to inequities in health outcomes across Asia Pacific.

#### *Extreme weather events and sea level rise*

Extreme weather events and rising sea levels can cause enormous damages to lives, property, crops and infrastructure. These are a real concern in the region, which has long and densely populated coastlines e.g. over 130 million people in China, and more than half the entire population in Viet Nam live in low elevation coastal zones, and around 50-70% of the coastal areas of Indonesia are inhabited (289).

#### **Box 32 – Indonesia: vulnerability to health inequities from rising sea level**

Being an archipelago, Indonesia is exceptionally susceptible to rising sea levels. Approximately 100 of Indonesia's more than 17 000 islands are considered as small and generally flat. Additionally, Indonesia has 81 000 kilometres of coast of which 50% to 70% is inhabited. Communities living on the small islands and along the coastal lines are at higher risk of flooding, and coastal waters will become more saline and soil salinity will increase, even the groundwater aquifers will be dried out. These environmental changes may necessitate coastal population evacuation. This could have a considerable impact on the population's health, especially on the health of the refugees. Most displaced people are housed in camps and shanties, which are vulnerable to increased social problems, violence, and communicable diseases.

Source: (289)

Extreme weather events – such as the cyclones that struck vulnerable, poor, and coastal populations living in poor sanitary and housing conditions and with inadequate social infrastructures in Bangladesh, Myanmar and Viet Nam in recent times – injure and kill (290). In more severe climate change scenarios, rising seas would submerge much of the Maldives and inundate 18% of Bangladesh. Sea level rise is at present the most critical threat to the sustainable development of Pacific Island Countries (PICs). The long-term effects of climate change may even threaten the very existence of some of them. Four populated Pacific islands (Tokelau, Marshall Islands, Tuvalu, Kiribati) are already at extreme risk from rising sea levels, with whole populations living within maximum elevations of only 4 metres. In Tuvalu, land is being eroded into the sea and the entire population

may be forced to evacuate in the not-too-distant future due to a recorded sea-level rise of 5.5 millimetres per year (291).

Coastal inundation, increasingly severe storm surges (especially at times of high tide) and damage to coastal infrastructure (roads, housing, and sanitation systems) would all pose direct risks to health. There is, too, a range of indirect risks to health. These include the salination of freshwater supplies – a particular problem for many small islands, as their aquifer ‘cells’ of water are encroached upon – the loss of productive farm land, and changes in breeding habitats for coastal-dwelling mosquitoes. Other indirect health risks include the mental health consequences of property loss, break-up of communities, displacement and emigration, and the possible risks of tension between displaced and receiving groups.

**Box 33 - Indonesia: poor most vulnerable to climate change**

Climate change threatens to undermine Indonesia’s recent progress in reducing poverty and achieving the Millennium Development Goals. The poorest communities that depend on the ongoing productivity of the local terrestrial, marine and freshwater environments for their livelihoods are particularly vulnerable to precipitation changes, droughts, floods, wildfires and landslides. A study from the Singapore-based Economy and Environment Program for Southeast Asia has revealed Indonesia's most populated island of Java is the most vulnerable to the negative impacts of climate change. The report showed that Jakarta's five municipalities were the most vulnerable in Southeast Asia, with a higher than expected susceptibility to natural disasters including floods, landslides, drought, sea-level rises and tropical storms. Moreover, the Coordination Ministry for Economic Affairs of the Government of Indonesia in 2008 has published a study which demonstrated the development of Java Island has overshot its carrying capacity due to water shortage.

Source: (287)

***Extreme temperatures and the effect on health inequities***

Heat-waves kill and maim people, primarily by causing heart attacks, strokes, respiratory failure and heat stroke. Temperature extremes also affect physiological functioning, mood, behaviour (accident-proneness) and workplace productivity. The already poorer health outcomes experienced among lower occupational grades will be exacerbated by temperature extremes, especially in outdoors workers and those working in poorly ventilated hot factory conditions (289,292).

Heat wave mortality and morbidity increases have been reported in cities across Asia (292–294). Heat-related health risk is socially graded, with urban slum dwellers, lower socioeconomic and minority ethnic groups more likely to live and work in warmer neighbourhoods and in buildings that are poorly ventilated and absorb heat (295).

***The influences of climate change on infectious diseases***

There are numerous ways in which climate change promotes the emergence and spread infectious diseases. South East Asia in particular, is a region which encompasses ecological niches for emerging infectious disease due to its continuous rapid social, environmental and demographic changes (296). Recently, serious new viruses such as the severe acute respiratory syndrome (SARS) and influenza A H5N1 both emerged in the Asia Pacific region (296). Furthermore, the risk for vector-borne and

waterborne disease is increasing due to climate related changes in the environment (297). For example, floods and droughts create circumstances that are beneficial for the survival of the cholera bacterium due to the effects on salinity, sanitary conditions, pH or nutrient concentrations and human susceptibility to disease (283). Increases in the prevalence of malaria and dengue fever are strongly related to a rise in global temperatures. Indonesia for example, is at great risk for an increase in malaria and dengue and water-borne diseases due to increased rainfall and corresponding expansion of transmission zones (289).

Climate change on top of numerous other factors leaves populations across Asia Pacific highly susceptible to infectious diseases, such as a large rate of population growth and density, limited reliable water and sanitation systems, unhygienic and overcrowded conditions, poor access to health services and unsafe interactions between humans, livestock and wildlife (296).

### ***Environmental pressures on food security***

The equity implications of environmental degradation appear to be particularly profound for food security. In 2008, 582 million people across Asia Pacific are believed to have gone hungry (262). Decline in agriculture and aquaculture productivity because of droughts in some areas, rising sea levels, and extreme weather events will affect the amount of food available for consumption and its price. Climate change related freshwater shortages and water scarcity are additional causes for a reduction in food production and simultaneously constitute a serious threat to health (285,289,298).

Many sub-regions of Asia Pacific rely heavily on their national agriculture and aquaculture which leaves them very vulnerable. But there will be winners and losers. According to the IPCC, mid-twenty-first century cereal crop yields could increase up to 20% in East and South-East Asia, but decrease up to 30% in Central and South Asia. By the end of the twenty-first century, rice production in Asia could decline by 3.8%. In North Asia, grain production could fall by 26% and fodder production by 9%. In China, a 2°C increase in mean air temperature could decrease rain-fed rice yield by 5 to 12% (299). In Indonesia, based on mean data of onset of the rainy



Taro patch exposure to salt water intrusion from extreme high tide – Palau. Source: Dr Caleb Otto

and dry season, it appears that the onset of the seasons has changed in a number of Sumatra and Java islands. The national rice production system is vulnerable to extreme climate events. The second planting in rice-growing areas (currently dependent on irrigation) will be at risk.

This is particularly problematic for countries that are already facing serious seasonal food shortages due to reduced crop productions in combination with continuous population growth, such as Bangladesh (283,300). South Asia, generally, suffers from an already stressed and largely degraded

natural resource base resulting from geography coupled with high levels of poverty and population density. The majority of the rural poor are subsistence farmers occupying mainly rain-fed land. Therefore, climate change poses a serious and additional threat to poor rural communities with impacts ranging from hunger and susceptibility to disease, to loss of income and human livelihoods.

In some PICs, environmental degradation resulting from over exploitation of natural resources has led to inequity of access to scarce resources. Coupled with frequent periods of extreme weather conditions, food security amongst others has become an ongoing challenge. As warming proceeds, various fish populations important to local food security are anticipated to move to higher latitudes. This will affect protein supplies, and livelihoods, in coastal populations in many small island states, and large Asian river deltas. The world's fisheries provide over 2.6 billion people with one-fifth of their average annual protein intake. In addition to the widely-reported ongoing decline in ocean



Extreme low tide exposing corals to heat- coral deaths: Palau.  
Photo: Dr Caleb Otto

fisheries, a 2007 report by the World Fish Centre concludes that climate 'shocks' such as coral reef damage, warmer waters, acidification (due to increasing uptake of CO<sub>2</sub>) and decreased river flows (a crucial source of recycled nutrients for both freshwater and ocean fisheries) will exacerbate the already serious problem of over-fishing. The report names Pacific countries such as Samoa, Vanuatu and the Solomon Islands as particularly vulnerable (301).

### ***Environmental refugees***

The United Nations High Commissioner for Refugees identified four root causes of refugee flows. These were political instability, economic tensions, ethnic conflict, and *environmental degradation* (302). Population displacements are already occurring, as climate change begins to adversely affect people's homes and livelihoods, and it is projected that millions may become climate refugees in future years (299). In his authoritative review, Stern described earlier projections of 200 million displaced persons as 'conservative' (303). The continuous rise in sea levels and the associated hazards from floods and loss of ecosystems is likely to lead to a movement of many people who reside in coastal regions (285,304). Small island states such as the Pacific islands and countries with low-lying coastal areas are particularly vulnerable to displacements as a result of rising sea levels. The Sundarbans Islands in Bengal are among the world's largest collection of river deltas and home to millions of people on the Indian side. Two of these islands have already submerged, displacing many families (305). It is likely that many people will move to urban areas, which in turn may put people at greater risk of overcrowding and unsanitary conditions. The mental health consequences

of these social and cultural disruptions, and of associated perceptions of future threats, pose an increasingly important risk to health. This may apply particularly in children (306).

### Environmental policy that supports health and health equity

Countries around Asia Pacific are increasingly acknowledging the interconnectedness between environmental sustainability, economic prosperity and human wellbeing. A number of initiatives seek to mitigate further environmental damage and/or adapt to the existing ecological destruction, while also promoting health and wellbeing, now and in the future. Much of the policy attention is on climate change. Climate change mitigation is concerned with measures or actions to reduce global warming and most often involves reductions in the concentration of greenhouse gases. Adaptation on the other hand is about enhancing resilience or reducing people's vulnerabilities to observed or expected changes in climate.

### Adapting to environmental change

Many national adaptation programmes for action have been developed, possibly because funding was allocated to these after the Conference of Parties 11 in 2005 (284). A key aim of adaptation policy is to improve communities' resilience through adaptive capacity building approaches.

#### *Increasing adaptive capacity to environmental degradation*

In Bangladesh, the Ministry of Environment and Forest established a poultry/biogas plant providing both electricity and food, which will alleviate the problem of declining fish stocks (307). Bangladesh is also using nationally standardised risk assessment procedures, in conjunction with communities, to develop community adaptation plans in Bangladesh (307).

Not all initiatives need to come from new technologies. Efforts are underway to reinstate traditional pastoral networks in Mongolia, to foster appropriate rangeland management practices in arid regions (307). In Sri Lanka, Pangu, a traditional system of cooperative irrigation reservoir maintenance, helps ensure water availability during droughts.



Source: International Rice Research Institute (IRRI), 2010.  
<http://www.flickr.com/photos/ricephotos/4762635472/>

The Philippines National Red Cross leads an integrated community disaster planning programme in five provinces particularly vulnerable to typhoons (308). This programme involves:

- Partnership with municipal and provincial government units
- Community disaster action team formation and training: The core of the programme is the group of community volunteers (including fishermen, women, youth and businessmen) who are trained in vulnerability and capacity assessments, disaster management and information dissemination. They work with the community to prepare a disaster action plan
- Risk and resources mapping: This identifies the most important local hazards, who and what may be at risk, and which mitigation measures are possible. The maps are often employed as land use planning tools by local government units.
- Community mitigation measures: Based on the disaster action plan, the community will initiate mitigation measures, which may be physical structures (e.g. seawalls), health related measures (e.g. clean water supply) or planning tools (e.g. land use plans, evacuation plans). These measures are undertaken by community volunteers with support from the Red Cross and local government.
- Training and education

In Nepal, the poor are especially vulnerable to floods because most houses are made of mud, and incomes are too low to recover from the damage. The Knowledge and Research program from CARE and the Nepal Red Cross Society together with Jaleshwar Municipality began implementing community-based low cost flood risk reduction measures through action planning (309). The project enhanced the capacity of communities to cope and manage flood disasters by building institutional capacities through establishing various committees including, Community Based Disaster Management Committee, Disaster Preparedness Sub-committees, First Aid Sub committees, Disaster Relief Subcommittees, and Coordination Subcommittees. These committees were provided with relevant skills and knowledge to enable them to handle disasters more efficiently and effectively. The project produced two pictorial manuals on how to prepare for floods, which were distributed among the communities. In Bangladesh, effort is being made to diversify livelihood strategies in areas vulnerable to flooding (307). The Himalayan Climate Centre is initiating a collective disaster insurance scheme in Western Nepal (307).

In the Solomon Islands, roads in areas highly sensitive to climate change are at risk from frequent landslides during the rainy season as well as from flooding due to sedimentation and subsequent reduced capacity of rivers and flood plains. The Solomon Islands Road Improvement Project uses local workers to improve road infrastructure, reducing climate change vulnerability of flooding, promoting local employment and addressing road safety (310). In Nepal, tunnels have been drilled to reduce the risk of glacial lake outburst flooding from Tsho Rolpa Lake (307). In Samoa, a number of villages are conserving nearby mangroves to safeguard biodiversity, provide income and protect the village from storm surges (307). The agriculture sector in Palau is working to increase taro patch resiliency in response to salt water intrusion resulting from extreme high tides. In Australia, the 2009 heatwave across southern Australia led to an integrated response across sectors (Box 34).

**Box 34 – Australia: heatwave planning for Victoria**

The major public health concerns stemming from the impacts of the 2009 heatwave in Victoria, Australia acted as a catalyst for the evaluation of heatwave planning policy and for the development of more comprehensive plans. Stakeholders now largely realise that the impacts from extreme heat events can be reduced considerably with appropriate planning that involves effective communication, coordination, cooperation, collaboration, training and education. One aspect of this planning has led to clearer threshold temperatures for activating and escalating coordinated responses in the lead-up to and during a heatwave, such as issuing heatwave alerts, and for declaration of an actual heatwave emergency. It has also resolved some of the uncertainties concerning which agencies would lead and/or coordinate the heatwave response. Some of the key mechanisms implemented in Victoria are listed below.

**Department of Health** is working with Personal Alert Victoria to provide additional support during a heat event to over 22000 vulnerable clients; is expanding the 'Keeping in Touch' weekly telephone program to include all 7000 public housing tenants aged 75 years or over; is providing bushfire and heat advice for Home and Community care organisations; is delivering public health messages and communications delivered through a range of community-based organisations; is establishing a system of consultation with health and community service providers; has fast-tracked funding for councils to develop heatwave plans for addressing preparedness; has further developed its Heat Health Intelligence Surveillance System in order to track and report on the health impact of heatwaves; is targeting large bodies working with the community that sit outside the responsibility of local councils and assist them to increase their capacity in response to a heat event; has developed programs to maintain public drinking fountains, and lighting parks in the evenings so people can cool off and also be safe, and is developing a strategy for educating health professionals on heat issues, with an emphasis on dealing with the homeless and mental health.

**Victoria Police** is using a web-based, real-time information-management system that provides a single access point for the collection and dissemination of emergency or event related information; has new command and control arrangements to improve its internal emergency management and communication.

**Red Cross** has developed a protocol around an internal early warning system for heatwaves, whereby heat health alerts broadcast by Department of Health would trigger a series of events and initiate communication strategies; has partnered with other organisations to augment its capacity during emergencies, and is conducting preparedness work with vulnerable community groups.

**Ambulance Victoria** is adjusting its triggers to make them more relevant to the situation to avoid over-notifying or over-preparing and has improved call monitoring and activation and coordination of the emergency management centre.

Source: (311)



***Addressing drivers of vulnerability to environmental change: policy to improve daily living conditions***

Many of the factors that make communities and countries vulnerable to the health risks associated with climate change and ecosystem damage are those social factors that in and of themselves increase the risk of poor health. Environmental change acts to amplify the health risks from existing inequities in social conditions.

The built environment can help people and communities adapt to climate change and mitigate further climate change, depending upon how energy-efficient and carbon-intensive the city's buildings, urban built form and transport systems are. However, they have the potential to widen inequities because people who are more socially disadvantaged are more likely to live in hazardous areas and have less access to adaptive technologies (such as air conditioning or services such as vector control, to give but two examples). Planning and land use controls can prevent people from building in zones at risk for flooding and landslides (see Box 35 for China example). When land development is not guided, planned or controlled, the land exposed to flood hazard is liable to be more highly developed due to its lower cost. In developing countries the proportion of structures subject to planning or building controls is low. The lack of controls implies that those people most at risk may well be increasingly placed at risk - uncontrolled development is likely to be denser, especially in informal settlements, and is typically characterized by substandard accommodation.

**Box 35 - China: addressing flood risk in Chengdu**

As part of a revitalization scheme of slum districts in Chengdu the inhabitants were moved away from the river bank into new accommodation. About 30,000 households were moved and this created space for a green buffer zone along the riverside. In 1985, the municipal government initiated the plan with the work carried out from 1993 to 1998. The plan had several best practice features including a clear target to reduce flood risk. In the past, households in the slums projected over the river and were often swept away by floods in rainy seasons. The rainy season brought constant vigilance so that evacuation could be effected. After the rain stopped, all the families had to deal with the mess brought about by the flood, resulting in great hardships, suffering and economic loss. As part of the plan the two rivers, Fu and Nan, were de-silted and widened thus reducing flood risk to a 200 year return period expectation. Engagement of the local community ensured that the public participated in the scheme and resettlement was completed without litigation. Per capita living space rose by a factor of 1.4 and the relocation of the slum dwellers reduced congestion in the city. There was also the benefit of 30-35% of owners gaining property rights which they had not held before. Green zones were created which improved the environment greatly and allowed for the construction of an award winning natural park area with water purification facilities which is now on the national tourist register.

Source: (312)

One way to help buffer the poor placement of development is through building quality guidelines and regulations, such as a decision issued in 2006 by the Thua Thien Hue provincial authorities in Viet Nam to encourage cyclone-resistant building practices, can increase cities resilience to climate change related risks and therefore health risks (UN-HABITAT 2010), although care needs to be taken that such policies do not price the less affluent out of building resilient houses. But unless

regulations are in force, developers and designers may have the tendency to ignore flood resilient designs because of increased cost and lack of expertise. For example, residents of Brisbane in Australia have observed that the practice of raising houses on stilts, which used to protect them from flooding, has largely been discontinued due to great cost in the recent flooding (312).

**Box 36 - Viet Nam: Integrative Urban and Environmental Planning in Ho Chi Minh City**

As a densely built-up urban area in a low-lying region, Ho Chi Minh City has been historically sensitive to climatic effects. However, the vulnerabilities of lives and livelihoods to climate-related environmental processes are primarily the result of inadequate and unsustainable urban development practices associated with complex natural settings and societal structures. This combination of factors results in a high degree of physical and social vulnerability in most parts of the city.

The “Megacity Research Project Ho Chi Minh – Integrative Urban and Environmental Planning Adaptation to Global Change” is a transdisciplinary cooperation between Vietnamese and German institutions. The project aims to develop strategies for adapting urban land, urban structures and urban development concepts to climate changes and to minimize or avoid impacts of climate change in the megacity Ho Chi Minh City.

Using the principles of adaptation policies, as formulated by the Intergovernmental Panel on Climate Change (IPCC), the work will focus on improving the ability of decision-makers to manage the information relevant to adaptation and on evaluating the range of technological options for adaptation in urban planning and design. The research project is divided into two Action Fields:

1. The Action Field “Urban Environment” will evaluate the local impacts of climate change as well as their spatial manifestations. It includes work streams on: adaptation planning framework, urban flooding, urban climate, urban redevelopment and upgrading, urban energy and urban transport.
2. The Action Field “Urban Development” will develop strategies for adapting the built urban environment. It includes work streams on: precaution and adaptation strategies to climate change impacts on the regional and city level; integrative planning approach for new energy- and climate-efficient neighbourhoods; liveable city, urban regeneration and community-based adaptation; and energy- and climate-efficient housing typologies.

Based on the knowledge gained from the research in Action Field 1, small-scale projects such as building structures and prototypes will be conducted with the Vietnamese partners to inform further appropriate responses, seeking to mainstream sustainable urban development strategies. Both the analytical and the implementation-oriented aspects of the research project can serve as useful approaches to the energy-efficient and climate-appropriate development of other future megacities, not only in Southeast Asia (313).

## Climate change mitigation

### *Taxation and regulation*

Taxation and regulation can be a powerful policy tools but are often highly controversial. Climate change mitigation is, generally, a highly political strategy. Putting a price on carbon will inevitably cause increases in energy prices, and failing to compensate low-income households for these increasing costs would be regressive (314). At the same time as the Australian government announced the carbon tax (Box 37), they announced other tax changes, with more than half the money raised by the carbon tax to be redistributed to households by way of tax cuts and increases in pensions, allowances and family payments.

#### **Box 37 – Australia: carbon tax**

At the centre of the Australian government’s policy on climate change is pricing carbon – commonly referred to as a “carbon tax”. The idea is that polluters will pay per tonne of carbon they release into the atmosphere. This cost will initially be set at AU\$23, and increase gradually until 2015, when there will be a shift to a trading scheme that will let the market set the cost. The role of civil society, particularly environmentalist and mainstream health associations, has been important in moving the agenda forward and creating public support to embolden the government.

In 2001 Japan enacted a tax on high-polluting vehicles while reducing the tax on low-pollution vehicles to encourage the development and purchase of greener vehicles. Japan also restructured its energy taxes to reflect the environmental impact of carbon dioxide emissions, including a new tax on coal. The Republic of Korea has a policy of “extended producer responsibility” which requires companies to recycle packaging, and has increased recycling by 14% (315). Bangladesh mandates the utilization of solar photovoltaics in new construction (315). In New Zealand, a retrofit of homes with government subsidised insulation and non-polluting heaters improved health, lowered the number of extreme temperature-related deaths, and helped reduce carbon emissions (316).



Source: aokettun, Viet Nam, 2008,  
<http://www.flickr.com/photos/aok/3108275694/>

**Box 38 – China: a multi-pronged approach to climate change**

The Government of China and a number of United Nations organizations have signed off on a US\$19 million three-year joint programme to coordinate strategies and policies designed to enable communities to withstand the adverse impacts of climate change (315). The aim is to incorporate the Strategy into policies and legal measures, improve local capacities and partnerships for financing technology transfer and models, and ensure the adaptation of vulnerable communities to climate change. While all of China is expected to feel the impact of climate change, poor areas are more vulnerable. In western China, glacial melting in the Himalayas and shifting patterns of land and water use for large upstream and downstream populations increase risks to livelihoods. On the south-east coast, rising sea levels threaten the lives of local people. Thus, vulnerability assessments and adaptation measures are needed, which tie in policies devised to eradicate poverty, combat diseases and ensure environmental sustainability. Vulnerability assessment and adaptation constitute one of the major components of the programme, the other two being mitigation and climate change policy.

The adaptation component addresses the areas of: (a) poverty reduction; (b) agriculture development in the Yellow River Basin, including vulnerability assessment and adaptation measures; (c) water management in the Yellow River Basin, including improved groundwater monitoring in high-risk areas; (d) a strategy for adapting China's health planning and practice to climate change; and (e) assessment of employment vulnerabilities and development of adaptation strategies. There is a need for the Government and the commercial sector to assess the potential impacts on employment in order to formulate effective policies and responses. The programme intends to build on United Nations experience derived from past and ongoing projects and from grappling with high-level policy issues, to build on potential synergies among organizations in the United Nations family, to utilize the complementary support of other bilateral and multilateral organizations, and to focus on rural areas so as to maximize environmental and social co-benefits. The process of consultation among United Nations institutions and the Government of China, identification of priorities, creation of partnerships and pursuit of implementation and monitoring activities will all contribute to the creation of a model for replication in other countries.

***Mitigation through development programmes***

Large numbers of the Asia Pacific poor depend on biomass fuels for household use, and these fuels are key contributors to climate change. Efforts have been made to reduce reliance on these fuels, and the environmental impact of firewood collection in India and Nepal through poverty reduction and the provision of stoves (Box 39). Poverty alleviation efforts and providing alternative sources of livelihood have also been used to reduce harmful environmental fishing practices in Bangladesh.

**Box 39 - Nepal: an intersectoral approach to clean air, for health and the environment**

In 2008, the Indoor Air Pollution and Health Forum Nepal (IAPHFN), Practical Action and World Health Organisation (WHO) jointly organised a two day workshop on Clean Indoor Air: The Right to a Healthy Life in Kathmandu, Nepal (317). The purpose of the workshop was to discuss a right based approach to health and environment focusing on access to clean energy and technologies to improve indoor air quality and ensure healthy living. More than 100 individuals participated in the workshop representing from government, nongovernment, private sector, academic institutions and various media houses. A main outcome of the workshop was the Kathmandu Declaration, which (among other things) called for integrated national policies encompassing all sectors on indoor air pollution, ensuring the participation of women, children, disadvantaged and socially excluded groups in designing energy policies, an Equitable Energy Policy with financing and subsidy mechanisms to ensure access of the poorest communities to microcredit facilities, as well as cooperation and networking among specialist groups on housing, health, gender, energy and environment in government and inter-government organisations so that they better assume their responsibilities. The IAPHFN continues as a strong network with organisations with similar goals and works to bring about effective policies that favour mitigation of indoor air pollution and health related problems.

Grameen Shakti (GS), a subsidiary of Grameen Bank in Bangladesh, began importing solar home system (SHS) units in 1996. By 2010, it had sold 650,000 to off-grid rural customers (315). The vast majority of field engineers who sell, install and maintain SHS in Bangladesh have received a diploma in engineering from the Bangladesh Technical Education Board. These engineers, many of whom are women, also train less educated women on how to construct and repair component parts of solar PV systems, which creates a positive effect cascading down to less educated workers. In addition to being involved in sales, GS is engaged in indigenous research, which has helped GS reduce the cost of the panels, adapt the technology and develop accessories, such as a mobile phone battery charger. All the parts are now produced domestically.

The Pacific Islands Greenhouse Gas Abatement through Renewable Energy Project (PIGGAREP) aims at helping 11 different island countries overcome the barriers to effectively using renewable energy technologies at the national level. The Cook Islands is a recipient of the benefits from PIGGAREP which is financed by the global Environment Facility, implemented by the United Nations Development Programme (UNDP) and executed by the Secretariat of the Pacific Regional Environment Programme. The Cook Islands has an electricity target of 50% renewable energy by 2015 and 100% by 2020.

**Maximising co-benefits**

It is important to consider the social as well as environmental impact of interventions to address environmental change. Reforestation of “bare-hills” in Viet Nam inadvertently exacerbated poverty and inequities for the poor (318).

The “Grain for Green” programme in China pursued dual goals of poverty alleviation and environmental sustainability (319). This programme was established in 2001 to restore the country’s forests and grasslands to prevent soil erosion and to alleviate poverty in some of China’s poorest regions. Participating households are each compensated with three forms of payments: an annual

compensation of grain (which later was converted to cash compensation), cash compensation and free seedlings. In addition to conserving soil and water in China's ecologically fragile areas, the program aims to restructure the rural economy so participating farmers can gradually shift into more environmentally and economically sustainable activities.

Economic stimulus responses that have co-benefits for environmental sustainability include Republic of Korea's 'green new deal' package, which allocates over US\$38 billion for green projects that will create close to one million green jobs over a four year period (110). China has focused 20 -30% of its package on low carbon production, and also earmarked US\$440 billion to support wind and solar energy (110).



Source: Ray Devlin, China, 2008 <http://www.flickr.com/photos/21061651@N08/3052798559/>

## Chapter 4: Governance models that rebalance power and resource distribution

### CSDH Recommendations:

- Place responsibility for action on health and health equity at the highest level of government, and ensure its coherent consideration across all policies.
- Get the health sector right – adopt a social determinants framework across the policy and programmatic functions of the ministry of health and strengthen its stewardship role in supporting a social determinants approach across government.
- Strengthen public finance for action on the social determinants of health.
- Fairly allocate government resources for action on the social determinants of health.
- Empower all groups in society through fair representation in decision-making about how society operates, particularly in relation to its effect on health equity, and create and maintain a socially inclusive framework for policy-making.
- Enable civil society to organize and act in a manner that promotes and realizes the political and social rights affecting health equity.

### Introduction

Good governance underpins action to improve health and health equity. It helps rebalance the power distribution and serves as a mechanism through which fairer financial, physical and social resource distribution can occur. Achieving health equity requires global, regional, national and local level governance, within which all sectors take responsibility for reducing health inequities, through actions to address the social and environmental determinants.

### Intersectoral action

One governance mechanism which can help address the social determinants of health is intersectoral action (ISA). As most of the environmental and social determinants of health inequity lie outside the health sector, coherence between sectors plus intersectoral approaches are essential if progress is to be made. Despite widespread recognition of the importance of taking a “joined-up” approach, implementing ISA on the social and environmental determinants of health and health equity (SEDH) has often proved challenging. There is no “one-size-fits-all” approach, and this section will describe a range of different approaches that have been used across Asia Pacific to implement ISA on the SEDH.

#### ***‘Health in All Policies’ approaches***

The adoption and implementation of Health in All Policies (HiAP) in South Australia (see Box 40) has been influenced by the following four essential factors: a high level mandate from central government, an overarching policy framework which can accommodate health lens application to diverse program areas, a commitment to work collaboratively and in partnership across agencies and a strong evaluation process. This represents a practical and applied inter-sectoral approach to complex policy issues.

**Box 40 – Australia: why Health in All Policies promises to promote health in South Australia**

As is the case for many other countries and areas, the South Australian health system is struggling with escalating health care costs, the growing burden of an ageing population and an increasing incidence of chronic disease. At the same time the evidence base has been documenting that the best opportunities to change the dynamics that influence health lie outside the direct control of the health sector. The social determinants of health provide the social, economic and environmental levers to influence population health outcomes. It was within this context that Professor Ilona Kickbusch proposed that South Australia adopt a HiAP approach and that this approach be applied to targets contained within South Australia's Strategic Plan (SASP); the Government's overarching vision for its State.

The unique advantage of this proposal was the significant and strategic importance of SASP to all South Australian government agencies. SASP contains 98 targets under 6 objectives and there is comfortable alignment between the SASP objectives and the social determinants of health. Oversight for HiAP was placed under the auspices of the high level committee (the Executive Committee of Cabinet) responsible for overseeing the implementation of SASP, reflecting the strategic importance of the work.

Investing in building strong inter-sectoral relationships provides an opportunity to explore some of the interconnections between the SASP targets, and to identify joint areas of work to achieve a win-win solution; that is to work towards the achievement of partner agencies' targets as well as improve the health of the population. HiAP provides a mechanism for agencies to jointly reflect on a particular policy issue, and work in a collaborative and deliberative way to determine issues and take timely and proper policy decisions.

The HiAP health lens analysis process builds on traditional health impact assessment methodology by incorporating a suite of additional methods (e.g. economic modelling) to allow the process to deliver both rigour and flexibility that accommodates the operational culture and policy imperatives of the partner agency. As a consequence, the methodology employed for a health lens is modified for each target area. Evaluation, an essential component of the HiAP process, is built into each individual health lens.

One of the important lessons learnt through working across government has been the recognition that the concept of 'health inequity' is rarely raised during the policy discussions and deliberations of other agencies. Yet in nearly all health lens projects the focus moves to issues related to equity as the core issue. It seems that often, the problematic policy areas for government agencies overlap with issues of equitable distribution and utilisation of government resources. While this is not a perfect explanation of a complex pattern of relationships between health and other agencies or the government and its citizens, it has aided the HiAP team in feeling confident that the health lens projects do have capacity to impact on health inequalities. Government departments have been very receptive to South Australia's HiAP processes, and responses from Executive Committee of Cabinet and in particular its sub group, the Chief Executive's Group, have been very positive.

**Key lessons learnt:**

- Inter-sectoral work requires compromise and trade-offs.
- Takes time and commitment



- Builds knowledge of the broad strategic agenda of government which helps to navigate health lens projects through potential politically sensitive areas.

#### **Ongoing Challenges**

- Language - different understanding and interpretations between sectors
- Linking the core business of other sectors to the SDH and to Health – there may be long pathways between health outcomes and policy action in another sector
- Gaining commitment from Government agencies in a time of limited resources
- Making the HiAP agenda and inter-sectoral work relevant for the health system
- Current evaluation methodologies do not adequately capture complexity of cross sectoral work and the impact of long term policy change.

Conducive structures are necessary but not sufficient to achieve ISA on the SEDH. In 2002 Mongolia established a National Public Health Council, headed by the Prime Minister and represented by all line ministries. This is an exciting mechanism for nurturing and initiating intersectoral collaboration for public health, and for broadening focus to include actions that address the SEDH. However, sadly it is almost inactive, despite public health being a major part of the Ministry's and the Government's remit (320).

In the Pacific, a vision of "Healthy Islands" has proven to be a powerful unifying driver for taking a more holistic approach to health and environmental wellbeing. The Ministers of Health of Pacific Island countries articulated the 1995 Yanuca Island Declaration, a vision of health for island countries that sought to encapsulate for their countries the ideals of New Horizons in Health. Healthy islands should be places where (148):

- children are nurtured in body and mind;
- environments invite learning and leisure;
- people work and age with dignity;
- ecological balance is a source of pride

In the two years following the Yanuca Island Meeting, the "Healthy Islands" vision inspired a series of diverse projects on the broader environmental determinants of health including, malaria control (Solomon Islands), environmental health and health promotion initiatives (Fiji); improvement of water supply and sanitation through community development (Tonga); participative assessment of health needs and development of a national Healthy Island plan (Nauru); and community-based health promotion projects in the Cook Islands, Kiribati, Niue, Tuvalu and Samoa (148).

**Box 41 - Malaysia: People First in All Policies**

At independence in 1957, Malaysia inherited a rural urban divide and racial identification of specific economic functions. Thus, the focus of the government's welfarist policy has been on growth with equity. This has involved the formulation of national social policies to reduce poverty and at the same time to restructure society by addressing economic imbalances and eliminating racial disparities.

The poverty reduction approaches placed a strong emphasis on rural socio-economic development addressing the social determinants of health. This approach has served Malaysia well over the decades but since the 1990s Malaysia has been caught in a middle income trap. Realising that achieving a high income country status by 2020 is not possible at the present economic trajectory, Malaysia has embarked on a national transformation agenda based on the four pillars of inculcating the cultural and societal values under the 1Malaysia Concept and the twin commitments of *people first* in all policies & projects and *performance now*; a government transformation programme; macroeconomic policies under the economic transformation programme; and the operationalisation of these policies through the 10<sup>th</sup> Malaysia Plan.

The highest political commitment is given to the implementation of these national policies by the various agencies, orchestrated and coordinated by a central planning process which cascades down to the state and district administrative levels of the government machinery. The government transformation programme, with its focus on a whole-of-government approach, is a natural progression for the primary health care approach to addressing the social determinants of health as a vehicle for social justice to reduce health inequalities.

The implementation of Healthy Public Policies in Malaysia, which emphasizes the role of intersectoral activity at the central governmental level, has been significantly enhanced since the late 1970s. The early driver to health equities was the New Economic Policy's focus on reducing urban-rural differentials. The coordinating agency at the central level is led by the National Development Council made up of selected ministers and is chaired by the Prime Minister. It resolves coordinating issues in the implementation of various development projects, giving particular attention to projects on poverty reduction and those targeted at improving the socio-economic position of the poor and underserved. In the New Economic Model, the National Development Planning Committee is the premier body for policy development, coordination and consultation before policy is presented to Cabinet, is being revived.

Source: Ministry of Health, Malaysia (174)

**Local level approaches**

Intersectoral approaches have also been successful at a local level. Let's Beat Diabetes (LBD), in Auckland, is an example of a local level-community partnership inter-sectoral approach, led by the health sector. A wide group of community partners, led by the Counties Manukau District Health Board (CMDHB) developed a five year district-wide intersectoral strategy aimed at long-term, sustainable change to prevent and slow diabetes. It was guided by the basic concept that a '*whole society, whole life course and whole whanau/family*' approach was needed including action on social determinants (321). LBD has been successful in facilitating and supporting a considerable range of

collective action and broadened relationships from over 500 partners. These partners range from ‘grassroots’ community groups, NGOs, and churches, to government agencies, large employers and multinational food companies.

LBD demonstrates the potential for health led ISA action to leverage funding from other sources – a small focus of LBD activity was to encourage the number of community vegetable gardens – this activity drew attention and co-funding from the Ministry of Health, the Ministry of Māori Development and charitable trusts; the local Manukau Institute of Technology developed an accredited horticulture course, the local councils have supported the activity on council controlled land, and neighbouring district health boards are introducing similar projects (321).

LBD also demonstrated some exciting partnerships with the private sector to address the environmental determinants of diabetes. The DHB and food industry representatives collaborated to undertake a range of practical activities, including making sugar-free drink the default option across 21 McDonald’s restaurants, which saw a 17% reduction in sugar consumption across the drinks range in 6 months, around 10 tonnes less sugar consumed (321). Other initiatives included fruit and vegetable promotion through a low cost supermarket chain, with pricing discounts, promotional activity and meal preparation demonstrations, as well as agreement by four large dairy providers to work together on increasing milk consumption – but with a greater proportion being low fat milk (321).



Source: nyaa\_birdies\_perch, 2007, New Zealand.  
<http://www.flickr.com/photos/birdies-perch/490121113/sizes/m/in/set-72157600186348397/>

The WHO Healthy Cities Program has encouraged ISA in many cities across the Asia Pacific region. There is an active Alliance of Healthy Cities in the region, with members from Australia, Cambodia, China, Japan, Republic of Korea, Malaysia, Mongolia, Philippines and Viet Nam. Members of the Alliance are municipal governments, national governments, NGOs, private sectors, academic institutions, and international agencies. The Alliance promotes the interaction of people and information exchange, research development, and capacity building programs. It also issues Partnership Development awards to acknowledge cities which demonstrate outstanding ISA. Recent awardees include the Health Promotion Board, Singapore, for its successes with partnerships; Sai Kung District, Hong Kong SAR, for extending the breadth and depth of intersectoral partnership through a district-wide holistic health promotion campaign; and Gangnam-gu, Seoul, for developing a partnerships to create a walking-friendly Eounju Street (322).

### Roles for the health sector

As discussed previously, the health systems itself contributes to inequities in health, and Chapter 3 of Section 3 outlined a number of ways that the health sector can intervene to address these inequities through public health programmes and health care services. This section considers the health sector's role in broader action on SEDH. The health sector has four broad, inter-related ways in which to contribute to governance for action on social determinants:

1. The health sector has a key role in advocating for a social determinants approach and explaining how this contributes to benefits across society and for different sectors.
2. The health sector has particular expertise and responsibility to monitor health inequities and the impact of policies on social determinants on health inequities.
3. The health sector can play an important role in bringing sectors together to plan and implement intersectoral action on social determinants of health. The health sector should avoid claiming this as an exclusive role, and facilitate rather than claim leadership.
4. The health sector has an important role in building capacities for work on social determinants.

### Promoting community participation

Improving governance for health equity requires social participation. There is a role for social participation in all aspects of action on the SEDH, from advocacy, agenda and priority setting, design of programmes and services, implementing and evaluating programmes and democratic political participation. Having power over the situations that shape peoples' lives addresses a determinant of health in itself, and one that is often not evenly distributed.



Source: (323)

**Participatory planning**

People who are the intended beneficiaries of government policies and actions have a right to participate in their design, delivery, and assessment. Evidence shows that successful engagement of target communities in decisions about how to address social determinants of health will increase the likelihood of policies and actions being appropriate, acceptable, and effective and can have a direct effect on individual health by raising people's sense of control over their lives (324).

In Thailand, the National Health Assembly, enshrined in law by the National Health Act of 2007, is a mechanism for opening up the debate on public health policy-making to citizens (325). Thailand's first National Health Assembly, took place in 2008 and was attended by over 1500 people. A broad cross-section of Thai society was represented, including 178 delegations from government agencies and provincial authorities, the private sector and civil society. In addition to health care and illness issues, the Assembly discusses a range of determinants such as agriculture, food prices, economic crises and safe media access for youth. In a format similar to the WHO World Health Assembly, each of the 178 participating groups has equal speaking rights, and once resolutions have been adopted they are considered by the National Health Commission, which reworks them for ministerial review and possible inclusion in national policy.

Village sustainable development plans are being used in all 366 villages in Samoa as the basis for delivering services. The methodology for these plans was adopted and scaled up from similar planning processes used in the 22 communities that had been affected by the 2004



Source: Rajkumar1220, Bhutan, 2009

<http://www.flickr.com/photos/ahinsajain/5977595181/sizes/s/in/photo stream/>

tsunami, emphasizing data collection and the prioritization of village goals through an inclusive process involving traditionally marginalized groups (115). Sri Lanka's Community Development Councils and Community Action Planning are both processes whereby community members discuss, consider, and take decisions on planning, implementing, and maintaining physical improvements to their settlements, as well as other useful developmental activities which affect them (326). A community visioning process has been used to develop land use plans in Palau.

**Decentralisation and local control**

Decentralisation, involving the transfer funds and decision-making power to local authorities, can be a useful strategy in encouraging community participation in planning. Decentralization of decision-making promises to improve health equity through greater citizen involvement in setting priorities, monitoring service provision, and designing services more aligned to local needs. However it has often been hard to achieve in practice, with insufficient attention given to building the capacities required to participate effectively and manage resources locally. Also there is no guarantee that

decentralised decision making will not mimic the inequity producing features of the centralised system. Decentralisation needs to be accompanied by increased participation of marginalised groups to improve equity impact of decisions.

Between 1999 and 2008, Indonesia decentralised health care funding and delivery to regional governments, paradoxically resulting in substantial exclusion of its poor and uneducated citizens from the health care system while simultaneously expanding the opportunities for political participation for educated elites (327). The example from Nepal (Box 42) also describes some of the challenges in making decentralisation work as a strategy to create genuine local participation and control.

#### **Box 42 - Nepal: Health Facility Operation and Management Committees**

Nepal instituted a set of health reforms from 2000, to improve the equity of health care services, especially for marginalised rural communities and women (328). The major objectives were to (a) increase coverage of essential health care services with a safety net for the poor and vulnerable population, (b) decentralized management of health services and (c) build public-private-partnership. As part of the decentralization strategy, 'Health Facility Operation and Management Committees' (HFOMC) were set up, to give local and community control over local health facilities. These committees consist of a variety of community representatives, including women and members of marginalized castes. The HFOMC's were to assume full responsibility for the planning operation of local health facilities, in order to make services more appropriate and accessible to community needs. However, health facilities were handed over with a short notice and without adequate planning and preparation. HFOMCs needed to build management skills to fulfil the intended objectives. The participation of women and marginalised caste members on committees was often token, and the decentralization instead placed increased responsibilities for management on health workers (329). In the HFOMCs, special emphasis needed to be given to promote the voices and interests women and marginalised caste groups in HFOMC meetings, and regular coaching to *dalits* and women members was necessary to support them in their roles and responsibilities (329).

Decentralisation can be a valuable tool to facilitate social participation in health, but it needs to be implemented in a staged and supported manner to maximise its success: "hand-over is not only the changing the signboard or letterhead, it should be a process to make local bodies capable to take up decentralized functions" (329). Capacity building in this context must be seen as a process not an event (330). Also, for social participation to truly address the needs of marginalised groups, additional efforts need to be made to address social exclusion to enable their contribution to be meaningful.

#### **Civil society and advocacy**

The CSDH called for support for a "social movement" to address health equity through the social determinants of health. This social movement requires expression through the political process, is sustained over generations, and has the strength to overcome the entrenched hold on power, money and resources that currently blocks the pursuit of health equity. Civil society organisations play a critical role, both in giving expression to these deeply held societal values, partnering with

government during implementation, holding governments to account for progress, and through advocacy with and for people who experience health inequity, environmental degradation and social injustice. Achieving equity in health will continue to require sustained advocacy from civil society to convince those with institutional power that action on the social determinants of health is the right thing to do, is necessary for human development, and possible.

The concept of what makes up civil society differs across countries, cultures and political perspectives. Here we refer to voluntary and organized collective action to advance shared interests and causes. Many public health gains in the past have resulted from the struggles of mobilised citizens through civil society organisations such as trade unions, environmental lobby groups and faith-based organisations (331).

Across Asia Pacific, local citizens engage in collective action for health in ways that are often overlooked by state agencies and external observers (332) – see Box 43 to Box 46. In the Solomon Islands, for example, churches provide about 27% of educational services, while in Papua New Guinea church NGOs provide 50% of rural health services (200). Some advocacy groups across the region promote specific policies on the SEDH. The Southeast Asia Tobacco Control Alliance (SEATCA) is a multi-sectoral alliance established to support ASEAN countries in developing and putting in place effective tobacco control policies, in response to a grave need to fast track tobacco control policies in Southeast Asia (333). The alliance works to identify tobacco control priorities in the region and to coordinate efforts on these priorities, and promotes knowledge-sharing among countries for effective, evidence-based tobacco control measures and regional cooperation among its advocacy partners. The changing nature of communication and increasing connectivity has led to civil society increasingly using social media for advocacy activities. GetUp is an Australian non-profit organisation that has co-ordinated a number of successful and high-profile campaigns on a range of social justice and political issues, primarily through the Internet (334). They use email and website communications to mobilise funding from supporters, to run campaigns in mainstream media, including newspaper and television advertisements. In Palau, young people used Facebook to mobilise civil society action against casino development (see Box 44).

**Box 43 - New Zealand: Action for Children and Youth Aotearoa**

Action for Children and Youth Aotearoa (ACYA) is a coalition of non-governmental organizations, families and individuals whose purpose is to promote the well-being and rights of children and young people in Aotearoa New Zealand. A key basis for ACYA's work is encouraging the Government to act on the recommendations of the United Nations Convention on the Rights of the Child. ACYA has provided alternative reports to the United Nations Committee on the Rights of the Child and facilitated and supported children to tell their views and experiences to the Committee. ACYA activities also include providing alternative reports to other human rights treaty monitoring bodies, making substantial submissions and giving advice to the New Zealand government, and sharing information about the rights of children and opportunities for advocacy.

Source: ACYA Incorporated (335)

**Box 44 - Palau: Council of Chiefs mobilising community action against casino development**

The people of Palau have fought against casino development in Palau for over 20 years. After strong influence from foreign business interests, a bill to introduce casino gaming was introduced in the House of Delegates by Palauan lawmakers, shortly after they were sworn into office in 2009. A public referendum to legalise casino development was held on 22 June 2011, in which over 75% of Palauans voted “no”. This strong message from Palauan citizens was mobilised in part by an intensive anti-casino campaign spear-headed by the Palau Council of Chiefs. The Council is made up of 16 Chiefs representing the 16 states of Palau. The Chiefs mobilized their communities including different church leaders, women organizations, youth and school groups. Children as young 5 and 6 year olds participated in the anti-casino campaign. Chiefs went on the local TV and Radio stations. They ran advertisements in local papers, and distributed flyers and t-shirts. Youth used Facebook to send messages to their friends to vote “no”. Two days before the referendum, a storm and rain came but women and their children stood by the busy intersection along the main street in Koror holding posters which read, "Vote No Casino"; and "Keep Palau Casino Free". Their umbrellas blew away, but women and their children stood there until darkness came.

**Box 45 - Sri Lanka: Sarvodaya Shramadana Movement**

The Sarvodaya Shramadana Movement is the largest people's organization in Sri Lanka. Over the last half century it has spread from one village to over 15,000 villages. Sarvodaya has about 1,500 fulltime employees and the gifting of voluntary time means it has about 200,000 full time equivalent workers. Sarodaya's activities centre on village development and span from humanitarian care for internally displaced people and war-affected communities to developing low cost housing to convening meditations for peace. Sarvodaya takes a comprehensive, empowering and participatory approach to wellbeing and human development, including social, environmental, economic, emotional and spiritual aspects throughout life. For example, the assessment of wellbeing is based on the community's broad understanding and definitions of health and the root causes of problems and wellbeing (the determinants of health) including the culture, values, assets and politics of a community and the wider macroeconomic and political issues influencing the community. The model of village development is a continuing process which begins with the assessment of needs and wellbeing; then the development of social infrastructure, forming groups, setting up a child development centre, and training; then implementing a programme for meeting basic human needs and the development of institutional infrastructure for the ongoing development of the village; then income, employment and self-financing activities; and then support for other villages. Levels of action are seen as going from the individual to the family to the village or community to the district or city to the country to the international.



**Box 46 - The People's Health Movement**

The People's Health Movement (PHM) was formed in December 2000 at the first People's Health Assembly held in Savar, Bangladesh. 1500 health activists gathered at this meeting and developed and endorsed the People's Charter for Health which is an advocacy document calling for global equity to be achieved through action on social and economic determinants of health, the empowerment of people's movements and the development of a genuinely comprehensive primary health care movement. The People's Charter for Health is the most widely endorsed consensus document on health since the 1978 WHO Alma Ata Declaration. By 2011 the PHM has grown into a global network of health activists who are active in countries, regions and globally. The strongest national network is in India where the national movement –Jan Swasthya Abhiyan - has been active in activities such as people's health tribunals, a right to health campaign, rural health watch, campaigns for essential drugs, and right to food campaigns. In the Asia Pacific Region there are also active PHM circles in Bangladesh, Sri Lanka, Pakistan, the Philippines, Malaysia and Australia. Health Action International – Asia Pacific, is a partner network of PHM (one of the co-founding networks) and also has a presence in a number of Asia Pacific countries, and its Secretariat is based in Penang.

The PHM co-produces the Global Health Watch, an alternative world health report, and organizes courses on the political economy of health and health activism through the International People's Health University. Courses have been run in the Asia Pacific region in Bangladesh and India. PHM also has a WHO-watch program which monitors and advocates on issues central to WHO agenda and campaigns for more democratic global governance. A third People's Health Assembly is to be held in Cape Town in July 2012, and regional assemblies will be held in the lead up to this. PHM was the nodal organisation in the Asia Pacific region, co-ordinating Civil Society engagement with the CSDH between 2005 and 2008.

***Government support for civil society***

Governments can actively facilitate the role of civil society in action on social determinants. They can formalize civil society involvement in policy-making processes to support their role in maintaining accountability.

The Thai Health Promotion Foundation has resulted in increased public resources to strengthen the role of civil society and the community in intersectoral action and action on the social determinants of health in Thailand (336). The Fund has actively sponsored civil society groups to build capacity for health promotion activities (336). The 73rd and 74th amendments to the Indian Constitution decentralized authority and power to local government units, and also specified the key roles in governance for community-based organizations, women's groups, the urban poor and various arms of civil society (326). The revised Philippine Constitution of 1987 upheld the right of community-based, non-governmental, and sectoral organizations to get directly involved in governance and to enable the people to pursue and protect, within the democratic framework, their legitimate and collective interests and aspirations through peaceful and lawful means (326).

In Kiribati in 2008, the Ministry of Internal and Social Affairs (MISA) conducted the Kiribati Family Health and Support Study to investigate the problem of gender-based violence (337). If this had

been organized or implemented by any of Kiribati's women's NGOs, the project may have been inadvertently branded as a "women's project" or "for women only," with low priority. However the MISA was seen as a neutral organizing party, respected as a government body and, by virtue of being a government body, always demonstrated to NGOs and community leaders that the government was taking gender-based violence seriously. NGOs and civil society were actively involved in guiding the research and supporting its implementation and follow-up, but leadership from the government gave the issue traction and credibility. As a result of this collaboration between government and civil society, Kiribati has developed a National Action Plan to eliminate violence against women.

### ***Tackling corruption***

Corruption is defined by Transparency International, a global civil society organisation which challenges corruption and supports anti-corruption movements to address it, as 'the abuse of entrusted power for private gain' (338). Corruption is one of the most important determinants of social exclusion, and therefore, health and well-being, but many commentators observe that it is also least likely to be included in any discourse on tackling the root causes of health and social inequity. Corruption hurts everyone, but the socially disadvantaged suffer the greatest burden of its impact. Indeed, the World Bank has warned that, 'corruption is the greatest obstacle to reducing poverty'.

There are many pathways through which corruption 'perpetuates and exacerbates' poverty. As explained by the U4 Anti-Corruption Resource Centre which assists donor agencies to more effectively address the challenges of corruption through their development support, resources and benefits may be diverted towards the rich and away from the poor, additional 'taxes' for services that are meant to be free, may be imposed by a corrupt administration on people least able to afford it, or legitimate rights and entitlements may be denied to those at the bottom of the social gradient with least likely access to political or economic decision-making (339). Petty corruption can have obvious and damaging impacts on individuals, families or organisations and sap their resources. But the impacts of political corruption which may influence laws, regulations, policies and large scale financial irregularities can seriously undermine the prospects for national development through consequences such as the reduction of a country's revenues, the collapse of public services, a deterioration of the natural and built environments and social, economic and political unrest.

The link between poverty, exclusion and corruption has been powerfully demonstrated by a comparative analysis of the Human Development Index (developed by the UNDP and including indicators such as education, literacy, household income and life expectancy) and the Corruption Perceptions Index (developed by Transparency International) of 177 countries. A strong correlation between corruption and lower levels of development was found.

Research also suggests that women are disproportionately more likely to suffer from corruption than men, because of their comparative educational, economic, social and political disadvantage. And yet, other studies have shown women to be less corrupt, and that there is a correlation between larger representation of women in the workforce and in parliament and lower levels of corruption, an association which persists even across countries with similar socio-economic characteristics such as levels of income and education.

Concerned by the influence of corruption in exacerbating inequalities and injustice, in undermining the economic performance particularly of developing countries and in placing democracy, the rule of law and the security of societies at risk, the United Nations adopted a Convention against Corruption in 2005. The aim was to send a clear message that the international community was determined to prevent and control corruption and to reaffirm the importance of core values such as honesty, accountability and transparency in promoting development.

**Box 47 - India: a social movement against corruption**

India has ratified the UN Convention against Corruption, but corruption continues to extract a heavy toll at the level of the national economy as well as on ordinary citizens, and is a likely contributor to growing socio-economic inequalities. The scale of the problem has been further highlighted by a number of high profile corruption scandals and alleged frauds involving breathtakingly large sums of money that rocked the country in recent times. It was against this background that an extraordinary and spontaneous movement swept across the country in August 2011, triggered by the arrest of Anna Hazare, a prominent anti-corruption activist (340). Thousands of Indians gave vent to their pent-up frustration and anger and took to the streets in protest.

At the heart of India's 2011 anti-corruption movement was a disagreement with the Government over the content of the Lokpal Bill (an Ombudsman Bill, with Lokpal meaning anti-corruption organisation) which was under consideration as a means to address corruption (341,342). Civil society leaders who were of the opinion that the Government's version of the proposed legislation was toothless, put forward a counter-proposal called the Jan Lokpal Bill (the citizen's Ombudsman Bill) which would establish a strong and independent body called the Lokpal with the powers to receive and investigate complaints promptly and to ensure speedy prosecution. In the Government's version the role of the Lokpal was mainly advisory.

Hazare, a follower of Gandhi, launched a hunger strike which lasted 12 days and harnessed the public abhorrence of corruption into a non-violent civil resistance movement characterised by peaceful marches and demonstrations which were unusual in having no political affiliations. The Government, which had underestimated the level of public outrage, held a debate on 27 August 2011 resulting in both houses of parliament passing a resolution agreeing to the 3 conditions set by the civil society leaders - a Citizen's Charter, Lokayuktas (ombudsmen) in all states with Lokpal powers and inclusion of the lowest to highest bureaucracy in the ambit of the Lokpal. Anna Hazare broke his fast the following day, before thousands of cheering followers, and declared the battle half won. A joint committee has been formed to draft the new legislation and includes civil society leaders and representatives of the government.

A survey carried out by Transparency International showed that 74 % of people in India could imagine themselves getting involved personally in the fight against corruption, far more than the Asia Pacific regional average of 31% and a global average of 49% (343).

## Chapter 5: Distributing power and resources using regional and global mechanisms

### CSDH Recommendations:

- Make health equity a global development goal, and adopt a social determinants of health framework to strengthen multilateral action on development.
- Strengthen WHO leadership in global action on the social determinants of health, institutionalizing social determinants of health as a guiding principle across WHO departments and country programmes.
- Increase international finance for health equity, and coordinate increased finance through a social determinants of health action framework.

### Cross border systems and processes and the implications for health equity

Many of the social and environmental determinants of health in the Asia Pacific region are influenced by factors outside national borders. Global actors (including bilateral cooperation agencies, regional agencies, philanthropic groups, international organizations, civil society groups and the private sector) can contribute to national and local action on social determinants. Regional and global actors play significant roles in the unequal distribution of the social and environmental determinants of health across Asia Pacific, and there are often vast differences in power and resources between these various groups. At the same time, many countries in Asia Pacific are working with a large range of international partners on other current global concerns which overlap considerably with the social and environmental determinants of health, such as climate change, human rights, poverty reduction and the MDGs. It is essential that policies in these areas are coherent, not undermining each other but instead mutually contributing to development.

### Policy coherence - UN agencies working together

The UN system can set an example for coherent and aligned economic, environmental, social and health policies and practices, by reorganizing the way it works with member states so that all agencies work together on priority issues (including health inequities). The UN Development Assistance Frameworks (UNDAFs) seek to provide a single coherent, overarching strategy for a country, which identifies the ways in which all UN agencies will respond to the respective government's development agenda (see Box 48). An unprecedented number of new UNDAFs are being developed in the Asia Pacific region, including 19 between 2009 and 2011 (115). This is a significant opportunity to strengthen the focus on equity in all objectives and activities, as well as supporting countries maximise the co-benefits between human health, development and environmental sustainability.

**Box 48 - Mongolia: using the UNDAF to consolidate action for equity**

Mongolia signed its United Nations Development Assistance Framework (UNDAF) agreement for 2012–2016 on 17 March 2011. It has been developed through a partnership between the UN system, the Mongolian Government, and the civil society, following a comprehensive analysis of development issues in Mongolia. Through this UNDAF, the UN system will work with the Government of Mongolia, civil society, and other development partners on 4 strategic priorities:

1. Economic development is inclusive and equitable contributing towards poverty alleviation.
2. Equitable access to, and utilization of, quality basic social services and sustainable social protection.
3. Improved sustainability of natural resources management and resilience of ecosystems and vulnerable populations to the changing climate
4. Strengthened governance for protection of human rights and reduction of disparities.

The budget for the UNDAF is approximately US\$100 million, part of which will be mobilised through the support of other donor organisations and communities. It represents a promising opportunity to bring together the agendas of the Government of Mongolia and 14 UN agencies, to focus efforts coherently around these four specific areas, of which equity is a prominent feature.

Source: Government of Mongolia & United Nations Country Team (344)

**Holding governments to account for health equity**

Countries in Asia Pacific have signed up to a number of UN treaties and conventions, and the reporting frameworks for these provide a mechanism for demanding accountability from governments on the SEDH and health equity (Box 49 and Box 25). Other examples include the UN Declaration on Human Rights, the Declaration on the Rights of Indigenous Peoples, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). In Sri Lanka, the reporting process instituted following the 2001 United Nations General Assembly Special Session (UNGASS) on HIV/AIDS has been helpful in local response to HIV/AIDS. The HIV/AIDS policy was developed in 2007 and the UNGASS reporting has assisted the country program to be inclusive of all the relevant stakeholders.

**Box 49 - The NGO Group for the Convention on the Rights of the Child**

The United Nations Convention on the Rights of the Child is a treaty that is legally binding in international law, which all countries in the Asia Pacific region have ratified. The Convention has spearheaded the growing international children's movement. It was the first human rights treaty to include the full range of human rights: civil, cultural, economic, political and social rights, and thus covers the spectrum of the determinants of health. State parties are accountable for their actions in implementing – or not implementing- the Convention to the international community through the United Nations Committee on the Rights of the Child. The NGO Group for the Convention on the Rights of the Child arose from the work of non-governmental organisations active in the drafting of the Convention. It is a network of 79 international and national non-governmental organisations which supports the work of national and international NGOs as well as the Committee on the Rights of the Child in monitoring and implementing the Convention and its Optional Protocols. Although it functions on a tiny budget, it has been remarkably effective in supporting the use of the reporting process as a vehicle for the children's movement within countries to come together to develop consensus about key issues and priorities, to hold governments to account, and for advocacy; and for informing the observations and recommendations of the Committee on the Rights of the Child. Hence the reporting process provides a vehicle for advocacy about the determinants of health of children and the health inequities between children from different groups and the particularly need to make the early childhood of all children one which is as health promoting as possible.

**Development agendas**

There is increasing potential for cooperation between countries in showcasing initiatives and building capacity for integrated action on health inequities. Technology transfers between low- and middle/high-income countries and capacity-building in action on social determinants are important contributors to development.

***Increasing the amount of aid***

Increasing the amount of assistance is a fundamental step in increasing the potential for aid to address the social and environmental determinants of health equity. So far, no high income countries in the region have fulfilled commitments made (for example, in the Monterrey consensus and Doha Declaration) to move towards the 0.7% target for official development assistance (ODA). Australia has rapidly been increasing its aid budget. In 2010–11, the aid budget was approximately AUD\$4.3 billion, or 0.33 % of GNI (345). The government has committed to reach 0.5% of GNI by 2015–16 which will, subject to future levels of economic growth, see the aid budget almost double again, to around AUD\$8 billion. Japan and the Republic of Korea have also committed to increase their levels of aid, working towards 0.7%, but in 2010 assistance was currently 0.2% for Japan, and 0.12% for the Republic of Korea (346).

***Taking a social and environmental determinants approach to aid***

Whilst no development agencies in the region appear to take an explicit social and environmental determinants of health framework, there are explicit commitments to equity as well as an

acknowledgement that development challenges are complex and intertwined. The Japanese International Cooperation Agency (JICA) recognises that it is the poorest people in developing countries who are particularly susceptible to the effects of economic crisis, conflict, and disaster, and notes that growing wealth gaps are a destabilizing factor in societies (347). JICA explicitly seek to promote equitable growth, that gives proper consideration to impoverished members of society, and public services like education and healthcare must be enhanced.

A 2011 review of aid effectiveness in Australia recommended that more emphasis should be given to whole-of-government approach, and proposed four high-level organising themes for the aid program: investing in pro-poor, sustainable economic growth and private sector development; promoting opportunities for all; supporting social stability, improving the quality of government and strengthening civil society; and preparing for and responding to crises (345). There is certainly scope within this reformulation to address SEDH issues in a less fragmented and more coherent way, recognising the overlap between many of these issues. It should also be noted that there has been sustained criticism of overseas aid policy in that the expenditures often favour the private sector companies and consultants of the donor countries (348).

### South-South cooperation

South-South cooperation (SSC) is a term historically used by policymakers and academics to describe the exchange of resources, technology, and knowledge between developing countries. SSC has resulted in a number of positive examples of policy and practice, to address the social and environmental determinants of health equity. China and India are the largest sources of assistance in the region, are beginning to spend around 0.07 % of their national income on SSC related activities (349), and donors are primarily helping their immediate neighbours.

Much of this aid thus goes into sectors such as infrastructure, energy, agriculture, health, and education where it can directly support the social and environmental determinants of health. For example, China and India have helped in building roads, bridges, hospitals, educational institutions and hydro-electric



Rural school, Indonesia. Source: [abdulrahman.stock](http://www.flickr.com/photos/abdulrahman-cc/6135694558/in/photostream/), 2011  
<http://www.flickr.com/photos/abdulrahman-cc/6135694558/in/photostream/>

plants in Cambodia, the Lao People's Democratic Republic, Nepal and Bhutan (110). Thailand has many cooperative programmes in the areas of agriculture and health with Malaysia, Indonesia and Timor-Leste. South-South assistance in the Asia Pacific region has also focused strongly on education – setting up educational institutions, funding vocational programmes to help improve productivity and incomes, and offering scholarships for students from recipient countries to study in the assisting country (110). China, India, the Republic of Korea, Malaysia, Singapore and Thailand all have several

such programmes. In addition to direct financial support, such assistance can help establish/strengthen institutions and relationships, improve capacities and ultimately boost the incomes of the poor (110).

**Box 50 - Samoa: one biogas project, with the help of nine partners**

In Samoa, electricity is costly and unreliable, and the collection of firewood is laborious and detrimental to the environment and human health. Much of the organic animal, human and kitchen waste is not properly managed, causing pollution to waterways and other health concerns.

An integrated approach to addressing these issues is currently being piloted in Samoa by the Youth with a Mission (YWAM) organization, with the support of the Samoan Government, UNESCAP and the Republic of Korea. A training and demonstration centre has been established at the YWAM campus in the Falelauniu community. Two digesters have been built to capture and treat various types of human, animal, agricultural and kitchen waste to produce methane gas for cooking, lighting and water heating, while the overflow is being used as a natural pesticide and fertilizer for the organic vegetable garden. A third digester is being built to incorporate livestock waste from pigs and cows and the overflow from this digester runs to a fishpond to promote algae growth which can be used as fish food. The technology for locally made bricks was developed by YWAM staff with some expert support from a Thailand inventor. The Samoan project has benefited 50 households directly, with more than 200 people now being trained.

A partner organization in Fiji, the Mainstreaming of Rural Development Innovations (MORDI) Programme, funded by the International Fund for Agricultural Development (IFAD) has expressed interest in developing a full-fledged training programme throughout eight Pacific Islands: the Cook Islands, Fiji, Kiribati, Samoa, Tonga, Papua New Guinea, Solomon Islands and Timor-Leste.

Source: UN ESCAP (350)

### Regional groupings in Asia Pacific

The process of regional cooperation in the Asia Pacific region is led by sub-regional groupings such as the Association of Southeast Asian Nations (ASEAN), the South Asian Association For Regional Cooperation (SAARC), the Bangladesh India Myanmar Sri Lanka Thailand Economic Cooperation (BIMSTEC), and the Pacific Islands Forum – which have evolved regional trading and investment arrangements (110). Such fora also offer the potential for regional collaboration on a broader range of social and development issues, as well as to consider more explicitly the impacts of economic and trade activities on health equity. Moves towards increasing regional integration (for example a common Asia Pacific market, similar to the integration of Europe) offer both opportunities and risks for health equity, and it is important that these impacts are considered, reported on and then used to inform policy.

Equity already features as a core principle of many of these bodies. For example, in its Roadmap for an ASEAN Community 2009-2015 (351), ASEAN commits to “enhance the well-being and livelihood of the peoples of ASEAN by providing them with equitable access to human development opportunities” as well as narrowing the development gap between member countries. Promoting



decent work, social protection, health systems based on primary health care and achieving universal primary education for all girls and boys in the region are key objectives. In addition, there are specific initiatives to enhance international and regional cooperation to combat adverse effects from regional trade agreements, and trans-boundary environmental pollution.



Source: UNISDR, Bangkok 2010

<http://www.flickr.com/photos/isdr/5139652648/sizes/l/in/photostream/>

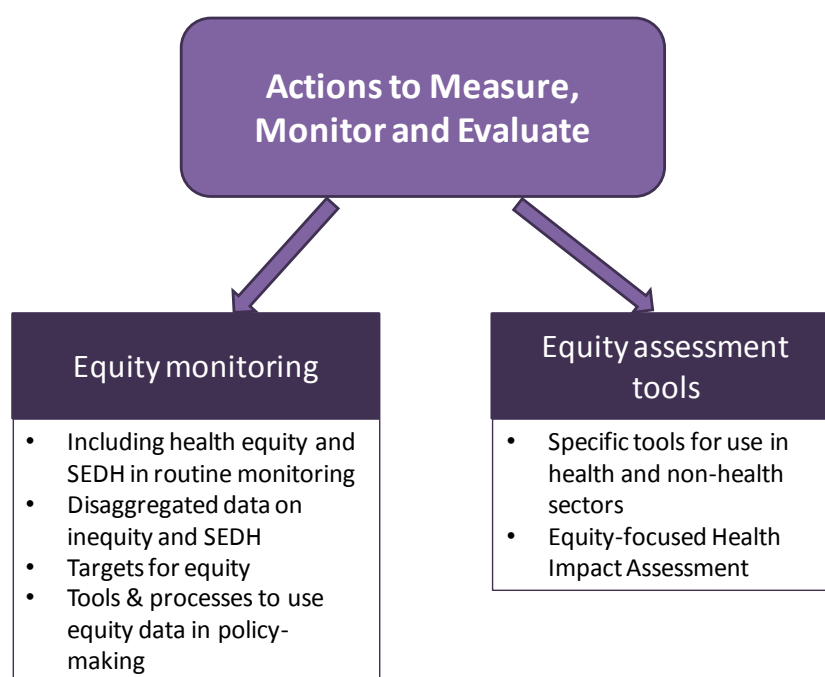
SAARC have contributed to the pursuit of gender equity through a number of initiatives, including the “SAARC Decade of the Girl Child” and the SAARC Regional Convention on Combating the Crime of Trafficking in Women and Children for Prostitution in 2002 (352). The Convention, adopted by all SAARC countries, calls for cooperation amongst Member States in dealing with prevention of trafficking of women and children as well as rehabilitation and

repatriation of victims. The Pacific Islands countries have used regional cooperation as a way to pool national resources to provide certain public goods at a regional level. For example, by providing tertiary education through the University of the South Pacific, Pacific Island governments can focus more on improving their individual primary and secondary education systems (353).

## SECTION 5: MEASUREMENT, MONITORING AND EVALUATION

### Overview

**Section 5** describes policies and practice that are designed to better measure and understand health inequities, and the social determinants of health. This includes equity monitoring, and specific tools to incorporate equity into policy and programme development. The section focuses on policies and strategies to improve the collection and use of data about health equity and the SEDH. This includes the selection of indicators, disaggregated data, the use of targets, and strategies for integrating equity data into policymaking and programme development.



#### CSDH Recommendations:

- Ensure that routine monitoring systems for health equity and the social determinants of health are in place, locally, nationally, and internationally.
- Invest in generating and sharing new evidence on the ways in which social determinants influence population health and health equity and on the effectiveness of measures to reduce health inequities through action on social determinants.
- Provide training on the social determinants of health to policy actors, stakeholders, and practitioners and invest in raising public awareness.

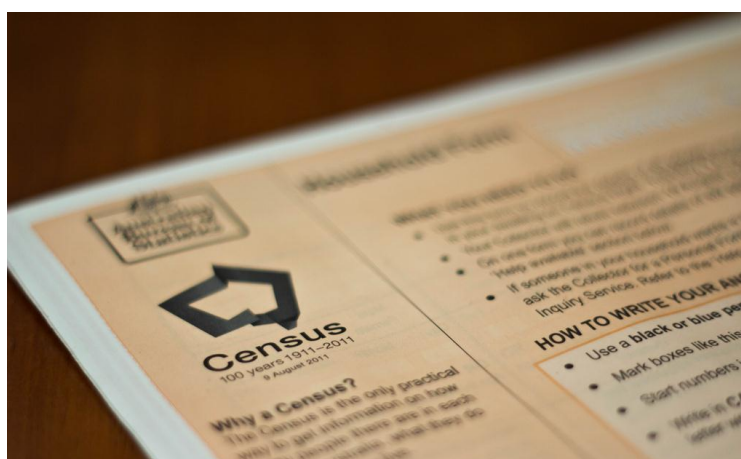
## Chapter 1: Indicators for equity and SEDH in routine monitoring

### Introduction

Health inequities remain invisible unless differences between groups are specifically measured and compared. As mentioned earlier, progress in average health indicators often masks persisting or worsening differences between groups. Having routinely collected, good quality data that can be disaggregated by the major equity stratifiers (e.g. sex, ethnicity, socioeconomic status, and rural vs urban location) is crucial to making health inequity a priority, and monitoring progress towards reducing inequalities.

### Collecting data

Data on health equity can be collected by a number of sources, including government bodies, research institutions and civil society. New Zealand relies on several public instruments for health equity monitoring, supported in parallel by the work of academics with an interest in health equity (354). The New Zealand Health Monitor is a coordinated 10 year cycle of population based health related surveys, all collecting data which can be disaggregated by ethnicity, gender and geographic deprivation index. To complement this largely health-focused data, the New Zealand Ministry of Social Development produces “The Social Report” on an annual basis. This report monitors progress on a range of social and environmental determinants, including income, employment, education and skills, social connectedness, civil and political rights, cultural identity, leisure and recreation and safety. All of these data are presented in a disaggregated format – but ethnicity, gender, age and geographic location.



Source: Doey, Australia, 2011  
<http://www.flickr.com/photos/andrewdo/6041209960/>

The existence of 33 well-functioning large-scale databases in Thailand (Figure 40) provides a solid platform for monitoring and evaluating equity in the Thai health care system (355). The three most common dimensions of health equity that can be monitored and evaluated through these large-scale survey databases are health status, health care utilization and health risk (355). The least available information on equity dimensions that is captured by the available surveys is quality of care and health systems’ responsiveness. On the determinants of inequity, geographic location (urban–rural differentials) and demographic parameters are the most common variables available in these databases. In contrast, economic characteristics of the population are the least common variables collected in the survey databases. A key lesson from the Thai experience reveals that there is a need to build up an institutional partnership between the statistics constituency who generate information, and the health constituency who use information for their policy making and equity monitoring. A genuine partnership between the National Statistical Office and Ministry of Public

Health through consistent dialogue, mutual recognition and trust, has been critical to strengthening health equity monitoring capacity in Thailand (355).

**Figure 40 - Numbers of surveys, surveillance registries and databases, containing information on health equity in Thailand**

	Health Financing	Coverage or availability	Health care utilisation	Quality and responsiveness	Health status	Health risk
<b>Geographic</b> Province, urban vs. rural	3-0-2 <sup>1</sup>	4-1-3	11-8-3	2-0-0	11-10-3	10-6-1
<b>Demographic</b> Sex, age group	3-0-2	4-0-2	12-8-2	2-0-0	12-9-2	11-5-0
<b>Social</b> Education, occupation	3-0-2	4-0-2	10-4-2	2-0-0	11-5-2	11-4-0
<b>Economic</b> Wealth, income, consumption	3-0-0	4-0-0	7-1-0	2-0-0	9-1-0	7-1-0

<sup>1</sup>First digit refers to the number of population and household surveys, second digit refers to surveillance or registries, and third digit refers to administrative databases

Source: (355)

The Social Health Atlas of Australia is an interactive online resource which illustrates visually the striking disparities that exist between groups in the population, in health status and in key social determinants of health (356). The same institution also provides online access to graphical data on inequities in health and social indicators in Australia (<http://www.publichealth.gov.au/inequality-graphs/monitoring-inequality-in-australia-introduction.html>).

It is not only vital to collect data that can be disaggregated, but also data must be accurate. New Zealand has undertaken efforts to improve the accuracy and completeness of its ethnicity data, in light of evidence that Māori have been systematically undercounted in numerous health datasets over the past decades (357). Adjusters have also been developed to correct the number of Māori (or other ethnic groups) health records to account for misclassification of ethnicity (358). This is achieved by linking health datasets to datasets with better quality ethnicity to estimate the misclassification of ethnicity in the health datasets, and to calculate adjusters that can be applied to aggregate health data to adjust numbers accordingly.

### Using data

Collecting data on health inequities will not result in changes by itself. Data need to be turned into useable information, for policy-makers to use in priority setting and policy formulation, and to help guide programme development and implementation. A number of such initiatives exist across Asia Pacific (see Box 51). The selection of “targets” for health system performance has implications for equity. Setting an aggregate target promotes inequity, by incentivizing giving priority to “low-hanging fruit” to reach the target. Setting targets for each sub-group is less effective than using a target for just the highest need. Setting an aggregate target promotes inequity, by incentivizing giving priority to “low-hanging fruit” to reach the target. Setting targets for each sub-group is less effective than using a target for just the highest need.

**Box 51 – Indonesia: Public Health Development Index**

When considering the health gap between Indonesian districts and cities, local governments usually look at the Human Development Index (HDI). While HDI is used by local government as an indicator of development, the health indicator used in this calculation (life expectancy at birth) is perceived by health researchers in Indonesia as too crude to pin point what public health programmes should be implemented at the local level to improve health status. In Indonesia health data are available from a number of sources, including:

- Baseline health research, which is done in all districts in Indonesia, covering basic health indicators and determinants
- National socio-economic survey of the Indonesian households
- Village census (about local village resources such as health workforces, health facilities etc)

Through discussion and statistics modelling, the Indonesian Public Health Index (IPHDI) was developed to better guide policy and practice to address health inequities. The IPHDI is a composite index of 24 health indicators, to determine the health development level and needs of each district in Indonesia. This information is then used to identify low-ranking districts in need of particular attention, and to inform which types of health interventions would be most helpful in each district.

Based on the index, 109 districts and 21 cities in Indonesia have been identified with severe unmet health needs. All those districts are allocated financial resources and technical resources from the central ministry, to support further analysis to identify the causes of the low IPHDI, select priority public health programme solutions, and plan and implement these programmes.

There can be a tension between having a comprehensive set of indicators that covers all relevant dimensions of inequity and determinants, and having a shorter set of indicators that is easier to interpret and manage. Waitemata District Health Board (DHB) in New Zealand developed an Ethnic Inequality Indicator Framework (359) to assess DHB performance on reducing inequalities, across a range of DHB activities. The set of 11 indicators was designed to achieve a balance across several dimensions:

- Stage in health service: access / process / outcome
- Stage in causal pathway: determinants / risk factors / physiological change & early disease / late disease / recovery & rehabilitation
- Service types: health promotion / primary / secondary & tertiary / follow-up

**Monitoring equity outside of government**

Civil society can also provide a professional oversight and monitoring function. The Bangladesh Health Equity Watch (BHEW) emerged out of a global initiative—Global Health Equity Initiative—that started in Chile in 1999 (360). In Bangladesh, it is coordinated by the Bangladesh Bureau of Statistics, the Bangladesh Institute of Development Studies, BRAC, and ICDDR,B. The BHEW conducts a national survey of health equity, analyses existing data with an equity focus, plays a strong advocacy function, and builds capacity in survey research. In 2005, in a similar gesture, with the same key players, a number of professional and civil society groups came together to create a network that would regularly and systematically measure the performance of Bangladesh in terms of health to

both inform policy and raise general awareness. Bangladesh Health Watch, housed at the BRAC School of Public Health, publishes a report every year focusing on specific themes and regularly reports on key indicators (360). The first report, published in 2006, addressed the theme of health and equity, raising awareness about the extent of inequalities and advocating for the incorporation of an equity dimension in data collection, analysis, and reporting. A similar approach has been used in India, for example with the Maharashtra Health Equity Watch (361). This initiative sought to document existing inequities in access to health care at a state level, and to monitor trends in key process indicators responsible for such inequities (with special focus on caste, tribe, class, gender, rural-urban and regional disparities).

## Chapter 2: Equity assessment tools

### Introduction

Equity assessment tools can serve a dual function - to support the monitoring and measurement of health equity and to help embed a consideration of equity into the policy-making process. There are several accepted statistical methods to express health inequities across population groups. These range from simple odds ratios between groups, to concentration indices and slope index to express social gradients in health outcomes. However, a more sophisticated approach is required to map health inequities with their social determinants that are useful to policymakers. In this regard, a number of tools have been developed around Asia Pacific to assist policy-makers and practitioners assess equity – some are highly context specific and others are more transferable in their nature. Health Impact Assessment is a process that has been used in a range of countries and on a range of issues, to assess the health equity implications of policies or programmes.

### Equity Tools

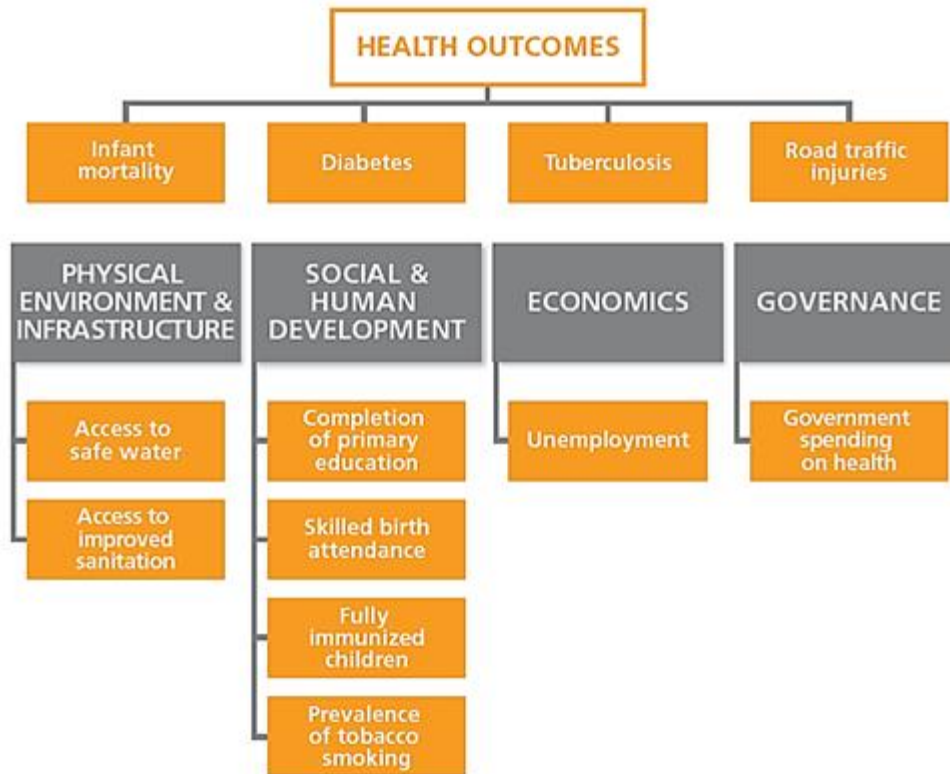
In Mumbai, a Rapid Assessment Scorecard has been developed to identify informal settlements at higher maternal and child health risk (362). The communities who live in urban informal settlements are diverse, as are their environmental conditions. Interventions to improve health should be equity-driven and target those at higher risk, but it is not clear how to prioritise informal settlements for health action (362). Detailed assessment of all of the factors can be complex and time-consuming. Based on more detailed vulnerability assessments, a simple scorecard based on six easily collected social determinants of health (inadequate access to water, toilets, and electricity; non-durable housing; hazardous location; and rental tenancy) was developed as a tool to select areas at particularly high risk. This scorecard had limited sensitivity and positive predictive value, but relatively high specificity and negative predictive value, indicating promising potential for ongoing refinement.

The Health Equity Assessment Tool (HEAT) (363) was developed in New Zealand to increase the capacity of the health sector to contribute to health equity. It consists of a set of 10 questions that enable assessment of policy, programme or service interventions for their current or future impact on health inequalities. The questions prompt users to consider the health inequalities that exist in a particular area of health, how to intervene to address them, and how to evaluate the effect of the intervention on health inequities. HEAT is a flexible tool that can be used in its entirety or, alternatively, selected questions or groups of questions can be asked for specific purposes. It can be used as a tool to provide a quick overview of potential issues and gaps in policies, services and programmes, or alternatively, can provide the framework for a more in-depth analysis for policy, service and programme development and/or evaluation.

Urban HEART, a tool developed by WHO (364), gives policy-makers and stakeholders at national and local levels a user-friendly guide to assess and respond to urban health inequities. Since the launch of the pilot programme in 2008, Urban HEART has been pilot-tested in a number of cities in the Asia Pacific region, in Indonesia, Malaysia, Mongolia, Philippines, Sri Lanka and Viet Nam. Urban HEART is based around an indicator framework (Figure 41) covering the major health determinants and risk factors across multiple levels and sectors in the urban environment, as they impact on

communicable, non-communicable diseases and injuries. These indicators can then be compiled into a matrix, to compare the situation across different sub-areas of a city. Urban HEART includes the interest areas of multiple sectors and serves as a tool to generate buy-in, and collaborative problem-solving from key stakeholders and communities.

**Figure 41 - Indicators for urban health equity used in Urban HEART**



Source: (364)

### Equity Focused Health Impact Assessment

Health impact assessment (HIA) can offer a formal process to assess the impact of policies (from the health sector or from non-health sectors) on health, wellbeing and equity. An equity-focused HIA enables the systematic consideration of health inequalities early on within the development of policies and programmes prior to their implementation, and can be used by policymakers in central, regional and local government as well as by those who may be affected by policy. For example, the “Sydney Metro Strategy” proposed that large undeveloped areas of land on suburban fringe of Sydney be opened up for development (365). Having identified food production as a determinant of health, a HIA uncovered that these areas in fact housed market gardens supplying large quantities of fruit and vegetables to the Sydney area. The HIA determined that the proposed strategy would likely lead to loss of livelihoods for market gardens, and raise fresh food prices across Sydney, disproportionately impacting on low income households, thus exacerbating inequalities.

HIAs have been undertaken in a number of countries around Asia Pacific, including New Zealand (366,367) Thailand (336,368), the Republic of Korea, the Lao People’s Democratic Republic, Cambodia and Viet Nam. Thailand’s National Health Act 2007 gives the public the right to ask for



and participate in HIA of any public policy. Factors for successful cross-sectoral health impact assessment in New Zealand and Thailand include:

- An inclusive process, with multidisciplinary input
- A previous history of collaboration. Existing strong relationships between agencies are beneficial, although stronger relationships are also an outcome of HIA
- The use of HIA earlier in the policy process is preferable to later
- The use of an independent facilitator in HIA workshops
- Embedding HIA into the existing policy and cross-sectoral processes of agencies and using existing forums to promote HIA
- A formal support unit and a legislative basis for HIA (such as the HIA Unit in the Ministry of Health, New Zealand, the HIA Division in the Ministry of Public Health, Thailand and proposed HIA Act in the Republic of Korea)
- Cross-party political understanding of the determinants of health
- Formal recognition of HIA skills and roles in job descriptions and contracts
- Flexible use of HIA - an exploratory process is important (e.g. it should be seen as a learning process, it is acceptable to do small, simple HIAs – i.e. “give it a go”)

The growth of HIA across the region is encouraging however equity still needs to be explicitly included in the assessment, for the HIA process to fulfil its potential as a tool to address health inequities. A rapid equity-focused HIA (365) has been developed in Australia to help ensure that equity is considered, and that HIA meets the time constraints of policy-making.

Political commitment and processes to manage trade-offs identified from the HIA process are essential. For example, an impact assessment into the Bakun Dam project in Malaysia identified health and environmental concerns and inequitable impact on 10,000 indigenous people, but these were overridden by strong economic interests and national economic development priorities.

## SECTION 6: A FUTURE FOR HEALTH EQUITY IN ASIA PACIFIC THROUGH ACTION IN THE SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH

This report argues for a paradigm shift in the way we think about and improve health equity. Health in the region is socially and increasingly environmentally determined. A sole focus on economic growth or on health systems will not be sufficient to meet the health needs of all people in the region in the coming decades. The paradigm shift calls for health and health equity to be addressed across all facets of life – social, economic and environmental.

The Asia Pacific region has the seeds of this paradigm shift as demonstrated in this report. The sheer size of Asia Pacific offers real opportunity for change to happen in a way that empowers more than half of the world's population, thereby increasing the chances of global health equity to be realised. This report provides the basis for hope. We have identified many entry points across different sectors through which improvements in the distribution of power, money and resources, and conditions of daily living can be tackled. As the review of actions across the region shows, there is indeed a lot happening within countries to address the determinants of health inequities. But significant challenges to health equity remain, requiring focused action and rapid region-wide learning about effective action.

### Challenges for health equity in Asia Pacific

#### Data –determinants of health inequities

The report documents several examples of gross inequities within the region. The challenge is to get policymakers, politicians and the public to accept this as an 'uncomfortable truth'. This challenge is partly hindered by the large gaps in the evidence base relating to health inequities in Asia Pacific. The ultimate inequity is not to be counted. Inadequacy of current data collection in the Asia Pacific region means that many inequities remain invisible, both in terms of health outcomes, and in access to the social and environmental resources for health.

National and local level health information systems do not routinely capture or report health outcomes broken down by different social strata. Very few countries have multilevel surveillance systems that routinely record and report, in an integrated manner, information on the various structural drivers of health inequities and the conditions of daily living that affect health. This makes it difficult to monitor progress in the determinants of health and health inequities.

There remains little empirical investigation of the way and degree to which social and environmental factors affect health inequities within countries across Asia Pacific. There are very few studies that focus on the social gradient in health - most of the focus is on the socially disadvantaged. There are very few evaluations of the health equity impact of cross-sectoral policy and practice.

#### Knowledge and skills

**Training focus:** There is a lack of training and skills development across Asia Pacific in both the science of the social and environmental determinants of health inequities and the translational skills necessary to bridge the know-do gap. There already exist a number of training programs and

teaching courses focusing on the social determinants in the Asia Pacific sub-regions, though their contents and the mode of delivery are heterogeneous, not necessarily consistent, and too often fragmented and/or experimental.

**Who is being trained?** There is growing recognition across Asia Pacific of the wider range of determinants of health inequities and an acknowledgement that health inequities is everybody's problem. This requires equipping the public health workforce as well as people from a wide range of disciplines, sectors and communities with the knowledge and skills to tackle these issues.

### Dominant paradigms

There are two paradigms that take primacy in governments across Asia Pacific. The first relates to what matters most for a society – currently the most common measure of societal success is economic growth, as measured by GDP. There is no doubt that countries and communities need money to survive and prosper but, as the evidence in this report and many others show it is how this money is spent that matters most for health, equity and well-being more generally. If economic growth at any cost remains the “holy grail”, then social, environmental and health concerns will struggle to receive the level of government commitment necessary to make real improvements. Might a better indicator of societal progress be one that captures economic, environment, social and health dimensions in an integrated way, or more progressively, one that uses the social distribution of health outcomes?

The second paradigm is that health by-and-large means health care. Most discussions across the Asia Pacific region that are about health inequities immediately go to health systems or health services and how they can cause health inequities or what they can do to reduce them. These are vitally important discussions but, as we point out in this report, they do not comprise the full story. While governments, especially ministries of health, continue to think that the health system is where most attention should be placed in order to address health inequities, actions in the non-health sectors - where most impact on health inequities is made - will continue in a way that may not pay attention to the effects on health and health inequity.

### Policy focus – average health not health equity

There are very few interventions across Asia Pacific that explicitly address health inequity. Most of the focus is on improving average population health. While both goals are important, it is important to differentiate between the two. Action to improve health by addressing social and environmental determinants of health is fundamentally different from action to improve health equity by addressing the unequal distribution of the determinants of health. That is, policies and programs aimed at addressing the determinants of health do not necessarily address the determinants of health inequities. The examples of work underway across Asia Pacific included in this report reflect both types of action but do indicate a scarcity of examples of action addressing the unequal distribution of the determinants of health.

### Who cares?

Many of the policies and programmes that we have identified in this report come from the ministries of health or other government departments and sector. Other than in a handful of countries, there is almost no activity to reflect commitment to health equity at the highest level of government.

Encouragingly, health is mentioned in many countries' national development plans but there is generally no explicit attention to the social gradient in health - the main focus is usually on the needs of some socially excluded groups.

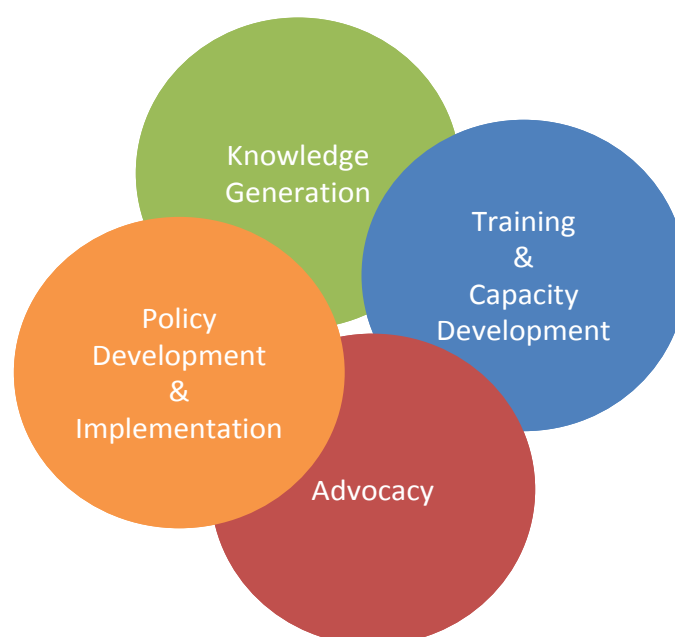
### Moving forward

Improving health equity is a complex business. Health inequity arises from the interaction of many societal and environmental level factors. And health inequity is everyone's problem. As the examples of policy and practice to improve health and address health inequities included in the report highlight, much of the action occurs beyond the health sector. However, the health sector does play a broader role in dealing with health equity by advocating, facilitating intersectoral collaboration and building capacity to address the social and environmental determinants of health and health equity. Collaborative, cross border and cross sectoral activity is needed.

#### One approach: AP-HealthGAEN

One mechanism that we hope can help achieve this is AP-HealthGAEN, a partnership of researchers, policymakers at the national and regional levels and non-government organisations. AP-HealthGAEN embraces the complexity of the health equity issue and acts to improve health equity through the intersection of the social, environmental, health-care and development agendas. The network's agenda for action consists of four inter-related domains of activity that include developing a region-specific knowledge-base on the wider determinants of health equity, a workforce with the necessary knowledge and skills to act on the determinants, and strategies to ensure that knowledge is translated into effective actions. Ongoing advocacy is also required to ensure that health equity remains a political priority. These overlapping domains will serve to promote action among the range of stakeholders necessary to reach the goal of health equity (Figure 42).

**Figure 42 – AP-HealthGAEN's four domains of activity**



AP-HealthGAEN draws on a range of disciplinary expertise and aims to build:

**COLLABORATIVE LEARNING AND ACTION:** AP-HealthGAEN seeks to break down the barriers between academics, policy-makers and NGO actors, who may be committed to health equity but find it challenging to operate and collaborate with others outside of their institutional settings. *To do this, AP-HealthGAEN aims not only to bring together at least one policy-maker, academic and NGO representative from each country to participate in the regional activity, but also to act as a core group to advance the issues in their home locations.*

**CROSS BORDER ACTION:** A key value of AP-HealthGAEN as a regional network is to provide space to initiate regional collaboration and cross-border activities – beyond the sharing of country and territory experiences. Coming together as a regional network allows new relationships to be forged, existing connections strengthened and evidence and experiences shared. *To fully realise the AP-HealthGAEN vision, the network includes mechanisms that are inclusive of low, middle and high income countries, and reflects the geographical and cultural diversity across the region.*

**CROSS-SECTORAL ACTION:** Many of the interventions to address health equity lie outside the health sector. A critical role for AP-HealthGAEN is to engage with key non-health actors in the region – including regional development agencies, regional governance groupings, non-health government sectors and the private sector in the development of interventions. *To do this, AP-HealthGAEN seeks to initiate action at a regional level between representatives from region-wide agencies. AP-HealthGAEN also aims to include representatives from non-health sectors in countries where meetings are held, around issues specific to that country, or around particular topics of regional interest (e.g. urbanisation).*

### Key elements of a systematic approach to health equity through the social and environmental determinants

In operationalising the AP-HealthGAEN four domains of activity identified in Figure 42, one could ask what is needed for a community (local, national, regional) to take a systematic approach to health equity through action on the social and environmental causes. The following should, at a minimum, be considered:

#### 1. High level commitment

Given the important role of government in working towards health equity, it is imperative to consider the nature of the commitment. The key features of a government commitment should include:

- Prioritizing health equity at the highest level.
- Explicit expression about the need to address health equity through the social determinants of health beyond the health system and health services.
- Integration of the social and environmental determinants of health into the national development agenda and not only within the national health plan.
- Consideration of health equity as a ‘whole-of-society’ issue, not one only impacting on a specific social group i.e. the concept of ‘gradient’ where all are involved and the need to address inequities between and within population groups.

- Government actions should be empowering of communities so that they are aware of and realize their active role in addressing health equity through addressing the social and environmental determinants of health.
- Designation of a specific machinery of government for addressing the issue at all levels, such as in policy-making, planning, targets and indicators, including instructions to government departments and chief executives regarding national indicators, monitoring and reporting.
- Assurance of consistency of the operational aspects and programs with the evidence base of actions that work to address health inequities.

## ***2. Menu of promising actions to select from***

Historical asymmetric economic growth, amplified by the current global economic crisis, poorly managed rapid urbanisation, escalating environmental degradation, unequal improvements in daily living conditions, and the unequal distribution and access to quality healthcare have each contributed to health inequities in the Asia Pacific region. They will likely continue to do so unless concerted action is taken. This report highlights a diversity of policies, systems and processes available to tackle these determinants of health inequities.

## ***3. A plan to address evidence gaps***

While demonstrating many promising ways to improve health equity, this report also highlights some real gaps in the evidence base across Asia Pacific. Ongoing monitoring of health inequities not just average health is needed, together with systematic evaluation of societal changes and their impact on health inequities. What is consistently missing is evaluation of the policies, programs and modes of governance with regards to health risks and health outcomes, let alone evaluation of the impact on health inequities.

Another vital component of a health equity research agenda relates to the translation of knowledge into action. Evidence highlighting inequities in health outcomes, does not automatically mean health equity becomes a priority for policy-makers. Evidence that a particular policy or programme works to improve health equity does not necessarily mean it gets implemented. Even if it is implemented, this does not guarantee it will be implemented effectively. Understanding effective implementation, especially given the strong influence of the different contexts found in Asia Pacific, requires a different body of knowledge to that of causation, one to do with political science and complexity theory - a much better understanding is needed of how to translate theoretical and empirical demonstrations of the social and environmental impact on health inequities into evidence-informed policies and programmes, in diverse geo-political, socio-economic and socio-cultural contexts across the Asia Pacific region and the range of associated complex policy processes.

Evidence generation should be characterised by the following methodological approach:

- **Interdisciplinary:** the problems of health equity can be best researched, evaluated and addressed using interdisciplinary approaches including but not limited to – epidemiology, political science, sociology, psychology, economics, development studies, law, history, nutrition, climate science and the biological underpinning of the relations between social determinants and health inequities.

- **Methodologically pluralistic:** including both quantitative and qualitative research, evaluated on basis of scientific rigour within specified methodological traditions, and on basis of fit for purpose.
- **In-depth country analysis combined with comparative analysis across countries:** addressing health equity requires analysis of what does and does not work within country, and at the same time encouraging cross country learning and comparative analyses.
- **Empowering in approach:** to facilitate a platform for marginalised groups to contribute experiences and analyses from their perspectives, to the global knowledge and understanding, and useful for marginalised groups advocating for change.

#### ***4. Training and capacity building to support above actions***

Translation of evidence to action needs a broad spectrum of skills ranging from scientific analytic methods to effective communication with political interest parties. To effectively meet the skill needs, core competency to address the social and environmental determinants of health equity must be broad and complex for global standard, yet at the same time, be context-specific for legitimacy in the local context.

There are four pivotal axes through which to strategically design programs: 1) target segmentation; who should be the target of program for what needs, 2) contents; what are the core set of knowledge and skills to meet the demand, 3) delivery channel; how the contents are efficiently delivered to those who need them, and 4) resources to realize the programs.

There is an associated wide variety of organisations and individuals with the opportunity to contribute to improving the health of communities through their sphere of influence. This requires equipping the public health workforce as well as people from a wide range of communities, disciplines and sectors with the skills and competence to make a positive difference.

Different target groups will have different needs, requirement, and goals. However, although the needs are diverse across the groups, there should be an overlap which should be identified as the core competency for tackling the social and environmental determinants of health equity. There are few examples of competency frameworks that have been developed with the aim of building a skilled cross-sectoral, multi-disciplinary workforce that is fit for purpose to address the social and environmental determinants of health and health inequity. One needs to be developed which resonates with the needs of Asia Pacific. Some preliminary core competencies for addressing the social and environmental determinants of health equity include:

Building knowledge basis: a system for monitoring and making data available and usable, provided with effective skills training to analyse data and to translate the evidence into policy and action plans. Also needed are synthetic skills to effectively test existing knowledge/evidence and to induce new frame/theories out of daily experience of practice in the field, or “learning from the field.”

Skills in planning and evaluation: skills/knowledge for agenda shaping, market research, building strategies and tactics, management of resources in order to make things happen. These management skills should be accompanied with a strong sense of accountability and governance of agencies.

Communication and advocacy: a frame for policy design and implementation, capacities and mechanisms for cross-government action and social participation; capacity for translating/communicating evidence to influence policy processes, skills/knowledge for community involvement/empowerment.

### **5. What an advocacy strategy could look like to maintain accountability and spotlight**

Achieving equity in health requires sustained advocacy to convince those in power that action on the social and environmental determinants of health is the socially just thing to do, is necessary for human development, and is possible. The CSDH called for support for a “social movement” to address health equity through the social determinants of health. This social movement requires expression through the political process, is sustained over generations, and has the strength to overcome the entrenched hold on power, money and resources that currently blocks the pursuit of health equity. Civil society organisations can play a critical role, both in giving expression to these deeply held societal values, partnering with government during implementation, as well as holding governments to account for progress.

Advocacy can originate from many stakeholders (government, NGOs, communities) and can work at many levels. Multiple strategies can be mutually reinforcing. There are a range of approaches to advocacy, such as the Sarvodaya Shramadana Movement which uses a holistic, multi-faceted, community focused advocacy strategy using villages as the unit to build a healthy country in Sri Lanka, to the role of formal structures such as the Thai Health Promotion Foundation in advocating for legislative and policy change at a national level. Building alliances and relationships are central to successful advocacy and important at many levels - from individual to international connections. In Australia for example, all three elements of VicHealth’s advocacy strategy: lobbying, stakeholder relationships and media advocacy are critically dependent on good partnerships.

Building capacity for advocacy is important. Capacity releasing is just as critical as capacity development, for example removing barriers and increasing opportunities for women in Palau, to enable them to better exercise the capacity that is already within them. Effective and ethical advocacy works with and for people experiencing health inequity, environmental degradation and social injustice. It builds coalitions, harnesses the power of evidence, engages the media and other stakeholders, makes the most of “windows of opportunity” that arise, and uses proactive strategies to bring about change

**This report provides the seeds of hope for action on health inequity in Asia Pacific but it remains a huge challenge. Without leadership, political courage, progressive social policy and social struggle, people will continue to live with illness and die needlessly.**



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## ABBREVIATIONS AND ACRONYMS

ACCHS	Aboriginal Community Controlled Health Service
ACYA	Action for Children and Youth Aotearoa
AIHW	Australian Institute of Health and Welfare
AP-HealthGAEN	Asia Pacific hub of the Global Action for Health Equity Network
ASEAN	Association of Southeast Asian Nations
AUD	Australian dollars
BIMSTEC	Bangladesh India Myanmar Sri Lanka Thailand Economic Cooperation
BITs	Bilateral investment treaties
BRAC	Bangladesh Rural Advancement Committee
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHCs	Commune health centres
CODI	Community Organising Development Initiative
CRP	Centre for Rehabilitation of the Paralyzed
CSDH	Commission on Social Determinants of Health
CSMBS	Civil Servant Medical Benefit Scheme
DHB	District Health Board
DPT	Diphtheria, tetanus and pertussis immunisation
EEPSEA	Economy and Environment Program for Southeast Asia
FAO	United Nations Food and Agriculture Organization
FCTC	Framework Convention for Tobacco Control
FDI	Foreign Direct Investment
FSP	Food Secure Pacific
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
GFC	Global Financial Crisis
GNI	Gross National Income
GP	General medical practitioner

GRNUHE	Global Research Network for Urban Health Equity
GS	Grameen Shakti
HCS	Health Card Scheme
HDI	Human Development Index
HealthGAEN	Global Action for Health Equity Network
HEAT	Health Equity Assessment Tool
HEF	Health equity fund
HFOMCs	Health Facility Operation and Management Committees
HIA	Health Impact Assessment
HiAP	Health in All Policies
HITAP	Health Intervention and Technology Assessment Program
IAPHFN	Indoor Air Pollution and Health Forum Nepal
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICT	Information communication technology
IFAD	International Fund for Agricultural Development
IJP	Indonesia Job Pact
ILO	International Labour Organization
IMF	International Monetary Fund
IPCC	Intergovernmental Panel on Climate Change
IPHDI	Indonesian Public Health Development Index
IRR	Incident Rate Ratios
ISA	Intersectoral Action
JICA	Japanese International Cooperation Agency
JSA	Jan Swasthya Abhiyan (Indian People's Health Movement)
Lao PDR	Lao People's Democratic Republic
LBD	Let's Beat Diabetes
LDC	Least developed country
MDGs	Millenniums Development Goals
MFA	Medical Financial Assistance Scheme
MISA	Ministry of Internal and Social Affairs

MNCs	Multi-national Corporations
MOH	Ministry of Health
MoPH	Ministry of Public Health
MORDI	Mainstreaming of Rural Development Innovations
NACCHO	National Aboriginal Community Controlled Health Organization
NCDs	Non-communicable Diseases
NGOs	Non-government organisations
NPR	Nepalese Rupees
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OR	Odds ratio
PACER	Pacific Agreement on Closer Economic Relations
PBS	Pharmaceutical Benefit Scheme
PET CT	Positron emission tomography - computed tomography
PHC	Primary Health Care
PHM	People's Health Movement
PIC	Pacific Island Countries
PIGGAREP	Pacific Islands Greenhouse Gas Abatement through Renewable Energy Project
PNG	Papua New Guinea
SAARC	South Asian Association For Regional Cooperation
SARA	Suku, Agama, Ras dan Antar Golongan
SARS	Severe acute respiratory syndrome
SASP	South Australian Strategic Plan
SEARO	South East Asia Regional Office of World Health Organization
SEATCA	Southeast Asia Tobacco Control Alliance
SEDH/SDH	Social and environmental determinants of health/Social determinants of health
SHS	Solar home system
SIRCHESI	Siem Reap Citizens for Health, Educational and Social Issues

SIRNet	Social Inequality Reduction Network
SSC	South-South collaboration
SSS	Social Security Scheme
TB	Tuberculosis
TPPA	Trans Pacific Partnership Agreement
TRIPs	Trade-Related Aspects of Intellectual Property Rights
TTCs	Transnational tobacco companies
UCS	Universal Coverage Scheme
UN	United Nations
UN HABITAT	United Nations Human Settlements Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
Urban HEART	Urban Health Equity Assessment and Response Tool
USA	United States of America
WCSDH	World Conference on Social Determinants of Health
WHA	World Health Assembly
WHO	World Health Organization
WPRO	Western Pacific Regional Office of World Health Organization
WTO	World Trade Organization
YLMP	Yumi Lukautim Mosbi Project
YWAM	Youth With A Mission





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