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The Regional Municipality of Durham
Information Report

From:	Commissioner & Medical Officer of Health
Report:	#2025-INFO-46
Date:	May 30, 2025

Subject:

World Report on Social Determinants of Health Equity

Recommendation:

Receive for information

Report:

1. Purpose

1.1 To provide an update on the report entitled World Report on Social Determinants of Health Equity, released by the World Health Organization (WHO) on May 6, 2025.

2. Background

2.1 Health inequalities are the measurable differences in health across population subgroups, and health inequities are those differences that are avoidable and unjust.

a. Health inequities are the result of political, cultural, social and economic systems that shape daily living conditions. These societal factors are referred to as the social determinants of health, or WHO's preferred term, the social determinants of health equity (SDOHE).

b. In 2005, WHO assembled the Commission on the Social Determinants of Health ("the Commission"). Its goal was to support countries in tackling the SDOHE to improve health equity globally. The Commission's 2008 Final Report identified policy options and opportunities for action to close the health gap in a generation (between 2000 and 2040). The Commission's three targets were:

- Halve the gap in life expectancy at birth (LEB) between countries and between social groups within countries.

- Halve adult mortality rates in all countries (probability of dying between 15 and 60 years of age).
- Achieve 90 per cent and 95 per cent reductions in child and maternal mortality, respectively.

2.2 The WHO report reviews global progress towards health equity since the Commission's 2008 Final Report. It draws on updated evidence to provide recommendations for further action on the SDOHE.

3. Report Findings

Progress against the Commission's targets

3.1 Chapter one of the report demonstrates that, although progress has been made against all three targets, the current rates of improvement are insufficient for the targets to be met by 2040:

a. The gap in LEB between the third of countries with the highest LEB and the third of countries with the lowest, has declined by 5.6 years between 2000 and 2021, from a gap of 18.2 years in 2000 to 12.5 years in 2021. This marks important progress, however, to achieve the 2040 target, an additional reduction of 4.4 years is needed.
b. Where data are available, LEB gaps between the most and least advantaged groups within countries have often widened during the past two decades.
c. Globally, the adult mortality rate fell by 14 per cent between 2000 and 2021. To meet the 2040 target, the adult mortality rate needs to decline by 58 per cent to reach 91 per 1,000 population.
d. Within countries, marginalized or disadvantaged population subgroups in relation to race and ethnicity, education, income and immigrant status tend to have higher adult mortality rates than more advantaged populations. In some countries with available data, inequalities within countries have widened. For example, the gap in life expectancy between the Indigenous and non-Indigenous population is 12.5 years for the Inuit in Canada.
e. Between 2000 and 2023, the global rate of under-five child mortality dramatically improved, halving from 77 to 37 deaths per 1,000 live births. Meeting the 2040 target will require a further reduction to eight deaths per 1,000 live births. In 2023, the rate of under-five mortality in low-income countries was still 13 times higher than in high-income countries.
f. Maternal mortality fell by 40 per cent globally between 2000 and 2023, from 328 to 197 deaths per 100,000 live births. This rate needs to fall to less than 16 deaths per 100,000 live births by 2040 to meet the target.
g. Women from disadvantaged or marginalized groups are still far more likely to die from pregnancy-related causes than their more advantaged counterparts in countries at all income levels.

- A population-based cohort study evaluated more than 1.8 million births in Ontario, Canada. Compared to women without a disability, the

adjusted relative risk of severe maternal morbidity or death was 14 per cent higher among women with a sensory disability, 29 per cent higher among women with a physical disability, 57 per cent higher among women with an intellectual/developmental disability, and 74 per cent higher among women with two or more disabilities.

3.2 Recent global crises – including conflict, climate change, inflation and the COVID-19 pandemic – have exposed even more starkly the consequences of unequal societies and the poor conditions experienced by a large proportion of the world's population, amplifying existing health inequities and creating new ones.

The social determinants of health equity

3.3 Chapter two describes the pathways and mechanisms through which the social determinants impact health equity.

3.4 Structural determinants create unequal distributions of money, power and resources according to a person's social status, as defined by gender, age, education, income, race or ethnicity, disability status and other characteristics. The structural determinants that drive health inequities, referred to as the upstream SDOHE, include:

a. Economic systems (e.g., income inequality, taxation systems, labour markets, industrial and trade policies, financial systems, informal economy, commercial determinants).
b. Social infrastructure (e.g., universal social policies and public services adapted to urbanization and demographic transitions).
c. Structural discrimination (e.g., racism, gender inequality, disability discrimination, ageism, class privilege and other divisions in society).
d. Conflict, forced migration and displacement.
e. Mega-trends (e.g., climate change and digitalization).

3.5 The structural determinants create inequities in the conditions of daily life that shape health. The conditions of daily living that impact health, referred to as the downstream SDOHE, include:

a. Early childhood development, adolescent support, and education.
b. Social connection.
c. Work and employment conditions.
d. Food environments and access to nutritious food.
e. Housing quality, affordability, and safety.
f. Access to basic amenities (water, sanitation, and clean energy).
g. Quality, safe and affordable public transport systems and mobility.

3.6 While there has been some global progress in improving health and reducing inequities, progress has not been widespread enough to meet the Commission's targets. This is largely due to insufficient structural-level action to address the upstream SDOHE outlined in this chapter.

Actions recommended by WHO

3.7 In chapters three to five, WHO shares evidence-based strategies and recommendations for further action on the SDOHE. WHO identifies target action areas, which are listed below.

a. Address economic inequality and invest in universal public services. The recommendations are to:

- Invest in accessible, high-quality universal public services. Use progressive taxation (tax rate that increases as taxable income level rises) to expand funding for income transfers and equitable infrastructure and services.
- Ensure that approaches to taxation, development financing, and debt relief include funding to address the SDOHE.
- Use the public sector to provide incentives for commercial activities that positively affect health equity and regulate health-harming activities by commercial actors.
- Expand coverage of universal social protection systems, income guarantees and care throughout the life course. Establish and broaden paid leave benefits for all workers.

b. Tackle structural discrimination and the determinants and impacts of conflict, emergencies and migration. The recommendations are to:

- Address structural discrimination by repairing discrimination embedded in policies, laws, institutions and social norms. Redress the negative impacts of colonization by developing standards for reparative justice that measure health impacts. Acknowledge Indigeneity as a SDOHE.
- Promote health equity during emergencies, migration and conflict by ensuring access to health and social services. Ensure emergency preparedness and responses incorporate the SDOHE, including additional social protection measures.

c. Steer action on climate change and digitalization towards health equity. The recommendations are to:

- Implement climate change mitigation and adaptation policies that maximize health equity benefits and preserve biodiversity. Support Indigenous communities in their stewardship of land and natural resources.
- Ensure that digital transformations and artificial intelligence promote health equity and public good. Address the digital divide, which describes the disparities in access to digital technologies between populations.

3.8 Chapters six to eight discuss the ways in which new approaches to governance in a variety of sectors can enable more equitable health outcomes. WHO makes the following recommendations:

a. Empower local governments to address the SDOHE through community-centred actions that support age-friendly communities and combat social isolation. Ensure healthy housing and built environments, including through universal design principles.
b. Incorporate representative community engagement and social participation in policy processes and delivery. Create conditions that maximize the capabilities of independent and inclusive civil society organizations.
c. Achieve universal health coverage through progressive health financing and primary health care approaches. Improve equitable access to a continuum of quality primary health services addressing both physical and mental health.
d. Build and retain a health and care workforce capable of delivering equity. Develop human capacity in health, social protection, education, labour, local government and service organizations, to enhance intersectoral efforts.
e. Integrate addressing the SDOHE in all health strategies, policies, emergency preparedness and response plans, and public health laws. Establish mechanisms for intersectoral collaboration and community engagement for health at all levels of government.
f. Strengthen statistical infrastructure and build capacity for the use of disaggregated data to measure progress on health equity.

3.9 Chapter nine outlines the roles required of interest groups, including national and local governments, health leaders, civil society, the private sector, the United Nations, global financial institutions, research institutions, and WHO.

a. Local governments must lead with strong policies, integrating action on the SDOHE into strategies, supported by intersectoral governance structures and investments.

4. Previous Reports and Decisions

4.1 The reports #2024-INFO-49, #2024-INFO-58, and #2025-INFO-13 provided updates on Durham Region Health Department's (DRHD) Climate Change and Health Vulnerability Assessments.

4.2 Report #2024-INFO-79 provided an update on the report: A Time for Urgent Action: The 2024 Report of the National Advisory Council on Poverty, which was released on October 29, 2024.

4.3 Report #2025-INFO-33 provided an update on the report: Food Insecurity and Food Affordability in Ontario, released by Public Health Ontario on April 9, 2025.

5. Local Initiatives

Health Equity

5.1 The Ontario Public Health Standards: Requirements for Programs, Services and Accountability (OPHS) articulate the expectations for public health programs and services to be delivered by boards of health.

5.2 The Health Equity Standard of the OPHS requires that boards of health engage in public health practice that results in decreased health inequities across all programs and services.

5.3 In accordance with the OPHS, DRHD incorporates a health equity lens in program planning, engages with priority populations to address public health needs, and works with community partners to address the social determinants of health.

Poverty

5.4 Locally, Durham Region Social Services Department and DRHD, with the support of Davis Pier Consulting, are working on development of a Poverty Response Program (PRP). The PRP will outline actions to address poverty across the region. The PRP will be informed by and developed with the community, service providers, community partners and individuals with lived experience. The PRP aims to better understand poverty in Durham Region and create actionable solutions.

Food Insecurity

5.5 DRHD uses the Ontario Nutritious Food Basket to monitor local food insecurity. DRHD found that in June 2024, the price of a basic healthy diet for a reference family of four in Durham Region was $286 per week or $1,232 per month. Additionally, in 2024, one in four households were food insecure. These statistics are similar to Ontario. Information about local food insecurity is available in the Food Poverty in Durham infographic.

5.6 DRHD also maintains a webpage on food insecurity on durham.ca. The webpage includes information about what food insecurity is and who is most impacted, monitoring information, policy solutions, and other relevant resources.

6. Relationship to Strategic Plan

6.1 This report aligns with/addresses the following Strategic Directions and Pathways in Durham Region's 2025-2035 Strategic Plan:

a. Healthy People, Caring Communities

- H1. Implement preventive strategies to support community health, including food security.

- H2. Collaborate with partners to respond to complex social issues that improve community safety and well-being, including mental health and addictions.
- H3. Integrate and co-ordinate service delivery for positive life outcomes, including investments in poverty prevention, housing solutions, and homelessness supports.
- H4. Support the development of healthy children and youth, including access to affordable and quality child care.
- H5. Provide services for seniors and work with community partners to support aging in place.
- H6. Collaborate with partners to co-ordinate settlement supports for newcomers.
- H7. Prepare for and respond to local health emergencies in partnership with the community.

b. Strong Relationships

- S1. Enhance inclusive opportunities for community engagement and meaningful collaboration.
- S2. Build and strengthen respectful relationships with First Nations, Inuit, Métis, and urban Indigenous communities.
- S3. Collaborate across local area municipalities, with agencies, non-profits, and community partners to deliver co-ordinated and efficient services.
- S4. Advocate to the federal and provincial government and agencies to advance regional priorities.
- S5. Ensure accountable and transparent decision-making to serve community needs, while responsibly managing available resources.

6.2 This report aligns with/addresses the following Foundation(s) in Durham Region's 2025-2035 Strategic Plan:

a. Processes: Continuously improving processes to ensure we are responsive to community needs.

7. Conclusion

7.1 In its report, WHO presents evidence-based strategies and policy recommendations to guide governments, civil society and international organizations in addressing the SDOHE to produce equitable health outcomes.

7.2 WHO recognizes that improvements in health equity have been too slow and, alarmingly, inequities between social groups within countries are often deepening.

7.3 Implementing WHO's recommendations would lead to better health, greater health equity and progress on the global Sustainable Development Goals, adopted by the United Nations in 2015.

Respectfully submitted,

Original signed by

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