The ROCKEFELLER FOUNDATION | BU School of Public Health

OVERVIEW | Middle East

Data, social determinants, and better decision-making for health: The report of the 3-D Commission

In April 2020, The Rockefeller Foundation and Boston University School of Public Health launched the Commission on Health Determinants, Data, and Decision-Making (3-D Commission) with the aim of creating a common language among health determinants, data science, and decision-making—both health and non-health related—toward the end of improving the health of populations. The report—an output of more than a year of discussion and research among a multisectoral group of distinguished experts representing academe, the private sector, civil society, and government—explores the key social and economic drivers that influence health outcomes and illustrates how data on social determinants of health (SDoH) can be integrated into decision-making processes. The report argues for a holistic definition of SDoH to drive cross-sectoral collaboration, address health inequities, and promote accountability and offers a set of principles and recommendations designed to support the development of a SDoH-based, data-driven approach to decision-making and foster demand for public and private investment in SDoH.

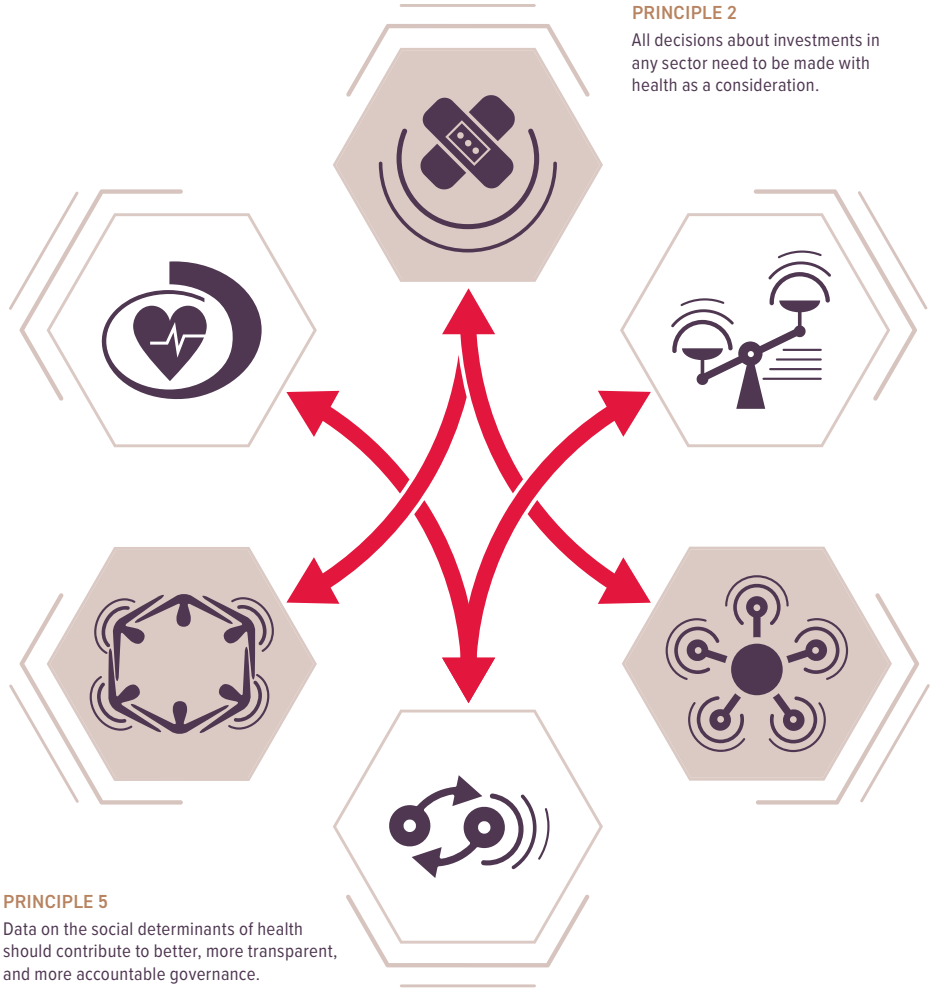
The recent proliferation of big data presents tremendous potential and opportunity both to understand SDoH better and to guide decision-making to improve the health of individuals and populations. However, a lack of leadership, priority setting, and investment has impeded progress in effective translation of such progress into data-driven action on SDoH. There are multiple challenges to achieving such goals—including data availability, data hierarchy, nonuniform definitions and measurements of SDoH, public mistrust in the use of big data, and lack of engagement of marginalized populations—that are experienced across high-income, middle-income, and low-income countries.

Despite increasing awareness of the need to incorporate SDoH into decision-making by academe and civil society, the uptake of evidence-informed policies and programs that tackle SDoH or build on the growing availability of data to improve health outcomes has been slow. Catalyzing action for health across different sectors requires a common language and an understanding that improved health should translate to returns on financial investment and gains in productivity as well as overall population well-being. Political will among decision-makers is also a critical challenge to enacting SDoH-focused policy. As the impact of policies addressing SDoH will likely be difficult to discern in the near term, promoting population health is a choice that the decision-maker must make consciously, sometimes irrespective of short-term political exigencies.

There are three interconnected, pragmatic areas needed for the vision of the 3-D Commission to translate into actionable policies and programs: political will, technical capacity, and community engagement. First, creating political will requires developing a common language with decision-makers in different sectors, highlighting the potential returns on investment for other sectors, and nuancing and broadening metrics of societal advancement beyond economic indicators. Second, technical capacity is needed to translate a new appreciation for data and SDoH into actionable directives that can be used to improve policy decisions and population health outcomes. Third, engaging communities in decision-making processes can then lead to better decisions being made. Inclusion in the decision-making process means that decision-makers listen to a wide range of stakeholders while formulating decisions: this diversity of thought and perspective helps to compensate for the lack of perfect data. The three areas also require a basic level of trust from the population, which, in turn, can lead to greater levels of trust that will inform, support, and reinforce better decision-making for health.

To improve the health of populations and address health disparities caused by social structural inequities—and exacerbated by COVID-19—a whole-of-society approach is needed. This will require a concerted effort to reframe key issues and adopt common understandings of cross-sector challenges that affect health. All relevant actors must understand the role that SDoH plays in shaping health outcomes; therefore, critical questions on data collection and use will need to be addressed. This report—and its principles and associated recommendations—offers a roadmap for making these goals a reality.

3-D Commission principles



PRINCIPLE 1
Evidence-informed decision-making to promote healthy societies needs to go beyond health care and incorporate data on the broader determinants of health.

PRINCIPLE 2
All decisions about investments in any sector need to be made with health as a consideration.

PRINCIPLE 3
Decision-making that affects the health of populations needs to embrace health equity, while also acknowledging potential trade-offs between short- and long-term costs and benefits.

PRINCIPLE 4
All available data resources on the determinants of health should be used to inform decision-making about health.

PRINCIPLE 5
Data on the social determinants of health should contribute to better, more transparent, and more accountable governance.

PRINCIPLE 6
Evidence-informed decision-making to promote healthy societies needs to be participatory and inclusive of multiple and diverse perspectives.

3-D Commission recommendations

- Relevant international, regional, national, and local entities, including funders, should **systematically collect and make available, in real time, quality data characterizing the full range of determinants of health—including for example, education, housing, economics—to decision-makers and communities locally and nationally.**
- National governments should **develop transparent systems that collect data about the social determinants of health, and explicitly use these data in decision-making processes.**
- Relevant international, regional, national, and local entities, including funders, should **embed follow-through monitoring processes to ensure accountability for data-informed decision-making around health.**
- Relevant international, regional, national, and local entities, including funders, should **center community engagement in acquisition and interpretation of data and make such data widely available to relevant communities.**

Case study: Addressing high rates of non-communicable disease among Middle Eastern refugees

As of 2017, more than 5.4 million people had been displaced due to the conflict in Syria. Syrian refugees fled the violence and settled in mostly urban environments in neighboring countries including Lebanon, Jordan and Turkey.[1] Such a large influx of refugees has placed enormous burdens on the economies, societies and infrastructure of these countries. Most notably, the health systems within these countries have struggled to address the health needs of refugees. In 2018, non-communicable diseases (NCDs) accounted for 74% of the deaths among Syrian refugees and host country citizens within the Middle East and North African region.[2] Although there are only a limited number of studies, researchers hypothesize that the stress that results from leaving one's home country, together with changes in dietary intake and activity levels, may increase the risk of NCDs among Syrian refugees.[3] To address the burden of these diseases, the 3-D Commission recommends that national governments should develop transparent systems that collect data about a broad range of health determinants – including those issues faced by refugee populations that are residing within their borders – and explicitly use these data in decision-making processes.

The ongoing conflict in Syria and the high burden NCDs among both Syrian refugees and host country nationals has led to a growing need for government intervention. However, evidence-informed decision making to promote healthy societies needs to go beyond healthcare alone and incorporate data on the broader determinants of health. Many Syrian refugees come from communities that are affected by poverty and conflict, poor or disrupted health systems, and high burdens of disease. The conditions surrounding migration exacerbate inequalities and expose migrants to additional health risks – including conditions experienced during transit, the legal status of the individual, and local policies that support or prevent access to health and social services. Such conditions increase vulnerability to infectious, chronic and NCDs including hypertension, diabetes and many types of cancers for refugees.[4]

Currently, there are limited data on refugee and migrant health in general, as well as limited evaluations of intervention strategies.[5] Nevertheless, policy makers should consider the available data that highlight best practice examples as well as the broader determinants of health. The Migration and Health program at the WHO Regional Office for Europe was established to support Member States to strengthen the health sector's capacity to provide evidence informed responses to the public health challenges of refugee and migrant health. This program was established to promote the health of refugee and migrants and to protect health in the host community.[6]

By collecting data on a broad range of health determinants, including religion and culture, the environment, and individual and collective emotions, and including consideration of these factors in their policy solutions, decision-makers can yield positive health results. This should be an essential element of the decision-making process. For Syrian refugees, there is tremendous potential for data to advance our understanding of social determinants of health, facilitate better evidence-informed decision making, and, in turn, decrease the rates of NCDs among migrants.

1 McNatt, Z. Addressing noncommunicable diseases among urban refugees in the Middle East and North Africa—a scoping review. *Conflict and Health*. 14, 9 (2020). doi:10.1186/s13031-020-0255-4
2 Ibid.
3 Naja, F., Shatila, H., El Koussa, M. et al. Burden of non-communicable diseases among Syrian refugees: a scoping review. *BMC Public Health*. 19, 637 (2019). doi:10.1186/s12889-019-6977-9
4 World Health Organization Regional Office for Europe. *Health promotion for improved refugee and migrant health—technical guidance*. World Health Organization; 2018.
5 Ibid.
6 Ibid.