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Commentary

Civil Society: Essential Player in Promoting Social Determinants of Health Equity Evidence in Policy Formation and Advocacy

Comment on "Civil Society's Evidence-Generating Role for Health Policy Decisions: A Thematic Analysis of a Healthcare Information for All (HIFA) Community Online Discussion"

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Abstract
Civil society's evidence-generation and advocacy roles are crucial for effective health policy and health equity. In response to Gopinathan et al we call for health policy research to include broader inclusion and examination of social, political, and commercial determinants in its scope. This widening of the theoretical and methodology lens is vital as it inevitably leads to inclusion of a wider range of civil society actors outside the health system whose work can address the underlying causes of health inequities. Building on the authors' insights into the different types of evidence civil society generates, we provide two case studies on civil society networks who produce evidence and advocacy on determinants of health and health equity: (1) the Australian based Health Equity Learning Lab (Oz) (HELLO); (2) the global People's Health Movement (PHM). We argue greater attention should be given to the mutually reinforcing role between evidence and advocacy to improve policy decisions.

Keywords: Civil Society, Health Equity, Evidence, Determinants of Health, Health Policy

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Introduction

Civil society has a vital role to play in improving health. It is one means by which the aim of community participation in health systems and public health has been enacted including by the World Health Organization (WHO) since the Alma Ata Declaration stressed its importance.[1-3] Consequently, we welcomed the article by Gopinathan et al[4] arguing for the value of civil society's role in generating evidence for health policy. Like previous research[5] they identify that civil society is diverse with many different types of groups coming under that term. Usefully they distinguish between those groups which are interested in an immediate issue (often patients) and those who have a stronger civic orientation. They also point to the potential for civil society to be a mouthpiece of vested interests as in Big Pharma using health consumers to encourage uptake of a particular drug and therefore emphasise understanding civil society within the political economy of health. The article also considers the different types of evidence and suggests these should be broad rather than narrow. In this commentary we add to Gopinathan and colleagues[4] perspective by considering the importance of incorporating social, commercial, and political determinants when examining health policy and the evidence that informs it and then present two examples of civil society contribution to evidence generation to illustrate why a broader definition is important.

What Counts as Health Policy?

We argue Gopinathan and colleagues[4] examination of the role of civil society in contributing to health policy-making would benefit from a broader approach to "health policy." The article focuses on health systems, and given the project the article derives from, the focus appears to be particularly on universal health coverage (UHC). The examples used in the article concern access to health services. This framing of health policy therefore has implications for the types of civil society, policy and other actors who may be involved in a forum such as Healthcare Information for All (HIFA) and their use and uptake of evidence. This points to two important considerations. Firstly, while universal access is a valuable goal, UHC is a narrow conception of what we should be trying to achieve globally, and the focus on

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UHC has supplanted more comprehensive visions for our healthcare system.[6,7] In particular, the framing of UHC has de-emphasised the Alma Ata Declaration's vision of primary healthcare that is community led, multi-disciplinary, and underpinned by a social view of health that incorporates disease prevention and health promotion, including action and advocacy on social determinants of health, alongside treatment and rehabilitation.[6-8] The WHO Ottawa Charter for Health Promotion also offers an expanded vision of the role of health policy through its advocacy for the importance of Healthy Public Policy.[9] The risk of a UHC framing is a narrower scope for civil society input into generating evidence on health systems.

Secondly, the social determinants of health have been shown to have more impact on population health outcomes than the health system.[10] There is also growing recognition of commercial determinants of health: how private commercial interests shape people's opportunities for healthy lives, as well as shaping health service access and quality.[11] Thus, to be truly effective in improving population health and health equity, health policy, and research on health policy, need to address social and commercial determinants of health, not just focus on the health system. We argue that civil society does indeed have a vital role in supporting primary healthcare but also in addressing the more powerful social and commercial determinants of health and health equity. Governments often neglect these broader determinants and lack political will to address them. Civil society can be powerful in ensuring they are kept on global and national policy agendas by both producing evidence and being powerful advocates.

National Example of Civil Society Evidence and Advocacy: Health Equity Learning Lab (Oz)

Through online analysis we identified 137 non-government organizations (NGOs) who were engaging in advocacy activities for change to address health inequities in Australia in 2022, including their role in policy formation.[12] We found 35 of the 137 NGOs were not health-based organisations, and they were advocating for health equity and the social determinants of health equity from varying sector positions (eg, housing, welfare, environment) including activities that provided evidence as part of health and other policy formation.[12] This analysis informed the creation of the Health Equity Learning Lab (Oz) (HELLO) (2023-), a learning network and research translation mechanism to work with civil society organizations (CSOs) to determine how to reduce health inequities in Australia. Table provides an overview of the members, who have been participating in meetings and a webinar series on health equity.

Similar to the Community of Practice described by Gopinathan et al,[4] HELLO has facilitated a collective process of evidence generation for translation into policy and advocacy strategies. Part of what has made it so fruitful is the inter-sectoral collaboration which provides different perspectives, types of evidence, and experiences of the policy formation processes.

Like Gopinathan and colleagues[4] observations, we found CSO members provide rich diverse experiential and lived experience knowledge, including the effects of policy on people. In HELLO equity perspectives are centred, including from priority population groups such as Aboriginal Torres Strait Islanders, rural communities, and people with disability, and how the CSOs capture this lived experience to present to policy-makers. For example, a member from a women's multicultural organisation explained in a meeting the impact of privatisation of health services on temporary visa holders and international students in Australia includes not having access to reproductive healthcare. They described collecting lived experience evidence to use in their advocacy campaign to improve access.

Table. Health Equity Learning Lab (Oz) Members

NGO Type	Members
Professional health NGO	Public Health Association of Australia Australian Health Promotion Association
Non-health NGO	Australian Council of Social Service New South Wales Council of Social Service South Australian Council of Social Service Victorian Council of Social Service
Disease/health sector specific NGO	Asthma Australia Cancer Council SA Diabetes SA Foundation for Alcohol Research & Education National Heart Foundation of Australia National Oral Health Alliance
Mental health NGO	Lived Experience Australia Western Australian Association for Mental Health
Population based NGO	Australian Women's Health Alliance Deafness Forum Australia Disability Advocacy Resource Unit Lowitja Institute Multicultural Centre for Women's Health National Rural Health Alliance
Academic health equity and advocacy experts	Research team (5 members) Other (3)

Abbreviations: NGO, non-government organization; SA, South Australia.

HELLO enables access to unpublished evidence from CSOs, such as on under researched topic areas and under researched groups, often not documented in academic literature until many years later. CSOs in HELLO also provide present-day commentary of public awareness on policy issues related to equity due to closer proximity to varied community groups, as well as policy actors. One activity included members participating in a HELLO webinar on "policy priorities for health and social equity in the 2025 Federal Election."

CSO members share informal knowledge on advocacy activities and their role in policy-making processes, including which forms of evidence they use. In HELLO meetings they comment on participation in policy consultation activities, including who else was in the room, what voices and interests were listened to or silent, what types of evidence were included, and how proposed policy was received in their sector or community. They provide knowledge to the research team on what types of evidence gets traction with policy-makers. One example of a social determinant of health discussed in HELLO was a campaign to increase the income support payment for unemployed people to a liveable amount. Members discussed using evidence on lived experience, financial and psychological distress, along with economic evidence in their advocacy, but noted a lack of political will by the federal government to support this issue.

The CSOs in HELLO vary in size, resources and integration into governance and policy-making mechanisms. Gopinathan et al argue, understanding the political economy factors and CSOs' place within the political economy can help to understand why civil society is able to inform and influence policy successfully.[4] As the authors highlight, CSOs such as the professional associations and peak bodies in HELLO hold greater administrative and professional power. They routinely get invited to government policy consultations alongside other powerful interests. We similarly found that smaller, less resourced CSOs are dependent on their alliances with more powerful CSO actors to influence policy, especially when challenging powerful commercial interests. Mechanisms like HELLO support alliance building and knowledge sharing relationships within civil society.

Global Example of Civil Society Evidence and Advocacy on Determinants of Health and Health Equity: People's Health Movement's WHO Watch and Policy Statements

The global People's Health Movement (PHM) was formed primarily because of great disappointment with the failure of the WHO's Health for All by the Year 2000 strategy in the years leading up to 2000.[13] Baum et al document the ways in which the People's Health Charter called for a radical transformation of the WHO so that it responds to health challenges in a way which benefits and involves community members and rejects selective and vertical approaches, by urging action in all sectors for health.[13] In this the PHM was drawing on the decade's long critiques of selective approaches to primary healthcare.[14,15] It called for people's organizations to be involved in the World Health Assembly (WHA) and for independence from corporate interests.[16] PHM's inaugural People's Health Assembly was held in 2000 and since then PHM has engaged with WHO and many low- and middle-income countries in relation to health policy.[13,17] This started with a WHO Advocacy Circle which involved annual participation in the NGO Forum for Health session at the WHA and a technical briefing on PHM and the Charter in 2003.[17] Later PHM established "WHO Watch" through which members of PHM have attended WHO Executive Board meetings and WHAs. The on-the-ground "Watchers" tend to be younger members and so the process is a great training ground and recruitment vehicle for PHM.[13] The sophisticated policy analysis is supported by experienced PHM members. Through their combined efforts, and supported by PHM members around the world, detailed, insightful and policy relevant critiques of governance structures of WHO and its proposals are available on-line available in a WHO Tracker.[18] Feedback to the authors from several low- and middle-income countries policy actors suggests that the PHM commentaries are immensely helpful in assisting them drafting their own national policy responses when policy analysis skills are lacking in their health ministries.

The other way in which PHM produces evidence and advocacy on health policy is through the declarations it issues after each of its global People's Health Assemblies. Since the original 2000 Assembly held in Bangladesh four more have been held (Ecuador in 2005, South Africa in 2012, Bangladesh in 2018, and Argentina in 2024). These declarations result from the sum of information fed to the Assemblies from over 70 various country circles and regional groupings of PHM. Most recently the Mar del Plata Call to Action[14] named capitalism as the root determinant of health problems:

> *"Capitalism is infinite in its pursuit of profit and consumption, but the world we live in is absolutely finite, and its physical limits are being attacked and exceeded. Only a radical change that replaces the mode of production, consumption and life generated by capitalism can reverse this destructive trend."*[19]

The Call to Action[14] includes these topic areas:

- Ecosystem health: food, energy, and climate;
- Diverse knowledges: Indigenous, ancestral, feminist, decolonial, anti-imperialist, and anti-capitalist;
- A world free of corporate control: resisting corporatisation, marketisation, and colonisation;
- Peace sovereignty and right to asylum and free movement: resisting war, occupation, and forced migration;
- Gender justice in health;
- Towards transformation of health systems.

This demonstrates that civil society involvement in health needs to go beyond narrow consideration of the health service system and how it operates to considering the underlying determinants which shape people's health chances.

Discussion and Conclusion

This commentary and the themes presented in Gopinathan and colleagues[4] article point to the important evidence-generating role of civil society to inform policy. The examples above highlight why it is important to include a diversity of voices in civil society evidence-generation and translation mechanisms, not just organisations representing health and

health consumer voices, to understand evidence on the causes of ill health and health inequities more broadly. It is also critical to ensuring evidence from cross-sectoral perspectives and priority population groups is included in policy formation. While the work of HIFA[4] should be commended for inclusion of multi-sector actors from civil society, policy, research, and with different health system expertise, the focus was still firmly on the health sector. Yet we know that most drivers of health lie outside the health sector and suggest that involving actors from outside of health that can add perspectives on crucial social, political and commercial determinants of health is vital and reflects the strong evidence on the impact of these determinants.[20] Therefore, mechanisms for research translation into policy which include a range of CSOs in evidence generation is crucial from an equity perspective to inform health policy.

Based on the examples of the HELLO and PHM we also argue evidence does not inform the policy-making and implementation process in isolation. More attention should be given to the combination of evidence with advocacy activities to understand how to influence policy. Plamandon et al[21] argue even when evidence is strong and feasible policy recommendations are readily available, connecting knowledge with action for health equity remains limited. Gopinathan et al[4] point to this through arguing for 'the need for institutionalized mechanisms that can counterbalance the influence of vested interests in health policy-making' and to investigate different participatory models for this to occur. While this is critical, understanding how to support advocacy alongside evidence generation is needed for better understanding of evidence translation, and how and why it gets taken up by policy-makers. We concur with Farrer etal[22] who argue civil society can bridge the worlds of civil society, research, and policy. We argue fostering networks between academics, civil society, practitioners and policy-makers can support evidence-informed policy-making to advance health equity especially when accompanied by strong advocacy.

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Disclosure of artificial intelligence (AI) use

Not applicable.

Ethical issues

The study was approved by the University of Adelaide Human Research Ethics Committee (H-2023-099).

Conflicts of interest

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