The social determinants of health: is there a role for health promotion foundations?

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Introduction

A vexing challenge faces health promoters. Even with great prosperity and improvements in population health overall, marked social differences in health and life expectancy negate these achievements. Evidence of these social variations is compelling and consistent across the globe. Acting on social determinants of health (SDH) to address these health inequities requires an understanding of a complex policy environment and other factors that shape the responses of a range of key actors, including the state. In this context, the paper examines the potential of health promotion foundations (HPFs), a semi-autonomous arm of the state, to act at several policy and program intervention points to address SDH and reduce health inequities.

What are health promotion foundations?

HPFs are organisations established through a general or specific Act of Parliament with the primary purpose of promoting health. Most often they are statutory authorities, as is the case in Australia; namely, the Victorian Health Promotion Foundation (VicHealth) and the Western Australian Health Promotion Foundation (HealthWay), although some are nested within central government, such as ThaiHealth. HPFs have been established in many countries in Europe and Asia and at the State level in Australia and Canada. New foundations are emerging in developing countries (most recently in Malaysia).

Foundations have several objectives prescribed in their enabling legislation to promote the health of the people in whatever government jurisdiction (nation or state) they are enacted. In line with, and to give substance to, these objectives a fundamental statutory function of many HPFs is to administer a long-term health promotion fund, also established by the enabling legislation. Money is collected through a range of mechanisms, including hypothecated tobacco and alcohol taxation, indexed grants from consolidated revenue and revenue raised through individual sickness insurance premiums. Statutory authorities are part of a broad group of quasi governmental organisations (QUAGOs) that undertake activities and administrative functions outside of the central functions of the state. The rationale for this form of organisation is to link public purpose with the enterprise and innovation potential of

Abstract

Issue addressed: If they are to respond effectively to health inequities, organisations involved in health promotion need to refocus on the social determinants of health (SDH) and the distribution of resources for health.

Methods: This paper examines the potential of health promotion foundations (HPFs), a semi-autonomous arm of the state, to act at several policy and program intervention points to address the SDH and reduce health inequities.

Conclusion: The public purpose, enterprise and innovation potential of health promotion foundations provides them with unique capacity to respond to SDH. In the complex and contested policy environment surrounding action on the determinants of health, the role that foundations can most usefully play is that of a change agent in a broader social movement seeking health equity.

Key words: Social determinants of health, health inequities, health inequalities, health promotion foundations.

So what?

No single model, approach, sector, organisation or group will be effective in reducing health inequities, although some may be more important players. It is valuable for health and other organisations – government, non-government and private alike – to reflect on their place in the apparatus of change and how they can most usefully work with others to achieve greater health equity.
being outside centralised government or in the private sector.7 While the reasons for establishing a statutory authority will vary, in general the advantages of HPFs in promoting health result from a combination of factors related to their organisational independence and longevity, stable funding and potential for innovation (see Table 1).

The last feature listed in Table 1 is significant as HPFs, along with concepts of health determinants, have evolved over the past two decades. From an initial role of buying out tobacco advertising and sponsorship in sport and the arts and establishing health promotion programs (as was the case in Australia), the roles have diversified to include the role of expert stakeholder, partner, facilitator, advocate, system and capacity builder, and change agent.

Although HPFs have some flexibility to advocate reform, they also have limitations. In Australia, two established foundations were reabsorbed into government portfolios (in South Australia and the Australian Capital Territory). While the reasons for their dissolution varied, HPFs can arguably be duplicative of other government programs; unresponsive to changing policy imperatives of government; seen as a third party increasing transaction costs; and no longer contemporary if the Act is outdated by other legislative or regulatory changes. These potential limitations create an environment where HPFs need to be able to anticipate and manage risks when challenging prevailing orthodoxies.

Table 1: Inherent features of statutory authorities.

<table>
<thead>
<tr>
<th>Ability to be independent yet accountable</th>
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<tr>
<td>• The independence, objectives and powers of the organisation are established by an Act of Parliament.</td>
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<td>• The board and chair of the organisation are relatively independent of the Minister and the capacity of the Minister to direct them can be defined or limited.</td>
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<td>• The organisation operates at arm’s length from the core machinery of government.</td>
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<td>• Within legislative and political limits, the organisation is free to advocate and act in its own right.</td>
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<th>Capacity to endure despite government and policy change</th>
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<tr>
<td>• Parliament must act in order to create or abolish the organisation.</td>
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<tr>
<td>• The organisation can withstand changing policies and fortunes of government to some extent and maintain their role and programs regardless of the government of the day.</td>
</tr>
<tr>
<td>• HPFs are a ‘trustee for the public interest’ where they have a perceived public purpose apart from party political interests.</td>
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<th>Security of resources to allow for sustainable interventions</th>
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<td>• The organisation administers a permanent statutory fund and/or has its own independently managed finances from the ministry of finance or other sources.</td>
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<th>Potential to facilitate innovation and intersectoral action and manage risk</th>
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<td>• Because of financial, program and policy independence from government and links to community sectors, HPFs can facilitate collaboration both within government across departments and outside of government across sectors.</td>
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<td>• Innovation and enterprise were the drivers of the emergence of the statutory authority form.</td>
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<td>• A combination of factors listed above allows HPF to manage and absorb risk (such as holding relatively controversial positions).</td>
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• Individualist and structural models of health.
• Models of the role of the state in the policy process.
• Policy processes addressing social determinants of health.

Different models of the value of health permeate the media, popular understanding and policy discourse. Agencies, and the constituencies they are trying to influence, may prioritise the intrinsic value of health (i.e. that health is of fundamental value and of itself) or the utilitarian value of health (i.e. the value of health is in its public utility and its usefulness in promoting some public good, for example economic wellbeing). Although these two views of health may not necessarily be dichotomous or in tension, it is necessary to understand their relative importance in policy discourse and positions when advocating for action.

Another set of considerations is whether prevailing views of health are based on individualist or socio-structural models of health. An individualist model posits health as under the control of, and therefore as the responsibility of, the individual. A socio-structural model posits health as determined by factors outside of the individual’s control, explaining health inequities as the result of patterns of social inequality and the concentration of power and resources in certain groups in society. Consequently, change in economic and social policy and improvements in living and working conditions (i.e. SDH) are emphasised as key pathways to health.

Hill describes a range of models of the role of the capitalist state in the policy process, including:

• A passive neutral entity – the state responds to the policy demands of interest groups and referees between them.
• A relatively autonomous actor – the state is an active interest group pursuing its own ends or acting on the interests of dominant groups.

Different parts of the state may work in one or more models at different times according to the policy issue being contested and the constituencies involved. These models help one reflect on how the state has responsibility for, influence over and power to change the SDH (and how it may be constrained) and consequently how the influence of different state agencies is best exercised.

Finally, insights from models of the process of developing policy on health inequities are also useful in understanding how the state and HPFs respond to SDH. Whitehead’s action spectrum on inequalities in health outlines the stages of the diffusion of ideas and development of action on health inequities (see Figure 1). Although not necessarily linear or progressive, the model suggests that in the process of developing policy on health inequities, states move between and through stages of measurement, recognition, awareness raising, denial/indifference, concern, will to take action, isolated initiatives, more structured developments and comprehensive co-ordinated policy. Whitehead compares three approaches to developing a national agenda on health inequities: a consensus-building strategy in the Netherlands; a confrontational approach in the United Kingdom; and an approach that emphasised social justice and solidarity in Sweden.

Mackenbach and Bakker completed a comparative study of the evolution of national health inequities policy agendas in Europe. Both Mackenbach and Bakker and Whitehead identified a series of factors that promoted policy progress including: deteriorating socio-economic conditions; worsening health trends; the availability of descriptive data; the presence of political will; general economic development and security; and the action of international agencies.

How can HPFs most effectively respond to SDH?

As already argued, organisational capacity associated with their statutory status provides HPFs with unique opportunities to address SDH (albeit there are limitations). Insights from conceptual models of health and the role and process of the state in developing policy on health inequities suggest that the policy environment is complex and uncertain. The apparatus of the state is likely to be constrained in its response by a range of factors such as the complexity of the issue, uncertain outcomes from different courses of action, the importance of the issues at stake, the dynamics of policy debates and disputes, and paradigm stalemates.

### Table 2: Policy challenges and sector responses in addressing health inequities

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<tr>
<th>Point of intervention</th>
<th>Point in differentiation process</th>
<th>Sector response</th>
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<tr>
<td>A: Reducing social inequities</td>
<td>Social stratification and exposure</td>
<td>All sectors</td>
</tr>
<tr>
<td>B: Addressing factors mediating the effect of social disadvantage on health</td>
<td>Exposure and vulnerability</td>
<td>Housing, education, welfare sectors, etc Health promotion primary care environmental, occupational and public health – Universal and selective health promotion and primary prevention</td>
</tr>
<tr>
<td>C: Improving accessibility and effectiveness of health services for low socio-economic groups</td>
<td>Vulnerability and consequences of ill health</td>
<td>Primary, acute and continuing care Universal, accessible, quality health care Secondary and tertiary prevention</td>
</tr>
<tr>
<td>D: Reducing negative impacts of poor health on socio-economic position</td>
<td>Consequences of ill health and social stratification</td>
<td>All sectors</td>
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Adapted from Diderichsen (1998) and Mackenbach and Stronks (2002).
Role of change agent

In this context, we argue that the most effective response by HPFs is to act in the role of change agent. This capitalises on their public purpose, enterprise and innovation capacities for addressing SDH. In this role, HPFs can undertake or support a range of activities including evidence building, internal government policy advocacy, cross-sectoral collaboration, community engagement and constituency building, and program funding for disadvantaged groups. Also, HPFs’ capacity to be flexible, opportunistic and strategic enables them to step outside standard health structures and frameworks and more effectively navigate this dynamic and contested space. No single model, approach, sector, organisation or group will be effective in reducing health inequities, although some may be more important players. A change agent seeking to connect, reconcile, bridge or shift positions, approaches and structures, is arguably required.

The independence of HPFs allows them to be relatively eclectic and pragmatic in their approach and act according to opportunities and constraints. Accordingly, HPFs may elect to sit at the junction between the intrinsic and utilitarian and the individualist and structuralist view of health (see Figure 2). This enables tactical shifts to either side of this junction as opportunities arise in the short term, assuming a long-term view to shifting action towards the social determinants end of the continuum. With this stance, they can work at bridging distances and contradictions between these positions without being caught in the doctrine associated with any extremity – all the while contributing to longer-term shifts in the policy agenda.

Linking and consolidating strategy

Similarly, a level of eclecticism is needed when adopting strategy: a mix of approaches is required across the four policy intervention points identified in Table 2. Much of the important work in addressing SDH and reducing health inequities is related to the first policy intervention point: reducing social inequities and disadvantage. This is not, in and of itself, the core business or province of the health sector. Most of the reform required to reduce social disadvantage is in the domain of other sectors, including finance, infrastructure, and education. The benefits of this reform will likewise be shared with other sectors including welfare, justice and environment.

HPFs can play a role in keeping the reform agenda moving by investigating and advocating the relationship between health and material disadvantage and the human and social costs of health inequities. This includes action from the level of macro-social policies that address material disadvantage, such as taxation and equal opportunity policies, to the level of local material disadvantage – focusing on people in places and trying to reduce negative health exposures in local environments. HPFs can be smart as advocates: there are arguments that support the reduction of health inequities that can appeal to different policy positions. These include: that social and economic environmental conditions are estimated to determine approximately half of population health status; health inequities have spill-over effects for the rest of society; and interventions to reduce them are cost effective and deserve priority on efficiency grounds.2,21

The second policy intervention point, to reduce the effect of social disadvantage on health, emphasises the need to intervene in psychosocial and behavioural pathways and address factors that mediate the relationship between disadvantage and poor health. HPFs have a role in investigating, explaining, and intervening in the relationship between poor health and psychosocial effects of poverty such as social marginalisation, social stress and lack of opportunity and control. An important part of this role is to seek community-generated understandings of and responses to these relationships. Also by adding to the understanding of common determinants of multiple risk behaviours and factors in disadvantaged groups and families, HPFs can intervene to leverage psychosocial protective factors and reduce risk; for example, by working in partnership with other sectors to support and evaluate health effects of their initiatives (e.g. home visiting programs, early childhood support and transition to school programs).

Policies on health inequities in Sweden and Norway include goals to reduce the difference across the socio-economic gradient in the percentage of people who have risk behaviours.
such as smoking, alcohol misuse, and insufficient physical activity.24,25 While acknowledging and working on behavioural pathways in disadvantaged groups, HPFs can help shift approaches away from individualism and develop more sophisticated ways of understanding and intervening to change behaviour. For example, HPFs could build further evidence that behavioural pathways are nested in and interact with material and psychosocial pathways.

Although much of the work of HPFs in addressing SDH is in the policy intervention points discussed above, they still need to consider advocacy and support for innovations to improve the accessibility and effectiveness of health services for low socio-economic groups and reduce the negative effects of poor health on socio-economic position (rows C and D of Table 2). While social position predominantly determines health, rather than the reverse, less healthy people are more likely to be downwardly socially mobile. HPFs arguably have a role in advocating universal access to appropriate, effective and quality health services across the health care spectrum, for example supporting initiatives such as Medicare and the Pharmaceutical Benefits Scheme. Likewise, there is a role in advocating for the maintenance of sickness, disability and Workcover benefits at sufficient levels to help avoid a health-related slide into poverty, along with strategies to assist the chronically ill or disabled to re-enter or participate more fully in the workforce.

Connecting organisations, sectors and people

As argued earlier, no single organisation, sector or group will be able to accomplish the fundamental changes required to address SDH. Positioning HPFs as change agents is also important in acknowledging the contribution they can feasibly make and in locating their efforts as only one part of a broader movement of social change. It is improbable that health promotion and public health, on their own, can accomplish major social change. Most of public health’s innovation could arguably be seen as responding to and reflecting social change rather than initiating it; hence, positioning HPFs as change agents is a more realistic reflection of their capacity to be a catalyst in, rather than a fundamental driver of, social change.

Accordingly, HPFs have a role in building and contributing to broad-based, intersectoral collaborations to address shared social determinants and find ‘joined up solutions to joined up problems’. The integration of effort and economy of scale offered by broad-based collaborations are key to progress on social inequities and delivering outcomes for any one sector.

If it is strategic to broaden the focus from determinants of health to shared determinants of health and other outcomes, it follows that it is also strategic to shift to executive, rather than health sector, leadership of initiatives. The high-level leadership of a committed executive, as demonstrated in the Treasury-led UK response to tackling health inequities, is arguably crucial to overcoming bureau-based administrative and budgeting silos.

Figure 2: Competing health paradigms.
and supporting cross-portfolio approaches.

While HPFs may build collaboration and commitment across sectors and at different levels of government, the decision stakes surrounding SDH are such that fundamental social change won’t happen without a people’s movement. Public health is arguably increasingly defaulting to a model of state control and not engaging people power to drive social change. HPFs, in their role as change agents, can refocus on this, engaging people as central agents in the formation and implementation of policy and ensuring those with the poorest health have their voices heard and opportunities for redress.26

Social determinism shifts us from “a focus on individuals to a recognition that relational and group-based phenomena shape and influence individual aspiration, capabilities, and agency”.26 Ironically, this loops one back to individual agency, within a social movement, as the key ingredient in addressing SDH.

**HPF as change agents: is it defensible?**

The eclecticism argued for may be of concern to some who prefer a more rational and instrumental approach. When always tactically responding to complex policy problems it may be perceived that HPFs become compartmentalised in their response rather than systemic. But as Whitehead’s schematic and the experience of other countries suggests, the trajectory of policy development in relation to SDH may have a logic of its own, where a flexible and strategic approach may be warranted in the early part of the process (to help constituencies and governments move through phases), consolidating efforts and strengthening momentum until a more co-ordinated, comprehensive and instrumental approach is possible.

Maintaining the flexibility and responsibility of a change agent may also be more challenging than the rigidity of a hard-line position. It requires an organisation to be more reflexive about what it does and represents and may require it to assess, bracket or compromise its position without losing sight of goals or values. It may also require their workforce to critically appraise assumptions and rhetoric that may be problematic in finding solutions, for example examining the contradictions inherent in the notion of empowerment.27,28

Despite the theoretical advantages of HPFs acting as change agents to address SDH, a question remains of how well they can perform in this role. We have not explored this directly but would argue that if HPFs are to shift the agenda from behavioural to SDH then they will need to consider how to reframe their aims, objectives and operations to reflect and foster the paradigm shift. For example, while still retaining their focus on health, HPFs may need to examine how they are addressing the nexus between health and: poverty and social inequality; workforce participation; lifelong education; consumption patterns; and environmental sustainability.

**Conclusion**

The multiple pathways through which SDH interact and the context-dependency of decisions for policy interventions creates an uncertain policy-making space for social change. HPFs’ position in the state apparatus enables them to act as agents for change. To do this, they must combine vision and wisdom so as to balance their independence and advocate with accountability in the workings of government.7 A part of this vision involves shifting their focus from the behavioural determinants of population health gains to patterns and trends in health inequities. Making inroads into SDH to reduce health inequities is going to be beset with gains and failures. What is certain is that HPFs cannot be idle and must act along with others. And now!

**References**

Policy

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