The social determinants of health: what are the three key roles for health promotion?

Dennis Raphael

Renewed interest in the social determinants of health represents yet another cycle of recognition of their importance that began in earnest in the 1850s with the writings of Frederich Engels and Rudolph Virchow. For more contemporary health promoters, the focus on early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion, and unemployment and employment security produces a déjà vu experience recalling the Ottawa Charter’s health prerequisites of peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, and equity. There was excitement then about addressing these structural determinants of health. There is excitement now about addressing the structural determinants of health. Restraining this enthusiasm and its policy outcomes in 1986 was the reality that the world’s English-speaking nations were on the cusp of a neo-liberal resurgence in public policy that served to effectively squash attempts to restructure society in favour of health. Now, 20 years later in the midst of neo-liberal inspired economic globalisation, we are again being urged to identify and modify the structural determinants of health that have since decayed in the interim. How likely are we to succeed in these efforts? The renewed focus on social determinants of health as exemplified by numerous volumes on the topic and various international, national, and regional initiatives can be traced to efforts by researchers to identify the specific exposures by which members of different socio-economic groups come to experience varying degrees of health and illness. While it was well documented that individuals in various socio-economic groups experienced differing health outcomes, the specific factors and means by which these factors led to illness remained to be identified – at least by social epidemiologists unfamiliar with the sociology of health literature. It is no accident that the term ‘social determinants of health’ made its contemporary appearance in a United Kingdom volume concerned with policy, social organisation, and health. Certainly, focus on structural determinants of health is a vast improvement over the dominant health promotion paradigm and activities associated with the holy trinity of risk of tobacco use, diet, and physical activity. It also represents an approach more consistent with the empirical evidence concerning the determinants of individual and population health.

The importance of the political and economic context

But a focus on the social determinants of health raises another important question that is infrequently considered by health...
promoters in English-speaking nations: What are the determinants of the social determinants of health? Income and its distribution, the quality of early life, food and housing security – as examples – do not exist in a vacuum. The quality of these social determinants of health is itself shaped by political, economic, and social forces that differ by nation, region, and municipality. While editing the volume Social Determinants of Health: Canadian Perspectives, I received a quick education by numerous contributors of how the quality of the social determinants of health of early childhood, employment security and working conditions, and the social safety net were predicted by whether a nation was identified as a liberal, conservative, or social democratic political economy as described by Gosta Esping-Andersen.16,17

Nations with what is termed a liberal political economy such as Australia, Canada, New Zealand, the United Kingdom (UK), and the United States (US) see relatively little government action in support of the social determinants of health; nations with social democratic political economies such as Denmark, Finland, Norway, and Sweden much more so. Nations with conservative political economies such as France, Germany and The Netherlands fall in the middle. Australia, for example, spends 18% of its GDP on social expenditures – 4.7% of GDP on pensions, 2.8% on families, and 2.3% on incapacity or disability benefits.18 These figures are high in relation to the US (14.8% of GDP total social expenditure) and Canada (17.8%), but low in relation to the social democratic nations (Denmark 29.2%; Norway 23.9%; Sweden 28.9%, and Finland 24.8%) as well as conservative nations (France 28.5%; Germany 27.4%; Belgium 27.2% and Switzerland 26.4%) – among others. Indeed, Australia is ranked 22nd of 30 OECD nations in social spending.18 Liberal nations also have higher rates of poverty and greater degrees of income and wealth inequalities.19 And not surprisingly, indicators of population health tend to parallel these classifications: liberal nations show highest rates of infant and premature mortality; social democratic nations less so.

The three roles for health promoters

Type of political economy determines societal receptiveness to the concept and policy implications raised by a social determinants of health approach. Consider the difficulties health promoters experience having these issues addressed in liberal nations governed by neo-liberal governments. This is not a problem of evidence, it is a problem of political will. Such an analysis suggests that there are three key roles that health promoters should play in addition to their day-to-day efforts to promote healthy public policy in each and every area influenced by the social determinants of health. These three roles are education, motivation, and activation in support of the social determinants of health. These roles are about building the political supports by which public policy in support of the social determinants of health can be implemented. Each is considered in turn.

Educate

In nations governed by liberal political economies, the public remains woefully uninformed about the social determinants of health. The population has also been subject to continuous messaging as to the benefits of a business-oriented laissez-faire approach to governance.20 What this messaging has not included is the societal effects of this approach: increasing income and wealth inequality, persistent poverty, and a relatively poor population health profile.21 These effects are profound and objectively influence – for the worse – the health and well-being of a majority of the population.17

There are hundreds – if not thousands – of Australians whose occupations are concerned with health promotion. These workers could take advantage of the citizenry’s continuing concern with health and the wealth of evidence of the importance of the social determinants of health to begin offering an alternative message to the dominant biomedical and lifestyle discourse. At a minimum, health promoters can carry out – and publicise the findings from – critical analysis of the social determinants of health and disease. This is not a question of being subversive – it is rather a simple matter of information and knowledge transfer.

There is no shortage of areas in which health promoters could engage: social determinants of health such as poverty, housing and food insecurity, and social exclusion appear to be the primary antecedents of just about every affliction known to humankind.22 My short list of such afflictions includes coronary heart disease, type II diabetes, arthritis, stroke, many forms of cancer, respiratory disease, HIV/AIDS, Alzheimers, asthma, injuries, death from injuries, mental illness, suicide, emergency room visits, school drop-out, delinquency and crime, unemployment, alienation, distress, and depression. Examples of such analyses and critiques of the dominant paradigms are available.22,23

Motivate

Health promoters can shift public, professional, and policymakers’ focus on the dominant biomedical and lifestyle health paradigms to a social determinants of health perspective by collecting and presenting stories about the impact social determinants of health have on people’s lives. Ethnographic and qualitative approaches to individual and community health produce vivid illustrations of the importance of these issues for people’s health and well-being.24 There is some indication that policymakers – and certainly the media – may be responsive to such forms of evidence.25 In Canada, such research clearly constitutes a small proportion of health promotion and health services research.26 This is probably the case in Australia as well. There is increasing recognition of the importance of community-based research and action.27,28 But frequently, these activities are narrow and seem unwilling to allow citizens to raise issues of public policy concerned with income distribution, employment and labour issues, and fundamental questions of citizen participation in governmental priorities and actions. Such activities can be a rich source of insights about the mainsprings of health and means of influencing public policy. Such a perspective allows community members to provide their own
critical reflections on society, power and inequality. At a minimum these approaches allow the voices of those most influenced by the social determinants of health to be heard and hold out the possibility of their concern being translated into political activity on their part and policy action on the part of health and government officials. Ultimately, the end of such activities should be the creation of social movements in support of health. The People’s Health Movement is but one example of such a movement in support of health.

Activate

The final role is the most important but potentially the most difficult: supporting political action in support of health. There is increasing evidence that the quality of any number of social determinants of health within a jurisdiction is shaped by the political ideology of governing parties. It is no accident that nations where the quality of the social determinants of health is high have had greater rule by social democratic parties of the left. Indeed, among developed nations, left cabinet share in national governments is the best predictor of child poverty rates, which itself is associated with extent of government social transfers. Nations with a larger left-cabinet share from 1946 to the 1990s had the lowest child poverty rates and highest social expenditures; nations with less left-share had the highest poverty rates and lowest social expenditures. It has also been documented that poverty rates and government support in favour of health – the extent of government transfers – is higher when popular vote is more directly translated into political representation through proportional representation, Australia, like the other liberal nations of Canada, New Zealand, Ireland, UK, and the US, is among the nations with the lowest left cabinet share (7%) and among the highest in child poverty rates (14.7%) in the 1990s (providing a poor poverty standing of 18th of 26 OECD nations). Australia also does not have proportional representation, the lack of which is associated with higher poverty rates. Proportional representation is important because it provides for an ongoing influence of left-parties regardless of which party forms the government.

Conclusion

A political approach recognises that the social democratic nations create the conditions necessary for health. These conditions include equitable distribution of wealth and progressive tax policies that create a large middle class, strong programs that support children, families, and women, and economies that support full employment:

For those wishing to optimize the health of populations by reducing social and income inequalities, it seems advisable to support political forces such as the labour movement and social democratic parties which have traditionally supported larger, more distributive policies. (p. 490)

While it is apparent that Australian public policy has been moving more and more towards a neo-liberal US-type model, reversals are possible. Indeed, New Zealand took a similar neo-liberal course during the 1990s, but has now reversed direction. Ideologies are malleable and national social policies can be changed. For more than 10 years I have been attempting to understand the growing gap between Canadian health promotion rhetoric and action. My analysis of developments in wealthy developed nations indicates that health promotion activities operate within the confines of the dominant political and economic discourses within a society. In many nations the rise of neo-liberal approaches to governance has made concern with the social determinants of health not only unpopular among governing circles but actually threatening to agency funding and individual health promoters’ career prospects.

Nevertheless, the best means of promoting population health through a social determinants of health perspective would involve agencies, organisations, and even government employees navigating the difficult task of informing citizens about the political and economic forces that shape the health of a society. Once so informed, they can consider political and other means of influencing these forces. I am not sure how this can be easily done. United Ways across Canada – the major charitable organisations in Canada – have been successful in raising fundamental issues about societal governance in a non-threatening manner. The Canadian Public Health Association and Health Canada workers continue to produce documents that clearly explicate the importance of fundamental issues such as income and wealth distribution. However, there has been little uptake – with some exceptions – of these developments on the ground. Taking up this challenge is not a role that health promoters have considered their own. It appears rather a daunting task, but one that holds the best hope of promoting the health of citizens in Australia and elsewhere.

References

Are social determinants of health the same as societal determinants of health?

Barbara Starfield

Despite the widespread appeal of the phrase ‘social determinants of health’, it erroneously suggests that health depends primarily on interrelationships among individuals as this is what ‘social’ means in most dictionary definitions. Inequities in health, however, involve systematic differences in health across population subgroups, thus changing the focus of influences from social interactions to societal characteristics.

Figure 1 captures the characteristics addressed by the large social determinants of health literature. In this literature, social characteristics of individuals and groups are considered to influence health, which is conceptualised as ‘average health’. The clusters of influences on the right side of the figure describe the focus of conventional social medicine. Extending the focus more to the left describes the ‘domain of community medicine, which also includes characteristics of physical and social environments in which individuals live and work. Largely ignored by social medicine researchers is the context in which these actions and interactions exist.

Figure 2 captures the types of societal influences on equity in health. It explicitly recognises the importance of distributions of health in populations and the likelihood that different interactions among influences may produce different mechanisms of illness generation and progression in different population subgroups. The figure also recognises that, where illness differs systematically across population subgroups, it is societal factors (represented by political and policy contexts) that generate and maintain social hierarchies that are the focus of ‘social medicine’ and ‘social influences’.

The importance of societal antecedents is increasingly recognised by scholars and researchers who are devising policy to reduce inequities in health. Most notably, the World Health Organization (WHO) Commission on Social Determinants of Health, formed in the early years of the 21st Century, is deliberately considering the role played by political factors as well as the supranational economic policies constituting globalisation and the commodification of influences on health.

Which societal determinants should receive the most attention in the search for effective strategies to reduce inequity in health? Studies have suggested a variety of likely foci, including (but not limited to) social pacts between labour, management, and government; percentage of people covered by public medical care; corporate and state profit, wage inequality; female literacy, enfranchisement, and involvement in political decision-making.