Social Determinants of Health and Policy Development

By John Steen

Remember Bill Clinton's 1992 mantra, "It's the economy, stupid?" Well, it is, but it's the social impact of the economy that has the single most powerful impact on the health of a nation. The research into that has been pursued for at least three decades in the U.K.,[1] particularly by Sir Michael Marmot, Chair of the World Health Organization's Commission on Social Determinants of Health and Director of the International Institute for Society and Health, and Richard Wilkinson, Professor Emeritus of Social Epidemiology at the University of Nottingham Medical School.

A new meta study[2] in the *British Medical Journal* reports that if the gap between the richest and poorest people in the 30 developed countries of the OECD was reduced, 1.5 million deaths per year could be prevented. The findings reveal that people living in regions with high income inequality are more likely to die younger, regardless of their income, socio-economic status, age, or gender. Despite the mounting evidence for the adverse systemic impact of social inequality, this phenomenon remains controversial.

In an accompanying editorial,[3] Kate Pickett and Richard Wilkinson suggest that this is possibly because of the "deep political implications of a causal relation between better health of the population and narrower differences between incomes." The evidence leads them to conclude that although the benefits of greater equality tend to be largest among the poor, those benefits seem to extend to almost everyone, and that "a more equal society might improve most people's quality of life." The factors underlying this are psychosocial stress resulting from invidious social comparisons that are divisive and corrosive, and the erosion of social cohesion. The authors write, "it is now clear that unequal societies have an increased prevalence of a host of social problems, including violence, bullying, teenage births, higher rates of imprisonment, low educational performance, reduced social mobility, low levels of trust, and longer working hours."[4] They conclude that "it is a task for politicians and policy experts to repair our 'broken society' by undoing the widening of inequalities that has taken place since the 1970s."[5]

One of those studies on which this is based is Daniel M. Hausman's, "Benevolence, Justice, Well-Being and the Health Gradient"[6] in which he finds that "for most people the good life lies in close and intricate social ties with others which can flourish only when inequalities are limited. The health gradient suggests that there is a story to be told in which egalitarian justice, solidarity, health and well-being go hand-in-hand."

The damage to health from invidious social comparisons is illustrated in a study of a prospective cohort of 565,697 Americans in poor and more affluent neighborhoods from six U.S. states and two metropolitan areas carried out by a team at the University of Massachusetts Medical School in Worcester. Compared to people living in the least deprived neighborhoods, those living in the most deprived neighborhoods had roughly a 22% higher risk of dying from any cause or cancer over a 10-year study period, **regardless of diet, lifestyle, and medical history**, and the risk for death increased as the levels of deprivation in the neighborhood increased.[7]

Infant mortality is the most commonly used indicator for the quality of a nation's healthcare system, and it is an indicator of social inequality as well. In November, the government's National Center for Health Statistics released a report[8] ranking us 30th in the world in infant mortality using 2005 data. The U.S. rate was 12th in the world in 1960, fell to 23rd in 1990, to 29th in 2004, and 30th in 2005. It finds that "the main cause of the United States' high infant mortality rate when compared with Europe is the very high percentage of preterm births in the United States." One in 8 births in the United States were born preterm, compared with 1 in 18 births in Ireland and Finland. The percentage of preterm births in the United States has risen 36% since 1984. This is a provocative sign of the lack of prenatal care and of untreated complications attending the pregnancies of U.S. mothers.[9] Prematurity is not the only factor behind infant mortality in the United States. Even for full-term infants, the U.S. rate was high at 2.4 per 1,000 births, placing us 10th in the world. Full-term babies here also had higher death rates than those in Europe from sudden infant death syndrome, accidents, assaults and homicides. For every 1,000 births in the United States, 6.9 infants died before they turned 1, compared with 2.4 in Sweden.

The U.S. has the greatest inequality in wealth of any industrialized nation. This inequality is unjust in itself, and it also increases the cost of our healthcare through both depreciated health status and the income gradient that is inherent in the delivery of healthcare itself. For example, as a multiple of average wage in each nation, physician income is 1.4 in the U.K., 1.5 in Sweden, but 5.5 in the U.S.[10]

It's Neoliberalism, Stupid!

What I find remarkable about all well-intentioned pleas to reduce widening social disparities is a failure to address its causes. It is its causes that are controversial, for they are to be found in the neoliberalism that has become an international orthodoxy promoted by those rich in resources, led by the U.S. over the last three decades.[11] The manner in which the political wars have been fought in Congress over "health care reform" may finally open the eyes of even ordinary citizens to this travesty.

Anyone in public health who doesn't yet understand this would do well to read Vicente Navarro's "What We Mean by Social Determinants of Health" in the *International Journal of Health Services* V39 no.3, pp. 423-441 (2009). Navarro finds the WHO Commission report to be "*profoundly apolitical*" for "it reproduces a widely held practice in international agencies that speaks of policies without touching on politics."[12](p. 440)

The Commission identifies the problems but not the solutions:

> Any serious effort to reduce health inequities will involve changing the distribution of power within society and global regions, empowering individuals and groups to represent strongly and effectively their needs and interests and, in so doing, to challenge and change the unfair and

> steeply graded distribution of social resources (the conditions for health) to which all, as citizens, have claims and rights.[13]

Perhaps the greatest question for public health in America to answer in this century is whether and how it will adopt a social medicine agenda to eliminate the disparity between its goals and its means. For decades, it has focused its attention on individuals whose morbidity is taken as a given in a socio-political context also taken as a given,[14] implicitly operationalizing the neoliberal policy model of assignment of responsibility for health status to the individual. Will public health be able to meet its responsibilities for promoting all that is encompassed by the hope and promise of good health and become "politicized" without losing its credibility?[15] All it needs to do is to understand politics as Aristotle did, as the "master art" that tries to produce the conditions of the happy life for all.

I think that here in the U.S., we would do well to take social epidemiology more seriously in order to properly assess all the damage being done to us in our "culture wars." The radical difference between private interests and public interests in health and in health policy development has been obscured from voters. **The message that needs to be taken to heart by public health is that it is social (including political and economic) determinants driven by a neoliberal agenda that do greatest harm to population health, and so it is incumbent upon public health to confront that agenda, an agenda not for health and health system improvement, but for rapacious health and health system exploitation.**[16]

It is the empowerment of the population as an imperative of human rights that results in the sought-after benefits of better population health, and these ensue only from good governance. **No professionally honest attempt at policy development in light of the social determinants of health can any longer ignore the political determinants of health.** The public health ethic requires its adherents to open its populations' eyes to all those inequities resulting from misuse of political power. True population health improvement cannot be achieved without the improvement of a democratically dysfunctional political process.

Most tragically of all, however, is what the neoliberal agenda is doing to defeat efforts to address the greatest threat ever faced by the world, that of climate change.[17] So now reread the above paragraph in the spirit of an even greater dedication to 21st century public health practice that is politically engaged to achieve its mission. In this cause, physicians in the U.K. are showing the way. On November 25th, they established the International Climate and Health Council on behalf of efforts by health professionals throughout the world to speak out in educating their populations and mobilizing the political will to meet the threat. Dr. Fiona Godlee, Editor in Chief of the *British Medical Journal* and *Lancet* Editor said: "Politicians may be scared to push for radical reductions in emissions because some of the necessary changes to the way we live won't please voters. Doctors are under no such constraint. On the contrary we have a responsibility as health professionals to warn people how bad things are likely to get if we don't act now. The good news is that we have a positive message - that what is good for the climate is

good for health."[18] Dr. Robin Stott, who co-chairs the UK Climate and Health Council, said the Council believes that "tackling climate change and ending poverty are the two most important, urgent priorities to ensure global health, justice, and survival for present and future generations."[19]

And in *The Lancet* on December 5th, Margaret Chan, Director-General of WHO, wrote:

> The pursuit of economic wealth took precedence over protection of the planet's ecological health, and over the most vulnerable in society. Fundamentally we are all facing a choice about values: improving lives, protecting the weakest, and fairness. These are the same values that motivate public health, and the health community is a willing partner in addressing this challenge.[20]

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[1] But let us remind ourselves that the social determinants of disease – poverty and living conditions – were first described by Rudolf Virchow in his medical report of a typhus epidemic in Upper Silesia in 1848.

[2] Naoki Kondo *et al*., "Income inequality, mortality, and self rated health: meta-analysis of multilevel studies," *BMJ*, v.339, 10 November 2009. http://www.bmj.com/cgi/content/full/339/nov10_2/b4471

[3] Kate E. Pickett and Richard G. Wilkinson, "Greater equality and better health," *BMJ*, v.339, 10 November 2009. http://www.bmj.com/cgi/content/full/339/nov10_2/b4320

[4] For more about this, see Wilkinson R, Pickett K. *The Spirit Level: Why More Equal Societies Almost Always Do Better*. Allen Lane, 2009.

[5] Inequalities in Western society diminished from the 1910s through the 1960s, particularly under the social democracy programs of neo-Keynesian governments that ensured the security of their citizens after World War II.

[6] Daniel M. Hausman, "Benevolence, Justice, Well-Being and the Social Gradient," *Public Health Ethics* 2009 2(3):235-243. http://phe.oxfordjournals.org/cgi/content/abstract/2/3/235.

[7] "People Living in Poorer Neighborhoods at Increased Risk for Death, Worse Health Risks," American Association for Cancer Research Press Release, December 8, 2009. http://www.aacr.org/home/public--media/aacr-press-releases.aspx?d=1672.

[8] http://www.cdc.gov/nchs/data/databriefs/db23.htm

[9] For a good summary of the full social context involved in this, see Michael C. Lu and Neal Halfon, "Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective," *Maternal and Child Health Journal*, Vol. 7, No. 1, March 2003, pp.13-30. http://www.healthychild.ucla.edu/DropDownMenu/StaffDirectory/Halfon%20Files/Racial%20and%20Ethnic%20Disparities%20in%20Birth%20Outcomes.pdf.

[10] Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999," *Health Affairs* 2002;21:169-181. http://content.healthaffairs.org/cgi/content/full/21/3/169.

[11] For a good overview of this, see Stephen Bezruchka, "Is globalization dangerous to our health?" *Western Journal of Medicine*. 172(5): 332-334 (May 2000). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070886/. That neoliberalism has compromised the WHO's

public health advocacy by its policy priority for economic over health impact assessment is made clear in Smith KE, Fooks G, Collin J, Weishaar H, Mandal S & Gilmore AB., "Working the System' – British American Tobacco's Influence on the European Union Treaty and Its Implications for Policy: An Analysis of Internal Tobacco Industry Documents," *PLoS Medicine*, 2010; 7 (1). The authors conclude that: "This increases the likelihood that the EU will produce policies that advance the interests of major corporations, including those that produce products damaging to health, rather than in the interests of its citizens." http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000202.

[12] One of the first observers to note this problem was Nancy Krieger in "Epidemiology and the Web of Causation: Has Anyone Seen the Spider?" *Social Science & Medicine* 39(7) (1994).

[13] Commission on Social Determinants of Health, *Closing the gap in a generation: Health equity through action on the social determinants of health*. WHO, 2008. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf. See also, Michael G. Marmot, "Status Syndrome: A Challenge to Medicine," *JAMA*, v295, no.11 (March 15, 2006), pp.1304-1307. http://jama.ama-assn.org/cgi/content/full/295/11/1304.

[14] For a brief history of public health's failure to meet its responsibilities toward a broader social and political agenda, see Amy L. Fairchild *et al*, "The EXODUS of Public Health What History Can Tell Us About the Future," *AJPH*, v100, no.1 (January 1, 2010), pp.54-63. http://ajph.aphapublications.org/cgi/content/full/100/1/54#BIB55. The authors conclude by identifying the choice to be made in setting a new agenda: "The current economic calamity, affecting the health and well-being of hundreds of millions of people around the world, provides the chance to rethink fundamental assumptions about our country's economic and social system… We can either accommodate the status quo or confront political and economic power in the name of the public's health."

[15] But a good summary of how political forces determine epidemiology, and of those factors that obscure that relationship, can be found in *Tackling Health Inequities Through Public Health Practice: A Handbook for Action*, ed., Richard Hofrichter, NACCHO and the Ingham County Health Department, 2006. www.naccho.org/pubs/product1.cfm?Product_ID=11. See pp.19-22: "Sources of Health Inequities, Social and Political Forces," and "Barriers in Concepts and Paradigms." It concludes that "public health practice cannot isolate itself from these concerns but rather must incorporate them within the appropriate scope of public health practice…. Can we find a way to integrate political and social analysis into the work of public health at the level of institutions in order to prevent future inequities?" A second edition of this anthology will be published by Oxford University Press in February 2010. http://www.naccho.org/topics/justice/upload/OxfordsFlyer-FINAL.pdf.

[16] For a timely and excellent source for the full range of political issues preventing public health from succeeding here and globally, I highly recommend *Morbid Symptoms: Health Under Capitalism*, edited by Leo Panitch and Colin Keys, *Socialist Register*, Vol 46, no.10 (October, 2009), accessible for table of contents and abstracts at http://socialistregister.com/index.php/srv/issue/view/527/showToc. It is published in book form by The Merlin Press (U.K.).

[17] In February 1990, the Global Climate Group representing industry got the White House to say that climate science wasn't reliable enough as a basis for initiatives that could threaten free market economic growth. http://www.nytimes.com/1990/02/06/us/bush-asks-cautious-response-to-threat-of-global-warming.html. In July 2001, President George W. Bush called the Kyoto Protocol reached by 178 nations "fatally flawed," and he refused to sign it because in requiring the industrial nations to bear most cleanup costs, it would weaken the American economy.

[18] http://www.bmj.com/cgi/content/full/339/nov25_3/b4933.

[19] *Ibid*.

[20] Margaret Chan, "Cutting carbon, improving health," *Lancet* 2009; 374: 1870-1871. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61993-0/fulltext. Nevertheless, the WHO has just issued a 36 page booklet entitled, *Protecting health from climate change: connecting science, policy and people* (2009) that falls short of connecting science and policy by addressing the effects of climate change but not its causes. http://whqlibdoc.who.int/publications/2009/9789241598880_eng.pdf.