The Social Determinants of Health: How Can a Radical Agenda Be Mainstreamed?

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ABSTRACT

The social justice framing within the WHO Commission's Report on the Social Determinants of Health is vital. Yet it can too easily be dismissed as ideology and an unfit justification for major change. Although the general public acknowledges that structural factors, such as poverty, can affect health, they tend to see personal health behaviours as the strongest determinants of health, mirroring the main focus of health providers in recent decades. Thus a social reform agenda, while being an integral part of public health history, is nowadays too often seen as remote from the essential core of work in health. Translating the Commission's agenda into action therefore requires a recalibration of our entire health system, starting with an understanding of how complex issues can be framed in ways that inspire action, endorse mutuality of interests and enhance the perceived efficacy of the solutions, among the myriad of actors in position to make the reduction of health inequities succeed or fail. A sophisticated discourse analysis and/or communications research agenda could help to move us forward. It involves understanding and reframing the way politicians, policy-makers, practitioners and the public see "the problem" and reframing the potential of many roles in "the solution".

Key words: Social determinants of health; discourse analysis; media; communication; values

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Can J Public Health 2009;100(4):291-93.

At a recent UK conference¹ on the WHO Report on the Social Determinants of Health (SDOH),² session chair Richard Horton, editor of the *Lancet*, held fire to the feet of the speaker from the World Bank for his inadequate answer to Ron Labonte's question about the bank's role in sub Saharan Africa. Dr. Horton wants medicine to reconnect with the societal and political spheres where health is generated,³ continuing a longstanding tradition of the *Lancet's* 19th century founders, when doctors were at the forefront of social reform and public health.

Yet over the years, as advances in medicine have been associated more and more with technical interventions administered in one-to-one practice, many people have come to think of health as distant from social reform. It is accepted that *Médecins Sans Frontières* be proactive about infrastructure for health in developing countries; but back home, health is seen to be mostly associated with the actions and choices of individuals, with structural factors like poverty and employment playing a more minor role.⁴⁻⁶

How could this happen? The pioneering Framingham study and others that followed in the 1970s showed that smoking, alcohol consumption, lack of exercise and so on play important roles in the development of chronic disease (controlling for socio-economic status).⁷ People consequently packaged the idea that lifestyle changing advice – as is the case with health care – could be dispensed. Phrases like "preventive dose" and "educational diagnosis" clothed the new field of health education in familiar terms in order to increase its endorsement by mainstream medicine and its spread (remember, this was back in the time when patient education and health promotion were seen as radical) (Personal communication, Green LW, September 1998). Repeated lifestyle-tackling practices have now given rise to the familiar structural "silos" in prevention. Entire funding programs, teams, organizations and public events are devoted to single issues like active living, healthy eating, and so on.

Some important health gains have been made. But just imagine, for a moment, how different the prevention landscape might look today if Sir Richard Doll's first idea had been right. Although famous for demonstrating that smoking is the cause of lung cancer, at the time his own hunch was that it was the tar in the roads being constructed in post World War II Britain that was the cause of the lung cancer increase.⁸ If he had shown this, how much easier might it be now to drive a health agenda around the social and physical environments and health, as today's health system would have had 50 years of side-by-side experience with engineers, urban planners or city councils, all in the name of mainstream health promotion.

But as it stands now, the International Union of Health Promotion and Health Education's newly struck working group on the SDOH has identified that one of the biggest gaps they may need to address is not only the health equity gap elucidated so well in the WHO Commission's Report, but the gap between the action agenda of the Report and the way health promotion practitioners are currently positioned to respond within their own agencies and institutions.

History has yielded us a system where few of our country's practitioners are able to affiliate with the SDOH directly, because many remain structured and socialized within the risk factor domains of the late 1970s. Some of our most honoured chronic disease institutions have acknowledged the contribution of social determinants

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Acknowledgements: Dr. Hawe is the Markin Chair in Health and Society and holds a Health Scientist award from the Alberta Heritage Foundation for Medical Research. She is a member of the International Union of Health Promotion and Health Education's Global Working Group on the social determinants of health. Thanks to Alan Shiell for comments on an earlier draft.

and are encouraging action on these fronts.⁹ But digging down to the coalface, many practitioners are still being told that, while being important, housing, employment, or poverty are “not health.” This translates to health region staff being able to work in partnership within intersectoral collaborations that address these issues,¹⁰ but many are not permitted to address them directly, so funds are not allocated to formal budget portfolios in these areas. Intersectoral collaborations are considered the best way to tackle complex problems. But the marginalization of SDOH domains within health care budgets potentially deprives these collaborations of sufficient resources, expertise and commitment from the health partners to maximize success. A health promotion system structured for the most part to address disease aetiology according to patterns popularized in the late 1970s, might never rise to fully address the challenge of the WHO Commission’s report. These points would not be lost on scholars who criticized the orthodoxy of the 1970s at the time, pointing bitterly to the neglect of social factors.¹¹⁻¹³

The way forward is not for academics to berate lifestyle risk factor-focussed practitioners for not working directly on the SDOH. This acts like a new form of victim blaming. Rather, we should help enable practitioners to reframe their work in ways that connect more strongly with what the Commission calls “the causes of the causes.”

Such action is within reach. Take the area of tobacco control, for example. Success has been achieved with awareness raising, public health advocacy,¹⁴ policy work and multilevel interventions that incorporate changes in taxation policy and industry advertising restrictions.¹⁵ These exact same actions and skills are needed in tackling many SDOH, ramping it up a notch to tackle global economic and political issues that underlie problems and exacerbate their continuation, particularly in developing countries. Yet currently most of our workforce is forbidden to be involved with advocacy. Many are removed from direct work with policy-makers and politicians. They are relegated to work on weak but politically palatable programs in health education,¹⁶ remaining largely focussed on lifestyle and medical conditions.¹⁷

Research to help more practitioners reframe their work and reclaim their structural change capabilities is needed. Policy-makers have to invite appropriate action; practitioners have to be enabled to take it; the public has to support it, or better, demand it in the first place.

This work starts with developing deep understandings of human discourse. When high-level policy-makers in this country remark that the WHO SDOH Report reads like “ideology with evidence attached” (as one did recently), then we need to uncover ways of communicating the Report’s science and recommendations in ways that are less coloured and less likely to provoke opposition. After all, the science that demonstrates that social factors cause ill health and are amenable to effective intervention is the exact same type of science that we have relied upon to disseminate new vaccines in the population or remove environmental hazards. We are just not familiar with, or accustomed to, having the capacity to use this science in political domains. It may take some getting used to. But that process could possibly be accelerated.

Currently, it’s widely believed that personal health behaviours are the strongest determinants of health,⁴⁻⁶ not surprisingly given the history of chronic disease prevention outlined earlier. Contrary

views are associated with the political left and potentially controversial. Programs of work are developing on framing the SDOH, such as those of Michael Hayes and his colleagues at Simon Fraser University and Lynn McIntyre and hers at the University of Calgary. This inquiry pathway has also been highlighted by Dennis Raphael.¹⁸ Researchers at Cornell University have mapped out a communications research agenda in SDOH, arguing that investigation of message framing, narratives, and use of visual images may allow the field of population and public health to increase external attribution for health problems.¹⁹

The required framing should extend not only to a broader perspective on the nature of the problem, but also to the *efficacy of the solutions*, because there are many. There is now Level 1 evidence, for example, that whole community interventions that enable and build social capital can have a dramatic effect on health and health behaviours.²⁰ Increased awareness of this is crucial. Although policy-makers and practitioners may quite easily articulate societal-level factors as the cause of individual-level distress, they struggle with language and frames of reference enabling them to speak to societal-level solutions.²¹ They are simply unpractised in doing so. Policy-level change involves working both vertically and horizontally, but most of all, *language is part of the action*.²² We need research to uncover that language. This requires careful, sophisticated work and respect for positions that have been long held, but perhaps rarely interrogated or reframed fruitfully.¹⁹

The payoffs could be huge. The UK conference on SDOH was opened with the image that for every station on the London underground going east from Westminster to Canning Town, life expectancy drops by one year.¹ The speaker was not a geographer or sociologist, a doctor or an epidemiologist. It was the British Prime Minister, whose speech modeled the language and leadership required to embrace the SDOH agenda. Most likely his words were crafted by his staff. But that, in essence, is the point. They were the right words, the right metaphor and the right image for the right person to convey the size and legitimacy of the equity agenda. Finding the Canadian equivalents of this discourse is in our own hands now, for diverse constituencies and contexts and actors in all parts of the system, many of whom may feel disconnected from the practice of social reform. The opportunity is history-making.

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Received: January 2, 2009
Accepted: April 15, 2009

RÉSUMÉ

Le cadre de justice sociale du *Rapport sur les déterminants sociaux* de la Commission de l'OMS est vital. Pourtant, il peut facilement être écarté en tant qu'idéologie et justification inappropriée pour un changement d'envergure. Même si le grand public reconnaît que les facteurs structurels, comme la pauvreté, peuvent avoir des répercussions sur la santé, il a tendance à percevoir les comportements personnels en matière de santé comme les déterminants les plus forts de la santé, reflétant le point de mire des fournisseurs de soins de santé des dernières décennies. Ainsi, un programme de réforme sociale, même s'il fait partie intégrante de l'histoire de la santé publique est, de nos jours, trop souvent perçu comme étant trop loin de l'essence du travail en santé. La traduction du programme de la Commission en des mesures concrètes exige ainsi un réajustement de l'ensemble de notre système de santé, en commençant par une compréhension de la façon dont les questions complexes peuvent être encadrées de sorte qu'elles inspirent l'action, par l'appui de la mutualité des intérêts et par l'amélioration de l'efficacité perçue des solutions, parmi une myriade d'acteurs, afin que la réduction des inégalités en santé réussisse ou échoue. Un programme haut de gamme de recherche en matière de communications ou d'analyse du discours pourrait contribuer à l'accomplissement de progrès à cet égard. Il exige la compréhension et le recadrage de la manière dont les politiciens, les décideurs, les praticiens et le public perçoivent « le problème » ainsi que le recadrage du potentiel de nombreux rôles dans la « solution ».

Mots clés : déterminants sociaux de la santé, analyse du discours, médias, communications, valeurs

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