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COMMENTARY

Next steps in the development of the social determinants of health approach: the need for a new narrative

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Abstract

During the past 15–20 years the Social Determinants of Health (SDoH) framework has become the main approach to understand health inequalities. With this model a range of factors important for health and inequalities in health over the life-course have been connected into a larger framework. Despite its usefulness and popularity within the field, and wide use in influential reviews, the SDoH framework has not been easy to communicate to stakeholders in other sectors, and we cannot as yet see much of substantial societal change as a result of it. In this Commentary I try to discuss possible reasons behind our difficulties to communicate the SDoH perspective. Some of these reasons relate to how we frame and present the different parts of the framework, others are more linked to common beliefs and practices that I think we should rethink. In both cases, I believe that we would benefit from a more general discussion around these fundamental issues, both in order to communicate our important insights but also to better understand our own key study objective, namely how health inequalities are generated, sustained and potentially reduced.

Keywords: *Social determinants of health, health inequalities, health policy,WHO*

The social determinants of health (SDoH) approach to understand health inequalities has been quite successful. For research, it has brought a framework that organises the wide range of more specific drivers and factors that contribute to health inequalities. In the context of policy, it has become a key framework for analysis as well as policy recommendations, both at the international, national regional and local levels. The seminal work presented by the Commission on Social Determinants of Health more than a decade ago[1] has been followed up at all these levels, most recently by the Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas[2].

Yet, although the comprehensive framework offered by the SDoH approach has proved very useful for analysis and policy recommendations, there have been fewer examples of actual policy changes following the recommendations made. Still, there are ongoing discussions around how to take further steps in order to develop the SDoH approach as well as the policy recommendations that can be derived from it (see, for example, [3, 4, 5]).

Also the World Health Organization, that has been a main advocate of the SDoH approach, is developing. As a key part of the WHO 13th General Programme of Work 2019–2023, the WHO has regrouped around a set of three interconnected strategic priorities and goals to ensure healthy lives and promote wellbeing for all at all ages, namely universal health coverage, health emergencies and healthier populations[6]. The last of these pillars has a unit devoted to SDoH, which has recently started to build up its work.

As a part of the new units strategic planning, a meeting with international experts was held at WHO headquarters in Geneva on 12–13 September 2019. At this meeting, suggestions were made by several

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participants that there is a need for a new way of framing and explaining what the SDoH approach is all about. This was referred to as a need for a new narrative. Essentially, it was a call for a simplified and yet more pedagogic way of explaining what we mean and refer to when we talk about the social determinants of health. The need for a new narrative arose from experiences of problems to communicate and join forces with other sectors, other professions and other academic disciplines, both within and outside the WHO.

However, a new narrative cannot simply be about re-labelling or re-branding the SDoH approach and its different components. Rather, there is a need to analyse why it may be difficult to communicate and explain this approach, when in fact this perspective should resonate well with most people's professional knowledge and everyday experiences. In the following, I will make an attempt, based on my long experience in this field, to discuss critically some of the elements of the existing narrative that I believe are likely to contribute to confusion or misconceptions. In doing so, I will also suggest ways to handle them in a way that may not only facilitate communication but also develop our own understanding of the SDoH approach.

The understanding of how poor health is caused

Everyone can easily see the impact on health and functional ability of an accident. The consequences of external violence imposed on the human body by, for example, a fall, a car crash or other events of external violence are visible and easy to grasp (even if we often underestimate both the risks of such events and the full consequences of them). When it comes to infectious diseases the process become more complex, because we are being attacked by things we cannot see. However, with the discovery of bacteria and viruses it became possible to understand these diseases fairly well also for lay persons. With non-communicable diseases (NCDs) it is still more difficult, partly because the mechanisms are more complex than a specific bacteria resulting in a specific disease, partly because the generative processes are still not fully known in many cases, despite the fact that many risk factors are well known.[1] In addition, many particular risk factors are not disease specific, but rather increase the risk for a range of different NCDs.

The social determinants of health are quite different from these three types of disease generating processes. They do not represent causes of diseases in the sense that bacteria or established risk factors do. Rather, it is the fact that such causes and risks are being concentrated among certain parts of the population that is in focus. It is the population regularities of poor health, how these regularities are created and how they may be counteracted that is the issue. Hence, there is actually no contradiction between the medical understanding of a certain disease or the health promotion understanding of certain risk factors on the one hand and social determinants on the other. Instead, the social determinants may be viewed as factors 'herding' more specific threats to health, or as factors that distil or dilute more direct risk factors.

Earlier on, this was often referred to as the 'causes of the causes', following Marmot [7], who in turn was following Geoffrey Rose [8] (see also Westin [9]). In the maturing process that has followed the CSDH, this label has been lost, mainly because it is self-evident within the field. I do not think that the way forward is to re-introduce the 'causes of the causes' concept, in part because it starts with the diseases and looks outward to the processes behind them. This is likely to be a way of reasoning that resonates well within the medical profession, but is less likely to be a good way of explaining the SDoH approach to other sectors, professions or academic disciplines, or to the general public for that matter. In addition, 'causes of the causes' has a deterministic flavour that is problematic (see below).

Instead, a renewed narrative should in my view focus on the population regularity[10] that health inequalities represent. While we cannot say which individuals will fall ill or die at younger ages, we can observe clear inequalities in health and mortality between social groups. We can also observe that the accumulation of risks and resilience across the life course will typically play out differently for people in different social positions. There are also clearly defined processes through which the social and economic conditions that people live in can enter the body and generate inequalities in health out of inequalities in conditions and opportunities. The health impact of conditions and opportunities across all social determinants of health arise through three main processes, identified by Diderichsen and colleagues[11]. These include: (a) inequalities in risks for illness and disease; (b) inequalities in vulnerability to these health risks; and (c) inequalities in the consequences of poor health. As stated above, these processes involve the more 'traditional' factors behind disease, such as accidents, bacteria and risk factors for NCDs.

Avoiding determinism

Social sciences, as well as epidemiology, deal with probabilistic theories and models. Indeed, that is what most sciences do, but it is important to be very clear about this in the field of public health, not least because we tend to use language and explanatory models that can sound rather deterministic. This creates problems both in our internal discussions and in our communication to other sectors and to the public.

Therefore, the concept of social *determinants* of health is unfortunate; however, it is too late to change that now. Still we need to be very clear about the fact that being less educated, or having a low income, or being a migrant does not *determine* you to poorer health and premature mortality. Rather, what we see are clear social regularities in which people in certain groups or places are having on average worse conditions and opportunities, and therefore on average worse health and higher mortality. However, these social regularities cannot be translated into individual predictions. The reason for this is that there are large individual variations within social groups, although it is also important to note that the size of the variation around the means also follows a social gradient. Groups higher up on the social ladder have on average better health and lower mortality, but they are also more concentrated around that mean. Groups further down have lower means, but also a wider distribution.

While it is in a sense very basic that we refer to averages of groups and not to all members of that group, it is something that the public health/SDoH community tends to overlook when communicating. In the narrative we use, in the stories we tell and in the pictures we show there is often (in my view) a tendency towards inevitability. We tend to convey a picture in which the higher risk of poor health easily comes across as a higher risk for everyone in that group. Take the nice picture of kids trying to look over a wall to see e.g. a football came. We can see that one is short, another tall and a third in between, reflecting the average circumstances of three groups. However, from a picture like this it is very easy to think that that everyone in a group is the same, whereas in reality there is a lot of variation within groups.

Sometimes we tend to trick ourselves into thinking that the average differences in living conditions and opportunities between groups can be translated into deterministic predictions at the individual level. We should rather embrace the variation within groups as a way to better understand the dynamics of inequality, as well as important policy entry points in terms of age groups or types of illnesses/causes of death. As an example, in the Swedish Commission for Equity in Health we could show that a quarter of the gap in life expectancy between well and less educated men aged 30–79 years was driven by accidents and suicides among men aged 30–44 years[12], an insight that could be used to guide policy.

Understanding structural versus individual level drivers

Another feature of the present narrative, in part linked to the deterministic language discussed above, is the tendency to emphasise structural level factors and drivers, and downplay the role of human agency. Historically, I believe that this is an expression of the desire to distance public health from curative medicine, and doing this by pointing to the need for prevention and structural change. This is of course important, but as a consequence we tend to view social structures and structural drivers of poor health as very distant from people and their everyday life, as well as inescapable. By downplaying the role of individual agency, trying very hard not to blame victims, we in fact tend to end up with a world view in which the poor or less educated are stripped of all agency and reduced to 'puppets on strings'.

In this respect, two things need to be addressed. First, social structures are not distant from people; rather it is the case that people are embedded in social structures. This may sound very theoretical, but a good starting point for a more practical approach is that social structures (such as organisations, legislation, institutions, norms) are all created by humans, are constantly upheld and recreated by humans, and can also be torn down by humans. We all live in direct connection with all those structures, at home, at work, in the community. To illustrate with a health policy example, we can use increased tobacco taxation versus individual smoking cessation counselling as two ways to reduce smoking rates. The former is a structural change, the latter a form of (preventive) individual treatment. However, the effect of tobacco taxation on smoking rates is realised only when the higher prices affect individual purchasing decisions, in other words when people buy fewer cigarettes because of the higher price. In fact, behavioural change is at the heart of many structural policies, although the method is quite different from individual counselling. The main point, however, is that people's lives are intertwined with social structures, and that the arguments for going 'upstream'[2] rather than 'downstream' completely miss this fact. Rather, we need to understand inequalities as a result of structural conditions and the individual responses to those. When proposing policies we also need to address both levels, because we cannot afford to refrain from one or the other.

Second, it is of course the case that not all people have the same variety of options and choices in life. On the contrary, the scope of action is also very much linked to social positions and the resources that people are able to command. Still, all people have some scope of action, which must be recognised and must be a part of the narrative. Take the socioeconomic differences in smoking as an example. While there are large differences in the percentage of daily smokers between educational groups in Sweden, the vast majority of less educated do not

smoke. Furthermore, the smoking rate among the less educated (aged 16–84 years) is 40% lower in 2018 as compared to 2008. The difference in structural conditions between educational groups (e.g. worse working conditions, more stressful lives and more smokers in the personal networks) most certainly provides important insights and explanations for the larger share of smokers among the less educated. However, the inequalities in structural conditions between educational groups have not been reduced during this period, if anything inequalities have tended to increase. Therefore, the historically low absolute level of smokers among the less educated, as well as the fast reduction of the percentage of daily smokers in this group clearly indicates that also people in more 'vulnerable' positions are able to act and make changes to their lives. It is important that this fact is also reflected in our narrative.

Handling the abundance of factors and groups

The social determinants of health include a wide range of factors or areas of life that are of importance for health and inequalities in health. These include the conditions in early life, education, labour market participation and working conditions, income and economic resources, housing conditions, health-related behaviours and more. Each and every one of these areas constitute their own branch of policy and their own research field, and often more than one. Creating the SDoH narrative on the basis of all those factors is difficult because of the number of factors involved, for the different types of links to health that they carry, and for the large number of scholars and policymakers who feel that we are crashing into their area of expertise.

In addition to the large number of 'determinants' that comes with the SDoH perspective, there is also a large number of groups in focus for the health equity considerations. We talk about socioeconomic groups (captured through education, income or social class based on occupations), but also about gender, ethnicity, geographical areas and a number of more specific 'vulnerable' groups. As if that was not enough, we have also started to talk about intersectionality, in other words combinations of these previous categories, such as less educated women of a certain ethnic group.

While all this is important, it not only makes the narrative more complex, but it also tends to overshadow the fact that the inequalities we observe between all these groups are generated in much the same way. In fact, there are many similarities between people from different walks of life and different places, in particular in relation to the tasks and challenges that we face across the life course. We will all have to grow up, acquire knowledge and skills, find and hold a job and make a living, form a family, raise children, take care of aging parents and relatives, just to mention a few. At all these stages of life, inequalities in conditions and opportunities will typically also create inequalities in results that in turn provide the conditions and opportunities further down the road. This is also why we often see a gradient in health inequalities – there is not a specific process for each of the groups or each of the factors discussed above, but rather a more general process of resource multiplication in which those who have a little more also have better possibilities to get a little more.

Social groups, individual variation and policy design

Following the line of reasoning above, there are challenges that everyone needs to handle across the life course, and these challenges are much the same in different groups and societies. However, the means and resources to handle them differ a lot both across and within social groups. Inequalities between groups therefore arise from a combination of unequal conditions, unequal opportunities and unequal scope for action, with lower social strata having on average poorer conditions, poorer opportunities and smaller scope for action.

It is important to stress, again, that the inequalities that we can observe as social regularities are driven by probabilistic processes. Inequalities between social classes or educational groups in living conditions, opportunities and health does not mean that every member of a particular group enjoys the same living conditions or the same health status. On the contrary, there are large variations within social groups, and as discussed above, these variations are also systematically different between groups. Inequalities between groups are driven by the fact that a larger share of members of the lower strata lives in poor circumstances, has poor health status and dies at a young age, not by all members being poor and dying young.

This distinction is crucial both for understanding the processes involved and for policy design, and policy design needs to take into account variations within groups. While it may be easy to conclude that we need tailored policies directed to the groups most exposed or in the most vulnerable positions, this will in most cases be erroneous. If only 15% of women with short education are smokers, it will not be very meaningful to target the whole group. Instead, each individual should be treated and supported according to his or her needs. Children with reading difficulties should receive adequate help and support irrespective of their gender, race or their parents'

education. Given the social inequalities in living conditions and opportunities that exist there will certainly be more children with less educated parents who will be in need of extra support to develop their reading abilities, but such support should be offered to all children in need and not conditioned on parents' educational level (an approach often referred to as 'proportionate universalism'[14].

Following the SDoH logic, it should be possible to reduce health inequalities by improving people's conditions and opportunities through welfare state institutions, such as maternal and child health units, pre-schools, public schooling systems, social insurances, active labour market policies, etc. However, if the compensatory ability of these services is low it is likely that such welfare state institutions may primarily improve conditions and opportunities for all, keeping relative inequalities rather intact. In fact, this is exactly what has happened in the wake of the massive expansion of education that has taken place during the post-war era.

There is no doubt that the general improvements in social and economic conditions that also working classes and poorer segments of many societies have experienced have been essential for the improvements in health and longevity that have taken place simultaneously. It is also clear that a range of welfare state institutions and policies have contributed to this development. However, these institutions, and in particular the educational systems, have most likely increased everybody's opportunities but not reduced the inequalities in opportunities between social groups[15]. This may be an important key to our understanding of why health inequalities still persist also in rich welfare states across Europe.

Elements of a new narrative around SDoH

I have tried to outline some of the key points that makes the social determinants perspective difficult to get across. I think there are two different types of problems that I have brought up here. First, there are problems that stem from what I regard as problems within the field of SDoH itself, like the misconception of structural conditions, the underestimation of the role of human agency and the conceptual drift from group mean values to group homogeneity. I believe that we need to provide room for a critical re-evaluation of the standard ways we use to describe and interpret social determinants and health inequalities, and it would be refreshing if the new WHO unit could contribute to that.

Second, there are problems linked to the fact that the SDoH approach is indeed complex. This cannot be changed, but the story we tell can take its point of departure in something that is easier to grasp. As hinted above, I find the individual life course perspective very attractive as a starting point for understanding how inequalities are generated. Using people's life courses as the starting point for a renewed narrative will help to focus on the conditions and opportunities at an individual level, which I believe is both scientifically correct and easier to communicate. Individual conditions and opportunities are of course nested in families, communities and societies, but it is at the individual level where the social circumstances enter the human body and are transformed into health problems. Starting with the individual life course and the universal challenges that have to be dealt with also makes it easier to understand the role of human agency and the large variations that occur within social groups.

Starting in the individual life course also makes it easier to balance the influence of structural differences between social groups that affect all of the members and the influence of drivers of variation within these groups. This, in turn, will also make it easier to resolve the structural-behavioural distinction, because the effects of structural drivers on health and wellbeing are generated through the experiences and actions of individuals. A better understanding of the interplay between structurally shaped conditions and individual responses across different social groups will also be essential for policy reforms, in particular in the area of welfare services and income transfer programmes that have the potential to improve conditions, opportunities and, ultimately, health.

Of course, the SDoH approach will remain highly complex even if the narrative is anchored in individual life courses. However, starting in individual life courses will make it a little easier to add on factors sequentially, and a little easier to identify crucial points in time and over the life course for the generation of inequalities as well as for policy interventions.

More than a new narrative

It is important to stress that the work by the WHO cannot be about an updated narrative alone. The WHO should actively work with the social determinants of health according to the present General Programme of Work[6]. At least three areas are of importance. First, there is a need to form alliances with other global and international actors, in particular those who have a stronger mandate and expertise in the policy areas covered by the SDoH framework. One obvious candidate is the Organisation for Economic Co-operation and Development (OECD), which during recent years has come forward as an advocate for smaller economic inequalities, and that recently published also on health inequalities[16].

Second, there is a need to advise member states on policies that are likely to reduce health inequalities through action on the SDoH approach. As I have argued elsewhere, such recommendations should be as specific as possible, which means that they also must be very context specific[5]. Therefore, it is unlikely that the WHO will be able to advise each member country on exactly what to do (although such advice is provided by the OECD on specific educational and economic policies). Instead, the WHO could develop more general but still also hands-on principles for policies. For example, action to reduce inequalities requires: (a) existing institutions and programmes; but (b) that these institutions should be accessible for all but (c) that they also must actively provide more support for those with greater needs. Again, it is important to stress that although social inequalities are detected and described as differences between social groups, policies should in general promote universal access but differential treatment on the basis of need.

Finally, as the leading normative actor in the health field the WHO should lead by example. Although health inequalities are not primarily generated by the health sector, there are too many examples of health inequalities being amplified rather than reduced by the way health services are organised, financed and operated. Given that the WHO does have a strong mandate and an important normative role in relation to the health sector in its member states, it would be natural to have qualified recommendations not only on how to provide equal access to health and preventive care services, but also how to provide more equal outcomes. Not only would this be important in itself, but it would also provide the WHO with a strong argument in relation to other sectors and agencies; this is how we have promoted equity, what can you do in your sectors?

Still, the narrative issue is important, not least for the research community. Following the arguments put forward above I am convinced that the whole research field on health inequalities and social determinants would benefit from re-thinking and re-formulating the theoretical framework, not only in order to communicate more effectively but also for a better understanding of how inequalities are generated and how best to reduce them. As has been pointed out by several authors there is a clear need for research in this area to address more firmly the empirical findings that do not seem to fit well with the SDoH perspective, such as the remaining and large health inequalities also in otherwise rather egalitarian welfare states[17, 18]. In my opinion, this and other seemingly contradictory findings could be resolved through a more systematic discussion of commonly held beliefs and positions in the field. Clarifying the matters I have brought up here might not change the world in itself, but it would definitively contribute to the ability of the SDoH approach to inform policy – and 'tis a consummation devoutly to be wish'd'.[3]

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Notes

1. The prime example here is of course cancer, which still is used as a strong metaphor for mysterious threats. The 'riddle of cancer' is also still around as an object for science to solve. It is no coincidence that one of the missions of the upcoming EU research programme Horizon Europe is cancer.
2. The analogy of upstream versus downstream is particularly misleading, not least because it was first launched as an argument for prevention – it is preferable to prevent people from falling in the river rather than putting all efforts into rescuing those who are drowning. Hence, the stream referred to represents time, not the macro-micro levels[13].
3. Hamlet, Act III, Scene I.

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