



**COMMISSION ON
SOCIAL DETERMINANTS OF
HEALTH**



**Towards a Conceptual Framework for Analysis and Action
on the Social Determinants of Health**

**Discussion paper for the Commission on Social Determinants of Health
DRAFT
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This draft paper was prepared for the second meeting of the Commission on Social Determinants of Health by the Commission secretariat, based in the WHO Health Equity Team, Office of the Assistant Director-General, Evidence and Information for Policy Cluster, WHO Geneva. The principal writers were Orielle Solar and Alec Irwin. Valuable input was provided by the other members of the Commission secretariat, in particular Jeanette Vega. Any errors are solely the responsibility of the principal writers.

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1. Introduction

The Commission on Social Determinants of Health (CSDH) has affirmed its desire to be judged not only on the scientific rigor of its analyses, but on the policy and institutional changes catalysed in countries through Commission advocacy and partnership. To set feasible objectives for its political work and send consistent messages to partners and the public, the CSDH requires clarity on basic conceptual issues. These include:

- The concept of social determinants of health (SDH)
- The values that ground the Commission's analysis and policy recommendations
- The pathways by which SDH affect health status and outcomes
- How SDH relate to health inequities
- The most important SDH for the Commission to address, and why
- Appropriate intervention levels and entry points for policy action on SDH
- The ultimate goal of SDH policies (improving average health status or reducing health inequities)

This paper outlines a conceptual framework we hope can serve as a basis for discussion and clarification of these issues within the CSDH. The paper in its current form is an *early draft*, which aims to open debate rather than furnish definitive answers. It summarizes the results of an initial phase of research and analysis by the CSDH secretariat. The paper will pass through subsequent iterations to incorporate input from Commissioners and yield a final document succinctly laying out the conceptual foundations of the Commission's work.

The paper begins by recalling the CSDH definition of social determinants and some methodological implications. It then takes up the question of values. We propose the concept of health equity as a cornerstone for the Commission's normative framework. Applying equity criteria, we consider the implications of policy approaches focused respectively on: (1) tackling health disadvantages in targeted population groups; (2) reducing health gaps; and (3) addressing the health gradient across the full spectrum of socioeconomic positions. The next section of the paper reviews several models that have sought to explain relationships among SDH and their causal role in generating health inequities. Drawing lessons from these approaches, we propose a comprehensive SDH framework that situates the major determinants and clarifies levels for policy action. Using this model, we then show how and why a set of key thematic foci for the Commission's work have been proposed. Finally, we review several evaluative frameworks the CSDH could use in developing policy recommendations and suggest some principles to ground those policy choices.

2. Social determinants: definitions; difference from individual risk factors

The social determinants of health (SDH) can be understood as the social conditions in which people live and work, or in Tarlov's phrase "the social characteristics within which living takes place".¹ SDH point to both specific features of the social context that affect health and to the pathways by which social conditions translate into health impacts. The SDH that merit attention are those that can potentially be altered by informed action².

The concept of SDH originated in a series of influential critiques published in the 1970s and early 1980s, which highlighted the limitations of health interventions oriented to the disease risks of individuals. Critics argued that understanding and enhancing health required a population focus, with research and policy action directed at the societies to which individuals belonged³. A case was made for "refocusing upstream" from individual risk factors to the social patterns and structures that shape people's chances to be healthy. Integral to these critiques is the argument that medical care is not the main driver of people's health. Instead, the concept of social determinants is directed to the "factors which help people stay healthy, rather than the service that help people when they are ill".⁴

In some contexts, health determinants have continued to be conceptualized primarily as characteristics of the individual, such as a person's social support network, income or employment status. Population are not merely collections of individuals, however; the causes of ill health are clustered in systematic patterns, and in addition effects on one individual may depend on the exposure and outcomes experienced by other individuals.⁵ This flows from the fact that the determinants of individual differences regarding some characteristic within a population may be different from the determinants of differences between populations.⁶ In this light, it is useful distinguish two kinds of etiological questions: the first seeks the causes of cases, the second the causes of incidence. When we talk about social determinants, we wish to understand how the causes of individual cases relate to the causes of population incidence⁷. Why do we observe a graded relationship between social position and health status that affects people at all levels of the social hierarchy? How is this gradient shifting over time? Are the factors determining health changing for the better? Is it the same for everyone? Where and for whom are they changing for the worse?⁸

3. Defining core values: SDH and health equity

A reflection on values will necessarily be part of Commissioners' shaping of a conceptual framework. We propose the concept of health equity as a foundation for this reflection. Health equity can be defined as the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically.⁹ Health inequity involves more than mere inequality, since some health inequalities (e.g., the gap in average life expectancy between women and men) cannot reasonably be described as unfair, and some are neither preventable nor remediable. Inequity implies a failure to avoid or overcome inequalities in health that infringes human rights norms or is otherwise unfair. Health inequities have their roots in social stratification.¹⁰ Health inequity thus defined is a moral category deeply embedded in political reality and the negotiation of social power relations.

The social determinants of health are not necessarily the same as the social determinants of health inequities.¹¹ Among the many social factors and processes that influence health, some but not all will be found to be significant contributors to health gaps among different social groups. It would be possible to promote SDH policies that might improve average health indicators in a country without altering the extent of health disparities between privileged and disadvantaged groups. A key question for the CSDH then becomes the following: is improving average health indicators a sufficient objective for the policies the Commission

will recommend, or should probable positive effects on health equity be a central criterion for the CSDH in selecting policy options?

We argue that the Commission should concentrate its attention on SDH that are major causes of *health inequities*, and that the policies recommended by the Commission should be policies that can be expected to have a substantial positive health equity impact. However, neither the philosophical value of the concept of health equity nor the desirability of a pro-equity approach to health policymaking can simply be assumed. It is necessary both to justify health equity conceptually and to "give arguments for the government's responsibility to reduce socioeconomic health differences".^{12 13} A number of valuable philosophical accounts of health equity and arguments for the political application of the concept have been put forward recently. Many of these contributions emanate from Amartya Sen or adopt his categories. It will be useful to recall the broad outlines of several of these arguments, giving particular attention to those that emphasize the political translation of health equity.

Stronks and Gunning-Schepers (1993) have drawn on the work of Sen, Berlin and others to construct an argument for government action on health inequities rooted in a theory of social justice. They argue that a just society is characterized by providing equally to all its members a high degree of freedom, specifically the "positive freedom" to choose from among a range of desirable options the life plan that most fully agrees with the particular individual's conception of the good life. A just government does not promote one particular conception of the good life. It leaves the choice of life plans open to individuals. However, a just government *is* obligated to provide the enabling conditions that make it possible for each individual to freely choose her life-plan. "The capability to be as healthy as possible is such a condition," since the presence or absence of this basic capability "determines the life plans from which an individual can choose". To the extent that social conditions can be shown to constrain the health capability of some people within a society, creating inequalities in people's opportunity to exercise positive freedom, a government is under obligation to take action on these social determinants in order to guarantee equality in the chances for health.

Importantly, the factor to be equalized is not health status but *health opportunity*, since individuals may employ their positive freedom to choose a way of life that compromises health in the pursuit of other goods. This underscores that health inequalities per se are not inherently problematic, since such "inequalities that are the result of free choices made by an individual are acceptable". The principle of justice applied here "does not require everyone to have the same level of health, but it demands such a distribution of determinants of health, to the extent they can be controlled, that every individual has the same possibilities to lead a long and healthy life".¹⁴

In recent work, Anand (2004) has further clarified the grounds for regarding health equity, and not just average levels of health achievement, as a public policy concern. In convergence with Sen, Anand stresses that health is a "special good" whose fair distribution merits the particular concern of political authorities. There are two principal reasons for regarding health as a special good: (1) health is directly constitutive of a person's well-being; and (2) health enables a person to function as an agent.¹⁵ Inequalities in health are thus recognized as "inequalities in people's capability to function". When such inequalities arise as a

consequence of individuals' different social positions, a grave breach of the political principle of equality of opportunity has occurred. Assuring the fair distribution of health among members of the society should thus be regarded as a primary responsibility of just governance.

Ruger (2005) has developed similar arguments, linking Sen's capability approach with Aristotle's political philosophy. "While recognizing the interrelatedness of health and other valuable social ends, such as education," Ruger "emphasizes the importance of health for individual agency—the ability to live a life one values". Health is seen as sustaining all other aspects of human flourishing or capability. Thus, promoting an equitable distribution of real opportunities for health emerges as a fundamental task of public policy. "Public policy should focus on individuals' capability to function, and health policy should aim to maintain and improve this capability by meeting health needs".¹⁶

A values framework based on health equity provides strong support for an SDH agenda.^{17,18} Meanwhile, policy action on social determinants can also be justified using a variety of other normative approaches, in particular human rights. The 2000 General Comment on the right to health by the UN Committee on Economic, Social and Cultural Rights characterized the right to health as an "inclusive right" extending "not only to timely and appropriate health care but also to the underlying determinants of health".¹⁹ Authoritative interpretations of international human rights accords thus acknowledge the responsibility for governments to act on SDH and may facilitate the translation of this responsibility into policy. Further reflection will be required to clarify complementarities and possible tensions between equity and human rights approaches to SDH, in light of recent analyses of the plurality of moral frameworks used to legitimate health actions.^{20,21}

To summarize, the concept of health equity provides a robust ethical foundation for the work of the CSDH. A close relationship exists between health equity and social determinants, both conceptually and in political terms. Substantial progress cannot be made on health equity without action on the social determinants of health. On the other hand, at a time when health inequalities between and within countries are the focus of increasing concern²², the potential contributions of SDH measures to health equity constitute an important scientific, ethical and political argument for action on SDH.

The preceding discussion represents only a first step in defining a values framework for the CSDH. It is proposed that a working group of Commissioners with special interest in this area take forward, with support from the secretariat, the project of developing this analysis. The results will be submitted to the full Commission for review and input. The discussion above points to several issues for this deeper exploration. These include the following questions, roughly ranked from broader to more circumscribed:

- A rigorous analysis of social determinants may lead to the conclusion that significantly reducing health gradients would require profound structural changes in many contemporary societies, e.g., in the functioning of markets and the redistributive role of the state. Is the CSDH prepared to "own" such ideas, and what forms of political philosophy will guide its deliberations and recommendations in this

respect? Much recent discussion of health equity has been subtended by models of social justice derived from liberal thinkers, in particular John Rawls, for whom liberal market democracy remains the paradigm of appropriate social organization among "well-ordered peoples". Rawls' ideas (and liberal democracy itself, where it may exist) clearly still have much to offer. Yet an analysis of contemporary societies in terms of health equity should be prepared to test and challenge the liberal democratic paradigm itself -- both at the level of Rawls' idealized abstractions and, more importantly, at the level of "really existing market democracies".

- A number of important and insufficiently clarified issues cluster around the notions of individual freedom, personal agency and choice. An equity-based SDH model appears to stand in a complex relationship to prevalent ideas of freedom and responsibility. On the one hand, an equity approach seeks to equalize *opportunities*, not outcomes, and maintains that health differences arising through individual free choice are acceptable; on the other, an analysis of structural determinants implies that certain forms of "free choice" (e.g., low-paid workers' "choice" to smoke more heavily than members of higher socioeconomic groups) are in fact shaped by social forces largely beyond the individual's control. A robust analysis of equity and SDH will need to develop a clear account of the scope and limits of personal freedom, as constructed and/or negated in different social contexts and through diverse forms of social constraint and conditioning. Of use in developing such an analysis will be Paul Farmer's notion of "structural violence",^{23,24} as well as accounts of the distortion of personal agency through systemic social oppression proposed by social scientists like Philippe Bourgois.²⁵ In reflecting on SDH, equity and individual agency, it should not be neglected that, in societies where health is regarded primarily as a private matter, the motif of "personal responsibility" has been deployed politically precisely to absolve government of responsibility for addressing health inequities and responding more actively to the health needs of poor and excluded groups.

This topic and the preceding point could perhaps best be summarized by stressing that a credible health equity framework must equip itself with a robust *theory of power*. This is in keeping with the observation that health inequities derive most fundamentally from the differential allocation of power and wealth to social positions.²⁶ Sen's work on capabilities, rationality and freedom will again open valuable lines of enquiry in this respect, especially if crossed with a concrete analysis of the mechanisms and practices of manipulation, exclusion, disinformation and disempowerment deployed in contemporary societies, both authoritarian and nominally democratic. Philosophy should do more than simply describe an ideal of human freedom (or equitably distributed human health). It must also show how we might begin to advance towards that ideal in concrete political terms.

- Human rights analysis emphasizes not only substantive rights, but also people's right to informed participation in the decision-making processes that affect their lives and the exercise of their liberties. Sen's work on the *process aspect* of freedom explores related concerns.²⁷ It will be important to clarify to what extent the concept of health equity implies a process aspect and how the relevant procedures might be specified.

Will health equity, in its concrete social and political operationalization, stipulate the participation of communities and other stakeholders in decision-making relative to health and health equity agendas (including action on SDH)? How might such participation be structured? What would be its precise objectives? At what level(s) would it take place, and who would be included? Ranaan Gillon has suggested what might be at stake in such choices by asking, in the framework of a discussion of value judgments about health equity, if it would not be appropriate for the taxpayers whose contributions fund national health programmes to be invited to vote on the broad composition of health sector budgets (e.g., proportion of spending devoted to prevention vs. curative care, special benefits for vulnerable groups, etc.).²⁸ Such a debate is of course just one entry point to a broader discussion about the modes of participation and community ownership required for a robust operationalization of health equity.

- More work is clearly needed on the translation of philosophical principles of health equity into the practice of planning and resource allocation at the various levels of government. A broad commitment to equity does not pre-determine priority among the different moral criteria that may legitimately be used at national and local levels in allocating scarce health resources. These criteria include, for example, allocation based on: need; maximization of individual benefit; and maximization of benefit at the population level. These criteria are all "morally respectable" but can, and in many cases will, lead to conflicting judgments on how resources available to promote health and social welfare should be invested (Gillon). It will be important to continue work currently underway to see if a health equity model of the type presented above can shed light on these operational issues, which are clearly of relevance to planners and programme implementers in countries: constituencies among whom the CSDH needs to be taken seriously.

4. Pursuing equity through health policy: health disadvantage, gaps and gradients

Today, health equity is increasingly embraced as a policy goal by international health agencies and national policymakers.²⁹ As Hilary Graham has shown, however, political leaders' commitment to "tackle health inequities " can be interpreted in different ways and authorize a variety of distinct policy strategies.

Three broad policy approaches to reducing health inequities can be identified: (1) improving the health of disadvantaged population groups through targeted programmes; (2) closing the health gaps between those in the poorest social circumstances and better off groups; (3) addressing the entire health gradient, that is, the association between socioeconomic position and health across the whole population.

To be successful, all three of these options would require action on SDH. All three constitute potentially effective ways to alleviate the unfair burden of illness borne by the socially disadvantaged. Yet the approaches differ significantly in their underlying values and implications for programming. Each offers specific advantages and raises distinctive problems.

Programmes to improve health among disadvantaged populations have the advantage of targeting a clearly defined, fairly small segment of the population and of allowing for relative ease in monitoring and assessing results. Targeted programmes to tackle health disadvantage may align well with other targeted interventions in a governmental anti-poverty agenda, for example social welfare programmes focused on particular disadvantaged neighborhoods. On the other hand, such an approach may be weakened politically precisely by the fact that it is not a population-wide strategy but instead benefits sub-groups that make up only a relatively small percentage of the population. Furthermore, this approach does not commit itself to bringing levels of health in the poorest groups closer to national averages. Even if a targeted programme is successful in generating absolute health gains among the disadvantaged, stronger progress among better-off groups may mean that health inequalities widen.

An approach targeting health gaps directly confronts the problem of relative outcomes. The UK's current health inequality targets on infant mortality and life expectancy are examples of such a gaps-focused approach. However, this model, too, brings problems. For one thing, its objectives will be technically more challenging than those associated with strategies conceived only to improve health status among the disadvantaged. "Movement towards the [gap reduction] targets requires both absolute improvements in the levels of health in lower socioeconomic groups, and a rate of improvement which outstrips that in higher socioeconomic groups". Meanwhile, Graham argues that gaps-oriented approaches share some of the underlying moral ambiguities of the focus on health disadvantage. Health-gaps models continue to direct efforts to minority groups within the population (they are concerned with the worst-off, measured against the best-off). By adopting this stance, "a health-gaps approach can underestimate the pervasive effect which socioeconomic inequality has on health, not only at the bottom but also across the socioeconomic hierarchy". By focusing too narrowly on the worst-off, gaps models can obscure what is happening to intermediate groups, including "next to the worst-off" groups that may also be facing major health difficulties.

Tackling the socioeconomic gradient in health right across the spectrum of social positions constitutes a much more comprehensive model for action on health inequities. With a health-gradient approach, "tackling health inequalities becomes a population-wide goal: like the goal of improving health, it includes everyone". On the other hand, this model must clearly contend with major technical and political challenges. Health gradients have subsisted stubbornly across epidemiological periods and are evident for virtually all major causes of mortality, raising doubts about the feasibility of significantly reducing them, even if political leaders have the will to do so. Public policy action to address gradients may prove complex and costly and, in addition, yield satisfactory results only in a long timeframe. Yet it is clear that an equity-based approach to social determinants, carried through consistently, must lead to a gradients focus.

Importantly, as Graham argues, strategies based on tackling health disadvantage, health gaps and gradients are not mutually exclusive and need not be cast as rivals. The approaches are complementary and can build on each other. "Remedying health disadvantages is integral to narrowing health gaps, and both objectives form part of a comprehensive strategy to reduce

health gradients". Thus a sequential pattern emerges, with "each goal add[ing] a further layer to policy impact". Of course the relevance of these approaches and their sequencing will vary with countries' levels of economic development and other contextual factors. A targeted approach may have little relevance in a country where 80% of the population is living in extreme poverty. Here the CSDH can contribute by linking a deepened reflection on the values underpinning an SDH agenda with country-level contextual analysis and a pragmatic mapping of policy options and sequencing.

5. Modeling health determinants and the pathways to inequity

Over the past 15 years, several models have been developed to show the mechanisms by which SDH affect health outcomes, to make explicit the linkages among different types of health determinants; and to locate strategic entry points for policy action. Influential models include those proposed by: Dahlgren and Whitehead (1991); Diderichsen and Hallqvist (1998, subsequently adapted in Diderichsen, Evans and Whitehead 2001); Mackenbach (1994); Marmot and Wilkinson (1999). These models are particularly important in making visible the ways SDH contribute to health inequities among groups in society.

5.1 Dahlgren and Whitehead: layered influences

Dahlgren's and Whitehead's frequently cited model explains how social inequalities in health are the results of interactions between different levels of causal conditions, from the individual to communities to the level of national health policies (see figure on next page).³⁰ Individuals are at the centre of the picture, endowed with age, sex and genetic factors that undoubtedly influence their final health potential. Moving outward from the centre, the next layer represents personal behaviors and lifestyles. People in disadvantage circumstances tend to exhibit a higher prevalence of behavioral factors such as smoking and poor diet, and will also face greater financial barriers to choosing a healthier lifestyle.

Social and community influences are represented in the next layer. These social interactions and peer pressures influence personal behaviors in the layer below, for better or worse. Indicators of community organization register fewer networks and support systems available to people towards the lower end of the social scale, compounded by the conditions prevalent in area of high deprivation, which have a fewer social services and amenities for community activity and weaker security arrangements. At the next level up, we find factors related to living and working conditions, food supplies and access to essential facilities and services. In this layer, poorer housing conditions, exposure to more dangerous or stressful working conditions and poorer access to services create differential risks for the socially disadvantaged.

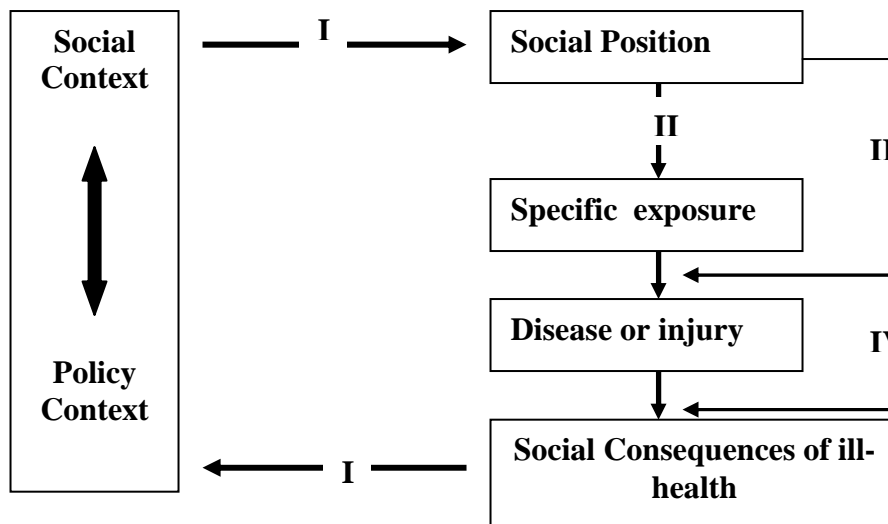
Overarching all other levels are the economic, cultural and environmental conditions prevalent in society as a whole. These conditions, such as the country's economic state and labor market conditions, have a bearing on every other layer. The standard of living achieved in a society, for example, can influence an individual's choice of housing, work and social interactions, as well as eating and drinking habits. Similarly, cultural beliefs about the place

of women in society or pervasive attitudes to minority ethnic communities can influence their standard of living and socioeconomic position.³¹



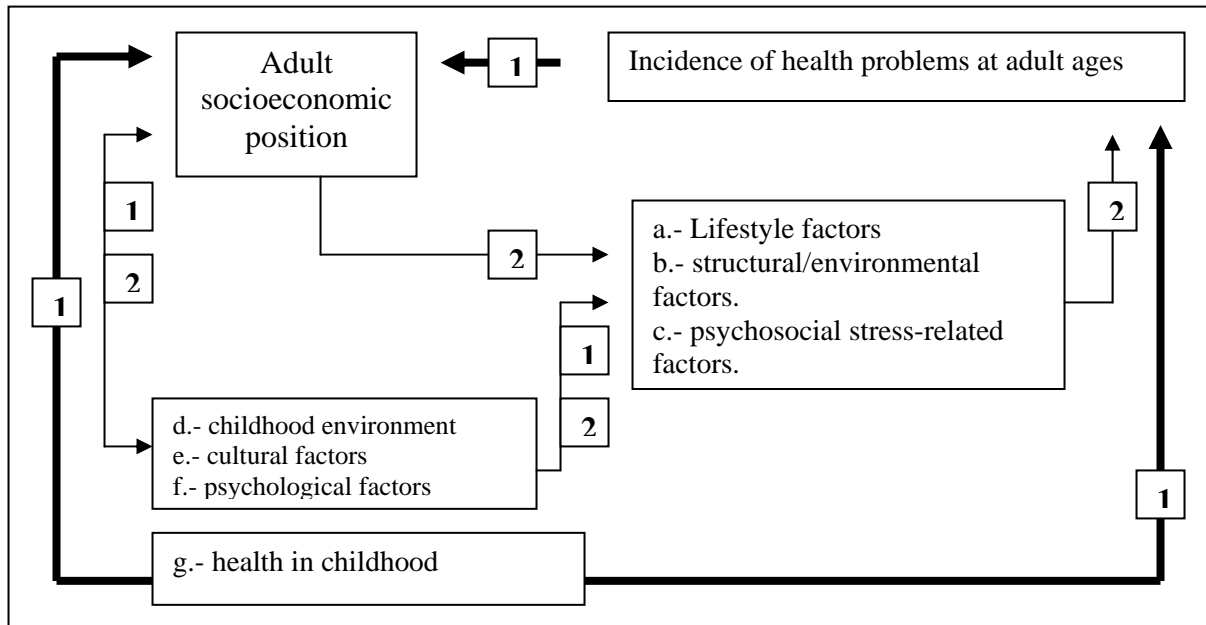
5.2 Diderichsen et al.: social stratification and disease production

Diderichsen's and Hallqvist's 1998 model was adapted by Diderichsen, Evans and Whitehead (2001). This model emphasizes how social contexts create social stratification and assign individuals to different social positions. People's social position determines their health opportunities. In the diagram below, the process of assigning individuals to social positions is shown as (I). The mechanisms involved are "those central engines of society that generate and distribute power, wealth and risk", for example the educational system, labour policies, gender norms and political institutions. Social stratification in turn engenders differential exposure to health-damaging conditions (II) and differential vulnerability (III), as well as differential consequences of ill health for more and less advantaged groups, shown as mechanism (IV). "Social consequences" refers to the impact a certain health event may have on an individual's or a family's socioeconomic circumstances. This model includes a discussion of entry points for policy action, an aspect we will take up in a later section.



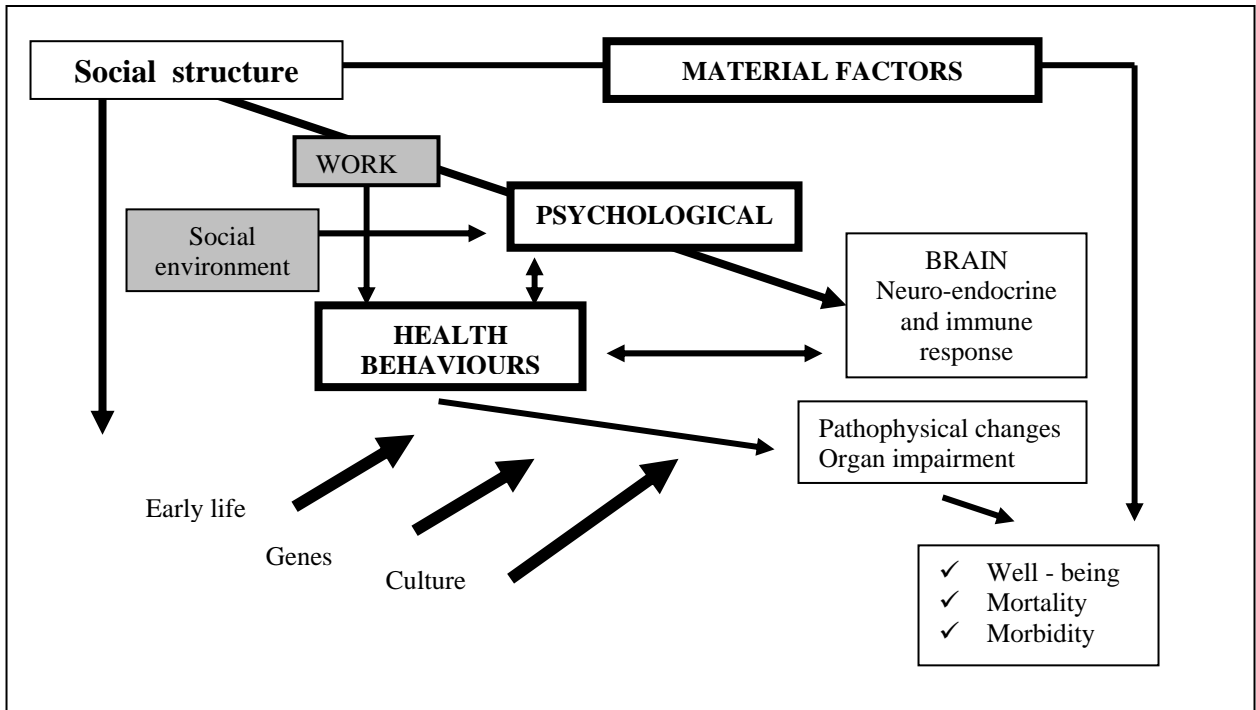
5.3 Mackenbach et al.: selection and causation

Mackenbach's model emphasizes the mechanisms by which inequities in health are generated: selection vs. causation. The number "1" marks the selection processes represented by an effect of health problems at adult ages on adult socioeconomic position, and by an effect of health in childhood on both adult socioeconomic position and health problems at adult ages. The number "2" is the causation mechanism is represented by the three groups of risk factors which are intermediary between socioeconomic position and health problems (Lifestyle factors, structural/environmental factors, psychosocial stress-related factors). Childhood environment, cultural factors and psychological factors are included in the model, which acknowledge their contribution to inequalities in health through both selection and causation.³²



5.4 Brunner, Marmot and Wilkinson: multiple influences across the life-course

This model was originally developed to connect clinical (curative) and public health (preventive) perspectives on health. It was subsequently applied to the social process underlying health inequalities as a model of the social factors that both cause ill health and contribute to health inequalities. The model is included in the United Kingdom's Acheson report, introduced explicitly to illustrate how socioeconomic inequalities in health result from differential exposure to risk- environmental, psychological and behavioral- across the life course^{33,34} This model links social structure to health and disease via material, psychosocial and behavioral pathways. Genetic, early life and culture factors are further important influences on population health.

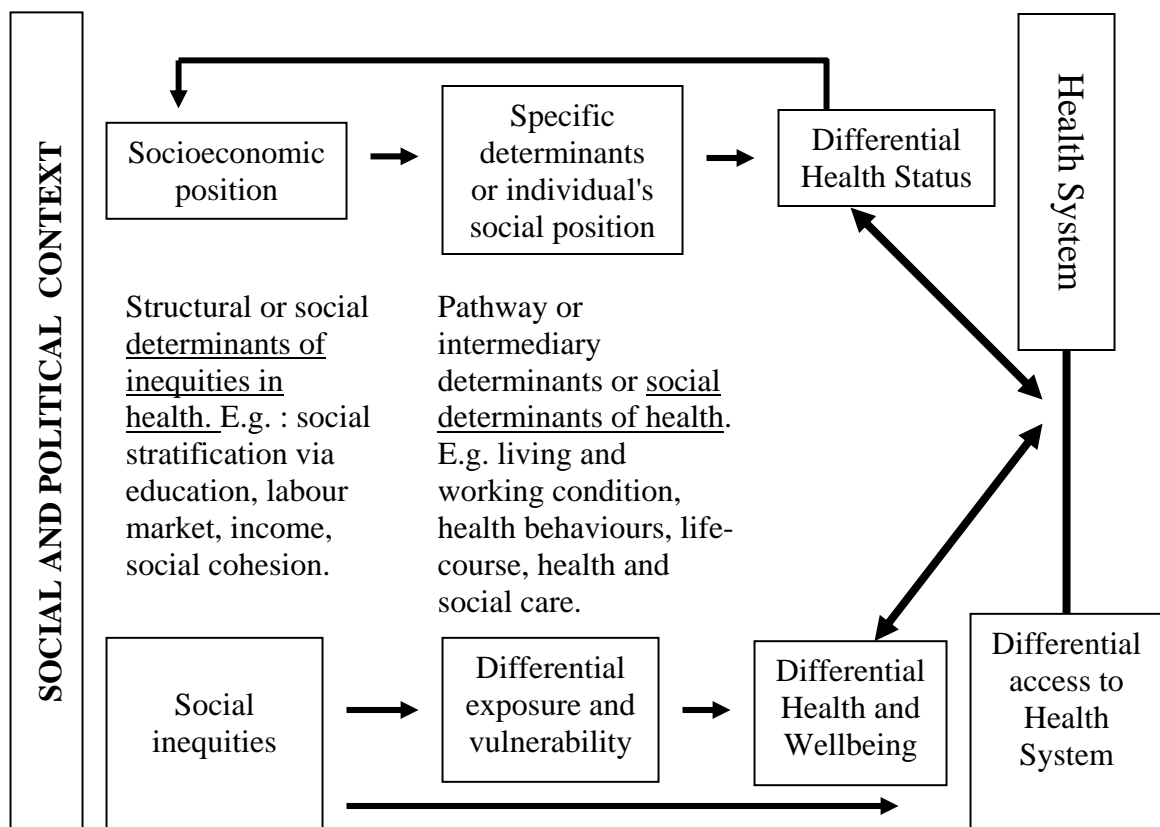


5.5 Synthesis

The various models we have examined (along with others not reviewed in detail here) seek to explain the mechanisms that generate health inequities via SDH. From these proposals, several themes emerge as deserving special attention, including "selection vs. causation", the "specific determinants" perspective and the "life course" approach. Life course analysts argue that policies that prevent an accumulation of risk in the critical biological and social periods - such as prenatal development, the transfer from primary to secondary school, entry to the labor market and exit from the labor market - should be especially important in protecting the most vulnerable³⁵. Ongoing debates reveal differences with respect to the incorporation of a life course perspective, however. Certain models are restrictive in this area, while others give strong priority to childhood events and conditions.

Other revealing differences can be noted among the models surveyed in our research. Some models ignore the reverse effect of health on socioeconomic position, while others incorporate it explicitly. Some make biological pathways explicit, while others leave this aspect unaddressed. (One could argue that biological pathways are more relevant for clinical intervention and less so for policymaking.) Health care service and systems are rarely accorded a place in the models, reflecting the fact that the concept of social determinants was originally introduced into debates about public health to underscore the importance of nonclinical factors in shaping the health of individuals and populations.³⁶

A comprehensive SDH model should achieve the following: (a) clarify the mechanisms by which social determinants generate health inequities; (b) show how major determinants relate to each other; (c) provide a framework for evaluating which SDH are the most important to address; and (d) map specific levels of intervention and policy entry points for action on SDH. Each of the models we have examined makes an important contribution, yet none on its own fully meets these requirements. However, by combining elements of various models, we can arrive at a synthetic construct that may advance the debate. The schema below is the first stage of such a synthetic model. A more developed version is presented and discussed in the next section, in which we will take up the question of specific thematic foci for the Commission. As a preliminary step, the model sketched below attempts to draw together the more significant insights of the approaches reviewed in the preceding pages.



Reading from left to right, we see the social and political context (including political institutions and economic processes) giving rise to a set of unequal socioeconomic positions. Groups are stratified according to income levels, education, professional status, gender, race/ethnicity and other factors. This column of the diagram ("Socioeconomic position") locates the underlying mechanisms of social stratification and the creation of social inequities. These socioeconomic stratification mechanisms can be described as *structural determinants* of health or as the social determinants of health inequities. These mechanisms configure the health opportunities of social groups based on their placement within hierarchies of power, prestige and access to resources.

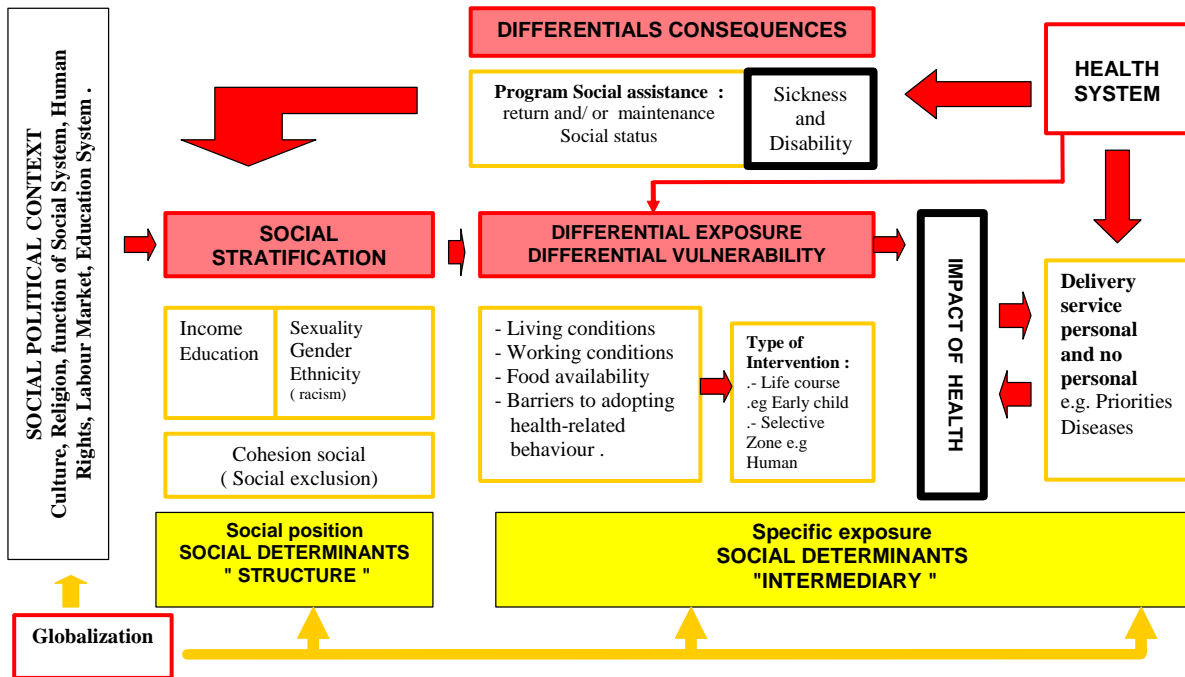
Moving to the right, we observe how these socioeconomic positions then translate into specific determinants of individual health status reflecting the individual's social location within the stratified system. Based on their respective social status, individuals experience differential exposure and vulnerability to health-compromising factors. The model shows that a person's socioeconomic position affects his/her health, but that this effect is not direct. Socioeconomic position influences health through more specific, intermediary determinants. Those intermediary factors include material conditions, such as working and housing conditions; psychosocial circumstances, such as psychosocial stressors; and also behavioral factors, such as smoking. The model assumes that members of lower socioeconomic groups live in less favorable material circumstances than higher socioeconomic groups, and that people closer to the bottom of the social scale more frequently engage in health-damaging behaviors and less frequently in health promoting behaviors than do the more privileged.

A distinctive element of this model is its explicit incorporation of the health system. Socioeconomic inequalities in health can in fact be partly explained by the "feedback" effect of health on socioeconomic position, e.g., when someone experiences a drop in income because of a work-induced disability. Persons who are in poor health less frequently move up and more frequently move down the social ladder than healthy persons. This implies that the health system itself can be viewed as a social determinant of health. This is in addition to the health sector's key role in promoting and coordinating SDH policy. On this point the UK Department of Health has argued that the health system should play a more active role in reducing health inequalities, not only by providing equitable access to health care services but also by putting in place public health programmes and by involving other policy bodies to improve the health of disadvantaged communities³⁷.

6. Proposed conceptual framework for the CSDH

The diagram below adds further elements to the schema just discussed. The expanded model seeks to summarize visually the key lessons of the preceding analysis and to organize in a single comprehensive framework the major categories of SDH; a specific set of recommended thematic foci for the Commission; and a mapping of potential levels of policy action. The graphic is necessarily somewhat complex, since it seeks to represent in schematic form an intricate social and political reality. We will "walk through" the diagram, spelling out the links among its components. This framework makes visible the concepts and categories discussed in this paper. It also locates the specific social determinants on which we propose that the Commission focus its work and provides a context for understanding why these particular determinants might be given priority. Before taking up the question of proposed thematic foci, it is helpful to become familiar with this expanded version of the framework. Key issues are: (a) structural vs. intermediate determinants; (b) what is meant by socio-political context; and (c) levels at which inequities in health can be tackled.

WHO Equity Team social determinants framework³⁸



6.1 Structural and intermediate social determinants

Fleshing out the previous schema, this framework likewise identifies two major groups of determinants, structural and intermediate, providing specific examples of each. *Structural* determinants are those that generate social stratification. These include the traditional factors of income and education. Today it is also vital to recognize gender, ethnicity and sexuality as social stratifiers. A central point for us is the aspect of social cohesion related to social capital. *Intermediate* determinants flow from the configuration of underlying social stratification and, in turn, determine differences in exposure and vulnerability to health-compromising conditions. Here the literature reflects ongoing discussions regarding the accumulation of exposures and about selection. We include in the category of intermediate determinants: living conditions, working conditions, the availability of food, population behaviours and barriers to adopting healthy lifestyles. Relevant population groupings for analysis and action on intermediate determinants can be defined in various ways. We introduce two examples of groups selected (1) by greater vulnerability (children) and (2) by geography (slum dwellers).

The *health system* itself should also be understood as an intermediate determinant. The role of the health system becomes particularly relevant through the issue of access, which incorporates differences in exposure and vulnerability. This is closely related to models for

the organization of personal and non-personal health service delivery. The health system can directly address differences in exposure and vulnerability not only by improving equitable access to care, but also in the promotion of intersectoral action to improve health status. Examples would include food supplementation through the health system. A further aspect of great importance is the role the health system plays in mediating the differential consequences of illness in people's lives. The health system is capable of ensuring that health problems do not lead to a further deterioration of people's social status and of facilitating sick people's social reintegration. Examples include programmes for the chronically ill to support their reinsertion in the workforce, as well as appropriate models of health financing that can prevent people from being forced into (deeper) poverty by the costs of medical care.

6.2 Socio-political context

This framework differs from some others in the importance attributed to the *socio-political context*. This is a deliberately broad term that refers to the spectrum of factors in society that cannot be directly measured at the individual level. 'Context' therefore encompasses a broad set of structural, cultural and functional aspects of a social system whose impact on individuals tends to elude quantification but which exert a powerful formative influence on patterns of social stratification and thus on people's health opportunities. Within the context in this sense will be found those social and political mechanisms that generate, configure and maintain social hierarchies, such as the labour market, the educational system and political institutions.

The most relevant contextual factors, i.e., those that play the greatest role in generating social inequalities, may differ considerably from one country to another.³⁹ For example, in some countries religion will be a decisive factor, in others less so. Contextual differences militate against "one-size-fits-all" policy approaches to address SDH. Since the mechanisms producing social stratification will be different in different settings, certain interventions or policies are likely to be effective for a given socio-political context but not for others. Meanwhile, the timing of interventions with respect to local processes must be considered, as well as for example partnerships, availability of resources, and how the intervention and/or policy under discussion is conceptualized and understood by the participants at national and local levels.⁴⁰

The specificities required for an appropriate understanding of context may vary with the specific health determinants on which one wishes to act. For example, the most relevant contextual elements for action on early child development will differ from those most relevant to globalization or health systems. In general, the construction/mapping of context should include at least four points: (1) political systems and processes, including definition of needs, existing public policies on determinants, patterns of discrimination, civil society participation, and accountability/transparency in public administration; (2) macroeconomic policy, including fiscal, monetary, balance of payments and trade policies; (3) policies affecting factors such as labor, land and housing distribution; (4) public policy in areas such as education, social welfare, medical care, water and sanitation.⁴¹

To set feasible policy goals, these general considerations should be supplemented with another, more health-specific element of contextual analysis, namely an assessment of the social value placed on health. The value placed on health and the degree to which health is seen as a collective social concern differ greatly across regional and national contexts. We have argued elsewhere, following Roemer and Kleczkowski, that the social value attributed to health in a country constitutes an important and often neglected aspect of the context in which health policies must be designed and implemented.⁴² In constructing a typology of health systems, Roemer and Kleczkowski have proposed three domains of analysis to indicate how health is valued in a given society:

- The extent to which health is a priority in the governmental /societal agenda, as reflected in the level of national resources allocated to health.
- The extent to which the society assumes collective responsibility for financing and organizing the provision of health services. In maximum collectivism (also referred to as a state-based model), the system is almost entirely concerned with providing collective benefits, leaving little or no choice to the individual. In maximum individualism, ill health and its care are viewed as private concerns.
- The extent of societal distributional responsibility. This is a measure of the degree to which society assumes responsibility for the distribution of its health resources. Distributional responsibility is at its maximum when the society guarantees equal access to services for all.⁴³

These criteria are important for health systems policy and evaluating systems performance. They are also relevant to assessing opportunities for action on SDH.

Increasingly, global institutions and processes influence the socio-political contexts of all countries, in many cases constraining the autonomy of national actors, including states. Global trade agreements, the deployment of new communications technologies, the activities of transnational corporations and other phenomena associated with *globalization* also directly impact health determinants at various levels. Hence the inclusion in the framework of globalization as a crosscutting factor with implications for all components of the model.

6.3 Levels for policy action on SDH

It will be crucial for the CSDH to identify the level(s) at which it will seek to promote change in tackling SDH through policy. The framework helps to situate these levels, clarify their relationships and suggest the scope and limits of policy action in each area. The crucial basic distinction is between policies that seek to address structural determinants, i.e., to alter the configuration of underlying social stratification, and those policies and interventions that target intermediate health determinants.

Drawing on Diderichsen et al., a typology or mapping of entry points for policy action on SDH identifies the following major options, marked by darkly shaded boxes within the framework: **social stratification**; **differential exposure/differential vulnerability**; and **differential consequences**. First is the option of altering **social stratification** itself, by reducing "inequalities in power, prestige, income and wealth linked to different socioeconomic positions".⁴⁴ For example, policies aimed at diminishing gender disparities

will influence the position of women relative to men. In this domain, one could envisage an impact assessment of social and economic policies to mitigate their effects on social stratification. Further to the right side of the framework, we see other levels where policies could engage: by decreasing people's **differential exposure** to health-damaging factors; by lessening the **vulnerability** of disadvantaged people to the health-damaging conditions they face; and by intervening through health system to reduce the **differential consequences** of ill-health. Policy options should marshal evidence for the range of interventions (both disease-specific and related to the broader social environment) that will reduce the likelihood of unequal consequences of ill health. For instance, additional resources for rehabilitation might be allocated to reduce the social consequences of illness. Equitable health care financing is a critical component at this level. It involves protection from the impoverishment arising from catastrophic illness as well as an understanding of the implications of various public and private financing mechanisms and their use by disadvantaged populations.

These issues will be explored in greater depth in a later section of the paper, on intervention and policy development models for action on SDH.

6.4. Selection of specific themes for the CSDH

Clearly, the CSDH cannot hope to address the full range of social determinants illustrated in the above framework. Reasoned choices must be made regarding specific topics on which the Commission will focus its knowledge-building activities, policy recommendations and advocacy. While the selection of themes is by no means rigidly fixed at this date, a set of proposals have been developed over the past months through research by the secretariat and the Chair, consultations with experts inside and outside WHO, and the initial discussions among Commissioners during their first meeting in Santiago. The following section outlines the thinking that has led to a specific set of recommendations regarding priority themes for the CSDH. Commissioners are invited to consider this rationale on their way to finalizing a list of themes for the Commission's Knowledge Networks, commissioned papers and other products/activities.

Some preliminary points merit attention. First, it is clear that for most if not all key SDH, precise data on the burden of morbidity and mortality directly attributable to these factors are not available. This means that a simple quantitative ranking of SDH by associated burden of disease is not yet (and may never be) feasible. (Whether such a ranking, if feasible, would be *desirable* is a separate question into which we will not enter here.) Inevitably, then, assessments of the relative importance of particular SDH must be developed in the absence of exhaustive quantitative data; all such assessments will involve a more or less openly "political" aspect.

The selection of recommended areas of work for the Commission has been strongly shaped by a concern with addressing "orphan" areas, i.e., important areas relatively neglected by previous research and heretofore insufficiently addressed by interventions. The evidence base concerning interventions on health determinants is not large.⁴⁵ However, an important finding from the available literature is that not all major determinants have been targeted for

interventions. In particular, social factors rarely appear to have been the object of interventions aimed at reducing inequity. In contrast, interventions are more frequently aimed at the accessibility of health care and at behavioral risk factors. Regarding the accessibility of health care, a majority of policies are concerned with financing. A notably high proportion of interventions are aimed at those determinants that fall within the domain of regular preventive care, including behavioral factors (individual health promotion and education). Fewer interventions have been found targeted at determinants that do not come under the direct responsibility of the health service or of public health organizations, e.g., factors in the social environment. In general, the smaller the number of determinants addressed by a particular type of intervention, the more frequently that sort of intervention is used.⁴⁶ In other words, people have an understandable appetite for simplicity. But simple models do not always lead to satisfactory results.

Interventions and policies on structural determinants of health constitute key orphan areas in the determinants field. More work has been done on intermediary determinants (decreasing vulnerability and exposure), but interventions at this level frequently target only one determinant, without relation to other intermediary factors or to the deeper structural factors. Interventions from the health system have generally been limited to issues of access, moreover focused largely on the financing component and on education activities to promote healthy behavior change. Interventions have not often had the scope to grapple seriously with the social barriers to healthy behavior. The CSDH can ensure that it brings genuine value-added to the determinants field by targeting research and advocacy on such neglected areas.

The following aspects informed the development of a proposed list of foci for the Commission:

- ✓ Themes that impact on the gradient of health inequity, that is, those areas that are closely related to the construction and maintenance of social stratification.
- ✓ Themes that incorporate a life course perspective, given the powerful impact of such factors on health inequities, linked to the possibility to address, through a life-course approach, groups facing unusually high health vulnerability.
- ✓ Themes particularly closely related to the health system and thus to the special responsibilities and opportunities of the health sector in tackling inequities in health. All themes selected should reflect policy areas in which the health sector can realistically expect to exert influence, favoring the implementation of SDH interventions and scaling up towards more comprehensive equity-oriented policies.
- ✓ Themes reflecting fast-growing health problems predominant in developing countries.
- ✓ Themes reflecting a strong concern in *all* countries, implying consequences both for developing and developed countries.
- ✓ Themes that would engage groups experiencing high exposure and vulnerability to the social determinants of health inequities.
- ✓ Themes that are already widely recognized as important SDH, such that from the start the Commission's work could focus, not on trying to convince partners of the theme's relevance, but instead on seeking and promoting effective interventions and policies to respond to the problem.

In what follows, we explore in some detail the basis for selection of each of the recommended themes, in keeping with the general criteria just outlined.

6.4.1 Focus on areas that directly impact the health gradient: gender and social exclusion.

Part of the CSDH value-added will be supporting countries not only in tackling intermediary determinants, but in implementing more ambitious policy options that can get at the deeper structural sources of health disparities. Gender and social exclusion have been identified as key structural determinants. They point to social forces that directly shape health inequities. As such, they are of central relevance for the Commission. At the same time, gender and social exclusion constitute structural determinants upon which the health system can actually intervene (directly or indirectly) and which can be incorporated into health sector programming, including but not limited to the delivery of clinical health services.

From a gender perspective, two central social determinants of health are: (1) the multiple impacts of the sexual division of labor; and (2) gender-based differential access to the resources that enable direct payment for medical services or participation in public or private insurance schemes. Both aspects are important for the analysis of gender and health equity.

Social exclusion is a major factor in shaping health inequities and is closely linked to a wide range of other SDH, as well as to social capital. The concept of social capital has increasingly been viewed as relevant to explaining patterns of health inequalities in communities. It is also informing policy and intervention options aimed at reducing health inequalities, particularly through effort and investment in building social capital in ways that can generate health benefits in socially disadvantaged communities. More broadly, policymakers increasingly view the potential of social capital for generating economic, social and health outcomes as a reason why working with communities and building social cohesion is a prerequisite to tackling deprivation and inequities.⁴⁷ Social cohesion and community engagement therefore become central for turning policy into practice. A growing body of empirical work tests the relationship between health and measures of social capital. Meanwhile, although positive effects of social capital on health have been identified, many questions remain to be addressed. Specific intervention studies may provide a way forward that allows for more precise testing of how health benefits might flow from specific elements of social capital.⁴⁸

6.4.2 Including a life-course perspective: early child development. Some studies shows that a principal explanation for the persistence and worsening of inequalities is the way in which health (both good and bad) is transmitted from generation to generation through economic, social and developmental processes, and that the advantages and disadvantages are reinforced in adult life. A life-course approach focuses on the different elements of the experience of health, from the moment of conception through childhood and adolescence to adulthood and old age. The life-course model describes the causal pathways of health inequalities and links these to broad social and economic factors as well as to studies of child development. It reveals critical points in the transitions from infancy through childhood into adult life, where an individual may move in the direction of advantages or disadvantages in health. This approach shows that mainstream policies in health, education and social welfare do not always provide enough protection for people at these crucial turning points. The patterns are not uniform, varying by social class but also by ethnicity. Social circumstances influence

health at all ages, but have particularly strong effects *in utero*, in infancy and in childhood. For many people, physical, emotional and cognitive development patterns are effectively fixed in childhood, with beneficial or harmful effects on subsequent health.

Such findings suggest that, to develop robust strategies for promoting health equity through social determinants policy, the CSDH requires a specific focus on early child development. Researchers have identified three main routes for the transmission of advantage and disadvantage through early childhood conditions and experiences: (1) poor childhood social circumstances predict poor adult circumstances; (2) poor childhood circumstances cause poor childhood health; and (3) poor adult circumstances determine poor adult health. Focusing for present purposes just on the first of these paths of transmission, we can observe that poor childhood social circumstances relate to poor adult circumstances in several ways. For example, education is still the major route out of disadvantage, but poorer children perform educationally less well than better-off children. Children not staying on in education, or not entering employment or training at 18, are a particularly high-risk group. Children from poorer backgrounds are much more likely to get into trouble with the police, to be excluded from school, or to become a teenage parent, all of which make moving up the social hierarchy more difficult. Meanwhile, analysts question whether some current policies on education, social welfare, employment, crime and health are helping solve these problems or are themselves part of the causes.^{49 50} The Commission can make an important contribution at this key intersection of health sciences, policymaking and social values.

6.4.3 Focus on areas closely connected with health systems. As previously discussed, the various models that have tried to explain the functioning and impact of SDH have not made sufficiently explicit the role of the health system as a social determinant. In some instances, the relevance of the health system has been seen as limited to its role in giving (or denying) access to preventive and curative services to vulnerable and exposed groups, particularly with regard to financial barriers. On the other hand, intersectoral action for health has at times been promoted as a major axis of health policy, with greater or less emphasis and varying degrees of success.⁵¹

Overall, the orientation of health systems policy has rarely included intervention on SDH. There is ample evidence that SDH dramatically impact health and substantially constrain the health opportunities of vulnerable groups; yet the direct, independent actions that the health system can undertake with respect to SDH are limited. What, then, should health systems do - particularly with regard to SDH and health inequities? Little guidance is currently available on these questions. This gap in knowledge and leadership represents a space in which the Commission to make a significant contribution.

Even if the health system is not itself considered as a direct determinant of health inequities, it influences how people move among the social strata. Benzeval, Judge and Whitehead argue that the health system has three obligations in confronting inequity: (1) to ensure that resources are distributed between areas in proportion to their relative needs; (2) to respond appropriately to the health care needs of different social groups; and (3) to take the lead in encouraging a wider and more strategic approach to developing healthy public policies at both the national and local level, to promote equity in health and social justice.⁵² In opting to

engage centrally with health systems, the CSDH will moreover underscore that health systems play a fundamental role, together with other social sectors, in preventing negative social consequences of ill health. It will highlight and reinforce the capacity of the health sector to place health equity goals, implying SDH actions, on the agendas of other governmental sectors.

From this perspective, two strategic themes are defined. The first, on priority public health conditions, primarily concerns the integration of SDH policies and actions into traditionally defined health programmes, such as those targeted at specific diseases. This will include aspects such as equitable access to service delivery (promotional, preventive and curative) for different health problems. In addition, a focus is recommended on health systems properly speaking, whose work will embrace intersectoral action; promoting equitable access at the systems level (including financing and the organization of services); and indirect health actions that affect SDH.

6.4.4 Focus on vulnerability and high exposure: employment conditions. Human production is the basis for both welfare and health. There is a clear correlation between gross national product (GNP) , income level, living standards and average life expectancy when nations are compared, but also notable differences in health and life expectancy between socioeconomic strata and occupational groups within nations.

Differences in working conditions and work-related health status have been reported for centuries. The spur for improvement has been the often appalling working conditions, especially for manual workers, who are likely to be poorly educated and have low incomes. Even when the health of manual workers improves, health inequalities do not necessarily diminish, as occupational groups with a better education also benefit from welfare improvements and increased economic resources. The main foci for improvements in work-related health are awareness of the health aspect in the planning of work and production; the eradication or control of known hazards; and improvements in the work environment. But even when these "classic" occupational hazards have been corrected, inequalities in health remain between higher and lower positions in the workforce, indicating the potential for further improvement.

Occupation is the most important criterion of social stratification in advanced societies and is the basis of the categorization of socioeconomic groups. Social approval depends largely on ones type of job, professional training and level of occupational achievement. Furthermore , type and quality of occupation, and especially the degree of self-direction at work, strongly influence personal attitudes and behavioral patterns in areas not directly related to work, such a leisure, family life, lifestyle, education and political activity . Research from the past two decades has demonstrated the importance of the place and content of work and their effects on coronary heart disease, mental health and musculoskeletal disorders, but many workplaces still have unacceptable safety risks and exposures.^{53 54} On the other hand , unemployment or changes in employment status have been shown to be linked to changes in health.

For the CSDH employment conditions should include both internal factors (workplace) and external factors (social, economic, governance structure and legal context) related to employment. Evidence will be provided on the health effects of internal factors including: psychological stress; physical and ergonomic risks; toxic chemical exposure; and employment conditions like income, job security, flexibility in working hours, job and task control, and employment-related migration. Evidence from a variety of different country contexts and vulnerable population subgroups such as migrants and child workers will be examined. Low self-esteem due to job insecurity and lifestyle choices associated with type of employment will also be considered. The effectiveness of engineering and administrative control measures, employment and industrial relations policy and worker safety legal frameworks—which are external factors that seek to mitigate the effects of the internal factors—will be mapped and analyzed. A concerted effort will be made to examine programmes that include workers' and labour associations in the development of interventions and policy.

6.4.5 Focus on fast-growing problems: urban settlements. Part of the Commission's opportunity to add value will involve engaging themes whose impact on global health is destined to expand rapidly in the coming years, and which have not yet registered sufficiently with the health community. The theme of urban settlements and in particular the health challenges of slum dwellers constitute a vast and growing challenge for developing countries. Interventions in this area imply the integration of actions simultaneously addressing a range of health determinants.

Urban slums are characterized as unplanned informal settlements where access to services is minimal-to-nonexistent and where overcrowding is the norm. The last ten years have seen a dramatic increase in the number of slum dwellers worldwide. Urban development has historically been seen as both a cause and solution for social inequalities in health. However, environmental and individual gradients within urban areas occur everywhere and are resistant change. Urban environments are influenced by the degree and type of industrialization, quality of housing, accessibility of green spaces and by transport, an increasing concern.⁵⁵ Slum upgrading includes: physical upgrading of housing, water and sanitation, infrastructure, and the environment; social upgrading through improved education; violence reduction programmes; better access to and improved health services; governance upgrading through participatory processes; community leadership and empowering civil society through knowledge and information.

6.4.6 Globalization. Globalization can be regarded as a social macro-determinant. As shown in the framework, global processes exert a powerful impact at all levels of the social production of health: on the evolution of sociopolitical contexts in countries; on social stratification; and on the configuration of numerous specific determinants (e.g., working conditions, food availability). Among the most relevant aspects of globalization for the work of the CSDH are: market access, trade barriers and liberalization, integration of production of goods, commercialization and privatization of public services, and consumption and lifestyle patterns.

While recent years have seen a rapid expansion of interest in globalization and health, numerous important questions remain inadequately explored.⁵⁶ By framing global processes as macro-determinants of health and health equity and marshalling the appropriate evidence to clarify these links, the CSDH can shed fresh light and open new perspectives. Above all, there is a need to identify and evaluate policy options through which national policymakers can respond to the challenges posed by globalization and capitalize on its opportunities. It is necessary to identify and characterize the degree of negative or positive health impact of globalization in specific cases: not only to clarify relevant causal processes, but as a contribution to evaluating the impact of interventions and policies on other social determinants of health. We are interested both in how global processes have shaped countries' sociopolitical contexts and in how the various modalities and tendencies associated with globalization have impacted countries' capacity to intervene successfully on other SDH. Meanwhile, the need for a new moral framework for globalization has been underscored by current actors and analysts, including the ILO-sponsored World Commission on the Social Dimension of Globalization: "The governance of globalization must be based on universally shared values and respect for human rights. Globalization has developed in an ethical vacuum, where market success and failure have tended to become the ultimate standard of behaviour, and where the attitude of 'the winner takes all' weakens the fabric of communities and societies".⁵⁷ Using its health equity framework, the CSDH will identify policies that can foster a more equitable distribution of globalization's benefits and a fairer portioning-out of opportunities for human flourishing.

7. Intervention and policy development models for action on SDH

The CSDH will consolidate evidence around its thematic foci not just to strengthen the scientific knowledge base, but above all to catalyze action. Action in this context primarily means public policies and interventions to tackle health inequities via SDH. To guide policy development, the type of schema presented above -- which shows the levels of SDH and their pathways of causal influence -- must be combined with a mapping of political structures, opportunities and processes. In other words, a scientific "imaging" of the way social determinants differentially impact health must be overlaid with a political grid. The result would be a comprehensive framework that could both locate the real sources of health problems at the social level (accurate diagnosis) and help identify politically workable solutions (effective prescription).

Our review of the literature has identified three particularly suggestive models for intervention and policy development on SDH. We will analyse these three proposals in turn. Throughout, it will be useful to recall the distinction between specific *interventions* (e.g., an innovative health education programme or a change in the organization of a screening programme) and broader *policies* (e.g., changes in income distribution or in the government mechanism for allocating health care resources).

7.1 K. Stronks framework

This model was proposed in the context of the Dutch national research programme on inequalities in health.⁵⁸ The programme report highlights three phases of analysis for the implementation of interventions and policies on SDH:

- ✓ **Phase one** involves filling in the social background on health inequalities in the specific country or socioeconomic context. The impact of each social determinant on health varies within a given country according to different socioeconomic contexts. Four intervention areas are identified:
 - The first and the most fundamental option is to reduce inequalities in the distribution of socioeconomic factors or *structural determinants*, like income and education. An example would be reducing the prevalence of poverty in the lowest socioeconomic groups.
 - The second option relates to the specific or *intermediary determinants* that mediate the effect of socioeconomic position on health, such as smoking or working conditions. Interventions at this level will aim to change the distribution of such specific or intermediary determinants across socioeconomic groups, e.g. by reducing the number of smokers in lower socioeconomic groups, or improving the working conditions of people in lower status jobs.
 - A third option addresses the *reverse effect of health status on socioeconomic position*. If bad health status leads to a worsening of people's socioeconomic position, inequalities in health might partly be diminished by preventing ill people from experiencing a fall in income, e.g., as a consequence of job loss. An example would be strategies to maintain people with chronic illness within the workforce.
 - The fourth policy option concerns the delivery of *curative healthcare*. It becomes relevant only after people have fallen ill. One might offer people from lower socioeconomic positions extra healthcare or another type of healthcare, in order to achieve the same effects as among people in higher socioeconomic positions.

- ✓ **Phase two** of the analysis concerns effectiveness. Having identified the possible strategies to tackle health inequalities, one must form an idea of the effectiveness of those strategies. There is clearly a lack of evidence on the effectiveness of interventions to reduce inequities in health. Reviews have shown that many interventions have been undertaken, including health promotion and measures within the healthcare sector. However, only a few them have been evaluated with respect to their effect on the size of socioeconomic inequities in health.⁵⁹

- ✓ **Phase three** looks at political feasibility. The question is: can one actually implement a given intervention in daily practice? Could it be scaled up to constitute a realistic policy? Enabling factors, opportunities and potential barriers to a specific policy or intervention must be clearly identified: examples would include legal constraints, norms and values, financial barriers, etc. A certain intervention judged successful in one country might not fit with the cultural norms of other countries, such that its implementation there might not yield the predicted positive effects.

7.2 M. Whitehead and G. Dahlgren framework

The framework proposed by Whitehead and Dahlgren indicates four interrelated levels to which policies can be addressed: strengthening individuals; strengthening communities; improving access to essential facilities and services; encouraging macroeconomic and culture change.⁶⁰

- ✓ The first level is strengthening individuals. Here, policy responses are aimed at supporting individuals in disadvantaged circumstances, using person-based strategies. These policies adopt the premise that building up a person's knowledge, motivation, competence or skills will enable them to alter their behavior in relation to personal risk factor, or to cope better with the stresses and strains imposed by external health hazard from other layers of influence. Examples would include stress management education for people working in monotonous conditions; counseling service for people who become unemployed to help prevent the associated decline in mental health; and supportive smoking cessation clinics for women with low incomes. The potential effect of this policies would be more indirect - counseling services for people who are unemployed are not going to reduce the unemployment rate, but may ameliorate the worst health effects of unemployment and prevent further damage.
- ✓ The second level is concerned with strengthening communities. This is focused on how people in disadvantaged communities can join together for mutual support and in so doing strengthen the whole community's defense against health hazards. The community development strategies at this level recognize the intrinsic strength that families, friends, voluntary organizations and communities can have , over and above the capabilities of individuals working in isolation. These policies recognize the importance to society of social cohesion, as well as the need to create conditions in deprived neighborhoods for communities dynamics to work.
- ✓ The third policy level focuses on improving access to essential facilities and services. These policies tackle the physical and psychosocial conditions in which people live and work, ensuring better access clean water, sanitation, adequate housing, safe and fulfilling employment, safe and nutritious , food supplies, essential health care, educational services and welfare in times of need. Such policies are normally the responsibility of separate sectors, often operating independently of each other but with the potential for co-operation. In this point is necessary program or action integrated.
- ✓ The fourth policy level is aimed at encouraging macroeconomic or cultural changes to reduce poverty and the wider adverse effects of inequality on society. These include macroeconomic and labors market policies, the encouragement of cultural values promoting equal opportunities and environmental hazard control on a national and international scale.

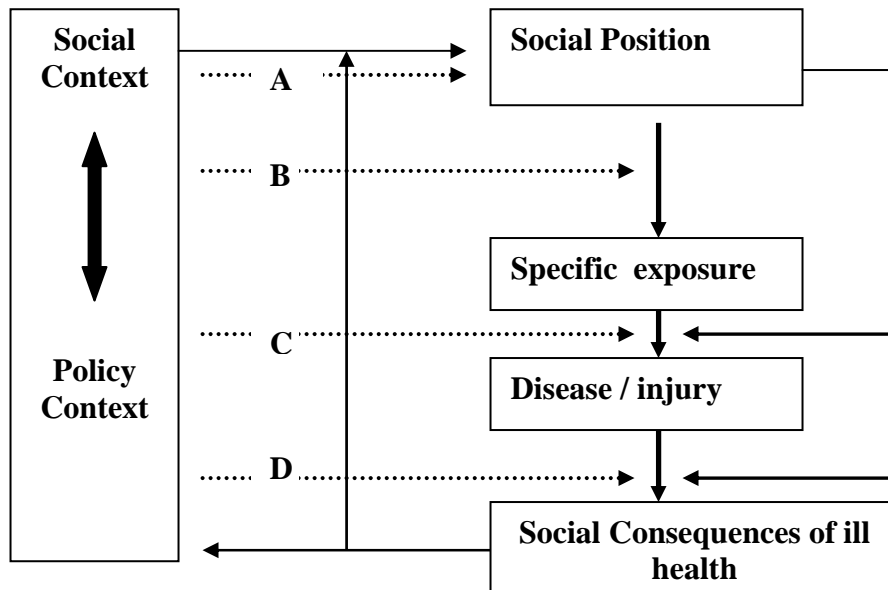
7.3 Diderichsen et al. framework

As mentioned above (section 5.2), the Diderichsen model identifies four entry points or levels of action for interventions and policies: influencing social stratification; decreasing differential exposure to health-damaging factors; decreasing vulnerability; and preventing unequal consequences of ill health that can deepen social inequities.

- ✓ Decreasing **social stratification** itself. While social stratification is often seen as the responsibility of other policy sectors and not central to health policy per se, Diderichsen and colleagues argue that addressing stratification is in fact "the most critical area in terms of diminishing disparities in health". They propose two general types of policies in this entry point: first the promotion of policies that diminish social inequalities, e.g., labor

market, education, and family welfare policies; second a systematic impact assessment of social and economic policies to mitigate their effects on social stratification. In the figure below, this approach is represented by **line A**.

- ✓ Decreasing the **specific exposure** to health-damaging factors suffered by people in disadvantaged positions. The authors indicate that, in general, most health policies do not differentiate exposure or risk reduction strategies according to social position. Earlier anti-tobacco efforts constitute one illustration. Today there is increasing experience, however, with health policies aiming to combat inequities in health that target the specific exposures of people in disadvantaged positions, including aspects such as unhealthy housing, dangerous working conditions and nutritional deficiencies. In the figure, this approach is represented by **line B**.
- ✓ Lessening the **vulnerability** of disadvantaged people to the health-damaging conditions they face. An alternative way of thinking about modifying the effect of exposures is through the concept of differential vulnerability. Intervention in a single exposure may have no effect on the underlying vulnerability of the disadvantaged population. Reduced vulnerability may only be achieved when interacting exposures are diminished or relative social conditions improve significantly. An example would be the benefits of female education as one of the most effective means of mediating women's differential vulnerability. This entry point is shown below by **line C**.
- ✓ Intervening through the health system to reduce the **unequal consequences of ill-health** and prevent further socioeconomic degradation among disadvantaged people who become ill. Examples would include additional care and support to disadvantaged patients; additional resources for rehabilitation programmes to reduce the effects of illness on people's earning potential; and equitable health care financing. This entry point appears in the figure as **line D**.



7.4. Synthesis: key policy principles

The intervention frameworks just reviewed should be seen in the light of our earlier discussion on health disadvantage, gaps and gradients (section 4). Following Graham, we argued that improving the health of poor groups and narrowing health gaps are necessary but not sufficient objectives. A commitment to health equity ultimately requires a health-gradients approach. A gradients model locates the cause of health inequalities not only in the disadvantaged circumstances and health-damaging behaviors of the poorest groups, but in the systematic differences in life chances, living standards and lifestyles associated with people's unequal positions in the socioeconomic hierarchy.⁶¹ While interventions targeted at the most disadvantaged may appeal to policymakers on cost grounds or for other reasons, an unintended effect of targeted interventions may be to legitimize poverty, making it both more tolerable for individuals and less burdensome for society.^{62, 63, 64} Health programmes (including SDH programmes) targeted at the poor have a constructive role in responding to acute human suffering. Yet the appeal to such strategies must not obscure the need to address the structured social inequalities that create health inequities in the first place.⁶⁵

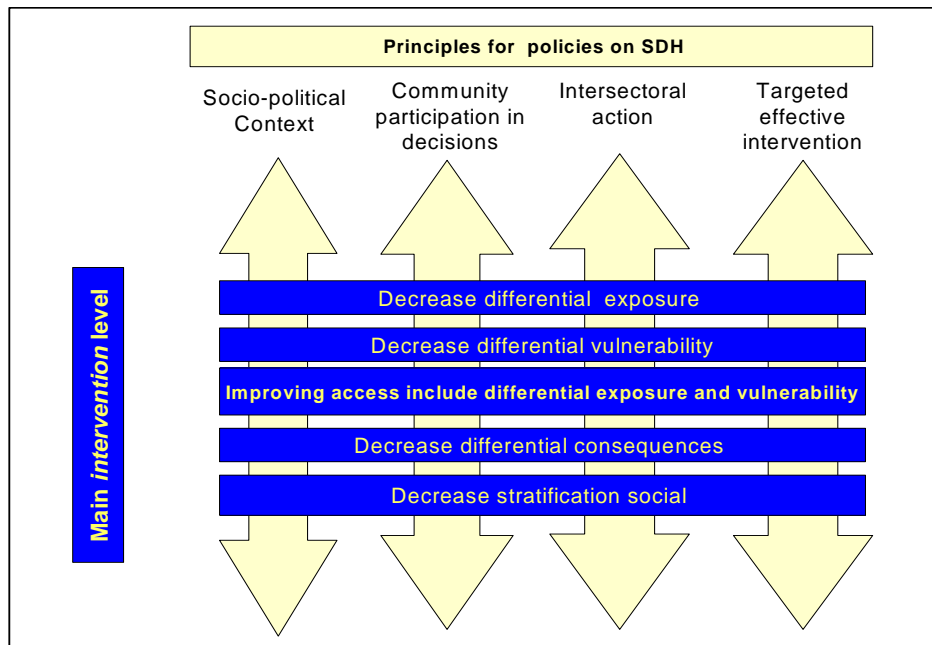
Health equity is not only about good or bad health outcomes. It fundamentally concerns health *opportunities*. These opportunities must be considered in the elaboration of interventions and policies addressing SDH. This means asking what interventions and policies most effectively promote health opportunities. Are health opportunities best enhanced by focusing action on the groups that are currently most severely affected in terms of health outcomes? Where does such an approach leave those groups that, without being among the most severely affected, experience vulnerability in terms of health opportunities? In the medium term, such vulnerable groups will begin to reproduce the health results now seen in the groups with the worst outcomes. Among groups suffering vulnerability in terms of health opportunities, will we find only people with very low incomes, women or people with certain ethnic or religious backgrounds? The social patterning of health opportunities is highly complex. This is why inequity gradients in SDH cannot be excluded when governments set objectives and build programmes. Including these gradients as an explicit area of policy action can assure that interventions and policies have an impact on health opportunities.

Specific interventions are selected and shaped according to more overarching policy frameworks. Thus, in addition to identifying potential intervention levels on SDH, principally following Diderichsen et al., we believe it is necessary to specify the policy principles within which interventions are implemented. The principles or modalities highlighted involve: intervening upon and shaping the socio-political context; developing policies from the standpoint of the community, with community participation in decision-making; developing intersectoral action, including the incorporation of SDH actions emanating from non-health sectors; and the prioritization of actions proven genuinely effective in tackling health inequities.

The figure below summarizes these ideas. The horizontal arrows mark the levels of intervention on SDH. Here, these levels are placed in relation to the policy modalities that can or should be implemented. The vertical arrows identify four policy principles we believe

are essential from the perspective of the CSDH. The first underscores the need for responsiveness to the socio-political context of each country and region. This is a central element for the development of policies adapted to the real capabilities of developing countries and not shaped according to pre-determined recipes. The second vertical arrow represents the principle of community participation in decision-making, underscoring as a central aspect of the CSDH the inclusion and participation of civil society. The third arrow represents intersectoral action, implying not only policies and actions managed from within the health sector, but also the integration of interventions and actions by other sectors that have included contributing to health within their goals. Partner sectors will likely include education, transport and housing, among others. The fourth vertical arrow recalls the need to focus on effective interventions: action based on evidence, evidence for action.

Diagram: new action on pathways and policies ⁶⁶



8. Conclusion

This draft paper has sketched a framework on social determinants of health intended to catalyze discussion within the CSDH. The paper in its present form is of course not a finished product, but a tool to stimulate shared thinking and advance debate. It is a step in a process whereby Commissioners, supported by the CSDH secretariat, will reach shared understandings on a set of fundamental conceptual issues important for the coherence and efficacy of the Commission's work. The paper has sought to clarify the concept of social determinants; to suggest a coherent values basis for action on SDH rooted in health equity; and to sketch a model locating intervention levels and entry points for policy action on SDH.

The key element of the framework presented here is the distinction drawn between structural and intermediate social determinants of health, also thought of as social determinants of *health equity* and more specific determinants of *health*. As we have noted, the feasibility of directly impacting health inequities requires intervention on structural determinants. However, such action will demand profound and possibly quite slow processes of social change and will only yield results in the long term. When will these processes begin? Are they even possible? Skepticism regarding the current feasibility of fundamental change is understandable. This being the case, if it is not possible to act directly upon the structural determinants, might one be able to identify pathways to influence them indirectly? The actions that can be undertaken by the health system have major relevance in this regard. It may be possible to influence and model the system in such a way as to bring us closer to the capacity to directly address the social determinants of health inequities.

The sustainability of health sector-led interventions on SDH and the underlying policy structure are inseparably related. It is not possible to maintain continuity in SDH interventions (e.g., incorporation of SDH into health programmes, intersectoral actions and programmes) if such interventions are not supported by broader, enabling government policies in the health sector and the whole range of other sectors. At the same time, a broad policy approach incorporating social determinants will not have any real impact if is not translated into specific, concrete interventions that apply these ideas at national and local levels. For the health sector, this final point implies a new perspective on the elaboration of goals and plans and on the deployment of health actions.

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