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Social determinants of health – a cross-cultural perspective

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The publication and broad discussion of the WHO-report on "Social Determinants of Health" reflects a significant development within international public health policy. While previously priorities were mainly set on specific health problems such as certain infectious diseases, nutrition-related health, maternal health or access to health care services the current focus addresses core societal factors that account for unequal chances for good health across populations. During the past three decades epidemiological and sociological research has established convincing evidence on social inequalities in health and has developed major explanatory frameworks[1–3]. Although some countries have recently implemented national health policy programs that take into account the economic and psychosocial dimensions of unequal health[4], there still exists a large gap between public health science and health policy.

This gap may even widen with the advent of economic globalisation where new challenges emerge. On the one hand, economic growth provides opportunities of reducing health inequalities by improving health care and public health conditions in rapidly developing countries. On the other hand, new health risks emerge with urbanisation, rapid social change, 'westernisation' of life styles and chronic psychosocial stress related to changing work and employment conditions, family life and social relationships.

In this context the question arises what rapidly developing countries can learn from western societies in terms of recognizing, explaining and reducing social inequalities in health. Is the knowledge accumulated in the West valid in different cultural contexts? It has been repeatedly stressed that modernization is rooted in European late medieval and early renaissance developments which favoured the rise of modern capitalism, technological and scientific progress together with the transformation of political power. Starting with the industrial and political revolutions of the late 18th and early 19th century, the process of industrialization expanded beyond North-Western Europe to include the United States and other regions of the world over the past hundred and fifty years. This process was paralleled and, in part, influenced by specific cultural norms and attitudes stressing values such as personal achievement and individual autonomy or independence. In meritocratic societies, achieved social status to a considerable extent became contingent on personal performance, thus blaming those at the bottom of the societal structure. Achieved social status in combination with economic success was considered a strong driving force of one's social identity. It may be assumed that the appraisal of social inequality, its meaning and significance varies according to cultural norms and attitudes. Moreover, it is not certain whether the theoretical concepts explaining the link between social inequality and health that were developed in modern western science can be applied to observed social differences in health in societies with markedly different cultures and traditions.

Given these rather fundamental issues, the promotion of trans-cultural explanatory research on social inequalities in health in developing countries – which currently is still in its infancy – deserves high priority. Several preliminary findings are available that support this case. For instance, in a comparative study on conflict between work and home in Japan, Finland and Britain it was found that Japanese women had the greatest conflicts and poorest mental health while Finnish women had the lowest conflict and best mental health[5]. The former finding was interpreted in the context of powerful traditional gender attitudes to domestic labour in the Japanese culture which, in addition, may vary according to the women's social standing. Yet, there are also cases documenting the trans-cultural reliability and validity of measurements of theoretical models with relevance to the explanation of unequal health, such as control at work and at home, social support, or reciprocity of efforts and rewards in social exchange.

Recent investigations demonstrate for instance that models of a stressful psychosocial work environment can be reliably measured in a number of Asian cultures and that their contribution towards explaining health variations is well comparable to the one reported in western studies[6–8].

In times of accelerated economic, technological and cultural globalisation it will be important to investigate the cross-cultural generalisability of existing explanatory models of social inequalities in health and to draw respective conclusions for policy recommendations.

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