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Editorial

Social determinants and adolescent health

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The Oxford English Dictionary defines "quixotic": of an action, attribute, idea: characteristic of or appropriate to Don Quixote; demonstrating or motivated by exaggerated notions of chivalry and romanticism; naively idealistic; unrealistic, impracticable; (also) unpredictable, capricious, whimsical.

When the Commission on Social Determinants of Health (CSDH)[1] published its final report the Economist described our commitment to equity as quixotic. Clearly, we had exaggerated notions of chivalry and romanticism. It is true that the Commission situated the causes of ill health and the population distribution of ill-health in the conditions of daily life and in the unfair distribution of power, money, and resources that gives rise to mal-distribution in those conditions. How capricious! How whimsical! The CSDH drew attention not just to the causes of illness in, for example, people's behaviour, but to the causes of the causes: the economic, social, cultural and environmental determinants of those behaviours. How naively idealistic! How unrealistic!

Perhaps I'm being unfair. The Economist was not referring to our analysis as quixotic, but wanting to act on that analysis. Don Quixote tilted at windmills because, in his distorted view, he imagined them to be something other than they were. We would argue – how could we not? – that the Commission on Social Determinants of Health saw the health inequities within and between countries without distortion, saw clearly where the potentially remediable causes lay, and proceeded from a strong position of social justice in wanting to remedy them. If all of that is romantic idealism then, on behalf of my fellow Commissioners, I plead guilty as charged.

The CSDH emphasised the causes of the causes – a theme consistent with the Health and Behaviour in School-aged Children Study. In her paper in this issue Candace Currie emphasised that the perspective of the study was "one in which adolescent health related behaviours were seen as part of young people's broader lifestyle and health viewed in social context. The wider society and the social domains that adolescents inhabited were considered important influences on behaviour."

The papers in this volume form a rich collection illustrating three themes that were part of the learning that formed the basis of the CSDH report.

Where's the individual?

One reaction to a Commission, and a report, emphasising the social determinants of health is that we seem to have forgotten individual agency. This is an old debate that goes back to the origins of health promotion. Individuals drink and smoke and have risky sex. Surely it is their right to chose to be healthy or otherwise.

There should, of course, be no conflict between a view that emphasises social determinants and one that privileges individual choice. The CSDH put empowerment at the centre of its focus. Amartya Sen, a member of the Commission, emphasises the freedom to be and to do: to live lives we have reason to value. Freedoms are central to his work. There may be need for some intellectual heavy lifting to distinguish among agency, empowerment, having control over one's life, enjoying fundamental freedoms, and Sen's capabilities and functionings. That said, they all put at the centre individuals having freedom to live flourishing lives. But, and it is a theme that runs through this volume on health behaviour in school children, freedom to choose is influenced by the circumstances in which people find themselves. A perspective that emphasises only individuals making choices has to account for the regularities of patterns observed. If individuals were simply making choices, regardless of where they lived or the sociocultural influences on them then the proportion of 15 year olds skipping breakfast or having sexual intercourse (no connection implied) would be the same everywhere. But it isn't. The proportions vary markedly by country.

Knowing that there are important sociocultural influences on behaviour does not imply what "ought" to happen. But if the data show that skipping breakfast, to choose the less sensitive of the two examples, is bad for health – increases obesity for example – knowing that there are systematic differences is the start in a process of deciding what might be done.

Start early

The CSDH report has a chapter entitled equity from the start. It builds on the report of the Commission's knowledge network on Early Child Development[2]. It makes the case that action on the social determinants of health should start at the beginning and continue throughout life. The health behaviours and, indeed, the health status of the young people included in the HBSC study is a likely harbinger of things to come. The contribution of Ravens-Sieberer et al.[3] in this supplement shows that already at age 15, for example, there is a socioeconomic gradient in health. At this age one can observe the link between physical activity, sedentary behaviour and obesity.

Alcohol consumption, and associated problems, provide another example. In Britain, it is common to look across the English Channel and comment that the French introduce alcohol to children in the family context; hence although young French people drink they do it more sensibly than young English. That would imply that the French would be more likely to drink but less likely to get drunk than the English. The data do not bear this out. The brief report by Simons-Morton et al.[4] shows that 15 year old English boys and girls are more likely to have drunk alcohol in the past month than their French counterparts; and much more likely to have been drunk more than once.

Given that alcohol consumption, per adult 15 and over, has been rising in the UK and falling in France, these data on 15 year olds suggest problems for the future.

Lives not just risk factors

A third clear message to come from this collection of papers is the inter-connectedness of the lives of these school children. Mental and physical health, health behaviours, relation with parents and peers are all of a piece. Yes, we may worry about smoking, and obesity, and alcohol consumption, but they are just part of these young people's lives. The CSDH called for action on the conditions of daily life: the circumstances in which people are born, grow, live, work, and age.

The papers here give a nuanced insight into the character of these lives of 15 year olds – the similarities and differences across cultures. By themselves these papers do not tell us what should happen next. They are, however, an important part of understanding, which surely must be the basis for informed debate about what should happen next.

In this context it is worth considering a recent paper by Morgan and Ziglio[5] that focuses on the positive rather than the negative. We are, in public health and medicine, used to focussing on the negative: unhealthy behaviours, risk conditions, disease. Morgan and Ziglio call, in addition for a focus on assets, on positive aspects of communities and individuals that protect from disease. Bartley and colleagues have led a programme of work on resilience[6]. Its purpose was to discover what keeps people from succumbing despite adversity.

This brings us back to the CSDH and Sen's freedoms. Certainly we need to analyse and take action on the causes and the causes of the causes of ill-health. But, too, we should pay attention to the conditions that empower people and enable them to lead flourishing lives.

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