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EDITORIAL

The social determinants of what?

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There was much excitement over the final report of the WHO Commission on Social Determinants of Health (2008) and there was good reason for it. The report underscores the enormous strides made in public health research over the last 40 years. For students entering the field of public health in 2010 it may seem self-evident that social factors influence health; the rhetoric is now commonplace in many parts of the world, although not in all. We must not forget, however, that what now seems "evident", such as the claim that socio-economic status (SES) influences health in individuals and groups, was not always common knowledge. Pioneers of the social epidemiology movement worked long and hard to convince the medical establishment, and adherents to the individual risk factor model, that social conditions matter when it comes to health. We have indeed come a long way.

There remains imprecision, however, in the study of social determinants of health. One of these issues will be the topic of this commentary. I focus specifically on the blurring of "the social determinants of health" with "the social determinants of *inequalities* in health". I will also briefly discuss the importance of capability theory (Sen 1992) in helping to distinguish the two.

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It has been argued that the "social determinants of health" concept has acquired a dual meaning referring *both* to the social factors promoting and undermining the health of individuals and populations as well as to the social processes underlying the unequal distribution of these factors between groups occupying unequal positions in society (Graham 2004). This blurring of the two is a fundamental problem that goes well beyond mere questions of nomenclature.

When we refer to the social determinants of health we are concerned with the overall effect of some social phenomenon on the health of individuals or populations. These determinants are currently seen to include socio-structural influences, such as living and working conditions, as well as social practices such as smoking, exercising, drinking alcohol, etc. When intervening on the social determinants of health we seek to create positive trends in them, such as increasing living standards and reducing smoking, for example. This approach has often associated with the population health approach of Geoffrey Rose (1984) who suggested that the greatest gain in health is experienced when every member of a population improves her status on the determinant of concern.

Recent debate, however, has suggested that this particular policy focus on social determinants of health may well improve the *average* level of health of a population, but may do little for, or may even worsen social inequalities in health (Frohlich and Potvin 2008). So for instance, policies focused on reducing smoking rates in the general population have been successful in bringing population smoking levels down but are believed to be aggravating the social distribution of smoking along SES lines (Smith et al. 2009).

I surmise that part of this unintended consequence is due to an oversight by those of us swayed by the population

approach. The population approach functions on the logic that through population interventions everyone's risk exposure in the distribution is shifted to the left (i.e. reduced) by the same amount, regardless of one's initial position in the risk exposure distribution. What is missing from this argument is the fact that not every member of the society has access to the same level of health promotion resources and capabilities that would permit them to respond equally to these population interventions. For instance, most public health innovations are taken up first by those members of society who are the most privileged, not always to be followed by their more disadvantaged peers, who are left behind.

In this sense the Commission's second overarching recommendation that societies should "tackle the inequitable distribution of power, money and resources" is pathbreaking. In effect, the Commission recommends that in order to tackle the social inequalities in health we need to shift public policy away from its traditional focus on health outcomes to reducing the inequalities in the distribution of social determinants (Frohlich et al. 2006; Graham 2004). This means that we not only need to shift focus from disease to the social causes of diseases, but we also need to understand how it is that these social causes are unequally distributed (Potvin 2009). Amartya Sen (1992) offers a convincing argument, based on his capability theory, that resource distribution alone cannot be simply based on the *amount* of resources given to each individual, but rather, on *what* people are actually able to do with these resources. So, for instance, children from privileged backgrounds, with parents who have professional jobs and high incomes, derive more benefit from their right to free public education than children from poorer families; they are better able to convert their years of compulsory schooling into more educational qualifications and thus higher status jobs and higher incomes.

I applaud the work of all of us working fervently to improve health by addressing social determinants. Work is needed on both fronts: the social determinants of health as well as the social determinants of inequalities in health. We should, however, be clear as to exactly what we desire for both of these agendas have important, but different, outcomes.

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