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EDITORIAL

Towards the social in the social determinants of health

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Public health researchers and professionals have understood for quite a while that influencing social determinants of health requires a comprehensive, multi-faceted action. The WHO Commission on Social Determinant of Health provides a useful summary of the challenges that we are facing with global health inequalities. The global perspective is described concisely by Denny Vågerö from the Commission (Vågerö 2008). Yet, our recommendations, policies and practices have tended to focus on end of the policy spectrum that rests on influencing the individual. This is mainly due to the inherent nature of many of the models applied and developed in health research. We tend to concentrate on facilitating (health-enhancing) individual choices, assuming an informed choice. A similar ill-founded assumption of informed choice underlies in the model of 'an economic man' applied by the economists.

Diversions from these models have arisen from frameworks that take into account the (life) chances people have in realizing their aspirations and better health. Indeed, there are models that arise from the more sociologically oriented conceptual spectrum. To take but one example, Anthony Giddens (2006) has recently developed a social model that aims at tackling social risks typical of 'post-scarcity situations'. Among the social risks he includes 'lifestyle habits' suggesting that these are the source of many of 'the diseases of affluence'. As these diseases become more and more prevalent, a comprehensive reorientation of the welfare state is required. This is an orientation towards positive welfare that requires lifestyle changes by consumption-oriented individuals, not so much action towards alleviating sickness or abolishing disease. These individuals operate in markets that Giddens calls decisionable, in other words in a society in which people are forced to take continuously decisions based on varying degrees of information.

While such models may fruitfully expand the perspectives traditionally available in public health research, again there features an imminent view of individuals and in some cases social groups taking more or less reasoned decisions. Even though these conceptualizations typically widen the perspective by including social context as an influential agent in the model, the public health policy based on these notions focuses on providing individuals more and better chances of 'doing the right thing'.

A more comprehensive approach would take as its point of departure those aspects of the societal reality that are precisely social. In other words, this would imply that in addition to discussing, specifying or assessing what are the factors that determine health, health care and health-related behavior, there is a need to complement this framework with a thoughtful insight of what is social about them: the societal processes that produce social hierarchies and power differences.

There can be little doubt that the research tradition that has identified social determinants of health is among the great success stories of social sciences over the past decades. And, as methodological approaches and data sources develop we will most probably witness even greater advances in this field as, for that matter, we shall gain

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better understanding of such issues as how, e.g., social class goes ‘under the skin’ (see also Potvin 2009).

However, unless we are able to move beyond these already classic research questions, the promise of the social determinants approach will not be fulfilled. This implies among other things asking what social class is about in the present day post-scarcity societies. Also, the association of poverty and health is relatively poorly understood. Longitudinal studies on poverty have shown that being poor is far from a stable condition (Moisio 2004). Rather, there is considerable fluctuation over time in and out of poverty. Yet, rarely has the role of health in this process been analysed. Equally, we know that health status influences an individual’s chances of moving up in the social hierarchy. However, few studies have explored whether social mobility affects health (Koivusilta et al. 2003) or if there are health-related intergenerational effects on mobility. The latter refers, e.g., to such effects as to whether social inheritance of occupational status is associated with health in the family. Furthermore, given that much of the observed health differences result from poor health among the most vulnerable population groups, better understanding is needed of the way poor health is embedded in other forms of deprivation.

Gaining insights in these issues would also provide clues to necessary policy implications. According to my assessment also these would have to lie more on the side of the spectrum of means and policies that focuses on the level of societies and communities. Even though it remains unclear which measures would be most efficient, the issues to be tackled will have to do with the sufficient level and nature of social security in alleviating deprivation and poverty, decreasing income inequalities in providing a socially more sustainable society and removing differences between population groups (ethnic, regions, social class, gender, etc.) in access to education and health care.

Such a research program would not have to start from scratch. Seeds for this were already sown by the Ottawa Charter (1986), but over the years other aspects of the Ottawa perspective gained more emphasis. It is good to see the WHO Commission has taken the initiative to this direction. Now it is up to the policy-oriented scientific social and public health researchers, governments, politicians, policy-makers and other relevant actors to take these matters seriously. In addition to a re-orientation in research, there is a growing need of a comprehensive assessment of the potential of distributive social policies in affecting the social determinants of health.

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