

Reflections

Social Determinants of Health

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In February 2005, when I was contacted by telephone by Sir Michael Marmot to discuss the possibility of my serving on the still to be announced Commission on Social Determinants of Health of the World Health Organization, I had no idea who he was. I was familiar with the 1980 Black Report as well as Margaret Whitehead's 1987 follow-up report, *The Great Divide*, which I used in my courses. I knew a bit about the Whitehall Studies I and II but did not follow their scientific publications. However, as far back as 1993, in speeches on women's health, I had referred to and discussed the social determinants of women's health. Gender, poverty, violence. I knew the words. I did not know the science behind them nor the research evidence.

So I Googled Sir Michael Marmot to get to know him and his work. One of the very first texts I accessed was a long interview with Marmot, conducted in March 2002 by Professor Harry Kreisler of the Institute of International Studies at the University of California at Berkeley. I was fascinated. An internationally known scientist, a physician with impeccable credentials in epidemiology who had been a clinician in a cardiac clinic and a chest clinic — a “British empiricist,” as Marmot calls himself — addressing the societal role in health, discussing individual versus societal causation of disease? I could not believe what I was reading. And right then, before we had met as a Commission and before I had met Sir Michael, what surprised me most was his observation that, besides the classical factors leading to pathologies, much had to do with the degree to which people are able to participate fully in society. “We found clear social gradients in people's participation in social networks,” he added. That was a very surprising observation, as the first Whitehall study was set up as a rather conventional study of risk factors for cardiovascular and respiratory disease in male British civil servants.

In a recent interview for the excellent PBS series *Unnatural Causes*, Marmot said:

We have strong evidence that there are two important influences on health in explaining the hierarchy in health. The first is autonomy,

control, empowerment. . . . The second is what I loosely call social participation. It's being able to take your place in society as a fully paid-up member of society, as it were, to benefit from all that society has to offer. Now, in part that's social supports and social networks, but it also functions at a psychological level. It's self-esteem; it's the esteem of others. It's saying that I can benefit from the fruits that society has to offer.

So it is not surprising that the Commission, having decided from the start to have eight so-called knowledge networks — international research teams, each working on a specific determinant of health — had one on Social Exclusion. We could have easily identified a dozen different determinants, but we focused on those eight. Jennie Popay, Professor of Sociology and Public Health at Lancaster University, chaired the knowledge network on Social Exclusion, which released a report titled *Understanding and Tackling Social Exclusion (A Person Is a Person Because of Other People)*. The report discussed country case studies both of situations and of processes of social exclusion as well as good practices in different parts of the world, and it offered recommendations to the Commission for our own final report.

As pointed out by the research team, the concept of social exclusion/inclusion overlaps with related concepts such as social cohesion, social capital, social justice, and social/human rights, as well as constituent elements of these concepts such as empowerment, emancipation, disaffiliation, and marginalization. The concept of social exclusion/inclusion speaks directly to the theme of this journal issue: social support, social networks, and health.

A proverb of the Nguni people (parts of eastern and southern Africa), “A person is a person because of other people,” which is used as the subtitle of the knowledge network report, captures the most fundamental piece of wisdom. Like the report itself, it focuses “on the central role of relational interdependence in the working of any social system.” It also makes explicit the individual and collective self-interest inherent in pursuing actions to promote inclusion. Here is the summary of the conceptual approach taken by the knowledge network research team as it appears in their report (p. 8):

- The concept of social exclusion is not equally salient around the world: alternative discourses may have greater relevance for policy and action.
- A relational understanding of social exclusion has advantages:
 - Providing a wider lens to understand the causes and consequences of unequal power relationships
 - Making explicit the links between exclusion and a “rights” approach to the social determinants of health

- Directing analytical attention to interactions between relationships and outcomes at different levels e.g. community, nation state and global regions
- Highlighting both active and passive exclusionary processes
- Recognising that exclusionary processes will impact in different ways to differing degrees on different groups and/or societies at different times
- Avoiding the stigma of labelling particular groups as “excluded”
- Allowing for the possibility of inequitable inclusion and extreme exclusion
- Acknowledging the potential for groups and/or nations to actively resist exclusionary processes and ensuing negative consequences
- Recognising diversity and hence providing for global relevance
- Both constitutive and instrumental pathways link SE to health inequities:
 - Constitutively: restricted participation in economic, social, political and cultural relationships will negatively impact on health and well-being.
 - Instrumentally, these restrictions result in other deprivations, for example, poor working conditions or complete exclusion from the labour market leading to low income, poor nutrition, etc which contribute to ill health.

A few additional observations. Social exclusion is often equated with, and reduced to, poverty. In fact it is much more than poverty, although poverty is often a part of it. How has the Commission on Social Determinants of Health dealt with these interrelated issues? We stated from the start our three principles of action embodied in our three overarching recommendations:

- Improve the conditions of daily life — the circumstances in which people are born, grow, live, work, and age.
- Tackle the inequitable distribution of power, money, and resources — the structural drivers of those conditions of daily life — globally, nationally, and locally.
- Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

At first glance, the importance for health of social support networks made up of friends, family members, and peers (not to diminish the key role of support groups, which are usually structured around a single issue) appears to pertain to daily living conditions. In fact social support networks have both an individual and — even more important — a societal dimension. Consequently, in its final report the Commission points to

the need to develop political empowerment, inclusion, and voice as overall structural changes — a societal responsibility as opposed to a daily living condition. It should be kept in mind that the report, being international, is addressing vastly different situations. In some countries the ability to develop social support networks requires, first and foremost, a basic respect for human rights. Inequity being at the root of our work, the chapter on social exclusion discusses issues of power imbalance, identity, and fairness in political representation and in decision-making generally. It also points to the importance of the growth of civil society organizations, networks, and movements “and their progressive ability to challenge inequity and push for the installation of equity — in general and in relation to health — in the centre of all existing and emerging political debates.” Above all, it takes a bottom-up approach to health equity and speaks to the power of the local community.

We do know that solidarity between neighbours, friends, family members, and colleagues has an effect on health status and outcome. It nurtures a sense of belonging. Spending time with people helps ward off loneliness. It also increases one’s sense of self-worth. Finally, it enhances one’s feeling of security. By reaching out and sharing with others, people have the added security of knowing that if they start to show signs of depression or an unhealthy lifestyle, their friends will alert them to the problem.

We have enough evidence to initiate action. This is not to say that additional monitoring, research, and capacity development are not needed.

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