





# A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

**Social Determinants of Health Discussion Paper 2** 

DEBATES, POLICY & PRACTICE, CASE STUDIES

## A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

#### The Series:

The Discussion Paper Series on Social Determinants of Health provides a forum for sharing knowledge on how to tackle the social determinants of health to improve health equity. Papers explore themes related to questions of strategy, governance, tools, and capacity building. They aim to review country experiences with an eye to understanding practice, innovations, and encouraging frank debate on the connections between health and the broader policy environment. Papers are all peer-reviewed.

#### **Background:**

A first draft of this paper was prepared for the May 2005 meeting of the Commission on Social Determinants of Health held in Cairo. In the course of discussions the members and the Chair of the CSDH contributed substantive insights and recommended the preparation of a revised draft, which was completed and submitted to the CSDH in 2007. The authors of this paper are Orielle Solar and Alec Irwin.

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### Foreword

onceptual frameworks in a public health context shall in the best of worlds serve two equally important purposes: guide empirical work to enhance our understanding of determinants and mechanisms and guide policy-making to illuminate entry points for interventions and policies. Effects of social determinants on population health and on health inequalities are characterized by working through long causal chains of mediating factors. Many of these factors tend to cluster among individuals living in underprivileged conditions and to interact with each other. Epidemiology and biostatistics are therefore facing several new challenges of how to estimate these mechanisms. The Commission on Social Determinants of Health made it perfectly clear that policies for health equity involve very different sectors with very different core tasks and very different scientific traditions. Policies for education, labour market, traffic and agriculture are not primarily put in place for health purposes. Conceptual frameworks shall not only make it clear which types of actions are needed to enhance their "side effects" on health, but also do it in such a way that these sectors with different scientific traditions find it relevant and useful.

This paper pursues an excellent and comprehensive discussion of conceptual frameworks for science and policy for health equity, and in so doing, takes the issue a long way further.

Finn Diderichsen MD, PhD Professor, University of Copenhagen October, 2010

## Executive summary

omplexity defines health. Now, more than ever, in the age of globalization, is this so. The Commission on Social Determinants of Health (CSDH) was set up by the World Health Organization (WHO) to get to the heart of this complexity. They were tasked with summarizing the evidence on how the structure of societies, through myriad social interactions, norms and institutions, are affecting population health, and what governments and public health can do about it. To guide the Commission in its mammoth task, the WHO Secretariat conducted a review and summary of different frameworks for understanding the social determinants of health. This review was summarized and synthesized into a single conceptual framework for action on the social determinants of health which was proposed to and, largely, accepted by, the CSDH for orienting their work. A key aim of the framework is to highlight the difference between levels of causation, distinguishing between the mechanisms by which social hierarchies are created, and the conditions of daily life which then result. This paper describes the review, how the proposed conceptual framework was developed, and identifies elements of policy directions for action implied by the proposed conceptual framework and analysis of policy approaches.

A key lesson from history (including results from the previous "historical" paper - see Discussion Paper 1 in this Series), is that international health agendas have tended to oscillate between: a focus on technology-based medical care and public health interventions, and an understanding of health as a social phenomenon, requiring more complex forms of intersectoral policy action. In this context, the Commission's purpose was to revive the latter understanding and therein WHO's constitutional commitments to health equity and social justice.

Having health framed as a social phenomenon emphasizes health as a topic of social justice more broadly. Consequently, health equity (described by the absence of unfair and avoidable or remediable differences in health among social groups) becomes a guiding criterion or principle. Moreover, the framing of social justice and health equity, points towards the adoption of related human rights frameworks as vehicles for enabling the realization of health equity, wherein the state is the primary responsible duty bearer. In spite of human rights having been interpreted in individualistic terms in some intellectual and legal traditions, notably the Anglo-Saxon, the frameworks and instruments associated with human rights guarantees are also able to form the basis for ensuring the collective well-being of social groups. Having been associated with historical struggles for solidarity and the empowerment of the deprived they form a powerful operational framework for articulating the principle of health equity.

#### Theories on the social production of health and disease

With this general framing in mind, developing a conceptual framework on social determinants of health (SDH) for the CSDH needs to take note of the specific theories of the social production of health. Three main theoretical non-mutually exclusive explanations were reviewed: (1) psychosocial approaches; (2) social production of disease/political economy of health; and (3) eco-social frameworks.

All three of these theoretical traditions, use the following main pathways and mechanisms to explain causation: (1) "social selection", or social mobility; (2) "social causation"; and (3) life course perspectives. Each of these theories and associated pathways and mechanisms strongly emphasize the concept of "social position", which is found to play a central role in the social determinants of health inequities.

A very persuasive account of how differences in social position account for health inequities is found in the Diderichsen's model of "the mechanisms of health inequality". Didierichsen's work identifies how the following mechanisms stratify health outcomes:

- Social contexts, which includes the structure of society or the social relations in society, create social stratification and assign individuals to different social positions.
- Social stratification in turn engenders differential exposure to health-damaging conditions and differential vulnerability, in terms of health conditions and material resource availability.
- Social stratification likewise determines differential consequences of ill health for more and less advantaged groups (including economic and social consequences, as well differential health outcomes per se).

The role of social position in generating *health inequities* necessitates a central role for a further two conceptual clarifications. First, the central role of *power*. While classical conceptualizations of power equate power with domination, these can also be complemented by alternative readings that emphasize more positive, creative aspects of power, based on collective action as embodied in legal system class suits. In this context, human rights embody a demand on the part of oppressed and marginalized communities for the expression of their collective social power. The central role of power in the understanding of social pathways and mechanisms means that tackling the social determinants of health inequities is a political process that engages both the agency of disadvantaged communities and the responsibility of the state. Second, it is important to clarify the conceptual and practical distinction between the *social causes of health and the social factors determining the distribution of these causes* between more and less advantaged groups. The CSDH framework makes a point of making clear this distinction.

On this second point of clarification, conflating the social determinants of health and the social processes that shape these determinants' unequal distribution can seriously mislead policy. Over recent decades, social and economic policies that have been associated with positive aggregate trends in health-determining social factors (e.g. income and educational attainment) have also been associated with persistent inequalities in the distribution of these factors across population groups. Furthermore, policy objectives are defined quite differently, depending on whether the aim is to address determinants of health or determinants of health inequities.

#### The CSDH Conceptual Framework

Bringing these various elements together, the CSDH framework, summarized in Figure A, shows how social, economic and political mechanisms give rise to a set of socioeconomic positions, whereby

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