EDITORIAL

Social Determinants of Health Equity

Language is important. The call for papers in this supplement was entitled health equity. Yet the call asked for papers that address disparities in health. In the United States, disparities, most often, has been used to refer to racial/ethnic differences in health, or more commonly health care. We note that the call in this supplement expands the focus and highlights differences by socioeconomic status and geographic location, among others. By tradition, in the United Kingdom we have used the term inequalities to describe the differences in health between groups defined on the basis of socioeconomic conditions.

To reduce health inequalities requires action to reduce socioeconomic and other inequalities. There are other factors that influence health, but these are outweighed by the overwhelming impact of social and economic factors—the material, social, political, and cultural conditions that shape our lives and our behaviors. Much of the evidence describing this was set out in the World Health Organization Global Commission on the Social Determinants of Health.[1]

In fact, so close is the link between social conditions and health, that the magnitude of health inequalities is an indicator of the impact of social and economic inequalities on people's lives. Health then becomes an important further cause for concern about the rapid increase in inequalities of wealth and income in our societies. Increasingly, we are using the language of health inequity to describe those health inequalities that, though avoidable, are not avoided and hence are unfair.

Two particular issues stand in the way before we can act on knowledge of social determinants of health to address health equities: lifestyle drift and overconcentration on health care.[2] Lifestyle drift describes the tendency in public health to focus on individual behaviors, such as smoking, diet, alcohol, and drugs, that are undoubted causes of health inequities, but to ignore the drivers of these behaviors—the causes of the causes.

Too often health is equated only with health care. Lack of access to health care has dominated the debate in the United States because of egregious inequities in access, despite spending far more on health care than any other country. A recent study by the Commonwealth Fund found that compared with other countries the US health system performed relatively poorly in terms of cost, equity, and efficiency.[3]

The Veterans Health Administration, however, does have a strong focus on equity. The Office of Health Equity ensures that the health care provision for veterans provides equitable care appropriate for the individual's circumstance and irrespective of geography, gender, race/ethnicity, age, culture, or sexual orientation. There is importance, too, in incorporating socioeconomic factors into provision of equitable access and care. The Office of Health Equity also brings an equity focus into organizational discussions of policy, decision-making, resource allocation, practice, and performance plans throughout the Veterans Health Administration—a health equity in all policies approach that could be extended to other relevant organizations and stakeholders.

Universal access to high quality care and a focus on equitable outcomes, then, is central to challenging health inequities. So too is challenging inequities in social conditions which lead to health inequalities. Attempts have been made to apportion determinants of health status of populations—see Figure 1, showing the relatively significant proportion of inequity attributed to social determinants.

The Robert Wood Johnson Foundation in the United States also sets out how social factors have as much, or even more impact on health as the medical care system, and it urges leaders across the United States to shift funding priorities to emphasize 3 areas essential to improving the nation's health: Increasing access to early childhood development programs; revitalizing low-income neighborhoods; and broadening the mission of health care providers beyond medical treatment.[5] Important goals, too, for the Veterans Health Administration.

In our English review of health inequalities, in 2010, we enlisted the help of 80 or so experts and set out a large evidence base, which demonstrated the most important influences on health and health inequalities.[6] We made recommendations in six priority areas. None was in health care because there is evidence of

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FIGURE 1—Estimates of the contribution of the main drivers of health status.

reasonably equitable, universal access to health care in England.

The six priority areas were: quality of experiences in the early years, education and building personal and community resilience, good quality employment and working conditions, having sufficient income to lead a healthy life, healthy environments, and priority public health conditions—taking a social determinants approach to tackling smoking, alcohol, and obesity.

At the heart of our approach is the finding that health inequalities are not limited to poor health for the worst off, or the most socially disadvantaged. There is a striking social gradient in health and disease running from top to bottom of society.[7] The social gradient has now been shown to be widespread across the world in countries at low, middle, and high income.[6] Figure 2 shows this gradient in England for life expectancy and healthy life expectancy.

There has been considerable progress in the recognition and adoption of the social determinants of health approach to health equity. Internationally, organizations such as the United Nations have expressed their broad commitment to health equity through action on the social determinants, and the European Union and World Health Organization have also acted on the social determinants of health and adopted this approach at the heart of their health improvement and health equity strategies. There have also been advancements at the national level—in many countries national governments have acted. There have been some great strides by local governments and authorities too. In England, 75% of local authorities have adopted this approach.

However, and it is a significant however, there are many further challenges to greater health equity

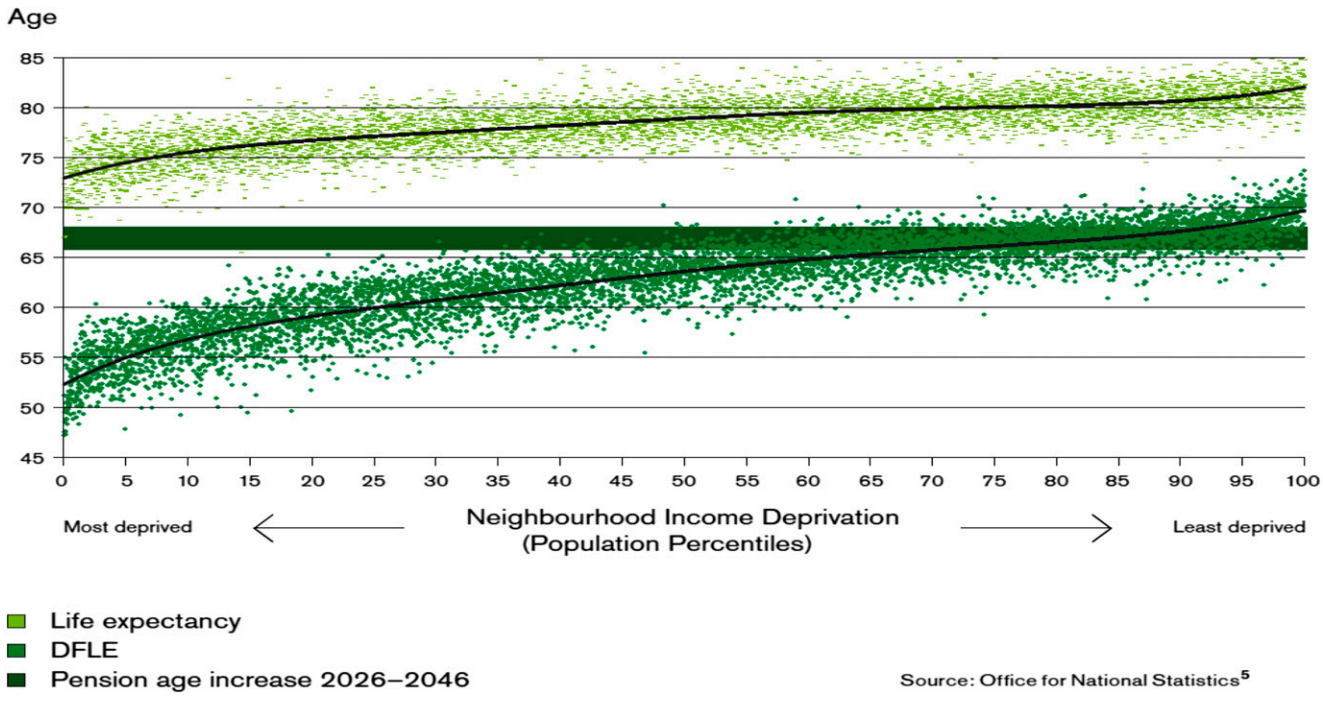

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FIGURE 2—Life expectancy and disability-free life expectancy (DFLE) at birth by neighborhood income and deprivation: 1999–2003.

and to the social determinants of health.

UNDERSTANDING HEALTH

The association between health and health care is so strong that many politicians and people assume that health and health care are the same. Until health and nonhealth stakeholders (and the public) start demanding that governments implement greater, more effective action to improve health and reduce inequities through action outside the health care sector, it is likely that this important distinction will continue to be lost.

BEHAVIOR AND HEALTH

There has been great, and increasing, focus on unhealthy behaviors that drive ill health. This approach sees that individuals are largely responsible for their own health and can improve health through better health behaviors—largely more sensible drinking and eating and not smoking. However, we need to understand and improve the social determinants of behaviors to reduce health inequalities and improve health while simultaneously trying to facilitate and support better existing behaviors.

EVIDENCE

There is an abundance of evidence showing the relationships between social and environmental factors and a whole raft of health outcomes. There is also plenty of evidence about what to do and what works best internationally, nationally, and at local levels. We have plenty of practical evidence about short- and long-term action at a variety of administrative levels, for different populations and for countries at different levels of development in different parts of the world. Citing a lack of knowledge about what to do is simply no longer credible. Cost benefit evidence is harder to provide, as evaluations are complex, outcomes long term, and the equity implications often overlooked. Notwithstanding all of this, there is enough cost benefit evidence to show that many interventions are efficient, equitable, and effective when designed and delivered in the right way. Moreover, and most importantly, the case is moral—reducing health inequities and improving health is a duty and should be a priority for governments and those with influence to improve health.

POLITICS

The objections and challenges to taking action on the social determinants of health are often intensely political. It is sometimes argued that it is not the government's responsibility to enforce changes of behaviors, but just to provide information, so that everyone is equally well informed, if that were possible. It is not simply ideology that contradicts this view. The facts are against it. Poverty, rising inequality in income and assets, and social exclusion all drive widening and deepening health inequalities in many countries. The generation and distribution of wealth in a country through income and welfare policy, in particular, reflects political priorities.

Much can be done to improve health and reduce gross health inequities. Some of this comes from provision of universal health care, designed to be equitable in access and outcomes—as the VHA has worked toward. But changes must also come from wider social and economic changes and reductions in inequalities, and many governments, civil society organizations, and others have shown the will to act to great effect. Greater impact requires greater action and will. As well as working toward more equitable provision, public health and the medical workforce have critical roles to play in social and political advocacy at all levels, helping lead more equitable health, and social and economic, systems—and we welcome the contributions on furthering equity in this supplement. ■

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