Social determinants of health — why we continue to ignore them in the search for improved population health outcomes!

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Abstract

There is now unequivocal evidence that the health status of individuals and of whole communities is socially and economically determined, as are many other aspects of our lives. This suggests, as advocates of public health and population health approaches argue, that our efforts in managing our health and wellbeing should focus much more on early intervention and prevention programs than has been the case to date.

However, although this ideology of social and economic determinism is generally accepted, practice does not reflect such values. Indeed, as increasing demand at the critical end of health service provision sees us spending more and more of our limited health care resources on acute and chronic illness, less resources are devoted to constructing and maintaining health-creating communities and environments. Paradoxically, while most of our leaders, academics and policy makers have themselves been nurtured in a sound understanding of cause and effect in the world, they are ignoring these fundamental premises in their approaches to the provision and management of health care.

This paper explores some of the reasons why this might be the case and draws on key evidence to suggest that the time has come for us to think more ideologically in approaching health care in the future.

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EVIDENCE CONTINUES TO highlight the fact that end-point interventions in the health system do not adequately tackle the comprehensive health problems that are emerging in our society as a consequence of adverse economic and social factors through our modern lifestyle options. The appalling health status of low-socioeconomic groups in Australia is, as has been pointed out elsewhere,[1-3] not being improved by chosen approaches, for example, of behaviour change, diet and exercise regimens. These approaches generally advantage those who have the options necessary for them to be able to make real lifestyle choices and to adjust their habits and life choices accordingly.

By contrast, the less well-off members of society represent a large component of the demand upon our health care system. Many of the presenting problems are directly linked to a lack of education, poor quality housing and lifestyle options that are a consequence of adverse employment and economic status. In short, people are sick because of their social condition, which is compounded by their lack of real choices influenced by their limited economic circumstances. A range of illness and diseases flow from this background in poverty and lack of options; illnesses which could be prevented, if as a society we had the will to do so.

Why do we continue to pretend that interventions like care planning and self-management training, for example, can address the wider health problems caused by deep-rooted social inequality and disadvantage? Australia is dominated by a political agenda, whether conservative or socialist, which represents retrograde values and holds a reactionary position on social and political economy. Even our politicians and health

bureaucrats, who have had the benefits of a liberal education, appear to be neglecting the fundamental aspects of economic determinism in their analyses.

It is a sobering indictment of the structure and approach of our modern social institutions that in the last 20 years or so we have conveniently learned to ignore the importance of economic determinism in the debate about how our health systems should function in order to improve health outcomes in Australia. Presumably, it is because this form of analysis of cause and effect is associated with a social view of health that such ideological approaches to health have been ignored.

Remember science?

In research we place emphasis on phrasing our research questions properly; the impact of this or that intervention on the HbA_{1c} scores of a diabetic population, the uptake rates of a new medication, or changes in hospital admissions across a defined population as a result of implementing a new patient discharge plan. Such questions are our business, and we explore them in different formats and numerous places around the country, presumably in order to improve people's health and wellbeing.

We are particularly interested in variations in outcomes for intervention groups compared with control groups, cost effectiveness of new health care strategies, and sustainability and application of new proven approaches to reducing morbidity. Indeed, the rush towards cost savings in managing patients with chronic illness would have us believe that real efficiencies can be found in the system and that a combination of new patient management measures will drive down hospital, drug and service utilisation costs. Further, this strategy implies that people, after living a lifetime subjected to gross consumption and poisons in their various forms,[4] can miraculously be trained at very little cost to manage their chronic conditions to reduce their impact upon the overburdened health care system.[5] Surely the more important intervention would be to prevent much of the chronic illness that we are now being forced to manage!

With all of this carefully orchestrated work in managing illness, we seem to miss a fundamental point — the improvements in population health outcomes, illness and disability rate that would be made by changing the social and economic condition of existence. If we were to focus on this point we would spend more of our resources on intervening at the preventive level of the health care dynamic and much less on tweaking HbA_{1c} levels or cholesterol levels through complex, costly and invasive interventions — extensive regimens that attempt to manage the chronic illness "horse" once it has well and truly bolted!

An even more fundamental research question, and one upon which this paper focuses, is: Why have we abandoned preventive and early intervention at the social and economic levels of health care in a preference for micro interventions at the end point of chronic illness scale? Why, in the face of overwhelming evidence that much chronic and complex illness, social dislocation and psychological upheaval is socially and economically determined, do we fail to grapple with these fundamental determinants of poor health status? Why, instead, are we satisfied to run people through costly care plans with the hope of ameliorating the symptoms of long-term illness instead of working at the social intervention end of the spectrum to ensure a great majority of these conditions do not occur or are delayed? Clearly, the chronic care management components are crucial to tackling the increasing levels of chronic illness in the community, but interventions at this level are not sufficient. What is needed is a more aggressive public education and early intervention approach to the prevention of lifestyle-related chronic conditions to complement the good work being done in caring better for people with chronic disease.

Bridge sums up the sentiments in a range of documentation on the social antecedents of poor health outcomes in communities,[6-8] with a special focus on his work in Indigenous communities.

> So what are the factors that appear to have such an overriding impact on both the lives

> of the less well to do and on their ability to make the lifestyle changes that are required? As medicos, we concentrate on cholesterol, blood pressure, etc. because they are the things we can do something about. It is thought that all these risk factors probably only add up to 30% of overall risk. So what's with the rest? Emerging evidence would suggest that the "social determinants of health" are the dominant factors. Unless these change, all health sector initiatives will be pissing into the wind. Scarier still, if these factors get worse or the gap between the well to do in our community and the Indigenous community gets larger, these health statistics will become even worse.
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> The social determinants of health take in such factors as socio-economic status but, more importantly, such concepts as the "gap" between the "haves" and the "have-nots", the locus of control both within a community and individually and personal self-esteem and empowerment.[9] (p. 4)

Why do we not only fail to intervene, but consciously aid and abet the processes that produce poor health in our community? Some may suggest that we have no resources for social health programs and that the health budget is consumed just meeting the health needs of our acutely and chronically ill populations. In such circumstances it will never be possible to channel resources into social interventions in proportion to the potential of such programs to reduce illness rates and, consequently, the acute and chronic illness demand on hospitals and health care providers.

Deserting ideology

Perhaps we are drifting toward conservatism even though most of our decision makers should know better. In the main, these decision makers have been educated in a liberal intellectual culture and have had the benefit of broad ideological discourse and studies in cause and effect and the basic scientific processes of logical and clear thinking. Paradoxically, the liberal generation turned its back on the fundamentals of economic and social determinism as Conway identified a generation ago in his social–psychological analysis of societies around the world.

> Despite the resurgence of radicalism in Western Europe since the Vietnam War, for example the rise of the Greens in Germany, many of the younger European intelligentsia have recently swung to the right. If American ways and nuclear installations are thought unwelcome, Marxist alternatives are equally so.[4] (p. 146)

This trend ultimately resulted in the mass rejection of socialist principles as a driving ideology in Europe. Conway also noted similar trends in Australia where our social leaders deserted the ideas underpinning economic and social determinism as mechanisms for describing and analysing social trends, including social cohesion, social capital and community health and wellbeing.

Conway concludes that this move to conservative values in Western society parallels our new preoccupation with material acquisition, production and constant economic growth and notes that

> The relationship between youth and the society which harbours it tends to deteriorate as adults become more absorbed in material acquisition and production and less concerned about the quality and value of life.[4] (p. 203)

It would appear that this new preoccupation with production, progress and profit is masking our collective compassion for people and our understanding of cause and effect, especially in relation to the overall health and wellbeing of communities and our nation.[10-12] Instead of focusing on improving the fundamentals upon which healthy existence is predicated, our pursuit of health for all is linked to interventions, processes and drug applications which generate profit and surplus capital for the wider economy.

As the managed care groups in America clearly believe, health care is a business from which proportionately large profits can be drawn. Conversely, given the way our economies are set up, there is less overt profit from keeping people

healthy. In short, if our predominant controlling political and social ideology has become one of profit and market driven growth, health and wellbeing therefore must be translated into a business as well,[13] and the business of health service provision and intervention does best if people are sick rather than healthy. Paradoxically, our health system appears to have little to do with health at all. As one leading researcher has it,[14] we should call it the "illth" system rather than the "health system".

This paradox is twofold. Firstly, although educated in a privileged culture to understand the fundamentals of economic determinism and its links to health, we have moved to reject this analysis. Secondly, health has become a massive business, which depends on people being sick. Simply put, much medicine is business first and health outcomes second as the costs associated with health care and the rewards available to providers continue to rise,[15] a situation that has been apparent in society for some time now. This logic leads us to a point where we abandon efforts to construct truly preventive intervention programs based on the fundamentals of materialism and the requirements for a healthy life and engage in social and economic behaviours which make us sick so we can profit from trying to make us well, after the fact.

Apart from being an indictment of our way of life, such an approach to health is tantamount to burning down our home so that someone else can benefit from the business that the rebuilding might generate. While it may be true that the business of rebuilding the home could be good for the economy in the short term, what this approach ignores is that in a world of finite resources, ultimately the unnecessary abuse and destruction of our limited physical means in the name of business progress is absurd in the extreme. Surely the longer a person can live peacefully in their house before needing to rebuild it, the better — but then again, the culture of pre-planned obsolescence in almost every aspect of our society appears to negate this fundamental ideal and may even be providing the model for the management of our very lives as well as the management of the things we use and abuse in the process of such a life.

Nasty, brutish and short

What distinguished modern societies from those of the past were elements of life quality and longevity made possible by the changing social and economic conditions of existence; sound education, reliable income and basic economic security, good housing, sanitation and nutrition, spare time, positive social interactions, self-expression and quality preventive health care programs that conquered major infectious diseases. Today, when the major public health initiatives of the past have secured quality of life, the lessons about fundamental platforms of community health are being ignored and we are on the verge, at least for a great many people in lower socio-economic existences, of returning to lives which are indeed "nasty, brutish, and short" (Thomas Hobbes; *Leviathan* Chapter XIII, 1651). This phenomenon is particularly stark for the health of Indigenous people.[3,9] If this process is allowed to continue, either the burden of "looking after" the coming generations will become unsustainable and an emerging underclass will be cut off from any real participation in modern culture, or we will need to intervene to change the essential conditions of existence of all groups in our community.[16]

This reality has not come about because of the conditions of labour, warfare or social neglect as they were once experienced, but because of an increasing separation between those who enjoy the benefits of modern culture and those who do not. Those caught in the poverty traps of modern culture are increasingly suffering from preventable chronic diseases and other adverse impacts upon their health and wellbeing, with lives lacking in quality, aesthetics or hope; lives in which individuals live out a brutish and short (relatively) alienated life that is often compounded by violence, drug or alcohol abuse and premature death. To illustrate the deterministic and compounding nature of the impact of deprivation, Marmot writes:

> There's actually some evidence for the proposition that if we simply invest in all schools equally we will simply increase the inequalities in educational outcome, because an equal quantity of investment in education will benefit children from an advantaged background

> to a greater degree than it would benefit those from disadvantaged backgrounds.[6] (p. 135)

Has all of this has come about because it is now no longer socially or economically advantageous for investors to maintain the quality of life standards for all at a relatively high level? Some economic advisers to politicians even argue that inequality is good for society as it fuels economic growth and helps to control and manage populations.[6] The situation is highlighted by the reality that while 35-year-old people die of kidney failure and diabetes in one part of town because they can't get treatment, people in other neighbourhoods are able to spend their health insurance dollars on facelifts, dietary supplements and other lifestyle-enhancing agents to their overwhelming benefit and advantage.

Conclusion

While we continue to produce ever more convincing examples of the social determinants of health in action and therefore of the need to tackle health and quality of life issues at a population level, there appears to be an enduring lack of will at an institutional level to either acknowledge or to act upon this emerging evidence. As outlined elsewhere,[17] the most informed and widely educated cohort in Australia's short history is now presiding over the creation of social and economic conditions that lead inexorably to the disproportionate health status across our communities and an increasing disparity between those who enjoy the benefits of our current society and those who do not. The indictment of such an approach exists not only in our evolving evidence, but also in the almost unbelievable paradox that although we are capable of population interventions to prevent illness and improve health status for all, we prefer to wait until illness and social dislocation becomes manifest before acting.

Competing interests

The author declares that he has no competing interests.

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