Iconography and Commission on the Social Determinants of Health (and health inequity)

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The report by the World Health Organization’s (WHO) Commission on Social Determinants of Health (CSDH) (Closing the gap in a generation: health equity through action on the social determinants of health)1 was launched on 28 August this year. In this issue, timed to coincide with a conference of the same name being held in London in November, we include two papers relevant to the CSDH’s work. First, a paper by Marmot (Chair of the CSDH) and Friel (CSDH staff) reflecting on some media responses in the first week following the report’s launch on how social justice is appropriately an explicit foundation for the work of the CSDH, and the process of collating evidence on how to address the social determinants of health (inequity). (see page 1095) Second, we include a paper by Krieger on the use of iconography (“the illustration of a subject by drawings or figures”, The concise Oxford dictionary) to depict models of the social determinants of health and health inequalities. (see page 1098)

All of us involved in research or policy advice on health or health inequalities use framework diagrams of one sort or another to help portray our assumptions and logic. A very commonly used diagram is the Dahlgren and Whitehead “main determinants of health” diagram, which depicts individuals surrounded by layers of lifestyles, social and community networking, living and working conditions and general socioeconomic, cultural and environmental conditions. This diagram was developed to depict the social determinants of health—not the determinants of social inequalities in health. Yet, it has widely been used as a model of both health and health inequalities. Indeed, I can speak to this personally. In 1997 I was a co-author of a report by the New Zealand Ministry of Health that included this diagram under a social determinants of health heading, yet it quickly became a commonly used diagram in the discourse on inequalities in health. A key theme in Krieger’s paper is that the determinants of health inequalities are different from those of health per se, and they need separate iconographic treatment. Krieger presents diagrams that explicitly include a depiction of how inequalities arise, including 2007 working models of the CSDH (figure 4c of her paper). These CSDH models specifically include the terms “power”, “class”, “racism” and “discrimination”, and separation of halves of the diagram into “structural determinants of health inequities” that act via “intermediary determinants of health”. It is interesting, therefore, to see the final version of the CSDH framework that appears in the report launched in August, and shown in figure 1. Gone is the explicit mention of racism and power; rather, a simpler diagram is presented. And this is the tension. Simple diagrams are useful for dissemination to new audiences, yet lose some of the explicit mechanisms by which inequalities in health arise that are depicted in more complex diagrams. Comparing figure 1 with its predecessors shown in figure 4c of Krieger’s paper, one can see that the final version is reasonably faithful to its predecessors. The problem is that figure 1, standing on its own, may not be conducive to a correct interpretation without careful verbal or text presentation wrapped around it.

So what does the CSDH report have to say? Well, it does not mince its words. The first two pages of the Executive Summary include sentences such as:

► “Social injustice is killing people on a grand scale.”
► “This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programme, unfair economic arrangement, and bad politics.”
► “Deep inequities in the distribution of power and economic arrangements, globally, are of key relevance to health equity.”

Thus, the CSDH report has power imbalances, sexism and discrimination very much in focus. The actors who can address inequalities in health are also clearly identified: multilateral agencies, national and local governments, civil society, the private sector and research institutions. (As readers of this journal, we would probably all fit under at least one of these actor groupings.) The CSDH report is a culmination of 5 years of effort at the request of the former Director General of the WHO, Dr Lee, and is based on numerous meetings around the world and the foundational work of nine knowledge networks and country partners that fed into the final report. The Commission had decided to present its findings and recommendations under three themes: daily living conditions (eg, early life, urban and rural environments, employment and healthcare); power, money and resources (eg, state and private sector, governance); and knowledge, monitoring and skills. Fifty-six recommendations are put forward under these three themes. The general tenor of these recommendations is captured in table 1, taken directly from the report.

The next year or so should comprise much discussion by the WHO secretariat and member countries, with more detailed plans of action then being promulgated, including more specification of who will do what by when. Many readers of this journal will be, and should be, active participants in these discussions—and have done so already. As stated in the report “Not to act will be seen, in decades to come, as a failure on a grand scale to accept the responsibility that rests on all our shoulders.” Many of us may have injected a different emphasis in sections of the report had we been the author, or added or deleted this or that. But the vast majority of us would agree with the majority of the report—it is a contemporary and authoritative account of what we know about, and what we need to do about, health inequalities.

The paper by Marmot and Friel includes reflections on the media interesting in the first week after the CSDH report was launched, and the need not to be bashful about social justice being an explicit premise that guides the assembling and interpretation of evidence. Should, and do, health researcher and sector employees care about social injustice? Yes, and yes. The majority of people working in health, in part at least, have altruism and fairness as a driver to their career choice. The unfairness of the international and intranational distributions of health status described in the
CSDH report is an affront to most people’s value systems.

Marmot and Friel also reflect on the process of collating and interpreting evidence during the preparation of the Closing the gap in a generation report. As they state, if ‘‘you think the only evidence worth considering is that from randomised controlled trials, you can happily save time by not reading our report.’’ Then:

…there is no simple translation of evidence of health effect to judgement and recommendation. In almost none of the areas of social determinants of health that the Commission considered was that the case. We were required to broaden the scope of what constituted evidence both to include a variety of types of evidence, including case studies, and chains of plausible reasoning. Failure to broaden in this way would have been a recipe for doing nothing.

Table 1 The Commission on Social Determinants of Health’s overarching recommendations

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<th>1. Improve daily living conditions</th>
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<td>Improve the well-being of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments and global institutions</td>
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<th>2. Tackle the inequitable distribution of power, money and resources</th>
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<td>In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities—such as those between men and women—in the way society is organised. This requires a strong public sector that is committed, capable and adequately financed. To achieve that requires more than strengthened government—it requires strengthened governance: legitimacy, space and support for civil society, for an accountable private sector and for people across society to agree public interests and reinvest in the value of collective action. In a globalised world, the need for governance dedicated to equity applies equally from the community level to global institutions</td>
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<th>3. Measure and understand the problem and assess the impact of action</th>
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<td>Acknowledging that there is a problem and ensuring that health inequity is measured—within countries and globally—is a vital platform for action. National governments and international organisations, supported by the WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should evaluate the health equity impact of policy and action. Creating the organisational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health. It also requires a stronger focus on social determinants in public health research</td>
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Source: CSDH.

Figure 1 The Commission on Social Determinants of Health’s framework of the social determinants of health and health inequities. Derived from Solar and Irwin.

Put another way, much of what we can learn about on the social determinants of health (inequalities) is from careful observation of health trends in contexts with varying economic, social and health policies. Unfortunately, we do have a time machine that will allow us to replay such “experiments” 100 times, with slight variations to social “exposures” in order to more robustly identify causal effect sizes. In New Zealand, we have witnessed most interesting, and concerning, variations in life expectancy trends between Māori (the indigenous population) and non-Māori. In the first 30 years after the Second World War, Māori life expectancy increased rapidly, whereas non-Māori made moderate progress. Then during the 1980s and 1990s Māori life expectancy increased little, but increased steadily for non-Māori. More recently, and thankfully, both Māori and non-Māori life expectancy have increased strongly—with Māori catching up again, with the life expectancy “gap” decreasing from approximately 9 to 7 years. Anyone familiar with New Zealand’s recent political, social and economic history will note that the widening gap in the 1980s and 1990s was coincident with structural reforms (eg, privatisation and deregulation) that resulted in unemployment rates of 25% for Māori in the early 1990s (compared with 8% for non-Māori). More recently, the strong improvements in Māori life expectancy coincide with improving socioeconomic conditions, more redistributive fiscal and welfare policy, a growing inequalities focus within primary and secondary care, and growing Māori development and delivery of social and health services. Although it seems inescapable that such distal social factors are part of the explanation for these varying life expectancy trends over recent decades, it is nearly impossible to “prove” it. Rather, we have to rely on sound “chains of plausible reasoning”, in the words of Marmot and Friel.

The CSDH report has the potential to become a landmark document, in much the same way that Alma Ata was 30 years ago. Whether it lives up to that potential will depend on the response from the WHO and its member countries in the next year, and the uptake by civil society, the private sector and other stakeholders. As readers of this journal, we have an important part to play in advancing the agenda. Using a Māori phrase, it is time to be strong—kia kaha!

Competing interests: None.

REFERENCES


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