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Review Article

Explaining social determinants of health from a political economy of health and ecosocial perspective

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ABSTRACT

Social determinants of health (SDH) is a common term used in public health and epidemiology. Public health researchers use social determinants of health to study various inequalities associated with health. Inequities in health involve systematic differences in health across population subgroups, thus changing the focus of influences from social interactions to societal characteristics. Several epidemiologic literatures focus on the social aspects of individuals and groups that are considered to influence the health status, which is conceptualized as 'average health'. Some studies look beyond the social factors affecting health; social determinants of health as arising from a social environment structured by government policies and status hierarchies, with social inequalities in health resulting from diverse groups being differentially exposed to factors that influence health, whereby 'social determinants', such as poverty, act as the 'causes of causes'. However, the most recent definitions of SDH include the factors such as political-economic systems, whereby health inequities result from the promotion of the political and economic interests of those with power and privilege and whose wealth and better health are achieved at the expense of those whom they subject to adverse living and working conditions. Hence, social determinants such as political-economic systems that prioritizes the highly concentrated accumulation of private wealth over the redistribution of power, property and privilege within and across countries constitute the 'causes of causes of causes'. In this paper, the concept of social determinants of health will be discussed in more detail, using two different theories of social epidemiology that focus on the SDH: the political economy of health and the ecosocial framework.

Keywords: Social determinants of health, Ecosocial framework, Political economy of health, Public health, Health equity, Health inequity

INTRODUCTION

'Social determinants of health' (SDH) is a common term used in public health and epidemiology. Most of the time, public health researchers use social determinants of health to study various inequalities associated with health.[1] Inequality in health refers to "the uneven distribution of health determinants between different population groups due to external factors or the lack of resources".[2] However, health equity refers to the "absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification".[3] Hence inequities in health involve systematic differences in health across population subgroups, thus changing the focus of influences from social interactions to societal characteristics.[4] In most epidemiologic literature, the social aspects of individuals and groups are considered to influence the health status, which is conceptualized as 'average health'.[5] When we look beyond the social factors affecting health, social determinants of health as arising from a social environment structured by government policies and status hierarchies, with social inequalities in health resulting from diverse groups being differentially exposed to factors that influence health, whereby 'social determinants', such as

poverty, act as the 'causes of causes'.[6] According to Krieger, SDH can be defined as "political-economic systems, whereby health inequities result from the promotion of the political and economic interests of those with power and privilege (within and across countries) against the rest, and whose wealth and better health is gained at the expense of those whom they subject to adverse living and working conditions".[6] Hence social determinants such as political-economic systems that prioritize the highly concentrated accumulation of private wealth over the redistribution of power, property and privilege within and across countries constitute the 'causes of causes of causes'.[6]

To elaborate on this debate, let us use social epidemiological theories of disease distribution, which "explain the observed and changing population patterns of health and diseases employing certain principles capable of elucidating the observed social inequities in the populations".[7] Although these theories have a common goal of studying the population patterning of health, each theory's explanations and suggestions depend upon its specific ways of looking at the social and health inequities.[8] Through these frameworks, social epidemiologic theories demonstrate a wide range of connections among multiple social determinants acting at various levels, capable of producing health inequities.[7] Throughout this paper, the example of the 'high prevalence of smoking among lower socio-economic classes of India' will be used.

POLITICAL ECONOMY OF HEALTH

The core idea of the political economy of health is that a "society's patterning of health and disease-including its social inequalities in health is produced by the structure, values and priorities of its political and economic systems".[7] Thus, society's structure directly impacts health, such as race, gender, and class stratifications. This implies that "analyzing and altering population distributions of and inequities in health and disease necessitates engaging with, if not confronting, extant political and economic systems, priorities, policies and programs".[7] The idea of production in a political economy requires one to understand "who is producing what, with what technologies, for whom and why". The theory conceptualizes the "who" here as political and economic systems operating within and across regions and countries, as well as the institutions and individuals who dominate them. "What" these systems produce are economic output, societal structure, means and materials used by social and economic groups to reinforce or challenge their social position and the norms, values and ideologies justifying or challenging their political and economic priorities. Hence, the theory suggests that analyzing causes of disease distribution needs attention to political and economic structures, processes and power relations that produce societal patterns of health and disease by shaping the conditions in which people live and work.[7]

When we explain this theory using the example of smoking, the high prevalence of smoking among economically weaker sections of society could be explained using the economic policies related to smoking. Although taxes on cigarettes in India have increased over the last decade, India does not show a drastic reduction in smoking and tobacco use.[9] The primary reason behind this could be the consumption of other readily available smokable forms of tobacco, such as bidi, especially among the lower quintiles of society.[10] Therefore, an increase in the taxation only on cigarettes rarely affects the behaviour of the bidi smokers. The theory would argue that the absence of a policy that includes all forms of tobacco may create an environment that is not prohibitive enough to reduce smoking among socioeconomically weaker sections of society. This theoretical perspective would also discuss the political factors associated with the tobacco industry, which plays a vital role in producing social patterning of smoking. The tobacco plantations and associated businesses are in the hands of influential politicians who can easily collaborate with the mediators to expand their business.[11] The theory would also look into the issues such as the proliferation of tobacco companies in the lower and middle-income countries and how globalization and capitalism played a role in it.

ECOSOCIAL THEORY OF DISEASE DISTRIBUTION

The ecosocial social theory of disease distribution tries to integrate social and biological reasoning and a dynamic, historical, and ecological perspective to develop new insights into determinants of population distributions of disease and social inequalities in health.[7] The eco-social framework integrates biophysical phenomena that translate societal exposure into population patterns of health and wellbeing with the framework of the political economy of health. This theory has four core constructs. For instance, if we explain this theory using the previous example.

Embodiment

Here, it suggests that a higher prevalence of smoking can be a combination of various social inequities which literally 'embody biologically' and create a social patterning of smoking-related illnesses. Exposure to higher amounts of nicotine and tar can make the weaker socio-economic sections more prone to biological consequences such as COPD, and lung cancer.

Pathways of embodiment

The pathways of embodiment describe multiple pathways through which health inequity results; for example, economic and social deprivation, easy access to bidis, poor housing conditions and discrimination and other forms of social trauma can be different pathways that embody the high risk of smoking.

Interaction of the above exposures with susceptibility and resistance

The third construct explains the interaction of the above exposures with susceptibility and resistance towards these exposures in the population at a given time and place. In this example, different processes across the life course may increase the susceptibility of certain sections of society to adopt the habit of smoking in adult life [7]. This approach would consider various factors such as parents' SES, SES of the individuals in their adolescence and adult life, and social environments with a large number of tobacco and bidi shops or tobacco farms which might force them to live in these conditions which promote smoking. In this case, a lack of education can play a crucial role as lack of education also forces the illiterate populations to accept occupations (such as farm labourers, daily wage workers) which may force them to adopt smoking.

Accountability (responsibility) and agency

Accountability (responsibility) and agency (individual and institutional capacity to act) for the existence; unlike the 'lifestyle model', which puts the onus of adopting the behaviour of smoking on the individuals, the ecosocial theory would argue that their environment fails to create opportunities where the accountability and agency of low socio-economic groups to quit smoking could be improved.[8] Macro (such as policies) rather than micro-level factors are accountable for creating the social patterns of smoking. They would influence the micro-level factors such as attitude towards smoking or self-efficacy to quit smoking.

POLICY IMPLICATIONS

Using social determinants of health as the core construct, the policy implications may focus on tackling the 'causes of causes of causes'. Hence, the policymakers would emphasize the political and structural causes of inequities rather than merely the social determinants. Thereby they may shift from the individual level to broader levels of action. Using this perspective, the policymakers can incorporate components of society's political, economic, cultural and ecologic priorities. The policy may focus on improving those factors and thereby help them shape the contexts in which individuals live their lives, with significant consequences for health. Policies focusing on these social determinants are considered a way to address disparities and may substantially impact preventing illness, injury, and premature death. For example, a policy designed to reduce the prevalence of smoking among low socio-economic groups may focus on different aspects. Starting from awareness generation through mass media campaigns, changing the context they live in order to adopt healthy choices (tobacco-free streets, prohibiting the selling of tobacco products in, punishments and rewards), taxation on cigarettes, bidis and other tobacco products, long-lasting protective interventions such as smoking cessation therapy and finally and most importantly changing the socio-economic conditions of the target population. This approach would also focus on stakeholder involvement and policy initiatives addressing the translation of social determinants research, effective communication strategies, community engagement and community-level behavioural change strategies. This perspective also demands implementing interventions that can enable society to overcome various causes of social inequities (such as targeting the reduction of societal level stratification such as disrupting caste-based stratification, and neutralizing gender-based stratification through policies aimed at empowering the woman). The policy implications should have strategies that can minimize the power hierarchies and measures to minimize the exposure to inequities of specific populations due to the existing power structures. The policy implications focusing on the social determinants of health would focus on measures ensuring health equity instead of widening health inequality.

CONCLUSION

The political economy perspective suggests that analyzing causes of disease distribution needs attention to political and economic structures, processes and power relations that produce societal patterns of health and disease by shaping the conditions in which people live and work. But, the eco-social framework is trying to explain disease distribution more comprehensively by arguing that people embody, biologically, their lived experience in a societal and ecological context, thereby creating population patterns of health and disease. The theory also argues that Societies' epidemiological profiles are shaped by the ways of living designed by their current and changing societal arrangements of power, property, and the production and reproduction of both social and biological life, involving people, other species, and the biophysical world in which we live.

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