Social Determinants, capabilities and health inequalities

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Doctors know about health – it is what you lose when you have disease. And they know about disease – it is what happens when you have disordered pathology. People interested in prevention know about health – ill-health can be prevented by behaving better and avoiding the evils of drink, drugs, overweight and unsafe sex. Health policy people know about health – it's what you spend money on when funding and organising health services. Economists and social policy people know about health – it is what you have to spend money on, they mean health services when they say 'health', in order to get more productive and richer individuals and societies.

Gross generalisations these, but much truth in them. There is a different approach to health, to examine the causes of good and bad health. These causes will include those above – disordered pathology, unhealthy behaviours, health services, policies – but also the nature of the society and environment in which people are born, grow, live, work and age; and inequities in power, money and resources that give rise to inequities in the conditions of daily life that, in turn, influence health and inequalities in health. This formulation comes from the WHO Commission on Social Determinants of Health (which I chaired) and is the theme of *The Health Gap.(1)* An approach emphasising social determinants of health should be of interest to health professionals, as illustrated in the commentaries from Giulia Greco, Dinesh Bhugra and Shailaja Fennell (refs to this issue). Social determinants of health also provide a framework in which human development and capabilities can fit, as illustrated by Sridhar Venkatapuram (ref to this issue). Conversely, the capability approach provides a way to understand the ways in which social organisation is so crucial to health and well-being.

One way to think about health inequalities is the difference between the mainstream and those discriminated against because of ethnicity, gender, sexual orientation, migrant status, or disability. All valid and important, but such an approach starts from a position of 'them and us'. Regrettably, when 'us' are powerful and uncaring they can simply ignore 'them'. When it comes to socioeconomic inequalities in health, by contrast, the social gradient in health is crucial. We can only take an approach that separates 'them', the poor, from 'us', the non-poor if we ignore the evidence of what is actually going on. People below the top have worse health than those at the top; there is a graded relation between socioeconomic position and health that runs from top to bottom of the social hierarchy. There is no them and us; there is all of us below the very top. A

functioning democracy will serve more than the interests of the top 1%. By seeking to improve society as a whole, it will address the gradient.

Venkatapuram highlights my call for proportionate universalism. The simple idea is that to address the gradient we need action, universalist, that will improve the whole of society. Yet, much of social policy, at least in the Anglo-Saxon world, is targeted at the worst off. To resolve these different approaches, proportionate universalism calls for universalist approaches, with effort proportional to need. And the perspective is not just universal health coverage, but addressing social determinants of health across the whole of society.

The gradient is relevant to Fennell's question. She is struck by my observation that within present day London the gap in life expectancy may be as big as twenty years; but, across the world, it is double that. Poverty can take different forms. At its extreme it is absolute: insufficient resources to support life. But, even among the poorest in low income countries, poverty may be graded. Starvation can occur in degrees of quality as well as quantity of food. Inadequate housing and sanitation can occur to varying extent. We see this with the gradient in under five mortality by income level of family – it suggests a gradient in the material conditions necessary for children to survive the first 5 years of life, in addition to access to immunisation and needed health care. In middle and higher income countries, poverty is more likely to take the form of disruption of the possibility to lead a dignified and flourishing life, relevant to the capability approach. We see this in the health effects of poverty. In the poor parts of London people are not dying prematurely of water-borne diseases, but of alcohol and drug-related problems, of the consequences of mental illness, of heart disease and cancer.

I do not take the view that in low income countries we need to get the basics of nutrition, shelter and sanitation right before we deal with the conditions to lead flourishing lives. We do need to get the basics right *and* deal with social determinants and capabilities at the same time. That is the double burden that we need to address.

As Bhugra emphasises, we have to take a life-course approach. In *The Health Gap*, I discuss the evidence on adverse child experiences. It is clear that disrupted childhoods are a key mechanism of inter-generational transmission of inequality. Parents' disordered lives are having deleterious effects on their children's development with subsequent strong impacts on health. At the top of this commentary I offered gentle criticism of those who, with the best intentions aimed at prevention, focus on unhealthy behaviours, ignoring the drivers of behaviours – what I call the causes of the causes. Among these drivers are adverse child experiences, and indeed poverty itself. Fennell picked up and emphasised my view that poverty leads to poor decision-making, not the other way round.

Both Greco and Fennell endorse my plea for improvements in education as means to better health, and narrower inequalities, but they make the vital point about socioeconomic context. If there are no jobs to be had, the benefits of education will

be more dubious. Somewhat artificially, I make a distinction between two ways education could reduce health inequalities. First are the general life skills that education confers. People with more education, in general, are better equipped to handle the complexities of life. Second, education is a route to other benefits – jobs, money, living conditions. If those other benefits are not available the health enhancing effects of education will be diminished.

Both of these pathways, and particularly the first, emphasise the crucial role of the mind, psychosocial processes, as an important gateway by which social characteristics influence health inequalities. It is our minds after all that make us human. And it is our minds as well as our bodies that are damaged by social inequalities. To pick up from Fenell, the evidence on health, on violence against women, and on capabilities more generally should be a key part of social action against inequality.

1. Marmot M. The Health Gap. London: Bloomsbury; 2015.