COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

A Conceptual Framework for Action on the Social Determinants of Health

Discussion paper for the Commission on Social Determinants of Health
DRAFT
April 2007

A first draft of this paper was prepared for the May 2005 Cairo meeting of the Commission on Social Determinants of Health by the Commission secretariat, based in the Department of Equity, Poverty and Social Determinants of Health, Evidence and Information for Policy Cluster, WHO Geneva. The principal writers were Orielle Solar and Alec Irwin. Valuable input to the original draft was provided by other members of the Commission secretariat, in particular Jeanette Vega. In the course of discussions in Cairo, Commissioners and the Chair contributed substantive insights. Commissioners recommended the preparation of a revised draft paper, which was completed in January 2007. It is planned that the current version of the paper will be submitted to CSDH Commissioners at their June 2007 meeting in Vancouver. In addition to the Chair and Commissioners of the CSDH, many colleagues have offered valuable comments and suggestions in the course of the revision process. Thanks are due in particular to: Joan Benach, Sharon Friel, Tanja Houweling, Ron Labonte, Carles Muntaner, Ted Schrecker, Sarah Simpson and Jeanette Vega. Any errors are solely the responsibility of the principal writers

TABLE OF CONTENTS

A conceptual framework for action on the social determinants of health

I. Introduction

When he announced his intention to create the Commission on Social Determinants of Health (CSDH), WHO Director-General Lee Jong-wook identified the Commission as part of a comprehensive effort to promote greater equity in global health, in a spirit of social justice[1]. The Commission's goal, then, is to advance health equity, driving action to reduce health differences among social groups, within and between countries. Getting to grips with this mission requires finding answers to three fundamental problems:

1. Where do health differences among social groups originate, if we trace them back to their deepest roots?
2. What pathways lead from root causes to the stark differences in health status observed at the population level?
3. In light of the answers to the first two questions, where and how should we intervene to reduce health inequities?

This paper seeks to make explicit a shared understanding of these issues that can orient the work of the CSDH.

The paper adopts the following structure. First, we recall the historical trajectory of which the CSDH forms a part. Then, we make explicit the Commission's fundamental values, in particular the concept of health equity and the commitment to human rights. We describe the broad outlines of current major theories on the social determinants of health, and review perspectives on the causal pathways that lead from social conditions to differential health outcomes. Then a new framework for analysis and action on social determinants is presented in several stages, as a specific contribution of the CSDH. The CSDH framework synthesizes many elements from previous models, yet we believe it represents a meaningful advance. We ground the framework in a theorization of social power and make clear our debt to the work of Diderichsen and colleagues. We present the core components of the framework, including: (1) socioeconomic and political context; (2) structural determinants of health inequities; and (3) intermediary determinants of health. Our answers to the first two questions above will be articulated by way of these concepts. In the last section of the paper, we deduce key directions for pro-equity policy action based on the framework, providing broad elements of a response to the third question.

An important definitional issue must be clarified in advance. The CSDH has purposely adopted a broad initial definition of the social determinants of health (SDH). The concept encompasses the full set of social conditions in which people live and work, summarized in Tarlov's phrase as "the social characteristics within which living takes place".[2] A broad initial definition of SDH is important in order not to foreclose fruitful avenues of investigation. However, within the field encompassed by this concept, not all factors have equal importance. Causal hierarchies will be ascertained, leading to crucial distinctions.[3] Much of this paper will be concerned with clarifying these distinctions and making explicit the relationships between underlying determinants of health inequities and the more immediate determinants of individual health.

II. Historical trajectory

Health is a complex phenomenon, and can be approached from many angles. Over recent decades, international health agendas have tended to oscillate between: (1) approaches relying on narrowly defined, technology-based medical and public health interventions; and (2) an understanding of health as a social phenomenon, requiring more complex forms of intersectoral policy action, and sometimes linked to a broader social justice agenda.

WHO's 1948 Constitution clearly acknowledge the impact of social and political conditions on health, and the need for collaboration with sectors such as agriculture, education, housing and social welfare to achieve health gains. During the 1950s and 60s, however, WHO and other global health actors emphasized technology-driven, 'vertical' campaigns targeting specific diseases, with little regard for social contexts.[4] A social model of health was revived by the 1978 Alma-Ata Declaration on Primary Health Care and the ensuing Health for All movement, which reasserted the need to strengthen health equity by addressing social conditions through intersectoral programmes.

Many governments embraced the principle of intersectoral action on SDH under the banner of Health for All. However, the neoliberal economic models that gained global ascendancy during the 1980s created obstacles to policy action on SDH. In the health sector, neoliberal approaches mandated market-oriented reforms that emphasized efficiency over equity as a system goal and often reduced disadvantaged social groups' access to health care services.[5] On the level of macroeconomic policy, the structural adjustment programmes (SAPs) imposed on many developing countries by the international financial institutions mandated sharp reductions in governments' social sector spending, constraining policymakers' capacity to address key SDH.[6]

Even as neoliberal policies were applied in both developing and developed countries, new, more systematic analyses of the powerful impact of social conditions on health began to emerge. A series of prominent studies, including those of McKeown and Illich, challenged the dominant biomedical paradigm and debunked the idea that better medical care alone can generate major gains in population health [7]. Great Britain's Black report on inequalities in health (1980) marked a milestone in understanding how social conditions shape health inequities. Black and his colleagues argued that reducing health gaps between privileged and disadvantaged social groups in Britain would require ambitious interventions in sectors such as education, housing and social welfare, in addition to improved clinical care.[8]

Through the 1980s and early 90s, the Black report sparked debates and inspired a series of national inquiries into health inequities in other countries, e.g., the Netherlands, Spain and Sweden. The pervasive effects of social gradients on health were progressively clarified, in particular by the Whitehall studies of comparative health outcomes among British civil servants[9]. Important work at WHO's European Office in the early 90s laid conceptual foundations for a new health equity agenda, and the vocabulary of SDH began to achieve wider dissemination.[10]

By the late 1990s and early 2000s, health equity and the social determinants of health had been embraced as explicit policy concerns by a growing number of countries, particularly but not exclusively in Europe, in response to mounting documentation of the scope of inequities, and evidence that existing health and social policies had failed to reduce equity gaps.[11] In the UK, the arrival in 1997 of a Labour government explicitly committed to reducing health inequalities focused fresh attention on SDH. Australia and New Zealand explored options for addressing

health determinants, with New Zealand's 2000 health strategy reflecting a strong SDH focus[12]. In 2002, Sweden approved a new, determinants-oriented national public health strategy, arguably the most comprehensive model of national policy action on SDH to date. New policies focused on tackling health inequities were passed in England, Ireland, Italy, the Netherlands, Northern Ireland, Scotland and Wales during this period[13]. Meanwhile, in developing regions including sub-Saharan Africa, Asia, the Eastern Mediterranean and Latin America, resurgent critical traditions allying health and social justice agendas, such as the Latin American social medicine movement, refined their critiques of market-based, technology-driven neoliberal health care models and called for action to tackle the social roots of ill-health.[14] [15]

In 2003, Lee Jong-wook took office as Director-General of WHO, on a platform marked by commitments to health equity, social justice and a reinvigoration of the values of Health For All. Lee's first announcement of his intention to create a Commission on Social Determinants of Health, at the 2004 World Health Assembly, positioned the CSDH as a key component of his equity agenda[16]. Lee welcomed rising global investments in health, but affirmed that 'interventions aimed at reducing disease and saving lives succeed only when they take the social determinants of health adequately into account'[17]. Lee charged the Commission to mobilize emerging knowledge on social determinants in a form that could be turned swiftly into policy action in the low- and middle-income countries where needs are greatest. In his speech at the launch of the CSDH in Chile in March 2005, Lee noted that the Commission would deliver its report in 2008, the thirtieth anniversary of the Alma-Ata conference and sixty years after the formal entry into force of the WHO Constitution. He urged the Commission to carry forward the values that had informed global public health in its most visionary moments, translating them into practical action for a new era.

Key messages from this section:

- Over recent decades, international health agendas have tended to oscillate between: (1) a focus on technology-based medical care and public health interventions; and (2) an understanding of health as a social phenomenon, requiring more complex forms of intersectoral policy action.
- The 1978 Declaration of Alma-Ata and the subsequent Health For All movement gave prominence to health equity and intersectoral action on SDH; however, neoliberal economic models dominant during the 1980s and 90s impeded the translation of these ideals into effective policies in many settings.
- During the late 1990s and early 2000s, evidence accumulated that existing health policies had failed to reduce inequities, and momentum for new, equity-focused approaches grew, primarily in wealthy countries. The CSDH aims to ensure that developing countries, too, can translate emerging knowledge on SDH into effective policy action.
- In his speech at the launch of the CSDH, WHO Director-General J.W. Lee noted that the Commission will deliver its report in 2008, the thirtieth anniversary of the Alma-Ata conference and sixty years after the WHO Constitution. He instructed the Commission to carry forward the values that have informed global public health in its most visionary moments, translating them into practical action.
- The CSDH revives WHO constitutional commitments to health equity and social justice and brings a reinvigoration of the values of Health For All.

III. Defining core values: health equity, human rights, and distribution of the power

Policy choices are guided by values, which may be implicit or explicit. The concept of *health equity* is the explicit ethical foundation of the Commission's work, while *human rights* provide the framework for social mobilization and political leverage to advance the health equity agenda. Realizing health equity requires *empowering* people, particularly socially disadvantaged groups, to exercise increased collective control over the factors that shape their health.

The WHO Department of Equity, Poverty and Social Determinants of Health defines health equity as ‘the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically’.[18] In essence, health inequities are health differences which are: socially produced; systematic in their distribution across the population; and unfair.[19] Identifying a health difference as inequitable is not an objective description, but necessarily implies an appeal to ethical norms.[20]

Primary responsibility for protecting and enhancing health equity rests in the first instance with national governments. An important strand of contemporary moral and political philosophy has built on the work of Amartya Sen to link the concepts of health equity and agency, and to make explicit the implications for just governance. Joining Sen, Anand (2004) stresses that health is a "special good" whose equitable distribution merits the particular concern of political authorities. There are two principal reasons for regarding health as a special good: (1) health is directly constitutive of a person's well-being; and (2) health enables a person to function as an agent.[21] Inequalities in health are thus recognized as "inequalities in people's capability to function"

which profoundly compromise freedom. When such inequalities arise systematically as a consequence of individuals' social position, governance has failed in one of its prime responsibilities, i.e., ensuring fair access to basic goods and opportunities that condition people's freedom to choose among life-plans they have reason to value[22]. Ruger (2005) argues similarly for the importance of health equity as a goal of public policy, based on "the importance of health for individual agency ".[23] The causal linkages between health and agency are not uni-directional, however. Health is a prerequisite for full individual agency and freedom; yet at the same time, social conditions that provide people with greater agency and control over their work and lives are associated with better health outcomes.[24] In other words, health enables agency, but greater agency and freedom also yield better health. The mutually reinforcing nature of this relationship has important consequences for policymaking.

The international human rights framework is the appropriate conceptual structure within which to advance towards health equity through action on SDH. The framework is based on the 1948 Universal Declaration of Human Rights (UDHR). The UDHR holds that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services' (Art. 25)[25], and additionally that 'Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized' (Art. 28). The human rights aspects of health, and in particular connections between the right to health and social and economic conditions, were clarified in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). In ICESCR Article 12, States signatories acknowledge 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and commit themselves to specific measures to pursue this goal, including improved medical care, but also health-enabling measures outside the medical realm per se, such as the 'improvement of all aspects of environmental and industrial hygiene'.[26]

The General Comment on the Human Right to Health released in 2000 by the UN Committee on Economic, Social and Cultural Rights explicitly affirms that the right to health must be interpreted broadly to embrace key health determinants including (but not limited to) 'food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.'[27] The General Comment echoes WHO's Constitution and the 1978 Declaration of Alma-Ata in asserting governments' responsibility to address social and environmental determinants in order to fulfil citizens' right to the highest attainable standard of health.

Human rights offer more than a conceptual armature connecting health, social conditions and broad governance principles, however. Rights concepts and standards provide an instrument for turning diffuse social demand into focused legal and political claims, as well as a set of criteria by which to evaluate the performance of political authorities in promoting people's wellbeing and creating conditions for equitable enjoyment of the fruits of development.[28] As Braveman and Gruskin argue: 'A human rights perspective removes actions to relieve poverty and ensure equity from the voluntary realm of charity … to the domain of law'. The health sector can use the 'internationally recognized human rights mechanisms for legal accountability' to push for aggressive social policies to tackle health inequities, since international human rights instruments 'provide not only a framework but also a legal obligation for policies towards achieving equal opportunity to be healthy, an obligation that necessarily requires consideration of poverty and social disadvantage'.[29] Over recent years, the work of the UN Special Rapporteur on the Right to Health has been instrumental in advancing the political agenda around the right to health at national and global levels[30].

While human rights have often been interpreted in individualistic terms in some intellectual and legal traditions, notably the Anglo-Saxon, human rights guarantees also concern the collective well-being of social groups and thus can serve to articulate and focus shared claims and an assertion of collective dignity on the part of marginalized communities. In this sense, human rights principles are intimately bound up with values of solidarity and with historical struggles for the empowerment of the disadvantaged.[31]

Alicia Yamin and others have shown that this dimension of *empowerment* is central to operationalizing the right to health and making this principle relevant to people's lives. 'A right to health based upon empowerment' implies fundamentally that 'the locus of decision-making about health shifts to the people whose health status is at issue'. For Yamin, echoing Sen, the full expression of empowerment is people's effective freedom to 'decide what the meaning of their life will be'. In this light, the right to health aims at the creation of social conditions under which previously disadvantaged and disempowered groups are enabled to 'achieve the greatest possible control over … their health'. Increased control over the major factors that influence their health is an indispensable component of individuals' and communities' broader capacity to make decisions about how they wish to live.[32]

Key messages of this section:

- The guiding ethical principle for the CSDH is health equity, defined as the absence of unfair and avoidable or remediable differences in health among social groups.
- Primary responsibility for protecting health equity rests with governments.
- The CSDH embraces the international human rights framework as the appropriate conceptual and legal structure within which to advance towards health equity through action on SDH.
- The realization of the human right to health implies the empowerment of disadvantaged communities to exercise the greatest possible control over the factors that determine their health.

IV. Previous theories and models

The CSDH does not begin in its conceptual work in a vacuum. Rather, we build on the contributions of many prior and contemporary analysts. In this section, we first cite three important directions emerging in recent theory in social epidemiology. Then we review a number of perspectives on the pathways through which social conditions influence health outcomes. These discussions will yield important elements to be included in a framework for action for the CSDH. Finally we highlight areas that previous theories leave insufficiently clarified, on which the CSDH framework can shed new light.

IV.1 Current directions in SDH theory

The three main theoretical directions invoked by current social epidemiologists, which are not mutually exclusive, can be designated as follows: (1) psychosocial approaches; (2) social production of disease/political economy of health; and (3) ecosocial theory and related multilevel frameworks. All three approaches seek to elucidate principles capable of explaining social

inequalities in health, and all represent what Krieger has called theories of disease distribution, which presume but cannot be reduced to mechanism–oriented theories of disease causation. Where they differ is in their respective emphasis on different aspects of social and biological conditions in shaping population health, how they integrate social and biological explanations, and thus their recommendations for action[33].

- The first school places primary emphasis on *psychosocial factors*, and is associated with the view that people's 'perception and experience of personal status in unequal societies lead to stress and poor health'[34]. This school traces its origins to a classic study by Cassel,[35] in which he argued that stress from the 'social environment' alters host susceptibility, affecting neuroendocrine function in ways that increase the organism's vulnerability to disease. More recent researchers, prominently including Richard Wilkinson, have sought to link altered neuroendocrine patterns and compromised health capability to people's perception and experience of their place in social hierarchies. According to these theorists, the experience of living in social settings of inequality forces people constantly to compare their status, possessions and other life circumstances with those of others, engendering feelings of shame and worthlessness in the disadvantaged, along with chronic stress that undermines health. At the level of society as a whole, meanwhile, steep hierarchies in income and social status weaken social cohesion, with this disintegration of social bonds also seen as negative for health. This research has inspired a substantial literature on the relationship between (perceptions of) social inequality, psychobiological mechanisms, and health status.[36]

- A *social production of disease/political economy of health* framework explicitly addresses economic and political determinants of health and disease. Researchers adopting this theoretical approach, also sometimes described as a materialist or neo-materialist position, do not deny negative psychosocial consequences of income inequality. However, they argue that interpretation of links between income inequality and health must begin with the structural causes of inequalities, and not just focus on perceptions of that inequality. Under this interpretation, the effect of income inequality on health reflects both lack of resources held by individuals, and systematic under-investments across a wide range of community infrastructure[37]. Economic processes and political decisions condition the private resources available to individuals and shape the nature of public infrastructure—education, health services, transportation, environmental controls, availability of food, quality of housing, occupational health regulations—that forms the "neo-material" matrix of contemporary life. Thus income inequality per se is but one manifestation of a cluster of material conditions that affect population health.

- Recently, Krieger's '*ecosocial*' approach and other emerging multi-level frameworks have sought to integrate social and biological reasoning and a dynamic, historical and ecological perspective to develop new insights into determinants of population distribution of disease and social inequities in health.[38] According to Krieger, newly emergent multilevel theories, including her own 'ecosocial' theory, seek to 'develop analysis of current and changing population patterns of health, disease and well-being in relation to each level of biological, ecological and social organization', all the way from the cell to human social groupings at all levels of complexity, through the ecosystem as a whole. 'Thus, more than simply adding "biology" to "social analysis", or "social factors" to "biological analyses", the ecosocial framework begins to envision a more systematic integrated approach capable of generating new hypotheses'. In this context, Krieger's notion of 'embodiment' is an especially important concept 'referring to how we literally incorporate biologically influences from the material and social world in which we live, from conception to death; a corollary is that no aspect of

our biology can be understood absent knowledge of history and individual and societal ways of living'. With these constructs in hand, Krieger argues, 'we can begin to elucidate population patterns of health, diseases, and well-being as biological expressions of social relations', while likewise grasping how social relations influence our most basic understandings of biology and our societal constructions of disease[39].

IV.2. Pathways and mechanisms through which SDH influence health

Having canvassed major theoretical approaches to SDH, we now proceed to review specific models that purport to explain socio-economic health inequities. We have chosen to characterize these models as 'perspectives', adopting Mackenbach's classification. This term underscores that the hypotheses examined have a potentially complementary character and, like the directions described in section IV.1, should not be regarded as necessarily mutually exclusive.

IV.2.1. Social selection perspective:

The social selection perspective implies that health determines socioeconomic position, instead of socioeconomic position determining health. The basis of this selection is that health exerts a strong effect on the attainment of social position, resulting in a pattern of social mobility through which unhealthy individuals drift down the social scale and the healthy move up. The literature on health and social mobility suggests that, in general, health status influences subsequent social mobility[40], but evidence is patchy and not entirely consistent across different life stages. Also, there has been limited and inconclusive evidence on the effect that this could have on health gradients.[41] Recently, it was proposed that health-related social mobility does not widen health inequalities, but rather it reduces them, because the upwardly mobile have poorer health status, and the downwardly mobile have better health, than those in the class of destination.[42] On this interpretation, people who are downwardly mobile because of their health still have better health than the people in the class of destination, upgrading this class. Similarly, upwardly mobile people will nonetheless lower the mean health in the higher socio-economic classes into which they become incorporated[43] [44] [45]. Again, the evidence is inconsistent, with some studies suggesting that health selection acts to reduce the magnitude of inequalities[46], whereas others do not.[47] Some studies conclude that health selection cannot be regarded as the predominant explanation for health inequalities.[48]

Several approaches have been used to establish the role and magnitude of health selection on the social gradient. One approach focuses on the effect of social mobility, that is all social mobility and not just that related to health status, on health or health gradients[49]. A second approach focuses on the effect of health status at an earlier life stage in relation to health gradients later on[50]. A third approach has been suggested to overcome these difficulties by focusing on both prior health status and social mobility[51]. It has been argued that health selection would have a stronger effect around the time of labour market entry, when the likelihood of social mobility is greatest[52]. Social mobility implies that an individual's social position can change within a lifetime, compared either with his or her parents' social status (inter-generational mobility) or with himself/herself at an earlier point in time (intra-generational mobility). It is important to distinguish between inter- and intra-generational health selection, although few studies are available that examine selection in both ways.

One might distinguish between when illness influences the allocation of individuals to socioeconomic positions and when ill-health has economic consequences owing to varying

eligibility for and coverage by social insurance or similar mechanisms. Blane and Manor argue that the effect of the "*direct selection*" mechanism on the social gradient is small, and therefore direct social mobility cannot be regarded as a main explanation for inequalities in health. The other and more common version of this perspective is "*indirect selection*": social mobility is selective on determinants of health, not on health itself.[53] It is also important to take into account that the health determinants on which indirect selection takes place could themselves be related to living circumstances during earlier stages of life. Indirect selection would then be part of a mechanism of accumulation of disadvantage over the life course.[54] The process of health selection may therefore contribute to the cumulative effects of social disadvantage across the life span[55]. Poor health at one life stage appears to influence the subsequent risk of being in a lower social position, and thus influences the individual's social trajectory that affects health outcomes later in life. There is some evidence that health selection does not explain the cumulative effect of disadvantage[56], but to date the inclusion of health selection into studies of life course relationships is scarce.

IV.2.2. Social causation perspective

In this perspective, social position determines health through intermediary factors. Longitudinal studies in which socioeconomic status has been measured before health problems are present, and in which the incidence of health problems has been measured during follow-up, show higher risk of developing health problem in the lower socioeconomic groups, ands suggest "social causation" as the main explanation for socioeconomic inequalities in health.[57] This causal effect of socioeconomic status on health is likely to be mainly indirect, through a number of more specific health determinants which are differently distributed across socioeconomic groups. Socioeconomic health differences occur when the quality of these intermediary factors in unevenly distributed between the different socioeconomic classes: socioeconomic status determines a person's behavior, life conditions, etc., and these determinants induce higher or lower prevalence of health problems. The main groups of factors that have been identified as playing an important part in the explanation of health inequalities are material, psychosocial, and behavioral and/or biological factors.

Material factors are linked to conditions of economic hardship, as well as to health-damaging conditions in the physical environment, e.g. housing, physical working conditions, etc. For researchers who emphasize this aspect, health inequalities result from the differential accumulation of exposures and experiences that have their sources in the material world. Meanwhile, material factors and social (dis)advantages predictably intertwine, such that 'people who have more resources in terms of knowledge, money, power, prestige, and social connections are better able to avoid risk … and to adopt the protective strategies that are available at a given time a given place'.[58]

Psychosocial factors are highlighted by the psychosocial theory described above. Relevant factors include stressors (e.g., negative life events), stressful living circumstances, lack of social support, etc. Researchers emphasizing this approach argue that socioeconomic inequalities in morbidity and mortality cannot be entirely explained by well known behavioral or material risk factors of disease. For example, in cardiovascular disease outcomes, risk factors such as smoking, high serum cholesterol and blood pressure can explain less than half of the socioeconomic gradient in mortality[59]. Marmot, Shipley and Rose have argued that the similarity of the risk gradient for a range of diseases could indicate the operation of factors affecting general susceptibility. Meanwhile, the inverse relation between height and mortality suggests that factors operating from early life may influence adult death rates.[60]

Behavioral factors, such as smoking, diet, alcohol consumption and physical exercise, are certainly important determinants of health. Moreover, since they can be unevenly distributed between different socioeconomic positions, they may appear to have important weight as determinants of health inequalities. Yet this hypothesis is controversial in light of the available evidence. Patterns differ significantly from one country to another. For example, smoking is generally more prevalent among lower socioeconomic groups; however, in Southern Europe, smoking rates are higher among higher income groups, and in particular among women.[61] The contribution of diet, alcohol consumption, and physical activities to inequalities in health is less clear and not always consistent. However, there is higher prevalence of obesity and excessive alcohol consumption in lower socioeconomic groups, particularly in richer countries.[62 63 64]

The health system itself constitutes an additional relevant intermediary factor, though one which has often not received adequate attention in the literature. We will discuss this topic in detail in subsequent sections of the paper.

IV.2.3. Life course perspective

A life course approach explicitly recognizes the importance of time and timing in understanding causal links between exposures and outcomes within an individual life course, across generations, and in population-level diseases trends.[65] Adopting a life course perspective directs attention to how social determinants of health operate at every level of development—early childhood, childhood, adolescence, and adulthood—both to immediately influence health and to provide the basis for health or illness later in life. The life course perspective attempts to understand how such temporal processes across the life course of one cohort are related to previous and subsequent cohorts and are manifested in disease trends observed over time at the population level. Time lags between exposure, disease initiation and clinical recognition (latency period) suggest that exposures early in life are involved in initiating diseases processes prior to clinical manifestations. However, the recognition of early-life influences on chronic diseases does not imply deterministic processes that negate the utility of later-life intervention.
In the table reproduced below, Ben-Shlomo and Kuh (2002) have proposed a simple classification of potential life course models of health.

Conceptual life course models	
Critical period model (focus on the importance of timing of exposure)	• With or without later-life risk factors. • With later- life effect modifiers
Accumulation of risk model (focus on the importance of exposure over time and the sequence of exposure)	• With independent and uncorrelated insults. • With correlated insults : o Risk clustering o Chain of risk with additive or trigger effects.

Ref: A life course approach to chronic disease epidemiology . Ann. Rev Health 2005 26:1-35,John Lynch and George Davey Smith .

Two main mechanisms are identified. The '*critical periods' model* is when an exposure acting during a specific period has lasting or lifelong effects on the structure or function of organs, tissues and body systems which are not modified in any dramatic way by later experiences. This is also known as biological programming, and is also sometimes referred to as a latency model. This conception is the basis of hypotheses on the fetal origins of adult diseases. This approach

does recognize the importance of later life effect modifiers, for example in the linkage of coronary heart disease, high blood pressure and insulin resistance with low birth weight.[66]

The *"accumulation of risk"* model suggests that factors that raise disease risk or promote good health may accumulate gradually over the life course, although there may be developmental periods when their effects have greater impact on later health than factors operating at other times. This idea is complementary to the notion that as the intensity, number and/or duration of exposures increase, there is increasing cumulative damage to biological systems. Understanding the health effects of childhood social class by identifying specific aspects of the early physical or psychosocial environment (such as exposure to air pollution or family conflict) or possible mechanisms (such as nutrition, infection or stress) that are associated with adult disease will provide further etiological insights. Circumstances in early life are seen as the initial stage in the pathway to adult health but with an indirect effect, influencing adult health through social trajectories, such as restricting educational opportunities, thus influencing socioeconomic circumstances and health in later life. Risk factors tend to cluster in socially patterned ways, for example, those living in adverse childhood social circumstances are more likely to be of low birth weight, and be exposed to poor diet, childhood infections and passive smoking. These exposures may raise the risk of adult respiratory disease, perhaps through chains of risk or pathways over time where one adverse (or protective) experience will tend to lead to another adverse (protective) experience in a cumulative way.

Ben-Shlomo and Kuh argue that the life course approach is not limited to individuals within a single generation but should intertwine biological and social transmission of risk across generations. It must contextualize any exposure both within a hierarchical structure as well as in relation to geographical and secular differences, which may be unique to that cohort of individuals. Recently the potential for a life course approach to aid understanding of variations in the health and disease of populations over time, across countries and between social groups has been given more attention. Davey Smith and his colleagues suggest that explanations for social inequalities in cause-specific adult mortality lie in socially patterned exposures at different stages of the life course.

Key messages from this section:

- In contemporary social epidemiology, the three main theoretical frameworks for explaining disease distribution are: (1) psychosocial approaches; (2) social production of disease/political economy of health; and (3) ecosocial and other emerging multi-level frameworks. All represent theories of disease distribution, which presume but cannot be reduced to mechanism–oriented theories of disease causation.
- The main social pathways and mechanisms through which social determinants affect people's health can usefully be seen through three perspectives: (1) 'social selection', or social mobility; (2) 'social causation'; and (3) lifecourse perspectives.
- These frameworks/directions and models are not mutually exclusive. On the contrary, they are complementary, and all contribute elements to the CSDH framework.
- Some previous frameworks for understanding SDH and disease distribution have paid insufficient attention to political variables. The CSDH framework will systematically incorporate these factors.

V. CSDH framework for action

V.1.- Purpose of constructing a model for the CSDH

We now proceed to present in detail the specific conceptual framework developed for the CSDH. This is an action-oriented framework, whose primary purpose is to support the CSDH in identifying the level(s) at which it will seek to promote change in tackling SDH through policy. The framework helps to situate these levels of intervention, clarify their relationships and suggest the scope and limits of policy action in each area. A comprehensive SDH model should achieve the following:

(a) Identify the social determinants of health and the social determinants of inequities in health;
(b) Show how major determinants relate to each other;
(c) Clarify the mechanisms by which social determinants generate health inequities;
(d) Provide a framework for evaluating which SDH are the most important to address; and
(e) Map specific levels of intervention and policy entry points for action on SDH.

To include all these aspects in one model is difficult and may complicate understanding. In an earlier version of the CSDH conceptual framework, drafted in 2005, we attempted to include all of these elements in a single synthetic diagram. However, this approach was not necessarily the most helpful. In the current presentation, we separate out the various major components of the framework, and we present and discuss each element separately, in detail.

We begin the presentation by sketching some additional important background elements: first, insights from the theorization of social power, which can help to clarify the dynamics of social stratification; second, an existing model of the social production of disease developed by

Diderichsen and colleagues, from which the CSDH framework draws significantly. With these background elements in place, we proceed to examine the key components of the CSDH framework in turn, including: (1) the socio-political context; (2) structural determinants and socioeconomic position; (3) intermediary determinants. We conclude the presentation with a synthetic review of the framework as a whole. The issue of entry points for policy action will be taken up explicitly in the next chapter.

V.2.- Theories of power to guide action on social determinants

Health inequities flow from patterns of social stratification—that is, from the systematically unequal distribution of power, prestige and resources among groups in society. As a critical factor shaping social hierarchies and thus conditioning health differences among groups, 'power' demands careful analysis from researchers concerned with health equity and SDH. Understanding the causal processes that underlie health inequities, and assessing realistically what may be done to alter them, requires understanding how power operates in multiple dimensions of economic, social and political relationships.

The theory of power is an active domain of inquiry in philosophy and the social sciences, and developing a full-fledged theory of power lies beyond the mandate of the CSDH. What the Commission can do is draw elements from philosophical and political analyses of power to guide its framing of the relationships among health determinants and its recommendations for interventions to alter the social distribution of health and sickness.

Power is 'arguably the single most important organizing concept in social and political theory',[67] yet this central concept remains contested and subject to diverse and often contradictory interpretations. Classic treatments of the concept of power have emphasized two fundamental aspects: (1) 'power to', i.e., what Giddens has termed 'the transformative capacity of human agency', in the broadest sense 'the capability of the actor to intervene in a series of events so as to alter their course";[68] and (2) 'power over', which characterizes a relationship in which an actor or group achieves its strategic ends by determining the behavior of another actor or group. Power in this second, more limited but politically crucial sense may be understood as 'the capability to secure outcomes where the realization of these outcomes depends upon the agency of others'.[69] 'Power over' is closely linked to notions of coercion, domination and oppression; it is this aspect of power which has been at the heart of most influential modern theories of power.[70] It is important to observe, meanwhile, that 'domination' and 'oppression' in the relevant senses need not involve the exercise of brute physical violence, nor even its overt threat. In a classic study, Steven Lukes showed that coercive power can take covert forms. For example, power expresses itself in the ability of advantaged groups to shape the agenda of public debate and decision-making in such a way that disadvantaged constituencies are denied a voice. At a still deeper level, dominant groups can mold people's perceptions and preferences, for example through control of the mass media, in such a way that the oppressed are convinced they do not have any serious grievances. 'The power to shape people's thoughts and desires is the most effective kind of power, since it pre-empts conflict and even pre-empts an awareness of possible conflicts'.[71] Iris Marion Young develops related insights on the presence of coercive power even where overt force is absent. She notes that 'oppression' can designate, not only 'brutal tyranny over a whole people by a few rulers', but also 'the disadvantage and injustice some people suffer … because of the everyday practices of a well-intentioned liberal society'. Young terms this 'structural oppression', whose forms are 'systematically reproduced in major economic, political and cultural institutions'.[72]

For all their explanatory value, power theories which tend to equate power with domination leave key dimensions of power insufficiently clarified. As Angus Stewart argues, such theories must be complemented by alternative readings that emphasize more positive, creative aspects of power. A crucial source for such alternative models is the work of philosopher Hannah Arendt. Arendt challenged fundamental aspects of conventional western political theory by stressing the inter-subjective character of power in collective action. In Arendt's philosophy, 'power is conceptually and *above all politically* distinguished, not by its implication in agency, but above all by its character as *collective action*'[73]. For Arendt, 'Power corresponds to the human ability not just to act, but to act in concert. Power is never the property of an individual; it belongs to a group and remains in existence only so long as the group keeps together'[74]. From this vantage point, power can be understood as 'a relation in which people are not dominated but empowered' through critical reflection leading to shared action[75].

Recent feminist theory has further enriched these perspectives. Luttrell, Quiroz and Scrutton (2007) follow Rowland (1997) in distinguishing four fundamental types of power:

- Power over (ability to influence or coerce)
- Power to (organize and change existing hierarchies)
- Power with (power from collective action)
- Power within (power from individual consciousness)

They note that these different interpretations of power have important operational consequences for development actors' efforts to facilitate the empowerment of women and other traditionally dominated groups. An approach based on 'power over' emphasizes greater participation of previously excluded groups within existing economic and political structures. In contrast, models based on 'power to' and 'power with', emphasizing new forms of collective action, push towards a transformation of existing structures and the creation of alternative modes of power-sharing: 'not a bigger piece of the cake, but a different cake'.[76]

This emphasis on power as collective action connects suggestively with a model of social ethics based on human rights. As one analyst has argued: 'Throughout its history, the struggle for human rights has a constant: in very different forms and with very different contents, this struggle has consisted of one basic reality: a demand by oppressed and marginalized social groups and classes *for the exercise of their social power*'.[77] Understood in this way, a human rights agenda means supporting the collective action of historically dominated communities to analyze, resist and overcome oppression, asserting their shared power and altering social hierarchies in the direction of greater equity.

The theories of power we have reviewed are relevant to analysis and action on the social determinants of health in a number of ways. First and most fundamentally, they remind us that any serious effort to reduce health inequities will involve changing the distribution of power within society to the benefit of disadvantaged groups. Changes in power relationships can take place at various levels, from the 'micro' level of individual households or workplaces to the 'macro' sphere of structural relations among social constituencies, mediated through economic, social and political institutions. Power analysis makes clear, however, that micro-level modifications will be insufficient to reduce health inequities unless micro-level action is supported and reinforced through structural changes.

By definition, then, action on the social determinants of health inequities is a political process that engages both the agency of disadvantaged communities and the responsibility of the state. This political process is likely to be contentious in most contexts, since it will be seen as pitting

the interests of social groups against each other in a struggle for power and control of resources. Theories of power rooted in collective action, such as Arendt's, open the perspective of a less agonistic model of equity-focused politics, emphasizing the creative self-empowerment of previously oppressed groups. 'Here the paradigm case is not one of command, but one of enablement in which a disorganized and unfocused group acquires an identity and a resolve to act'.[78] However, there can be little doubt that the political expression of vulnerable groups' 'enablement' will generate tensions among those constituencies that perceive their interests as threatened. On the other hand, theories that highlight both the overt and covert forms through which coercive power operates provide a sobering reminder of the obstacles confronting collective action among oppressed groups.

Theorizing the impact of social power on health suggests that the empowerment of vulnerable and disadvantaged social groups will be vital to reducing health inequities. However, the theories reviewed here also encourage us to problematize the concept of 'empowerment' itself. They point to the different (in some cases incompatible) meanings this term can carry. What different groups mean by empowerment depends on their underlying views about power. The theories we have discussed acknowledge different forms of power and thus, potentially, different kinds and levels of empowerment. However, these theories urge skepticism towards depoliticized models of empowerment and approaches that claim to empower disadvantaged individuals and groups while leaving the distribution of key social and material goods largely unchanged. Those concerned to reduce health inequities cannot accept a model of empowerment that stresses process and psychological aspects at the expense of political outcomes and downplays verifiable change in disadvantaged groups' ability to exercise control over processes that affect their wellbeing. This again raises the issue of state responsibility in creating spaces and conditions under which the empowerment of disadvantaged communities can become a reality. A model of community or civil society empowerment appropriate for action on health inequities cannot be separated from the responsibility of the state to guarantee a comprehensive set of rights and ensure the fair distribution of essential material and social goods among population groups. This theme is explored more fully in section VI.4.3, below.

Key messages from this section:

- An explicit theorization of power is useful for guiding action to tackle health inequities.
- Classic conceptualizations of power have emphasized two basic aspects: (1) 'power to', i.e., the ability to bring about change through willed action; and (2) 'power over', the ability to determine other people's behavior, associated with domination and coercion.
- Theories that equate power with domination can be complemented by alternative readings that emphasize more positive, creative aspects of power, based on collective action. In this perspective, human rights can be understood as embodying a demand on the part of oppressed and marginalized communities for the expression of their collective social power.
- Any serious effort to reduce health inequities will involve changing the distribution of power within society to the benefit of disadvantaged groups.
- Changes in power relationships can range from the 'micro' level of individual households or workplaces to the 'macro' sphere of structural relations among social constituencies, mediated through economic, social and political institutions. Micro-level modifications will be insufficient to reduce health inequities unless supported by structural changes.
- This means that action on the social determinants of health inequities is a political process that engages both the agency of disadvantaged communities and the responsibility of the state.

V.3.- Relevance of the Diderichsen model for the CSDH framework

The CSDH framework for action draws substantially on the contributions of many previous researchers, prominently including Finn Diderichsen. Diderichsen's and Hallqvist's 1998 model of the social production of disease was subsequently adapted by Diderichsen, Evans and Whitehead (2001)[79]. The concept of social position is at the center of Diderichsen's interpretation of "the mechanisms of health inequality"[80]. In its initial formulation, the model emphasized the pathway from society through social position and specific exposures to health. The framework was subsequently elaborated to give greater emphasis to "mechanisms that play a role in stratifying health outcomes,"[81] including "those central engines of society that generate and distribute power, wealth and risks" and thereby determine the pattern of social stratification. The model emphasizes how social contexts create social stratification and assign individuals to different social positions. Social stratification in turn engenders differential exposure to health-damaging conditions and differential vulnerability, in terms of health conditions and material resource availability. Social stratification likewise determines differential consequences of ill health for more and less advantaged groups (including economic and social consequences, as well as differential health outcomes per se).
At the individual level, the figure depicts the pathway from social position, through exposure to specific contributing causal factors, and on to health outcomes. As many different interacting causes in the same pathway might be related to social position, the effect of a single cause might

differ across social positions as it interacts with some other cause related to social position[82]. Diderichsen's most recent version of the model provides some additional insights.[83] Both *differential exposure* (Roman numeral 'I' in the diagram below) and *differential vulnerability* (II) may contribute to the relation between social position and health outcomes, as can be tested empirically[84]. Ill health has serious social and economic consequences due to inability to work and the cost of health care. These consequences depend not only on the extent of disability but also on the individual's social position (III—*differential consequences*) and on the society's environment and social policies. The social and economical consequences of illness may feed back into the etiological pathways and contribute to the further development of disease in the individual (IV). This effect might even, on an aggregate level, feed into the context of society, as well, and influence aggregate social and economic development[85].

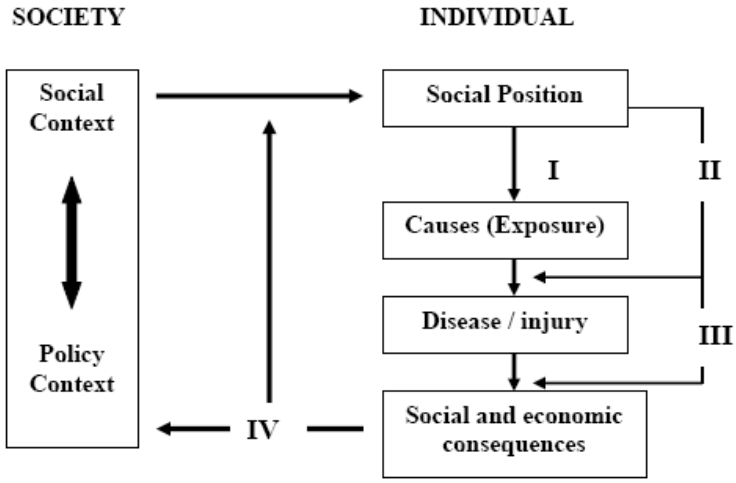


Fig: Diderichsen, et al. (2001).

Many of the insights from Diderichsen's model will be taken up into the CSDH framework, which we will now begin to explain, presenting its key components one by one.

Key messages from this section:

- Social position is at the center of Diderichsen's model of 'the mechanisms of health inequality'.
- The mechanisms that play a role in stratifying health outcomes operate in the following manner :
  - **Social contexts** create social stratification and assign individuals to different social positions.
  - **Social stratification** in turn engenders **differential exposure** to health-damaging conditions and **differential vulnerability**, in terms of health conditions and material resource availability.
  - Social stratification likewise determines **differential consequences** of ill health for more and less advantaged groups (including economic and social consequences, as well differential health outcomes per se).

V.4 .- First element of the CSDH framework : socio-economic and political context

The social determinants framework developed by the CSDH differs from some others in the importance attributed to the *socioeconomic-political context*. This is a deliberately broad term that refers to the spectrum of factors in society that cannot be directly measured at the individual level. 'Context' therefore encompasses a broad set of structural, cultural and functional aspects of a social system whose impact on individuals tends to elude quantification but which exert a powerful formative influence on patterns of social stratification and thus on people's health opportunities. Within the context in this sense will be found those social and political mechanisms that generate, configure and maintain social hierarchies, such as for example the labor market, the educational system, and political institutions including the welfare state.

One point noted by some analysts, and which we also wish to emphasize, is the relative inattention to issues of political context in a substantial portion of the literature on health determinants. It has become commonplace among population health researchers to acknowledge that the health of individuals and populations is strongly influenced by SDH. It is much less common to aver that the quality of SDH is in turn shaped by the policies that guide how societies (re)distribute material resources among their members[86]. In the growing area of SDH research, a subject rarely studied is the impact on social inequalities and health of political movements and parties and the policies they adopt when in government[87].

Meanwhile, Navarro and other researchers have compiled over the years an increasingly solid body of evidence that the quality of many social determinants of health is conditioned by approaches to public policy. To name just one example, the state of Kerala in India has been widely studied, showing the relationship between its impressive reduction of inequalities in the last 40 years and improvements in the health status of its population. With very few exceptions, however, these reductions in social inequalities and improvements in health have rarely been traced to the public policies carried out by the state’s governing communist party, which has governed in Kerala for the longest period during those 40 years[88]. Hung and Muntaner find similarly that few studies have explored the relationship between political variables and population health at the national level, and none has included a comprehensive number of political variables to understand their effect on population health, while simultaneously adjusting for economic determinants.[89] As an illustration of the powerful impact of political variables on health outcomes, these researchers concluded in a recent study of 18 wealthy countries in Europe, North America and the Asia-Pacific region that 20 % of the differences in infant mortality rate among countries could be explained by the type of welfare state. Similarly, different welfare state models among the countries accounted for about 10 % of differences in the rate of low birth weight babies.[90]

Raphael similarly emphasizes how policy decisions impact a broad range of factors that influence the distribution and effects of SDH across population groups. Policy choices are reflected for example in: family-friendly labor policies; active employment policies involving training and support; the provision of social safety nets; and the degree to which health and social services and other resources are available to citizens[91]. The organization of health care is also a direct result of policy decisions made by governments. Public policy decisions made by governments are of course themselves driven by a variety of political, economic, and social forces, constituting a complex space in which the relationship between politics, policy and health works itself out.

It is safe to say that these specifically political aspects of context are important for the social distribution of health and sickness in virtually all settings, and have been seriously understudied. On the other hand, it is also the case that the most relevant contextual factors, i.e., those that play the greatest role in generating social inequalities, may differ considerably from one country to another.[92] For example, in some countries religion will be a decisive factor, in others less so. In general, the construction/mapping of context should include at least six points: (1) **governance** in the broadest sense and its processes, including definition of needs, patterns of discrimination, civil society participation, and accountability/transparence in public administration; (2) **macroeconomic policy**, including fiscal, monetary, balance of payments and trade policies, and underlying labour market structures; (3**) social policies** affecting factors such as labor, social welfare, land and housing distribution; (4) **public policy** in other relevant areas such as education, medical care, water and sanitation;[93] (5) **culture and societal values**; (6) **epidemiological conditions**, particularly in the case of major epidemics such as HIV/AIDS, which exert a powerful influence on social structures and must be factored into global and national policy-setting. In what follows, we highlight some of these contextual elements, focusing particularly on those with major importance for health equity.

We have adopted the UNDP definition of governance, which is as follows: "[the] system of values, policies and institutions by which society manages economic, political and social affairs through interactions within and among the state, civil society and private sector. It is the way a society organizes itself to make and implement decisions. It comprises the mechanisms and processes for citizens and groups to articulate their interests, mediate their differences and exercise their legal rights and obligations. It is the rules, institutions and practices that set limits and provide incentives for individuals, organizations and firms. Governance, including its social, political and economic dimensions, operates at every level of human enterprise, be it the household, village, municipality, nation, region or globe".[94] It is important to acknowledge, meanwhile, that there is no general agreement on the definition of governance, or of good governance. Development agencies, international organizations and academic institutions define governance in different ways, this being generally related to the nature of their interests and mandates.[95]

Regarding labour market policies, we adopt aspects included in the glossary elaborated for the CSDH's Employment Conditions Knowledge Network[96]: "Labour market policies mediate between supply (jobseekers) and demand (jobs offered) in the labour market and their intervention can take several forms. There are policies that contribute directly to matching workers to jobs and jobs to workers or enhancing workers' skills and capacities, reducing labour supply, creating jobs or changing the structure of employment in favour of disadvantaged groups (e.g. employment subsidies for target groups). Typical passive programmes are unemployment insurance and assistance and early retirement; typical active measures are labour market training, job creation in form of public and community work programmes, programmes to promote enterprise creation and hiring subsidies. Active policies are usually targeted at specific groups facing particular labour market integration difficulties: younger and older people, women and those particularly hard to place such as the disabled".

The concept of the 'welfare state' is one in which the state plays a key role in the protection and promotion of the economic and social well-being of its citizens. It is based on the principles of equality of opportunity, equitable distribution of wealth, and public responsibility for those unable to avail themselves of the minimal provisions for a good life. The general term may cover a variety of forms of economic and social organization. A fundamental feature of the welfare state is social insurance. The welfare state also usually includes public provision of basic

education, health services, and housing (in some cases at low cost or without charge). Antipoverty programs and the system of personal taxation may also be regarded as aspects of the welfare state. Personal taxation falls into this category insofar as its progressively is used to achieve greater justice in income distribution (rather than merely to raise revenue) and also insofar as it used to finance social insurance payments and other benefits not completely financed by compulsory contributions. In socialist countries the welfare state also covers employment and administration of consumer prices.[97]

One of the main functions of the welfare state is 'income redistribution'; therefore, the welfare state framework has been applied to the fields of social epidemiology and health policy as an amendment to the 'relative income hypothesis'. Welfare state variables have been added to measures of income inequality to determine the structural mechanism through which economic inequality affects population health status.[98]

Chung and Muntaner provide a classification of welfare state types and explore the health effects of their respective policy approaches. Their study concludes that countries exhibit distinctive levels of population health by welfare regime types, even when adjusted by the level of economic development (GDP per capita) and intra-country correlations. They find, specifically, that Social Democratic countries exhibit significantly better population health status, i.e., lower infant mortality rate and low birth weight rate, compared to other countries.[99]

Institutions and processes connected with globalization constitute an important dimension of context as we understand it. 'Globalization' is defined by the CSDH Globalization Knowledge Network, following Jenkins, as: '"a process of greater integration within the world economy through movements of goods and services, capital, technology and (to a lesser extent) labour, which lead increasingly to economic decisions being influenced by global conditions"– in other words, to the emergence of a global marketplace'[100]. Non-economic aspects of globalization, including social and cultural aspects, are acknowledged and relevant. However, economic globalization is understood as the force that has driven other aspects of globalization over recent decades. The importance of globalization signifies that contextual analysis on health inequities will often need to examine the strategies pursued by actors such as transnational corporations and supranational political institutions, including the World Bank and International Monetary Fund.

'Context' also includes social and cultural values. The value placed on health and the degree to which health is seen as a collective social concern differs greatly across regional and national contexts. We have argued elsewhere, following Roemer and Kleczkowski, that the social value attributed to health in a country constitutes an important and often neglected aspect of the context in which health policies must be designed and implemented.[101] In constructing a typology of health systems, Roemer and Kleczkowski have proposed three domains of analysis to indicate how health is valued in a given society:

- The extent to which health is a priority in the governmental /societal agenda, as reflected in the level of national resources allocated to health.
- The extent to which the society assumes collective responsibility for financing and organizing the provision of health services. In maximum collectivism (also referred to as a state-based model), the system is almost entirely concerned with providing collective benefits, leaving little or no choice to the individual. In maximum individualism, ill health and its care are viewed as private concerns.
- The extent of societal distributional responsibility. This is a measure of the degree to which society assumes responsibility for the distribution of its health resources. Distributional

responsibility is at its maximum when the society guarantees equal access to services for all.[102]

These criteria are important for health systems policy and evaluating systems performance. They are also relevant to assessing opportunities for action on SDH.

To fully characterize all major components of the socioeconomic and political context is beyond the scope of the present paper. Here, we have considered only a small number of those components likely to have particular importance for health equity in many settings.

V.5. - Second element of the framework: structural determinants and socioeconomic position

Graham observes that the concept of 'social determinants of health' has acquired a dual meaning, referring both to the social factors promoting and undermining the health of individuals and populations and to the social processes underlying the unequal distribution of these factors between groups occupying unequal positions in society. The central concept of 'social determinants' thus remains ambiguous, referring simultaneously to the determinants of health and to the determinants of inequalities in health. Graham notes that: "using a single term to refer to both the social factors influencing health and the social processes shaping their social distribution would not be problematic if the main determinants of health—like living standards, environmental influences, and health behaviors—were equally distributed between socioeconomic groups". But the evidence points to marked socioeconomic differences in access to material resources, health-promoting resources, and in exposure to risk factors. Furthermore, policies associated with positive trends in health determinants (e.g., a rise in living standards and a decline in smoking) have also been associated with persistent socioeconomic disparities in the distribution of these determinants (marked socioeconomic differences in living standards and smoking rates). [103] We have attempted to resolve this linguistic ambiguity by introducing additional differentiations within the field of concepts conventionally included under the heading 'social determinants'. We adopt the term ***'structural determinants'*** to refer specifically to the components of people's socioeconomic position. Structural determinants, combined with the main features of the socioeconomic and political context described above, together constitute what we call the ***social determinants of health inequities***. This concept corresponds to Graham's notion of the 'social processes shaping the distribution' of downstream social determinants. When referring to the more downstream factors, we will use the term '***intermediary determinants of health***'. We attach to this term specific nuances that will be spelt out in a later section (see section V.6., below).

Within each society, material and other resources are unequally distributed. This inequality can be portrayed as a system of social stratification or social hierarchy[104]. People attain different positions in the social hierarchy according mainly to their social class, occupational status, educational achievement and income level. Their position in the social stratification system can be summarized as their socioeconomic position. (A variety of other terms, such as social class, social stratum, and social or socioeconomic status, are often used more or less interchangeably in the literature, despite their different theoretical bases.)

The two major variables used to operationalize socioeconomic position in studies of social inequities in health are *social stratification* and *social class.* The term stratification is used in sociology to refer to social hierarchies in which individuals or groups can be arranged along a ranked order of some attribute. Income or years of education provide familiar examples.

Measures of social stratification are important predictors of patterns of mortality and morbidity. However, despite their usefulness in predicting health outcomes, these measures do not reveal the social mechanisms that explain how individuals arrive at different levels of economic, political and cultural resources. 'Social class', meanwhile, is defined by relations of ownership or control over productive resources (i.e. physical, financial, organizational)[105]. This concept adds significant value, in our view, and for that reason we have chosen to include it as an additional, distinct component in our discussion of socioeconomic position. The particularities of the concept of social class will be described in greater detail when we analyze this concept under point V.5.4., below.

Two central figures in the study of socioeconomic position were Karl Marx and Max Weber. For Marx, socioeconomic position was entirely determined by ''social class'', whereby an individual is defined by their relation to the ''means of production'' (for example, factories, land). Social class, and class relations, is characterized by the inherent conflict between exploited workers and the exploiting capitalists or those who control the means of production. Class, as such, is not an a priori property of individual human beings, but is a social relationship created by societies. One explicit adaptation of Marx's theory of social class that takes into account contemporary employment and social circumstances is Wright's social class classification. In this scheme, people are classified according to the interplay of three forms of exploitation: (a) ownership of capital assets, (b) control of organizational assets, and (c) possession of skills or credential assets[106].

Weber developed a different view of social class. According to Weber, differential societal position is based on three dimensions: class, status and party (or power). Class is assumed to have an economic base. It implies ownership and control of resources and is indicated by measures of income. Status is considered to be prestige or honor in the community. Weber considers status to imply "access to life chances" based on social and cultural factors such as family background, lifestyle and social networks. Finally, power is related to a political context.[107] In this paper, we use the term "socioeconomic position", acknowledging the three separate but linked dimensions of social class reflected in the Weberian conceptualization.

Krieger, Williams and Moss refer to *socioeconomic position* as an aggregate concept that includes both resource-based and prestige-based measures, as linked to both childhood and adult social class position. Resource-based measures refer to material and social resources and assets, including income, wealth, and educational credentials; terms used to describe inadequate resources include "poverty" and "deprivation". Prestige-based measures refer to individuals' rank or status in a social hierarchy, typically evaluated with reference to people's access to and consumption of goods, services, and knowledge, as linked to their occupational prestige, income, and educational level. Given distinctions between resource-based and prestige-based aspects of socioeconomic position and the diverse pathways by which they affect health, epidemiological studies should state clearly how measures of socioeconomic position are conceptualized. [108] Educational level creates differences between people in terms of access to information and the level of proficiency in benefiting from new knowledge, whereas income creates differences in access to scarce material goods. Occupational status includes both these aspect and adds to them benefits accruing from the exercise of specific jobs, such prestige, privileges, power and social and technical skills.

Kunst and Mackenbach have argued that there are several indicators for socioeconomic position, and that the most important are occupational status, level of education and income level. Each indicator covers a different aspect of social stratification, and it is therefore preferable to use all

three instead of only one. They add that the measurement of these three indicators is far from straightforward, and due attention should be paid to the application of appropriate classifications , for example, children, women and economically inactive people, for whom one or more of these indicators may not be directly available. Information on education, occupation and income may be unavailable, and it may then necessary to use proxy measures of socioeconomic status such as indicators of living standards (for example, car ownership or housing tenure).

Singh-Manoux and colleagues have argued that the social gradient is sensitive to the proximal/distal nature of the indicator of socioeconomic position employed. The idea is that there is valid basis for causal and temporal ordering in the various measures of socioeconomic position. An analysis of the socioeconomic status of individuals at several stages of their lives showed that socioeconomic origins have enduring effects on adult mortality through their effect on later socioeconomic circumstances such as education, occupation and financial resources. This approach is derived from the life course perspective, where education is seen to structure occupation and income. In this model, education influences health outcomes both directly and indirectly through its effect on occupation and income.[109] The disadvantage with education is that it does not capture changes in adult socioeconomic circumstances or accumulated socioeconomic position.

Reporting that educational attainment, occupational category, social class, and income are probably the most often used indicators of current socioeconomic status in studies on health inequalities, Lahelman and colleagues find that each indicator is likely to reflect both common impacts of a general hierarchical ranking in society, and particular impacts specific to the indicator. (1) Educational attainment is usually acquired by early adulthood. The specific nature of education is knowledge and other non-material resources that are likely to promote healthy lifestyles. Additionally, education provides formal qualifications that contribute to the socioeconomic status of destination through occupation and income. (2) Occupation-based social class relates people to social structure. Occupational social class positions indicate status and power, and reflect material conditions related to paid work. (3) Individual and household income derive primarily from paid employment. Income provides individuals and families necessary material resources and determines their purchasing power. Thus income contributes to resources needed in maintaining good health. Following these considerations, education is typically acquired first over the life course. Education contributes to occupational class position and through this to income. The effect of education on income is assumed to be mediated mainly through occupation[110].

Socioeconomic position can be measured meaningfully at three complementary levels: individual, household, and neighborhood. Each level may independently contribute to distributions of exposure and outcomes. Also, socioeconomic position can be measured meaningfully at different points of the lifespan: e.g., infancy, childhood, adolescent, adult (current, past 5 years, etc). Relevant time periods depend on presumed exposures, causal pathways, and associated etiologic periods. Today it is also vital to recognize gender, ethnicity and sexuality as social stratifiers linked to systematic forms of discrimination.[111]

The CSDH framework posits that *structural determinants* are those that generate or reinforce social stratification in the society and that define individual socioeconomic position. These mechanisms configure the health opportunities of social groups based on their placement within hierarchies of **power, prestige** and **access to resources** (economic status). We prefer to speak of *structural determinants*, rather than ‘distal’ factors, in order to capture and underscore the causal hierarchy of social determinants involved in producing health inequities. Structural social

stratification mechanisms, joined to and influenced by institutions and processes embedded in the socioeconomic and political context (e.g., redistributive welfare state policies), can together be conceptualized as ***the social determinants of health inequities.***

We now examine briefly each of the major variables used to operationalize socioeconomic position. First we analyse the proxies use to measure social stratification, including income, education and occupation. Income and education can be understood as social outcomes of stratification processes, while occupation serves as a proxy for social stratification. Having reviewed the use of these variables, we then turn to analyse social class, gender and ethnicity, which operate as important structural determinants.

V.5.1.- Income

Income is the indicator of socioeconomic position that most directly measures the material resources component. As with other indicators such as education, income has a ‘‘dose-response’’ association with health, and can influence a wide range of material circumstances with direct implications for health[112] [113] Income also has a cumulative effect over the life course and is the socioeconomic position indicator that can change most on a short term basis. It is implausible that money in itself directly affects health, thus it is the conversion of money and assets into health enhancing commodities and services via expenditure that may be the more relevant concept for interpreting how income affects health. Consumption measures are, however, rarely used in epidemiological studies, [114] and are in fact seriously flawed when used in health equity research because high medical costs (an element of consumption) may make a household appear non-poor[115].

Income is not a simple variable. Components include wage earning, dividends, interest, child support, alimony, transfer payments and pensions. Kunst and Mackenbach argued that this is more proximate indicator of access to scare material resources or of standard of living. It can be expressed most adequately when the income level is measured by: adding all income components (this yield total gross income); subtracting deductions of tax and social contribution (net income); adding the net income of all household members (household income); or adjusting for the size of the household (household equivalent income)[116] .

While individual income will capture individual material characteristics, household income may be a useful indicator, since the benefits of many elements of consumption and asset accumulation are shared among household members. This cannot be presumed, especially in the context of gender divisions of labour and power within the household, in particular for women, who may not be the main earners in the household. Using household income information to apply to all the people in the household assumes an even distribution of income according to needs within the household, which may or may not be true. However income is nevertheless the best single indicator of material living standards. Ideally, data are collected on disposable income (what individuals/households can actually spend), but often data are collected instead on gross incomes, or incomes that do not take account in-kind transfers that function as hypothecated income. The meaning of current income for different age groups may vary and be most sensitive during the prime earning years. Income for young and older adults may be a less reliable indicator of their true socioeconomic position because income typically follows a curvilinear trajectory with age. Measures at one point in time may thus fail to capture important information about income fluctuations.[117] [118] Macinko, Shi, Starfield and Wulu propose the following summary table of explanations for the relationship between income inequality and health [119]:

Explanation	*Synopsis of the Argument*
Psychosocial (micro) : Social status	Income inequality results in "invidious processes of social comparison" that enforce social hierarchies causing chronic stress leading to poorer health outcomes for those at the bottom.
Psychosocial (macro): Social cohesion	Income inequality erodes social bonds that allow people to work together, decreases social resources, and results in less trust and civic participation, greater crime, and other unhealthy conditions.
Neo-material (micro): Individual income	Income inequality means fewer economic resources among the poorest, resulting in lessened ability to avoid risks, cure injury or disease, and/or prevent illness.
Neo-material (macro): Social disinvestment	Income inequality results in less investment in social and environmental conditions (safe housing, good schools, etc.) necessary for promoting health among the poorest.
Statistical artifact	The poorest in any society are usually the sickest. A society with high levels of income inequality has high numbers of poor and consequently will have more people who are sick.
Health selection	People are not sick because they are poor. Rather, poor Health lowers one's income and limits one's earning potential.

Galobardes, Shaw, Lawler, Lynch and Davey Smith, conversely, have argued that income primarily influences health through a direct effect on material resources that are in turn mediated by more proximal factors in the causal chain, such as behaviors. The mechanisms through which income could affect health are:

- Buying access to better quality material resources such as food and shelter.
- Allowing access to services, which may improve health directly (such as health services, leisure activities) or indirectly (such as education).
- Fostering self esteem and social standing by providing the outward material characteristics relevant to participation in society.
- Health selection (also referred to as 'reverse causality') may also be considered as income level can be affected by health status.

V.5.2.- Education

Education is a frequently used indicator in epidemiology. As formal education is frequently completed in young adulthood and is strongly determined by parental characteristics[120 121], it can be conceptualized within a life course framework as an indicator that in part measures early life socioeconomic position. Education can be measured as a continuous variable (years of completed education), or as a categorical variable by assessing educational milestones such as completion of primary or high school, higher education diplomas, or degrees. Although education is often used as a generic measure of socioeconomic position, specific interpretations explain its association with health outcomes:

- Education captures the transition from parents' (received) socioeconomic position to adulthood (own) socioeconomic position and it is also a strong determinant of future employment and income. It reflects material, intellectual, and other resources of the family of origin, begins at early ages, is influenced by access to and performance in primary and secondary school and reaches final attainment in young adulthood for most people. Therefore it captures the long term influences of both early life circumstances on adult health, as well as the influence of adult resources (for example, through employment status) on health.
- The knowledge and skills attained through education may affect a person's cognitive functioning, make them more receptive to health education messages, or more able to communicate with and access appropriate health services.
- Ill health in childhood could limit educational attendance and/or attainment and predispose to adult disease, generating a health selection influence on health inequalities.

Finally, measuring the number of years of education or levels of attainment may contain no information about the quality of the educational experience, which is likely to be important if conceptualizing the role of education in health outcomes specifically related to knowledge, cognitive skills, and analytical abilities but may be less important if education is simply used as a broad indicator of socioeconomic position.

V.5.3.- Occupation

Occupation-based indicators of socioeconomic position are widely used. Kunst and Mackenbach emphasize that this measure is relevant because it determines people's place in the societal hierarchy and not just because it indicates exposure to specific occupational risk, such as toxic compounds. Galobardes, Shaw, Lawler, Lynch & Davey Smith suggest that occupation can be seen as a proxy for represent Weber's notion of socioeconomic position, as a reflection of a person's place in society related to their social standing, income and intellect. Occupation can also identify working relations of domination and subordination between employers and employees or, less frequently, characterize people as exploiters or exploited in class relations.

The main issue, then, is how to classify people with a specific job according to their place in the social hierarchy. The most usual approach consists of classifying people based on their position in the labour market into a number of discrete groups or social classes. People can be assigned to social classes by means of a set of detail rules that use information on such items as occupational title, skills required, income pay-off and leadership functions. For example Wright's typology distinguishes among four basic class categories: wage laborers, petty bourgeois (self-employed with no more than one employee; small employers (2-9 employees) and capitalist (10 or more employees). Also other classifications - called "social class" but more accurately termed "occupational class"- have been used in European public health surveillance and research. Among the best known and longest lived of these occupational class measures is the British Registrar General's social class schema, developed in 1913. This schema has proven to be powerfully predictive of inequalities in morbidity or mortality, especially among employed men[122 123]. The model has five categories based on a graded hierarchy of occupations ranked according to skill. Importantly, these occupational categories are not necessarily reflective of class relations.

Most studies use the current or longest held occupation of a person to characterize their adult socioeconomic position. However, with increasing interest in the role of socioeconomic position across the life course, some studies include parental occupation as an indicator of childhood socioeconomic position in conjunction with individuals' occupations at different stages in adult

life. Some of the more general mechanisms that may explain the association between occupation and health related outcomes are presented by:

- Occupation (parental or own adult) is strongly related to income and therefore the association with health may be one of a direct relation between material resources—the monetary and other tangible rewards for work that determines material living standards—and health.
- Occupations reflect social standing and may be related to health outcomes because of certain privileges—such as easier access to better health care, access to education, and more salubrious residential facilities—that are afforded to those of higher standing.
- Occupation may reflect social networks, work based stress, control, and autonomy and thereby affect health outcomes through psychosocial processes.
- Occupation may also reflect specific toxic environmental or work task exposures such as physical demands (for example, transport driver, labourer).

One of the most important limitations of occupational indicators is that they cannot be readily assigned to people who are not currently employed. As a result, if used as the only source of information on socioeconomic position, socioeconomic differentials may be underestimated through the exclusion of retired people, people whose work is inside the home (mainly affecting women), disabled people (including those disabled by work-related illness and injury), the unemployed, students, and people working in unpaid, informal, or illegal jobs.[124] Given the growing prevalence of insecure and precarious employment, knowing a person's occupation is of limited value without further information about the individual's employment history and the nature of the current employment relationship. Further, socioeconomic indicators based on occupational classification may not adequately capture disparities in working and living conditions across divisions of race/ethnicity and gender.[125]

V.5.4.- Social Class

Social class is defined by relations of ownership or control over productive resources (i.e. physical, financial, and organizational). Social class provides an explicit relational mechanism (property, management) that explains how economic inequalities are generated and how they may affect health. Social class has important consequences for the lives of individuals. The extent of an individual's legal right and power to control productive assets determines an individual's strategies and practices devoted to acquire income and, as a result, determines the individual's standard of living. Thus the class position of 'business owner' compels its members to hire 'workers' and extract labour from them, while the 'worker' class position compels its members to find employment and perform labour. Most importantly, class is an inherently relational concept. It is not defined according to an order or hierarchy, but according to relations of power and control. Although there have been few empirical studies of social class and health, the need to study social class has been noted by social epidemiologists. [126]

Class, in contrast to stratification, indicates the employment relations and conditions of each occupation. The criteria used to allocate occupations into classes vary somewhat between the two major systems presently in widespread use: the Goldthorpe schema and the Wright schema. According to Wright, power and authority are 'organisational assets' that allow some workers to benefit from the abilities and energies of other workers. The hypothetical pathway linking class (as opposed to prestige) to health is that some members of a work organization are expending less energy and effort and getting more (pay, promotions, job security, etc.) in return, while others are getting less for more effort. So the less powerful are at greater risk of running down their stocks of energy and ending up in some kind of physical or psychological 'health deficit'. French industrial sociologists called this 'l'usure de travail'—the usury of work. At the most

obvious level, the manager sits in an office while the routine workers are exposed to all the dangers of heavy loads, dusts, chemical hazards and the like[127].

The task of class analysis is precisely to understand not only how macro structures (e.g. class relations at the national level) constrain micro processes (e.g. interpersonal behavior) but also how micro processes (e.g. interpersonal behavior) can affect macro structures (e.g. via collective action)[128]. Social class is among the strongest known predictors of illness and health and yet is, paradoxically, a variable about which very little research has been conducted.[129] Muntaner and colleagues have observed that, while there is substantial scholarship on the psychology of racism and gender, little research has been done on the effects of class ideology (i.e., classism). This asymmetry could reflect that in most wealthy democratic capitalist countries, income inequalities are perceived as legitimate while gender and race inequalities are not[130].

V.5.5. - Gender

'Gender' refers to those characteristics of women and men which are socially constructed, whereas 'sex' designates those characteristics that are biologically determined[131]. Gender involves 'culture-bound conventions, roles, and behaviours' that shape relations between and among women and men and boys and girls[132]. In many societies, gender constitutes a fundamental basis for discrimination, which can be defined as the process by which 'members of a socially defined group … are treated differently (especially unfairly)' because of their inclusion in that group[133]. Socially constructed models of masculinity can have deleterious health consequences for men and boys (e.g., when these models encourage violence or alcohol abuse). However, women and girls bear the major burden of negative health effects from gender-based social hierarchies.

In many societies, girls and women suffer systematic discrimination in access to power, prestige and resources. Health effects of discrimination can be immediate and brutal: e.g., in cases of female infanticide, or when women suffer genital mutilation, rape or gender-based domestic violence. Gender divisions within society also affect health through less visible biosocial processes, whereby girls' and women's lower social status and lack of control over resources exposes them to health risks. Disproportionately high levels of HIV infection among young women in some sub-Saharan African countries are fueled by patterns of sexual coercion, forced early marriage, and economic dependency among women and girls[134]. Widespread patterns of underfeeding girl children, relative to their male siblings, provide another example of how gender-based discrimination undermines health. As Doyal argues, 'A large part of the burden of preventable morbidity and mortality experienced by women is related directly or indirectly to the patterning of gender divisions. If this harm is to be avoided, there will need to be significant changes in related aspects of social and economic organization. In particular, strategies will be required to deal with the damage done to women's health by men, masculinities and male institutions'[135].

Gender-based discrimination often includes limitations on girls' and women's ability to obtain education and to gain access to respected and well remunerated forms of employment. These patterns reinforce women's social disadvantage and, in consequence, their health risks. Gender norms and assumptions define differential employment conditions for women and men and fuel differential exposures and health risks linked to work. Women generally work in different sectors than men and occupy lower professional ranks. 'Women are more likely to work in the informal sector, for example in domestic work and street vending'[136]. Broadly, gender disadvantage is manifested in women's often fragmented and economically uncertain work trajectories: domestic

responsibilities disrupt career paths, reducing lifetime earning capacity and increasing the risks of poverty in adulthood and old age[137]. For these reasons, Doyal argues that 'the removal of gender inequalities in access to resources' would be one of the most important policy steps towards gender equity in health. 'Since it is now accepted that gender identities are essentially negotiated, policies are needed which will enable people to shape their own identities and actions in healthier ways. These could include a range of educational strategies, as well as … employment policies and changes in the structure of state benefits'[138].

V.5.6.- Race/ethnicity

Constructions of racial or ethnic differences are the basis of social divisions and discriminatory practices in many contexts. As Krieger observes, it is important to be clear that 'race/ethnicity is a social, not biological, category'. The term refers to social groups, often sharing cultural heritage and ancestry, whose contours are forged by systems in which 'one group benefits from dominating other groups, and defines itself and others through this domination and the possession of selective and arbitrary physical characteristics (for example, skin colour)'[139].

In societies marked by racial discrimination and exclusion, people's belonging to a marginalized racial/ethnic group affects every aspect of their status, opportunities and trajectory throughout the life-course. Health status and outcomes among oppressed racial/ethnic groups are often significantly worse than those registered in more privileged groups or than population averages. Thus, in the United States, life expectancy for African-Americans is significantly lower than for whites, while an African-American woman is twice as likely as a white woman to give birth to an underweight baby[140]. Indigenous groups endure racial discrimination in many countries and often have health indicators inferior to those of non-indigenous populations. In Australia, the average life expectancy of Aboriginal and Torres Strait Islanders lags 20 years behind that of non-Aboriginal Australians. Perhaps as a result of the compounded forms of discrimination suffered by members of minority and oppressed races/ethnicities, the 'biological expressions of racism' are closely intertwined with the impact of other determinants associated with disadvantaged social positions (low income, poor education, poor housing, etc.).

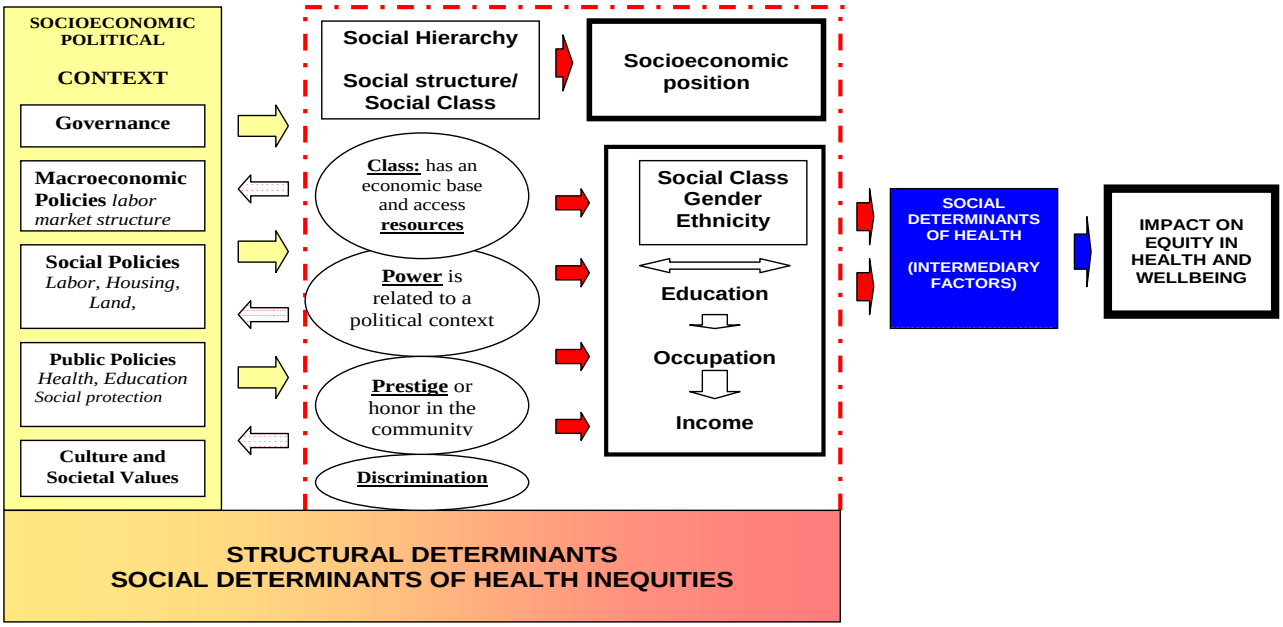
V.5.7. – Links and mutual influence between social-political context and structural determinants

A close relationship exists between the social-political context and what we term the structural determinants of health inequities. The CSDH framework posits that *structural determinants* are those that generate or reinforce stratification in the society and that define individual socioeconomic position. In all cases, structural determinants present themselves in a specific political and historical context. It is not possible to analyze the impact of structural determinants on health inequities, nor to assess policy and intervention options, if contextual aspects are not included. As we have noted, key elements of the context include: governance patterns; macroeconomic policies; social policies; and public policies in other relevant sectors, among other factors. Contextual aspects, including education, employment and social protection policies, act as modifiers or buffers influencing the effects of socioeconomic position on health outcomes and wellbeing among social groups. At the same time, the context forms part of the 'origin' and sustenance of a given distribution of power, prestige and access to material resources in a society and thus, in the end, of the pattern of social stratification and social class relations existing in that society. The positive significance of this linkage is that it is possible to address the effects of the structural determinants of health inequities through purposive action on contextual features, particularly the policy dimension.

V.5.8.- Diagram synthesizing the major aspects of the framework presented thus far

In this diagram we have summarized the main elements of the social and political context that model and directly influence the pattern of social stratification and social class existing in a country. We have included in the diagram, in the far left column, the main contextual aspects that affect inequities in health, e.g., governance, macroeconomic policies, social policies, public policies in other relevant areas, culture and societal values, and epidemiological conditions. The context exerts an influence on health through socioeconomic position.

Moving to the right, in the next column of the diagram, we have situated the main aspects of social hierarchy, which define social structure and social class relationships within the society. These features are given according to the distribution of power, prestige and resources. The principal domain is social class / position within the social structure, which is connected with the economic base and access to resources. This factor is also linked with people's degree of power, which is in turn again influenced by the political context (functioning democratic institutions or their absence, corruption, etc.).). The other key domain in this area encompasses systems of prestige and discrimination that exist in the society.



Again moving to the right, in the next column, we have described the main aspects of socioeconomic position. Studies and evaluations of equity frequently use income, education and occupation as proxies for these domains (power, prestige and economic status). When we refer to the domains of prestige and discrimination, we find them strongly related to gender, ethnicity and education. Social class also has a close connection to these different domains, as previously indicated. As an inherently relational variable, class is able to provide greater understanding of the mechanisms associated with the social production of health inequities.

Meanwhile, the patterns according to which people are assigned to socioeconomic positions can turn back to influence the broader context, for example by generating momentum for or against particular social welfare policies, or affecting the level of participation in trade unions.

Proceeding again to the next column to the right (blue rectangle), we see that it is socioeconomic position as assigned within the existing social hierarchy which determines differences in exposure and vulnerability to intermediary health-affecting factors, (what we call the 'social determinants of health' in the limited and specific sense), depending on people's positions in the hierarchy.

Together, context and socioeconomic position constitute the social determinants of health inequities, whose effect is to give rise to an inequitable distribution of health, wellbeing and disease across social groups.

Key messages from this section:

- The CSDH framework is distinguished from some others by its emphasis on the socio-economic and political context and the structural determinants of health inequity
- 'Context' is broadly defined to include all social and political mechanisms that generate, configure and maintain social hierarchies, including: the labor market; the educational system political institutions and other cultural and societal values.
- Among the contextual factors that most powerfully affect health are the welfare state and its redistributive policies (or the absence of such policies)
- In the CSDH framework, *structural determinants* are those that generate stratification and social class divisions in the society and that define individual socioeconomic position within hierarchies of power, prestige and access to resources. Structural determinants are rooted in the key institutions and mechanisms of the socioeconomic and political context. The most important structural stratifiers and their proxy makers include:
    - Income
    - Education
    - Occupation
    - Social Class
    - Gender
    - Race/ethnicity
- Together, context and structural determinants constitute the *social determinants of health inequities*. We began this study by asking the question of where health inequities come from. The answer to that question lies here. The structural mechanisms that shape social hierarchies according to these key stratifiers are the root cause of inequities in health.

V.6.- Third element of the framework: intermediary determinants

The structural determinants operate through a series of what we will term ***intermediary social factors or social determinants of health***. The social determinants of health inequities are causally antecedent to these intermediary determinants, which are linked, on the other side, to a set of individual-level influences, including health-related behaviors and physiological factors. The intermediary factors flow from the configuration of underlying social stratification and, in turn, determine differences in exposure and vulnerability to health-compromising conditions. At the most proximal point in the models, genetic and biological processes are emphasized, mediating the health effects of social determinants.[141] The main categories of intermediary determinants of health are: material circumstances; psychosocial circumstances; behavioral and/or biological factors; and the health system itself as a social determinant. We once again review these elements in turn.

V.6.1.-Material circumstances include determinants linked to the physical environment, such as housing (relating to both the dwelling itself and its location), consumption potential, i.e. the financial means to buy healthy food, warm clothing, etc., and the physical working and neighbourhood environments. Depending on their quality, these circumstances both provide resources for health and contain health risks.

Differences in material living standards are probably the most important intermediary factor. The material standards of living are probably directly significant for the health status of marginalized groups, and also for the lower socioeconomic position, especially if we include environmental factors. Housing characteristics measure material aspects of socioeconomic circumstances[142]. A number of aspects of housing have direct impact on health: the structure of dwellings; internal conditions such as damp, cold and indoor contamination. Indirect housing effects related to housing tenure, including wealth impacts, and neighborhood effects are seen as increasingly important. Housing as a neglected site for public health action, include indoor and outdoor housing condition, as well as, material and social aspect of housing, and local neighborhood have an impact on health of occupants. Galobardes, Shaw, Lawler, Lynch and Davey Smith propose a number of household amenities include access to hot and cold water in the house, having central heating and carpets, sole use of bathrooms and toilets, whether the toilet is inside or outside the home, having a refrigerator, washing machine, or telephone. These household amenities are markers of material circumstances and may also be associated with specific mechanisms of disease. For example, lack of running water and a household toilet may be associated with increased risk of infection[143]. In addition to household amenities, household conditions such as the presence of damp and condensation, building materials, rooms in the dwelling, and overcrowding are housing-related indicators of material resources. These are used in both industrialized and non-industrialized countries.[144] Crowding is calculated as the number of persons living in the household per number of rooms available in the house. Overcrowding can plausibly affect health outcomes through a number of different mechanisms: overcrowded households are often households with few economic resources and there may also be a direct effect on health through facilitation of the spread of infectious diseases. Galobardes et al. add that recent efforts to better understand the mechanisms underlying socioeconomic inequalities in health have lead to the development of some innovative area level indicators that use aspects of housing. For example, a ‘‘broken windows’’ index measured housing quality, abandoned cars, graffiti, trash, and public school deterioration at the census block level in the USA [145].

An explicit definition incorporating the causal relationship between work and health is given by the Spanish National Institute of Work, Health and Safety: "The variables that define the making of any given task as well as the environment in which it is carried out, determining the health of the workers in threefold sense: physical, psychological and social".[146] There are clear social differences in physical, mental, chemical and ergonomic strains in the workplace. The accumulation of negative environmental factors throughout working life probably has a significant effect on variations in the general health of the population, especially when people are exposed to such factors over a long period of time. Main types of hazards at the workplace include physical, chemical, ergonomic, biological, and psychosocial risk factors. General conditions of work define, in many ways, peoples' experience of work. Minimum standards for working conditions are defined in each country but the large majority of workers, including many of those whose conditions are most in need of improvement, are excluded from the scope of existing labour protection measures. In many countries, workers in cottage industries, the urban informal economy, agricultural workers (except for plantations), small shops and local vendors, domestic workers and home workers are outside the scope of protective legislation. Other workers are deprived of effective protection because of weaknesses in labour law enforcement. This is particularly true for workers in small enterprises, which account for over 90 per cent of enterprises in many countries, with a high proportion of women workers.

V.6.2.- Social-environmental or psychosocial circumstances include psychosocial stressors (for example, negative life events, job strain), stressful living circumstances (e.g. high debt) and (lack of) social support, coping styles, etc. Different social groups are exposed to different degrees to experiences and life situations that are perceived as threatening, frightening and difficult to deal with. This partly explains the long-term pattern of social inequalities in health.

Stress may be a causal factor and trigger direct many forms of illness, and detrimental, long-term stress may also be part of the causal complex behind many somatic illnesses. A person's socioeconomic position may itself be a source of long-term stress, and will also affect the opportunities to deal with stressful and difficult situations. However, there are also other, more indirect explanations of the pathway from stress to social inequalities in health. Firstly, there is an on-going international debate on what is often called Wilkinson's «income inequality and social cohesion» model. The model states that, in rich societies, the size of differences in income is more important from a health point of view than the size of the average income. Wilkinson's hypothesis is that the greater the income disparities are in a society, the greater becomes the distance between the social strata. Social interaction is thus characterized by less solidarity and community spirit.[147] The people who lose most are those at the bottom of the income hierarchy, who are particularly affected by psychosocial stress linked to social exclusion, lack of self-respect and more or less concealed contempt from the people around them. Secondly, there are significant social differences in the prevalence of episodes of stress occurrence of short-term and long-term episodes of mental stress, linked to uncertainty about the financial situation, the labor market and social relations. The same applies to the probability of experiencing violence or threats of violence. Disadvantaged people have experienced far more insecurity, uncertainty and stressful events in their life course, and this affects social inequalities in health. This is illustrated in the following table published in the Norwegian Action Plan to Reduce Social Inequalities in Health 2005-06.[148]

	SOCIAL STATUS:[1]	
PERCENTAGES WHO HAVE EXPERIENCED IN THEIR ADULT LIFE:	LOW:	HIGH:
– several episodes of 3+ months of unemployment	11%	1%
– lost their job several times (involuntarily)	7%	2%
– received social security benefits	11%	2%
– had a serious accident	21%	6%
– been unemployed at the age of 55	29%	7%
– been unmarried/had no cohabitant at the age of 55	26%	14%
– had a low income at the age of 53	20%	2%

[1]Low status = the third with the lowest occupational prestige, high status = the third with the highest occupational prestige.

Some studies refer to the association between socio-economical status and health locus control. This concept refers to the way people perceive the events related to their healthy: as controllable (internal control), or as controlled by others (external control). People with education below university level more frequently identified an external locus of control.[149] Other important challenges arise from increased incidence and prevalence of precarious and informal employments consequent on changes in the labor market raise many issues and challenges for health care providers, organizational psychologists, personnel and senior managers, employers and trade union representatives, and workers and their families. Job insecurity and non-employment are also matters of concern to the wider community.[150]

V.6.3.- Behavioural and biological factors include smoking, diet, alcohol consumption, and lack of physical exercise, which again can be either health protecting and enhancing (like exercise) or health damaging (cigarette smoking and obesity) , between biological factor we are including genetics factor and from perspective of social determinants of health age and sex distribution could be including..

Social inequalities in health have also been associated with social differences in lifestyle or behaviors. Such differences are found in nutrition, physical activity, tobacco and alcohol consumption. This indicates that differences in lifestyle could partially explain social inequalities in health, but researchers do not agree on their importance: some regard differences in lifestyle as a sufficient explanation without further elaboration; others regard them as contributory factors that in turn result from more fundamental causes. For example, Margolis et al. found that the prevalence of both acute and persistent respiratory symptoms in infants showed dose response relationships with SEP. When risk factors such as crowding and exposure to smoking in the household were adjusted for, relative risk associated with SEP was reduced but still remained significant. The data further suggest that risk factors operated differently for different SEP levels; being in day care was associated with somewhat reduced incidence in lower SEP families but with increased incidence among infants from high SEP families[151] Health risk behaviors such as cigarette smoking, physical inactivity, poor diet, and substance abuse are closely tied to both SEP and health outcomes. Despite the close ties, the association of SEP and health is reduced but not eliminated when these behaviors are statistically controlled [152]

Cigarette smoking is strongly linked to SEP, including education, income, and employment status, and it is significantly associated with morbidity and mortality, particularly from

cardiovascular disease and cancer[153]. A linear gradient between education and smoking prevalence was also shown in a community sample of middle-aged women: Additionally, among current smokers the number of cigarettes smoked was related to SEP [154] Significant employment grade differences in smoking were found in the Whitehall II study, which examined a new cohort of 10,314 subjects from the British Civil Service beginning in 1985 [155]Moving from the lowest to the highest employment grades, the prevalence of current smoking among men was 33.6%, 21.9%, 18.4%, 13.0%, 10.2%, and 8.3%, respectively. For women, the comparable figures were 27.5%, 22.7%, 20.3%, 15.2%, 11.6%, and 18.3%, respectively. Social class differences in smoking are likely to continue because rates of smoking initiation are inversely related to SEP and because rates of cessation are positively related to SEP[156].
Lifestyle factors are relatively accessible for research, so this is one of the causal areas we know a good deal about. Although descriptions of the correlation of lifestyle factors with social status are relatively detailed and well-founded, this should not be taken to indicate that these factors are the most important causes of social inequalities in health. Other, more fundamental factors may cause variations in both lifestyle and health. Some surveys indicate that differences in lifestyle can only explain a small proportion of social inequalities in health.[157] For instance, material factors may act as a source of psychosocial stress, and psychosocial stress may influence health related behaviors. Each of them can influence health through specific biological factors. For example a diet rich in saturated fat will lead to atherosclerosis, which will increase the risk of a myocardial infarction. Stress will activate hormonal systems that may increase blood pressure and reduce the immune response. Adoption of health-threatening behaviors is a response to material deprivation and stress. Environments determine whether individuals take up tobacco, use alcohol, have poor diets, and engage in physical activity. Tobacco and excessive alcohol use, and carbohydrate-dense diets, are means of coping with difficult circumstances. [158]

V.6.4.- The health system as a social determinant of health. As previously discussed, various models that have tried to explain the functioning and impact of SDH have not made sufficiently explicit the role of the health system as a social determinant. The role of the health system becomes particularly relevant through the issue of access, which incorporates differences in exposure and vulnerability. On the other hand, differences in access to health care certainly do not fully account for the social patterning of health outcomes. Adler, Boyce, Chesney, Folkman and Syme, for instance, have considered the role of access to care in explaining the SEP-health gradient and concluded that access alone could not explain the gradient[159].

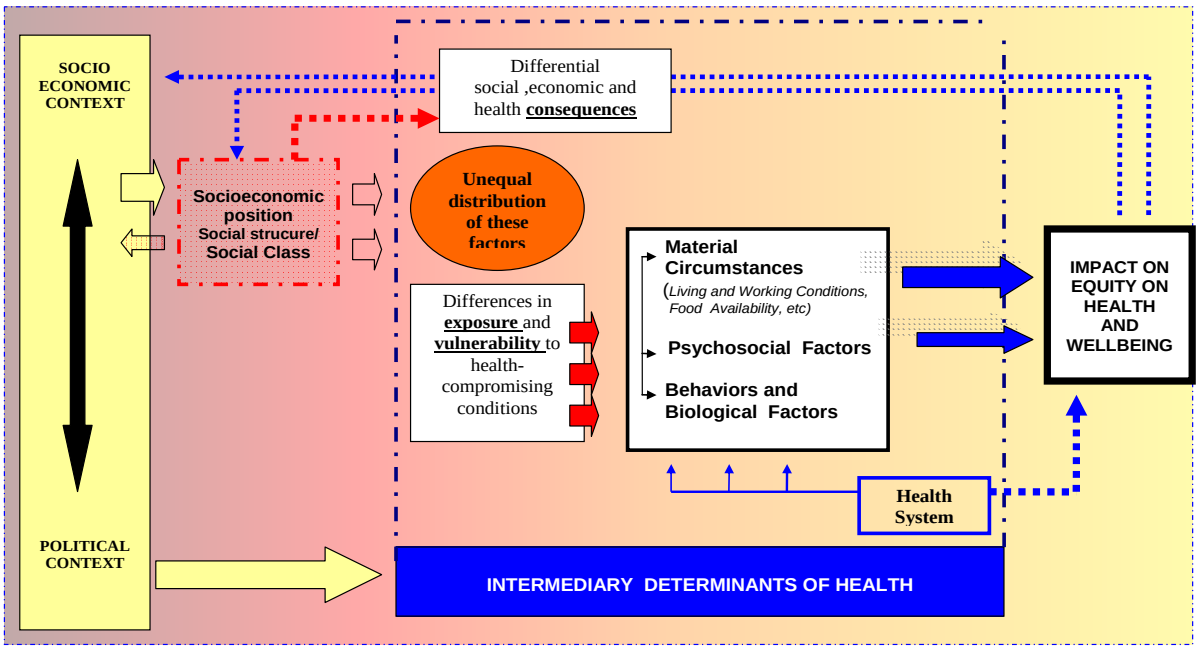
In a comprehensive model, the health system itself should be viewed as an intermediary determinant. This is closely related to models for the organization of personal and non-personal health service delivery. The health system can directly address differences in exposure and vulnerability not only by improving equitable access to care, but also in the promotion of intersectoral action to improve health status. Examples would include food supplementation through the health system and transport policies and intervention for tackling geographic barrier to access health care. A further aspect of great importance is the role the health system plays in mediating the differential consequences of illness in people's lives. The health system is capable of ensuring that health problems do not lead to a further deterioration of people's social status and of facilitating sick people's social reintegration. Examples include programmes for the chronically ill to support their reinsertion in the workforce, as well as appropriate models of health financing that can prevent people from being forced into (deeper) poverty by the costs of medical care. Another important component to analyze relates to the way in which the health system contributes to social participation and the empowerment of the people, if in fact this is defined as one of the main axes for the development of pro-equity health policy. In this context, we can reflect on the hierarchical and authoritarian structure that predominates in the

organization of most health systems. Within health systems, people enjoy little participatory space through which to take part in monitoring, evaluation and decision-making about system priorities and the investment of resources.

Diderichsen suggests that services through which the health sector deals with inequalities in health can be of five different types: (1) reducing the inequality level among the poor with respect to the causal factors that mediate the effects of poverty on health in such areas as nutrition, sanitation, housing, and working conditions; (2) reinforcing factors that might reduce susceptibility to health effects from inequitable exposures, using various means including vaccination, empowerment, and social support; (3) treating and rehabilitating the health problems that constitute the socioeconomic gap of burden of disease (the rehabilitation of disabilities, in particular, is often overlooked as a potential contributor to the reduction of health inequalities); (4) strengthening policies that reproduce contextual factors such as social capital that might modify the health effects of poverty; (5) protecting against social and economic consequences of ill health though health insurance sickness benefits and labor market policies.[160]

Even if there were some dispute as to whether the health system can itself be considered an indirect determinant of health inequities, it is clear that the system influences how people move among the social strata. Benzeval, Judge and Whitehead argue that the health system has three obligations in confronting inequity: (1) to ensure that resources are distributed between areas in proportion to their relative needs; (2) to respond appropriately to the health care needs of different social groups; and (3) to take the lead in encouraging a wider and more strategic approach to developing healthy public policies at both the national and local level, to promote equity in health and social justice.[161] On this point the UK Department of Health has argued that the health system should play a more active role in reducing health inequalities, not only by providing equitable access to health care services but also by putting in place public health programmes and by involving other policy bodies to improve the health of disadvantaged communities[162].

V.6.5.- Diagram summarizing the content of the preceding section on intermediary determinants



[i] Figure Mechanisms and intermediary factors of social determinants of health elaborated for EQH/EIP (OPSH) 2006

Socioeconomic context directly affects intermediary factors, e.g. through kind, magnitude and availability (large yellow arrow). But for the population, the more important path of influence is through socioeconomic position. Socioeconomic position influences health through more specific, intermediary determinants. Those intermediary factors include: material circumstances, such as neighborhood, working and housing conditions; psychosocial circumstances, and also behavioral and biological factors. The model assumes that members of lower socioeconomic groups live in less favorable material circumstances than higher socioeconomic groups, and that people closer to the bottom of the social scale more frequently engage in health-damaging behaviors and less frequently in heath-promoting behaviors than do the more privileged. The unequal distribution of these intermediary factors (associated with differences in exposure and vulnerability to health-compromising conditions, as well as with differential consequences of ill-health) constitutes the primary mechanism through which socioeconomic position generates health inequities. The model includes the health system as a social determinant of health and illustrates the capacity of the heath sector to influence the process in three ways, by acting upon: differences in exposures, differences in vulnerability and differences in the consequences of illness for people's health and their social and economic circumstances.

V.6.6.- A crosscutting determinant: social cohesion / social capital[163]. The concepts of social cohesion and 'social capital' occupy an unusual (and contested) place in understandings of SDH. Over the past decade, these concepts have been among the most widely discussed in the social sciences and social epidemiology. Influential researchers have proclaimed social capital a key factor in shaping population health[164] [165] [166] [167]. However, controversies surround the definition and importance of social capital.

In the most influential recent discussions, three broad approaches to the characterization and analysis of social capital can be distinguished: communitarian approaches, network approaches and resource distribution approaches. The *communitarian approach* defines social capital as a psychosocial mechanism, corresponding to a neo-Durkheimian perspective on the relation between individual health and society[168]. This school includes influential authors such as Robert Putnam and Richard Wilkinson. Putnam defines social capital as "features of social organization, such as networks, norms, and social trust, that facilitate coordination and cooperation for mutual benefit"[169]. Social capital is looked upon as an extension of social relationships and the norms of reciprocity[170], influencing health by way of the social support mechanisms that these relationships provide to those who participate on them. The *network approach* considers social capital in terms of resources that flow and emerge through social networks. It begins with a systemic relational perspective; in other words, an ecological vision is taken that sees beyond individual resources and additive characteristics. This involves an analysis of the influence of social structure, power hierarchies and access to resources on population health[171]. This approach implies that decisions that groups or individuals make, in relation to their lifestyle and behavioural habits, cannot be considered outside the social context where such choices take place. Two of the most outstanding conceptualisations in this regard have been elaborated by James Coleman and Pierre Bourdieu, whose work has focused primarily on notions of social cohesion. Finally, the *resource distribution approach*, adopting a materialistic perspective, suggests that there is a danger in promoting social capital as a substitute for structural change when facing health inequity. Some representatives of this group openly criticize psychosocial approaches that have suggested social capital and cohesion as the most important mediators of the association between income and health inequality[172]. The resource distribution approach insists that psychosocial aspects affecting population health are a consequence of material life conditions[173].

Recent work by Szreter and Woolcock (2004)[174] has enriched the debates around social capital and its health impacts. These authors distinguish between bonding, bridging and linking social capital. *Bonding social* capital refers to the trust and cooperative relationships between members of a network that are similar in terms of their social identity. *Bridging social capital*, on the other hand, refers to respectful relationships and mutuality between individuals and groups that are aware that they do not possess the same characteristics in socio-demographic terms. Finally, *linking social capital* corresponds with the norms of respect and trust relationships between individuals, groups, networks and institutions that interact from different positions along explicit gradients of institutionalised power[175].

Some scholars have critiqued what they see as the faddish, ideologically driven adoption of the term 'social capital'. Muntaner, for example, has suggested that the term serves primarily as a 'comforting metaphor' for those in public health who wish to maintain that 'capitalism … and social cohesion/social integration are compatible'. Beyond such ideological reassurance, Muntaner argues, the vocabulary of social capital provides few if any fresh insights, and may in fact provoke confusion. Those innovations that have been achieved by researchers investigating social capital could just as well 'have been carried out under the label of "social integration" or "social cohesion"'. Indeed, 'it would be more adequate to use terms such as "cohesion" and "integration" to avoid the confusion and implicit endorsement of [a specific] economic system that the term [social capital] conveys'[176].

We share with Muntaner the concern that the current interest in 'social capital' may further encourage depoliticized approaches to population health and SDH. Indeed, it is clear that the concept of social capital has not infrequently been deployed as part of a broader discourse promoting reduced state responsibility for health, linked to an emphasis on individual and community characteristics, values and lifestyles as primary shapers of health outcomes. Logically, if communities can take care of their own health problems by generating 'social capital', then government can be increasingly discharged of responsibility for addressing health and health care issues, much less taking steps to tackle underlying social inequities. Navarro suggests that foundational work on social capital, including Putnam's, 'reproduced the classical … dichotomy between civil and political society, in which the growth of one (civil society) requires the contraction of the other (political society—the state)'. From this perspective, the adoption of social capital as a key for understanding and promoting population health is part of a broader, radically depoliticizing trend.[177]

On the other hand, however, it can be argued that the recognition of linking social capital through Szreter's and Woolcock's work has contributed to a higher consideration of the dimension of power and of structural aspects in tackling social capital as a social determinant of health. This may help move discussions of social capital resolutely beyond the level of informal relationships and social support. The idea of linking social capital has also been fundamental as a new element when discussing the role that the state occupies or should occupy in the development of strategies that favour equity. Linking social capital offers the opportunity to analyse how relationships that are established with institutions in general, and with the state in particular, affect people's quality of life. Such discussions highlight the role of political institutions and public policy in shaping opportunities for civic involvement and democratic behaviour[178] [179]. The CSDH adopts the position that the state possesses a fundamental role in social protection, ensuring that public services are provided with equity and effectiveness. The welfare state is characterized as systematic defense against social insecurity, this being understood as individuals', groups' or communities' vulnerability to diverse environmental threats[180]. In this context, while remaining alert to ways in which notions of 'social capital' or

community may be deployed to excuse the state from responsibility for the wellbeing of the population[181] [182] [183], we can also look for aspects of these concepts that shed fresh light on key state functions.

The notion of linking social capital speaks to the idea that one of the central points of health politics should be the configuration of cooperative relationships between citizens and institutions. In this sense, the state should assume the responsibility of developing more flexible systems that facilitate access and develop real participation by citizens. Here, a fundamental aspect is the strengthening of local or regional governments so that they can constitute concrete spaces of participation[184] [185]. The development of social capital, understood in these terms, is based on citizen participation. True participation implies a (re)distribution of empowerment, that is to say, a redistribution of the power that allows the community to possess a high level of influence in decision-making and the development of policies affecting its well being and quality of life.

The competing definitions and approaches suggest that 'social capital' cannot be regarded as a uniform concept. Debate surrounds whether it should be as seen a property of individuals, groups, networks, or communities, and thus where it should be located with respect to other features of the social order. It is unquestionably difficult to situate social capital definitively as either a structural or an intermediary determinant of health, under the categories we have developed here. It may be most appropriate to think of this component as 'cross-cutting' the structural and intermediary dimensions, with features that link it to both.

V.7. - Impact on equity in health and wellbeing

This section summarizes some of the outcomes that emerge at the end of the social 'production chain' of health inequities depicted in the framework. At this stage (far right side of the framework diagrams), we find the measurable impacts of social factors upon comparative health status and outcomes among different population groups, i.e., health equity. According to the analysis we have developed, the structural factors associated with the key components of socioeconomic position (SEP) are at the root of health inequities measured at the population level. This relationship is confirmed by a substantial body of evidence.

socioeconomic health differences are captured in general measures of health, like life expectancy, all-cause mortality and self-rated health.[186] Differences correlated with people's socioeconomic position are found for rates of mortality and morbidity from almost every disease and condition[187]. SEP is also linked to prevalence and course of disease and self-rated health[188]. Socioeconomic health inequalities are evident in specific causes of disease, disability and premature death, including lung cancer, coronary heart disease, accidents and suicide. Low birth weight provides an additional important example. This is a sensitive measure of child health and a major risk factor for impaired development through childhood, including intellectual development[189]. There are marked differences in national rates of low birth weight, with higher rates in the US and UK and lower rates in Nordic countries like Sweden, Norway and the Netherlands. These rates vary in line with the proportion of the child population living in poverty (in households with incomes below 50% of average income): at their lowest in low-poverty countries like Sweden and Norway, and at their highest in high-poverty countries like the UK and US [190].

a) *Impact along the gradient*: There is evidence that the association of SEP and health occurs at every level of the social hierarchy, not simply below the threshold of poverty. Not only do those

in poverty have poorer health than those in more favored circumstances, but those at the highest level enjoy better health than do those just below[191]. The effects of severe poverty on health may seem obvious through the impact of poor nutrition, crowded and unsanitary living conditions, and inadequate medical care. Identifying factors that can account for the link to health all across the SEP hierarchy may shed light on new mechanisms that have heretofore been ignored because of a focus on the more readily apparent correlates of poverty. The most notable of the studies demonstrating the SEP-health gradient is the Whitehall study of mortality (Marmot et al., 1984), which covered British civil servants over a period of 10 years. Similar findings emerge from census data in the United Kingdom (Susser, Watson and Hopper 1985)[192]. Surprisingly, we know rather little about how SEP operates to influence biological functions that determine health status. Part of the problem may be the way in which SEP is conceptualized and analyzed. SEP has been almost universally relegated to the status of a control variable and has not been systematically studied as an important etiologic factor in its own right. It is usually treated as a main effect, operating independently of other variables to predict health.

b) ***Life course perspective on the impact***: Children born into poorer circumstances are at greater risk of the forms of developmental delay associated with intellectual disability, including speech impairments, cognitive difficulties and behavioral problems[193] [194]. Some other conditions, like stroke and stomach cancer, appear to depend considerably on childhood circumstances, while for others, including deaths from lung cancer and accidents/violence, adult circumstances play the more important role. In another group are health outcomes where it is cumulative exposure that appears to be important. A number of studies suggest that this is the case for coronary heart disease and respiratory disease, for example[195].

c) ***Selection processes and health-related mobility:*** As discussed above, people with weaker health resources, allegedly, have a tendency to end up or remain low on the ladder of socioeconomic position. According to some analysts, the status of research on selection processes and health-related mobility within the socioeconomic structure can be summarized in three points: (1) Variations in health in youth have some significance for educational paths and for the kind of job a person has at the beginning of his or her working career; (2) For those who are already established in working life, variations in health have little significance for the overall progress of a person's career; (3) People who develop serious health problems in adult life are often excluded from working life, and often long before the ordinary retirement age[196].

Graham argues that people with intellectual disabilities are more exposed to the social conditions associated with poor health and have poorer health than the wider population[197]. She adds that, for example, those with mild disabilities are more likely than non-disabled people to have employment histories punctured by repeated periods of unemployment. Women with mild intellectual disabilities are further disadvantaged by high rates of teenage motherhood[198]. In both childhood and adulthood, co-morbidity – the experience of multiple illnesses and functional limitations – disproportionately affects people with intellectual disabilities[199]. For example, in the British 1958 birth cohort study, children with mild mental retardation were at higher risk of sensory impairments and emotional difficulties; they were also more likely to be in contact with psychiatric services. In adulthood, mild mental retardation was associated with limiting long-term illness and disability, and, particularly for women, with depressed mood.

One might assume such effects to be inevitable. But they are in part due to discriminatory practices, in part also to failures to adapt educational institutions and working life to special needs. To the extent that this is the case, social selection is neither necessary, nor inevitable, nor

fair. This phenomenon particularly affects persons with disabilities, persons from immigrant backgrounds and, to a certain extent, women[200].

d) ***Impact on the socioeconomic and political context***: From a population standpoint, we observe that the magnitude of certain diseases can translate into direct effects on features of the socioeconomic and political context, through high prevalence rates and levels of mortality and morbidity. The HIV/AIDS pandemic in sub-Saharan Africa can be seen in this light, with its associated plunge in life expectancy and stresses on agricultural productivity, economic growth, and sectoral capacities in areas such as health and education. The magnitude of the impact of epidemics and emergencies will depend on the historical, political and social contexts in which they occur, as well as on the demographic composition of the societies affected. These are aspects that must be considered when analyzing welfare state structures, in particular models of health system organization that may be considered to respond to such challenges[201].

Key messages from this section:

- The underlying social determinants of health inequities operate through a set of intermediary determinants of health to shape health outcomes. The vocabulary of 'structural determinants' and 'intermediary determinants' underscores the causal priority of the structural factors.
- The main categories of intermediary determinants of health are: material circumstances; psychosocial circumstances; behavioral and/or biological factors; and the health system itself as a social determinant
- Material circumstances include factors such as housing and neighborhood quality; consumption potential (i.e., the financial means to buy healthy food, warm clothing, etc.), and the physical work environment.
- Psychosocial circumstances include psychosocial stressors, stressful living circumstances and relationships, and social support and coping styles (or the lack thereof).
- Behavioral and biological factors include nutrition, physical activity, tobacco consumption and alcohol consumption, which are distributed differently among different social groups. Biological factors also include genetic factors.
- The CSDH framework departs from many previous models by conceptualizing the health system itself as a social determinant of health. The role of the health system becomes particularly relevant through the issue of access, which incorporates differences in exposure and vulnerability, and through intersectoral action led from within the health sector. The health system plays an important role in mediating the differential consequences of illness in people's lives.
- The concepts of social cohesion and social capital occupy a conspicuous (and contested) place in discussions of SDH. Social capital cuts across the structural and intermediary dimensions, with features that link it to both.
- Focus on social capital risks reinforcing depoliticized approaches to public health and SDH; however, certain interpretations, including Szreter's and Woolcock's notion of 'linking social capital', have spurred new thinking on the role of the state in promoting equity.

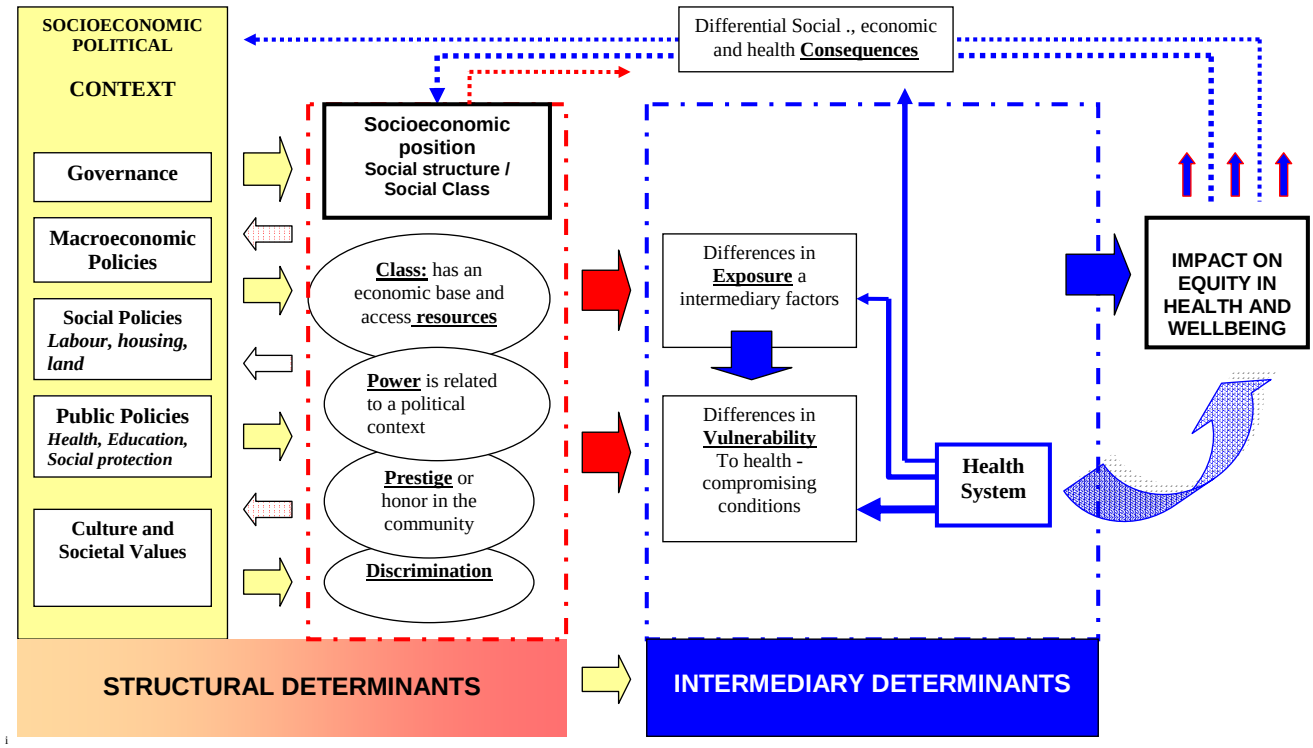
- A key task for health politics is nurturing cooperative relationships between citizens and institutions. The state should take responsibility for developing flexible systems that facilitate access and participation on the part of the citizens.
- The social, economic and other consequences of specific forms of illness and injury vary significantly, depending on the social position of the person who falls sick.
- Illness and injury have an indirect impact in the socioeconomic position of individuals. From the population perspective, the magnitude of certain illnesses can directly impact key contextual factors (e.g., the performance of institutions
- Looking at the ultimate impact of social processes on health equity, we find that the structural factors associated with the key components of socioeconomic position (SEP) are at the root of health inequities at the population level. This relationship is confirmed by a substantial body of evidence.
- Differences correlated with people's socioeconomic position are found for rates of mortality and morbidity from almost every disease and condition. SEP is also linked to prevalence and course of disease and self-rated health.
- The magnitude of certain diseases can directly affect features of the socioeconomic and political context, through high prevalence rates and levels of mortality and morbidity. The HIV/AIDS pandemic in sub-Saharan Africa provides one example, with its impact on agriculture, economic growth and sectoral capacities in areas such as health and education.

V.8. Summary of the mechanisms and pathways represented in the framework

In this section, we summarize key features of the CSDH model and begin to sketch some of the considerations for policymaking to which the model gives rise. The next chapter will explore policy implications and entry points in greater depth.

The figure below illustrates the main processes captured in the CSDH framework, as we have explored them, step by step, in the present chapter. The diagram also highlights the reverse or feedback effects through which illness may affect individual social position, and widely prevalent diseases may affect key social, economic and political institutions. Reading the diagram from left to right, we see the social and political context (in yellow), which gives rise to a set of unequal socioeconomic positions or social classes (red column). (Phenomena related to socioeconomic position can also influence aspects of the context, as suggested by the pale red arrows pointing back to the left.) Groups are stratified according to the economic status, power and prestige they enjoy, for which we use income levels, education, occupation status, gender, race/ethnicity and other factors as proxy indicators. This column of the diagram ("socioeconomic position") locates the underlying mechanisms of social stratification and the creation of social inequities.
Moving to the right, we observe how these socioeconomic positions then translate into specific determinants of individual health status reflecting the individual's social location within the

stratified system. The model shows that a person's socioeconomic position affects his/her health, but that this effect is not direct. Socioeconomic position influences health through more specific, intermediary determinants.



[i] **Figure** summary pathway and mechanism of social determinants of health inequities elaborated EQH/EIP 2006 (OPSH)

Based on their respective social status, individuals experience differences in exposure and vulnerability to health-compromising conditions. Socioeconomic position directly affects the level or frequencies of exposure and the level of vulnerability, in connection with intermediary factors. Also, differences in exposure can generate more or less vulnerability in the population after exposure.

Once again, a distinctive element of this model is its explicit incorporation of the health system. Socioeconomic inequalities in health can in fact be partly explained by the "feedback" effect of health on socioeconomic position, e.g., when someone experiences a drop in income because of a work-induced disability or the medical costs associated with major illness. Persons who are in poor health less frequently move up and more frequently move down the social ladder than healthy persons. This implies that the health system itself can be viewed as a social determinant of health. This is in addition to the health sector's key role in promoting and coordinating SDH policy, as regards interventions to alter differential exposures and differential vulnerability through action on intermediary factors (material circumstances, psychosocial factors and behavioral/biological factors). It may be noted, in addition, that some specific diseases can impact people’s socioeconomic position not only by undermining their physical capacities, but also through associated stigma and discrimination, e.g., in the case of HIV/AIDS. Because of their magnitude, certain diseases, such as HIV/AIDS and malaria, can also impact key contextual components directly, e.g., the labour market and governance institutions. This effect is illustrated by the blue arrow in the diagram. The whole set of ‘feedback’ mechanisms just described is brought together under the heading of ‘differential social, economic and health consequences’.

We have included the impact of social position on these mechanisms, indicating that path with a red arrow.

We have repeatedly referred to Hilary Graham's warning about the tendency to conflate the social determinants of health and the social processes that shape these determinants' unequal distribution, by lumping the two phenomena together under a single label. Maintaining the distinction is more than a matter of precision in language. As Graham argues, blurring these concepts may lead to seriously misguided policy choices. "There are drawbacks to applying health-determinant models to health inequalities." To do so may "blur the distinction between the social factors that influence health and the social processes that determine their unequal distribution. The blurring of this distinction can feed the policy assumption that health inequalities can be diminished by policies that focus only on the social determinants of health. Trends in older industrial societies over the last 30 years caution against assuming that tackling "the layers of influence" on individual and population health will reduce health inequalities. This period has seen significant improvements in health determinants (e.g., rising living standards and declining smoking rates) and parallel improvements in people's health (e.g., higher life expectancy). But these improvements have broken neither the link between social disadvantage and premature death nor the wider link between socioeconomic position and health. As this suggests, those social and economic policies that have been associated with positive trends in health-determining social factors have also been associated with persistent inequalities in the distribution of these social influences**.'**[202]

Many existing models of the social determinants of health may need to be modified in order to help the policy community understand the social causes of health inequalities. Because inequalities in determinants are not factored into the models, their central role in driving inequalities in health may not be recognized. They are designed to capture schematically the distinction between health determinants and health inequality determinants, which can be obscured in the translation of research into policy. Evidence points to the importance of representing the concept of social determinants to policymakers in ways that clarify the distinction between the social causes of health and the factors determining their distribution between more and less advantaged groups. Our CSDH framework attempts to fulfill this objective. Indeed, this is one of its most important intended functions.

Graham argues that what is obscured in many previous treatments of these topics '*is that tackling the determinants of health inequalities is about tackling the* ***unequal distribution of health determinants'***. Focusing on the unequal distribution of determinants is important for thinking about policy. This is because policies that have achieved overall improvements in key determinants such as living standards and smoking have not reduced inequalities in these major influences on health. When health equity is the goal, the priority of a determinants-oriented strategy is to reduce inequalities in the major influences on people's health. Tackling inequalities in social position is likely to be at the heart of such a strategy. For, according to Graham, social position is the pivotal point in the causal chain linking broad ('wider') determinants to the risk factors that directly damage people's health.

Graham emphasizes that policy objectives will be defined quite differently, depending on whether our aim is to address determinants of health or determinants of health inequities:

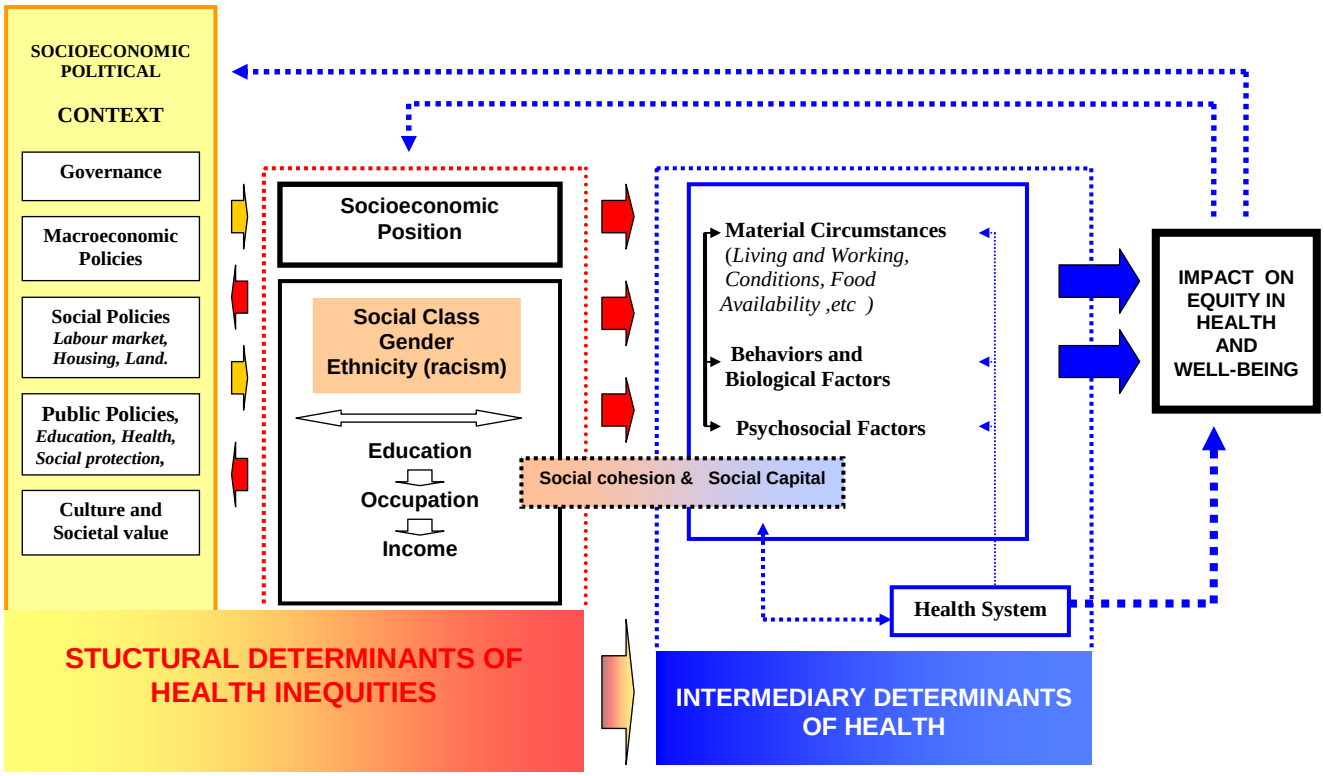
- ***Objectives for health determinants*** are likely to focus on reducing overall exposure to health-damaging factors along the causal pathway. These objectives are being taken forward by a range of current national and local targets: for example, to raise educational standards

and living standards (important constituents of socioeconomic position) and to reduce rates of smoking (a major intermediary risk factor).

- ***Objectives for health inequity determinants*** are likely to focus on leveling up the distribution of major health determinants. How these objectives are framed will depend on the health inequities goals that are being pursued. For example, if the goal is to narrow the health gap, the key policies will be those which bring standards of living and diet, housing and local services in the poorest groups closer to those enjoyed by the majority of the population. If the health inequities goal is to reduce the wider socioeconomic gradient in health, then the policy objective will be to lift the level of health determinants across society towards the levels in the highest socioeconomic group.[203]

V.9. Final form of the CSDH framework

The diagram below brings together the key elements of the account developed in successive stages throughout this chapter. This image seeks to summarize visually the main lessons of the preceding analysis and to organize in a single comprehensive framework the major categories of determinants and the processes and pathways that generate health inequities.



The framework makes visible the concepts and categories discussed in this paper. It can also serve to situate the specific social determinants on which the Commission has chosen to focus its efforts, and can provide a basis for understanding how these choices were made (balance of structural and intermediary determinants, etc.).

Key messages of this section:

- This section recapitulates key elements of the CSDH framework and begins to explore implications for policy.
- The framework shows how social, economic and political mechanisms give rise to a set of socioeconomic positions, whereby populations are stratified according to income, education, occupation, gender, race/ethnicity and other factors; these socioeconomic positions in turn shape specific determinants of health status (intermediary determinants) reflective of people's place within social hierarchies; based on their respective social status, individuals experience differences in exposure and vulnerability to health-compromising conditions.
- Illness can 'feed back' on a given individual's social position, e.g., by compromising employment opportunities and reducing income; certain epidemic diseases can similarly 'feed back' to affect the functioning of social, economic and political institutions.
- Conflating the social determinants of health and the social processes that shape these determinants' unequal distribution can seriously mislead policy; over recent decades, social and economic policies that have been associated with positive aggregate trends in health-determining social factors (e.g., income, educational attainment) have also been associated with persistent inequalities in the distribution of these factors across population groups.
- Policy objectives will be defined quite differently, depending on whether the aim is to address determinants of health or determinants of health inequities.
- Thus, Graham argues for the importance of representing the concept of social determinants to policymakers in ways that clarify the distinction between the social causes of health and the factors determining the distribution of these causes between more and less advantaged groups. The CSDH framework attempts to fulfill this objective.

VI. Policies and interventions

In this section, we draw upon the conceptual framework elaborated above to derive lessons for policy action on SDH. First, we consider the issue of conceptualizing health inequities and their distribution across the population in terms of 'gaps' or of a continuous social gradient in health. Then we present two policy analysis frameworks (from Stronks et al. and Diderichsen et al., respectively) useful to illustrate the type of processes that can guide policy decision-making on SDH. Then we review a number of key directions which the CSDH model suggests should guide policy choices as decision-makers seek to tackle health inequities through action on SDH.

VI.1 Gaps and gradients

Today, health equity is increasingly embraced as a policy goal by international health agencies and national policymakers.[204] However, political leaders' commitment to "tackle health

inequities" can be interpreted in different ways and authorize a variety of distinct policy strategies.

Three broad policy approaches to reducing health inequities can be identified: (1) improving the health of low SEP groups through targeted programmes; (2) closing the health gaps between those in the poorest social circumstances and better off groups; (3) addressing the entire health gradient, that is, the association between socioeconomic position and health across the whole population.

To be successful, all three of these options would require action on SDH. All three constitute potentially effective ways to alleviate the unfair burden of illness borne by the socially disadvantaged. Yet the approaches differ significantly in their underlying values and implications for programming. Each offers specific advantages and raises distinctive problems.

Programmes to improve health among low SEP populations have the advantage of targeting a clearly defined, fairly small segment of the population and of allowing for relative ease in monitoring and assessing results. Targeted programmes to tackle health disadvantage may align well with other targeted interventions in a governmental anti-poverty agenda, for example social welfare programmes focused on particular disadvantaged neighborhoods. On the other hand, such an approach may be weakened politically precisely by the fact that it is not a population-wide strategy but instead benefits sub-groups that make up only a relatively small percentage of the population, thus undermining the politics of solidarity that are important to maintaining support for public provision[205]. Furthermore, this approach does not commit itself to bringing levels of health in the poorest groups closer to national averages. Even if a targeted programme is successful in generating absolute health gains among the disadvantaged, stronger progress among better-off groups may mean that health inequalities widen.

An approach targeting health gaps directly confronts the problem of relative outcomes. The UK's current health inequality targets on infant mortality and life expectancy are examples of such a gaps-focused approach. However, this model, too, brings problems. For one thing, its objectives will be technically more challenging than those associated with strategies conceived only to improve health status among the disadvantaged. "Movement towards the [gap reduction] targets requires both absolute improvements in the levels of health in lower socioeconomic groups, and a rate of improvement which outstrips that in higher socioeconomic groups". Meanwhile, gaps-oriented approaches share some of the ambiguities underlying the focus on health disadvantage. Health-gaps models continue to direct efforts to minority groups within the population (they are concerned with the worst-off, measured against the best-off). By adopting this stance, "a health-gaps approach can underestimate the pervasive effect which socioeconomic inequality has on health, not only at the bottom but also across the socioeconomic hierarchy". By focusing too narrowly on the worst-off, gaps models can obscure what is happening to intermediary groups, including "next to the worst-off" groups that may also be facing major health difficulties.

Tackling the socioeconomic gradient in health right across the spectrum of social positions constitutes a much more comprehensive model for action on health inequities. With a health-gradient approach, "tackling health inequalities becomes a population-wide goal: like the goal of improving health, it includes everyone". On the other hand, this model must clearly contend with major technical and political challenges. Health gradients have persisted stubbornly across epidemiological periods and are evident for virtually all major causes of mortality, raising doubts about the feasibility of significantly reducing them, even if political leaders have the will to do so. Public policy action to address gradients may prove complex and costly and, in addition,

yield satisfactory results only in a long timeframe. Yet it is clear that an equity-based approach to social determinants, carried through consistently, must lead to a gradients focus.

Strategies based on tackling health disadvantage, health gaps and gradients are not mutually exclusive. The approaches are complementary and can build on each other. "Remedying health disadvantages is integral to narrowing health gaps, and both objectives form part of a comprehensive strategy to reduce health gradients". Thus a sequential pattern emerges, with "each goal add[ing] a further layer to policy impact". Of course the relevance of these approaches and their sequencing will vary with countries' levels of economic development and other contextual factors. A targeted approach may have little relevance in a country where 80% of the population is living in extreme poverty. Here the CSDH can contribute by linking a deepened reflection on the values underpinning an SDH agenda with country-level contextual analysis and a pragmatic mapping of policy options and sequencing.

VI.2 Frameworks for policy analysis and decision-making

Our review of the literature has identified several suggestive analytic frameworks for policy development on SDH. One of the proposals most relevant to current purposes was elaborated in the context of the Dutch national research programme on inequalities in health.[206] The programme report highlights phases of analysis for the implementation of interventions and policies on SDH. The first phase involves filling in the social background on health inequalities in the specific country or socioeconomic context. The impact of each social determinant on health varies within a given country according to different socioeconomic contexts. Four intervention areas are identified:

- The first and the most fundamental option is to reduce inequalities in the distribution of socioeconomic factors or *structural determinants*, like income and education. An example would be reducing the prevalence of poverty.
- The second option relates to the specific or *intermediary determinants* that mediate the effect of socioeconomic position on health, such as smoking or working conditions. Interventions at this level will aim to change the distribution of such specific or intermediary determinants across socioeconomic groups, e.g. by reducing the number of smokers in lower socioeconomic groups, or improving the working conditions of people in lower status jobs.
- A third option addresses the *reverse effect of health status on socioeconomic position*. If bad health status leads to a worsening of people's socioeconomic position, inequalities in health might partly be diminished by preventing ill people from experiencing a fall in income, e.g., as a consequence of job loss. An example would be strategies to maintain people with chronic illness within the workforce.
- The fourth policy option concerns the delivery of *curative healthcare*. It becomes relevant only after people have fallen ill. One might offer people from lower socioeconomic positions extra healthcare or another type of healthcare, in other to achieve the same effects as among people in higher socioeconomic positions.

This and other policy frameworks should be seen in the light of the preceding discussion on health disadvantage, gaps and gradients. Following Graham, we argued that improving the heath of poor groups and narrowing health gaps are necessary but not sufficient objectives. A commitment to health equity ultimately requires a health-gradients approach. A gradients model locates the cause of health inequalities not only in the disadvantaged circumstances and health-damaging behaviors of the poorest groups, but in the systematic differences in life chances, living standards and lifestyles associated with people's unequal positions in the socioeconomic hierarchy.[207] While interventions targeted at the most disadvantaged may appeal to policymakers

on cost grounds or for other reasons, an unintended effect of targeted interventions may be to legitimize economic disadvantage, making it both more tolerable for individuals and less burdensome for society.[208,209,210] Health programmes (including SDH programmes) targeted at the poor have a constructive role in responding to acute human suffering. Yet the appeal to such strategies must not obscure the need to address the structured social inequalities that create health inequities in the first place.[211]

In another approach, Diderichsen and colleagues propose a typology or mapping of entry points for policy action on SDH. They identify the following major options: **social stratification**; **differential exposure**/**differential vulnerability**; **differential consequences and macro social conditions**. The figure elaborated by Diderichsen that illustrates these ideas is shown below.[212] The following entry points are identified:

- ✓ First, altering **social stratification** itself, by reducing "inequalities in power, prestige, income and wealth linked to different socioeconomic positions".[213] For example, policies aimed at diminishing gender disparities will influence the position of women relative to men. In this domain, one could envisage an impact assessment of social and economic policies to mitigate their effects on social stratification. While social stratification is often seen as the responsibility of other policy sectors and not central to health policy per se, Diderichsen and colleagues argue that addressing stratification is in fact "the most critical area in terms of diminishing disparities in health". They propose two general types of policies in this entry point: first the promotion of policies that diminish social inequalities, e.g., labor market, education, and family welfare policies; second a systematic impact assessment of social and economic policies to mitigate their effects on social stratification. In the figure below, this approach is represented by **line A**.

- ✓ Decreasing the **specific exposure** to health-damaging factors suffered by people in disadvantaged positions. The authors indicate that, in general, most health policies do not differentiate exposure or risk reduction strategies according to social position. Earlier anti-tobacco efforts constitute one illustration. Today there is increasing experience with health policies aiming to combat inequities in health that target the specific exposures of people in disadvantaged positions, including aspects such as unhealthy housing, dangerous working conditions and nutritional deficiencies. Children living in extreme poverty (below US$1 per day, according to the World Bank's contentious and problematic definition) have very different mortality rates in different countries, which shows that the national policy context modifies the effect of poverty (Wagstaff 2002). Living in a society with strong safety nets, active employment policies, or strong social cohesion may make day-today life less threatening and relieve some of the social stress involved in having very little money or being unemployed (Whitehead, et al. 2000).In the figure, this approach is represented by **line B**.

- ✓ Lessening the **vulnerability** of disadvantaged people to the health-damaging conditions they face. An alternative way of thinking about modifying the effect of exposures is through the concept of differential vulnerability. Intervention in a single exposure may have no effect on the underlying vulnerability of the disadvantaged population. Reduced vulnerability may only be achieved when interacting exposures are diminished or relative social conditions improve significantly. An example would be the benefits of female education as one of the most effective means of mediating women's differential vulnerability. This entry point is shown below by **line C**. This line is bifurcated to emphasize that conditions of differential vulnerability exist previous to specific exposures.

- ✓ Intervening through the health system to reduce the **unequal consequences of ill-health** and prevent further socioeconomic degradation among disadvantaged people who become ill. Examples would include additional care and support to disadvantaged patients; additional resources for rehabilitation programmes to reduce the effects of illness on people's earning potential; and equitable health care financing. Policy options should marshal evidence for the range of interventions (both disease-specific and related to the broader social environment) that will reduce the likelihood of unequal consequences of ill health. For instance, additional resources for rehabilitation might be allocated to reduce the social consequences of illness. Equitable health care financing is a critical component at this level. It involves protection from the impoverishment arising from catastrophic illness as well as an understanding of the implications of various public and private financing mechanisms and their use by disadvantaged populations. In poor countries, the impoverishing effects of user fees play an increasing role in the economic consequences of illness. Social consequences of diseases have a much steeper socioeconomic gradient than the incidence and prevalence of the same diseases. This entry point appears in the figure as **line D**.

- ✓ Policies influencing ***macro-social conditions (context)***. Social and economic policies may influence social cohesion, integration and social capital of communities. Channels of influence and intervention can be defined for the development of redistributive policies, strengthening social policies, in particular for the neediest and most vulnerable social groups. This entry point appears in the figure as **line E**.

These points are summarized in the diagram below.

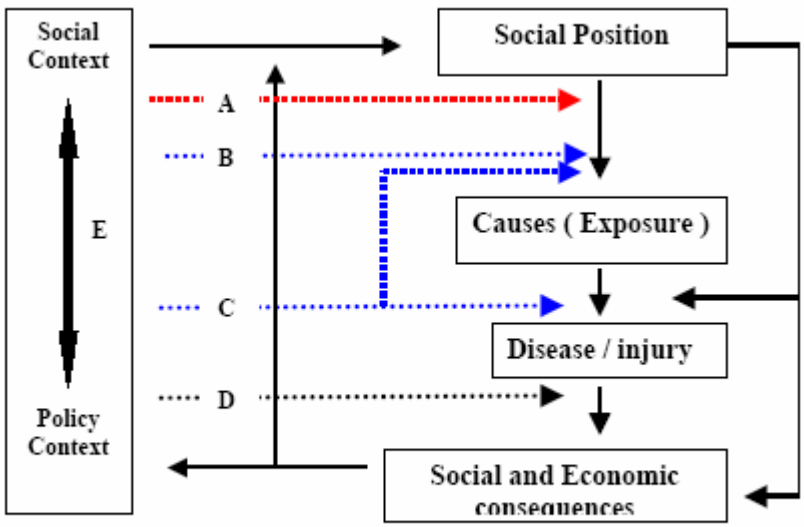


Figure : Source: Diderichsen, et al. (2001).

VI.4 Key dimensions and directions for policy

On the basis of the model developed in the preceding chapter and the policy analysis frameworks just reviewed, we can identify fundamental orientations for policy action to reduce health inequities through action on SDH. We do not attempt here to recommend specific policies and

interventions, which will be the task of the Commission in its final report. Rather, our aim is to highlight broad policy directions which the CSDH conceptual framework suggests must be considered as decision-makers weigh options and develop more specific strategies. The directions we take up here are the following: (1) the importance of context-specific strategies and tackling structural as well as intermediary determinants; (2) intersectoral action: and (3) social participation and empowerment as crucial components of a successful policy agenda on SDH and health equity.

VI.4.1 Context-specific strategies tackling both structural and intermediary determinants

A key implication of the CSDH framework, with its strong emphasis on the impact of socio-political context on health, is that SDH policies must not pin their hopes on a "one-size-fits-all" approach, but should instead be crafted with careful attention to contextual specificities. Since the mechanisms producing social stratification will be different in different settings, certain interventions or policies are likely to be effective for a given socio-political context but not for others. Meanwhile, the timing of interventions with respect to local processes must be considered, as well as partnerships, availability of resources, and how the intervention and/or policy under discussion is conceptualized and understood by participants at national and local levels.[214]

In addition to specificities related to subnational, national and regional factors, context also includes a global component which is of growing importance. The actions of rich and powerful countries, in particular, have effects far outside their borders. Global institutions and processes increasingly influence the socio-political contexts of all countries, in some cases threatening the autonomy of national actors. International trade agreements, the deployment of new communications technologies, the activities of transnational corporations and other phenomena associated with globalization impact health determinants directly and indirectly through multiple pathways. Hence the importance of the findings and recommendations of the CSDH Knowledge Network on globalization for countries seeking to frame effective SDH policies.

Some of the major institutions and processes situated in the socioeconomic and political context (for example, models of governance, labour market structures or the education system) may appear too vast and intractable to be realistic targets for concerted action to bring change. The CSDH may hesitate to recommend ambitious forms of policy action (particularly expanded redistributive policies) that could be considered quixotic. Yet significant aspects of the context in our sense-- the established institutional landscape and broad governance philosophies--can be (and historically have been) changed. Such changes have taken place through political action, often spurred by organized social demand. The contextual factors that powerfully shape social stratification and in turn the distribution of health opportunities are not (entirely) beyond people's collective control. This is among the important implications of recent analyses of welfare state policies and health.[215] [216] [217] [218] Social policies matter for health, and for the degree of social and health equity that exists in society. Evidence-based action to alter key determinants of health inequities is by no means politically unachievable. Notably, in a recent strategy document on 'The Challenge of the Gradient', the Norwegian Directorate for Health and Social Affairs argues that health inequities will probably be most effectively reduced through 'social equalization policies', though the authors acknowledge the political challenges involved in implementation.[219] Indeed, the single most significant lesson of the CSDH conceptual framework may be that interventions and policies to reduce health inequities must not limit themselves to intermediary determinants, but must include policies specifically crafted to tackle the underlying structural determinants of health inequities.

Not all major determinants have been targeted for interventions. In particular, social factors rarely appear to have been the object of interventions aimed at reducing inequity. In contrast, interventions are more frequently aimed at the accessibility of health care and at behavioral risk factors. Regarding the accessibility of health care, a majority of policies are concerned with financing. A notably high proportion of interventions are aimed at those determinants that fall within the domain of regular preventive care, including behavioral factors (individual health promotion and education). Indeed, interventions and policies that address structural determinants of health constitute orphan areas in the determinants field. More work has been done on intermediary determinants (decreasing vulnerability and exposure), but interventions at this level frequently target only one determinant, without relation to other intermediary factors or to the deeper structural factors.

In England, recent discussions on resource allocation formulas have introduced the issue of reducing inequalities in health, not only in access to medical care. Growing political concern about the persistence of social inequalities in health has led the government to add a new resource allocation objective for the NHS: to contribute to the reduction in avoidable health inequalities[220]. The review is not yet finalized, and as an interim solution an index of mortality (years of life lost under age 75) has been proposed. Resource allocation to disease prevention to improve health equity has to be based on an understanding of some of the causal relationships outlined above. Efforts should therefore be made to break socioeconomic inequality in health into its different causes so as to allow evaluation of their different roles in mediating the effect of social position and poverty on health[221].

National policies in Sweden have recently given strong priority to psychosocial working conditions as well as tobacco smoking and alcohol abuse as major causes mediating the effect of social position on health[222]. A similar British overview recently put strong emphasis on living conditions and health behaviors of mothers and children[223]. The World Health Report 2002 emphasized the enormous potential impact of improvements in nutrition and vaccination programs on the poverty-related burden of disease. Common to proposals in both rich and poor countries is the emphasis on strong coordination between social policies and health policies in any effort to mitigate social inequalities in health[224].

Whitehead and Dahlgren (2006) have produced a list of broad recommendations for policy approaches to reduce underlying social inequities. Their primary focus is on income inequalities, but the principles apply to other structural determinants. Their recommendations for national policy directions include the following:

- Describe present and future possibilities to reduce social inequalities in income through cash benefits, taxes and subsidized public services. The magnitude of these transfers can be illustrated by an example from the United Kingdom[225]: “Before redistribution the highest income quintile earn 15 times that of the lowest income quintile. After distribution of government cash benefits this ratio is reduced to 6 to 1, and after direct and local taxes the ratio falls further to 5 to 1. Finally, after adjustment for indirect taxes and use of certain free government services such as health and education, the highest income quintile enjoys a final income 4 times higher than the lowest income quintile”….
- Regulate the invisible hand of the market with a visible hand, promoting equity-oriented and labour-intensive growth strategies. A strong labour movement is important for promoting such policies, and it should be coupled with a broad public debate with strong

links to the democratic or political decision-making process. Within this policy framework, the following special efforts should be made.

- Maintain or strengthen active wage policies, where special efforts are made to secure jobs with adequate pay for those in the weakest position in the labour market. Secure minimum wage levels through agreements or legislation that are adequate and that eliminate the risk of a population of working poor.
- Introduce or maintain progressive taxation, related both to income and to different tax credits, so that differences in net income are reduced after tax.
- Intensify efforts to eliminate gender differences in income, by securing equal pay for equal jobs – regardless of sex. Some gender differences in income are also brought about when occupations that are typically male receive greater remuneration than occupations that are seen as female, because women are concentrated in them. These differences also need to be challenged.
- Increase or maintain public financing of health, education and public transport. The distributional effects of these services are significant – in particular for health services – in universal systems financed according to ability to pay and utilized according to need.[226]

VI.4.2 Intersectoral action

As the preceding discussion has begun to suggest, a commitment to tackle structural, as well as intermediary, determinants has far-reaching implications for policy. This focus notably requires intersectoral action, because structural determinants of health inequities can only be addressed by policies that reach beyond the health sector. If the aim is attacking the deepest roots of health inequities, an intersectoral approach is indispensable.

Intersectoral action for health has been defined as: A recognized relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to achieve health outcomes in a way that is more effective, efficient or sustainable than could be achieved by the health sector working alone[227]. Since the Alma-Ata era, WHO has recognized a wide range of sectors with the potential to influence the determinants of health and, in some cases, the underlying structures responsible for determinants' inequitable distribution among social groups. Relevant sectors include agriculture, food and nutrition; education; gender and women's rights; labour market and employment policy; welfare and social protection; finance, trade and industrial policy; culture and media; environment, water and sanitation; habitat, housing, land use and urbanization[228].

Collaboration with these and other relevant sectors offers distinctive opportunities, while also raising specific challenges. Numerous approaches to planning and implementing intersectoral action exist, and a substantial literature has grown up around the facilitators and inhibitors of such action[229]. Challis et al (1988) divide potential facilitating and obstructing factors into two categories: behavioural and structural. Behavioural elements concern individual attitudes and comportments among those being asked to work collaboratively across sectoral boundaries. Structural influences include political factors (e.g., political backing, political style, values and ideology), policy issues (such as consensus on the nature of problems and their solutions), and specific technical factors related to the policy field(s) in question[230].

Shannon (2002) proposes a 'conceptual framework for emergent governance' that suggests how levels of decision-making from global to local can be brought into flexible but coherent connection ('loose coupling') by linking intersectoral policymaking and participatory

approaches. 'Participatory approaches' in this context means 'political processes that self-consciously and directly engage the people interested in and affected by [policy] choices', as well as the officials charged with making and carrying out policy. Shannon argues that intersectoral action and participation can work together to enable more collaborative, responsive modes of governance. Specific elements of collaboration in governance include 'sharing resources (including staff and budgets), working to craft joint decisions, engaging the opposition in creative solutions to shared problems, and building new relationships as needs and problems arise'[231].

Three frequent approaches to intersectoral action involve policies and interventions defined according to: (1) specific issues; (2) designated target groups within the population; and (3) particular geographical areas ('area-based strategies'). These approaches can be implemented separately or combined in various forms.

(1). Whitehead and Dahlgren (2006) have stressed the importance of intersectoral approaches for reducing health inequities and provided illustrative intersectoral strategies focused on the specific issue of improving health equity through education. Policies approaching health from the angle of education can be universal in scope (addressed to the whole population), for example a nationwide Healthy Schools programme or a universal programme to provide greater support in the transition from school to work. On the other hand, thematically defined intersectoral policies can be linked with social or geographical targeting. Examples would include introducing comprehensive support programmes for children from less privileged families, to promote preschool development.[232]

(2). Some intersectoral strategies are built around the needs of specific vulnerable groups within the population. This is the case of Chile's 'Puente' programme, for example, which seeks to provide a personalized benefits package to the country's poorest families to help them assume increased control of their own lives and enjoy measurably improved life quality across 53 indicators of social wellbeing. The Puente programme, aimed at the 'hard core' of Chilean families living in long-term poverty, is constructed to coordinate support services from multiple sectors, including health, education, employment and social welfare, while strengthening families' social networks and their planning, conflict resolution, relational and life-management skills.[233] A 2005 evaluation of the Puente programme found mixed results after Puente's first three years of operation, revealing both successful aspects and limitations of the effort to construct a network model of integrated service provision at the local level. Effectiveness of service networking was inconsistent and highly dependent on the quality of local leadership within the municipalities where the programme operates. The evaluation concluded that despite its problems, the Puente model 'stands out through its requirement that services connect up in networks to coordinate provision to very poor sectors'[234]. Another example of intersectoral action crafted to meet the needs of specific groups is the New Zealand government's programming for health improvement among the country's Maori minority[235].

(3). A third form of intersectoral policymaking is oriented to designated geographical areas. A widely discussed (and contested) recent example is provided by the United Kingdom's Health Action Zones (HAZ).[236] Venezuela's Barrio Adentro ('Inside the Neighborhood') programme offers a very different model of an area-focused healthcare programme incorporating intersectoral elements. Barrio Adentro forms part of a multidimensional national policy effort introduced by the government of President Hugo Chavez to improve health and living conditions for residents of fragile, historically marginalized urban neighborhoods. Barrio Adentro was consciously constructed as an equity-focused response to the neoliberal health care reforms

implemented throughout Latin America during the 1980s and 90s, whose result had been to 'redefine[e] health care less as a social right and more as a market commodity'. Muntaner et al. argue that 'popular resistance to neoliberalism' helped drive the creation of Barrio Adentro and the array of innovative social welfare measures with which the programme is intertwined. They suggest that Barrio Adentro 'not only provides a compelling model of health care reform for other low- to middle-income countries but also offers policy lessons to wealthy countries'.[237]

Of course, the intersectoral nature of SDH challenges adds considerably to their complexity. While WHO and other health authorities have long recognized the importance of intersectoral action for health, effective implementation of intersectoral policies has often proven elusive, and the Commission does not underestimate the challenges involved.[238] Stronks and Gunning-Schepers argue that: "Although there is great potential for improving the distribution of health through intersectoral action … there very often will be a conflict of interest with other societal goals. … The major constraint in trying to redress socio-economic health differences results from the fact that interventions on most determinants of health will have to come from [government] departments other than the department of public health. … Whereas the primary goal of health policy is (equality in) health, other policy fields have other primary goals." For example, in the area of employment and workforce policies, loosening regulation in the hope of raising the number of new jobs may take precedence over concerns for maintaining a living wage or for workplace safety. "In intersectoral action, conflicts between the goal of equity in health and goals in other policy fields, especially economic policies, are to be expected."[239] In light of such concerns, an important task for the CSDH will be: (1) to identify successful examples of intersectoral action on SDH at the national and sub-national level in jurisdictions with different levels of resources and administrative capacity; (2) to characterize in detail the political and management mechanisms that have enabled effective intersectoral programmes to function sustainably; and (3) to identify key examples of intersectoral action, and needs for future action, in the international frame of reference. Often, these will require initiatives by several countries acting jointly, within or outside the framework provided by existing multilateral institutions.

VI.4.3 Social participation and empowerment

A final crucial direction for policy to promote health equity concerns the participation of civil society and the empowerment of affected communities to become active protagonists in shaping their own health.

Broad social participation in shaping policies to advance health equity is justified on ethical and human rights grounds, but also pragmatically. Human rights norms concern processes as well as outcomes. They stipulate that people have the right to participate actively in shaping the social and health policies that affect their lives. This principle implies a particular effort to include groups and communities that have tended to suffer acute forms of marginalization and disempowerment. Meanwhile, from a strategic point of view, promoting civil society ownership of the SDH agenda is vital to the agenda's long-term sustainability. When the CSDH completes its work in 2008, the task of implementing the Commission's recommendations and advancing action for health equity must be taken up by governments. In turn, governments' commitment in pursuing this work will depend heavily on the degree to which organized demand from civil society holds political leaders accountable. By nurturing civil society participation in action on SDH during its lifetime, the Commission is laying the groundwork for sustained progress in health equity over the long run. The Cuenca Declaration adopted at the Second People's Health Assembly (2005) rightly states that the best hope for equitable progress in health comes when

empowered communities are allied with the State in action against the economic and political interests currently tending to undermine the public sector.[240]

While the primary responsibility for promoting health equity and human rights lies with governments, participation in decision-making processes by civil society groups and movements is "vital in ensuring people's power and control in policy development"[241]. When governments solicit social participation, this term can have a range of quite different meanings:[242]

- **Informing:** To provide people with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions
- **Consulting:** To obtain feedback from affected communities on analysis, alternatives and/or decisions
- **Involving:** To work directly with communities throughout the process to ensure that public concerns and aspirations are consistently understood and considered
- **Collaborating**: To partner with affected communities in each aspect of the decision including the development of alternatives and the identification of the preferred solution
- **Empowering:** To ensure that communities have 'the last word' – ultimate control over the key decisions that affect their wellbeing

Policymaking on social determinants of health equity should work towards the highest form of participation as authentic empowerment of civil society and affected communities.

As noted above, of course, definitions of 'empowerment' are diverse and contested. To some, empowerment is a 'political concept that involves a collective struggle against oppressive social relations' and the effort to gain power over resources. To others, it 'refers to the consciousness of individuals, or the power to express and act on one's desires'[243]. When promoting 'empowerment' and 'participation' as key aspects of policy strategies to tackle heath inequities, we must be aware of the historical and conceptual ambiguities that surround these terms. The concept of empowerment in particular has generated a voluminous and often polemical recent literature[244]. Here, we cannot hope to reflect all the nuances of these debates. However, we can highlight relevant aspects that clarify our interpretation of these concepts and their implications for policymaking.

Historically, key sources of the concept of empowerment include the Popular Education movement and the women's movement. The Popular Education approach gained prominence in Latin America and elsewhere in the 1970s. It is based on the pioneering work of Paolo Freire in the education of oppressed people, and notably on Freire's model of conscientization (conscientisaçao). In the 1980s, movements inspired by Popular Education played an important role in progressive political struggles and resistance against authoritarian governments in Latin America.[245]. The actual term 'empowerment' first achieved wide usage in the women's movement, which drew inspiration from Freire's work. Luttrell and colleagues argue that, in contrast to other progressive intellectual currents dominated by voices from the global north, groundbreaking work on empowerment and gender emerged from the south, for example through the movement of Development Alternatives from Women from a New Era (DAWN), which shaped grassroots analysis and strategies for women challenging inequalities[246]. Subsequently, notions of collective empowerment became central to the liberation movements of ethnic minorities, including indigenous groups in Latin America and African-Americans in the United States.

During the 1990s, the association between empowerment and progressive politics tended to break down. In the context of neoliberal economic and social policies and the rolling-back of the state, 'notions of participation and empowerment, previously reserved to social movements and NGOs, were reformulated and became a central part of the mainstream discourse'.[247] A substantially depoliticized model of empowerment emerged. Whereas it had previously been linked to progressive political agendas, empowerment now came increasingly to appear as a *substitute* for political change. During this same period, the vocabulary of empowerment was being adopted by mainstream international development agencies, including the World Bank. Thus, empowerment came to suffer ambiguities similar to those surrounding social capital[248]. Today, critics argue that the embrace of empowerment by leading development actors has not led to any meaningful changes in development practice. 'Some critiques go further to suggest that the use of the term allows organisations to say they are tackling injustice without having to back any political or structural change, or the redistribution of resources (Fiedrich et al. 2003)'.

In contrast to this depoliticized understanding, we follow recent critics in adopting a political model of the meaning and practice of empowerment[249]. Empowerment as we understand it is inseparably linked to marginalized and dominated communities' gaining effective control over the political and economic processes that affect their wellbeing. Like these critics, we value participation but question whether participation alone can be considered genuinely empowering, without attention to outcomes, namely, the redistribution of resources and power over political processes. We endorse the call to 'mov[e] beyond mere participation in decision-making to an emphasis on *control'*[250]. Indeed, the increased ability of oppressed and marginalized communities to control key processes that affect their lives is the essence of empowerment as we understand it. Their capacity to promote such control should be a significant criterion in evaluating policies on the social determinants of health.

A framework originally developed by Longwe (1991) provides a useful way of distinguishing among different levels of empowerment, while also suggesting the step-wise, progressive nature of empowerment processes. The framework describes the following levels:

1. The **welfare** level: where basic needs are satisfied. This does not necessarily require structural causes to be addressed and tends to assume that those involved are passive recipients.
2. The **access** level: where equal access to education, land and credit is assured.
3. The **conscientisation and awareness-raising** level: where structural and institutional discrimination is addressed.
4. The **participation and mobilisation** level: where the equal taking of decisions is enabled
5. The **control** level: where individuals can make decisions and are fully recognised and rewarded.

'This framework stresses the importance of gaining of *control* over decisions and resources that determine the quality of one's life and suggests that 'lower' degrees of empowerment are a pre-requisite for achieving higher ones'[251].

Importantly, the empowerment of disadvantaged communities as we understand it is inseparably intertwined with principles of state responsibility. This point has fundamental implications for policymaking on SDH. The empowerment of marginalized communities is not a psychological process unfolding in a private sphere separate from politics. Empowerment happens in ongoing engagement with the political, and the deepening of that engagement is an indicator that

empowerment is real. The state bears responsibility for creating spaces and conditions of participation that can enable vulnerable and marginalized communities to achieve increased control over the material, social and political determinants of their own wellbeing. Addressing this concern defines a crucial direction for policy action on health equity. It also suggests how the policymaking process itself, structured in the right way, might open space for the progressive reinforcement of vulnerable people's collective capacity to control the factors that shape their opportunities for health.

VI.4.4. Diagram summarizing key policy directions and entry points

The diagram below summarizes the main ideas presented in the preceding sections and attempts to clarify their relationships via a visual representation. It recalls that the Commission's broad aim, politically speaking, is to promote context-specific strategies to address structural as well as intermediary determinants. Such strategies will necessarily include intersectoral policies, through which structural determinants can be most effectively addressed, and will aim to ensure that policies are crafted so as to engage and ultimately empower civil society and affected communities. These broad directions for policy action can utilize various entry points or levels of engagement, represented in the image by the cross-cutting horizontal bars.

Moving from the lower to the higher bars (from more 'downstream' to more structural approaches), these entry points include: seeking to palliate the differential consequences of illness; seeking to reduce differential vulnerabilities and exposures for disadvantaged social groups; and, ultimately, altering the patterns of social stratification. At the same time, policies and interventions can be targeted at the 'micro' level of individual interactions; at the 'meso' level of community conditions; or at the broadest 'macro' level of universal public policies and the global environment.

The CSDH and policy partners must also be concerned with an additional set of issues relevant to all these types of policies (summarized in the box at the lower right): monitoring of the effects of policies and interventions on health equity and determinants; assembling and disseminating evidence of effective interventions, including intersectoral strategies; and advocating for the incorporation of health equity as a goal into the formulation and evaluation, not only of health policies, but of all social policies.

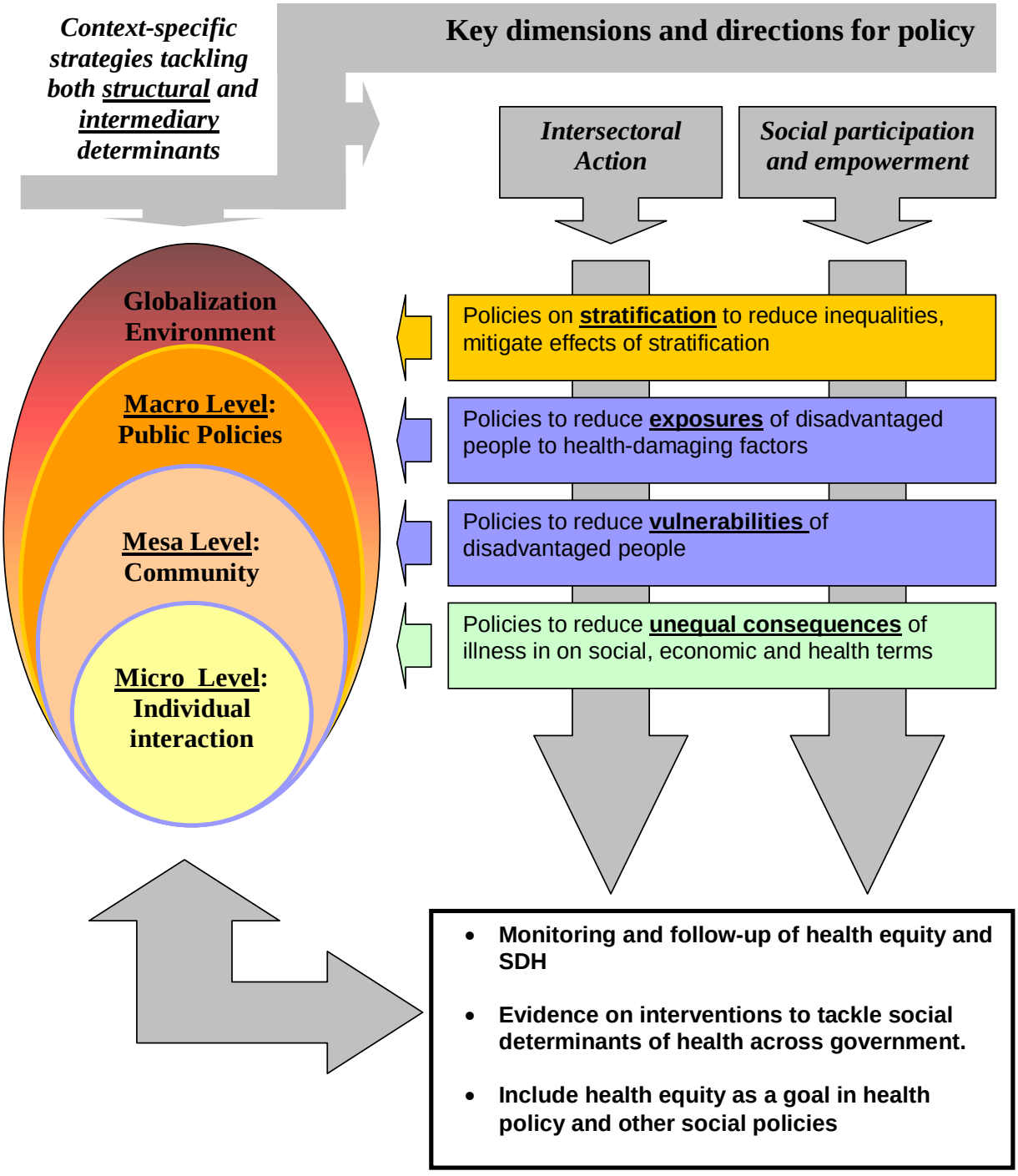


Figure: Framework for action on tackling social determinants of health inequities
Elaborated by EQH/EIP 2006 (OPSH)

As Stewart-Brown points out, to date, public health research has focused more on the impact of social inequalities than on their causes, or a fortiori on realistic political strategies to address underlying causes. Studies of interventions to mitigate the impact of social inequalities have tended to focus on methods of reducing the level of disease at the lower end of the income distribution. The application of public health theory, however, suggests that the causes of social

inequalities are likely to lie as much with the attributes of high-income groups as with those of low-income groups[252]. This insight sharpens our sense of the political challenges. Solutions such as redistribution of income that may appear simple in the abstract are anything but simple to achieve in reality.

Fundamental to formulating effective policy in this area is the vexed problem of universal vs. targeted approaches. Thandika Mkandawire has recently summarized the issue as follows: 'For much of its history, social policy has involved choices about whether the core principle behind social provisioning will be "universalism", or selectivity through "targeting". Under universalism, the entire population is the beneficiary of social benefits as a basic right, while under targeting, eligibility to social benefits involves some kind of means-testing to determine the "truly deserving". Policy regimes are hardly ever purely universal or pu rely based on targeting, however; they tend to lie somewhere between the two extremes on a continuum, and are often hybrid, but where they lie on this continuum can be decisive in spelling out individuals' life chances and in characterizing the social order. Each of the core concerns of social policy—need, deserts and citizenship—are social constructs that derive full meaning from the cultural and ideological definition of "deserving poor", "entitlement" and "citizens' rights". Although in current parlance, the choice between targeting and universalism is couched in the language of efficient allocation of resources subject to budget constraints and the exigencies of globalization, what is actually at stake is the fundamental question about a polity's values and its responsibilities to all its members. The technical nature of the argument cannot conceal the fact that, ultimately, value judgments matter not only with respect to determining the needy and how they are perceived, but also in attaching weights to the types of costs and benefits of approaches chosen. Such a weighting is often reflective of one's ideological predisposition. In addition, societies chose either targeting or universalism in conjunction with other policies that are ideologically compatible with the choice, and that are deemed constitutive of the desired social and economic policy regime'[253].

In a report developed by the United Nations Research Institute for Social Development (UNRISD), Mkandawire and his colleagues have highlighted the contradictions of dominant approaches: 'One remarkable feature of the debate on universalism and targeting is the disjuncture between an unrelenting argumentation for targeting, and a stubborn slew of empirical evidence suggesting that targeting is not effective in addressing issues of poverty (as broadly understood). Many studies clearly show that identifying the poor with the precision suggested in the theoretical models involves extremely high administrative costs and an administrative sophistication and capacity that may simply not exist in developing countries An interesting phenomenon is that while the international goals are stated in international conferences, in universalistic terms (such as "education for all" and "primary health care for all"), the means for reaching them are highly selective and targeted. The need to create institutions appropriate for targeting has, in many cases, undermined the capacity to provide universal services. Social policies not only define the boundaries of social communities and the position of individuals in the social order of things, but also affect people's access to material well-being and social status. This follows from the very process of setting eligibility criteria for benefits and rights. The choice between universalism and targeting is therefore not merely a technical one dictated by the need for optimal allocation of limited resources. Furthermore, it is necessary to consider the kind of political coalitions that would be expected to make such policies politically sustainable. Consequently, there is a lot of reinvention of the wheel, and wasteful and socially costly experimentation with ideas that have been clearly demonstrated to be the wrong ones for the countries in which they are being imposed. There is ample evidence of poor countries that have significantly reduced poverty through universalistic approaches to social provision and from

whose experiences much can be learnt (Ghai 1999; Mehrotra and Jolly 1997a, 1997b). Although we have posed the issue in what Atkinson calls "gladiator terms", in reality most governments tend to have a mixture of both universal and targeted social policies. However, in the more successful countries, overall social policy itself has been universalistic, and targeting has been be used as simply one instrument for making universalism effective; this is what Theda Skocpol has referred as "targeting within universalism", in which extra benefits are directed to low-income groups within the context of a universal policy design (Skocpol 1990) and involves the fine-tuning of what are fundamentally universalist policies'.[254]

We now present a summary of concrete examples of SDH interventions organized according to the framework for action developed in this paper[255].

Level of entry point	**Stategies**	
	Universal	**Selective**
Policies on **stratification** to reduce inequalities and mitigate effects of stratification.	1. Active policies reduce income inequality through taxes and subsidized public services. 2. Free government service such as health, education and public transport. 3. Labor market policies : secure jobs with adequate pay, and labour intensive growth strategies 4. Policies and mechanism of redistribution and allocation resources in care and other social sector. 5. Promove equal opportunity for women and gender 6. Promove development and strengthening of social movement of such autonomy .	1. Social segurity for disadvantaged people in particular . 2. Child welfare Early childhood development programmes, including the provision of nutritional supplements, regular monitoring by health staff and cognitive development for children of pre-primary school age;. To promote preschool\ development
Policies to reduce **exposures** to health-damaging factors of disadvantaged people in particular.	1. Neigboorhood physical and social environmental healthy and safee.g service basic access 2. Living physical and social environmental healthy and safe ; water and sanitation 3. Working physical and social enviromental healthy and safe. 4. Health Promotion and lifestyle healthy e.g. smoking, alcohol, other.	1. Policies about heating and cooking fuel for disadvantaged people in particular. 2. Housing policies subsidized for disadventage people
Policies to reduce **vulnerabilities** of disadvantaged people in particular.	1. Social segurity for unemeployment. 2. Protection mother alone for access work and education ; 3. Social segurity for older and discapacity people 4. Policies for developlemte social network in community.	1. Extra support to student from less privileged families and in the transition from school to work. 2. Free healthy school lunches. 3. Additional access and support to preventive activities. 4. Active policies through cash benefits or transfer
Policies to reduce **unequal consequences** on social, economic and ill-health over disadvantaged people in particular.	1. Equitable health care financing and protection from impoverishing arising from catastrophic illness 2. To maintain people with chronic illness within the workforce. 3. Active labour policies for discapacity people. 4. Social proteccion and earning in illness and injury.	1. Additional care and support to disadvantaged patient 2. Additional resources of rehabilitation programs for to disadvantaged people.

Key messages of this section:

- Three broad approaches to reducing health inequities can be identified, based on: (1) targeted programmes for disadvantaged populations; (2) closing health gaps between worse-off and better-off groups; (3) addressing the social health gradient across the whole population.

- A consistent equity-based approach to SDH must ultimately lead to a gradients focus. However, strategies based on tackling health disadvantage, health gaps and gradients are not mutually exclusive. They can complement and build on each other.

- Policy development frameworks, including those from Stronks et al. and Diderichsen, can help analysts and policymakers to identify levels of intervention and entry points for action on SDH, ranging from policies tackling underlying structural determinants to approaches focused on the health system and reducing inequities in the consequences of ill health suffered by different social groups.

- The CSDH framework suggests a number of broad directions for policy action. We highlight three:
    - Context-specific strategies to tackle both structural and intermediary determinants
    - Intersectoral action
    - Social participation and empowerment

- SDH policies must be crafted with careful attention to contextual specificities, which should be rigorously characterized using methodologies developed by social and political science.

- Arguably the single most significant lesson of the CSDH conceptual framework is that interventions and policies to reduce health inequities must not limit themselves to intermediary determinants, but must include policies specifically crafted to tackle underlying structural determinants: the social mechanisms that systematically produce an inequitable distribution of the determinants of health among population groups.

- To tackle structural as well as intermediary determinants requires intersectoral policy approaches. A key task for the CSDH will be: (1) to identify successful examples of intersect oral action on SDH in jurisdictions with different levels of resources and administrative capacity; and (2) to characterize in detail the political and management mechanisms that have enabled effective intersectoral programmes to function sustainably.

- Participation of civil society and affected communities in the design and implementation of policies to address SDH is essential to success. However, the concept of ‘participation’ has a range of meanings, and choices among them should be explicit. Policymaking on social determinants of health equity should work towards the highest form of participation as authentic empowerment of civil society and affected communities.

Key messages of this section:

- In turn, definitions of 'empowerment' are diverse and contested. A depoliticized interpretation of empowerment became a feature of neoliberal development discourse in the 1990s. Whereas 'empowerment' had previously been linked to progressive political agendas, the concept was increasingly presented as a substitute for political change. Such depoliticized interpretations empty the concept of empowerment of its vital content.

- The essence of empowerment is the increased ability of oppressed and marginalized communities to control the political and economic processes that affect their wellbeing. The extent to which different SDH policies promote such control is a significant criterion for evaluating policy options.

- The empowerment of disadvantaged communities is intertwined with state responsibility. The state bears responsibility for creating spaces and conditions of participation that can enable vulnerable and marginalized communities to achieve increased control over the material, social and political determinants of their own wellbeing.

- Policymaking on SDH must confront the vexed problem of universal vs. targeted approaches. In practice, as Mkandawire and colleagues have shown, most governments tend to have a mixture of both universal and targeted social policies. However, in most countries that have been highly successful in promoting social welfare, overall social policy itself has been universalistic, and targeting has been be used as one instrument for making universalism effective.

- Again following Mkandawire, while choices between targeting and universalism are often couched in the language of efficient resource allocation, what is actually at stake is the fundamental question about a polity's values and its responsibilities to all its members.

VII. Conclusion

This paper has sought to clarify shared understandings around a series of foundational questions. The architects of the CSDH gave it the mission of helping to reduce health inequities, understood as avoidable or remediable health differences among population groups
defined socially, economically, demographically or geographically. Getting to grips with this mission requires finding answers to three basic problems:

1. If we trace health differences among social groups back to their deepest roots, where do they originate?
2. What pathways lead from root causes to the stark differences in health status observed at the population level?
3. In light of the answers to the first two questions, where and how should we intervene to reduce health inequities?

The framework presented in these pages has been developed to provide responses to these questions and to buttress those responses with solid evidence, canvassing a range of views among theorists, researchers and practitioners in the field of SDH and other relevant disciplines. To the first question, on the origins of health inequities, we have answered as follows. The root causes of health inequities are to be found in the social, economic and political mechanisms that give rise to a set of hierarchically ordered socioeconomic positions within society, whereby groups are stratified according to income, education, occupation, gender, race/ethnicity and other factors. The fundamental mechanisms that produce and maintain (but that can also reduce or mitigate effect) this stratification include: governance; the education system; labour market structures; and redistributive welfare state policies (or their absence). We have referred to the component factors of socioeconomic position as *structural determinants*. Structural determinants, together with the features of the socioeconomic and political context that mediate their impact, constitute the *social determinants of health inequities*. The structural mechanisms that shape social hierarchies according to key stratifiers are the root cause of health inequities.

Our answer to the second question, about pathways from root causes to observed inequities in health, was elaborated by tracing how the underlying social determinants of health inequities operate through a set of what we call *intermediary determinants of health* to shape health outcomes. The main categories of intermediary determinants of health are: material circumstances; psychosocial circumstances; behavioral and/or biological factors; and the health system itself as a social determinant. We argued that the important complex of phenomena toward which the unsatisfactory term ‘social capital’ directs our attention cannot be classified definitively under the headings of either structural or intermediary determinants of health. ‘Social capital’ cuts across the structural and intermediary dimensions, with features that link it to both. The vocabulary of ‘structural determinants’ and ‘intermediary determinants’ underscores the causal priority of the structural factors.

This paper provides only a partial answer to the third and most important question: what we should do reduce health inequities. The Commission’s final report will bring a robust set of responses to this problem. However, we believe the principles sketched here to be of importance in suggesting directions for action to improve health equity. We derive three key policy orientations from the CSDH framework:

- Arguably the single most significant lesson of the CSDH conceptual framework is that interventions and policies to reduce health inequities must not limit themselves to intermediary determinants, but must include policies crafted to tackle structural determinants. In conventional usage, the term ‘social determinants of health’ has often encompassed only intermediary determinants. However, interventions addressing intermediary determinants can improve average health indicators while leaving health inequities unchanged. For this reason, policy action on structural determinants is necessary. To achieve solid results, SDH policies must be designed with attention to contextual specificities, which should be rigorously characterized using methodologies developed by social and political science.
- Intersectoral policymaking and implementation are crucial for progress on SDH. This is because structural determinants can only be tackled through strategies that reach beyond the health sector. A key task for the CSDH will be to: (1) identify successful examples of intersectoral action on SDH in jurisdictions with different levels of resources and administrative capacity; and (2) characterize in detail the political and management mechanisms that have enabled effective intersectoral programmes.

- Participation of civil society and affected communities in the design and implementation of policies to address SDH is essential to success. Social participation is an ethical obligation for the CSDH and its partner governments. Moreover, the empowerment of civil society and communities and their ownership of the SDH agenda is the best way to build a sustained global movement for health equity that will continue after the Commission completes its work.

The broad policy directions mapped by this framework are empty unless translated into concrete action. To be effective, however, action in the complex field of health inequities must be guided by careful theoretical analysis grounded in explicit value commitments. The framework offered here proposes basic conceptual foundations for the Commission's work in what we hope is a clear form, so that they can be subjected to examination and reasoned debate.

References

[1] Lee JW. 2004. Address to the World Health Assembly. Geneva, May 2004.
[2] Tarlov A. 1996. Social determinants of health: the sociobiological translation. In Blane D, Brunner E, Wilkinson R (eds). Health and social organization. London: Routledge. 71-93.
[3]Graham H 2004 Social determinants and their unequal distribution Milbank Q. 2004;82(1):101-24.
[4] Cueto M. 2004. The origins of primary health care and selective primary health care. Joint Learning Initiative: JLI Working Papers Series. Werner D, Sanders D. 1997. Questioning the solution: the politics of primary health care and child survival. Palo Alto, CA: Healthwrights. Brown, T., Cueto M. and Fee, E. (2006) The World Health Organization and the transition from international to global public health. American Journal of Public Health 96(1): 62-72.
[5] Homedes N, Ugalde A. 2005. Why neoliberal health reforms have failed in Latin America. Health Policy 71: 83-96.
[6] Hofrichter R. (ed.) 2003. Health and social justice. San Francisco : Jossey Bass. Kim J, Millen J, Irwin A, Gershman J (eds). 2000. Dying for growth: global inequality and the health of the poor. Monroe, Maine: Common Courage.
[7] Illich I. 1976. Medical nemesis: the expropriation of health. New York: Pantheon. McKeown T. 1976. The Modern Rise of Population. New York: Academic Press Colgrove, J. (2002) The McKeown thesis: a historical controversy and its enduring influence. American Journal of Public Health 92(5): 725-29. Szreter, S. (2004) Industrialization and health. British Medical Bulletin 69: 75-86.
[8] Black D et al. 1980. Report of the working group on inequalities in health. London: Stationery Office
[9] Marmot, M., Rose, G., Shipley, M. and Hamilton, P.J. (1978) Employment grade and coronary heart disease in British civil servants. Journal of Epidemiology and Community Health 32:244-9. Marmot, M., Smith, G., Stansfeld, S., Patel, C., North, F., Head, J., White, I., Brunner, E. and Feeney, A. (1991) Health inequalities among British civil servants: The Whitehall II study. Lancet 337: 1387-1393
[10] Whitehead M. 1990 Concept of equity in health. WHO. Braveman P. 1998. Monitoring equity in health: a policy-oriented approach in low- and middle-income countries. Geneva: WHO. Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M (eds). 2001. Challenging inequities in health. New York: Oxford UP.
[11] Graham H 2004. Whitehead 1990. Mackenbach J, Bakker M (eds). 2002. Reducing Inequalities in Health: A European Perspective.
[12] Oldenburg B, McGuffog ID, Turrell G. 2000. Socioeconomic determinants of health in Australia: policy responses and intervention options. Med J Aust. 2000 May 15;172(10):489-92. Ministry of Health of New Zealand. 2000. New Zealand Health Strategy.
http://www.moh.govt.nz/moh.nsf/0/1c468f0b47a6e7024c2568f000707c03/$FILE/ATTYVNM3/nzhsdisc.pdf
[13] Graham H. 2004. Social determinants and their unequal distribution: clarifying policy understandings. The Milkbank Vol 82, n 1, 2004 .pp 101-124.
[14] Tajer D. 2003. Latin American social medicine: roots, development during the 1990s, and current challenges. Am J Public Health. 2003 Dec;93(12):1989-91. Werner D, Sanders D. 1997. Questioning the solution: the politics of primary health care and child survival. Palo Alto, CA: Healthwrights
[15] People's Health Declaration (2000).
[16] Lee, J.W. (2004) Speech to the 57th World Health Assembly, 17 May 2004.
[17] Lee, J.W. (2005) Public health is a social issue. Lancet 365: 1005-06.
[18] WHO Equity Team working definition. Also cf. ISEqH definition.
[19] Dahlgren G, Whitehead M. 2006. Levelling up (part 1): a discussion paper on European strategies for tackling social inequities in health. WHO EURO.
[20] Braveman P, Gruskin S. 2003. Defining equity in health. Journal of Epidemiology and Community Health 2003;57:254-258
[21] Anand S. 2004. The concern for equity in health. In Anand S, Peter F, Sen A (eds). Public health, ethics and equity. Oxford: Oxford UP.
[22] Rawls J. 1971. A theory of justice. Harvard UP.
[23] Ruger JP. 2006. Health, capability, and justice: toward a new paradigm of health ethics, policy and law. Cornell J Law Public Policy. 2006 Spring;15(2):403-82. Ruger JP. 2004. Ethics of the social determinants of health. Lancet. 2004 Sep 18-24;364(9439):1092-7. Ruger JP. 2004. Health and social justice. Lancet. 2004 Sep 18-24;364(9439):1075-80.
[24] Marmot M. 2004. The Status Syndrome: How Social Standing Affects Our Health and Longevity. London: Times Books.
[25] Universal Declaration of Human Rights. 1948.
[26] ICESCR. 1966.
[27] UN Committee on Economic Social and Cultural Rights. 2000. General comment number 14: on the right to the highest attainable standard of health. Para 4. http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En

[28] See e.g., the Global Right to Health and Health Care Campaign of the People's Health Movement. http://phmovement.org/

[29] Braveman P, Gruskin S. 2003. Poverty, equity, human rights and health. Bull World Health Organ. 2003;81(7):539-45.

[30] See www.ohchr.org/english/issues/health/right

[31] Tajer D. 2003. Latin American social medicine: roots, development during the 1990s, and current challenges. Am J Public Health. 2003 Dec;93(12):1989-91. Solar O, Irwin A. 2006. Social determinants, political contexts and civil society action: a historical perspective on the Commission on Social Determinants of Health. Health Promot J Austr. 2006 Dec;17(3):180-5.

[32] Yamin A. 1996. Defining Questions: Situating Issues of Power in the Formulation of a Right to Health under International Law Human Rights Quarterly 18.2 (1996) 398-438

[33] Krieger N. 2001. Theories for social epidemiology in the 21st century: an ecosocial perspective. Int J Epidemiol. 2001 Aug;30(4):668-77 Krieger N. 2002. A glossary for social epidemiology. Epidemiol Bull. 2002 Mar;23(1):7-11. Krieger N. 2005. Embodiment: a conceptual glossary for epidemiology. J Epidemiol Community Health. 2005 May;59(5):350-5.

[34] Raphael D. 2006. Social determinants of health: present status, unanswered questions, and future directions. Int J Health Serv. 2006;36(4):651-77. Raphael D, Bryant T. 2006. Maintaining population health in a period of welfare state decline: political economy as the missing dimension in health promotion theory and practice. Promot Educ. 2006;13(4):236-42.

[35] John Cassel The contribution of the Social environment to host resistance. American Journal of Epidemiology. Vol 104 No 2 1976 pag 107 -123.

[36] Wilkinson RG, Pickett KE. 2006. Income inequality and population health: a review and explanation of the evidence. Soc Sci Med. 2006 Apr;62(7):1768-84. Lynch J, Smith GD, Hillemeier M, Shaw M, Raghunathan T, Kaplan G. 2001. Income inequality, the psychosocial environment, and health: comparisons of wealthy nations. Lancet. 2001 Jul 21;358(9277):194-200. Wilkinson RG. Related 2000. Inequality and the social environment: a reply to Lynch et al. J Epidemiol Community Health. 2000 Jun;54(6):411-3. Marmot M, Wilkinson RG. 2001. Psychosocial and material pathways in the relation between income and health: a response to Lynch et al. BMJ. 2001 May 19;322(7296):1233-6. Lobmayer P, Wilkinson RG. 2002. Inequality, residential segregation by income, and mortality in US cities. J Epidemiol Community Health. 2002 Mar;56(3):183-7. Marmot M. 2002. The influence of income on health: views of an epidemiologist. Health Aff (Millwood). 2002 Mar-Apr;21(2):31-46.

[37] Kaplan GA, Pamuk ER, Lynch JW, Cohen RD, Balfour JL. 1996. Inequality in income and mortality in the United States: analysis of mortality and potential pathways.BMJ. 1996 Apr 20;312(7037):999-1003. Lynch JW, Kaplan GA, Pamuk ER, Cohen RD, Heck KE, Balfour JL, Yen IH. 1998. Income inequality and mortality in metropolitan areas of the United States. Am J Public Health. 1998 Jul;88(7):1074-80. Smith GD, Egger M. Commentary: understanding it all--health, meta-theories, and mortality trends. BMJ. 1996 Dec 21-28;313(7072):1584-5. (Davey Smith, 1996; Lynch & Kaplan, 1997; Lynch et al., 1998)

[38] Krieger N. 2001. Theories for social epidemiology in the 21st century: an ecosocial perspective. Int J Epidemiol. 2001 Aug;30(4):668-77 Krieger N. 2002. A glossary for social epidemiology. Epidemiol Bull. 2002 Mar;23(1):7-11. Krieger N. 2005. Embodiment: a conceptual glossary for epidemiology. J Epidemiol Community Health. 2005 May;59(5):350-5.

[39] Krieger N. 2001. Theories for social epidemiology in the 21st century: an ecosocial perspective. Int J Epidemiol. 2001 Aug;30(4):668-77.

[40] ILLSLEY R. 1955. Social class selection and class differences in relation to stillbirths and infant deaths. Br Med J. 1955 Dec 24;2(4955):1520-4. West P. 1991. Rethinking the health selection explanation for health inequalities. Soc Sci Med. 1991;32(4):373-84. (Wadsworth, 1986)

[41] Blane D, Bartley M, Smith GD, Filakti H, Bethune A, Harding S. 1994. Social patterning of medical mortality in youth and early adulthood. Soc Sci Med. 1994 Aug;39(3):361-6. Blane D, Smith GD, Bartley M. 1990. Social class differences in years of potential life lost: size, trends, and principal causes. BMJ. 1990 Sep 1;301(6749):429-32. Bartley M, Power C, Blane D, Smith GD, Shipley M. 1994. Birth weight and later socioeconomic disadvantage: evidence from the 1958 British cohort study. BMJ. 1994 Dec 3;309(6967):1475-8. Bartley M, Plewis I. 1997. Does health-selective mobility account for socioeconomic differences in health? Evidence from England and Wales, 1971 to 1991. J Health Soc Behav. 1997 Dec;38(4):376-86.

[42] Bartley M, Plewis I. 1997. Does health-selective mobility account for socioeconomic differences in health? Evidence from England and Wales, 1971 to 1991. J Health Soc Behav. 1997 Dec;38(4):376-86.

[43] West P. 1991. Rethinking the health selection explanation for health inequalities. Soc Sci Med. 1991;32(4):373-84. (Blane Journal of the royal statistical 1999 ; Manor Soc Scie Med 1991,).

[44] Manor O, Matthews S, Power C. 2003. Health selection: the role of inter- and intra-generational mobility on social inequalities in health. Soc Sci Med. 2003 Dec;57(11):2217-27.

[45] West P. 1991. Rethinking the health selection explanation for health inequalities. Soc Sci Med. 1991;32(4):373-84.
[46] Power C, Stansfeld SA, Matthews S, Manor O, Hope S. 2002. Childhood and adulthood risk factors for socio-economic differentials in psychological distress: evidence from the 1958 British birth cohort. Soc Sci Med. 2002 Dec;55(11):1989-2004. Blane D, Harding S, Rosato M. 1999. Does social mobility affect the size of the socioeconomic mortality differential?: evidence from the Office for National Statistics Longitudinal Study. J R Stat Soc Ser A Stat Soc. 1999;162(Pt. 1):59-70. Hart CL, Smith GD, Blane D. 1998. Social mobility and 21 year mortality in a cohort of Scottish men. Soc Sci Med. 1998 Oct;47(8):1121-30. Smith GD, Hart C, Blane D, Hole D. 1998. Adverse socioeconomic conditions in childhood and cause specific adult mortality: prospective observational study. BMJ. 1998 May 30;316(7145):1631-5. Davey Smith G, Hart C, Hole D, MacKinnon P, Gillis C, Watt G, Blane D, Hawthorne V. 1998. Education and occupational social class: which is the more important indicator of mortality risk? J Epidemiol Community Health. 1998 Mar;52(3):153-60.
[47] Elstad JI. 2001. Health-related mobility, health inequalities and gradient constraint. Discussion and results from a Norwegian study. Eur J Public Health. 2001 Jun;11(2):135-40.
[48] :Smith GD, Morris J. 1994. Increasing inequalities in the health of the nation. BMJ. 1994 Dec 3;309(6967):1453-4. Marmot M, Ryff CD, Bumpass LL, Shipley M, Marks NF 1997. Social inequalities in health: next questions and converging evidence. Soc Sci Med. 1997 Mar;44(6):901-10.
[49] Power C, Matthews S, Manor O. 1996. Inequalities in self rated health in the 1958 birth cohort: lifetime social circumstances or social mobility? BMJ. 1996 Aug 24;313(7055):449-53. Rahkonen O, Arber S, Lahelma E. 1997. Health-related social mobility: a comparison of currently employed men and women in Britain and Finland. Scand J Soc Med. 1997 Jun;25(2):83-92.
[50] Power, Manor, Fox, & Fogelman, 1990. van de Mheen H, Stronks K, Looman CW, Mackenbach JP. 1998. Does childhood socioeconomic status influence adult health through behavioural factors? Int J Epidemiol. 1998 Jun;27(3):431-7.
[51] Lundberg O. 1991. Causal explanations for class inequality in health--an empirical analysis. Soc Sci Med. 1991;32(4):385-93. Rodgers B, Mann SL. 1993. Re-thinking the analysis of intergenerational social mobility: a comment on John W. Fox's "Social class, mental illness, and social mobility". J Health Soc Behav. 1993 Jun;34(2):165-72; discussion 173-7.
[52] West P. 1991. Rethinking the health selection explanation for health inequalities. Soc Sci Med. 1991;32(4):373-84. (Blane et al., 1993)
[53] West P. 1991. Rethinking the health selection explanation for health inequalities. Soc Sci Med. 1991;32(4):373-84. Mackenbach J EPI C H 2005.
[54] Smith GD 1994. Europe Journal P H 1994 (4)131-144).
[55] Mare, 1990; Lynch, Kaplan, & Shema, 1997; Davey Smith, Hart, Blane & Hole 1998.
[56] (Lynch et al., 1997)
[57] (Fox JECH 1985, Rose Marmot British Heart J 1981, Marmot Smith Lancet 1991)
[58] Link B, Norhtridge M, Phelan Social epidemiology and the fundamental cause Concept. Milbank Q 1998;76(3) 375-402.
[59] (Fox JECH 1985(39); Lynch, Kaplan AJE 1996 (144), Smith Shipley JECH 1990 (44)
[60] Marmot, Shipley and Rose Lancet 1984
[61] Cavelaars 1998 JECH (52)
[62] Mackenbach, p 15
[63] Olson CM, Bove CF, Miller EO Growing up poor: Long-term implications for eating patterns and body weight. Appetite. 2007 Feb 22.
[64] Olivares C S, Bustos Z N, Lera M L, Zelada ME. 2007. [Nutritional status, food consumption and physical activity in female school children of different socioeconomic levels from Santiago, Chile.] Rev Med Chil. 2007 Jan;135(1):71-8.
[65] (Lynch, Smith Annual RPH 2005).
[66] (Frankel et al, 1996; Lithell et al 1996; Leon et al, 1996)
[67] Ball T, New faces of power. In Wartenberg T (ed). 1992. Rethinking power. Albany: SUNY Press: 14.
[68] Cited in Stewart A 2001. Theories of power and domination : the politics of empowerment in late modernity. London /Thousand Oaks, Calif. : SAGE: 15.
[69] Giddens 1976 cited in Stewart 2001: 14.
[70] Stewart A 2001. Theories of power and domination : the politics of empowerment in late modernity. London/Thousand Oaks, Calif. : SAGE.
[71] Quiroz S (2006). Empowerment: a selected annotated bibliography, p 6-7.
[72] Young IM. Five Faces of Oppression. In Wartenberg T (ed). 1992. Rethinking power. Albany: SUNY Press: 175-76

[73] Stewart A 2001. Theories of power and domination : the politics of empowerment in late modernity. London/Thousand Oaks, Calif. : SAGE: p 36, emphasis in original
[74] Arendt, cited in Wartenberg 22.
[75] Fay B, cited in Ball T, New faces of power. In Wartenberg, 23.
[76] In Luttrell C, with Quiroz S and Scrutton C (2007). Empowerment: an overview (poverty-wellbeing.net).
[77] Instituto de Estudios Politicos para America Latina y Africa. http://www.iepala.es/curso_ddhh/ddhh27.htm Emphasis ours.
[78] Fay, cited in Ball, in Wartenberg 23
[79] In Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M (eds). 2001. Challenging inequities in health. New York: Oxford UP.
[80] (Diderichsen 1998, 102)
[81] (Diderichsen, Evans, and Whitehead 2001, 15)
[82] (Hallqvist, et al. 1998)
[83] Resource allocation for Health Equity : Issues and Methods . Finn Diderichsen ,September 2004 Health, Nutrition and Population (HNP) The World Bank
[84] (Whitehead, Diderichsen, and Burström 2000)
[85] (Sen 1999)
[86] Esping-Andersen G Why we need a new Welfare State Oxford University 2002
[87] Navarro V. Shi L. The Political context of Social Inequalities and Health International Journal of Helath Services , Vol 31 , Pages 1-21, 2001
[88] Navarro V. Shi L. The Political context of Social Inequalities and Health International Journal of Helath Services , Vol 31 , Pages 1-21, 2001
[89] Chung H, Muntaner C. 2006. Political and welfare state determinants of infant and child health indicators: an analysis of wealthy countries. Soc Sci Med. 2006 Aug;63(3):829-42.
[90] Chung H, Muntaner C. 2006. Political and welfare state determinants of infant and child health indicators: an analysis of wealthy countries. Soc Sci Med. 2006 Aug;63(3):829-42.
[91] Raphael D. 2006. Social determinants of health: present status, unanswered questions, and future directions. Int J Health Serv. 2006;36(4):651-77. Raphael D, Bryant T. 2006. Maintaining population health in a period of welfare state decline: political economy as the missing dimension in health promotion theory and practice. Promot Educ. 2006;13(4):236-42..
[92] Socieconomic inequalities in health , Part 1 , Mackenbach , Bakker, Kunst and Diderichsen . reducing Inequalities in health : European Perspective. 2002.
[93] Rockefeller Health Equity programme , from Concept and trends in research on Social determinants of Health in Latin America and the Caribbean J.A. Casas WHO.
[94] As cited in Gender-sensitive and Pro-poor Indicators of Good Governance.
[95] A first approach to Labour Market , Governance and Educational Indicators ,Update 7th December 2006 , Antía Castedo García.
[96] CSDH Employment Conditions Knowledge Network (EMCONET). A Glossary of key concepts 2006.
[97] 'Welfare state'. Encyclopædia Britannica. 2006. Encyclopædia Britannica Online. 14 Dec. 2006 <http://www.search.eb.com/eb/article-9076482>.
[98] Coburn D. Income inequality, social cohesion and the health status of populations: the role of neo-liberalism. Social Science & Medicine 2000;51(1):135–46.
[99] Chung H, Muntaner C. 2007. Welfare state matters: a typological multilevel analysis of wealthy countries. Health Policy. 2007 Feb;80(2):328-39.
[100] Labonte R, Schrecker T. 2005. Globalization and social determinants of health: strategic and analytic review paper. http://www.who.int/social_determinants/resources/globalization.pdf
[101] Orielle HSR and repro health paper.
[102] Solar O, Irwin A, Vega J. 2004. Equity in Health Sector Reform and Reproductive Health: Measurement Issues and the Health Systems Context. WHO Health Equity Team working paper. [i] Kleczkowki BM, Roemer M, Van Der Werff A. 1984. National health systems and their reorientation toward health for all: guidance for policymaking. Geneva: WHO.

[103] (Hills 1998; Howden-Chapman and Tobias 2000; Kubzansky et al. 2001; Perrson et al. 2001).

[104] Giddens E. 1993 cited in A. Kunst and Johan P Mackenbach . Measuring socioeconomic inequalities in Health WHO Regional Office Europe 2000.
[105] Muntaner C, Borell c, Benach J Pasarin MI Fernadez E. The associations of social class and social stratification with patterns of general and mental health in a Spanish population. International journal of epidemiology 2003;32:950-958
[106] Wright EO The class analysis of poverty Int J Health Serv 1995.25:85-100.

[107] Liberatos P Link BG Kelsey JL. The measurement of social class in epidemiology . Epidemiology Review 1988;10:87-121
[108] Krieger, Willimas and Moss. Measuring Social Class. Annu. Review Public Health 1997,18:341-378
[109] Singh – Manoux, Clarke P, Marmot M Multiple measure of socioeconomic position and psychosocial health: proximal and distal measures . International Journal of Epidemiology 2002; 31:1192 -1199
[110] Pathways between socioeconomic determinants of health . E Lahelma, P Martikainen, M Laaksonen and A Aittomäki. Journal Epidemiol. Community Health 2004;58;327-332
[111] Krieger N, Rowley DL, Herman AA, Avery B, Phillips MT .1993 . Racism, Sexism and social class, implications for studies of health , diseases and well being Ann J Prev. Med 9:82-122
[112] Ecob R. Davey Smith G. Income and health: what is the nature of the relationship? Soc Sci Med 1999, 48 693-705.
[113] Liberatos P Link BG Kelsey JL. The measurement of social class in epidemiology . Epidemiology Review 1988;10:87-121
[114] Galobardes B. Shaw M Lawler D Lynch J Davey Smith G. J. Epidemiol Community Health 2006;60:7-12
[115] See E. van Doorslaer et al. (2006), Effect of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data, *Lancet* 368:1357-1364)
[116] Kunst and Johan P Mackenbach . Measuring socioeconomic inequalities in Health WHO Regional Office Europe 2000.
[117] Galobardes B. Shaw M Lawler D Lynch J Davey Smith G. J. Epidemiol Community Health 2006;60:7-12
[118] Krieger, Williams and Moss. Measuring Social Class. Annu. Review Public Health 1997,18:341-378
[119] Macinko J., Shi L. Starfield B. AND Wulu J. Income Inequality and Health: A critical Review of the Literature Medical Care Research and review , Vol 60 n 4 (December 2003) 407 -452
[120] Matthijs Kalmijn Mother's Occupational Status and Children's Schooling American Sociological Review, Vol. 59, No. 2. (Apr., 1994), pp. 257-275
[121] Duane F. Alwin Family of Origin and Cohort Differences in Verbal Ability
American Sociological Review, Vol. 56, No. 5. (Oct., 1991), pp. 625-638
[122] Marmot M Bobak M Smith DG 1995 Explanations for social inequalities on Health, In Society and Health. Oxford Univ. Express.
[123] Towsend P, Davinson N Whitehead M 1990 , Inequalities in Health: The Black Report and the health Divide London Peguin Books
[124] Galobardes B. Shaw M Lawler D Lynch J Davey Smith G. J. Epidemiol Community Health 2006;60:7-12
[125] Krieger, Williams and Moss. Measuring Social Class. Annu. Review Public Health 1997,18:341-378
[126] Oakes JM, Rossi PH. The measurement of SES in health research: current practice and steps toward a new approach. *Soc Sci Med* 2003;**56:**769–84.
[127] M Bartley Commentary: Relating social structure and health *International Journal of Epidemiology* 2003;**32**:958–960
[128] Muntaner, Lynch and Oates The Social class determinants of income inequality and social cohesion International Journal of Health service 1999, Vol 20, Number 4 : 699-732
[129] Socioeconomic Status and Health The challenge of the gradient Adler N, Boyce T, and colleagues American Psychologist January 1994: 15-24
[130] Muntaner, Lynch and Oates The Social class determinants of income inequality and social cohesion International Journal of Health service 1999, Vol 20, Number 4 : 699-732
[131] WHO (2002). Gender glossary. Appendix to Integrating gender perspectives in the work of WHO: WHO gender policy. Geneva: WHO, 2002.
[132] Krieger N. 2001. Theories for social epidemiology in the 21st century: an ecosocial perspective. Int J Epidemiol. 2001 Aug;30(4):668-77.
[133] Krieger N. 2001. Theories for social epidemiology in the 21st century: an ecosocial perspective. Int J Epidemiol. 2001 Aug;30(4):668-77.
[134] Centre for AIDS Development, Research and Evaluation. 2003. Gender-based violence and HIV/AIDS in South Africa : organisational responses / developed by Centre for AIDS Development, Research and Evaluation (CADRE), for the Department of Health, South Africa. Braamfontein : Centre for AIDS Development, Research and Evaluation.
[135] Doyal 2000
[136] WHO, http://www.who.int/gender/other_health/Gender,HealthandWorklast.pdf
[137] (Walby 1999)
[138] Doyal 2000
[139] Krieger N. 2001. Theories for social epidemiology in the 21st century: an ecosocial perspective. Int J Epidemiol. 2001 Aug;30(4):668-77.
[140] UNDP. Human Development Report 2005. New York: UNDP.

[141] Hilary Graham Social Determinants and their unequal distribution: clarifying policy understandings. The Milkbank Vol 82, n 1, 2004 .pp 101-124
[142] P Howden-Chapman Housing Standards: a glossary of housing and Health J Epidemiol Community Helath 2004;58:162-168.
[143] Dedman DJ, Gunnell D, Davey Smith G, et al. Childhood housing conditions and later mortality in the Boyd Orr cohort. J Epidemiol Community Health 2001;55:10–15.
[144] Lenz R. Jakarta kampung morbidity variations: some policy implications. Soc Sci Med 1988;26:641–9.
[145] Cohen D, Spear S, Scribner R, et al. ''Broken windows'' and the risk of gonorrhea. Am J Public Health 2000;90:230–6.
[146] Employment Conditions Knowledge Network (EMCONET) A Glossary of key concepts for EMCONET 2006
[147] R. G. Wilkinson: Unhealthy societies. The Affliction of inequality. London: Routlegde, 1996.
[148]Reference Published : Jon Ivar Elstad / Statistisk sentralbyrå: Livsløpsundersøkelse blant 55-årige menn i 2001 (previously unpublished)
[149] Willems Sara .The socioeconomic gradient in health : a never –ending history ? A descriptive and explorative study in Belgium . October 2005 Department of General Practice and Primary Health Care.
[150] Labour market changes and job insecurity: a challenge for social welfare and health promotion *Edited by* Jane E. Ferrie, Michael G. Marmot, John Griffiths *and* Erio Ziglio WHO 1999
[151] Margolis, P. A., Greenberg, R. A., Keyes, L. L., Lavange, L. M., Chapman, R. S., Denny, F. W, Bauman, K. E., & Boat, B. W. (1992). Lower respiratory illness in infants and low socioeconomic status. *American Journal of Public Health, 82*, 1119-1126.
[152] (Marmot et al., 1984).
[153] (Adelstein, 1980; Centers for Disease Control, 1987; Devesa & Diamond, 1983; Escobedo, Anda, Smith, Remington, & Mast, 1990; Kraus et al., 1980; Marmot et al., 1991; Pugh, Power, Goldblatt, & Arber, 1991; Remington et al., 1985; Seccareccia, Menotti,& Prati, 1991; U.S. Department of Health, Education, and Welfare [DHEW], 1979; Winkleby, Fortmann,& Barrett, 1990
[154] (Matthews, Kelsey, Meilahn, Kuller, & Wing, 1989).
[155] (Marmot et al., 1991).
[156] (Escobedo et al., 1990; Kaprio & Koskenvuo, 1988; Pugh etal., 1991).
[157] M. G. Marmot, G. Rose, M. Shipley and P. J. S. Hamilton: «Employment grade and coronary heart disease in British civil servants». *Journal of Epidemiology and Community Health* 32 (1978), pp. 244–249.
[158] (ref Mackenbach book
[159] (Adler, Boyce, Chesney, Folkman, & Syme, 1993).
[160] Diderichsen.
[161] Benzeval, Judge and Whitehead
[162] J, Mackenbach, L.J. Gunning-Schepers How should interventions to reduce inequalities in helath be evaluated ? Journal of Epidemiology and communities Health 1997;51:359-364
[163] This part of the paper was taken of the background paper elaborated for Pamela Bernales May 2006 Internship of the Department Equity, Poverty and Social Determinants , EIP,WHO.
[164] Ferguson, K. (2006). Social capital and children's wellbeing: a critical synthesis of the international social capital literature. *International Journal of Social Welfare*, 15: 2-18.
[165]Kawachi, I., Kennedy, B. P., Lochner, K. and Prothrow-Stith, D. (1997). Social capital, income inequality, and mortality. *American Journal of Public Health*, 87: 1491-1498.
[166]Putnam, R. (2000). *Bowling alone: The collapse and revival of American community*. New York: Simon & Schuster.
[167] Putnam, R. (2001). Foreword. In S. Saegert, J. P. Thompson and M. R. Warren (Eds.), *Social capital and poor communities* (pp. xv-xvi). New York: Russell Sage Foundation.
[168] Popay, J. (2000). Social capital: the role of narrative and historical research. *Epidemiology and Community Health*, 54: 401.
[169] Putnam, R. (1995). Bowling alone: America's declining social capital. *Journal of Democracy*, 6: 65-78. (p. 67)
[170] Szreter, S. and Woolcock, M. (2004). Health by association?. Social capital, social theory, and the political economy of public health. *International Journal of Epidemilogy*, 33: 650-667.
[171]Moore, S., Haines, V., Hawe, P. and Shiell, A. (2006). Lost in translation: a genealogy of the "social capital" concept in public health. *Journal of Epidemiology and Community Health*, 60: 729-734.
[172] Lynch, J., Due, P., Muntaner, C. and Davey Smith, G. (2000). Social capital –Is it a good investment strategy for public health?. *Journal of Epidemiology and Community Health*, 54: 404-408.
[173] Lynch, J. (2000). Income inequality and health: expanding the debate. *Social Science and Medicine*, 51: 1001-1005.
[174] Szreter, S. and Woolcock, M. (2004). Health by association?. Social capital, social theory, and the political economy of public health. *International Journal of Epidemilogy*, 33: 650-667.

[175] Szreter, S. and Woolcock, M. (2004). Health by association?. Social capital, social theory, and the political economy of public health. *International Journal of Epidemilogy*, 33: 650-667.
[176] Muntaner C 2004 Social capital, social class and the slow progress of psychosocial epidemiology. Int J Epidemiol 2004;33: 1-7
[177] Navarro V (2004). Is capital the solution or the problem? Int J of Epidemiology 2004;33: 672-74.
[178] Cropper, S. (2002). What contributions might ideas of social capital make to policy implementation for reducing health inequalities?. *Paper to HAD Seminar Series 'Tackling Health Inequalities: turning policy into practice'. Seminar 3: Organisational Change and Systems Management*. 17th September 2002, Royal Aeronautical Society, London.
[179] Lowndes, V. and Wilson, D. (2001). Social capital and local governance: exploring the institutional design variable. *Political Studies*, 49: 629-647.
[180] Castel, R. (2005). Estado e inseguridad social. Conferencia Subsecretaría de la Gestión Pública, República de Argentina, 03 Agosto de 2005.
[181] Crawshaw, P., Bunton, R. and Gillen, K. (2002). Health action zones and the problem of community. *Health and Social Care in the Community*, 11 (1): 36-44.
[182] Labra, M. (2002). Capital social y consejos en salud en Brasil. ¿Un círculoo virtuoso?. *Cuadernos de Saúde Pública vol. 18 suppl. Río de Janeiro*. Download 13-07-2006 de http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2002000700006&...
[183] Rose, N. (1999). Inventiveness in politics. *Economy and Society*, 28 (3): 467-493.
[184] Castel, R. (2005). Estado e inseguridad social. Conferencia Subsecretaría de la Gestión Pública, República de Argentina, 03 Agosto de 2005.
[185] Szreter, S. and Woolcock, M. (2004). Health by association?. Social capital, social theory, and the political economy of public health. *International Journal of Epidemilogy*, 33: 650-667.
[186] (Drever & Whitehead 1997; Kubzansky et al. 2001; Mackenbach et al. 2002; Singh & Yu 1996).
[187] (Antonovsky, 1967; Ulsley& Baker, 1991)
[188] Quality of life fundation .....
[189] Graham H. 2005. Intellectual disabilities and Socieconomic inequalities in Health : An overview of research Journal of Applied Research in Intellectualities 2005,18,101-111
[190] (Emerson 2004) .
[191] Adelstein, 1980; Kraus, Borhani, & Franti, 1980; Marmot et al., 1991; Marmot, Shipley, & Rose, 1984).
[192] Marmot, Kogevinas, and Elston (1987)
[193] (Power & Hertzman 2004)
[194] (Maughan et al. 1999)
[195] Davey Smith at al 2001
[196] Ref
[197] (Cf. Leonard & Wen 2002; US Department of Health and Human Services (USDHSS) 2002; Elliott et al. 2003). Graham 2004.
[198] (Maughan et al. 1999)
[199] (Elliott et al. 2003)
[200] Graham H. Social Determinants and their unequal distribution: clarifying policy understandings. The Milbank Quarterly Vol 82, n 1, 2004
[201] Buscar referencia
[202] Graham H. 2004. Social Determinants and their unequal distribution: clarifying policy understandings. The Milbank Quarterly Vol 82, n 1, 2004 .pp 101-.124.
[203] Graham H. 2004. Social Determinants and their unequal distribution: clarifying policy understandings. The Milbank Quarterly Vol 82, n 1, 2004 .pp 101-.124
[204] Graham H. Tackling inequalities in health in England.
[205] (B. Deacon et al., (2005), Copenhagen Social Summit ten years on: The need for effective social policies nationally, regionally and globally, GASPP Policy Brief 6 (Helsinki: Globalization and Social Policy Program, STAKES; http://gaspp.stakes.fi/NR/rdonlyres/4F9C6B91-94FD-4042-B781-3DB7BB9D7496/0/policybrief6.pdf)
[206] K. Stronks Generating evidence on interventions to reduce inequalities in health : The Dutch case. Scandinavia Journal public Health 30 (suppl 59) pp 21-25.
[207] H. Graham , M P. Kelly Health inequalities : concepts, frameworks and policy. Briefing paper NHS Health development Agency 2004
[208] Petticrew M, Macintyre S. 2001. What do we know about effectiveness and cost - effectiveness of measures to reduce inequalities in health ?
[209] Macintyre S, Petticrew M. 2000. Good intentions and received wisdom are not enough. Journal of epidemiology and Community Health 54 :802-803.

[210] H. Graham , M P. Kelly Health inequalities : concepts, frameworks and policy. Briefing paper NHS Health development Agency 2004.
[211] M . Petticrew , S. Macintyre. What do we Know about effectiveness and cost - effectiveness of measure to reduce inequalities in Health ? 2001 Oliver A. Cookson R. McDaid D Issues Panel for Equity in Health Niffield Foundation , London .
[212] Hallqvist J, Diderichsen F, Theorell T, Reuterwall C, Ahlbom A: Is the effect of job strain due to interaction between high psychological demand and low decision latitude. *Soc Sci Med 1998;46:1405-1415*
[213] Diderichsen F, Evans T, Whitehead M: The Social Basis of Disparities in Health in Evans Whitehead M, Diderichsen F, Bhuiya A, Wirth M (eds). *Challenging Inequities in health*.
[214] National evaluation of Health Action Zone ,The final report of the tackling inequalities in health module Michaela Benzeval Queen Mary 2003.
[215] Navarro V. Shi L. The Political context of Social Inequalities and Health International Journal of Helath Services , Vol 31 , Pages 1-21, 2001
[216] H. Chung, C. Muntaner , 2006. Welfare State Matters: A typology multilevel analysis of wealthy countries.
[217] Previous publications notably by Muntaner
[218] Raphael ed (2004). Social determinants of health: Canadian perspectives.
[219] Challenge of the gradient 22.
[220] See e.g. the memorandum from Professor Margaret Whitehead, House of Commons Select Committee on Health Minutes of Evidence http://www.publications.parliament.uk/pa/cm199900/cmselect/cmhealth/786/0111602.htm
[221] (Wagstaff 2002)
[222] (SOU 2000)
[223] (Acheson, et al.1998)
[224] (McIntyre 2002)
[225] (Summerfield, 2005)
[226] Whitehead and Dahlgren 2006. Levelling Up, part II. WHO EURO.
[227] (Harris et al. 1995: 7)
[228] WHO. 1986. Intersectoral action for health. Geneva: WHO. WHO/Rockefeller Foundation. 1986. Intersectoral action for health: the way ahead. Report of the WHO/Rockefeller Foundation meeting 3-6 March 1986. New York: Rockefeller Foundation.
[229] See e.g., Meijers E, Stead D (2004), Policy integration: what does it mean and how can it be achieved? A multi-disciplinary review
[230] Challis et al 1988, summarized in Meijers and Stead 2004.
[231] Shannon 2002
[232] Whitehead and Dahlgren 2006. Levelling up.
[233] http://www.programapuente.cl/.
[234] Winchester L (2005). Gestión social municipal de programas de superación de la pobreza en Chile: reflexiones a partir de la experiencia con el Programa Puente y Chile Solidario. X Congreso Internacional del CLAD sobre la Reforma del Estado y de la Administración Pública, Santiago, Chile, 18 - 21 Oct. 2005. Available: http://www.clad.org.ve/fulltext/0053053.pdf .
[235] Ministry of Health of New Zealand. 2002. Maori Health Strategy. http://www.moh.govt.nz/moh.nsf/0/8221e7d1c52c9d2ccc256a37007467df/$FILE/mhs-english.pdf
[236] Sullivan H, Judge K. Sewel K. 2004. 'In the eye of the beholder': perceptions of local impact in English Health Action Zones. Social Science & Medicine 59 (2004) 1603–1612.
[237] Muntaner et al. 2006. Venezuela's Barrio Adentro: an alternative to neoliberalism in health care. Int J Health Serv. 2006;36(4):803-11
[238] WHO. 1997. Intersectoral action for health: a cornerstone for Health for All in the Twenty-first Century. Geneva: WHO.
[239] Stronks and Gunning-Schepers, "Target number 1"
[240] Cuenca Declaration 2005
[241] People's Health Charter
[242] Adapted from IAP2 Copyright IAP2. All rights reserved.
[243] Luttrell et al 2007
[244] Quiroz 2006 Annotated bibliography
[245] Examples include education programmes among guerrilla groups in El Salvador and the use of Freirean methods by the Sandinista movement in Nicaragua Luttrell et al 2007, notes 1 and 2, Hammond 1998, Arnove and Dewees 1991.
[246] Luttrell et al 2007, cf. Sen and Grown, 1985; 1988.
[247] Luttrell et al 2007, 2
[248] Cornwall and Brock 2005, cited in Luttrell 2007, 3.

[249] See eg Luttrell et al 2007.

[250] Luttrell et al 2007, 6.

[251] Luttrell et al 2007, 6.

[252] What causes social inequalities: why is this question taboo? Sarah Stewart –Brown Health Services Research Unit, Institute of Health Sciences, University of Oxford, UK Critical Public Health,Vol. 10, No. 2, 2000

[253] Targeting and Universalism in Poverty Reduction Thandika Mkandawire Director of the United Nations Research Institute for Social Development (UNRISD). Social Policy and development Programme PAPER Number 23 December 2005

[254] Targeting and Universalism in Poverty Reduction Thandika Mkandawire Director of the United Nations Research Institute for Social Development (UNRISD). Social Policy and development Programme PAPER Number 23 December 2005

[255] This summary draws, among other sources, on policy measures discussed in the Norwegian Health Directorate's 2005 publication The Challenge of the gradient (http://www.shdir.no/vp/multimedia/archive/00002/IS-1245_2905a.pdf).