Are social determinants of health the same as societal determinants of health?

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Despite the widespread appeal of the phrase ‘social determinants of health’, it erroneously suggests that health depends primarily on interrelationships among individuals as this is what ‘social’ means in most dictionary definitions. Inequities in health, however, involve systematic differences in health across population subgroups, thus changing the focus of influences from social interactions to societal characteristics. Figure 1 captures the characteristics addressed by the large social determinants of health literature. In this literature, societal characteristics of individuals and groups are considered to influence health, which is conceptualised as ‘average health’. The clusters of influences on the right side of the figure describe the focus of conventional social medicine. Extending the focus more to the left describes the domain of community medicine, which also includes characteristics of physical and social environments in which individuals live and work. Largely ignored by social medicine researchers is the context in which these actions and interactions exist.

Figure 2 captures the types of societal influences on equity in health. It explicitly recognises the importance of distributions of health in populations and the likelihood that different interactions among influences may produce different mechanisms of illness generation and progression in different population subgroups. The figure also recognises that, where illness differs systematically across population subgroups, it is societal factors (represented by political and policy contexts) that generate and maintain social hierarchies that are the focus of ‘social medicine’ and ‘social influences’. The importance of societal antecedents is increasingly recognised by scholars and researchers who are devising policy to reduce inequities in health. Most notably, the World Health Organization (WHO) Commission on Social Determinants of Health, formed in the early years of the 21st Century, is deliberately considering the role played by political factors as well as the supranational economic policies constituting globalisation and the commodification of influences on health.

Which societal determinants should receive the most attention in the search for effective strategies to reduce inequity in health? Studies have suggested a variety of likely foci, including (but not limited to) social pacts between labour, management, and government; percentage of people covered by public medical care; corporate and state profits; wage inequality; female literacy, enfranchisement, and involvement in political decision-making.
generosity of social welfare programs by government;⁵ and characteristics of a country’s involvement in global trade.⁶ One recent long-term comparison of Canada and the United States demonstrates how a focus on national policies for public spending on health and social programs in Canada was associated with greater improvements in life expectancy in Canada than in the US (pers. comm.). However, all of these studies examine impact on average health, not on distribution of health in populations.

It is critical to recognise that average health, as reflected in national or regional health statistics, has little to do with the distribution of health within populations and that improvements in health often do not improve the distribution of health. For example, in 13 of 21 countries, improvements in under-five mortality between 1996 and 2000 mask the lack of change or worsening of inequities in under-five mortality in 17 of the countries.⁷ Only one recent study specifically addressed inequity in health;⁸ in contrast to previously demonstrated relationships between type of political regime and average health, trends in inequality in mortality in middle-age men in several industrialised countries had no relationship with type of political regime.

Income redistribution, as a societal strategy, has received the most attention as a mechanism to reduce inequity in health, but the evidence on the association between income inequality and better equity in health is weak.⁹ Why should better distribution of income reduce inequities in health? Such an effect would only be plausible if income redistribution disproportionately benefited deprived social groups either through psychological stress-reducing effects on individuals in these groups and/or through programs to provide health-inducing interventions such as healthy diets, beneficial physical exercise, healthy environments, and better health services. These must be in place when income is redistributed.¹⁰

In contrast to the absence of evidence of impact on equity in health of the variety of societal characteristics that have been proposed as influential, a strong primary care infrastructure in health systems shows the potential for societal programs directed at improving the health of disadvantaged populations more than the health of more advantaged populations. Primary care does this by three mechanisms:

1. By providing services that are nearer to people and more accessible, focusing on people’s health problems in their entirety rather than on specific diseases one at a time, providing a broader range of services in one setting and co-ordinating all aspects of care, primary care achieves better outcomes and better distribution of health at lower costs.¹¹

2. By maximising the likelihood of management with less expensive and more appropriate interventions for the populations, primary care reaches people at risk so that the

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Figure 1: Influences on the health of individuals.

For influences at the community level, there is a spectrum from those that are aggregations from individual-level data to those that are ecological in nature.
overall effect is greater, even though the marginally greater benefit on any given individual may be greater with newer and more expensive technology and pharmaceuticals.12

3. By training practitioners in the community rather than in hospital settings, primary care practitioners are a well-set filter to more expensive and less accessible specialty services,14 thus reducing unnecessary visits to specialists and the adverse effects resulting from seeing multiple physicians,15,16 and by reducing adverse effects from the cascade of diagnostic tests ordered by medical personnel whose training and experience lead them to overestimate the likelihood of serious illness in the patients they see.17

Equity in health, as a societal goal, will require societal strategies that influence the evidence-based chain of mechanisms, from those at the global and national levels through community and social characteristics. Intervening later in the chain runs the risk of changing interactions within the chain in ways that interfere with the achievement of the goal. Health impact assessments of societal policies, despite their challenges, have the potential to improve attention to the societal determinants of health.18 Well-conceived theory, buttressed by empirical evidence of benefit, is the only hope for more rapid improvements in equity in health.

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**Figure 2: Influences on health equity.**

- **Environmental characteristics**
- **Occupational & environmental policy**
- **Social policy**
- **Economic policy**
- **Power relationships**
- **Health policy**
- **Health system characteristics**
- **Wealth: level & distribution**
- **Average health**
- **EQUITY in health**
- **HISTORICAL health disadvantage**
- **Historical health disadvantage**
- **Behavioral & cultural characteristics**
- **Demographic structure**

Dashed lines indicate the existence of pathways through individual-level characteristics that most proximally influence health.

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**References**


12. Woolf SH, Johnson RE. The break-even point: when medical advances are less important than improving the fidelity with which they are delivered. Ann Fam Med. 2005;3(6):545-52.


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Early Child Development. Well-established evidence illustrates that opportunities provided to young children are crucial in shaping lifelong health and development status.

Globalisation. The scope is to examine how globalisation’s dynamics and processes affect health outcomes: trade liberalisation, integration of production of goods.

Health Systems. The focus will be on innovative approaches that effectively incorporate action on social determinants of health. Recommendations will be relevant for countries with tight resources.

Measurement and Evidence. The focus is on leading the development of methodologies and tools for measuring the causes, pathways and health outcomes of policy interventions.

Urban Settings. The focus will be on urbanisations, particularly broad policy interventions related to healthy urbanisation, and will closely examine slum upgrading.

Employment Conditions. It will help to develop measures to clarify how different types of jobs and threat of unemployment affect workers’ health.

Social Exclusion. It will examine the relational processes that lead to the exclusion of particular groups of people from engaging fully in community and social life.

Priority Public Health Conditions. It will review factors in the design and implementation of programs that increase access to health care for socially and economically disadvantaged groups.

Women and Gender Equity. It will focus on mechanisms, processes and actions that can be taken to reduce gender-based inequities in health by examining different areas.