Placing the individual within a social determinants approach to health inequity

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The Final Report of the WHO Commission on Social Determinants of Health is a welcome challenge to governments. It sets out the core conditions that have to be met to give everyone a fair chance of leading a healthy and flourishing life.

The Commission distinguishes two contrasting approaches to public health—action through the individual and his or her choices versus action on social determinants.[1] It justifies its preference for action on social determinants by reasoning that "Contemporary public health interventions have often given primary emphasis to the role of individuals and their behaviours. The Commission recognizes the important role of these factors, but sets them in the wider social context in order to illustrate that behaviour and its social patterning...is largely determined by social factors. We believe that unless action also takes account of the structural drivers of inequity in behaviour, it will not tackle health inequities."[2] Thereafter, very little attention is given to the potential of individual agency and its effect on health.

We fully endorse the necessity of structural action, but argue against an approach for achieving good health and reducing health inequalities that has an exclusive focus on social determinants. We believe that the role of the individual should be integrated with the social determinants approach for three reasons. Firstly, plausible, individual-level determinants can be identified and so need to be accepted, not least because they are integrally entwined with social factors. Secondly, we cannot assume that individual change will flow as a direct consequence of social and economic change. Finally, the opportunity to influence policy depends partly on presenting a message that accords with current government thinking.

Social factors such as poverty and its sequelae substantially affect people's abilities to adopt healthy behaviours; individual factors such as functional differences and cultural beliefs also facilitate or constrain behaviour change. Attempts to build causal hierarchies and quantify the relative explanatory power of the social versus the individual, however, are vigorously contested.[3] Krieger[4] argues that an artificial division obscures "the intermingling of ecosystems, economics, politics, history and specific exposures and processes at every level, macro to micro, from societal to inside the body". Putting this statement in the Commission's language, the causes of the causes cannot, and so should not, be separated from the causes of poor health. The two are conjoined in effect and require a richer ecoepidemiology that discards the proximal-distal mindset.[5] Polarised frameworks in general are rarely useful conceptions of the world and are increasingly being replaced.

Even if the primacy of a social approach could be shown, a policy response that attempts sequential progress across ordered determinants might have little effect. Rather than concerning ourselves with base issues such as health systems, gender relations, and globalisation and only then addressing second-order determinants such as lifestyle choice, we should not assume that good intentions flow naturally from the creation of a level playing field. Individual factors such as beliefs, capabilities, and experiences might have a pivotal role. Individuals therefore need to be actively and genuinely engaged to protect, promote, and invest in their health. Recognising this need, the WHO Framework Convention on Tobacco Control is an exemplar of a combined approach. The Framework asserts the importance of demand reduction strategies such as smoking cessation programmes as well as supply issues including restricted sale to minors and tackling the illicit tobacco trade, and represents a shift in the regulatory approach to addictive substances.

A solely social approach to better health is poorly aligned to the *realpolitik* of contemporary policy trends in health and social care. Faced with the constraints of rising costs and intensifying expectations of a consumer society, health policy promotes individual autonomy as an increasingly explicit principle. Publications such as the English Department of Health's "Our Health, Our Care, Our Say" make this clear,[6] as do other initiatives such as home-school agreements[7] and restorative justice programmes.[8] The rhetoric here refers to the need of the individual to take responsibility and to make choices. This approach falls into the other half of the social versus individual trap in that it tends to pay little more than lip service to, for example, material conditions. A response that indicates the entwined influences of individual as well as environmental factors on behaviour change is more likely to capture politicians' attention.

The inability and undesirability of isolating the individual from the social aspect, together with the current policy emphasis on personal responsibility, point to the need for an integral role for genuinely informed personal autonomy in achieving better health and reducing inequality. The Commission partly considers the issue in relation to women's autonomy over reproduction, autonomy within work, communities' rights to education, and political participation, but does not give a complete account of the issue in relation to health and wellbeing. A crucial question thus presents itself: what is the role of personal autonomy in a social determinants framework? How do we articulate a comprehensive and coherent so-called third way between the causes and the causes of the causes?

To raise the question of personal autonomy is not to lapse into political trading between libertarian and socialist values; nor is it to suggest that victim-blaming can ever be a reasonable response to illness or disability. Rather, it is to recognise that supporting people to engage with decisions about their own health is crucial.

In our view, the best way to achieve integration between these two contrasting public-health approaches is to drive the successful co-production of health. By this we mean that responsibility for better health should be shared between society and the individual, that society's efforts for health improvement should be dovetailed with individuals' and families' efforts. Co-production is an idea that originated within public sector reform, and it was conceived as a means of reforming local public services, particularly those councils, schools, or hospitals that were failing or under-resourced.[9] Governments identified and made use of the vast potential of individuals' time, energy, experience, and knowledge to develop local solutions to local problems and build stronger communities.[10] Here, we transport the idea to another setting to refer to the building of personal capital (by which we mean an individual's capabilities and knowledge) to enable good health. The development of personal capital has to some extent always depended on co-production. The complexity of health, its multiple dimensions and determinants, makes it a markedly fertile area for fruitful co-production.

A comprehensive policy approach to achieving successful co-production can be built from several important elements. We present a coherent series of proposals that consider co-production at the inter-personal level between the health-care user and their clinician before elaborating to describe the state's role in addressing the wider determinants of health inequity.

Social patterning does not just exist in people's health beliefs and behaviours, but also in the way patients interact with doctors. In a systematic review, Willems and colleagues[11] found that patients from lower social classes had a more directive and less participatory consultation than did patients from a higher social class, possibly because of doctors' misperception of their desire for information and ability to take part in the care process. Schouten and Meeuwesen[12] found that doctors behaved less affectively during consultations with patients from minority ethnic backgrounds than with white patients, displaying fewer expressions of empathy or rapport. Successful co-production cannot occur if these prejudicial behaviours are not acknowledged and addressed.[13] Once this is achieved, the establishment of common ground between the doctor and patient—where agreement is reached with respect to the nature of the medical problem, the goals of treatment, and their respective roles—can be effective.[14]

Additionally, the timely flow of meaningful information back to individuals can be transformative within agreed programmes of action. Good information increases health literacy (defined as the degree to which individuals have the capacity to obtain, process, and understand health information and services to make appropriate health decisions). Crucial to co-production, information also facilitates a shared understanding of cause and effect. For example, converting spirometry data into lung age and relaying this back to smokers doubles rates of quitting.[15] Flow of good information also enables co-production at a structural level. In the USA, Baltimore's award-winning Citistat programme[16] relays accurate and timely data back to residents on issues such as crime, social housing, and environmental quality. Officials are held accountable for their work in the public arena and so have a powerful incentive to deliver. The Health Department's "B'More Healthy" campaign is an integral element; it advises residents on what they themselves can do to improve health and identifies city services they can access for support.

Also important is to focus on peoples' abilities rather than their dependencies. Co-production seeks to tap into individuals' potential, exploring and maximising this with professional help. Australia's Disabled Apprentice Wage Support Program is an innovative, sophisticated example of the idea.[17] The programme provides financial assistance to employers who employ apprentices with disabilities or those who become disabled during their apprenticeship. Assistance includes wage support payments, tutorials, interpreter or mentor services, leasing or purchasing essential equipment, or modifying the workplace. A full range of resources and service contacts for employers and employees underpins the programme.[17] Similarly, Sweden's "Passion for Life" policy provides older people with the tools for a healthy lifestyle and empowers them to continue to live fulfilled lives as they grow older.[18]

Detailed population profiles provide a valuable resource for co-production. Social segmentation, which distils market research to understand why consumers act the way they do, is increasingly being used to yield insights into the varying health priorities, beliefs, and perceived needs that exist within communities. An understanding of these priorities, beliefs, and needs is vital if we are to engage individuals and communities in investing in their health. The Commission recognises that profound social patterning in health behaviours and expectations exists and seeks to discover the reasons behind this. A co-production approach goes beyond recognition and explanation to use such patterns to identify the best ways to engage individuals and communities in producing better health. Some promising examples are beginning to emerge, such as the English Department of Health's "Healthy Weight, Healthy Lives" obesity strategy. The Department is investing £75m in social segmentation work to provide

families with appropriate and relevant support to make changes to their children's diet and rates of physical activity.

Information alone, however refined, is insufficient to affect behaviour change. Strategically placed, tailored, additional resources are essential. Thus, amplification of personal resources such as education, external resources such as income, and change in social structures are all required to increase individuals' opportunity to overcome disadvantage.[19] Conditional cash incentive schemes are receiving much attention and could address these issues. Perhaps the most sophisticated of these is the Chilean "Puentes" programme.[20] Here, marginalised families work with a health or social care professional to draw up a list of aspirations that will enable them to better participate in society. They range from the most basic aspirations, such as having all disabled family members appropriately registered with health and social care services, to higher order aspirations for training and employment. Cash grants are given monthly to enable the family to meet their goals.

Successful co-production is difficult; although it will require meaningful and sustained engagement from government and society at large, evidence shows that it leads to better outcomes and can be cost effective.[21] Furthermore, individuals are keen to take part in co-production,[22] something which governments tend to underestimate.

The co-production approach we suggest does not underplay the importance of social determinants. The "equitable distribution of power, money and resources"[1] is a must, as is the establishment of trust between the state and the individual so that they share the same motives, goals, and commitment to health improvement, whatever the individual's circumstances. The great challenge is to respond to the Commission's call to implement change by addressing the structural drivers of inequity while simultaneously supporting genuine personal engagement in securing better health and overcoming disadvantage.

Conflict of interest statement
IF and RR both work in the Department headed by Sir Michael Marmot, Chair of the Commission on Social Determinants of Health. IF formed part of the Commission's UCL-based secretariat. The views expressed are those of the authors and should not be ascribed to their institution or to the Commission.

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