



We Need Action on Social Determinants of Health – but Do We Want It, too?

Comment on “Understanding the Role of Public Administration in Implementing Action on the Social Determinants of Health and Health Inequities”

Evelyne de Leeuw^{1,2,3*}



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*Correspondence to:

Evelyne de Leeuw

Email: e.deleeuw@unsw.edu.au

Abstract

Recently a number of calls have been made to mobilise the arsenal of political science insights to investigate – and point to improvements in – the social determinants of health (SDH), and health equity. Recently, in this journal, such a rallying appeal was made for the field of public administration. This commentary argues that, although scholarly potential should justifiably be redirected to resolve these critical issues for humanity, a key ingredient in taking action may have been neglected. This factor is ‘community.’ Community health has been a standard element of the public health and health promotion, even political, repertoire for decades now. But this commentary claims that communities are insufficiently charged, equipped or appreciated to play the role that scholarship attributes (or occasionally avoids to identify) to them. Community is too important to not fully engage and understand. Rhetorical tools and inquiries can support their quintessential role.

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In a recent piece in this journal, Carey and Friel¹ argue that the discipline of public administration has much to offer to deal with taking action on the (so far rather) barren field of implementation of policies that would deal with social determinants of health (SDH), and ultimately contribute to reducing the health inequity gap. They argue that the field of public administration should be seen as key to growing this capacity.

Carey and Friel are, of course, right. The fields of public health and health promotion have remained largely a-theoretical when it comes to policy development and implementation, whether it concerns the politics of the endeavour, or the bureaucratic and organisational environments in which policy materializes. In fact, I have argued with colleagues² that rigorous application of theoretical frameworks and deliberate conceptual heuristics from political science – and in particular theories of the policy process – is a ‘sine qua non’ for the further development of our thinking about SDH and the types of policies that are required to deal with these effectively. Carey and Crammond in fact are building a critical scholarly mass for the discourse.³ In this commentary, I will, therefore, not regurgitate the argument.

Theorising about the role of institutions and their positions in advancing the policy agenda of social determinants thinking (eventually leading to, eg, ‘Health in All Policies,’ HiAP⁴) is one thing. Considering, conceptually and theoretically, how people, communities, and civil society impact on those processes is another. A key issue to sustain visionary action on SDH and the development of HiAP is whether people are

willing to support a political agenda that advocates such an ‘abstract’ discourse.

Community Beyond Rhetoric

The idea that communities are at the core of health development is part of the official health sector gospel. Community participation, community development and community empowerment are concepts that easily roll off the tongues of health scholars, health sector bureaucrats and healthcare practitioners alike. The reasoning is, of course, inescapable: health, even individual health experiences, are shaped in the man-made (and natural) environments that we live in. Humans tend to live in groups, and those groups (communities) accomplish more things, better things, and more sustainable things than simply the capacities of the sum of the individuals would achieve. Communities also shape collective arrangements for running their lives – through institutions, governance, representation, etc.

Building healthy communities, is the argument, would significantly lead to individual health capacity. Communities find themselves, unwittingly, ‘between a rock and a hard place’: collectively they may have the potential to create and sustain the institutions that would make for healthful life conditions, through political and social choice processes. Communities as settings for health (eg, in the sense of Healthy Cities, Health Promoting Schools, Workplaces, Islands, etc.) would support their individual members in making healthy choices the easier choices. But individually people may construct the determinants of health in a sickness context frame than a

¹Centre for Health Equity Training Research and Evaluation (CHETRE), University of New South Wales, Sydney, NSW, Australia. ²South Western Sydney Local Health District, Liverpool, NSW, Australia. ³Ingham Institute, Liverpool, NSW, Australia.

social context.⁵

An assumption in the rather romantic world view that communities can take action on HiAP and the social determinants perspective would be that communities are fully informed, and have the capacities and skills to act on that information. But just like the failure of the mere presence of scientific evidence to drive policy processes unequivocally, or full knowledge among individuals about carcinogens in the environment (eg, tobacco smoke) failing to lead to lifestyle change, communities seem to drive and deliver neither systems nor individual change very well. This is already true for relatively 'simple' monocausal disease pathways (eg, in infectious disease control), let alone when it comes to the wicked world of multi-level, complex networks of determinants in the field of non-communicable disease.

Moving to Empiricism – but not in Politics

'Community' has not been a neglected element in the public health and health promotion discourses. A Google Scholar search for 'community' and 'health' in titles since the year 2000 yields approximately 22 400 'hits' (with nearly 80 000 since indexing by Google started). Also, we do see a slow but steady increase in focus from the scholarly rhetorical to a scholarly empirical perspective.

In the SDH discourse, arguments to involve 'community' have been pervasive. Blas and colleagues even see its role as absolutely essential.⁶ They appeal to an understanding of community as an environment or situation that can mobilise its potential – in connection and coordination with other influential actors – to change the (determinants) world around them. The potential is there. Is it in fact mobilised? The godfather of 'asset-based community development' (ABCD), John McKnight, made compelling arguments that community assets (and by inference all local SDH and the institutions surrounding them) are potential resources in a community—not only financial resources but also the talents and skills of individuals, organizational capacity, political connections, buildings and facilities, and so on.⁷ Some authors⁸ criticize such a broad conceptualization as such assets might be taken to mean "all good things" and in order to make assets more tangible prefer to frame them in a more economic manner. Such a view denies, in our view, the fact that (social and health) equity depends on much more than only financial and resource capability and also reflects culture, history and heritage.⁹ Friedli¹⁰ counters the ABCD rhetoric with more rhetoric: she contends that 'proper' community development "...includes the relationship between public sector professionals and the communities they serve, the democratic deficit and abandonment of areas of deprivation by both the market and the state, steep income hierarchies within the NHS [UK National Health Service – EdL] and the social, material and emotional distance between those who design public health interventions and those who experience them. International comparative studies suggest that status (the respect we receive from others), control (influence over the things that affect our lives) and affiliation (sense of belonging) are universal determinants of wellbeing (...). Public health needs to pay more attention to the factors that injure these needs and the health impact of injuries to these needs, undermining what Sen has called the freedom to live a valued life. But in these efforts to address the missing

dimensions of poverty and deprivation, the distribution of economic assets is still of fundamental importance. There is a link between living conditions and dignity. The idea of justice is paramount."

Some authors seem to take on this challenge. There are reviews how communities actually take control of their (economic, social, and health) destiny. For instance, Jagosh and colleagues demonstrate that community-based participatory research yields better and more sustainable health efforts and outcomes.¹¹ Others review how *partnering* in the community between a range of government and non-government actors effectively contributes to health improvement.¹²

But these excellent reviews at best peripherally touch on community action for policy development, leaving alone holding public administration accountable to (or change it to better address) the complexities of SDH and health equity. Fortunately, strong evidence is emerging (particularly sponsored by the World Bank for mostly non-OECD countries) that certain forms of community decision-making are effective: deliberative and participatory decision-making allocates resources better, for greater (health) equity.

Participatory decision-making has acquired some fame through international examples around 'participatory budgeting' (PB). PB is a process of democratic deliberation and decision-making in which ordinary people decide how to allocate part of a municipal or public budget. PB allows citizens to identify, discuss, and prioritize public spending projects, and gives them the power to make real decisions about how money is spent. When PB is taken seriously and is based on mutual trust, local governments and citizen can benefit equally. In some cases, PB even raised people's willingness to pay taxes.

PB generally involves several basic steps:

1. Community members identify spending priorities and select budget delegates
2. Budget delegates develop specific spending proposals, with help from experts
3. Community members vote on which proposals to fund
4. The city or institution implements the top proposals

Evaluations have shown that PB – after a period of trial-and-error engagement to establish sufficient commitment and trust – results in more equitable public spending, greater government transparency and accountability, increased levels of public participation (especially by marginalized or poorer residents), and democratic and citizenship learning.

The first city in documented modern history to embark on PB as a practice to allocate the entire municipal budget (apart from fixed expenses, eg, on pensions) was Porto Alegre, in Brazil, in 1989. A World Bank paper¹³ suggests that PB has led to direct improvements in facilities in Porto Alegre. For example, sewer and water connections increased from 75% of households in 1988 to 98% in 1997. The number of schools quadrupled since 1986. The high number of participants, after more than a decade, suggests that PB encourages increasing citizen involvement, according to the paper. Also, Porto Alegre's health and education budget increased from 13% (1985) to almost 40% (1996), and the share of the participatory budget in the total budget increased from 17% (1992) to 21% (1999). There are now 1500 municipalities around the world where smaller or larger parts of (and in some cases the entire)

public sector budget is decided through PB. Many of these cities are in Europe and North America and participatory forms of governance are seen as convincing models for true democratic decision-making for the future.^{14,15}

The literature is, however, rife with cautions to see community participation as the miracle solution to dealing with complexity in a network age. Crawshaw et al have analysed appeals to community action as a means of reinventing the relationship between the individual and society, and the championing of civic responsibility.¹⁶ To achieve this, neo-liberal ideology frames the role of individuals as active citizens with both rights and responsibilities, and with a duty to participate. Thus, community is promoted as a panacea for reconstructing civil society, a middle ground between statist models of 'society' and market models of the 'individual,' both of which are understood to have failed as modes of governance.¹⁷ This reinvention of community as a site of social and political action has been influential in both policy and academic discourses, as shown by the emergence of new concepts such as social capital¹⁸ and capacity building.¹⁹

A Tentative Wrap-up: Do Communities 'Get' Social Determinants?

Consistently, opinion polls around the world show that 'health' is one of the highest valued attributes of individuals and communities. One would expect that, with such high priority, people are willing to act on 'health.'

One investigation sought to review systematically the impact of community engagement on health.²⁰ The authors found only 13 studies with methods rigorous enough to be included (but found strong suggestions that community engagement 'works'). The study was informed by Popay's conceptual heuristic to relate levels of community engagement with outcomes (Figure).²¹

Interestingly, the notion that communities determine their destiny by influencing policy, and civil and public institutions is not captured in this heuristic. Why? The work by Commers may shed some light on this question.²² It maps

the understanding of the Dutch population, media and politicians of SDH and finds that unprompted queries such as 'what is health?' and 'what determines your health?' produce responses that neatly fit with the biomedical paradigm. In other words: the Dutch community prioritises proximal determinants of health (pathogens and lifestyles) over more distal determinants (such as corporate interests, politics, systems parameters). Commers also finds that, if prompted appropriately (for instance, by asking 'who determines your health?'), the same community quite adequately frames virtually all SDH as important.

Australian researchers have argued some factors that exacerbate such findings.²³ They investigated lay understandings of (the causes of) health inequity. The authors conclude that "... the findings in this study are evocative of a kind of collective inertia within the public health field. The lack of congruence between explanations and public policy responses suggests that public health arguments directed at addressing the social determinants of health have not become absorbed into bodies of lay knowledge." Clearly very few communities, or members in communities, 'get' social determinants well enough to start advocating for it at a systems level, be it through PB, through influencing policy processes, or through activism aimed at reshaping public administration.

One of very few research efforts to consider what it would take to mobilise communities politically towards a more substantive social determinants policy effort has been undertaken by the Robert Wood Johnson Foundation.²⁴ Over four years they systematically investigated frames and metaphors for health in the United States and found that there is a meaningful divide between language and rhetoric deployed by public health professionals and scholars, and what the US public (across the Democratic-Republican spectrum) feels. The social determinants message needs to resonate at a deep metaphorical level. Such an approach is consistent with framing theory²⁵ and the messages on language use in policy discourse by Stone.²⁶

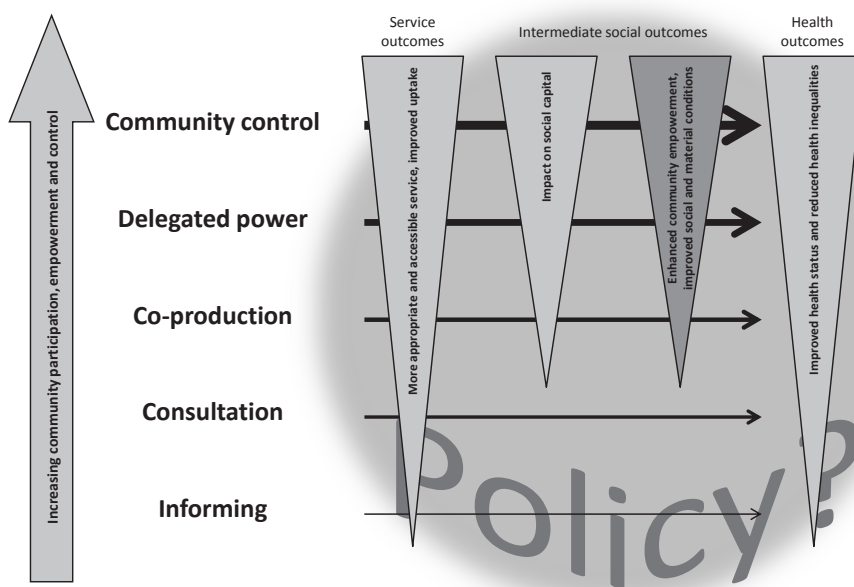


Figure. Pathways From Community Participation, Empowerment and Control to Health Improvement, Adapted From Popay.²¹

Moving Forward - Connected

Calls made by Carey and Friel¹ for public administration, and our team for political theory^{2,27} are important in shaping scholarship and a degree of (ivory tower) activism to deal with SDH, and health equity. But as long as work in these fields is not sustained and fed by a strong foundation in concerns and hopes held by the community, it remains aloof and essentially pointless. If we really want to create a world where the unfair health gap between communities is closed, we need to better understand, and better engage with those communities. Most of all, we need to get our language connected, more than academically 'right.'

Ethical issues

Not applicable.

Competing interests

Author declares that she has no competing interests.

Author's contribution

EDL is the single author of the paper.

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