

Going global with social determinants of health: some reflections

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The article by Abdalla *et al*¹ raises some interesting points and presents a timely opportunity to reflect on aspects of the continuously evolving academic, policy and public engagement with ‘social determinants of health’ (SDOH). The study focuses on public understanding of SDOH, and surveyed people across eight countries (Brazil, China, Germany, Egypt, India, Indonesia, Nigeria and the USA). The top line finding is that across countries the people surveyed consistently ranked healthcare as the most important determinant of health (among a list of options) except in China. There, respondents ranked education first then, healthcare.

Aside from selecting and ranking their top three determinants of health, respondents were also asked about how they think policymakers might rank top three health determinants. From the results, the researchers conclude that as found elsewhere, the respondents ranked downstream/proximate causes (eg, personal behaviour, genetics, healthcare and so on) as the most important determinants of health versus policymakers who might rank higher the upstream/distal-macro or social determinants (eg, politics, employment conditions and so on). What is unclear is why the list of options included both proximate determinants of health such as genetics and healthcare as well as some SDOH. It is also not clear why personal behaviours/choices were not included if the list contained the most common kinds of both determinants.

Nevertheless, the two big findings align with what is already known from surveys of public understanding of SDOH in high-income countries (HICs).² The potentially novel findings have to do with differences in second and third rankings. For example, Egyptians ranked education and culture as being important. Could it be that education is seen as an antidote to ignorance about disease causation and/or informs good health practices? Is culture seen to provide health protecting religious/moral behaviours?

And, why would respondents in the USA and Germany rank genetics as being an important health determinant unlike respondents from all the other countries?

The main conclusion of the article is that the respondent’s rankings show the neglect of the public as an important audience in SDOH knowledge dissemination and advocacy. From that, the researchers advocate for more investment in ‘communication efforts to the general public’ about the importance of SDOH. Aside from interesting findings about public understanding of determinants of health outside HICs, some statements in the article provide an opportunity to reflect on the current state of engagement with SDOH, particularly as HIC SDOH researchers go global.

First, the authors write that despite the enormous body of scientific scholarship on SDOH, ‘wider action remains in its early stages’. Many social epidemiologists and SDOH policy advocates would likely state they wish more social action would be taken to address harmful SDOH. But to state that we are in the early stages of SDOH action reflects a huge blind-spot of the fact that every human being on the planet has just experienced the most expansive and expensive SDOH policy actions in public health and human history.

Social lockdowns around the world and other ‘non-pharmaceutical interventions’ to contain the spread of COVID-19 infections were interventions to mitigate the social determinants of potentially fatal infections. Laws were enacted, national borders were closed, trillions of dollars dispersed to individuals and corporations, information was consistently provided, education was moved to online, working from home became the norm and so forth. All of these non-healthcare actions were taken to transform macrolevel factors and reduce risk of infections at the individual and population levels. Many of the constituent parts of lockdown and social-distancing policies would easily fall under SDOH categories such as politics,



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culture, built environment, social support, income and wealth and so forth. The biomedical focus and fixation on vaccines as the solution to the pandemic should not blind us to the important role and scale of SDOH policies addressing COVID-19 in various countries and their impacts, both positive and negative.

A second point for reflection comes from the researchers' belief in the causal story that broad public understanding and support leads to successful SDOH policies as well accountability. While this is not the place to examine the empirical evidence regarding the link between public understanding and support and public policy making and outcomes, the statement does invite wider consideration on why the publics across countries have limited understanding of SDOH. In particular, while SDOH researchers may be just talking to other researchers and policymakers, it must be recognised that there have been active efforts to limit the publics' awareness and understanding of SDOH. One prime example is the history of SDOH work inside the WHO. Building on decades of research, the WHO established the Commission on Social Determinants of Health in 2004, and its report was released in 2008. Immediately after, the SDOH department at the WHO was systematically disbanded under Dr Margaret Chan, then Director General of the WHO. It is only recently that an SDOH department has been re-established. In other words, for over 10 years, the WHO's efforts to increase the public and policymakers' understanding worldwide of SDOH as well as integration of SDOH into all the other work the WHO does was purposefully curtailed.

There are numerous other aspects such as the polarised politics inside the USA and other HICs, the biomedical and foreign aid industrial complexes, technocratic and security paradigms in health research funding and policy making that actively drown out efforts to increase public understanding and deliberations of SDOH. Yet, over the past 2 years, people worldwide have become acutely aware that national and global politics and power inequalities within and across countries directly affect their health, that of their families and communities. But as people need and want to return to normal life, that awareness and the empathy for others also vulnerable will likely recede. SDOH researchers and policy advocates have a rare and crucial window of opportunity to expand public understanding of how SDOH cause and distribute preventable disease and death within and across countries.

A third point for reflection is raised by the authors' explanation that the survey countries included low and middle-income countries (LMICs) as 'they are often excluded from discussions of how SDOH shape population health'. The statement is accurate in a sense because most social epidemiological studies published in scholarly journals and that are indexed in databases are usually conducted by HIC researchers and about HIC populations. Those scholarly discussions do exclude LMICs. This does not, however, mean that the publics or

policymakers of LMICs are not aware of the impact of SDOH on population health. Indeed, it is in LMICs that most people are aware of the non-healthcare determinants of disease and death, foremost being poverty. LMIC publics are aware that factors such as poor housing, education, income, social status and exclusion, race/ethnicity, caste/class, discrimination, good governance and so forth are profoundly important for individual and population health. Even the poorest people in LMICs are well aware of SDOH. For example, the World Bank's three volume *Voices of the Poor* series documented valuable insights into the daily lives of the poorest people in the world, and of relevance here, their understanding of SDOH and health.³⁻⁵ What they don't do is use the term SDOH.

While particular policies motivated by HIC social epidemiological research may be hard to find in LMICs, there are numerous examples over decades of LMIC public awareness and social mobilisation to address harmful SDOH. Movements against structural adjustment programmes, apartheid, epic corruption, civil conflict, gender inequality, discrimination based on sexuality, religion, caste and so forth are all linked to an understanding of the social and global factors impacting mortality and morbidity. This worry about LMIC exclusion from SDOH discussions reveals that HIC SDOH researchers need to learn more about the longstanding scholarly debates and work in other academic fields such as development economics, international political economy, development studies, human rights law and advocacy, gender studies which have long been focused on SDOH in LMICs.

A final point for reflection raised by the article relates to people across countries ranking healthcare as the most important determinant of health. The priority of healthcare does not necessarily contradict people recognising the importance of SDOH, particularly in one's own life. People are likely to identify healthcare and other proximate determinants of disease and death as being important to their health because those are what people have most control over. But there is something else worth considering. In this survey, people were asked to pick from the given list of options what they thought were the most important determinants of health. Instead of using the word health, what if the question asked what are the most important determinants of your body and mind working well? And, what if respondents were asked to type in what they thought were the most important health determinants? It is plausible that many people worldwide might say God or luck. Where would those fit on the upstream–downstream spectrum?

Indeed, as the researchers posit, public awareness and understanding is an important component of any social and global efforts to address the macrolevel factors that cause and distribute disease and death in individuals and populations. At least in the USA and UK, there have been concerted efforts to assess the public's understanding of SDOH and persistent health inequalities.^{6,7} Based on

those findings, efforts now are focused on shaping the public's understanding of SDOH and health inequalities. It is a brave new chapter in addressing SDOH in HICs that seeks to engage with the current social and political contexts of societies, harness both scientific knowledge and communication strategies in order to breakthrough the dominant discourse focused on healthcare and individual actions.⁷⁻¹⁰ While LMICs are not part of this new chapter of 'message framing', the pandemic has galvanised diverse social movements for COVID-19 vaccine equity, health sovereignty and global governance reform that are profoundly shaping the LMIC publics' understanding of which SDOH are most relevant to them right now. The inability to recognise all these and other efforts as tackling harmful SDOH in LMICs because they do not exist in the HIC produced epidemiological SDOH literature would reveal a lack of epistemic imagination and inclusivity.

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