

## **The Commission on Social Determinants of Health:**

### **Ten years on, a tale of a sinking stone, or of promise yet unrealised?**

#### **Summary**

Ten years after the August 2008 release of the report of the WHO Commission on Social Determinants of Health, it is important to reflect on the fate of its recommendations for reducing ‘health inequity’. The article describes some key developments in the decade, notably in understanding the etiology of health inequalities, and then juxtaposes a hopeful comparison of an earlier (1987) UN Commission on Environment and Development with a sceptical view based on the expanding social science literature on the politics of economic inequality.

#### **The last ten years**

On 28 August 2008, the World Health Organization’s Commission on Social Determinants of Health released its final report. The end product of three years’ work by 19 commissioners led by Sir Michael Marmot and supported by nine transnational knowledge networks, the report was organised around the concept of health equity\* and began with the assertion that the ‘unequal distribution of health-damaging experiences’ within and across national borders ‘is in no sense a “natural” phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics’ (Commission on Social Determinants of Health, 2008, p. 1).

Such language is not normally encountered in United Nations system documents and led *The Economist*, in a generally laudatory review, to comment that the Commission ‘seems, at times, to be baying at the moon when it attacks global imbalances in the distribution of power and money’ (The price of being well, 2008). The report was released as a financial crisis spread across the world from an epicentre in the United States, with effects that underscored the value and urgency of the Commission’s focus on “upstream” influences on health

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\* The Commission defined health equity with reference to ‘systematic differences in health [that] are judged to be avoidable by reasonable action’. Whilst this definition invites debate about what might constitute reasonable action, there is widespread agreement on the distinction between health equity and the strictly descriptive terminology of health inequalities or health disparities.

inequalities, as noted at the time by the then-Director General of the World Health Organization (Chan, 2008).

Ten years on, what has happened? In some respects the report has sunk like a stone; it has produced ripples on the surface of the pond into which it was cast (Figure 1), but not the erosion of the pond's shoreline that some of us had hoped for.

- Figure 1 about here -

### **Figure 1. A tale of a sinking stone?**

A conspicuous ripple is the steady increase in the number of PubMed citations generated by a search for 'social determinants of health' (Figure 2), along with growing recognition of 'the political origins of health inequity' in global health policy analysis (Ottersen et al., 2014). Important advances have been made in such areas as understanding the physiological mechanisms by which chronic stress associated with privation and insecurity impairs health, often with a long time lag between initial exposure and effect (Barboza Solís, Fantin, Kelly-Irving, & Delpierre, 2016; Barboza Solís et al., 2015; Gallo, Fortmann, & Mattei, 2014; McEwen, 2015; McEwen, 2012; Delpierre et al., 2016) and the multiple pathways by which reduced 'control over destiny', which may occur at the individual level but as a consequence of macro-scale economic and social processes, leads to negative health outcomes (Whitehead et al., 2016). In addition, the importance of environmental pollution as a contributor to the burden of noncommunicable disease, especially (although not only) in low- and middle-income countries, is belatedly being acknowledged (Vineis, Stringhini, & Porta, 2014; Fuller et al., 2018; Landrigan et al., 2018). As in the case of stress, exposures are unequally distributed and socioeconomically patterned.

- Figure 2 about here -

The effect is to make available a far richer and more compelling portfolio of evidence in support of the Commission's perspective than was available in 2008. The portfolio will further expand with results from initiatives like the remarkable LIFEPAATH consortium of cohort studies linking epidemiology and biological markers over the lifespan (Vineis et al., 2017). The LIFEPAATH investigators, like earlier commentators (Glasgow & Schrecker,

2015), note the limitations of a focus on behavioural risk factors (Vineis et al., 2017, p. 420) and have underscored this point in a recent systematic review (Petrovic et al., 2018).

The most familiar followups to the Commission's work are probably the "Marmot reviews" of health inequalities in England (Strategic Review, 2010) and in the 53-nation WHO European region (Marmot & UCL Institute of Health Equity, 2013). The social impacts of the 2008 financial crisis and subsequent recession were often exacerbated by austerity measures in Europe and much of the developing world (Ball, Fuceri, Leigh, & Loungani, 2013; Ortiz, Cummins, Capaldo, & Karunanethy, 2015) that were actually contraindicated in macroeconomic policy terms (Ostry, Loungani, & Fuceri, 2016). Critically, 'austerity is increasingly a developing country phenomenon' (Ortiz et al., 2015, p. 3) despite the negative implications for health and development. The data-rich WHO Euro review's core principle that 'economic difficulties are a reason for action on social determinants of health, not inaction' might have assumed special importance, but with a few exceptions this was not the case (Stuckler & Basu, 2013; Basu, Carney, & Kenworthy, 2017). Indeed, 'systematic efforts to reduce inequalities in the 'fundamental causes' of health have been vanishingly rare' (Lynch, 2017, p. 656) and claims persist that evidence linking such structural influences as poverty to health inequalities is insufficient (Butler, 2017).

Such claims miss an important political point: evidence is sufficient when "decision makers" say it is; the choice of a standard of proof is not scientific, but inescapably political. Recent studies of health inequalities and the policy process (Smith, 2013; Lynch, 2017; Baker et al., 2018) focus on the complexity of the relevant causal pathways, and associated challenges for coordinated policy responses; the predominance of individualised, biomedical understandings of health and illness; and widespread scepticism about redistributive policies. As important as these findings are, such studies neglect a fundamental question about the reasons for that skepticism, the answers to which must be sought with reference to such variables as the shrinking policy space for national economic and social policy and the highly uneven and economically patterned distribution of political influence (in the US context see Gilens, 2012; MacLean, 2017).

### **Into the future: The hard (difficult) politics of inequality**

Economic inequality is the essential substrate of health inequality, and academic interest in economic inequality and its consequences has expanded rapidly. Piketty's *Capital in the Twenty-First Century* became a surprise best-seller, but it is only one of several thorough

recent treatments of the topic (Box 1). In Organisation for Economic Co-operation and Development (OECD) countries as a whole, income inequality as measured by the Gini coefficient is at ‘the highest value on record since the mid-1980s’ (OECD Centre for Opportunity and Equality, 2016, p. 1) and has been increasing within most national economies. In the United States, in 2012 top income and wealth shares ‘for the first time exceeded the high-water mark of 1929’ (Scheidel, 2017, p. 409). Meanwhile, the income share of (roughly) the lower 40 percent of the income distribution in many OECD countries had been stagnant or even declining (Organisation for Economic Co-operation and Development, 2015, p. 19-57) A strong *prima facie* case can be made that this is likely to increase health inequalities across a range of outcomes for which a socioeconomic gradient exists.

- Box 1 about here -

Increases in economic inequality in some large emerging economies (India, China, post-Soviet Russia and to a lesser extent Indonesia) have been even more striking (Scheidel, 2017, p. 222, 410-11) On a regional basis, the conspicuous exception is Latin America (including Brazil, another large emerging economy), where reductions in inequality post-2002, from extremely high levels, were largely policy-driven, although the continuation of this trend is uncertain for reasons related both to external conditions and internal politics (Cornia, 2017). Even if one does not accept the argument that lower levels of inequality are causally associated with better health outcomes across entire populations (Pickett & Wilkinson, 2015), and the evidence is now stronger than when *The Spirit Level* (Wilkinson & Pickett, 2010) appeared, the seemingly intractable problem of compensating for rising inequality of market outcomes through redistributive policies across a range of contexts is likely to represent the central challenge for future efforts to reduce health inequity. This is especially the case as global reorganization of production means that distributional conflicts are no longer contained, and need not be resolved, within national borders (on the mechanics of this process see Baldwin, 2016).

On the optimistic side, the international community in 2015 adopted the ambitious Sustainable Development Goals (for 2030) (United Nations General Assembly, 2015). The goals and targets explicitly address reduction of poverty and inequality within national borders; social determinants of health such as hunger and malnutrition; and health objectives including reduced maternal and child mortality and universal health coverage. The concept

of sustainable development traces back to the 1987 release of the report of the World Commission on Environment and Development (the Brundtland Commission; World Commission on Environment and Development, 1987), which suggests an interesting parallel. Ten years post-Brundtland, anyone who proposed adoption of the SDGs at the United Nations level might well have been dismissed as ‘baying at the moon’. Scepticism is in order about the viability and the internal coherence of the SDGs (Pogge & Sengupta, 2015; People's Health Movement et al., 2017, p. 13-48) and their probable effects on inequality (van der Hoeven, 2017), and difficult and conflictual politics remain. However, the parallel suggests that it may be too soon to assess the long-term impact of the Commission’s report, keeping in mind the late development scholar Albert Hirschman’s observation that ‘large-scale social change’ must be understood ‘as a unique, nonrepeatable, and *ex ante* highly improbable complex of events’ (Hirschman, 1987, p. 194).

On the other hand, there is so far little evidence at the crucial level of national politics of the ‘social movement, based on evidence, to reduce inequalities in health’ (Marmot, Allen, & Goldblatt, 2010) that the Commission’s chair called for after the report’s release. Such movements depend on complex and context-specific dynamics both for their initial formation and for their eventual success (Schrecker, 2017). And the work of many social scientists calls into question prospects for reducing economic inequalities in more than marginal, incremental ways. As a result both of the routine dynamics of globalisation and the effects of financial crises and austerity (Ball et al., 2013; UNCTAD, 2017, p. 93-117), path dependencies introduced by rising levels of inequality may be such that within specific national or sub-national contexts there may be points of no return as economic opportunity structures for differently situated populations diverge. Especially in the European context, current obstacles include corporate tax rate competition facilitated by the ability to shift profits, if not actual economic activity, to jurisdictions with the lowest rates; the increased ratio of government debt to GDP following the financial crisis; and the growing power of financial markets to dictate a ‘consolidation state’ that prioritises maintaining credibility in terms of servicing that debt (Streeck, 2015; Schäfer & Streeck, eds., 2013). Worldwide, the ability of the ultra-rich to take advantage of offshore financial centres, and sometimes to shop for nationality, creates an additional obstacle (Harrington, 2016).

Scheve & Stasavage (2016), considering the United States and Europe, argue that inequality-reducing taxes on the rich have only been politically possible in eras of mass mobilisation for warfare (thus, ‘conscription of wealth’), which in their view is unlikely to occur again. The

plausibility of this view in the context of possibilities for (e.g.) nationally destructive cyberwarfare is a matter for further research and debate. Drawing on this work but considering a much longer historical time frame and a much larger range of countries, Scheidel argues in *The Great Leveller* (2017) that substantial redistribution from rich to poor has only been accomplished in connection with disaster or violence, whether through the ‘great compression’ during and after the two World Wars of the twentieth century (Scheidel, 2017, p. 115-173); violent revolutions and their aftermath, including state collapse; or large-scale epidemics like the Black Death. He is therefore highly sceptical about the contemporary possibility of substantial redistribution under peaceful circumstances (Scheidel, 2017, p. 424-444), raising important questions about the viability of claims that contemporary societies have reached “peak inequality” (Dorling, 2018).

A further complication is added by the tension between the assumed desirability of continued economic growth – in particular, of accelerated growth outside the high-income world – and biospheric limits to human activity that may have their own, direct and indirect, consequences for human health (Gaffney & Steffen, 2017; Steffen, Broadgate, Deutsch, Gaffney, & Ludwig, 2015; Whitmee et al., 2015). Avoiding those limits while acknowledging the legitimate claims of the majority of humanity outside the high-income world to something like its standard of living implies more extensive redistribution, on a global scale, even than that associated with the ‘great compression’. This is an especially sobering prospect if, as Scheidel suggests, the ‘great compression’ itself instantiates Hirschman’s ‘improbable complex of events’.

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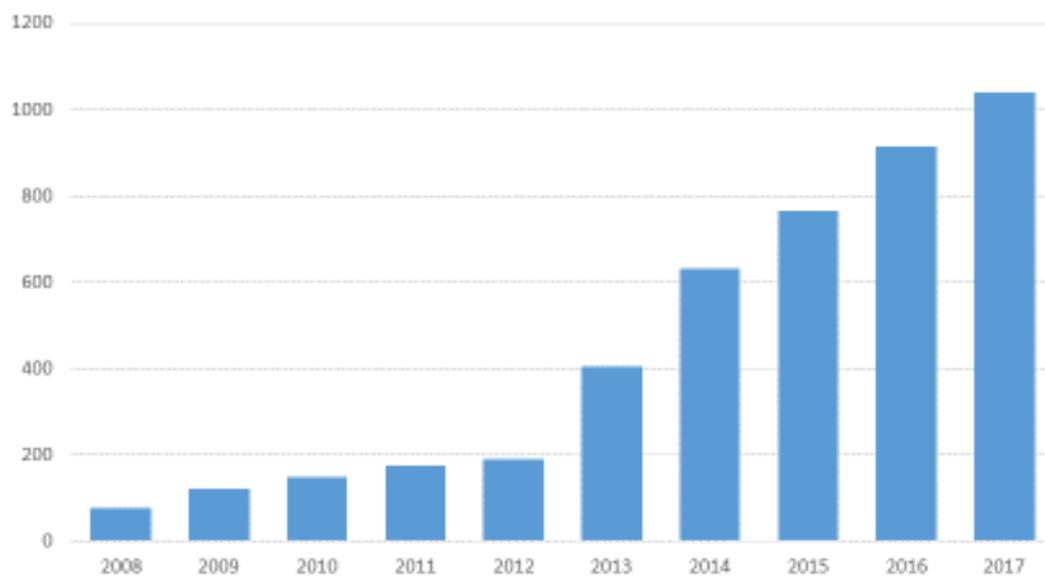
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**Figure 1**



**Figure 2. Number of PubMed entries for search term 'social determinants of health', 2008-2017\***



\* Search undertaken 26 March 2018

## **Box 1. Important recent studies of economic inequality**

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