
THE NORMATIVE SIGNIFICANCE OF SOCIAL DETERMINANTS OF HEALTH

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Abstract: In this paper I critically discuss the normative significance of so-called social determinants of health and their use in public health policy. I will highlight certain possible and real misperceptions that are common in public health research and public health policy. After introducing the concept of the social determinants of health, the first issue I discuss concerns the confusion surrounding the notion of health in public health. Public health is mainly concerned with health dispositions or risks. This is different from a concern for people being unhealthy in the sense of suffering from a disease. The difference is important for the notion of health inequalities as well. In order to deem some people less healthy than others, a gradual concept of health is needed. Once the two concepts of health are confused, it is more difficult to acknowledge normative differences between being unhealthy and being less healthy. I submit that public health policies tend to exploit the common attitude towards diseases, namely that they ought to be treated and that they establish claims of justice. It is then another step of public health practitioners to campaign against social conditions that lead to certain health inequalities, which are deemed unjust. In other words, public health allows a normative argument, via the value of health, against specific social conditions. I reject this approach and allow only an indirect role for inequalities of health dispositions in an account of social justice. They might be regarded as symptoms of social ills, but they are not, according to my

mind, as such unjust. Injustice in social conditions needs to be established in its own right, not mainly via its impact on health dispositions in specific populations. In the final section I hint towards an alternative, a noncomparative theory of social justice, which aims at enabling citizens to make healthy choices, but is not per se interested in comparative differences between people.

Keywords: *public health, social determinants of health, concept of health, health inequalities, noncomparative justice*

SOCIAL DETERMINANTS OF HEALTH

The health status of individuals is determined by many factors. They might suffer accidents if safety measures are inadequate; they might be under threat of falling ill when living or working in a dangerous and unhealthy environment, such as slums or coalmines. They might also be under risk to develop chronic diseases if not treated adequately by medical means. Public health measures have therefore, for a long time, focused on improving the environment of citizens by getting rid of directly harmful determinants of health and by enhancing access to medical resources, such as hospitals and doctors. In the last few decades, new determinants of individual health statuses have been recognized. They have led to a new focus of public health policies: these are the so-called social determinants of health. They are elements of the circumstances of individuals, which have to do with their socio-economic status, the quality of their work, their income, but also with internal resources, such as level of education, coping disposition or their general life-style. It has been shown, in the relevant research in social epidemiology, that health status is distributed along a socio-economic gradient (Venkatapuram 2017).

Social determinants of health work indirectly and often cumulatively. For instance, a person who is poorly qualified for a job might struggle to get or keep a job, so they might be under constant threat to lose their source of income. This might slowly build up to have an impact on their health. Citizens might also be uninformed about a healthy diet. In addition, they might struggle, due to challenging circumstances such as being a single mum, to prepare nutritious meals for their family. Due to such unhealthy diet, children may become overweight, and eventually suffer from health-related impairments. Social determinants of health might also

be circumstantial elements, such as having access to recreational activities, for instance to enjoy a stroll at the park.

The focus on social determinants of health, as opposed to environmental and medical determinants of health, has sometimes been described as the contribution of a new wave of public health efforts, or even as “new public health” (Awofeso 2004). The indirect nature of these determinants has also occasionally been flagged up by using the expression “causes of the causes” health and disease. In this paper, I intend to highlight a couple of theoretical and normative problems that come with the above-mentioned more recent focal point of public health.

BEING UNHEALTHY IS NOT THE SAME AS BEING LESS HEALTHY

When individuals have a disease, they are unhealthy. A disease affects what might be called their absolute health status. This is in line with the usual medical perspective, where a person either has a disease or is healthy. To be sure, even in the medical perspective we can appreciate that there are different levels of organismic functioning, and that therefore the exact threshold between health and disease is somewhat fluid. Still, there are thresholds determined for different levels of biological functioning – these can be found in official documents, such as the *International Classification of Diseases*. The concept of health, in this perspective, is a minimal one, as it applies whenever a person does not have a disease.

We can also talk about people being unhealthy in a comparative sense (Schroeder 2012). It is important to see this we then switch the perspective to disposition and risks, and use a different concept of health altogether. This second perspective is also the one taken in public health (Schramme 2017). People can be healthier than another person, or healthier than they themselves were before, if they are less likely to fall ill. In this respect, a person who lives in a dangerous environment or in a destitute financial situation might be less healthy than someone living in safe circumstances or someone who is wealthy.

Being less healthy is not the same as suffering from ill health or being unhealthy. Being less healthy is rather a point on a continuum of dispositions to fall ill. If people are in good physical shape, have a strong immune system and live in an advantageous environment, then they are on the upper end of the grades of health. In contrasting circumstances a person

might be at the lower tail, meaning she is less healthy, implying that she might be very likely fall ill. However, it is important to appreciate that such a person is not (yet) ill because of the poor health disposition. In other words, she has not fallen below the threshold of minimal health.

The point I want to make here is not merely important for conceptual clarity – it has a normative significance as well. As we will see in the following section, the conceptual confusion between being unhealthy and being less healthy leads to a related confusion regarding the evaluation of the relevant conditions. Being unhealthy is bad for a person, but it is not so clear why being less healthy is also bad (in the same way). I will discuss later in a bit more detail that being less healthy might be bad in presenting a person with a disadvantage. The latter could be called a comparative harm, as it involves being worse off than others. Given that undeserved disadvantages are widely considered to raise claims of justice, being less healthy might still be normatively significant. Yet there is a different kind of harm involved than the absolute harm that comes with being unhealthy.

In addition, there is also a methodological issue with the very idea of being less healthy. Since it is a comparative notion, it requires a metric. A pertinent question here is in what respect a person is less healthy. It seems to make perfect sense, for instance, to compare levels of organismic functioning in different people. If my lung capacity, say, is better than yours, then I am healthier in terms of lung capacity. However, can we ever say that a person is healthier than another *tout court*? Is a professional sportsperson who has clinical depression more healthy than a person confined to the wheelchair who is well integrated in a network of friends? This simple example instantly establishes the problem of comparing health statuses of different people (Hausman 2012). It is not simply the manifold elements of individual health that make such a comparison a difficult aim to achieve, but also the need for making judgements about the significance of diseases.

To be fair, research in public health partly deals with these concerns and partly ignores them for good reasons. Public health policies usually do not focus on health differences as such, but on those differences that are deemed to be of political importance. In addition, research in public health usually does not compare individuals anyway, but populations. For instance, in epidemiological studies it might be established that people with higher academic education live longer, on average, than people with a poor educational level. Here, life expectancy is a proxy for general health

status within a chosen population, i.e. a certain statistically generalized health-related disposition, averaged across a group of individuals. Obviously, average life expectancy can be meaningfully compared between different populations. However, it should be clear that we are then talking about people being healthier than others only in a derivative sense. For normative purposes, this difference should be acknowledged.

FREE-RIDING ON THE NORMATIVE STANCE TOWARDS DISEASE

Disease is usually bad for us. It might come along with pain and incapacity. Disease can also be instrumentally bad, that is, bad in terms of its consequences, for instance when it prevents us from performing a job or from enhancing our skills or knowledge. The latter detrimental consequences of disease might be described as disadvantages, as the harms suffered by disease can be seen here in relation to other possible health statuses. A person might be worse off than other people, who are less ill or more healthy, or the person might be worse off than she could have been, had she not fallen ill.

Obviously the normative considerations surrounding health care provision are due to both the intrinsically harmful as well as the instrumentally disadvantageous aspects of disease. We deem citizens to have a justified claim to using health care resources when they are suffering from a disease because they should not suffer or be disadvantaged due to no fault of their own (Wolff & de-Shalit 2007). This is a very common, basic assumption of many theories of social justice, which are obviously pertinent to our discussion. To be sure, the common proviso regarding individual responsibility, i.e. that disease is not due to their own voluntary choice, is an important bone of contention in the contemporary debate. Individual responsibility plays a significant role in theories of justice. However, in relation to health care justice its role is debatable. I will only mention the issue here, as the discussion on responsibility for health status could have an impact on the assessment of some public health policies. Obviously, health-related disadvantages, such as persistent stress in a job, could be due to voluntary choices. Such health-related disadvantages might therefore change their normative status and not ground claims of justice after all. Be that as it may, the topic cannot and need not be discussed more thoroughly in this paper.

More importantly for the purposes of this paper, the step from the normative significance of suffering from a disease to being confronted with a health-related disadvantage is not straightforward. Most people will accept that suffering from a disease can justify a claim of justice – normally to get access to health care resources. However, this is not obvious for conditions that are not diseases as such, but only lead to an impaired health status with a certain increased probability. To be sure, I do not want to claim, of course, that preventive measures in medicine and public health are unjustified. But the normative significance of treating a disease is different from preventing a disease, because there are different levels of urgency involved.

The new public health has expanded the concerns of policies even further. Here it is not just direct causes of diseases that are being targeted, such as pollution or bacteria, but also the social conditions that might influence the health dispositions of populations. In terms of a common normative concern it is not at all clear why being under an increased risk of falling ill, say due to living in a destitute neighbourhood, should raise normative concerns at all. To be sure, it might raise normative concerns in its own right, meaning that we might deem it sufficiently bad to live in a destitute neighbourhood. But this has nothing to do with the potential health impact of the circumstances of life. With examples like these I believe we can see that some public health policies trade on the normative significance of occurrent disease and transfer it to dispositions and risks. However, such a step requires argument.

CONDEMNING SOCIAL CONDITIONS BECAUSE OF THEIR HEALTH IMPACT

Because new public health is concerned with social determinants of health, and since health is considered to be of significant value for individuals – perhaps even a human right – these social determinants, such as housing, work conditions and access to recreational activities, are turned into normatively relevant issues as well. This is not only done by pointing out the impact of poor health on the well-being of citizens, but also by highlighting the economic burden of disease (Hausman 2015). In other words, certain social conditions are flagged up as important concerns of justice via their health impact. Depending on one's political taste, this need not be deemed bad, of course. After all, there are serious social

problems in many societies. If these social problems are not acknowledged as injustices in their own right – perhaps because they are seen as necessary consequences of a capitalist economy – there might be a different route to condemning them if they are connected to the important value of health.

Norman Daniels seems to support such a strategy in his influential book *Just Health*: “Many who are not at all troubled by significant inequalities in income, wealth, or opportunities for a higher quality of life are particularly troubled by health inequalities. They believe that a socioeconomic inequality that otherwise seems just becomes unjust if it contributes to health inequalities” (Daniels 2005, 81). Yet Daniels does not himself support such a straightforward link between “avoidable, unnecessary and unfair” health differences and injustice (Whitehead 1990; cf. Preda & Voigt 2015).

Again, I do not intend to undermine the reasonableness of challenging certain social conditions as social ills, and perhaps even to call them social injustices. However, I believe this should be done so in their own right, not by taking an indirect route via health. Otherwise there is a danger of confusing social and medical problems.

An already observable development is the close connection and occasional identification of socio-economically induced health risks with diseases. Perhaps the most obvious examples in this respect are smoking, unhealthy diets and lack of exercise. These go along with increased risks to develop diseases, and they are at least partly caused by social determinants, such as peer pressure or lack of access to recreational environments. Smoking is today regularly seen as an addiction, which it can be of course, but need not be. Unhealthy diets and lack of exercise are closely connected to obesity, and sometimes relevant choices are described as based on a kind of mental defects, for instance time discounting (Barlow et al 2016). However, choices that are not directly threatening health, but are merely risky in terms of health cannot plausibly be categorized as irrational. Again, this does not mean that we should not try to encourage healthy lifestyles and to create healthy environments; only we should not assume that unhealthy behaviour is itself pathologically or even morally wrong. Confusing health conditions and health risks is not only conceptually mistaken but normatively dangerous as well.

It should further be noted that there is yet another reason why it is erroneous to believe that certain social conditions can be established to be harmful or unjust merely due to their status as determinants of ill health: this is because the normative status of health is itself not straight-

forward. It is true, of course, that if we assume that health is the highest good we can achieve in society, then everything that protects this value should also be deemed of high normative significance. However, health is not such an overriding value. Individually and politically, we balance the value of health against other values, such as liberty, pleasure, social relationships, avoidance of patronizing citizens and so on. The price might be a less optimal health disposition of people, but it might well be a price worth paying.

To be sure, it might be objected that this objection is unconvincing as differences in health dispositions can be translated into socio-economic advantages and disadvantages. For instance, an employer who struggles at work due to a noisy home and resulting lack of sleep, might be less likely to achieve a promotion than her colleague who lives in a favourable environment. We can also safely assume that such disadvantages are unwanted and usually not voluntarily caused by affected people themselves. In other words, comparatively worse health disposition might constitute undeserved disadvantages and hence unjust conditions. Considering again the instrumental value of health, understood as an asset in competitive scenarios, for example the labour market, levelling the playing field might require the enhancement of certain social conditions, which have been established as determinants of health.

Again, I believe such a type of argument is based on a confusion (for a more detailed analysis, see Schramme 2009). First, it should be noted that in the public health perspective we do not refer to individual disadvantages, but to statistically determined propensities of certain populations to suffer disadvantages. Normally we want to level the playing field, as a matter of justice, between individuals in a specific competitive context, such as running for a job. We therefore need to have information about the required provisions to be fully able to compete and whether each competitor has achieved or accessed these conditions. However, this kind of information cannot be determined by social epidemiology. Second, an increased likelihood to suffer from a disadvantage is simply not the same as suffering from a disadvantage. Equality of opportunity is not about levelling the odds of winning, but of competing on fair terms.

To be sure, it seems certainly wrong if certain populations have a significantly lower life expectancy than others. However, what I want to argue is that it is neither the comparatively lower life expectancy that should cause normative outrage, nor the length of life as such. Rather, we should focus on the social determinants of health in their own right,

from the traditional perspective of social justice. Epidemiological findings might lead us to identifying a specific direction of the concerns of justice. In other terms, health-related differences might be symptoms of social ills, but they are not social pathologies as such. This makes social determinants of health inequalities only indirectly relevant for questions of social justice (cf. Peter 2001; Sreenivasan 2009).

SOCIAL DETERMINANTS FROM THE PERSPECTIVE OF NONCOMPARATIVE JUSTICE

Health care aims at providing for health needs. These needs of citizens are constituted by their specific health status. First and foremost, the health status of a person is due to their specific level of organismic functioning. It is not based on any comparison with other persons. In terms of justice this calls for a perspective of noncomparative justice. Joel Feinberg introduced the relevant terminology a couple of decades ago: “In all cases, of course, justice consists in giving a person his due, but in some cases one’s due is determined independently of that of other people, while in other cases, a person’s due is determinable *only* by reference to his relations to other persons. I shall refer to contexts, criteria, and principles of the former kind as *noncomparative*, and those of the latter sort as *comparative*” (Feinberg 1974: 298; emphases in original).

I have discussed the noncomparative perspective on justice in public health more thoroughly in a different paper (Schramme 2015). I believe it leads us to a theory of justice, which is called sufficientarianism and which mainly contrasts with egalitarianism (Segall 2013). Sufficientarianism in public health aims at providing good enough health for every citizen. This includes preventive measures as well, and hence public health policies are indeed justified in aiming at certain social determinants of health. However, sufficientarianism is not concerned with inequalities between people or populations as such. Unequal health statuses might be an indicator of noncomparative justice, because occasionally the relative position between citizens might result in exclusion from society. But the latter aim, avoiding exclusion, puts forward a noncomparative standard.

The goal of public health can be described as providing the necessary means for everyone to be able to make healthy choices, not to actually make people equally healthy, or as healthy as possible. It is concerned with achieving an aim that can be described as “enabling the playing field”.

Admittedly this idea is still fairly abstract. In the end, I believe, it will have to be fleshed out by real societies in political processes. It is important to see, however, that social determinants of health will have to be considered in their impact on elements of comparative and noncomparative justice. Prior to determining which differences in health risks are unjust, it needs to be discussed what justice in general requires. It is an important insight of the new public health movement to acknowledge the social determinants of health. The debate about their normative significance, however, should not be bypassed by simplified ideas regarding the concept of health and by inflated beliefs about the value of health.

CONCLUSION

The main aim of this paper was to highlight certain conceptual and theoretical confusions in public health, when discussing the social determinants of health. The concept of health used in public health needs to be clarified and distinguished from the concept of health used in medicine. In addition, common normative assumptions in public health policies need to be challenged, as the value of health itself cannot simply be taken for granted, especially not its relative value in balance to other important social goals. Even if social conditions causally contribute to significant inequalities in health dispositions, this might still be justified. Such inequalities might be helpful evidence when thinking about justice, but the normative perspective has to be widened over and above the focus of public health. Hence public health needs to be linked to debates in ethics and political philosophy. Public health policy should not set its own agenda.

REFERENCES

- Awofeso, N. 2004. What's New About the "New Public Health"? *American Journal of Public Health* 94 (5): 705-9.
- Barlow, P.; Reeves, A.; McKee, M.; Galea, G.; Stuckler, D. 2016 Unhealthy diets, obesity and time discounting: a systematic literature review and network analysis. *Obesity Reviews* 17(9): 810-9.
- Daniels N. 2008. *Just health: meeting health needs fairly*. New York: Cambridge University Press.

- Feinberg, J. 1974. Non-Comparative Justice. *Philosophical Review* 83: 297–338.
- Hausman, D. 2012. Measuring or Valuing Population Health: Some Conceptual Problems. *Public Health Ethics* 5 (3): 229–239.
- Hausman, D. 2015. *Valuing Health: Well-Being, Freedom, and Suffering*. Oxford: Oxford University Press.
- Peter, F. 2001. Health Equity and Social Justice. *Journal of Applied Philosophy* 18 (2): 159-70.
- Preda, A; Voigt, K. 2015. The Social Determinants of Health: Why Should We Care? *American Journal of Bioethics* 15 (3): 25-36.
- Schramme, T. 2009. On Norman Daniels' interpretation of the moral significance of healthcare. *Journal of Medical Ethics* 35: 17-20.
- Schramme, T. 2015. Setting limits to public health efforts and the healthisation of society. *Zeitschrift für Menschenrechte* 9 (2): 50-68.
- Schramme 2017. Health as Notion in Public Health. In: Schramme, T. & Edwards, S. *Handbook of the Philosophy of Medicine*. Heidelberg, etc.: Springer, 975-84.
- Schroeder, S.A. 2013. Rethinking Health: Healthy or Healthier than? *British Journal for the Philosophy of Science* 64 (1): 131-159.
- Segall, S. 2013. *Equality and Opportunity*. Oxford: Oxford University Press.
- Sreenivasan 2009 Ethics and Epidemiology: Residual Health Inequalities. *Public Health Ethics* 2 (3): 244–9.
- Venkatapuram, S. 2017 Social Determinants of Health. In: Schramme, T. & Edwards, S. *Handbook of the Philosophy of Medicine*. Heidelberg, etc.: Springer, 1077-88.
- Whitehead, M. 1990. *The Concepts and Principles of Equity and Health*, Copenhagen: World Health Organization.
- Wolff, J.; de-Shalit, A. 2007. *Disadvantage*. Oxford: Oxford University Press.

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