Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings

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Public health policy in older industrialized societies is being reconfigured to improve population health and to address inequalities in the social distribution of health. The concept of social determinants is central to these policies, with tackling the social influences on health seen as a way to reduce health inequalities. But the social factors promoting and undermining the health of individuals and populations should not be confused with the social processes underlying their unequal distribution. This distinction is important because, despite better health and improvement in health determinants, social disparities persist. The article argues that more emphasis on social inequalities is required for a determinants-oriented approach to be able to inform policies to address health inequalities.

THE LAST DECADE HAS SEEN MAJOR DEVELOPMENTS IN public health policy in a number of older industrialized societies. The traditional focus on improving the population's overall health has been widened to include a commitment to reducing health differences between population groups. This commitment is often expressed in terms of reducing health inequalities, although in some countries, *health inequities* and *health disparities* are the preferred terms. What they all capture are the systematic differences in the health of groups and communities occupying unequal positions in society.

The concept of social determinants occupies a pivotal place in these new policies and draws attention to those social factors—like people's

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social and economic circumstances—that play a major part in the health of individuals and populations. Introduced in the 1970s by researchers who were critical of the narrow focus of public health research on disease processes and health care interventions, the concept has become incorporated into the policy discourse. It includes both societal-level influences on health (living and working conditions and the broader social structures in which they are embedded) and individual-level risk factors (like health behaviors).

In the policy reports and blueprints informing the new health strategies, "tackling social determinants" is represented as a way of launching a joint attack on the social causes of ill health and of disparities in health. As this suggests, the concept has acquired a dual meaning, referring both to the social factors promoting and undermining the health of individuals and populations and to the social processes underlying the unequal distribution of these factors between groups occupying unequal positions in society.

This article turns the spotlight on this dual meaning. It begins with examples from policy documents that have marked the development of the new health policies and then discusses the models that researchers have developed to explain the concept to a policy audience. Next, it considers how the distinction between the social causes of health and health inequality can be clarified by focusing on social position as the point in the causal chain where societal resources are both distributed and unequally distributed between social groups. The final section suggests some implications for policy, paying particular attention to how policies can moderate inequalities in social position.

In this article I use the shorthand terms *health determinants* and *health inequality determinants* to avoid repeating *social determinants of health* and *social determinants of the distribution of these determinants*.

I discuss inequalities primarily in reference to socioeconomic inequalities, the equity dimension that has received the most attention in public health research and policy. But the argument that I develop in this article can be applied to other dimensions of inequality, like ethnic and gender inequality, that shape people's health.

Promoting Health and Tackling Health Inequalities

Poor-quality population health has been associated with large absolute inequalities in mortality between socioeconomic groups. As mortality

rates have declined in older industrialized societies, absolute inequalities have tended to narrow, albeit with exceptions (see Drever and Whitehead 1997; Mackenbach et al. 2002; Pamuk 1985). Nonetheless, relative inequalities in mortality have remained pronounced, with socioeconomic differences in the risk of premature death evident across societies and over time (Mackenbach et al. 1997; Whitehead and Diderichsen 1997).

Over the last decade, governments in older industrialized societies have begun to focus on inequalities in both the rates and risks of poor health between population subgroups. In several countries, the goals of public health policy have been widened from a concern with improving population health to a broader commitment to promoting both health and health equity. This broader commitment is particularly evident in Europe. New policies have been launched in the United Kingdom (with separate policies in England, Northern Ireland, Scotland, and Wales), Ireland, Italy, the Netherlands, and Sweden (Department of Health and Children 2001; Department of Health, Social Services and Public Safety 2000; Ministero della Sanita 1998; Secretary of State for Health 1999). In Finland, health equity has been an avowed goal of public heath policy since the 1980s (Ministry of Social Affairs and Health 2001). Beyond Europe, the twin goals of improving health and reducing health disparities underpinned the United States' *Healthy People 2000* program; similarly, New Zealand's new health strategy seeks "to reduce inequalities and improve health status" (King 2000, 3; National Center for Health Statistics 2001).

In the new policy agenda, the goals of promoting health and reducing health inequalities are often brought together through an overarching commitment to tackle determinants. In the World Health Organization's European strategy of Health for All, for example, both improving health and reducing health inequalities are seen to depend on addressing "basic determinants" and "root causes of socioeconomic inequities" (WHO Europe 1999). Indeed, the strategy's supporting documents acknowledge "the essential role played by the main determinants of health in the generation and development of socioeconomic inequities" (WHO Europe 2002, 135). At the national level, too, a determinants-oriented approach is seen as providing a way of securing health gain and greater health equity. For example, England's policy documents emphasize how the twin goals of "improving the health of everyone and the health of the worst off in particular" are to be advanced by tackling "the fundamental determinants of ill-health" and "the determinants of unequal

health between different groups" (CMO 2001, 4, 5; Secretary of State for Health 1999, viii). Similarly, Northern Ireland's "new approach to public health . . . aims to improve the health of our people and to reduce inequalities in health . . . by addressing the wider determinants of health" (Department of Health, Social Services and Public Safety 2000, 6, 12). Sweden also is pursuing a determinants-oriented public health strategy, which seeks "good health on equal terms" by tackling "factors in society or our living conditions that contribute to good or bad health" (Ågren 2003, 5).

Despite providing a unifying focus for the new health policies, the central concept remains ambiguous, referring simultaneously to the determinants of both health and inequalities in health. Thus, when the Northern Ireland strategy document speaks of addressing root causes, it includes "the root causes of ill-health" and "the root causes of health inequalities" (Secretary of State for Northern Ireland 1999, 2). In a similar vein, England's recent cross-departmental review of health inequalities rests on "a social model of health" that encompasses "determinants of health" as well as "determinants of health inequalities" (Department of Health 2002b, 22–3).

Using a single term to refer to both the social factors influencing health and the social processes shaping their social distribution would not be problematic if the main determinants of health—like living standards, environmental influences, and health behaviors—were equally distributed between socioeconomic groups. But the evidence points to marked socioeconomic differences in access to health-promoting resources. Further, it suggests that policies associated with positive trends in health determinants (e.g., a rise in living standards and a decline in smoking) have also been associated with persistent socioeconomic disparities in their distribution (marked socioeconomic differences in living standards and smoking rates) (Hills 1998; Howden-Chapman and Tobias 2000; Kubzansky et al. 2001; Perrson et al. 2001).

The fact that positive trends in health and in health determinants can be accompanied by persistent socioeconomic differences in both indicates that the distinction between health determinants and health inequality determinants is important. To clarify the distinction, it is helpful to look at how the concept of social determinants entered the discourse of public health research and policy.

The Concept of Social Determinants of Health

The *social determinants of health* is an imprecisely defined concept that directs attention to the social factors shaping people's health. The concept originated in a series of influential critiques published in the 1970s and early 1980s, which highlighted the limitations of perspectives and interventions targeted at individuals at risk of disease (e.g., McKeown 1979; McKinlay 1975; Rose 1985). Critics argued that understanding and enhancing health required a population focus, with research and policy directed at the societies to which individuals belonged. There was "a case for refocusing upstream" from the individual risk factors for disease to the social determinants of health (McKinlay 1975, 7). These social influences were seen as operating at both the individual and the population levels. As Evans, Barer, and Marmor put it, they are powerful influences on "how healthy we are as individuals and societies," explaining both "the health of populations" and "why some people are healthy and others are not" (Evans, Barer, and Marmor 1994, xiii).

Integral to these early critiques is the argument that medical care is not the main driver of people's health (e.g., Evans and Stoddart 1990; McKeown 1979; McKinlay 1975). Instead, the concept of social determinants is directed to the "factors which help people stay healthy, rather than the services that help people when they are ill" (London Health Observatory 2002, 6).

This was a perspective that quickly found its way into debates about public health policy. An early and influential example was Canada's Lalonde report, credited as being the first government report to identify factors other than the health care system as driving population health (Lalonde 1974). Its *New Perspective on the Health of Canadians* prepared the ground for the Health for All (HFA) charter of the late 1970s, which in turn stimulated the World Health Organization (WHO) strategy of HFA in 2000 (WHO 1981, 1985). Since then, a social determinants approach has gained widespread acceptance as the appropriate framework for developing and delivering public health policy. The HFA strategy addresses "basic determinants"; the European Commission's new public health framework similarly emphasizes "health determinants, in other words, the underlying factors which affect people's health" (Commission of the European Communities 2000, 12).

Models have been developed to translate the concept of social determinants for a policy audience. One of the most widely known is Dahlgren and Whitehead's model, which contributed to the first HFA strategy for Europe (Dahlgren and Whitehead 1991). The model represents the "main determinants of health" as a set of concentric arcs around the individual. The arcs range from broad social conditions, through social and community networks, to individual lifestyle factors. Although highly influential, this model is not the only framework that researchers have developed to capture the social influences on health. Brunner and Marmot's model of the social determinants of health is another that is increasingly cited (Brunner and Marmot 1999, cited in Independent Inquiry 1998; Eckersley 2001; Marmot 2000). Additional examples are Najman's model of the causal pathways linking the social and biological causes of disease which, like a range of others, represents the pathways as linear (Najman 2001; see also Diderichsen 1998; Stronks et al. 1997). Other models include Evans and Stoddart's model of the relationship between social and individual factors and health, and Hertzman's framework for human development and the social determinants of health (Evans and Stoddart 1990; Hertzman 1999; for more models, see also Hertzman, Frank, and Evans 1994; Howden-Chapman and Tobias 2000; Turrell et al. 1999).

Although the models differ in style and complexity, most represent health as the outcome of a web of social influences (e.g., Brunner and Marmot 1999; Dahlgren and Whitehead 1991; Diderichsen 1998; Najman 2001; Stronks et al. 1997; Turrell et al. 1999). This web can be seen to constitute "the social determinants of health." The most distal factor is the social structure of society, variously labeled *general socioeconomic, cultural, and environmental conditions*, *social structure*, *social context*, and *social, economic, and cultural characteristics of a society* (Brunner and Marmot 1999; Dahlgren and Whitehead 1991; Diderichsen 1998; Najman 2001; Stronks et al. 1997). Radiating out from this societal level, the models contain a set of intermediate social factors: social position and its attendant working and living conditions, and the social networks of family and community. The intermediate social factors are ranged above a set of individual-level influences, including health-related behaviors and physiological factors. At the most proximal point in the models, genetic and biological processes are emphasized, mediating the health effects of social determinants. Health care services are rarely accorded a place in these models, an exclusion reflecting the fact that the concept of social

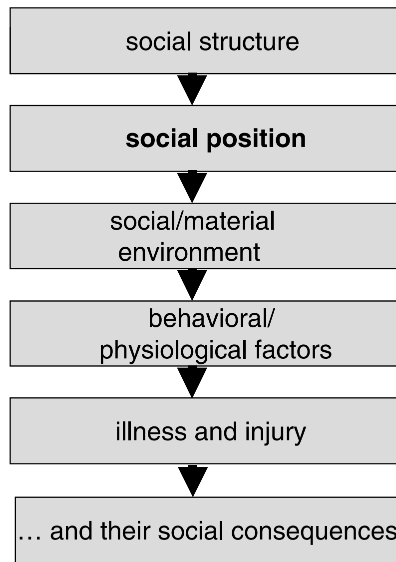


FIGURE 1. Social Determinants of Health

determinants was originally introduced into debates about public health to underscore the importance of nonclinical factors in shaping the health of individuals and populations.

The similarities in these models' structure mean that they can be combined into a composite form. Figure 1 illustrates what such a model might look like. Note its heuristic function: It is not designed to replace existing models but to capture the constituent elements and the central pathway identified in models of the social determinants of health.

Like the models from which it derives, Figure 1 represents health as the outcome of causal processes that originate in the social structure, in which social position is embedded. Although the definitions vary, *social position* usually refers to an individual's location in the social hierarchies around which his or her society is built. Social position thus includes such dimensions as socioeconomic position, gender, and ethnicity. Other analyses incorporate other structures of inequality—including those related to nationality and sexuality—that have a great influence on how individuals (can) live their lives (Krieger 2000; Runnymede Trust 2000).

Social position marks the point in the model at which societal-level resources enter and affect the lives of individuals. These resources include social resources like education, employment opportunities, and political

influence, as well as material resources like income and property. Social position, in turn, shapes access and exposure to a set of intermediate factors. These intermediate factors encompass the *social and material environments* of home, neighborhood, and workplace, which both provide resources for health and contain risks for health. They include, too, *behavioral and physiological factors*, which again can be either health protecting and enhancing (like exercise) or health damaging (cigarette smoking and obesity). Together, intermediate factors, shaped by the social positions to which they are linked, affect people's vulnerability to *illness and injury*. Finally, these conditions have *consequences* for social position, for example, by restricting opportunities for education and qualifications, employment and job security, and earnings and pensions.

Extending the Concept of Social Determinants

The concept of the social determinants of health highlights various points and pathways in the social production of health. Through the scientific inquiries and research reports established by governments to inform the development of the new health policies, this concept has been extended to cover the social determinants of health inequalities as well. For example, it figures prominently in the *Report of the Independent Inquiry into Inequalities in Health* (Acheson report) sponsored by the British government to review the evidence and policies relating to health inequalities. The concept of the social determinants of health also informs the reviews guiding public health policy in the Netherlands and Sweden (Independent Inquiry 1998; Persson et al. 2001; Programme Committee 2001). Outside Europe, the concept underpins the reports commissioned by the governments of Australia and New Zealand (Howden-Chapman and Tobias 2000; National Health Committee 1998; Turrell et al. 1999). For example, the report on the determinants of health for the New Zealand government argues for "acting on the determinants of health in order to improve population health and reduce health inequalities" (National Health Committee 1998, 8). Although health determinants can refer to the health of either individuals or populations, the unit of analysis is more precisely defined when the concept of social determinants is applied to health inequalities. It necessarily refers to subgroups within a wider population (e.g., socioeconomic groups and areas within countries).

Like the concept from which they are derived, models of the social determinants of health are also being extended to cover the social determinants of health inequalities. For example, Brunner and Marmot's model was originally developed to connect clinical (curative) and public health (preventive) perspectives on health (Brunner and Marmot 1999). But it subsequently was applied to the social processes underlying health inequalities as a model of the social factors that both cause ill health and contribute to health inequalities (Marmot 2000, 353). The model is included in the United Kingdom's Acheson report, introduced explicitly to illustrate how socioeconomic inequalities in health result from differential exposure to risks—environmental, psychological, and behavioral—across the lifecourse (Independent Inquiry 1998, 6–7). Similarly, Whitehead suggested that the model she developed with Dahlgren provides a way of thinking through policy options to tackle "the determinants of health in general and inequalities in health in particular" (Whitehead 1995, 22). As the Acheson report puts it, the model provides "a model of health and its inequalities" (Independent Inquiry 1998, 5).

Like the influential models developed by Dahlgren and Whitehead and by Brunner and Marmot, other models of health determinants are also being used to explain the social determinants of health inequalities to the policy community. For example, Turrell's report for the Australian government includes a model of "socioeconomic determinants of health" as "a conceptual framework that identifies the main determinants of socioeconomic health inequalities" (Turrell et al. 1999, 2). In a comparable way, the report on inequalities in health commissioned by the New Zealand government uses a model of the social determinants of health to identify "major components of social inequalities as they relate to health" (Howden-Chapman and Tobias 2000, 3).

Using these models makes the important point that health inequalities are socially produced. It signals, too, that exposure to health-damaging factors plays the principal role in the poor health of poor groups (Jarvis and Wardle 1999). But there are drawbacks to applying health-determinant models to health inequalities. Using one model to explain both health and health inequalities can blur the distinction between the social factors that influence health and the social processes that determine their unequal distribution. The blurring of this distinction can feed the policy assumption that health inequalities can be diminished by policies that focus only on the social determinants of health. For example, the British government's consultation paper *Tackling Health*

Inequalities in England notes: "The Acheson [report] examined the determinants of health as 'layers of influence'. . . . Tackling health inequalities will require us to address all of these 'layers of influence'" (Department of Health 2001, 16).

Similarly, the more recent cross-departmental strategy for *Tackling Health Inequalities* notes how it used Dahlgren and Whitehead's "social model of health" to address "the causes and risk factors that produce health inequalities" (Department of Health 2002b, 22). In a similar vein, the new health policy in Wales is built on "the recognition that to reduce health inequalities a multi-faceted strategy is required . . . to tackle the economic and environmental determinants of health" (National Assembly for Wales 2002, 24).

Trends in older industrial societies over the last 30 years caution against assuming that tackling "the layers of influence" on individual and population health will reduce health inequalities. This period has seen significant improvements in health determinants (e.g., rising living standards and declining smoking rates) and parallel improvements in people's health (e.g., higher life expectancy). But these improvements have broken neither the link between social disadvantage and premature death nor the wider link between socioeconomic position and health. As this suggests, those social and economic policies that have been associated with positive trends in health-determining social factors have also been associated with persistent inequalities in the distribution of these social influences.

The United Kingdom illustrates this pattern. In recent decades, economic growth and prosperity have markedly improved key components of socioeconomic position: in educational qualifications, in the proportion of the population employed in higher occupational groups, in real incomes, and in living standards (Hills 1998; Nickell, Redding, and Swaffield 2002; ONS 2001). While delivering aggregate gains, however, these policies have widened the inequalities in their distribution: For example, socioeconomic differentials have increased with respect to participation in higher education, access to professional occupations, income, and housing tenure (Glennerster 2001; Hills 1998; Machin 2003; ONS 2001). A similar pattern is evident for other health determinants. For example, since the 1970s, the United Kingdom's investment in tobacco control policies has been associated with a fall in smoking rates, but the gap in those rates between manual and nonmanual socioeconomic groups has widened in both absolute and relative terms (ONS 2001).

Such evidence points to the importance of representing the concept of social determinants to policymakers in ways that clarify the distinction between the social causes of health and the factors determining their distribution between more and less advantaged groups.

Making Explicit the Inequalities in the Social Determinants of Health

The approach adopted in the research reports guiding the new public health policies is one in which the underlying perspective linking the determinants of health and health inequalities remains implicit. The reports include evidence that key health determinants, including living standards and health behaviors, are unequally distributed, but they do not provide models that capture these inequalities (see, e.g., Aromaa, Koskinen, and Huttunen 1999; Howden-Chapman and Tobias 2000; Independent Inquiry 1998; National Health Committee 1998; Persson et al. 2001; Programme Committee 2001; Turrell et al. 1999). When the reports do include models of social determinants, the models map the determinants of health, and the authors rely on the accompanying text to signal their unequal distribution (see, e.g., Howden-Chapman and Tobias 2000; Independent Inquiry 1998; National Health Committee 1998; Turrell et al. 1999).

These research reviews are informed by a wider body of epidemiological research whose underlying perspective also tends to be implicit. When researchers do acknowledge the links between the social determinants of health and of health inequalities, it is clear that social position is the common axis on which both turn (e.g., Blane 1995; Lynch and Kaplan 2000; Moss 1997; Najman 2001). Although the argument, like the broader perspective, is rarely spelled out, it can be summarized as follows:

- Social positions are inherently unequal because they are part of broader social hierarchies. For example, occupying a particular socioeconomic position inevitably leaves a person advantaged (or disadvantaged) relative to those in lower (or higher) socioeconomic positions.
- Because the social positions that people occupy are unequal, societal-level resources also enter people's lives unequally. As a result, "those

who command most resources are best able to avoid risks, diseases and the consequences of disease. Thus no matter what the current profile of diseases and known risks happens to be, those who are best positioned with regard to important social and economic resources will be less afflicted by disease" (Link and Phelan 1995, 87).

- Because social position mediates access to societal resources, it determines access to resources at every point in the causal chain: societal, environmental, behavioral, and disease related.
- Social position is therefore the "fundamental social cause" of health (Link and Phelan 1996, 472). The defining feature of such a cause is that it has an enduring association with health, over time and across different health outcomes. Fundamental social causes "affect multiple disease outcomes through multiple mechanisms and . . . maintain an association with disease even when the intervening mechanisms change" (Link and Phelan 1995, 80).

To date, the research on social position has concentrated mainly on socioeconomic position. It has found, for example, that socioeconomic position shapes "people's experience of and exposure to virtually all psycho-social, behavioural and environmental risk factors for health—past, present and future—and these in turn operate through a very broad range of physiological mechanisms to influence the incidence and cause of virtually all major causes of disease" (House and Williams 2000, 90). Socioeconomic position should therefore be regarded as "the fundamental cause of health and the fundamental lever for improving health" (House and Williams 2000, 90). Research, however, is making a powerful case for widening the category of "fundamental cause" to take account of the fact that other social positions also influence people's access to health determinants. Ethnicity, gender, and sexuality all can qualify as fundamental causes of people's (unequal) health, representing enduring dimensions of both social and health inequality (Krieger 2000; Mays et al. 2002).

Social position is at the center of Diderichsen's model of "the mechanisms of health inequality" (Diderichsen 1998, 102). In its initial formulation, it emphasized the pathway from society through social position and specific exposures to health. The framework was subsequently elaborated to give greater emphasis to "mechanisms that play a role in stratifying health outcomes" (Diderichsen, Evans, and Whitehead 2001, 15). These mechanisms are "those central engines of society that generate and distribute power, wealth and risks," differential exposure and

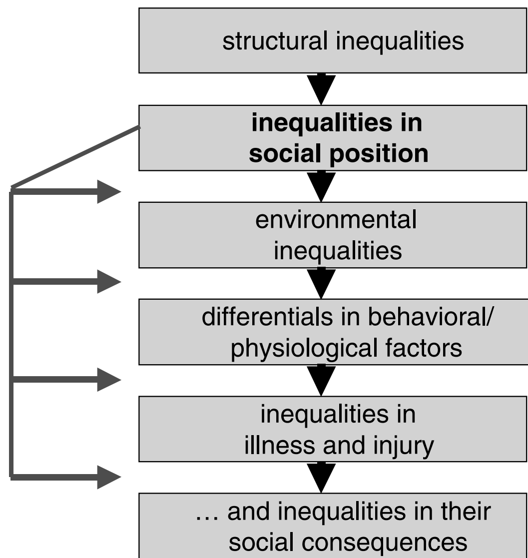


FIGURE 2. Social Determinants of Health Inequalities

vulnerability, and the differential consequences of ill health for more and less advantaged groups.

Taken together, these analyses of fundamental causes and mediating mechanisms suggest that the models of the social determinants of health may need to be modified in order to help the policy community understand the social causes of health inequalities. Because inequalities in determinants are not factored into the models, their central role in driving inequalities in health may not be recognized. Figure 2 illustrates this point. Again, the heuristic purpose of Figures 1 and 2 need to be underscored: They are designed to capture schematically the distinction between health determinants and health inequality determinants, which can be obscured in the translation of research into policy.

In Figure 2, structural inequalities—in the education system and the labor market, property and wealth, and political influence—work through inequalities in social position, which, in line with Link and Phelan's critique, is identified as the central link in the chain. The figure recognizes that unequal social positions carry with them unequal probabilities of being exposed to health hazards along the environment/risk factors/illness pathway (represented by the vertical arrows). By building in Diderichsen's emphasis on mediating mechanisms, it makes clear that

people's social position can affect the impact of these determinants on their health, as well as the consequences of poor health for their future social position (signaled by the horizontal arrows).

Thinking Through Policies to Tackle Health Inequalities

The new health policies have brought together the goals of improving health and tackling health inequalities through a focus on social determinants. Research has accorded social position the central place among these determinants: the point at which the social structure affects, and affects unequally, people's access to key resources for health.

As this suggests, a combined attack on the social causes of health and health inequalities implies a dual, not a single, policy agenda. It requires engaging with not only the social influences on health and how people's social conditions can damage their health. It requires, too, simultaneously engaging with how social inequalities are maintained over time and across generations. Facing this challenge is particularly important when, as in the older industrialized nations, social changes are widening social inequalities. Economic restructuring is central to this process of change, with the decline of the agricultural and manufacturing sectors and the rapid growth of the technology-led service industries. The result has been a collapse in the demand for manual work, the economic mainstay of working-class communities. There has been a parallel increase in highly skilled nonmanual jobs which, without training and education, remain largely inaccessible to displaced manual workers. The result, evident in the United Kingdom, the United States, and elsewhere, has been a widening gap between those enjoying well-paid jobs and rising living standards and those facing irregular employment and long-term poverty (Hills, Le Grand, and Piachaud 2002; Massey 1996).

Expanding the reach of public health to include the determinants of social inequality has extensive implications for health policy. For example, it affects the setting of targets, the development of policy, and the evaluation of policy effects. Next I consider these three examples.

When setting targets, a commitment to tackling health inequalities points to the need to shift public health policy away from its traditional focus on health outcomes (e.g., reducing the number of deaths from coronary heart disease). Such a commitment means that along with health,

the targets should include reducing the inequalities in the distribution of health determinants. For example, if the health equity goals concentrate on reducing socioeconomic inequalities in health, the targets could be set to reduce inequalities in living standards, environmental exposures, and behavioral risk factors among socioeconomic groups. In England, some targets for narrowing socioeconomic inequalities in health determinants have been incorporated into the performance-management frameworks laid down for the National Health Service. For example, the new frameworks specify targets to reduce smoking rates in manual socioeconomic groups (Department of Health 2002a). Targeting inequalities in health determinants is most advanced in Sweden's new health strategy. This strategy builds on the work of a national health commission, made up of researchers, politicians, and public health professionals, whose report contended that the goals of health gain and health equity required targets to be set to reduce both the level of and the social disparities in "determining factors" (Swedish National Committee 2000, 6). These determining factors include social conditions and health behaviors that contribute to "the level and distribution of different diseases" (Östlin and Diderichsen 2001, 8).

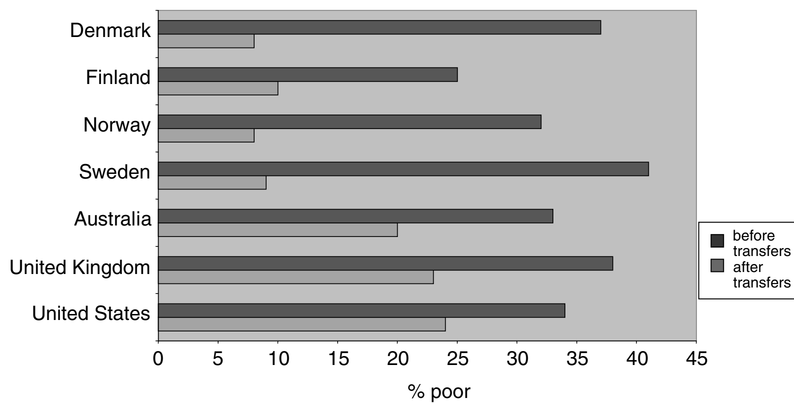
With respect to policy development, a determinants-oriented approach to tackling health inequalities turns the spotlight on policies with the potential to influence the distribution of health determinants, particularly inequalities in social position. Here, there is evidence that interventions directed to disadvantaged groups and communities can be important levers for reducing inequalities in social position. One example is early childhood intervention programs to improve the life chances of poor children. Evaluations show that these programs accelerate children's social and cognitive development throughout childhood and have a positive impact on their social position in adulthood (Hertzman and Weins 1996; Zorich, Roberts, and Oakley 1998). But even though they are important elements of an equity strategy, targeted interventions alone are not enough. The reason is that their effects will be mediated by more far-reaching policies: by employment and fiscal policy and by the public provision of education, housing, and social security. These mainstream policies have a more powerful impact on an individual's life chances and living standards and on the scale of inequality in the wider society.

Important evidence on mainstream policies comes from the diverging trends in inequality among richer countries during those decades

in which all were exposed to transformations in global and national economies. In some countries, including the United States, the United Kingdom, and New Zealand, these changes have been associated with a rapid widening of inequalities in social position. From the 1970s through the 1990s, income inequalities increased markedly in all three societies (Dalziel 2002; Hills 1998; Kubzansky et al. 2001). But evidence from other countries makes clear that increasing social polarization is not the inevitable result of structural change. For example, Sweden experienced economic recession and a rapid rise in unemployment in the early 1990s, but only a modest increase in income inequality during this period. Poverty rates, defined as the proportion of households with incomes less than 50 percent of the average, were low and remained under 4 percent in all socioeconomic groups (Burström and Diderichsen 1999). Finland's economic crisis was more severe, with unemployment climbing from 4 to 18 percent between 1990 and 1994 and the proportion of the population dependent on welfare benefits rising sharply. But shallow income inequalities and low poverty rates persisted (Manderbacka, Lahelma, and Rahkonen 2001).

Mainstream economic and social policies lie at the heart of these national differences. Throughout the 1980s and 1990s, the United Kingdom, the United States, and New Zealand pursued monetarist economic policies designed to deregulate the labor market and social policies to restrict social welfare payments. Their market-oriented policies amplified the stratification effects of economic change (Atkinson 1999; Dalziel 2002; Hout, Arum, and Voss 1996). In contrast, in the Nordic countries, economic and social policy combined to moderate these effects. In Sweden, for example, active labor market policies combined with welfare benefits to protect the living standards of vulnerable groups.

The extent to which policy can diminish inequalities in social position is captured in international data on poverty rates. In most international analyses, those people living in poverty are defined relative to average living standards in the society to which they belong: The income needed to secure what the wider society regards as a decent minimal living standard is higher in richer than in poorer societies. A household income that is less than half the average household income (adjusted for household size and composition) is widely used as the poverty line. In the United States, however, the official poverty line is an absolute income threshold based on the minimal cost of a basket of goods necessary for survival. In the 1990s, this poverty line was equivalent to



Source: Bradshaw and Chen 1997.

FIGURE 3. Proportion of Households with Incomes below 50% of Average Income, before and after Transfers, circa 1990

approximately one-third (rather than one-half) the average household income (Glennerster 2002).

Figure 3 is based on national poverty data from a set of rich societies, with poverty measured as household income that is less than 50 percent of average household income. It describes the position of households both before and after direct taxation and the payment of social security benefits. Before the effect of direct taxes and social security benefits are factored in, poverty rates are high in all the rich societies. But the figure points to marked differences in the effectiveness of national policies in protecting living standards. In Nordic countries, fiscal and social security policies combine to reduce post-transfer rates of poverty to under 10 percent. In the United Kingdom, the United States, and Australia, these instruments of redistribution leave more than 30 percent of the population in poverty. What the national comparisons bring out is the role of established welfare systems in moderating inequalities in social position (Graham 2002). They underline the importance of recognizing the contribution of mainstream policies to moderating inequalities in social position, particularly when governments favor cutbacks in public expenditure (Programme Committee 2001).

In regard to policy evaluation, tracking and assessing the impact of mainstream policies and targeted interventions is recognized as a

complex process. It takes time for potentially beneficial effects to be manifested, whether in improvements in social position, risk factors, or better health. Furthermore, established policies and new programs are operating in a dynamic social and policy environment. Their effects therefore may vary across contexts and cohorts and may be mediated through social and policy changes. Such realities make it difficult to disentangle and measure the net contribution of an individual intervention (or cluster of interventions) to changes in the social circumstances and risk exposures of the recipient groups. Policy impact analyses therefore rely on a mix of methods, including longitudinal and time-series data, as well as data collected on the process and outcomes of interventions (Schmid 1997).

Concluding Comments

This article examined how the concept of social determinants is being used in national public health policies and in the research reports that are informing them. Covering a broad canvas, it has identified tendencies and underscored ambiguities. In other words, it is an exploratory review, not a comprehensive analysis.

In the process of bringing research into policy, health determinants and health inequality determinants can become conflated. Consequently, I argued that models of the social determinants of health are not always helpful in explaining the social determinants of health inequalities to a policy audience.

I have tried to convey the distinction between the social determinants of health and of health inequalities through heuristic models, which illustrate, albeit in a highly simplified form, that the social factors influencing health and the social processes shaping their unequal social distribution are not the same. Policies to achieve health gain seek aggregate improvements in the level of health determinants (Figure 1); policies to promote health equity address the unequal distribution of these determinants between advantaged and disadvantaged groups (Figure 2). Therefore, those governments committed to improving health and reducing health inequalities need to address the effects of their policies on the population as a whole. In addition, they must attend to the differing consequences of their policies for groups with unequal access to the determinants of good health.

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