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Justice in Health Care: Health Inequities and Social Determinants of Health

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In 2005, the World Health Organization (WHO) established the Commission on Social Determinants of Health. Its mandate was "to support countries and global health partners to address the social factors leading to ill health and inequities." In doing this, the Commission "drew attention of society to the social determinants of health that are known to be among the worst causes of poor health between and within countries."[1]

Ordinarily we think of health care as being focused on patient care and the treatment and prevention of disease. The thrust of health care, then, is to search for and prescribe medicines, vaccines, and therapies that are disease- and condition-specific and aimed at achieving the well-being of patients, with patients being encouraged to take responsibility for their health as well. However, when we move away from individuals and consider populations, there is a huge disparity globally between those who are healthy and those who are not.

For instance, according to one observer, the mortality rates in children under five vary dramatically among countries: in Sierra Leone, the rate is 316 per 1000 live births compared with 3/1000, 4/1000 and 5/1000 in Iceland, Finland and Japan respectively. [2] The disparities in adult mortality rates are similarly striking: "The probability of a man dying between age 15 and 60 years is 8.3% in Sweden, 82.1% in Zimbabwe, and 90.2% in Lesotho."[3] In Sweden, one woman out of 17,400 is at risk of death during pregnancy or shortly after childbirth in her lifetime compared to one woman in eight in Afghanistan.[4] Statistics like these led members of WHO to the conclusion that biological factors alone could not account for such immense inequities in health; clearly there were social and economic factors at work. And if the health and well being of persons around the world were to be achieved, then these social determinants of health had to be addressed.

WHAT ARE SOME OF THESE SOCIAL DETERMINANTS?

The first International Conference on Health Promotion held in Ottawa in 1986 and co-sponsored by the Canadian Public Health Association, Health and Welfare Canada, and WHO, recognized that to be healthy people required "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity."[5]

According to the Public Health Agency of Canada, beyond biological and genetic factors, determinants of health include: income, social status, social support networks, education, employment, working conditions, social and physical environments, healthy child development, health services, gender and culture.[6] Of these, Health Canada has identified poverty "as being the single most important determinant of health."[7]

WHAT DOES POVERTY MEAN?

In global terms: "The poor are not only those with the lowest incomes but also those who are most deprived of health, education and other aspects of human well-being. Poor mothers are more likely to die in childbirth; children of poor families are more likely to be malnourished and are correspondingly more susceptible to an early death from

childhood diseases; poor children receive less education and some may receive none at all; and gender imbalances are more pronounced among the poor, excluding them from recognized development benefits and opportunities."[8]

In so-called developed countries it may be difficult to grasp the depth of poverty and its effects experienced daily by the forty per cent of the world's population who live on less than US$2 per day[9] or by the one billion people world-wide who live in slums[10] or by the more than 140 million undernourished children in the world.[11] However, the Commission notes that health inequities are not present only in countries that are poorer in the global scheme of things; they are present within countries, including comparatively rich ones. In other words, the Commission found that not only were the world's poorest people the least healthy as a population but that, within countries, persons who were further down the socio-economic scale were more vulnerable to ill health than those further up the scale.

Canada is not exempt from this phenomenon. According to the Public Health Agency of Canada, longevity is influenced by income, with "men in the top 20 per cent income bracket [living] on average six years longer than those in the bottom 20 per cent. For women, the difference is 3 years."[12] In poorer neighbourhoods in Canada, babies are at twice the risk of death as babies born into affluent neighbourhoods.[13]. Within countries, even comparatively rich ones, social determinants influence health.

CHANGING SOCIAL DETERMINANTS

The Commission maintains that social determinants of health are not fixed or inevitable, but are the result of political and economic choices made by policy makers and governments. As such, they can be reversed. But this, the Commission admits, is well beyond the capacity of what the health care sector can deliver. To be truly effective, change to social determinants of health must be undertaken by governing groups at all levels.[14] On a practical level, such changes will benefit governments by increasing productivity and economic development as populations become healthier.[15]

From a health care perspective, attending to social determinants of health along with disease treatment means that health care itself will be able to provide better patient care.[16] According to a Canadian Nurses Association Backgrounder, "nurses and other health professionals will not be able to achieve the success they seek in their individual work with patients … until we make it a priority to address social determinants."[17]

A pediatrician in the UK makes the case that understanding the effects of social determinants of health – poverty especially – on the health of children is crucial if children are to be treated effectively.[18] Furthermore: "Given the profound effects of poverty and low income on health in childhood and across the life course, pediatricians and their organizations (local and national) have a critical role to play in advocating for policies that protect children from a life in poverty."[19] He contends that health care research must also be undertaken with a sensitivity to social determinants of health.[20]

Aside from these practical considerations, the Commission sees a moral dimension to acting upon social determinants of health. It is a "matter of social justice", with the global health inequities that exist among countries and within countries "an appalling unfairness" that can and must be rectified.[21] As Marmot writes: "action on the social determinants of health is necessary not only to improve health but also because such improvement will indicate that society has moved in a direction of meeting human needs."[22]

As Catholics and Christians, we are called to attend to the well-being of one another by confronting human distress in all of its forms. We are called to feed the hungry, to clothe the naked, to provide shelter for the homeless, to provide companionship for the imprisoned. We are called to be neighbours even to strangers when they should fall among robbers, be beaten and stripped of all of their possessions and left at the side of the road. We are not only to clean their wounds and bandage them, but to place them on our own conveyance and arrange further care and shelter for them, just as the Good Samaritan did.

The WHO Commission on Social Determinants of Health contends that by truly committing ourselves to the well-being of the poorest of the poor in the world as well as to the marginalized among us in our own countries, by addressing inequities in social determinants and therefore in health, we will be righting the social injustices and building a society where the health of all is a priority. In Christian terms, this is what it is to participate in building the Kingdom of God.■

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[13] Ibid.
[14] CSDH, Closing the gap, p. 35.
[15] Ibid., p. 39.
[16] Ibid., p. 35.
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[19] Ibid., pp. 705-706.
[20] Ibid., p. 706.
[21] CSDH, Closing the gap, p. 26.
[22] Marmot, p. 1103.

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