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# Practice

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## Policy change for the social determinants of health: the strange irrelevance of social epidemiology

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The considerable evidence base linking social conditions to population health has spurred many in public health to call for political action. Most of these conditions fall outside the purview of health departments, meaning that advocates are increasingly calling on other government sectors to improve health. Whether levelled at the whole-of-government or individual departments these calls seek a paradigm shift in governmental goals. Paradigmatic political change is an essentially normative process – one based upon ethical, rather than empirical, reasoning. Successfully achieving political change requires that public health advocates improve their normative justification for change and reduce their reliance upon evidence-based arguments.

**evidence-based policy • social determinants of health**

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### Introduction and background

According to the evidence compiled by social epidemiology, the most influential determinants of health fall outside what is traditionally thought of as the health sector (CSDH, 2008; Marmot Review, 2010; UCL Institute of Health Equity, 2013). This evidence also demonstrates that inequalities in the distribution of these determinants are responsible for the ethically troubling inequalities in health outcomes within and between nations (Venkatapuram, 2011; Venkatapuram and Marmot, 2009). On the basis of this evidence, advocates for improving and equalising the social determinants of health (SDH) seek substantive policy change across the whole of government – which includes asking non-health sectors such as housing, transport, taxation and education to implement policies which are health promoting (Marmot Review, 2010; Waldbrook, 2015; Pickett and Wilkinson, 2015; Kickbusch, 2015).

There is broad agreement, even in public health, that research evidence is not sufficient on its own to instigate policy change (Farrer et al, 2015). Though political decision making can be enhanced by an engagement with available research evidence, increasingly it is argued that the promises of ‘evidence-based policy’ have not been fulfilled (Smith, 2013). The rational, linear model of policy making (in which evidence feeds directly into policy which is then implemented) has been shown to be out of step with both political science and the practical reality of policy making (Black, 2001; Sabatier, 1991; Clavier and de Leeuw, 2013). Current social determinants of health

research explicitly recognises the limitations of linear evidence-based policy discourses (Baum et al, 2013; Smith and Joyce, 2012; Exworthy, 2008). Exworthy (2008), for example, notes that SDH is often neglected in policy making for reasons which do not pertain to the quality of SDH evidence, most particularly the complexity of the problem and the dominance of other priorities.

In the first half of 2014 we interviewed 21 Australian politicians, policy makers and lobbyists, collecting their perspectives on the most effective ways to make the social determinants of health agenda politically powerful. The results of that study have been published elsewhere (Carey and Crammond, 2015). In all of the interviews, participants noted that the evidence on social determinants of health is not sufficient on its own to prompt changes to government policy. Many participants concluded that in order to be successful, social determinants of health advocacy would need to be broken down into smaller interventions which fit within the siloed reality of government structure and practice. Almost half of respondents [n=10] also considered the role of values in political decision making and the consequences for social determinants of health.

In this paper we take these observations as a starting point to discuss a particular problem for all those relying upon SDH evidence to initiate policy change, namely that the sort of paradigmatic policy change being sought is also the type of change least amenable to being 'evidence-based'. We argue that the claims for whole-of-government action made by SDH advocates do not align with the necessarily political questions to which they are addressed. As such, if we are to take seriously the evidence that theoretical argument and political values are inherent facets of policy making, advocates of SDH must first declare, and then substantially develop, their justification of the need for SDH-promoting public policy.

## The political claims of SDH

I think the instrumental arguments are the weaker arguments for reducing inequality. I think in some sense the use of them has portrayed a lack of confidence among many social advocates in the sort of core moral principles. I think the right argument is [it's the right thing to do], not 'lets reduce inequality because it will reduce crime'. (Carey and Crammond, 2015, 16, 139)

The most powerful versions of SDH make political claims encompassing whole suites of interventions across all levels of government (Carey et al, 2014). At the domestic level, the Marmot Review sets out recommendations for action across six areas of government, taking in early childhood services, education, employment, welfare, urban planning and preventive health (Marmot Review, 2010). Achieving the Review's overall aims of flattening the social gradient requires that the interventions be implemented as a package, rather than individually. Aimed internationally, the Report of the WHO Commission on the Social Determinants of Health (CSDH) sets broad goals, calling on governments to 'improve the conditions of daily life' and to 'tackle the inequitable distribution of power, money and resources' (CSDH, 2008). When translated into the *Rio Political Declaration on Social Determinants of Health* (the only international declaration to focus specifically on health equity), the role for government is expressed in the following terms:

health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an ‘all for equity’ and ‘health for all’ global action. (WHO, 2011)

The policy change envisaged by these documents is not the incremental improvement of existing policy but rather a revision of governmental goals to include health equity across all sectors. Change of this nature is described variously in the literature as transformative change, a ‘punctuation’ of policy equilibrium (Baumgartner et al, 2009; Baumgartner and Jones, 1993) and a policy paradigm shift (Hall, 1993). In this paper we will use the term ‘paradigm shift’.

The justification for placing health equity at the heart of policy making is described as deriving primarily and exclusively from the epidemiological evidence demonstrating the existence of health inequalities between social groups. Referring to the CSDH, for example, Venkatapuram et al (2010) reject the suggestion that political ideology has any role in its work and state:

The Commission’s recommendations for action to improve individual health and the distribution of health are grounded in identifying the causal chain based on empirical evidence. (Venkatapuram et al, 2010, 5)

They go on to explain that empirical evidence is given ‘epistemological priority or precedence’ over any discussion of normative values (that is, how things *ought* to be) (Venkatapuram et al, 2010, 12). Favouring research evidence over abstract political values to drive government action is described as one of the great strengths of advocacy for health equity (Baum et al, 2013; CSDH, 2008). Despite a common acknowledgement of the importance of political values, (Marmot and Friel, 2008) in SDH debates the evidence on the social determinants of health is routinely presented as a way to avoid the inherent ‘messiness’ of politics, (Baum et al, 2013) or of being value-free and therefore palatable to both sides of politics (Marmot et al, 2010).

In the remainder of this paper we argue (1) that the paradigm shifting policy change sought by SDH advocates is least amenable to being influenced by evidence, and (2) that evidence from SDH is poorly equipped to influence the course of policy in sectors which are regarded as having social value beyond their effect on health.

## Shifting policy paradigms

As soon as a senior official, a minister or an advisor to a minister sees data they kind of switch off. The power to persuade... is not based upon evidence. It is based upon constructing an intellectual appeal and coherence of argument. In some ways it is more philosophical. A lot of the evolution of public policy is actually quote ‘philosophical and values based’. You can fit ethics and morality within that much more easily. (Carey and Crammond, 2015, 16, 139)

Many theories of policy change draw a distinction between ‘incremental’ or ‘normal’ policy change on the one hand and ‘transformative’ or ‘paradigm shifting’ change on the other (Baumgartner and Jones, 1993; Hall, 1993; Kingdon, 1995). Incremental

change occurs as part of everyday decision making and is the daily business of government. Transformative change, in contrast, occurs only rarely and then only when external influences converge favourably. The role and relative importance of research evidence varies according to the type of change being contemplated.

Research evidence is most likely to be utilised effectively in contexts of incremental change for a number of reasons. First is that when the scope of a problem is relatively constrained it is more easily researched. Despite widespread recognition of the complexity of policy environments, most research remains ‘mono-causal’ owing both to it fitting more neatly into traditional research methods and to a preference for “‘hard” data’ among policy makers. (Smith and Joyce, 2012, 73)

The second reason for the greater applicability of research to incremental change is that when change occurs within existing paradigms, the criteria for evaluating the evidence are stable. Evaluative criteria are central to our ability to translate a research finding like ‘social inequalities in educational attainment lead to education-based health inequalities’ into a conclusion that educational inequalities should be reduced. Without relevant criteria (in this example the belief that health should be equally distributed) the research finding is simply a statement of fact (a ‘positive’ statement) and does not prompt the *should* of the conclusion (which is a ‘normative’ statement). In policy work, a bureaucrat tasked with revising homelessness policy could collect and compare research findings on different interventions because the criteria for comparison – a combination of reducing homelessness balanced against cost – are agreed upon. The comparison may be complicated, and the criteria competing, but the evaluation and implementation of research findings is possible.

In the case of policy paradigm shifts, however, the very criteria of evaluation are contested. A policy paradigm, in this sense, is a set of beliefs about the role of government which, importantly, structures the way problems and solutions are identified and evaluated (Smith, 2013; Bacchi, 2009). Neoliberalism is a policy paradigm which, by setting certain growth and monetary goals, determines the set of criteria by which policy can be considered successful. The description of health equity contained in the CSDH Report, Marmot Review and *Rio Declaration* is equally a policy paradigm which contains an entirely different set of evaluative criteria (the improvement and equalisation of population health). Exchanging the pursuit of economic growth for the attainment of health equity as the guiding principle of government can therefore be understood as a paradigm shift.

When paradigms clash the utility of empirical research evidence is greatly reduced. Since each paradigm contains incommensurate goals, ‘it is often impossible for the advocates of different paradigms to agree on a common body of data against which a technical judgment in favor of one paradigm over another might be made’ (Hall, 1993, 280). In other words, research evidence cannot easily contribute to a decision between paradigms because there are no settled criteria by which to evaluate it – what is at stake is the nature of those criteria. Evidence of the existence of health inequalities cannot explain why a health equity paradigm should be adopted over a neoliberal paradigm.

Perhaps in recognition of the limitations of evidence in this context, advocates for SDH have increasingly incorporated calls to social justice in their work (Marmot, 2012; Marmot and Bell, 2011; Marmot et al, 2008). These calls, such as the CSDH Report’s famous ‘social justice is a matter of life and death’, appeal to a deeper paradigm: that the goals and outcomes of government should be held to a standard

which transcends politics rather than being hostage to it. This incorporation of political philosophy into SDH is aided by similarities in their objects of inquiry, especially their shared concern with the proper distribution of resources like income, education and employment opportunities (Rawls, 1971; Kymlicka, 2002; Nussbaum, 2000; Sen, 2009; Venkatapuram, 2011).

Since political argument is the primary tool to force policy paradigm shifts, the incorporation of social justice into advocacy for SDH is to be welcomed. It does not, however, improve the utility of epidemiological evidence. This can be best illustrated by reference to Norman Daniels' work on health justice, which represents the most sustained and sophisticated attempt to combine political philosophy with evidence on the SDH (Daniels, 2008). Daniels takes as his starting point Rawls' seminal *A Theory of Justice* which, in terms of resource distribution, takes justice to require that the least well-off be as well off as possible (Rawls, 1971). Daniels argues that a distribution according to this rule (called the difference principle) would be likely to reduce socioeconomic inequality and thus also health inequalities. The priority of justice over evidence is, however, made clear. If a society was structured according to Rawlsian principles, according to Daniels it is properly considered to be just. Any health inequalities which persisted are, then, 'required by justice' (Daniels, 2008, 99). Thus, though there may be some confluence between the demands of justice and those of SDH, no evidence of health inequalities can impugn the principles of justice.

For those in government who believe the proper purpose of government to be the pursuit of economic growth, the promotion of private industry, or the reduction of budget deficits, evidence of the existence of health inequalities or health inequities is unlikely to prompt the type of whole-of-government changes being sought. The existence of health inequity does not, on its own, amount to an argument for its incorporation as an aim of government.

## The independent value of other sectors

Twenty years ago people who were fiddling around with this stuff [SDH policy] in North America and Europe, indeed in the World Health Organisation, were saying 'if you want this sort of stuff to work then you don't mention the word health, because people are only interested in pursuing their own policy objectives.' So if health can work behind the scenes and demonstrate how (through a variety of formal and informal mechanisms) the pursuit of particular policy objectives will assist in, say, the achievement of productivity or employment or housing outcomes or whatever, then that's the way to do it. The sheer mention of the word health is a bad starting point, given the adversarial nature of cabinet policy.

Even that starting point is like a red rag to a bull when it comes to trying to get cross-sectoral collaboration. (Carey and Crammond, 2015, 14)

A consequence of the whole-of-government claims made in the name of health equity is that non-health sectors be required to consider the health consequences of their policies. Achieving this aim is the clearly stated objective of programmes like 'Health in All Policies' (Freiler et al, 2013). Seeking to include health concerns in,

for example, education policy exhibits analogous problems of values and evidence as those shown in relation to the whole-of-government.

Taking education as an example, the health inequalities research is clear that there is a strong association between education level and health (Mackenbach et al, 2008). More consistent than the relationship between income level and health, across the world those with the highest educational attainment live longer, healthier lives than their poorly-educated compatriots (Mackenbach et al, 2008). Most importantly, childhood social position is strongly associated with eventual educational attainment, creating social inequalities in educational attainment which then flow through into educational inequalities in health outcomes (Marks, 2005; Marks et al, 2006). Any intervention which can improve overall educational attainment and break the association with childhood social position is likely to have beneficial effects on health equity. On this basis many recommendations are made for health equity-promoting education policy, such as the Marmot Review's '[e]xtending provision of social, behavioural, psychiatric and other special needs support progressively across the social gradient' (Marmot Review, 2010, 183).

Harnessing education policy for the improvement of health equity highlights the instrumental role of education in promoting health equity. Yet, it glosses over the inherent *value* generally held regarding the public provision of education. Early opposition to child labour invoked the loss of educational opportunities as being equally important to the many terrible health consequences and today, political debate about education funding refers primarily to the direct role that education plays in promoting social justice. These debates are not reducible to their effect on health equity. As one education commentator explains:

Education is dangerous, because schools and colleges do not just reproduce culture, they shape the new society that is coming into existence all around us. Social justice in education therefore not only concerns equality in the distribution of an educational service (important as fair distribution is). Social justice concerns the nature of the service itself, and its consequences for society through time (Connell, 2012, 681)

Globally people struggle to secure and protect their access to quality education. Nowhere is this clearer than in Nigeria, Afghanistan and Pakistan, where advocates seek the right for girls to attend school in the face of violent opposition. In less extreme circumstances, students in places like Australia, Canada and the United Kingdom protest reductions in government expenditure on education (Ratcliffe, 2015; ABC News, 2014). Similarly social justice campaigners in the United States seek more equitable education funding on the basis that poor quality education excludes poor students from the high income professions and the social mobility they provide (Anyon, 2014; Engel, 2000). In research terms Piketty (2014) identifies education as a contributor to the vast accumulation of capital among the top 1% and Stiglitz (2012) describes the unequal availability of education as both a cause and consequence of increasing social inequality.

In all of these cases, education is valued for its direct contribution to justice or equality and not simply for its effect on health. The wealth of convincing evidence on education-related health inequalities is, therefore, of limited relevance to education campaigners and, equally, to education department bureaucrats. Fortunately in many

cases the aims of progressive education policy align with those of health equity – namely to reduce social inequality in education availability and attainment. In these cases social epidemiological evidence is simply irrelevant: the goals of education policy are pursued on their own terms which happen to be consistent with health. In other cases, where an education policy is inconsistent with the demands of health equity, social epidemiological evidence can have no persuasive effect where the aim of the policy is an end unrelated to health. A recent Australian government proposal was to deregulate university fees (fees are currently set by the government and are consistent across all universities). The chief aim of this policy is to sacrifice equality across universities in favour of creating a small number of extremely successful universities. To argue that such a policy will increase health inequalities is beside the point: the very aim of the policy is excellence over equality. Instead the pertinent argument (and indeed the one which has been successful in derailing the policy) is that maintaining equal higher education availability is itself desirable.

Too often, researchers and advocates for health equity fail to engage with the other sectors of government on their own terms and explain why they, the Departments of Education, Transport or Employment *should* take health equity into consideration in their work. Stating that ‘the main determinants of health exist outside the health sector’ explains why those working to improve health should be concerned about the actions of other sectors. But it does not necessarily explain why a bureaucrat working on the provision of public education – fighting the good fight on any definition – should turn her mind to health equity.

## Conclusion

In the opening statements of the CSDH Report, the CSDH states that:

The development of a society, rich or poor, can be judged by the quality of its population’s health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health. (CSDH, 2008)

This is a normative claim and, as such, needs to be supported by theoretical argument rather than a solely evidence-based argument. As a normative statement, the accumulation of further evidence is highly unlikely to persuade politicians to act because it necessarily fails to explain why they *should* be persuaded to act. Without underestimating the difficulty of achieving widespread political change, embracing moral and political arguments is therefore essential if advocates for action on the social determinants of health are to successfully gain traction with politicians and non-health departments. Let us not lament that the evidence on social determinants of health has not led to comprehensive government action, but rather let us be more critical of why it is that social determinants of health advocates have failed to capture (and sustain) the attention and commitment of policy makers.

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