

Improving Health Social Determinants and Personal Choice

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Although medical care is important, our reviews of research and the hearings we've held have led us to conclude that building a healthier America will hinge largely on what we do beyond the health care system. It means changing policies that influence economic opportunity, early childhood development, schools, housing, the workplace, community design and nutrition, so that all Americans can live, work, play and learn in environments that protect and actively promote health.

Statement from commissioners from Commission to Build a Healthier America¹

This clear, crisp statement is fundamental. It has the possibility to change the way policymakers and the public think about health. Health care grabs the headlines. The noisy discussion of reform of the U.S. healthcare system—characterized less by informed debate than by misinformation (“don’t let the government meddle with my Medicare” was particularly appealing)—should be put in this broader context. Providing health care for people when they are sick is important. But the Robert Wood Johnson Foundation (RWJF) commissioners’ statement above makes clear that it is environments in which people live, learn, work, and play that need to be changed if Americans are to enjoy good health.

In its report to the commission, *Overcoming Obstacles to Health*, which was the starting point for the commission’s deliberations, the RWJF highlighted two issues.² First, despite spending more than any other country on health care, the U.S. ranks poorly on measures of health: its world ranking on infant mortality has slipped from 18th in 1980 to 25th in 2002; for life expectancy it has slipped from 14th to 23rd; and by some measures it does even worse.³

Second, there are huge health inequalities—social disparities in the language of the report—within the U.S. [Figure 1](#) is taken from the RWJF report to the commission.² This figure makes two clear points. Much of the discussion on health disparities in the U.S. has been on

racial/ethnic differences. [Figure 1](#) demonstrates simply that the differences in health according to socioeconomic position, measured here by income, are much bigger than the racial/ethnic differences within income group. There are racial/ethnic differences within income groups but, taking the groups as a whole, much of the differences between racial/ethnic groups is likely to be socioeconomic. In other words, the prestigious RWJF commission has put socioeconomic inequalities in health firmly on the political agenda. [Figure 1](#) also shows that health follows the social gradient. It is not simply the case that people with low incomes have poor health—they do—but there is a graded relationship between income and health.

Given the strong statement from the RWJF commissioners at the top of this piece, which we applaud, the question is how far the commission’s recommendations go in meeting the challenge of America’s relatively poor global health record and the large social gradient in health within the country. That is the subject of this commentary. We will draw on our experience elsewhere; we have chaired (MM) and been a member of the secretariat (RB) of the Commission on Social Determinants of Health (CSDH) set up by WHO, the report of which, *Closing the Gap in a Generation*,⁴ was published in 2008. Following this global report, the British Government invited MM to chair a review (“The Strategic Review of Health Inequalities in England post 2010: the Marmot Review”) of how the findings of the global report, and other evidence, could be applied to reduce health inequalities in England. The Marmot Review was published as “Fair Society, Healthy Lives” in 2010.⁵ We refer to this review from now on as “Fair Society.”

We Feel Their Pain

The strong statement from RWJF commissioners at the head of this commentary is not quite matched in what follows in their report. After their recommendations, which we will come to in a moment, the report has a series of highlighted orange boxes that, presumably, contain key messages of the report. The first one¹ says:

Good health depends on personal choice and responsibility . . . Each of us must make a commitment to:

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0749-3797/\$17.00

doi: 10.1016/j.amepre.2010.10.010

- Eat a healthy diet
- Physical activity
- Avoid risky behaviors . . .
- Avoid health and safety hazards at home and at work
- Nurture children

If this box is intended to set the tone of the RWJF commission report, and indeed it is borne out by many of the highlighted boxes that follow, it is rather different from the tone that we tried to set with the CSDH report.⁴

At the start of the CSDH report we said that:

Social injustice is killing people on a grand scale.

and

The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives . . .

This unequal distribution of health damaging experience . . . is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics.⁴

The differences in tone between the two reports are not subtle. The RWJF report emphasizes personal choice and responsibility; the CSDH emphasizes the structural drivers of health inequalities. Having a workplace free of hazards or having a municipal water supply that is safe for human consumption is not primarily a matter of individual choice and responsibility. It is reasonable to ask, as indeed some political commentators asked: Where is personal responsibility in the CSDH view of the world? Conversely, where are the structural drivers of health inequity in the RWJF commission?

To answer the latter question—the social determinants in RWJF—they are there, just not emphasized in the highlighted boxes, and not greatly in evidence in the

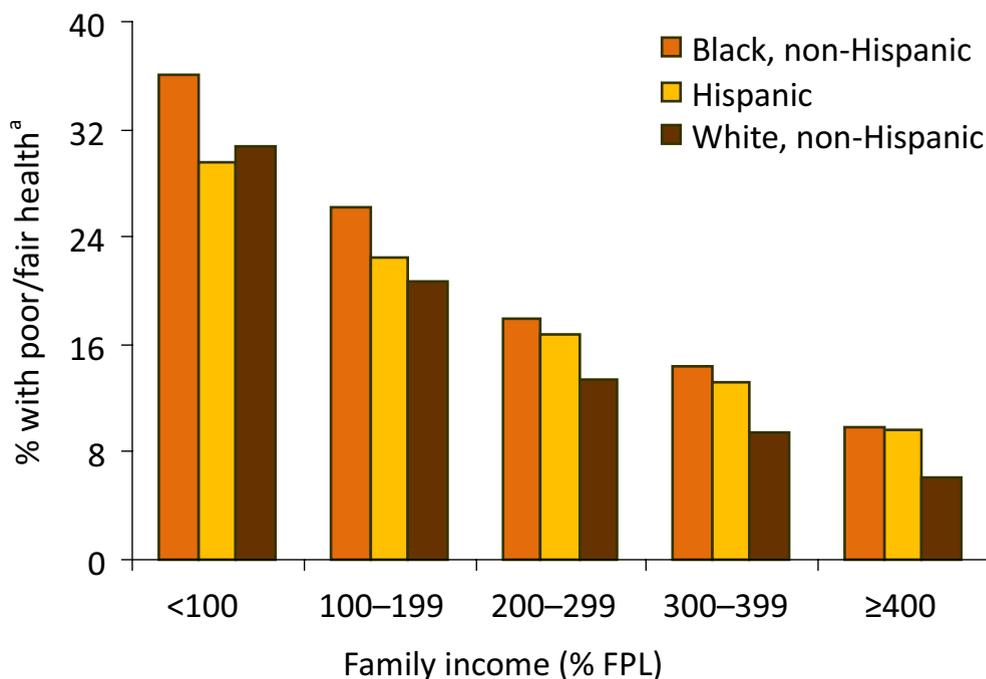


Figure 1. Health status, by income level and race/ethnicity²

^aAt age ≥ 25 years; age-adjusted

FPL, federal poverty level

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recommendations. For example, in the text that follows the orange box quoted above, on personal responsibility, there is the following strong emphasis on the contexts in which people make choices:

Unquestionably, we must take individual responsibility for our health and the health of our families. At the same time, we must recognize that, in many instances, the barriers to good health exceed an individual's abilities, even with great motivation, to overcome these barriers on his or her own. In seeking a healthy society, we must consider the choices available to individuals and the contexts in which choices occur—including conditions in homes, neighborhoods, schools and workplaces—that can constrain or enable healthier living.¹

One has to assume that the RWJ commissioners were looking both ways—it was a bi-partisan commission—and trying to satisfy “liberal” opinion while not being discarded by conservative opinion at the same time. We are not in a position to judge whether that was the correct political judgment, but it was clearly different from the one reached by the CSDH commissioners. One test: Did the CSDH frighten the horses? Not as far as we know. When a resolution to adopt the CSDH recommendations was debated at the World Health Assembly in 2009, representatives of 39 member states spoke, positively, in the discussion, and the resolution was adopted unanimously.

The U.S. was one of the member states adopting the resolution.

Which is dominant, then, in the RWJF report? The individual choice model of the orange boxes or the harder hitting social determinants thrust of the text between boxes, and admirably represented in the articles prepared for this supplement to the *American Journal of Preventive Medicine*?^{6–11} One answer: Look at the recommendations. The RWJF commission contained ten, summarized here:

1. early child development particularly for children in poverty;
2. food stamps and other programs for the poor;
3. public private partnerships to provide grocery stores in communities without them;
4. feed children only healthy food in school;
5. all schools to have time for physical activity;
6. become a smoke-free nation;
7. healthy communities to provide a range of health promotion;
8. health impact assessment for housing and infrastructure projects;
9. safety and wellness into community life;
10. have the information on health impacts of decisions in other sectors.

These recommendations, while largely oriented to individual behavior and healthy choices, clearly put these behaviors and choices in a social context. The last three recommendations, particularly, are potentially oriented to environments.

We could make the point about what might have been here, and is not, by contrasting the recommendations from “Fair Society.” First, this review started not with the emphasis on personal responsibility, important as that is, but with creating a fair society. It put fairness in society at the center of all decision making about the key drivers of health inequalities—hence the title “Fair Society Healthy Lives”—then made recommendations in six domains:

1. early child development;
2. education, lifelong learning, and giving people the capabilities to take control over their lives;
3. employment and working conditions;
4. ensuring that everyone has at least the minimum income needed for healthy living—this included making the tax and benefit system more progressive;
5. sustainable communities;
6. prevention.

There is clear overlap between the RWJF commission and “Fair Society” and clear differences. Take early child development as an example. Even though both agree on the fundamental importance of early child development,

there is still an important difference. The task group convened in England to review the evidence on early child development and education concluded that if the aim is to reduce inequalities in early child development and education, there has to be reduction of inequalities in society. While this perspective is not lacking in the background papers for the RWJF commission, it has little prominence in their recommendations.

To summarize, there are at least three important differences between the RWJF recommendations and those of “Fair Society”:

1. “Fair Society” placed emphasis on the tax and benefit system as one important mechanism for reducing inequalities in the lives people are able to lead, and hence their health. While we did not think that the whole picture of health inequalities was driven by income inequalities—“Fair Society” had five other domains of recommendations apart from income—it nevertheless recognized that insufficient money for the poor and the lack of a properly progressive tax system made health inequalities worse.
2. “Fair Society” did not see school and work only as settings in which to conduct health promotion activities—the thrust of the RWJF commission—but inequalities in educational achievement have a determining influence on health inequalities, as do physical and psychosocial hazards at work, and unemployment and job insecurity.
3. “Fair Society” was more explicit about addressing the social gradient in health, difficult as this is. “Fair Society” discussed proportionate universalism: in favor of universal programs, a National Health Service for example, and pointing to the need to make special efforts aimed at those in greater need.

Are the Differences Simply a Matter of Taste?

We recognize the necessity for political judgments. As stated above, the evidence from the text and background papers suggests that the RWJF commission had a similar conceptual approach to both the CSDH and Strategic Review of Health Inequalities in England. The differences arise in the recommendations, and the orange boxes. The RWJF commission gives ample evidence for a “health promotion” approach to changing individual behaviors—very encouraging. What they do not do is take up the challenge raised by the RWJF commissioners’ reference to economic opportunity in the opening statement. The level of social and economic inequality in the U.S. is not an epiphenomenon. It is central to the issue of providing people with opportunities to get out of poverty and to reducing inequalities in life chances and hence health.

Figure 2 shows a measure of lack of social mobility—the similarity of the income of adult offspring to that of their parents.^{12,13}

The high correlation between parents' income and that of the next generation means that social mobility in the U.S. and UK is less than in most other advanced countries. John Hills, chair of the UK's National Equality Panel, makes the point that

social mobility is related to income inequality: The wider the gap between rungs of the ladder, the more difficult it is to climb the ladder.¹²

A Report on the Robert Wood Johnson Foundation Report

It is important to emphasize what we said at the beginning. The clear statement by RWJF commissioners that health in America will be improved when action is taken outside the healthcare system is of vital importance. If heeded, it has the potential to make a major difference in the way that social and health policies are conducted. Presumably, the RWJF commission made the judgment that its voice was more likely to be heeded, and its sensible recommendations acted on, if less was said about the gross inequalities in society that have a major effect on the differences in choices that people make. And even more chance of being acted on if the RWJF commission remained silent on reducing these inequalities in society.

With “Fair Society,” we, the commissioners and the review team, were concerned about political acceptability, too. But we made the judgment that there was no point in being acceptable if some of the key areas were left out of our recommendations. That said, we took steps to make acceptance more likely. Rather than simply wait to see what a new government would make of our recommendations, the review team has been working with partners in localities and regions within England. There has been enthusiastic uptake of the review's recommendations.

Some commentators would have had both the CSDH and “Fair Society” be more overtly political and address who in the messy world of politics is responsible for our

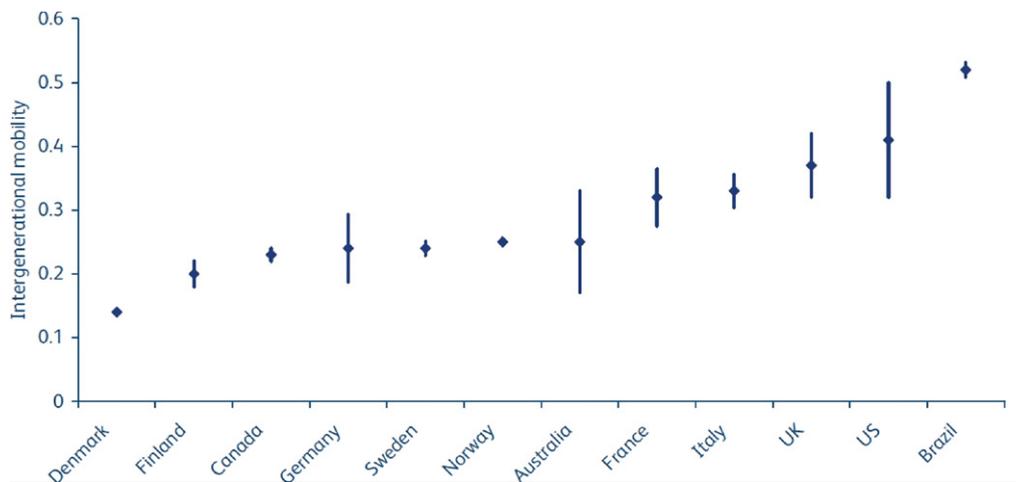


Figure 2. International comparisons of income mobility^{12,13}

Note: Each vertical line shows the 95% CI for the corresponding estimate.

social and economic arrangements. Even if this would have been the right thing to do, which is debatable, it was beyond our competence.

Should the RWJF commission have built on its excellent analysis and gone further in addressing what we call the structural drivers of the conditions of daily life? This has echoes of the discussion on reform of health care in the U.S. We hear comment that the agreed-on health reform plan is truly transformational in that it exists at all. The fact that it did not deal properly with cost containment is not to condemn it, but to hail it as an important first step in a process. Cost containment must come in the future.

We would take the same approach with the RWJF commission report. It has taken a potentially transformational first step. It is now of great importance to move to the further steps that are needed, along the lines laid out above, and that are consistent with its analysis. The good health of all Americans, the stated goal, requires it.

No financial disclosures were reported by the authors of this paper.

Publication of this article was supported by the Robert Wood Johnson Foundation and the Department of Health Policy, George Washington University School of Public Health and Health Services, as part of a supplement to the *American Journal of Preventive Medicine* (*Am J Prev Med* 2011;40[1S1]).

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