guidelines regarding research ethics are lacking and in need of establishment.

SEE ALSO *Autonomy; Health and Disease; Informed Consent; Paternalism; Privacy and Confidentiality in Research*

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VIII. SOCIAL AND SOCIETAL DETERMINANTS OF HEALTH

The social determinants of health (SDH) are "the conditions in which people are born, grow, live, work, and age" (CSDH 2008, 1) and include the household context; neighborhood environment; (un)employment conditions and protections; regional, national, and global economic forces; and all levels of politics and policies, including those related to health care. These conditions, if favorable, engender good health; conversely, poor conditions of daily life are at the root of most instances of severe illness and premature death (CSDH 2005) and contribute to inequitable patterns of health and disease (Friel and Marmot 2011) within and across societies. SDH reflect people's relative social and economic positions: people of upper social classes are better protected from the adverse working and living conditions that negatively affect the health of those of lower social classes.

SDH are manifested across a range of living and working conditions and include neighborhood conditions (e.g., housing stock, transportation and leisure/exercise options, air and environmental quality, public safety, and access to nutritious food); the employment situation, including living wages and workplace protections; socioeconomic conditions, such as land tenure, income (re)distribution, poverty, class, and racial, gender, and religious stratification; social policies, including accessibility and affordability of education and quality health care; and political conditions in terms of voting and democratic participation, human rights, violence, and discrimination. Strictly interpreted, SDH include only those factors concerning interpersonal and community interactions, that is, the "social characteristics within which living takes place" (Irwin and Scali 2005, 23).

SOCIAL VERSUS SOCIETAL DETERMINANTS OF HEALTH

SDH are themselves shaped by the larger political-economic order, which in turn influences the distribution of resources, money, and power within and across countries (CSDH 2008). These factors are known as the *societal* determinants of health—the underlying structures and forces that deeply affect living and working conditions as well as the health inequities that stem from power inequalities between elite and oppressed groups. Societal determinants take into account a broader spectrum of influences at the structural level than do social determinants, and include militarism, imperialism, industrial and corporate power, neoliberal globalization, and international financial and trade regimes and institutions (Birn, Pillay, and Holtz 2009). As such, "If the social determinants of health are the 'causes of the causes,' the societal determinants of health are the 'causes of the causes of the causes' of health and disease" (Birn 2011, 38).

Both social and societal determinants of health operate at multiple levels. Although their effects are acutely experienced in households and communities, their underlying sources are typically national and global. People's experiences of "living conditions, psychosocial circumstances, behavioural and/or biological factors, and

the health system itself" (WHO 2011a, 2) are thus contextualized by government regulations, international trade agreements, and global economic systems.

How these determinants play out may be illustrated in an example of access to water at the household and community level in a low-income country. Consider a young child who falls ill from diarrheal disease, traced to the contaminated water used to cook her/his daily porridge. With no running water in the home, the child's siblings regularly miss school to walk over 5 miles to fetch water at a community well, for which they must pay a small fee. The government has only vague regulations about water quality and scarcely monitors or enforces these standards. Perhaps, as in many settings, a multinational corporation has privatized water and sanitation services in this country, a process enabled by global neoliberal economic forces that prioritize corporate profit making at the expense of environmental protection and human need. The effects of societal factors at global and national levels are thus intensely felt in communities and households and play out in both immediate (child sickness) and long-term health (as linked to education, safety, sanitation, disposable income) in a variety of ways.

HISTORY OF SOCIAL DETERMINANTS OF HEALTH

Almost two centuries ago, public health experts and social scientists began to conduct and disseminate research on the social conditions and structures that generate health inequities, demonstrating how health and disease are socially produced, not related to cosmology, sinful behavior, or topography as previously believed.

Nineteenth Century. In the first half of the nineteenth century, French military surgeon–turned–researcher Louis-René Villermé (1782–1863), English social reformer Edwin Chadwick (1800–1890), and German political philosopher Friedrich Engels (1820–1895) each recognized that health was a function of a variety of societal factors, resulting in markedly worse health for the poor compared to the rich. Although these analysts shared similar observations about the *existence* of class-based differences in mortality and the strong associations between ill health and poverty, they diverged on *how these inequalities should be addressed*. Villermé supported laissez-faire capitalist approaches, Chadwick called for state-led environmental cleanup, and Engels advocated redistribution of power through revolutionary means.

In 1848, the year Karl Marx and Engels penned *The Communist Manifesto* and political uprisings surged across Europe and beyond, physician Rudolf Virchow (1821–1902), the father of cellular pathology, argued that a typhus epidemic plaguing Upper Silesia could only be resolved through greater democracy, not medical measures alone. In doing so, he effectively "pioneered the integration of the societal (structural, political, and medical) determinants of health perspective with the special role to be played by physicians in decrying the conditions of poverty and deprivation that lead to disease" (Birn 2009, 171). This became known as social medicine, a field that predates and complements SDH by integrating political and structural understandings of health with medical approaches.

Into the Twentieth Century. Social medicine efforts were subsequently adopted, and at times suppressed, in a variety of settings across Europe and the Americas, including at the League of Nations Health Organisation. Perhaps most notably, in twentieth-century Chile, Salvador Allende (1908–1973), as minister of health in 1939 and then as president from 1970 to 1973, extended Virchow's analysis to include the political contexts of imperialism and underdevelopment as key determinants of health, contending that ending inequitable patterns of health and disease in Chile could only be achieved through redistribution of land and wealth. Latin American social medicine became a vibrant sphere of activity, favorably so in times of growing government involvement in improving nutrition, sanitation, housing, and social protections (and most dramatically in physician-revolutionary Ernesto "Che" Guevara's role in the Cuban Revolution), but also jeopardizing the careers and lives of its proponents during periods of repression (Waitzkin et al. 2001).

This movement helped spawn Brazil's collective health association (ABRASCO, founded in 1979) and the Latin American Social Medicine Association (ALAMES, founded in 1984), whose members have been active in both the intellectual and political realms. As early as the 1970s, Ecuadorian epidemiologist Jaime Breilh pioneered the idea of social *determination* of health, which understands the shaping of health not as the result of discrete factors, such as the distribution of and access to resources, but as a function of societal power formation and the related processes that produce and reproduce health and disease (Breilh 2003; González Guzmán 2009).

In Europe, meanwhile, social medicine and social epidemiology developed, sometimes haltingly, alongside the growth of the welfare state. Before and after World War II, a range of medical sociologists, epidemiologists, and physician activists—including René Sand of Belgium; Jacques Parisot of France; J. Alfred Ryle, Richard Titmuss, and Jerry Morris of Great Britain; Gustavo Pittaluga of Spain; Nikolai Semashko of the Soviet Union; and various others—studied systematically and/or addressed through policy the relationship of social factors to disease.

In the United States, social medicine advocates and approaches (including research on the severe impact of economic deprivation and poor working conditions carried out during the early twentieth century and through the Great Depression by US Public Health Service statistician-epidemiologist Edgar Sydenstricker) were politically quashed during various "Red scares" and especially during the Cold War (Krieger and Fee 1996). Instead, epidemiology became dominated by risk-factor approaches, which focused on narrowly defined individual biological and behavioral characteristics rather than addressing the social and political contexts of health. The postwar period marked the ascendance in the United States and beyond of biomedicine, whose primacy quickly overshadowed sociomedical approaches in the context of the Cold War.

Towards the Twenty-First Century. From the 1960s through the 1980s, British social medicine advocate, physician, and demographer Thomas McKeown pointedly and controversially challenged the medical establishment's hubris through his historical findings that vast improvements in life expectancy in England and Wales since the late eighteenth century resulted largely from better living conditions due to social and economic development, predating the germ theory and widespread application of immunizations and other medical measures (Colgrove 2002).

The elaboration of the McKeown thesis was contemporaneous with a variety of renewed approaches to the social factors shaping health. On one hand, Canada's Lalonde Report (Lalonde 1974) pointed to the limits of medical care even when publicly funded and universally available, as it was in Canada by the early 1970s, emphasizing the importance of "lifestyle" and personal responsibility. On the other hand, in 1980 the United Kingdom's Black Report (Townsend and Black 1992), which had been commissioned by a prior administration to gauge the impact of the country's National Health Service and was almost buried, lambasted the government for failing to redress persistent mortality and morbidity differentials by social class (Smith, Bartley, and Blane 1990). In the United States, meanwhile, social medicine slowly reemerged, notably at New York's Montefiore Medical Center (*Social Medicine* 2006).

At a global level, WHO's seminal 1978 Alma-Ata International Conference on Primary Health Care called for a reorientation of international health from biomedically based disease campaigns to approaches grounded in social and political understandings. Guided by a strategy called Health for All by the Year 2000, WHO emphasized that health should be viewed not simply as a means of attaining economic development but as an objective of development itself. In recognition of the sociopolitical underpinnings of health, WHO's director-general called for intersectoral efforts, arguing that "action undertaken outside the health sector can have health effects much greater than those obtained within it" (Mahler 1981, 8).

WHO'S COMMISSION ON SOCIAL DETERMINANTS OF HEALTH

The long history of understanding, investigating, and promulgating social and political approaches to health came to center stage in 2005 with WHO's independent Commission on Social Determinants of Health (CSDH). Urged by advocacy groups responding to WHO's reductionist 2000–2002 Commission on Macroeconomics and Health—which viewed health instrumentally as a means to achieve economic growth and wealth, not as health for its own sake—WHO convened the CSDH "because of concern with global health inequity" (Marmot and Bell 2009, 1169). The CSDH was established to review the evidence on SDH, analyze their implementation, and show concretely how global health inequity could be addressed through SDH (Marmot 2005).

In 2008 the CSDH issued a "groundbreaking" (Whitehead and Popay 2010, 1236) report entitled *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, which roundly declared on its back cover: "Social injustice is killing people on a grand scale" (CSDH 2008). The report calls on governments, civil society, and multilateral institutions, including WHO, to actively address the social determinants of health in order to strive for greater equity in health, through three over-arching recommendations: "1. Improve daily living conditions; 2. Tackle the inequitable distribution of power, money, and resources; 3. Measure and understand the problem and assess the impact of action" (CSDH 2008, 2).

Like the 1978 Declaration of Alma-Ata, which cited the "gross inequality" in health as "politically, socially and economically unacceptable" (WHO 1978, 1) and called for both a primary health care approach and a new international economic order, the CSDH report has garnered considerable attention among public health scholars, activists, policy makers, and development experts (Whitehead and Popay 2010; Friel and Marmot 2011). Many value the CSDH report for providing an accurate (if overly generalized and abstract) overview of current conditions in global health and for emphasizing the need to incorporate SDH into policy across the political spectrum (Whitehead and Popay 2010). Its "radical" agenda has also not gone unnoticed: "The Commission may not have had the remit to design a new international economic order—but they have presented an overwhelming case for the need for it, and an invaluable starting point for developing it" (Woodward 2008).

Critics, however, maintain that the commission, in failing to provide specific recommendations to address the power and resource inequities that affect health, did not go far enough (Birn 2009; Escudero 2009; Katz 2009). Others lament its narrow focus on community-level action and monitoring systems, which downplays and leaves vague national-level responsibilities concerning coordination and leadership (Whitehead and Popay 2010).

Public health experts and social scientists also decry the CSDH's "profoundly apolitical" (Navarro 2009, 15) perspective. A discussion of power—which is arguably central to any analysis of SDH—is sidestepped in the report, and the focus remains on symptoms (inequalities) rather than their causes (unequal power) (González Guzmán 2009). Regarding the report's suggestion that "social inequalities kill," political economist Vicente Navarro contends, "It is not *inequalities* that kill, but *those who benefit from the inequalities* that kill. [The commission] does emphasize, in generic terms, the need to redistribute resources, but it is silent on the topic of whose resources, and how and through what instruments" (2009, 15).

MODELS FOR UNDERSTANDING HEALTH, DISEASE, AND EQUITY

Contemporary social epidemiology-based explanations for disease distribution fall within three (not mutually exclusive) categories: "(1) psychosocial approaches; (2) social production of disease/political economy of health; and (3) ecosocial theory and related multi-level frameworks" (Solar and Irwin 2010, 15). Each approach challenges and greatly enriches both the biomedical and mechanistic approaches that predominated in the post–World War II era and the subsequent "lifestyle" models.

The psychosocial approach posits that higher levels of ill health among those lowest in the social hierarchy result from social-environment stress that increases susceptibility to disease (Cassel 1976). Here it is the *perception* (not the reality) of inferior status or inequality that induces a physiological response, raising blood pressure, depressing the immunological system, and affecting health in a range of ways. More recent iterations of this perspective suggest that at a societal level, income and social status inequalities reduce social cohesion, thereby contributing to poor health (Wilkinson and Pickett 2006).

The political economy of health framework, by contrast, focuses on the macro and structural causes of inequality—and the links between social class and health due to the unequal distribution of power and resources—rather than perceptions of inequality. This model argues that "the structures, institutions, and relations of the capitalist economic system generate and are reflected in social inequalities": health inequity is thus a manifestation of underlying material conditions, and policies must be aimed at this structural level (Birn, Pillay, and Holtz 2009, 349).

Nancy Krieger's (2005) multi-level ecosocial framework integrates biological, historical, and ecological perspectives, arguing that health is the biological embodiment of living conditions, social relations, and the structures of power that play out dynamically over the life course and across generations. This approach "goes beyond the search for particular determinants of health, instead pursuing the mechanisms through which societal conditions and biological processes interact to produce health or ill health" (Krieger 2005; Birn, Pillay, and Holtz 2009, 350). The ecosocial framework examines both "how underlying causal factors generate social inequalities in health and how these conditions lead to different experiences of and reactions to physical, biological, social, and chemical exposures" (Birn, Pillay, and Holtz 2009, 350).

Understanding the profound impact of SDH on health equity is also linked to respecting, fulfilling, and enforcing human rights (Baru and Sivaramakrishnan 2009), which are a government's responsibility in any society (Gruskin and Tarantola 2005). Indeed, "the intersecting health equity and human rights movements can constructively work together to realize the potential of rights-based instruments, such as legal mechanisms, indicators, and accountability frameworks, in addressing the social determinants of health" (Rasanathan, Norenhag, and Valentine 2010, 55).

POLICY IMPLICATIONS OF SDH

According to the CSDH, a variety of economic, political, and social measures must be integrated at all levels of policy making as a means of influencing the social determinants of health and reducing/redressing global health inequalities and inequities. These include policies focusing on "education, health, taxation, labor, social welfare, human rights and environmental policies and regulations" (Birn 2011, 42). However, most countries have done little more than rhetorically reference the need to incorporate SDH in national health agendas (see, for example, Canada's weak performance in this regard [Bryant et al. 2011]). Decisive national action on SDH in much of the world has thus far remained limited to ratifying the 2011 Rio Political Declaration on Social Determinants of Health (WHO 2011b). Two notable exceptions—Brazil and Finland—have taken bona fide action toward national policy making based on SDH.

Brazil's Ministry of Health hosts a National Commission on Social Determinants of Health (2012), which works along various lines of action. These include:

- promoting knowledge production about SDH and their relation to health;
- developing and implementing pro-poor policies and programs at national and subnational levels, such as the Bolsa Família (Family Grant) antipoverty social welfare program extending conditional cash transfers to impoverished families, and Fome Zero (Zero Hunger), an integrated, cross-sectoral program supported by civil society to address poverty and food insecurity;
- partnering with and mobilizing civil society organizations;
- communicating the commission's activities and project results through multiple media; and
- hosting the 2011 World Conference on Social Determinants of Health and supporting the WHO's SDH efforts through other international activities.

While Brazil's social policies have helped remove tens of millions of people from conditions of extreme poverty, a surge of popular mobilization in 2013 is pushing the government to tackle persistent inequality at its roots.

For its part, Finland's exemplary adoption of an intersectoral approach to health over the last four decades has created governance structures that facilitate collaboration across ministries, departments, and sectors, which in turn enables actions that integrate health objectives into governance and policies at all stages (McQueen et al. 2012). In collaboration with WHO, Finland transitioned from a 1970s focus on key health behaviors (e.g., smoking, accidents, nutrition) to becoming a prime promoter of the European Union Constitution's requirement to "protect health in all policies" (Melkas 2013, 3). Finland's Health in All Policies (HiAP) approach, initially implemented in the context of a 1990s recession (in contrast to narrowly targeted austerity policies promulgated by many governments in the wake of the 2008 financial crisis), has involved the systematization and institutionalization of accountability frameworks, such as through the enactment of the Finnish Public Health Act in 2010, specifically obliging municipalities to promote health intersectorally; the creation of interministerial committees, including the Advisory Board for Public Health; and the formation of a merged Ministry of Social Affairs and Health (Leppo et al. 2013). Finland's HiAP approach has generated enviable population health improvements and has made it one of the world's healthiest societies, with among the world's lowest infant and maternal mortality rates, even as it carries on its struggle against health inequalities.

CONCLUSION

Although researchers continue to learn more about the processes through which SDH affect specific health outcomes, there is already overwhelming evidence of the effectiveness of addressing SDH to improve health equity. Yet a key obstacle remains—"lack of political will" (Braveman 2011, 392), or, more pointedly, as Virchow put it, lack of real democracy. Fundamentally individualistic societies such as the United States find it challenging to act in a way that requires "a sense of social solidarity" (392).

Tackling SDH may indeed be the "global health ethics imperative of our times" (Birn 2011, 50). To truly "close the gap in a generation," as WHO aspires to, the "apolitical and ahistorical discourse" (Katz 2009, 571) of WHO's CSDH report must be challenged and the CSDH recommendations translated into concrete, politically grounded processes and actions based on analysis of "society as a whole" (González Guzmán 2009). In most settings this responsibility, for the moment, falls on the shoulders of civil society (Woodward 2008). Starfield and Birn (2007, 140) call for "increased social and political participation in decision-making concerning the availability of universal service programs that make a difference to the lives of all people" in order to effectively influence policies that perpetuate underlying causes of health inequities. ALAMES, the People's Health Movement, and a range of other public-interest civil society movements and organizations (2011) propose collective mobilization to reclaim the idea that health is socially determined, which—if adequately heeded—has transformative potential. Confronting global inequities in health through SDH is most profoundly "a matter of social justice" (Baru and Sivaramakrishnan 2009, 33).

SEE ALSO *Bioethics: VIII. Sociology of; Global Health Inequalities and Inequities; Health and Disease: II. Sociological Perspectives; Public Policy and Bioethics; Science, Technology, and Society Studies*

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IX. LIFESTYLES

The people of every nation would be healthier if they adopted healthier lifestyles. Ninety percent of those who die of lung cancer would not have contracted the disease if they had not smoked. Exercise, sensible diet, and compliance with treatment for high blood pressure can and do prevent countless episodes of cardiovascular disease. Practicing safe sex reduces the risk of contracting AIDS. Use of seat belts and motorcycle helmets lowers the chance of injury from accidents on the road.

The prospect of improving health and reducing illness through changes in living habits rather than through curative health care is attractive on a number of grounds. Since it is preventive, it avoids the distress of disease; side effects and iatrogenic consequences may be fewer; cost may be lower; and the healthier ways of living may be rewarding in their own right. For these reasons any government that failed to promote healthy lifestyles could be faulted on ethical grounds.

Nevertheless the encouragement of healthier lifestyles has drawn moral criticism in the literatures of bioethics and health policy. The chief concern is that governmental (and even private) attempts to bring about changes in living habits will encroach on personal liberty or privacy. A second complaint is that lifestyle-change programs carried out in the name of health may actually have different and less justifiable aims, such as enforcing conventional social norms or deflecting attention from social injustices by "blaming the victim." Both of these concerns should be given serious attention in respect to some efforts to foster healthier lifestyles. Nevertheless efforts to improve health by encouraging healthy behavior may have justifications that are consistent with these concerns.

A third criticism is that the nostrum "if everyone adopted healthy lifestyles" can be just that, a pious nostrum. A crucial element of a healthy lifestyle is available health care, yet millions in the United States, even after the implementation of the Patient Protection and Affordable Care Act of 2010 (ACA or "Obamacare"), will still lack health insurance. Also millions of American citizens still live in poverty or economic inequality that leads to higher levels of poor health and early death.

The idea of "healthy lifestyles" must stand alongside the paradox of public health: no matter what we wish for in improving individual lifestyles, we must also consider social conditions that still condemn millions of Americans to early death or serious illness and injury and for which a healthy lifestyle is simply a mocking dream. The health of each of us is influenced by the health of all of us together.

HEALTH VERSUS LIBERTY

Nearly everything we do affects health in some way if only because the time spent could be devoted to exercise or other health-enhancing behavior. The notion of unhealthy lifestyles, however, is typically associated with a small number of habits. Smoking, the leading killer in the United States, always takes first place, closely followed by alcohol and other drug abuse, lack of exercise, and being overweight. Other risk factors affected by individual choice veer toward the medical, including behavioral change intended to control serum cholesterol and hypertension, perhaps including compliance with doctors' orders. Construed still more broadly, a "healthy lifestyle" would include living in a region not plagued by pollution or recurring natural disasters; avoidance of unsafe jobs; and purchasing the safest cars and appliances.

Public health programs that aim to change unhealthy behavior often employ relatively uncontroversial strategies, such as education and exhortation. People are free to ignore these messages if they prefer, and their impacts on personal liberty may be minimal. Moral controversy increases when more intrusive and freedom-limiting measures are considered, such as penalties, taxes, restrictions, or prohibitions. Britain's Nuffield Council on Bioethics (2007) offers a "ladder of intervention" linking the increasing burden of justification to the degree of intrusion or coercion involved:

- eliminate choice
- restrict choice
- guide choice by disincentives