Social Determinants of Health:

Current Theories (an overview)
The persistence of health inequalities in modern welfare states: The explanation of a paradox

Johan P. Mackenbach
Department of Public Health, Erasmus MC, P.O. Box 2040, 3000 CA Rotterdam, Netherlands

ARTICLE INFO

Article history:
Available online 20 March 2012

Keywords:
Health inequalities
Welfare state
Welfare policies
Trends
Europe

ABSTRACT

The persistence of socioeconomic inequalities in health, even in the highly developed ‘welfare states’ of Western Europe, is one of the great disappointments of public health. Health inequalities have not only persisted even though welfare states were being built up, but on some measures have even widened, and are not smaller in European countries with more generous welfare arrangements. This paper attempts to identify potential explanations for this paradox, by reviewing nine modern ‘theories’ of the explanation of health inequalities. The theories reviewed are: mathematical artifact, fundamental causes, life course perspective, social selection, personal characteristics, neo-materialism, psychosocial factors, diffusion of innovations, and cultural capital.

Based on these theories it is hypothesized that three circumstances may help to explain the persistence of health inequalities despite attenuation of inequalities in material conditions by the welfare state: (1) inequalities in access to material and immaterial resources have not been eliminated by the welfare state, and are still substantial; (2) due to greater intergenerational mobility, the composition of lower socioeconomic groups has become more homogeneous with regard to personal characteristics associated with ill-health; and (3) due to a change in epidemiological regime, in which consumption behavior became the most important determinant of ill-health, the marginal benefits of the immaterial resources to which a higher social position gives access have increased.

Further research is necessary to test these hypotheses. If they are correct, the persistence of health inequalities in modern European welfare states can partly be seen as a failure of these welfare states to implement more radical redistribution measures, and partly as a form of ‘bad luck’ related to concurrent developments that have changed the composition of socioeconomic groups and made health inequalities more sensitive to immaterial factors. It is argued that normative evaluations of health inequalities should
Theories for social epidemiology in the 21st century: an ecosocial perspective

Nancy Krieger

Keywords: Ecology, epidemiology, gender, inequality, political science, psychosocial, race/ethnicity, racism, social class, social determinants of health, social science, socioeconomic, theory

Both thinking and facts are changeable, if only because changes in thinking manifest themselves in changed facts. Conversely, fundamentally new facts can be discovered only through new thinking. Ludwig Fleck (1935) *Genesis and Development of a Scientific Fact*.1,pp.50-51

Once we recognize the state of the art is a social product, we are freer to look critically at the agenda of our science, its conceptual framework, and accepted methodologies, and to make conscious research choices. Richard Lewins and Richard Lewontin (1987) *The Dialectical Biologist*.2,p.286

Theory

In social epidemiology, to speak of theory is simultaneously to speak of society and biology. It is, I will argue, to speak of embodiment. At issue is how we literally incorporate, biologically, the world around us, a world in which we simultaneously are of deprivation and privilege. Comments to this effect can be found in the Hippocratic corpus4 and in early texts of ancient Chinese medicine.5 Shared observations of disparities in health, however, do not necessarily translate to common understandings of cause; it is for this reason theory is key. Consider only centuries of debate in the US over the poor health of black Americans. In the 1830s and 1840s, contrary schools of thought ask: is it because blacks are intrinsically inferior to whites—the majority view, or because they are enslaved—as argued by Dr James McCune Smith (1811-1865) and Dr James S Rock (1825-1866), two of the country's first credentialed African American physicians.6 In contemporary parlance, the questions become: do the causes lie in bad genes?, bad behaviours?, or accumulations of bad living and working conditions born of egregious social policies, past and present?7,8 The fundamental tension, then and now, is between theories that seek causes of social inequalities in health in innate versus imposed, or individual versus social, characteristics.
Complex problems require complex solutions: the utility of social quality theory for addressing the Social Determinants of Health

Paul R Ward¹, Samantha B Meyer¹, Fiona Verity², Tiffany K Gill³ and Tini CN Luong¹

Abstract

Background: In order to improve the health of the most vulnerable groups in society, the WHO Commission on Social Determinants of Health (CSDH) called for multi-sectoral action which is often difficult to achieve.
Identity-Based Motivation: Implications for Health and Health Disparities

Daphna Oyserman*
University of Southern California

George C. Smith and Kristen Elmore
University of Michigan

People aspire to be healthy but often fall short of this goal. Poor health is associated with macro-level factors—social stratification and low socioeconomic position, including low education, low income, and low status racial-ethnic group membership. These social determinants differentially expose people to health-promoting (or undermining) contexts and to having (not having) choice and control over their lives. But social determinants cannot cause individual action directly. Identity-based motivation theory addresses this gap, articulating how social determinants operate at the micro-level to influence whether or not a behavior or choice feels congruent with important identities and how such identity-congruence, in turn, influences which strategies are chosen and how difficulty is interpreted. Lack of choice and control make an interpretation of difficulty as meaning that effort is pointless and “not for people like me” (rather than important) more likely, reducing belief that one’s action and effort matter.

Americans aspire to be healthy and want to model healthy behavior for their
GLOSSARY

A guide and glossary on postpositivist theory building for population health

Richard M Carpiano, Dorothy M Daley

This guide and glossary focuses on the role of theory and conceptual models within population health research. Upon discussing the critical need for theory in conducting interdisciplinary research, it provides strategies for crafting theories that can be empirically tested and a glossary of theory building terms that are useful for guiding research. In addition to general concepts, the glossary includes some terminology commonly found in the social sciences, whose well-established traditions and practices of formal theory building may be particularly informative for epidemiologists and other population health researchers who have minimal formal social science training, but study social factors in their research.

Theory is the cornerstone of scientific endeavours. It is the lens through which we conceptualise a research question, propose hypotheses, design a study to test them, discuss the findings, and propose next steps for empirical inquiry. Yet, ironically, it can be one of the more under-appreciated aspects of research; it is very easy for anyone, from a first year graduate student to a senior researcher, to find a wealth understand population health determinants and tackle health inequalities. We draw on principles and ideas from a variety of disciplines including epidemiology, sociology, political science, environmental studies, public policy, and public health to present an overview of what constitutes a theory, basic criteria necessary for constructing (and evaluating) a theory, the role of conceptual models within population health research, and a glossary of terms relevant to theory building for guiding research. In keeping with the intended aim of the JECH glossary series, we provide a broad range of concepts that junior researchers, practitioners, and even senior scholars will find useful for designing research and instructing students.

THE EVER PRESENT NEED FOR THEORY IN STUDYING POPULATION HEALTH

While more research is needed that focuses on the multiple determinants of population health, a solid theoretical basis should underpin this research. Indeed, the theoretical foundations, or lack thereof, in population health research is the subject of a vibrant and ongoing debate. While this manuscript does not speak directly to that debate, it is motivated by the recognition that much research in population health lacks a robust theoretical base. In an era where interdisciplinary research is encouraged and embraced, where
Health Lifestyle Theory and the Convergence of Agency and Structure

William C. Cockerham

1William C. Cockerham is professor of sociology, medicine, and public health and co-director of the Center for Social Medicine at the University of Alabama at Birmingham. He is the 2004 recipient of the university's Ireland Prize for Scholarly Distinction.

William C. Cockerham, Department of Sociology, University of Alabama at Birmingham, 237 Ullman Building, 1530 Third Avenue South, Birmingham, AL 35294-3350 (email: wcocker@uab.edu).

Abstract

This article utilizes the agency-structure debate as a framework for constructing a health lifestyle theory. No such theory currently exists, yet the need for one is underscored by the fact that many daily lifestyle practices involve considerations of health outcomes. An individualist paradigm has influenced concepts of health lifestyles in several disciplines, but this approach neglects the structural dimensions of such lifestyles and has limited applicability to the empirical world. The direction of this article is to present a theory of health lifestyles that includes considerations of both agency and structure, with an emphasis upon restoring structure to its appropriate position. The article begins by defining agency and structure, followed by presentation of a health lifestyle model and the theoretical and empirical studies that
Critical Public Health

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/ccph20

Intersectionality and the determinants of health: a Canadian perspective

Olena Hankivsky a & Ashlee Christoffersen b

a Public Policy Program and Institute for Critical Studies in Gender and Health, Simon Fraser University, Vancouver, Canada
b Institute for Critical Studies in Gender and Health, Simon Fraser University, Vancouver, Canada

Available online: 30 Sep 2008

To cite this article: Olena Hankivsky & Ashlee Christoffersen (2008): Intersectionality and the determinants of health: a Canadian perspective, Critical Public Health, 18:3, 271-283

To link to this article: http://dx.doi.org/10.1080/09581590802294296

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.tandfonline.com/page/terms-and-conditions
Outline

1- What is a theory? (5 min.)
2- Social Determinants of Health (SDH) (5 min.)
3- SDH Theories (40 min.)
4- Conclusion (2 min.)
Theory

A lens through which we conceptualize a research question, propose hypotheses, design a study to test them, discuss the findings, and propose next steps.

For interdisciplinary thinking, *theory is a necessity*!
Theory maybe defined as logically related propositions that aim to explain and predict a fairly general set of phenomena.

Theories allow for a systematization of knowledge, explanation, and prediction as well as generating new research hypotheses.
SDH

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.
Theories.....
<table>
<thead>
<tr>
<th>Theory</th>
<th>Authors &amp; Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mathematical artefact theory</td>
<td>Scalan, 2001; Vagero &amp; Erikson, 1997</td>
</tr>
<tr>
<td>Fundamental cause theory</td>
<td>Link &amp; Phelan, 1995</td>
</tr>
<tr>
<td>Life course theory</td>
<td>Wadsworth, 1997; Bambra et al, 2010</td>
</tr>
<tr>
<td>Personal characteristics theory</td>
<td>Batty et al, 2006; Mackenbach 2010</td>
</tr>
<tr>
<td>Materialist theory</td>
<td>Lynch et al, 2000; Davey Smith, 1994</td>
</tr>
<tr>
<td>Psychosocial theory</td>
<td>Marmot, 2004; Wilkinson, 2005</td>
</tr>
<tr>
<td>Diffusion of innovations theory</td>
<td>Rogers, 1962; Victoria, 2000</td>
</tr>
<tr>
<td>Cultural capital theory</td>
<td>Bourdieu, 1984; Abel, 2008</td>
</tr>
<tr>
<td>Identity-Based Motivation Theory</td>
<td>Oyserman et al, 2014</td>
</tr>
<tr>
<td>Health lifestyle theory</td>
<td>Cockerham, 2005</td>
</tr>
<tr>
<td>Eco-social theory</td>
<td>Krieger, 2001</td>
</tr>
<tr>
<td>Environmental affordances</td>
<td>Mezuk et al, 2013</td>
</tr>
</tbody>
</table>
Mathematical artifact theory

Increasing relative inequalities in health outcomes are inevitable when the over-all level of the outcome falls.

There is indeed an association between the average of frequency of health problems in a population and the level of the relative risk for socioeconomic status.

Relative risks for mortality and morbidity tend to be higher when average mortality and morbidity are lower.
Fundamental cause theory

It stipulates that it is social forces underlying social stratification that ultimately causes health inequalities, and not exposure to proximal factors (like smoking, psychosocial stress, working conditions etc.) which are usually studies by researchers.

It is a person’s socioeconomic status that provides them with “flexible resources” (knowledge, money, power, prestige, and beneficial social connections) that can be used to avoid disease risks or to minimize the consequences of disease regardless of prevailing circumstances (disease and risks).

The SES & health association is reproduced over time via the replacement of intervening mechanisms.
Life course theory ...

It is based on the observation that health at adult ages is partly determined by experiences in early life, both biological and social.

Biological programming of the fetus has been hypothesized to increase vulnerability to chronic disease and unfavorable social and health conditions in childhood may be the starting-points of pathways leading into both health and social disadvantage in adulthood.

Health inequalities may therefore lie in inequalities experienced in the womb and during childhood and adolescence.
Social selection...

It suggests that health inequalities result from health-related selection during social mobility. Health problems may lead to downward social mobility (direct health selection), and upward mobility is more likely for those with personal characteristics conductive to good health (indirect health selection).

Direct health selection = reverse causality
Indirect health selection = confounder
Personal characteristics

Personal characteristics = cognitive ability and personality features, positive relation with health and health behaviors

Meritocracy = educational and occupational achievement are no longer dependent on family background but on personal talent and effort.

How about socioeconomic inequalities in these characteristics?
(Neo-)materialist theory

It puts that despite increase in average prosperity, there are inequalities in access to material resources (advantages) that are associated with health, health behavior, and health inequalities.

Material resources like income, wealth, assets, etc.

These resources lead to accumulation over the life course of exposures and experiences which affect health.
Psychosocial theory

It holds that unequal distribution of psychosocial stress, lack of social support, and sense of control may lead to unequal distribution of health. People with a better socioeconomic status have a much stronger sense of control over their own lives, and this is linked to healthier behavior, and lower mortality and morbidity.

The perception of material inequality and in particular of one’s own relative deprivation may have a direct effect on a person’s health via psychosocial stress mechanisms.
Diffusion of innovations

It observes that people with a higher socioeconomic status often tend to be early adopters of new (health) behaviors, only later to be followed by those with a lower social position.

Those better-off people tend to come first in terms of improvements. This dynamic leads to large and widening inequalities in health behavior which, in turn, lead to inequalities in health.

“Inverse equity” hypothesis, new interventions, early increase in inequity ratios in healthcare
Cultural capital theory

It explains inequalities in consumption behavior from differences in attitude, knowledge, and competency between SES groups. These differences partly arise from the for “social distinction”: people in higher socioeconomic groups behave differently to show off their social position, but doing this successfully requires a lot of “cultural capital”, taste. Healthy lifestyle (body) is going to be one of those distinctive tastes.
Identity-based motivation (IBM) theory

Social determinants differentially exposure people to health promoting (or demoting) contexts and to having (not having) choice and control over their lives.

But social determinants cannot cause individual actions directly.
Health lifestyle theory (agency + structure)
Eco-social theory (embodiment)

Level of organization, dynamic state, social production of disease

Elements: Embodiment, pathways of embodiment (social arrangements + possibilities and constraints of our biology), multilevel interplay, systems epidemiology
Environmental Affordances (EA)
Intersectionality

Importance of multiple categories (axes) of social identity and inequality, none is important a priori. Intersectionality does not simply add social categories together to understand diverse experiences. Instead, it seeks convergence of those experiences. It strives to understand what is created and experienced at intersection of two or more axes of oppression, on the basis that it is precisely at the intersection that a completely new emergent status is formed.
Do we need more theory?

Nancy Krieger:
Shared observation of disparities in health, however, do not necessarily translate to common understandings of causes, that is why we need theories.