Primary health care and the social determinants of health: essential and complementary approaches for reducing inequities in health

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ABSTRACT

Increasing focus on health inequities has brought renewed attention to two related policy discourses - primary health care and the social determinants of health. Both prioritise health equity and also promote a broad view of health, multisectoral action and the participation of empowered communities. Differences arise in the lens each applies to the health sector, with resultant tensions around their mutual ability to reform health systems and address the social determinants. However, pitting them against each is unproductive. Health services that do not consciously address social determinants exacerbate health inequities. If a revitalised primary health care is to be the key approach to organise society to minimise health inequities, action on social determinants has to be a major constituent strategy. Success in reducing health inequities will require ensuring that the broad focus of primary health care and the social determinants is kept foremost in policy - instead of the common historical experience of efforts being limited to a part of the health sector.

Concern about health inequities - unfair, avoidable and remediable differences between the health status of different groups of people[1] - is not new. A 1973 study by the Executive Board of the WHO decried the 'wide gap (which is not closing) in health status between countries, and between different groups within countries.'[2] The last two decades have seen an explosion in the measurement and documentation of health inequities according to a range of factors including country, gender, ethnicity, socioeconomic status and education. This increase in knowledge has shown that health inequities continue to widen, even as average health status often improves, and has put health inequities at the forefront of the health policy agenda.[3]

Policy attempts to reduce health inequities have brought renewed attention to two related paradigms that prioritise health equity - primary health care (PHC) and the social determinants of health (SDH). There has been a proliferation of recent efforts from many actors, including countries, international organisations, academia and civil society to shape health policy around these discourses. The WHO has itself made two comprehensive contributions to these two policy tracks - the Commission on Social Determinants of Health (CSDH)[4] and the World Health Report 2008 on PHC[5] - which influenced resolutions passed at the 2009 World Health Assembly.[6 7] Both of these tracks make mutual and explicit reference to PHC and SDH. However, there is lingering confusion as to how PHC and SDH relate to each other. This essay reviews the 'sisterhood'[8] between PHC and SDH, considering their commonalities and differences, and discusses how they can both coherently contribute to progress in improving health equity.

THE SOCIAL DETERMINANTS OF HEALTH

The CSDH defines SDH as 'the structural determinants and conditions of daily life responsible for a major part of health inequities between and within countries'.[4] That is, 'the distribution of power, income, goods and services, globally and nationally…[and] the visible circumstances of people's lives—their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns and cities—and their chances of leading a flourishing life'. 'Social determinants' is thus used as shorthand for the broad and complex array of social, political, economic, environmental and cultural factors that strongly impact on health status and equity.

The term SDH may be relatively new, but the concept, and the need for health improvement to address factors beyond the health sector, has long been understood. Such understanding can be found in the discipline of social medicine developed in Latin America and Europe through the 20th century, focusing on the social construction of health. Similarly, the work of McKeown and Illich presented strong empirical evidence on the link between non-medical interventions and health improvements in modern societies.[9 10] The 1946 WHO Constitution recognised the need 'to promote, in cooperation with other specialised agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene'.[11]

Indeed, awareness of SDH predates even the 20th century. Among a range of pioneers contributing to health progress in the 19th century by focusing on social, political and environmental factors, the German pathologist Rudolf Virchow famously asserted that 'medicine is a social science, and politics nothing more than medicine on a grand scale'.[12] Even earlier, the ancient Egyptians recognised the unequal impact of occupation and social status on health, as recorded in millennia old papyruses,[13] and indigenous peoples developed holistic views of health, which implicitly understood the impact of SDH.

The reinvigoration of interest in factors beyond medical care that impact on health has seen the rapid development of a new SDH discourse that provides a systematic analysis of the causes of health inequities and identifies entry points for action to resolve them. The 3-year process of the CSDH has provided a clearing-house to collect and synthesise this new knowledge, identifying priorities for action in improving daily living conditions and tackling structural inequities, along with gaps in knowledge for further research. The CSDH proposes a framework to explain health inequities (see figure 1), which is similar to that used by others, adapted from a model originally described by Diderichsen.[15 16] Within this framework, there are four corresponding points of entry for action to reduce health inequities: structural inequities, differential exposure to health threats, differential vulnerabilities and differential consequences of illness.

PRIMARY HEALTH CARE

Primary health care has sparked renewed interest in the last decade after a period of relative neglect, at least in policy circles, in the 1990s. The vision described in the Declaration of Alma Ata in 1978[17] of PHC as a tool to reach 'health for all' (by focusing health systems and other parts of government on health equity, community participation, solidarity and intersectoral action) has found renewed relevance. A diverse range of countries, such as Brazil,[18] Thailand,[19] Chile,[20] Venezuela[21] and New Zealand,[22] have attempted ambitious recent health system reform inspired by PHC. Other countries, including India[23] and China,[24] are embarking on renewed efforts to move towards universal coverage by strengthening the first point of contact with their health systems. Many of these national efforts at renewing PHC have been strongly advocated for and contributed to by civil society, and there has been similar global advocacy to restore PHC to the centre of the global health agenda by groups such as the People's Health Movement.[25]

Responding to this interest from countries and civil society, international organisations such as the WHO have also begun to revisit PHC. In 2005, the regional meeting of the Pan American Health Organization produced the Declaration of Montevideo, endorsed by all countries in the region, reiterating support for PHC as the basis of health systems in all countries.[26] The current Director-General of WHO, Dr Margaret Chan has placed the revitalisation of PHC at the centre of her agenda,[27] with the recent WHO World Health Report presenting a vision of how PHC can address current health challenges through reforms around universal coverage, service delivery, public policy and health governance (see figure 2).[5]

All of these renewed efforts at conceptualising PHC restate the continued relevance of the vision codified at the Alma Ata conference. This vision had its origins in community-based healthcare efforts from around the developing world in the 1950s and 1960s. By the time of Alma Ata, experiences that extended beyond biomedical curative interventions, to identify and address the basic causes of health and well-being, were available from throughout the world and were being promoted by the WHO[28] and civil society actors such as the Christian Medical Commission of the World Council of Churches.

The Alma Ata Declaration was clear that a major driver for PHC was 'the existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries [which was] politically, socially and economically unacceptable'. It was also clear that PHC involved 'in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demand[ed] the coordinated efforts of all those sectors'.

PHC was, therefore, always conceived as an approach that included more than health systems, with the need to address SDH implicit. However, the decision by many global health policymakers to pursue so-called selective primary health care, focusing on a narrow range of biomedical interventions that were seen to offer the most benefit,[29] deliberately ignored this. Further confusion was caused by the equivocal use of PHC as a term to refer to only a part of the health system - the primary level of care (people's first point of contact). The World Health Report 2008 describes the scope of primary health care as including not just the first contact, but, instead, comprehensive, integrated and people-centred care, coordinated through the entire health system. The revitalisation of PHC also aims to renew the broad commitments to health equity and intersectoral action on SDH articulated at Alma Ata, updated to current understandings of health challenges and their causes.

THE RELATIONSHIP BETWEEN SOCIAL DETERMINANTS OF HEALTH AND PRIMARY HEALTH CARE

As shown above, PHC and SDH share much in common (see box 1). Most importantly, they share a central focus on health equity as a core value and focus for policy. This concern for

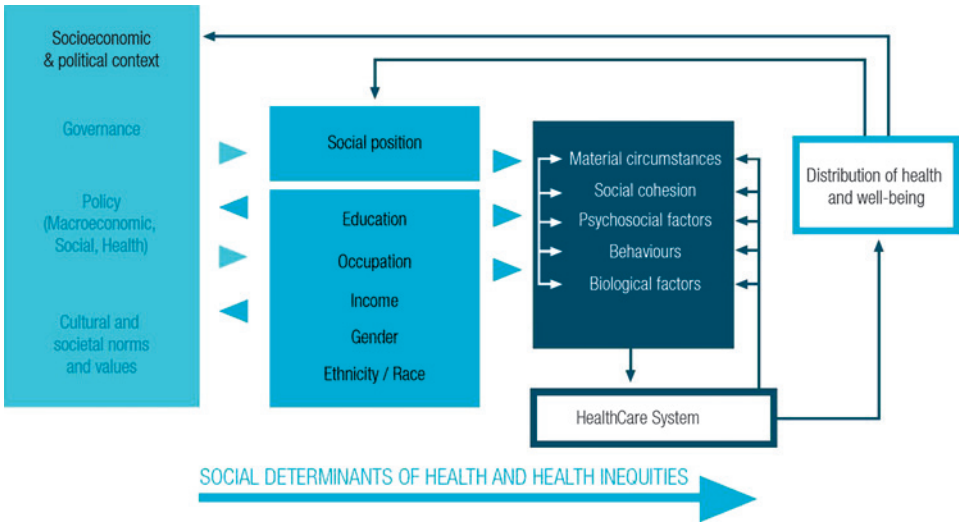

Figure 1 The framework for social determinants of health and health inequities of the Commission on Social Determinants of Health[4] (reproduced by Solar O and Irwin A 2007[14]).

Figure 2 The primary health care reforms necessary to refocus health systems towards Health for All (reproduced by WHO 2008[5]).

health equity is linked to a broad view of health as a human right, more than just the absence of disease, which traces its roots to the 1946 WHO Constitution.[11] As a result, both paradigms place a strong emphasis on health promotion and prevention, and on increasing the ability of people to access the resources (both within and outside the health sector) required to stay healthy and protect themselves from disease and illness.

PHC and SDH share a strong focus on intersectoral action for health. PHC recognises that the health sector is not the only contributor to improving health. The SDH discourse clearly shows how most health inequities are not caused by a lack of access to health services, but by the influence of inequalities in other sectors such as housing, occupation, education or income. Thus, action on the SDH involves the whole of society, but the health sector has a key role in moving towards health equity and championing intersectoral action. Moreover, both PHC and SDH recognise that the organisation of health systems can have a significant impact on health equity. The CSDH recommends that health systems should provide universal coverage and be based on a PHC approach to ensure equity of access and avoid themselves causing impoverishment.

PHC and SDH also both identify disempowerment and alienation of marginalised groups in society as a major obstacle to achieving health equity, and call for processes and responses that address the inequitable distribution of power. PHC emphasises the importance of health services responding to community need and facilitating community participation - in service provision and health policy decision-making. The SDH analysis considers the impact on health of community factors such as the distribution of resources, empowerment, social inclusion and exclusion, relative social status and community resiliency and support.

Box 1 Key commonalities between primary health care and the social determinants of health paradigms

- Central focus on health equity.
- Relevant in all countries and contexts, regardless of income level.
- Health as more than the absence of disease.
- Key role for health sector.
- Promotion of multisectoral action and consideration of health in all policies.
- Emphasise role of empowered communities and the social environment.

Despite the high level of commonality between the PHC and SDH discourses, and significant overlap in their proponents, there is some unease at considering them together.[30] On the one hand, champions of addressing SDH are concerned about the tendency for health policymakers to focus on curative health services at the expense of other influences on health. The experience of selective PHC causes some of those who advocate action on SDH to question whether PHC, despite its broad principles, is robust enough to motivate action beyond the health sector, or even curative medicine. The fear, then, is that if PHC and SDH are considered as one, action on SDH beyond the health sector may be ignored due to health sector attention being consumed by transforming health systems based on the principles of PHC. These doubts are reinforced by the tendency of some PHC advocates to pay lip service to sectors outside of the health system. This latter trend relates to a corresponding concern of some champions of PHC about the health sector having too broad a focus by prioritising SDH. The fear here is that this could weaken the required attention on health systems, especially the first level of care, which is already typically an under-resourced part of the health system.

At the heart of these concerns are the undeniable differences between PHC and addressing SDH. PHC is an approach to organising society, including health systems, with the aim of achieving health equity. However, it is owned by and thus starts with health systems. From there, it then reaches out to consider how the rest of society can support health systems to reduce health inequities through intersectoral action and public policy. By contrast, the SDH paradigm provides an analysis of why health inequities exist, which sees potential entry points for action to reduce health inequities in the whole of society. In this analysis, the health sector is itself a social determinant of health - among many others as the SDH discourse does not privilege health systems for action. So despite their multiple commonalities, PHC and SDH as concepts do have a difference in lens or perspective.

What then are the practical implications of this difference in perspective? Although previous attempts at implementing PHC have often focused on first-level healthcare services, there is widespread acknowledgement that reducing health inequities through a revitalised PHC will not be successful if the Alma Ata principle of acting across and beyond the health sector is again ignored. All factors that impact on health can be seen as the legitimate interest of the PHC approach. In the context of increased global will to address inequities, pitching SDH and PHC against each other is likely to be unproductive. There is the potential to unproductively rehearse the polemic debates between the value of health systems compared to social factors triggered by the aforementioned work of McKeown and Illich. In the same way that further reflection on these debates has shown that health systems and broader factors have both made major contributions to health progress,[31 32] it appears more constructive to consider how PHC and SDH can both be applied to resolve current health challenges and reduce health inequities.[33]

ACTING ON THE SOCIAL DETERMINANTS OF HEALTH TO IMPLEMENT A PRIMARY HEALTH CARE APPROACH

Among the goals of PHC, it is not only health equity that needs a consideration of SDH. All of the broad measures that are

currently being mooted, such as in the World Health Report, to transform systems in a PHC direction, require attention to SDH. This applies not only to the obvious need for public policies aimed at intersectoral action, such as tobacco control, to address SDH, but also to achieving universal coverage, reforming service delivery and reconfiguring health leadership.

As the CSDH notes, the health sector itself is also an important social determinant. Health systems invariably exacerbate health inequities (for example, through the inverse care law, by providing differential treatment for marginalised groups or by impoverishing people through healthcare costs), but this does not have to be the case. Implementing universal coverage requires attention to SDH in guaranteeing fair financing mechanisms (such as prepayment) and social protection for all groups.

Reforming service delivery to address the differential experience of disadvantaged groups through the continuum of care first requires a SDH analysis to detect these inequities in health system utilisation and outcomes. Without disaggregation of data by factors such as ethnicity, social class or geographical area, such inequities remain invisible. A SDH analysis also assists the reform of health services to prioritise the needs and access challenges of marginalised groups, through universal approaches that aim to make the mainstream system fairer complemented by targeted measures aimed at 'hard-to-reach' populations. Transforming health services to improve health equity fundamentally requires addressing the power gap between health systems and the people they serve. The Alma Ata principle of community participation was an attempt to address this, but paying attention to SDH reinforces health systems to respond to people's expectations at all levels based on need and demand rather than supply.

The CSDH's recommendation to tackle the inequitable distribution of power is also implicit in the reconfiguration of health leadership towards PHC. If health leaders are to move towards health equity with any effectiveness, all partners in society need to be mobilised. Governance structures that enable intersectoral action are necessary. More importantly, health leaders need to consider SDH and be informed by the status of health inequities in their jurisdictions to allow those groups who are disadvantaged to claim more power to press their claims for better health. Without such participation, progress is unlikely. Reconfiguring health leadership also involves moving from offering top-down solutions to negotiating between different partners and facilitating participatory democracy by providing a space for civil society action to improve health. For example, the equity improvements seen in the aforementioned examples of Brazil and New Zealand have partly been prompted by increased engagement of, and learning from, civil society movements.

A specific driver for renewed interest in PHC is stalled progress in several priority public health targets, including the health-related Millennium Development Goals (MDGs). Weakness of health systems has been identified as a barrier to health progress, but inattention to SDH has also played a critical role, underlining the interdependence of health system development with improvements in other sectors if inequities are to be addressed. PHC reform and addressing SDH thus promises a means to transcend the vertical/horizontal debate with regard to health systems. Most public health conditions prioritised on the global health agenda share key social determinants of exposure to risk factors, disease vulnerability, access to care and the social consequences of disease. Significant opportunities exist to address these determinants together via a PHC approach. The transformation of health systems to address the complex needs of people, allied to policy reforms that attack the root causes of disease in SDH, provides a realistic means to make comprehensive healthcare services available and achieve priority targets for individual diseases.

CONCLUSION

Health services are necessary but insufficient to achieve health equity. Health systems that do not consciously address SDH exacerbate health inequities, as seen in most current systems. If a revitalised PHC is to be the key approach to organise society to minimise health inequities and respond to people's expectations about their health, action on SDH has be to a major constituent strategy.

Thus, there is little value in arguing which discourse is more important or more useful. A true PHC approach is impossible without addressing SDH in the same way that concern for SDH moves towards PHC in terms of policy. Priority public health targets, such as the health-related MDGs, require both addressing SDH and reforming health systems based on PHC. Recent examples of progress on health inequities show the importance of both health system reform and action on broader social development, keenly informed by health gaps.[34–36]

However, even with political will and community empowerment, the ability to reform health and other systems based on PHC to address SDH is not a given. To do so will require building capacity on the understanding of SDH among those who implement PHC reforms, and among the health workforce. In addition, awareness of SDH must become the core business of other sectors. This will require explicit attention to the ability of societal systems to analyse inequities in terms of SDH, monitor the existence of and changes in SDH, and implement policies that move towards health equity, strongly underpinned by action on SDH. Most of all, it will require ensuring that the broad focus of PHC and SDH is kept foremost in policy instead of the common historical experience of efforts being limited to a part of the health sector.

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Contributors KR and EVM conceived the study. KR wrote the first draft. KR, EVM, DM, CE and TE critically revised the manuscript. All authors approved the final manuscript.

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