

Title

Final Recommendations from the World Health Organisation Commission on the Social Determinants of Health: Nurses, part of the solution? A discussion paper.

## **Abstract**

Aim

This paper suggests that nursing needs a new paradigm for research and practice that recognises the social determinants of health as potentially preventable causes of ill health. It is clear from the recent report from the World Health Organisation Commission on the Social Determinants of Health that nurses are critical to global change through their ability to champion a 'social determinants of health' approach with partner agencies.

## **Data Sources**

Relevant literature searches have been undertaken to inform this discussion paper using the following databases in late 2008/early 2009 including the previous twenty years as relevant (British Nursing Index, Medline and Cinahl). In addition relevant international policy documents have been referred to from 2000 on.

## **Discussion**

On the publication of this report it is timely for nurses to take stock of how they might be most effective in reducing inequities in health as part of a global work force and resource for health. Many nurses will feel that they already work to promote social justice and poverty reduction yet their scope of action is often limited by their specific sector. Do nurses need a new paradigm for research and practice that focuses on the social determinants of health as potentially preventable causes of ill health?

## **Conclusion**

Nurses need to strengthen their strategic skills to reaffirm inequities in health as a priority within often complex local circumstances and to enable them and those they care for to influence local and national policy, research and practice development.

**Key words** – health, inequities, nursing practice

## **What is already known about this topic?**

- Nurses are critical to achieving global change on the social determinants of health through their ability to champion an approach which prioritises these areas within health services and with partner agencies.
- On the publication of the Commission on the Social Determinants of Health report it is timely for nurses to take stock of how they might be most effective at tackling inequities in health as part of a global work force and resource for health.

## **What this paper adds?**

- Nurses need a new paradigm for research and practice that focuses on the social determinants of health as potentially preventable causes of ill health.

- Nurses need to strengthen their strategic skills to reaffirm inequities in health as a priority within often complex local circumstances.
- Nurses need to both be able to influence local and national policy and research on how to tackle inequities in health and inequities in access to health care and enable those they care for to be heard and to influence these debates.

## **Introduction**

Addressing health inequities has been identified as an important area for nursing practice and research (Lynam 2005, Hart & Freeman 2005) both within the nursing and health care literature and within national and international scrutiny and discussion documents (World Health Organisation, WHO 2000, 2001, 2002).

The Commission on the Social Determinants of Health was created in 2005 by the then Director General of the WHO J.W. Lee and it published its final recommendations late in 2008. It was created to marshal the evidence on what needs to be done in order to promote health equity and to foster a global movement to achieve this. The Commission is a global collaboration of policy makers, researchers and civil society with a blend of political, academic and advocacy experience.

Traditionally society has looked to the health sector to deal with health problems and prevent disease. The mal distribution of health care documented in the UK and around the world (Hart 1971, CSDH 2008) which results in none delivery of care to those who most need it is now recognised as one of the social determinants of health. However globally premature loss of life arises in large part because of the conditions in which people are born, live, work and age (CSDH 2007/8). Action on the social determinants of health requires the involvement of the whole of government and civil society, local communities, business and international agencies. It is clear however from the evidence that health systems and health professionals are critical to global change. They can champion an approach which focuses on action to tackle the social determinants of health through their roles both in health care and with partner agencies.

With the arrival of the final recommendations on what works to positively influence the social

determinants of health from the WHO Commission on the Social Determinants of Health (CSDH, 2005-2008) it is timely for nursing and nurses to reflect on their place in this potential 'global movement for change'. The Commission calls for closing the health gap in a generation, as an aspiration not a prediction, the knowledge now exists to make a huge difference to life chances and therefore to provide marked improvement in health equity.

## **Background**

There is no mystery as to why poor people in low income countries suffer high rates of illness and early death. Little food, dirty water, poor shelter and sanitation and frequent exposure to infectious agents and vectors combined with lack of adequate and appropriate care add up to a much greater risk of early illness and death (WHO 2007). We also understand now the causes of non communicable diseases that create the largest burden of disease for poorer people in middle or high income countries. The WHO/World Bank global burden of disease study identified the major causes of mortality and morbidity in both cases; underweight, overweight, smoking, alcohol consumption, hypertension and sexual behaviour (Johansson et al., 2005, WHO 2007).

What then are the social determinants of health and how can we as nurses ensure that we consider them as a priority in our research, and practice? In a review of the evidence to establish the social determinants (WHO 2003) the following areas were outlined as crucially important influences on health and well being:

- Stress – “Stressful circumstances, making people feel unable to cope are damaging to health and may lead to premature death.” (WHO 2003 p12/13).
- Early life – “A good start in life means supporting mothers and young children, slow growth and emotional and educational development raise the lifetime risk of poor health” (WHO 2003 p14/15).
- Social exclusion – “Life is short where its quality is poor. By causing hardship and resentment, poverty, social exclusion and discrimination cost lives” (WHO 2003 p 16).
- Stress and work – “Stress in the work place increase the risk of disease. People who have more control over their work have better health while people in work have better health than those who are unemployed” (WHO 2003 p18).
- Social support – “Friendship, good social relations and strong support networks improve health at home, at work and in local communities” (WHO 2003 p22).
- Addiction – “Individuals turn to alcohol, drugs and tobacco and suffer from their use, but use is influenced by the wider social setting” (WHO 2003 p24).
- Food – “Access to good quality affordable food makes more difference to what people eat than health education” (WHO 2003 p26).
- Transport – “Cycling walking and the use of public transport promote health in four ways. They provide exercise, reduce fatal accidents, increase social contact and reduce pollution” (WHO 2003 p.28).

This paper will discuss how nurses can develop their role to influence these areas through acting as role models and activists bearing witness to where the negative impacts of the social dimensions of health are apparent.

The term inequity is preferred to inequality in this paper. Whitehead (1992, page 430) describes

health inequality as the “measurable differences in health experience and health outcomes between different population groups – according to socioeconomic status, geographical area, age, disability, gender or ethnic group”. Health inequity is defined as “differences in opportunity” (Whitehead, 1992, page 430) for different population groups which result in for example unequal life chances, access to services, food, housing etc. These differences may still be measurable they are however preventable and as such considered to be unfair and unjust.

Literature searches have been undertaken relevant to nursing and the findings of the CSDH to inform this discussion paper using the following databases in 2009 including the previous twenty years as relevant (British Nursing Index, Medline and Cinahl). In addition relevant international policy documents have been referred to in light of the findings of the CSDH from 2000 to date.

## **Discussion**

On the publication of this report it is timely for nurses to take stock of how they might be most effective in this area as part of a global work force and resource for health (WHO 2002). Many nurses will feel that they already work to promote social justice and poverty reduction, yet the scope of their actions are often limited by their specific agency or sector resulting in fragmentation of activity. It would seem that increasingly nurses and the profession of nursing realises that its efforts toward addressing individual health needs are often wasted and undermined when they have no resources, strategies or mandate to address the social determinants of health that underlie them (Drevdahl et al., 2001).

Nursing interventions to prevent illness often focus on the role of individuals and their behaviour (Hart & Freeman 2005). The CSDH recognise that these are important however it is vital to set them in their social context and that unless action/interventions also take account of the structural drivers of inequity in health, inequity in access to health care and importantly inequity and its influence on health behaviour they will not tackle inequalities in health (WHO 2008).

Programmes within countries and localities to control priority public health areas must pay attention to the social determinants of health through multi sector action; it is clear from the CSDH report that it is not sufficient to provide treatment for those with diabetes and not deal with the drivers of the obesity epidemic, or to deliver health education to people and not be concerned with their poverty or social isolation; or to deal with stress related illness and ignore the conditions in which a person lives and works.

Three conceptual and methodological factors appear to have impeded nursing research and practice development relevant to the social determinants of health:

- Ambiguity about the terms used to define them.
- A narrow focus on biological and behavioural risks for disease development,
- the persistent centrality of an individual behaviour focused approach to examining life style (Kneipp et al., 2003).

Researchers when considering professional roles in health and the provision of health services (Hart 1971, Butterfield 1991, Harker & Hemingway 2005, Wilkinson & Pickett 2009) have

argued that models of disease prevention have not traditionally recognised that healthy choices may be constrained by social conditions for the most part outside of the control of an individual. Indeed these researchers argue that change may result when the social dimensions of health are made visible and suggest that interventions need to help create an environment where power imbalances which prohibit people from achieving their potential are exposed.

It is interesting that within the interim and final recommendations from the CSDH power and empowerment particularly is a major focus of their guidance on what works to tackle inequities with a particular focus on three areas of empowerment:

- Material - to enable people to have the resources they need to live healthily.
- Psychosocial – to be able to exert control over how they live and gain support from others, and
- Political – to be able to influence the circumstances in which they and their community live.

Empowerment is both a process and an outcome and is defined as an individual or groups ability to influence or control significant features of their lives (Nyatanga & Dann 2002). Within nursing and health care however empowerment is a contested concept with a diversity of interpretations (Wilkinson 1999). Nursing authors have suggested that nurses and their professional culture may exert a negative influence on those they care for (Hart & Freeman 2005) through the effect of the ‘professional ego’ on relationships with clients which ensures the power and control in any intervention stays with the professional. This can then disempower vulnerable individuals and prevent them accessing health care, support and advice. It has been suggested that to assume that empowered nurses means empowered clients or patients is naive (Skelton 1994) as empowered professionals will not automatically extend an empowering hand to those they care for as can be seen in other professional groups (Suominen et al., 2006).

Other nursing authors have suggested that nurses cannot empower those they care for as they themselves do not hold power within a health care context in many instances (Christensen & Hewitt-Taylor 2006). This would suggest that if nurses are to achieve a change in power and status they must be prepared to take leadership roles in local areas and engage in political debate, seeking to change their public and political status. Malin and Teasdale (1991) viewed empowerment as having the potential to occur at both the micro and macro levels. At the micro level empowerment may occur between the nurse and an individual or community however Malin and Teasdale (1991) argue that this micro level empowerment cannot occur without macro level empowerment of nurses as the largest work force for health globally. Empowerment of nurses and nursing is essential to enable nurses to influence the planning and provision of health care and to help enable those they care for to influence the social determinants of health in their local community.

It would appear from the report that individually focused interventions must be coupled with initiatives that work to address structural barriers to health, healthy lifestyles or to care delivery. There is a clear message within the report of the Commission; as a key resource for health globally nurses need to adopt a practice perspective that considers both individuals and their social determinants of health (Lynam 2005, CSDH 2008).

Sir Michael Marmot the Chair of the CSDH at the launch conference in London (November 2008) argued for “being idealistic and recognising the magnitude of the problem of health inequities”. Considering nurses as a single professional group may not be within the multi sector nature of the report, however, the report offers us a framework for action and a global language in relation to inequity.

The over arching recommendations from the three year global review of what works to reduce inequities in health are as follows:

### 1. Improve Daily Living Conditions

This recommendation focuses on five key areas, equity from the start of life, healthy places healthy people, fair employment and decent work, social protection across the life course and universal health care. Each of these areas is directly impacted upon by nurses and nursing and the team or networks which nurses are members of or lead wherever they work around the globe. Whatever role a nurse is taking they can consider both equity of provision of service and access to services and the direct impact of the social determinants of health upon their community of patients and carers. These areas can influence practice or roles as an advocate or ‘witness‘ and can be considered as an individual nurse, as a local nurse leader or manager, as a researcher as an educator or as a national or international nurse leader. Nurses need to consider that although health systems cannot cure poverty they do have a vital part to play in influencing equity from the start of life, healthy places, employment, social protection and universal health care which can help to positively influence daily living conditions. The health system in any country is potentially:

- A witness to the health impacts of poverty and inequity of access to services.
- Its recording capacity (if effective) can record the impacts of inequity.
- Its public health work can target inequity both directly and through lobbying and influencing policy and practice development.
- It can measure its actions to see if they are effective, and
- As an employer it can set a positive example in its locality, region or country.

### 2. Tackle the Inequitable Distribution of Power, Money and Resources

This recommendation focuses on six key areas, health equity in all policy systems and programmes, fair financing, market responsibility, gender equity, political empowerment (inclusion and voice) and good global governance. Once again nurses are involved in many of these areas either directly or as advisers or leaders of teams or managers. We have a key role in ensuring a wider understanding of the social determinants of health and ensuring a focus on equity of access to services through our involvement. The involvement of patients, carers, users and local residents in the development or redesign of services is a key part of enabling empowerment, inclusion, access to services and good global governance through the use of transparent consistent policies and processes.

### 3. Measure and Understand the Problem and Assess the Impact of Action

This recommendation focuses on the social determinants of health, monitoring, training and research. Nurses need to both consider the impact of their practice and policy development on the social determinants of health but also ensure that they are fully understood and integrated effectively into training and development programmes. Nurses need to understand the issue and be able to evaluate their effect on it.

Arguably nursing has focused on the individual patient interaction to the detriment of considering service design and their influence on policy in relation to the social determinants of health and vice versa (Hart & Freeman 2005, Kniepp & Drevdahl 2003). However, in order to do this effectively nurses need to understand these dimensions themselves and see them as relevant to their practice and within their sphere of influence. The CSDH report findings specifically mentions the 'drain' of health professionals away from some parts of the globe and into others, which has been so marked within the global nursing workforce (CSDH 2008). The report recommends bi lateral agreements to regulate gains and losses. The current potential for sharing expertise and experiences across the globe with the growth of distance/e-learning opportunities has great potential for sharing nursing learning and strategies to tackle inequities. Arguably global nursing bodies need to take a leadership position in order to champion this approach and offer opportunities for international collaborations, e-partnerships and exchanges for the future to develop practitioners in their own countries.

Nurses and nursing need to ask some key questions of the profession and the way we prepare nurses currently:

- Do nurses understand the impacts of the social determinants of health?
- Are they prepared for their roles as advocate, witness, role model, leader and influencer in this area?
- Do they consider the potential impact on health inequity of service development (by undertaking health impact assessments for example)?
- Do they design services for their local population whether they are hospital or primary care based practitioners (by undertaking health needs assessment for example)?
- Do they have the skills to evaluate their work on this area (evaluation and research skills)?

### **Implications for nursing**

Do nurses need a new paradigm for research and practice that recognises the social determinants of health as 'potential causes of ill health' which all nurses need to develop interventions, strategies and skills to prevent or reduce. There is an international acknowledgement that evidence about what works to tackle inequities in health is not well developed currently and within nursing literature is clearly under developed (WHO 2002, Villeneuve 2008). However a distinction must be drawn between absence of evidence, poor evidence and evidence of ineffectiveness. The two former statements do not equal the latter, and are not an excuse for not discussing, exposing and attempting to act to reduce, mitigate or expunge the inequities in health which nurses experience both as carers and users of services on a day to day basis around the world.

In a recent paper Villeneuve (2008) outlines indicators in three areas which nurses must be well versed in to take effective action to reduce inequities in health. The first of these is economics.

### Economics

Why should basic economics be important for nursing? We need to understand that higher socio economic status is directly linked to better health and as the report from the CSDH shows us we need to better understand why this is the case. If behavioural interventions (which are seen as a core part of the nursing role globally) are to be designed appropriately for their audience then recognition of the economic well being of that individual or group is crucial to the nurse role as intervention designer, deliverer and evaluator. In addition as a witness to the negative impacts of economic

decline on the health and well being of those nurses care for we have a key role in highlighting the priority which needs to be given to this area by policy makers and the more influential the nursing post held the more of a priority this area needs to be for the nurse. In these times of global economic upheaval it is imperative that policy makers understand the social dimensions of health and that their decision making is influenced positively; nurses are in a key position within communities to enable this to happen. Health is perhaps the most important asset of any community or nation and as such matters to governments and business investors.

### Global Demographics

The second area outlined in Villeneuve's paper (2008) focusing on enabling effective nursing practice in this area is global demographics. More than 400 million people now live in the world's 25 largest cities and more than half of the world's population overall now lives in cities. This development offers opportunities in terms of efficient provision of health care however urban overcrowding also brings with it many complex public health problems. A billion people live in urban slums and that number seems to be rising (United Nations Population Fund, 2007). In addition rural areas are left bereft of workers including health care workers and effective infrastructure as populations migrate and while in some countries there are many people surviving to older age in others there are many younger people without a means of earning a living for themselves and their families. It is essential that nurses understand these areas as we are involved in planning and providing services in urban and rural areas and preparing the nurse of the future to manage the challenges caused by issues relating to global demographics.

### Access to Health Care

The third area outlined by Villeneuve is access to care. Globally nothing is more important to access to health care and improved health outcomes than having a health work force. As WHO noted in 2006, "57 countries, most of them in African and Asia face a severe health workforce crisis" WHO estimated that over four million staff both health service providers and management/support workers are needed to fill the gap. If nurses are going to play their part in reducing inequities in health they need to find policy levers which enable the development of healthy public policy based on the social determinants of health both on a local, national and international level. For those who educate nurses around the world surely there is a moral imperative to exploit internet based learning opportunities internationally to share the global resource to develop new practitioners.

### Prevention and promotion of health



Health systems can do much more than treat disease when it occurs. Research shows how a significant proportion of the global burden of non communicable and communicable disease can be reduced through improved preventive action (Lopez et al 2006). Health practitioners have a strong influence over how a society thinks about health. Alongside other advocates from politics, economics, social and cultural activism nurses can bear witness to the ethical imperative of action on the social determinants of health just as much as the efficiency value of acting on the social causes of exposure and vulnerability to poor health (WHO CSDH 2008).

The Priority Public Health Conditions Knowledge Network (of the WHO CSDH) is working on showing how health programmes can be better designed, delivered and monitored to recognise health inequity and act on the social determinants of health.

Interestingly the report mentions explicitly the importance of both quantitative research (and its importance in documenting the extent of the impact of the social determinants of health) and qualitative research (and its importance in sharing the 'lived experience' of social inequity) and its key role in influencing policy and service development. Arguably nurses and nursing have made a considerable contribution to the development and use of qualitative research methods in health care research and have successfully utilised them to share the experiences and feelings of patients and users (Kleiman 2004). However, once again this work could be criticised for a lack of a specific focus on the social determinants of health (Whitehead 1992, Villeneuve 2008).

## **Conclusions**

Many nurses will rightly feel that they already work to promote social justice and poverty reduction, yet the scope of their actions are often limited by their specific agency or sector resulting in fragmentation of activity. Nurses need to strengthen their strategic skills in order to reaffirm inequities in health as a priority within often complex local circumstances and to enable themselves and those they care for to influence local and national policy and practice development.

Nursing needs to develop an ability to cope with the complexity of responding to the social determinants of health for individuals. This means listening to individuals and taking time to understand their circumstances and how they impact on their health and well being. This may mean partnership working and lobbying with local communities or other agencies, or providing care and services in a different way, in a different place, or at a different time. Are we focusing our practice on the health needs of the communities or groups we serve? Do we try to put the power and control into the hands of our patients or our local community or do we disempower in the way we practice and structure our services or interventions? Globally are our nurse leaders challenging policies on the basis of health equity, do we either collectively or as individual practitioners consider this area as a priority for nurses?

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