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The Politics of Public Health: Inequality, Social Determinants and Statistical Lives

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This year's Boyer Lecture Series on the ABC, titled *A Fair Australia: Social Justice and the Health Gap*, has recently been delivered by Professor Sir Michael Marmot, President of the World Medical Association and Director of the UCL Institute of Health Equity.

Professor Marmot is a leading researcher and advocate for action on health inequality with a distinguished track record that includes serving as Chair of the WHO Commission on the Social Determinants of health as well as the European Review of Social Determinants and the Health Divide, and he will chair the forthcoming review of health inequalities across the Americas for the WHO's Pan-American Health Organization. Marmot has emerged as an influential and highly visible figure in questions of health inequality and what we can do about them, his book last year *The Health Gap: The Challenge of an Unequal World* (Marmot 2015) widely read by governments, policy-makers and advocates around the world and can be accurately described as agenda setting. Its recommendations adopted by World Health Assembly and many countries.

The purpose of my Presidential Address is to argue that there is something interesting going on in public health scholarship on the social determinants of health inequality that deserves attention in political science. The theme of our conference this year, The Politics of Justice and Rights: Challenges and Future Directions, connects with the WHO's Commission on Social Determinants of Health, chaired by Marmot, whose headline was: 'Social injustice is killing on a Grand Scale'. This provocative claim and the work behind it should make us think about comparative politics, public policy, political theory and motivating political action as well as contentious politics, to use the Tilly, Tarrow and McAdam definition, in distributive struggles in a democracy. Although I won't touch on it there is important IR work on health that should be acknowledged.

My core argument is that there are several meeting points between political studies and public health, and rather than seeing health as another sub-field or separate seam of research we should see public health as something that is of broader import in the study of democratic politics. Further, from an APSA point of view, health is an example where there is much political scholarship being undertaken outside conventional groupings of political scientists, schools or departments of politics. Although working in leading Schools of Public Health, there are several prominent political scientists around the world calling for a politics of public health; my own sample would highlight the work of Claire Bambra in the UK, Ted Schrecker in Canada, now in the UK, Jeremy Schiffman and Scott Greer in the United States. In Australia, the work of the recently launched NHMRC-funded Centre of Research Excellence on Social Determinants of Health Equity (CRESDHE), co-directed by Professor Fran Baum and Professor Sharon Friel, promises to contribute much to this endeavour.

Something I think APSA as our national association needs to bear in mind and make sure political scientists working on particular social problems and concerns outside of politics departments are included and feel part of the Association. Many research puzzles do start from the public and its problems and are not always generated from within our discipline; health like environmental studies, social policy, disability studies and several others generates political scholarship.

Initially I want to make a few remarks about health, what it is, and health inequality, what that is and why it is different from other inequalities that are the subject of politics. Also look briefly at the theory of the social determinants of health and what this suggests may be done about health inequalities.

In the *second and main part* of the address, I want to sketch out some of these important points of contact between political science and public health; survey briefly several sub-fields within APSA that have something to contribute to understanding politics of action on SDH, as well as perhaps considering the implications of work on health inequalities in their own work.

Health inequality. What is it?

In the WHO Constitution of 1948, health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. That is a definition packed with big concepts but it does allows us to say that health is not same thing medical care; even if the politics of health seems invariably to be about medical care. In terms of something tangible and quantifiable, health is conventionally defined as years of life expectancy, or otherwise years of healthy life expectancy.

Health inequality slightly different from other inequalities that are the subject of political analysis has contributed. Health inequalities are not so much expressed about differences between individuals as between groups of individuals. Immediately, this presents a theoretical question and political one: what are the relevant groups? These are sometimes racial comparisons in US, or in Australia between indigenous and non-indigenous health, whilst elsewhere in the UK and Europe they are more class-related. Further, inequality in health is often expressed in territorial terms though ward-level comparisons of life expectancy within a big city; among other things, this provides extreme cases such as differences in male life expectancy between the richest and poorest parts of Glasgow 28 years, Baltimore 20 years and London 17 years. Presenting health disparities between areas just a few kilometres from each other is an attempt to make the statistics 'real' or grounded in some sense that health inequality stated between countries or continents may not.

In Australia, as the first Boyer lecture points out, often expressed in health aboriginal Australians. The life expectancy gap between Indigenous and non-Indigenous Australians is about 11 years currently. Aboriginal men are six times more likely — and Aboriginal women 11 times more likely — to die of heart disease than non-Indigenous men and women.

There has also been important comparisons between different quintiles of the population in terms of Socio-Economic Status (SES) are made in the *2014-15 National Health Survey* produced by the ABS. These show a social gradient in *health risk factors* between the lowest SES quintile and the highest SES quintile. The poorest in society more likely to smoke, take no or low exercise, be overweight/obese, suffer high blood pressure compared to those in the middle, who in term have higher risk factors in these categories than those in the highest SES quintile.

This social gradient pattern is repeated for long-term health conditions; such as Arthritis, Cancer, Deafness, Strokes, CVD, Kidney Disease, Mental Health, where the proportion of persons suffering from these is higher in the lowest SES quintile as compared to the middle quintiles, which in turn suffer more compared to the highest SES quintile.

The message is clear: people at the bottom of the social hierarchy tend to have higher health risk factors and worse health than those in the middle, who in turn have poorer health and higher risk factors than those at the top.

Marmot presents ***this social gradient*** as the general picture and the frame through which we should view health inequality. This allows claims about everybody being on the gradient and observing the health they lose, the years they lose in life, because of the gradient. Social determinants do not only affect the health and life expectancy rates of those on either end of the scale: the very rich and the very poor. The social gradient of health applies to everyone. Marmot, in the first Boyer lecture, says: "In Australia…we see a clear gradient: the fewer the years of education, the higher the risk of death. Men and women in their 40s with fewer than 12 years of education have a 70 per cent higher mortality rate than the most educated." Understanding this gradient, Sir Michael claims, dramatically changes people's perceptions of health inequality. For him, the implications of gradient profound: we're all involved and Mr and Mrs Average, public health's median voter, should be concerned.

What is wrong with health inequality? Why should we care?

Within public health there is a distinction drawn between health inequality and health inequity. Very strongly held to: there are some disparities in health that are given, facts of biology or genetic luck, but there is a set of other disparities that are inequitable or unfair. This is an interesting, plausible and useful distinction to make, which I don't think is widely drawn in political analysis and scholarship.

Question is, therefore, *where you draw such a line*. This is unavoidably a political question. Professor Dame Margaret Whitehead (1992), a health disparity is judged *inequitable* against three standards.

(i) *Avoidable*. Some differences are luck, or genetic, and not necessarily a matter of inequity.
(ii) *Unnecessary*. Some health inequalities might be considered necessary. Industrial development might mean more male workers poor health; war is another one. Men of fighting age cause health inequality but not necessary inequity.
(iii) *Unjust*. Even if (i) and (ii) satisfied, there is an additional hurdle, the difference must be *unjust*. This is a bit more difficult because it seems to restate problem of deciding what is inequitable but the example given is skiing injuries.

There are alternatives to this formulation. An arguably more persuasive and readily operationalized equity line is given by Paula Braveman and Sofia Gruskin (2003): equity in health is the absence of 'systematic disparities' in health between groups with different levels of underlying social advantage/disadvantage (wealth, power, or prestige). At the core of health inequity is the idea of compounding disadvantage; that disparities in health compound the disadvantage of those groups of people who as a baseline are already socially disadvantaged.

This account is relevant to how we think about democracy: health equity requires the identification and amelioration of patterns of *systematic disadvantage* that undermine the well-being of people whose prospects for good health are so limited that their life choices, including political ones, **are not like those of others**. Some work in public health and population health makes a connection to John Rawls' *Theory of Justice*. For example, influential scholar in the ethics of population health, Norman Daniels (2006), argues that equality of opportunity – second of Rawls' principles of justice – requires efforts to achieve as equitable a distribution of health as possible. Health is also essential to basic liberties that are Rawls' first principle of justice. So basic liberty and equality of opportunity require equitable distribution of health, or alternative terms, equity in health is a *prerequistise* of primary social goods that Rawls sets out (such as this category includes rights (civil rights and political rights), liberties, income and wealth)

This **is one influential answer to the question: is health different from other inequalities present in society?**

What can be done?

The most common answer is that most advanced industrial democracies provide (or at least attempt to) equitable access to medical care, and also employ public health measures equitably at the population-level. Medical care should be universally available on the basis of need rather than ability to pay. Most often achieved through public rather than private health insurance. We need only witness this year's Federal election campaign and the 'Mediscare' to see that this sense of health equity runs deeply as a value through the policy. So why do we have inequities?

Medical care is only one thing that contributes to health. More to do with illness, you need medical care when you're ill.

What makes you ill though is whole host of factors in your life that are outside medical professions control or outside departments of health control.

This is where ***the theory of the SDH is critical*** (Berkman and Kawachi 2000). A series of social phenomena make a significant contribution to the health of populations. Some are material; and the distribution of these underlying factors - the causes of the causes - is unequal and argues Marmot, in his Boyer lectures as well as across a life's work, is unjust. However, even after controlling for all that disparity there is still some variation in health associated directly with inequality. As we know from the work by leading political scientist Robert Putnam, his *Bowling Alone* book and many other writers on social capital, there is an influential argument that higher levels of income inequality in a society increase the status differentials between individuals and reduce bridging capital. This reduces social mixing across groups, thereby reducing levels of interpersonal trust. This can give rise to feelings of social exclusion, insecurity and anxiety, which in epidemiological terms has been linked to poorer health.

Appropriate to a political science audience, these effects were first uncovered in the renowned Whitehall studies. The first of these was a prospective cohort study of nearly 20k British civil servants starting the mid-1960s for 10 years. Senior civil servants had initially commissioned the work as part of concern about executive stress (and perhaps the need for increased civil service pay to compensate). The first Whitehall Study compared mortality of people and showed that among

British civil servants, mortality was higher among those in the lower grade when compared to the higher grade. **The more senior one was in the employment hierarchy, the longer one might expect to live compared to people in lower employment grades**. This was the *exact opposite* of what had been expected. All have access to NHS; literacy; none could be described as living in deprivation or poverty yet there was a strong social gradient in health. This has provoked significant work since about status effects, how social psychological stress linked to control/autonomy in work and life generally affects health. Inequality itself, and not just associated material disadvantage, is bad for your health.

POLITICAL SCIENCE-PUBLIC HEALTH CONTACT POINTS

The politics of action on the social determinants of health

A joint appearance of Marmot and Warren Mundine on Q&A in August lead to an exchange where Marmot argued for enormous redistribution provoking challenge from Mundine: "I think you're very much in fantasy land."

I think several sub-fields of political studies can say something this 'fantasy land'.

Study of contentious politics

One way into this question is to draw on the distinction between identified and statistical lives. The *Identified lives effect* is greater inclination (or bias) of human beings to assist people or groups of people that are identified as compared to helping persons or groups who will, or who are, suffering similar harm but are unidentified. Thomas Schelling (1968), Nobel Prize winner in Economics but whose works have been influential right through political science, was the first to establish a distinction between identified and statistical lives, and it was in terms of a Brookings Institute publication on public expenditure analysis. In terms of contentious politics of the SDH, this is relevant: dealing with statistical lives not identified lives.

In medical care, there is a well-known rule of rescue. Here it is considered appropriate to spend millions of dollars in intensive care for identified people with a high risk of dying soon, even though same millions of dollars might save many more statistical lives if spent on prevention or action on SDH. Observed in many political questions, arguably the effect is exacerbated in contemporary public politics in the 24/7 media cycle, dominated by search for sensation and penchant for the sentimental.

Genuine ethical question if this is a bias that should be corrected should be judged normatively as an error. I am not using in that sense, but political scholarship does spend substantial amounts of time examining the techniques and processes of contentious politics where competing views and disagreements about what to do, and who should do it, are characterised by this identified lives effect. Practical implications of this priority to identified persons from advocates and voters are significant. This is something that can contribute to debates in public health about motivating action in SDH.

One political angle is to explore statistical lives as political devices. In particular, to study how the claim that health inequities are avoidable and remediable, is prosecuted politically. There exist cost effective interventions, and they benefit us all but the political problem is that while this is true when you think in a population sense, it is not so evident in terms of disaggregated publics. The benefits of action on SDH expressed in statistical lives terms are not necessarily recognised by any individual citizen; does or can anyone recognise themselves as a statistical live? Can Mr and Mrs Average, as Sir Michael is wont to call them, recognise the benefits of action on SDH? This is something that Jennifer touched on this morning in her discussion of misinformation in politics. Benefits are long term and expressed in statistical lives terms. The costs of action though are in the shorter term, expressed by the media in identified lives terms such as those seen as losing from hospital funding restrictions.

Comparative Politics and Public Policy

A perennial dilemma that confronts all political movements is: are we engaged in a transformative or revolutionary project in which all is changed and we rebuild according to an ideal vision; or are we engaged in improving what we have, adapting, converting and ameliorating a system that in its core components endures?

On one view, attempts to define comprehensive ethical frameworks, such as social injustice is killing on a grand scale, that can guide policy makers in their attempt to transform existing institutions are of this first type. Yet it rarely seems the case that such revolutions work in practice, or at least much endures in revolutions, and it therefore becomes unclear how political theory or social justice claims about causes of causes of health, or in the terms of this year's conference, how conceiving of a just society can contribute to policy debates.

Another way to think about this is to take view that governments are inheritors more than they are choosers. As the wide body of scholarship in comparative politics under the banner of new institutionalism argues, what is inherited is institutions as guides when there is conflict about conceptions of what to do, competing versions of the good life. **Institutions emerge and develop to cover multiple values, multiple reasons: institutions may function achieve legitimacy even if not necessarily coherent or consistent set of values**.

There are health equity institutions that endure and remain popular. Equivalents of 'Mediscare' exist comparatively. In general in OECD countries, universal health care coverage achieved before social epidemiology evidence began to mount up. So why doesn't this evidence work to change institutions? Institutions are sticky; they institutionalise values and interests. Sometimes these are called policy paradigms. Like their Kuhnian counterparts, filter out disconfirming evidence. There are also beneficiaries or stakeholders in current set up that would lose in a shift to prevention or SDH action. There is a research agenda here in comparative politics and public policy about the transition of health systems from ones dominated by medical care to broader system embracing action on the SDH. Questions of adaption, conversion and layering of existing institutions for organising the delivery of medical care for these broader determinants of health.

The Politics of Framing

The explicit appeals to social justice to motivate political and policy action by Marmot and several others takes place against the dominant background of utilitarianism as the ethical framework in the politics of action on population health; one is characterised by its proponents in public health as **utilitarianism plus paternalism** (Lawrence Gostin and others). This gives us two frames to consider politically: one based on action on the 'causes of the causes' as a social justice question as compared to alternative that says it is duty of government to have good intentions and promote public health.

Political scholarship has lots to say about the gap between how you identify problem and form beliefs about why it matters and what should be done and how you subsequently frame it politically for effective action. There are, of course, dangers though of framing public action in ways that might be different from private motivations. In commentary on recently elections around the world, authenticity and transparency are revealed as highly prized in democratic politics, and there are not many things worse for political leaders than being accused of hypocrisy risked.

We hope that ideas and actions are consistent, and that ideas control actions. But we also know, as students of politics, the difficulties in achieving consistency and control.

The political theorist David Runciman (2008) has written about the great dance of democracy between hypocrisy and anti-hypocrisy, between cynicism and sanctimony. If we accept that there is a difficult terrain for professional politicians to mount arguments framed by social justice, the question becomes can one be sincere in a commitment to social justice and health but frame the argument publicly with a utilitarian mask on?

Much of the political analysis in public health is about permissible paternalism. For example, an influential and in many ways ahead of its time by a political scientist and political philosopher based here in Australia, Robert Goodin, sets out in his 1989 book on the ethics of smoking/smoking bans, draws on a well-known two kinds of rights choice rights and interest rights (Goodin 1989). If the exclusive concern is choice rights, the entitlement to choose, then paternalism is a threat. However, if the existence of interest rights is admitted then interfering for the sake of the persons own self-proclaimed interests and their entitlement to the benefits of public action, then paternalism may be acceptable.

In terms of smoking, Goodin has four arguments for paternalism:

The first two are based on **informed consent**, the second two are based on the **idea of autonomy**.

1) Preferences are not relevant if based on false information (smoking is not harmful). If people base their preferences on false information then their consent is not informed and governments may be justified in overriding them if this promotes their interests.

2) Some preferences are merely transitory. Smoking preferences are not stable over time and if we can reasonably expect personal preferences to change through life, governments may be justified in overriding them. In smoking terms, we want to give priority to a smoking preference just because it emerged in youth if we expect this preference to change later in life.

3) Addiction and Weakness of the Will. There are genuine cases of weakness of will, where people may want to do something but lack the capacity. The highly addictive properties of nicotine often makes quitting smoking one such case. In such cases autonomy has been compromised. Paternalistic laws that force us do realize our own desires may thus be justifiable. The law might better respect your own preferences better than you would.

4) In order to respect preferences, governments are required to ensure they are genuine. Some choices are made under the influence of advertising and peer-pressure to the extent where it is not obvious that we should respect them. Further, the seam of work on behavioural insights shows how several cognitive traits such as wishful thinking, the anchoring fallacy, and inconsistent time-discounting reveal public policy concerns with just respecting individual preferences.

All political action for public health policy faces troubling conflicts between the collective benefits to population health on the one hand, and individual rights on the other. Public health powers encroach on and implicate civil rights such as privacy, bodily integrity, and freedom of movement and association. Sanitary regulations similarly intrude on rights exercised in the market sphere such as freedom of contract, pursuit of professional status, and use of personal property. But the idea that government needs to take actions to safeguard the public's health is well established and series of legitimate and successful public health interventions from air pollution, infectious disease control, to seat belt laws exist. However, politically these have been mounted using frame that governments have a duty to do good things rather than an explicit social justice frame based on health inequality.

Is action SDH different from other public health policy? I am not so sure. Efforts to regulate lifestyle - the proximate causes of health - seem to sit within conventional public health frame of permissible paternalism that supported highly successful action on smoking. Governments requiring that we avoid fatty foods, drink alcohol in moderated amounts, exercise daily and so on look like tobacco consumption issues. Smoking may be unusual in that all the informed consent and autonomy justifications for paternalism that Goodin identifies apply and perhaps other activities on SDH may only fall under 2 or 3. But still evidence that permissible paternalism plus utilitarianism has worked as a form of social advocacy: why not for SDH?

Conclusion

Political feasibility as a concept is an important guide to action. This is something, of course, that we as political scientists have a lot to say about.

Interventions that do attempt to change lifestyle and individual behaviour, whilst inadequate in the account of the SDH, might still be useful; might establish **permissible paternalism** from which causes of the causes type interventions may be subsequently extended.

This seems to me a separate argument from conceding the point it is all an individual lifestyle question and all the responsibility of individual citizens. The *lifestyle drif*t which many public health scholars refer to, perjoratively, is defined as the tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors; also used to refer to a trend to individual behaviour regulation and should be resisted.

But many public policies have this characteristic, such as superannuation, elements of economic policy, social transfer policy. I acknowledge points about stigmatisation, or responsibility shifting, but just not quite convinced that labelling this lifestyle drift and something to be resisted without qualification is not necessarily successful politics. Furthermore, so much of standard policy analysis played out in governments in Australia is of this utilitarian plus paternal nature and to suggest this should all be avoided isolates the influence of SDH advocacy for no obvious gain. It may well be neoliberal discourse about responsibility but the fact that behavioural interventions are currently at least more politically palatable, more immediately relatable to the problem at hand and easier to devise than upstream interventions.

As scholars of political action, we might also raised concerns that the evidence about changing behaviours is not as developed as the broader work on social epidemiology and the social determinants of health. Accepting a strong causal relationship between social determinants and health does not imply necessarily that changing the level of those determinants will change health. A theory of behavioural change, that includes status and relational factors, is necessary. This is often a provocative observation in public health, but something that perhaps political scholarship can more readily apprehend as a barrier in reform efforts.

Perhaps embracing this tradition of paternalism in public and encourage action ‘upstream’ on causes of causes as opposed to mounting a social justice all embracing argument may be a better place to start. Less imaginative and less ambitious undoubtedly but perhaps be more likely to make progress in the constraints of current political feasibility.

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