

DETERMINANTS OF HEALTH

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LEARNING OUTCOMES

By the end of the lecture and tutorial, students should be able to:

- Explain how structural and intermediary factors interact to influence health outcomes using the Social Determinants of Health framework.
- Describe the mechanism by which the social determinants of health contribute to differences in health outcomes within and between populations.
- Apply the concepts of structural violence, structure and agency, implicit bias, and social exclusion to explain the influence on health inequities.
- Analyze how the ecological model informs clinical and public health decision-making, recognizing the multi-level influences on health outcomes.

Assess the implications of the social determinants of health for clinical and public health practice.

This E-Book should be reviewed alongside the lecture videos and the *required reading* materials. This PDF is interactive. Please click on the links to navigate through the E-Book content.

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CONCEPTS

HEALTH INEQUALITIES

Health inequalities refer to observable differences in health status or in the distribution of health determinants between different population groups.

This can be measured via health outcomes, rates of disease, and access to and utilization of healthcare.

HEALTH DISPARITY

According to the Centres for Disease Control and Prevention (CDC), the occurrence of diseases at greater levels among certain population groups more than among others is often referred to as a **health disparity**. For instance, the HIV prevalence in a specific country may be elevated among men who have sex with men (MSM) compared to the general population.

These disparities can be seen across a wide range of health indicators, such as disease prevalence, morbidity, mortality, life expectancy, access to treatment, and quality of healthcare. For example, the prevalence of HIV or TB may be higher in one population group than among others.

HEALTH GAP

A **health gap** is the difference in health

between the worst off and everyone else. It does not address the root cause of the differences in health outcomes.

HEALTH INEQUITY

Health inequity refers to the unfair, avoidable, or remediable differences in health status or distribution of health resources between different population groups. This term specifically focuses on disparities in health that are deemed unfair or unjust.

Health inequities are often rooted in social, economic, or environmental disadvantages that affect certain groups disproportionately. These inequities arise from circumstances that are considered to be avoidable and unnecessary. They are often the result of systemic issues such as discrimination, poverty, and lack of access to education, nutritious food, or adequate healthcare.

This can include:

- Unfair treatment - race, gender, citizenship (immigration) status, sexual orientation, socio-economic status.
- Unequal access to resources and a safe and healthy environment.
- Lack of equality of opportunity.

While health disparities are the measurable differences in health closely linked to social or economic disadvantage, health equity is the underlying principle of social justice in health that seeks to eliminate these disparities by ensuring everyone has a fair chance to be healthy (Braveman, 2014).

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the circumstances in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies and political systems.” ([World Health Organization, 2025](#)). This definition emphasizes that many of the major influences on health operate outside the health-care system itself, through how societies organize resources, opportunities and power across different groups ([Braveman et al., 2011](#)).

SOCIAL EXCLUSION

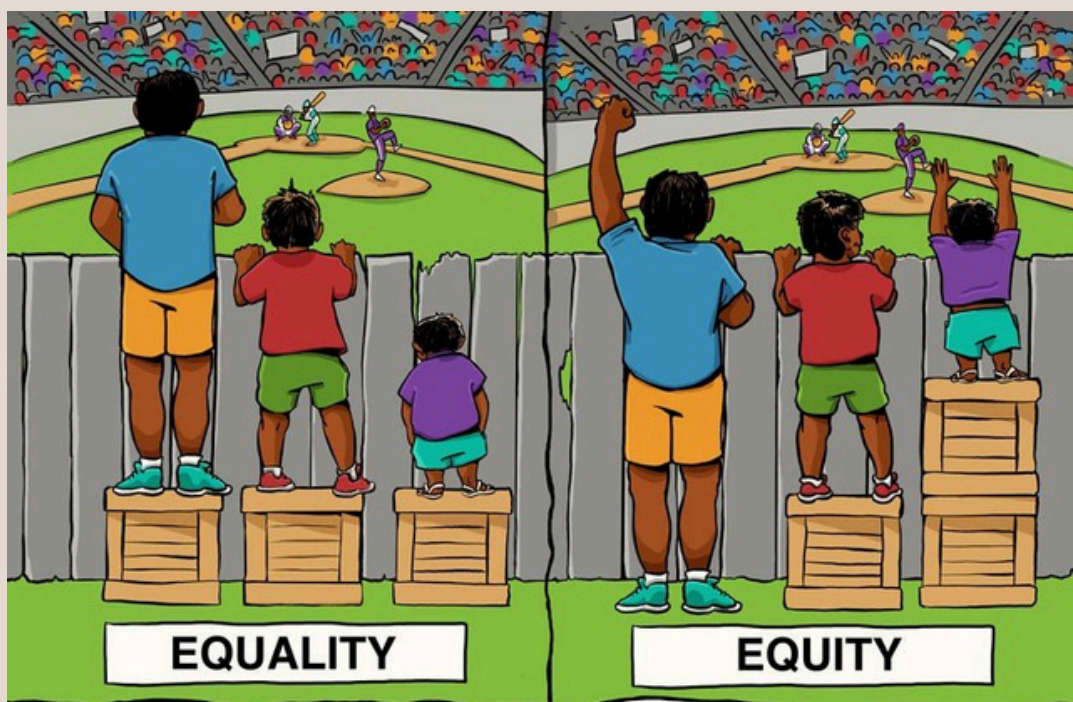
Social exclusion is a process whereby certain individuals are born into or pushed to the margins of society and prevented from participating in social, cultural, economic, and political life ([Siersbaek et al., 2023](#)).

STRUCTURAL VIOLENCE

‘Structural violence is one way of describing social arrangements that put individuals and populations in harm's way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people (typically, not those responsible for perpetuating such inequalities).’ ([Farmer et al., 2006](#))

IMPLICIT BIAS

Implicit bias refers to the ‘attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner.’ ([Staats, 2016](#)).



WHY ARE SOCIAL DETERMINANTS OF HEALTH IMPORTANT IN THE STUDY OF MEDICINE

Social determinants of health (SDH) refer to the non-medical factors that shape health outcomes.

These determinants encompass a wide range of social, economic, and environmental factors that can have profound effects on health outcomes.

A robust body of evidence over the last two decades emphasizes the significant impact of social factors, distinct from medical care, on health outcomes across various health indicators, settings, and populations (Marmot and Bell, 2012; Commission on Social Determinants of Health, 2008; Marmot et al., 2008), challenging the perspective that medical care alone determines health, especially in determining initial vulnerability to illness or injury.

Social determinants contribute to health inequalities based on socioeconomic status. Recognizing and addressing these determinants is essential for promoting health equity and reducing disparities in health.

Social determinants play a significant role in determining access to healthcare services via income, education, and geographic location leading to disparities in health outcomes.

Behaviors and lifestyle choices have been associated with low socioeconomic status via poor dietary habits and physical activity levels, and substance use patterns. Understanding these influences helps healthcare professionals tailor interventions to address specific risk factors.

Environmental factors such as air and water quality, housing conditions, and neighborhood safety can influence vulnerability to certain diseases and conditions.

Discrimination, poverty, and inadequate social support systems can contribute to chronic stress, which, in turn, affects physical and mental health.

Cultural and social factors influence health beliefs, healthcare-seeking behaviors, and adherence to medical advice. Being aware of these determinants improves the quality of patient care.

Addressing social determinants is fundamental to preventive medicine.

SOCIAL DETERMINANTS OF HEALTH

SIR MICHAEL MARMOT

In recent times, Sir Michael Marmot's groundbreaking research has focused on the impact of social and economic inequalities on health outcomes. One of Marmot's most influential contributions is the Whitehall Studies, a series of investigations that began in the 1960s and examined the health of British civil servants.

1. **Whitehall I Study (1967–1970)** by Sir Michael Marmot and Richard G. Wilkinson examined the correlation between employment grade and cardiovascular disease outcomes among male civil servants in London. The study revealed a distinct social gradient in health, indicating that individuals in higher occupational positions had better health outcomes compared to those in lower positions. This groundbreaking research highlighted the significant impact of social factors on health disparities, setting the stage for further investigations into the social determinants of health.
2. **Whitehall II Study (1985–ongoing):** Building on the findings of Whitehall I, the second phase known as Whitehall II commenced in 1985 and is an ongoing, long-

term study. Led by Sir Michael Marmot, Whitehall II expanded the scope to include both male and female civil servants. The study has explored a broader range of health outcomes, including cardiovascular disease, mental health, and overall well-being. Whitehall II continues to provide valuable insights into the social determinants of health and the impact of social, economic, and workplace factors on individuals' health trajectories.

In 2003, Marmot co-authored '**The Solid Facts**' with Wilkinson. The book outlines the following 10 key areas where social factors most profoundly impact health and life expectancy:

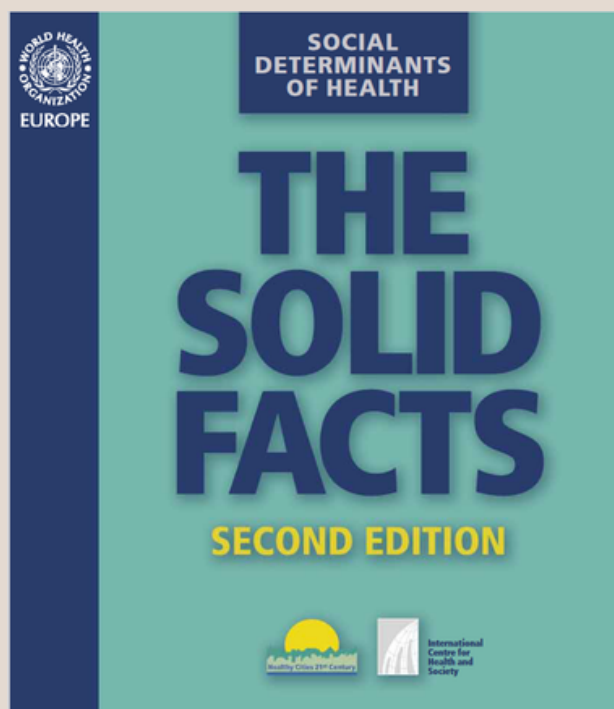
- **Social Gradient:** This refers to the way health outcomes improve as social status increases. Lower socio-economic status is often associated with poorer health.
- **Stress:** Chronic stress, especially in early life or over long periods, can negatively affect health.
- **Early Life:** Conditions in early childhood have lasting effects on health, with poor early development leading to health issues later in life.
- **Social Exclusion:** Being socially excluded, which can happen due to poverty, discrimination, or other factors, negatively impacts health.
- **Work:** Employment and working conditions greatly affect health. Unemployment, job insecurity, and stressful work environments can have harmful effects.
- **Unemployment:** Unemployment is linked to poorer health and higher mortality rates.

- **Social Support:** A lack of social support and isolation can have significant negative effects on health.
- **Addiction:** Substance abuse and addiction can be both a cause and a consequence of social and health problems.
- **Food:** Access to quality food and food security is a major determinant of health.
- **Transport:** Transportation and urban planning affect health in various ways, including through physical activity and accidents.

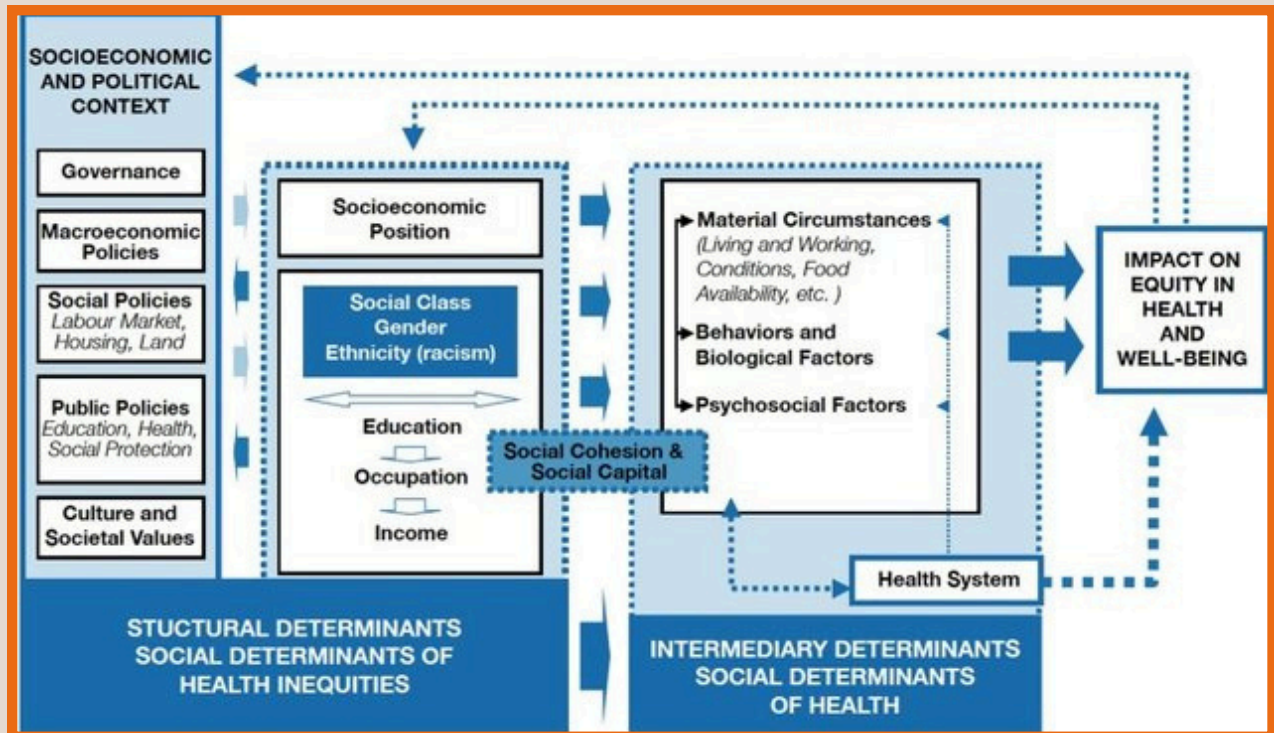
Marmot served as the chair of the World Health Organization (WHO) Commission on Social Determinants of Health from 2005 to 2008. The commission's report provided a comprehensive analysis of global health inequalities and proposed policy recommendations to address social determinants and promote health equity.

To sum up, **the key principles in the body of work on the social determinants of health include:**

1. The existence of systematic and avoidable differences in health outcomes between different social groups.
2. Health follows a social gradient; individuals in lower socioeconomic positions experience worse health than those in higher positions, even within the same society.
3. The importance of early life conditions, including factors such as childhood nutrition, education, and socioeconomic status, in shaping lifelong health trajectories.
4. The significance of addressing structural determinants, such as income inequality, social policies, and employment conditions, to reduce health inequities.



THE WHO FRAMEWORK OF THE SDOH



A Conceptual Framework for Action on the Social Determinants of Health (WHO, 2010)

The World Health Organization defines the social determinants of health as the conditions in which people are born, grow, live, work and age, and the wider forces that shape these conditions, including how money, power and resources are distributed. These non-medical factors strongly influence health outcomes and are central to both clinical care and public health practice.

The WHO's conceptual framework shows how these determinants are organized into two linked layers that generate health inequities. Structural determinants refer to the wider social, economic and political context, such as governance, macroeconomic and social policies, public policies, and dominant cultural values, and to the way these shape a person's socioeconomic position, including their social class, gender and ethnicity.

Structural determinants then give rise to intermediary determinants: the more immediate conditions of daily life that directly affect exposure to risk and capacity to respond. These include material circumstances (for example housing quality, neighborhood conditions, working environment and income), psychosocial factors (such as stress and social support), and health-related behaviors and biological factors. For instance, a low-income cleaner living in overcrowded housing and working without sick leave is more exposed to infectious disease, less able to isolate when unwell, and more likely to delay seeking care than a higher-income professional who can work from home, leading to worse outcomes despite similar clinical needs.

The framework also treats the health system as an intermediary determinant, because how services are organised, financed and delivered can either narrow or widen existing social gradients in health. Two patients with the same diagnosis of hypertension, for example, may have very different blood pressure control if one has regular access to affordable care and medicines, while the other faces user fees, long travel times and fragmented services.

By tracing connections from structural determinants, through intermediary conditions, to unequal health outcomes, the WHO framework makes clear that health inequities are produced by social, economic and political arrangements rather than by isolated individual choices. For health professionals and policymakers, it highlights the need to act not only on proximal risk factors in the clinic, but also on the upstream structures that systematically advantage some groups and disadvantage others.





THE STRUCTURE- AGENCY DEBATE

MECHANISMS THAT LINK STRUCTURES TO HEALTH INEQUITIES

Structure refers to enduring societal frameworks and institutions that shape individual and group actions and behavior. It represents the external and institutionalized aspects of social life which sets the boundaries within which individuals engage and experience opportunities and constraints. For example, factors like socioeconomic status and healthcare systems significantly influence health outcomes, with higher socioeconomic status often correlating with better healthcare access and improved health.

Agency, on the other hand, pertains to the capacity of individuals and groups to act intentionally and make choices. It reflects the ability of individuals to exert influence, make decisions, and take actions within the boundaries of

social structures. It emphasizes the active role of individuals in shaping their own lives. In the context of health, individual agency involves personal choices, behaviors, and the ability to navigate within existing structures. For instance, an individual's decision to adopt a healthy lifestyle or seek medical care reflects their agency.

Various assets, including tangible assets like property and savings, and intangible capabilities such as health, education, social relationships, and psychological factors like a sense of belonging, identity, self-esteem, and aspiration influence individual agency. Shared assets and capabilities, including communal voice, organizational skills, and identity shape collective agency.

Structure and agency exist in a dialectical relationship, with individuals both influencing and being influenced by social structures. While structures establish a framework, agency enables individuals to navigate and influence these structures.

Health outcomes emerge from the dynamic interplay between structural factors (like social determinants of health) and individual or collective agency (such as health behaviors, lifestyle choices, and health equity advocacy) to shape health trajectories.

Individual choices are influenced by and often constrained within, the broader context of societal structures such as economic systems, social norms, and institutional policies. These structures not only shape individual behaviors but also create unequal access to health resources, leading to health disparities. At the same time, when there is equal opportunity, social structures can also offer opportunities to access resources and foster healthy, flourishing lives. To leverage the power of societal structures, it is essential to view health as a social phenomenon and a matter of social justice.

Therefore, the social structure should not automatically be viewed in a negative way, as only serving to constrain human freedom, since in many ways the social structure enables us to live, by providing health care, welfare, education, and work - Germov, 2013

Integrating sociological insights with epidemiological data allows for a more comprehensive analysis that considers both the empirical trends in health outcomes and the broader social and economic contexts influencing these trends. For example, epidemiological data might show a high prevalence of diabetes in a particular community. Sociological insights can then provide context, revealing factors like such as restricted access to nutritious food and recreational facilities influenced by socio-economic policies, a stressful environment with limited social protection, and limited access to healthcare for timely check-ups, facilitating early detection and disease management.

This integrated approach helps understand how structural conditions and individual behaviors interact, contributing to health disparities. By combining these perspectives, we can develop more effective public health strategies that address both individual health behaviors and the broader social determinants of health.

Crear-Perry J, Correa-de-Araujo R, Lewis Johnson T, McLemore MR, Neilson E, Wallace M. Social and structural determinants of health Inequities in maternal health. *J Womens Health (Larchmt)*. 2021;30(2):230-5. doi:10.1089/jwh.2020.8882.

Germov J. *Second Opinion : An Introduction to Health Sociology*. Melbourne: Oxford University Press; 2013.

Rütten A, Gelius P. The interplay of structure and agency in health promotion: Integrating a concept of structural change and the policy dimension into a multi-level model and applying it to health promotion principles and practice. *Social Science & Medicine*. 2011;73(7):953-9. doi:https://doi.org/10.1016/j.socscimed.2011.07.10.

Ryan RS, Travis JW. *Wellness workbook*. Berkeley, CA: Ten Speed; 1981.

Williams GH. The determinants of health: structure, context and agency. *Sociol Health Illn*. 2003;25:131-54.

STRUCTURAL VIOLENCE

MECHANISMS THAT LINK STRUCTURES TO HEALTH INEQUITIES



The social determinants of health, which are intricately linked to social justice in health, are also linked to the concept of structural violence.

According to Farmer et al (2006),

“structural violence” is one way of describing social arrangements that put individuals and populations in harm's way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people (typically, not those responsible for perpetuating such inequalities) (e449).

The term "structural violence" was initially conceptualized by Johan Galtung, highlighting its role as a detriment to marginalized communities through the negative influence of social institutions and systems of social organization. This concept includes various forms of institutionalized discrimination, including racism, sexism, and classism. Subsequently, Dr. Paul Farmer, a distinguished medical anthropologist, applied the concept of structural violence to the domains of public health and global health. Farmer postulated that large-scale societal forces, such as poverty, racism, gender inequality, and political violence, serve as systemic impediments to health and well-being. These forces, often covert



Paul Farmer, 2011, Wikipedia

and ingrained in social and political institutions, result in health disparities and unnecessary suffering, particularly in the world's most impoverished populations.

His empirical work in Haiti and other resource-limited settings illustrated how these structural elements can precipitate adverse health outcomes. Farmer emphasized that effective

interventions must address these broader social determinants of health.

Farmer's holistic approach to global health seamlessly integrated clinical medicine with an acute awareness of the wider social and political milieu. He underscored the necessity of considering both the biological and social-structural factors contributing to the proliferation and severity of diseases such as HIV/AIDS, tuberculosis, and other infectious diseases. This perspective has significantly influenced contemporary global health strategies, fostering more effective and equitable health interventions on a global scale.

Rylko-Bauer B, Farmer P. Structural violence, poverty, and social suffering. In: Brady D, Burton LM, editors. *The Oxford Handbook of the Social Science of Poverty*: Oxford University Press; 2016. p. 47–74.

Farmer P. *Haiti after the earthquake*. New York: Public Affairs; 2011.

Farmer P, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. *PLoS Med*. 2006;3(10):e449. doi:10.1371/journal.pmed.0030449

Farmer P. On suffering and structural violence: A View from Below. *Daedalus*. 2004;133(1):261-273. doi:10.1162/001152604772747676.



SOCIAL DETERMINANTS OF HEALTH: SOCIAL EXCLUSION

MECHANISMS THAT LINK STRUCTURES TO HEALTH INEQUITIES



Social exclusion ‘involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole’ (Levitas et al., 2007).

Social exclusion is a critical social determinant of health. Individuals experiencing homelessness, those who use injectable drugs, sex workers, Romani people, migrants, individuals with disabilities, people facing mental

health challenges, and families led by single parents are among the groups commonly associated with experiencing social exclusion (O’Donnell, O’Donovan, and Elmusharaf, 2018).

The denial of rights, opportunities, and resources that are crucial for social integration leads to reduced participation in various aspects of social, economic, educational, and political life. Social exclusion, through mechanisms like material deprivation, lack of social support, reduced access to healthcare, and the psychological impacts of exclusion, leads to adverse health outcomes (Popay et al., 2008).

This relationship is evident in the way marginalized groups often face greater health risks and poorer access to health services, resulting in a cycle of poor health and continued exclusion.

Health systems, particularly primary healthcare, play a crucial role in fostering social inclusion and promoting good health. By offering accessible and comprehensive care, primary healthcare can address the diverse needs of marginalized populations, reducing health disparities. Services such as preventive care, health education, and community-based interventions are key in promoting health equity and reducing social exclusion (Starfield et al., 2005).

The role of the State is crucial in enabling these outcomes via well-crafted policies promoting inclusion and equal opportunities (Levitas et al, 2007). The State must not only develop and implement supportive policies for robust, inclusive health systems but

also ensure these systems are well-funded and integrated with other social policies and initiatives. Integrating healthcare policies with broader social policies for a holistic strategy combining healthcare with broader social actions will effectively promote social inclusion and good health (Marmot et al. 2008).

Levitas R, Pantazis C, Fahmy E, Gordon D, Lloyd-Reichling E, Patsios D. The multi-dimensional analysis of social exclusion. Bristol: University of Bristol; 2007.

Marmot M, Friel S, Bell R, Houweling T, Taylor S. Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet*. 2008 Nov 8;372(9650):1661-9.

O'Donnell P, O'Donovan D, Elmusharaf K. Measuring social exclusion in healthcare settings: a scoping review. *Int J Equity Health*. 2018;17(1):15.doi:10.1186/s12939-018-0732-1.

Popay J, Escorel S, Hernández M, Johnston H, Mathieson J, Rispel L. Understanding and tackling social exclusion: Final report to the WHO Commission on Social Determinants of Health 2008 [cited 24 Jan 2024]. Available from: file:///C:/Users/User/Downloads/Understanding_and_tackling_social_exclusion.pdf.

Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502.doi:10.1111/j.1468-0009.2005.00409.x.

Social inclusion is defined as the process of improving the terms of participation in society for people who are disadvantaged on the basis of age, sex, disability, race, ethnicity, origin, religion, or economic or other status. This definition acknowledges that while everyone may not start from the same place, efforts should be made to ensure that everyone has the same opportunities to participate fully in societal activities.

WORLD BANK(2013)



IMPLICIT BIAS

MECHANISMS THAT LINK STRUCTURES TO HEALTH INEQUITIES

With few exceptions, clinicians are not trained to understand such social forces, nor are we trained to alter them. Yet it has long been clear that many medical and public health interventions will fail if we are unable to understand the social determinants of disease (Farmer et al., 2006)

The oversight of social determinants of health in clinical practice by doctors can often be linked to implicit biases, which may unconsciously influence their decision-making and perceptions, leading to a narrower focus on immediate clinical symptoms rather than considering the broader, contextual factors affecting a patient's health.

Implicit bias refers to the 'attitudes or stereotypes that affect our

understanding, actions, and decisions in an unconscious manner' (Staat, 2016). These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Unlike explicit biases, which are deliberate and conscious, implicit biases are often incompatible with one's conscious values.

Evidence of implicit bias in healthcare can be particularly impactful. A notable example is the study by Schulman et al. (1999), which examined the influence of race and sex on physicians' recommendations for cardiac catheterization. The study revealed that physicians were less likely to recommend cardiac catheterization for African American



patients compared to white patients, and for women compared to men. This finding was significant because it highlighted how implicit biases can lead to disparities in healthcare recommendations and treatment, even among well-trained and well-intentioned professionals.

The implications of this study are profound, underscoring the need for

awareness and strategies to mitigate implicit bias in healthcare settings. It serves as a reminder of the subtle yet pervasive nature of unconscious biases and their potential to influence decision-making in critical areas like health care.

Impact of implicit bias:

DOCTOR:

- inequitable doctor-patient interactions
- biased clinical decision-making

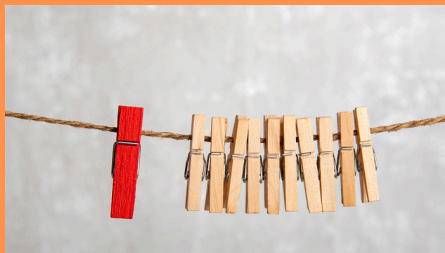
PATIENT

- treatment non-adherence
- avoidance of healthcare
- poor health outcomes

Schulman KA, Berlin JA, Harless W, Kerner JF, Sistrunk S, Gersh BJ, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med.* 1999;340(8):618-26.doi:10.1056/nejm199902253400806.

MECHANISMS THAT LINK STRUCTURES TO HEALTH INEQUITIES

OTHERING



Johnson et al. (2004) define the concept of Othering as the process of distinguishing individuals who are perceived as different from oneself or the mainstream. This process not only highlights differences but also reinforces and sustains power imbalances,

often leading to the domination of one group over another. Factors such as race, geography, ethnicity, economic status, ideology, and gender are commonly employed in perpetuating Othering. This concept involves not only recognizing 'difference' but also attributing 'inferiority' to those deemed different, thereby justifying their exclusion and marginalization. Consequently, Othering serves to reinforce one's own identity and dominance by systematically disempowering and sidelining the 'Other'.

Johnson JL, Bottorff JL, Browne AJ, Grewal S, Hilton BA, Clarke H. Othering and being othered in the context of health care services. *Health Commun.* 2004;16(2):255-71.doi:10.1207/s15327027hc1602_7.

THE EFFECTS OF THE SOCIAL DETERMINANTS OF HEALTH

ON CLINICAL AND PUBLIC HEALTH PRACTICE

Understanding the effects of social determinants of health is crucial for clinical and public health practice, as these determinants profoundly shape patient outcomes, influence health behaviors, and contribute to the health disparities observed across different populations.

- **Access to Healthcare Services:** Individuals in lower socioeconomic statuses often have limited access to healthcare services. This results in delayed or neglected care, leading to worse health outcomes. Clinical practices need to focus on providing accessible and affordable healthcare to bridge this gap.
- **Education and Health Literacy:** Education level influences health outcomes. Higher education levels often correlate with better health, partially due to increased health literacy. Public health efforts should focus on educational programs to improve health literacy across all population segments.
- **Employment and Working Conditions:** Employment status and working conditions directly impact health. Unemployment, job insecurity, and stressful work environments contribute to poor health outcomes. Clinical and public health interventions should address occupational health and safety.
- **Social and Community Context:** Social cohesion and social support systems play a significant role in individual health. Isolation and lack of social support are linked to higher rates of mental health problems. Both clinical and public health practices should incorporate strategies to improve social support and community engagement.
- **Economic Stability:** Poverty and economic instability are significant determinants of health. They are associated with higher rates of diseases such as diabetes, heart disease, and mental illness. Primary healthcare programs should work towards reducing poverty and economic disparities to improve health.
- **Physical Environment:** The physical environment, including housing, air quality, and access to recreational areas, significantly affects health. Poor living conditions are associated with a range of chronic diseases. Clinical practices should consider environmental factors in patient care, and public health initiatives should aim to improve living conditions.

These examples illustrate the importance of considering the social determinants of health within clinical and public health practices, emphasizing the profound impact of social factors on overall well-being and healthcare outcomes.

Before the emergence of social determinants of health advocacy, prevailing viewpoints endorsed by behavioral and health psychologists such as Albert Bandura and John C. Norcross and others attributed health outcomes primarily to individual choices.

However, the evidence on the social determinants of health has challenged this perspective, contributing

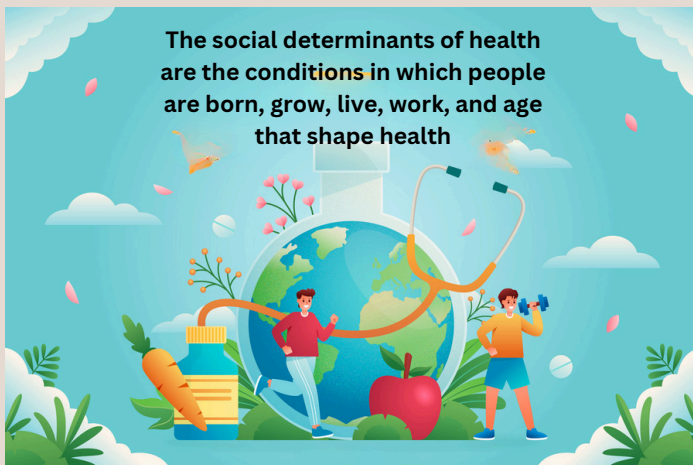
additional evidence that, beyond individual agency, societal structures also significantly shape health outcomes.

In the next section, we will explore the structure-agency debate.

Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. *Public Health Rep.* 2014 Jan-Feb;129 Suppl 2(Suppl 2):19-31. doi: 10.1177/00333549141291S206.

Irwin A, Scali E. A conceptual framework for action on the social determinants of health. *Social , determinants of health discussion paper 1: Debates , policy & practice, case studies.* Geneva: World Health Organization.; 2010.

WHO. Taking action on the social determinants of health: World Health Organization; 2024 [cited 11 Jan 2024]. Available from: <https://www.who.int/westernpacific/activities/taking-action-on-the-social-determinants-of-health>.



Check out this video which discusses the health of two individuals from two different socio-economic levels and how this mediates their health outcomes.

<https://www.youtube.com/watch?v=IZZA4SSHm1k>

A multilevel lens on health Social Ecological Model

18



THE SOCIAL ECOLOGICAL MODEL

The social ecological model is a way of understanding health that looks beyond individual choices and considers how people are embedded within families, organisations, communities, and policy environments. McLeroy and colleagues adapted Bronfenbrenner's ecological theory to health promotion and proposed five levels of influence on health behaviour: intrapersonal, interpersonal, institutional, community, and public policy (McLeroy et al., 1988). The model assumes that behavior is shaped by reciprocal interactions between individuals and their environments, so that changing social contexts can support changes in individual behaviour, and individual action can, over time, contribute to environmental change (McLeroy et al., 1988).

At the intrapersonal level, determinants include a person's knowledge, attitudes, beliefs, skills, and other individual characteristics that influence behaviour (McLeroy et al., 1988). For example, in the context of physical activity, individual-level factors such as motivation, self-efficacy, and perceived benefits and barriers have been associated with whether people achieve recommended activity level (Sallis et al., 2006; Spence & Lee, 2003).

Interpersonal influences arise from family, friends, and other close social networks, which can provide social support, role modelling, and normative expectations around health behaviours (McLeroy et al., 1988). Continuing with the example of physical activity, studies have shown that support from

family and peers, such as encouragement to be active or having someone to exercise with, is positively associated with higher activity levels (Sallis et al., 2006).

Institutional factors refer to the policies, rules, and organisational cultures of settings such as schools, workplaces, and health-care organisations (McLeroy et al., 1988). In the case of physical activity, institutional influences include whether schools provide regular, high-quality physical education, whether workplaces offer facilities and time for exercise, and whether clinics systematically assess and counsel patients on physical activity (Sallis et al., 2006).

Community factors concern relationships among organisations and broader features of the local environment, such as neighbourhood design, availability of recreational facilities, and community norms (McLeroy et al., 1988). Evidence suggests that living in neighbourhoods with safe sidewalks, parks, and accessible recreational facilities is associated with higher levels of walking and other forms of physical activity (Sallis et al., 2006; Spence & Lee, 2003).

At the public policy level, laws, regulations, and broader policy frameworks shape the conditions under which individuals and communities make decisions about health (McLeroy et al., 1988). For physical activity, examples include

urban planning policies that support active transport, national guidelines on school physical education, and transport policies that prioritise pedestrians and cyclists (Sallis et al., 2006).

Putting these levels together, we can use walking to and from university as a concrete example. A student's decision to walk may depend on their personal beliefs about the health benefits of walking and their confidence that they can incorporate it into their routine (intrapersonal) (Bauman et al., 2012). It may also depend on whether friends walk with them or whether family members encourage or discourage walking because of safety concerns (interpersonal) (Sallis et al., 2006). The university's policies on car parking, provision of bicycle racks, and availability of lockers and showers can make active commuting more or less attractive (institutional) (Sallis et al., 2006). Features of the surrounding neighbourhood, such as the presence of continuous sidewalks, lighting, and crossing points, as well as perceived safety from traffic and crime, further influence the likelihood that students will choose to walk (community) (Sallis et al., 2006). Finally, city-level transport and land-use policies that prioritise compact, mixed-use development and investment in pedestrian infrastructure can increase walking rates across the population, including among students (Sallis et al., 2006).

The value of the social ecological model lies in how it changes the kinds

of questions we ask about clinical and public health problems. Instead of asking only “Why does this person not exercise?”, the model encourages us to ask, “What is happening at each level: intrapersonal, interpersonal, institutional, community, and policy that makes regular physical activity more or less feasible?” (McLeroy et al., 1988).

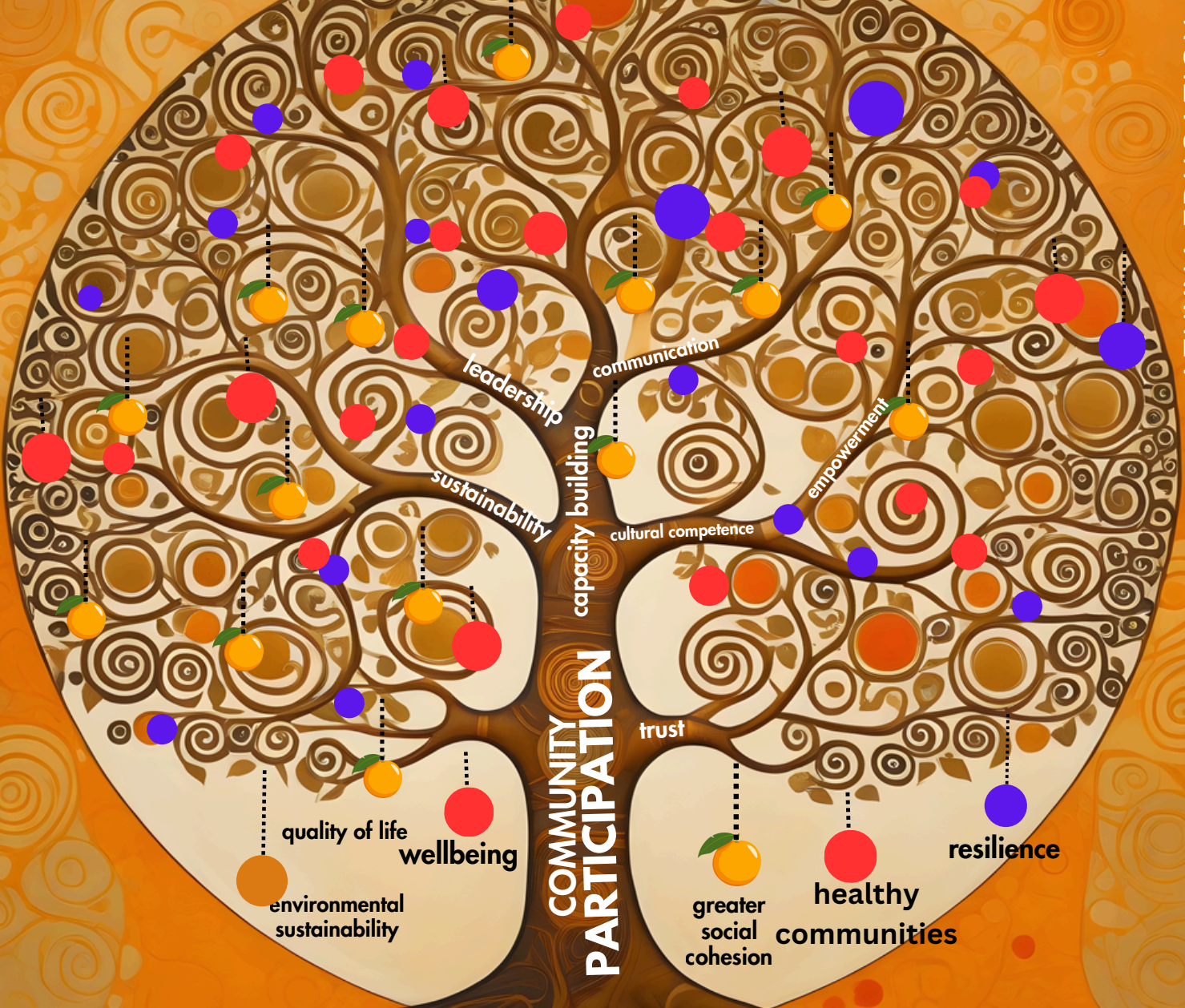
In clinical practice, this may translate into taking a brief but structured history that includes interpersonal supports, workplace barriers, and neighbourhood constraints, rather than focusing solely on motivation. In public health, it supports the design of multilevel interventions, combining education with changes to school timetables, workplace policies, urban design, and transport systems, because evidence suggests that such multilevel approaches are more likely to produce sustained changes in physical activity and related health outcomes than single-level interventions (Sallis et al., 2006).

For you as a future doctor, becoming familiar with this way of thinking is an early step towards recognising that health outcomes are co-produced by patients, professionals, organisations, and systems, and that effective action often requires coordinated change across several levels at once (McLeroy et al., 1988).

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MUST KNOW

1. The WHO model of the social determinants of health.
2. Key principles of the social determinants of health
3. The social gradient in health and the Whitehall studies; 10 key areas (the "Solid Facts") where social factors most profoundly impact health and life expectancy
4. Concepts : Structure and agency; structural violence; social exclusion; implicit bias.
5. The social-ecological model - its significance (multi-level determinants), intersection in clinical decision making.



DETERMINANTS OF HEALTH

Dr. Sharuna Verghis

THEME II: POPULATION, SOCIETY HEALTH AND ILLNESS
Med1100/1200 Semester 1

 MONASH University MALAYSIA	JEFFREY CHEAH SCHOOL OF MEDICINE & HEALTH SCIENCES
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