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Social inequalities in health: The need for a new concept of health

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In this paper, we discuss how the World Health Organisation's concept of health can direcly or indirectly function as a cultural determinant of health and increase or maintain social inequalities in health. This goes against the sustainable development goals of the United Nations and accentuates a need to replace or complement the existing health definition. The paper concludes with what an alternative definition should include.

Background

The World Health Organisation's definition of health[1] from 1947 describes health as *'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* (Callahan, 1973: 77). Such an idealised, limitless definition of health can be meaningful and valuable to aspire to in some settings, e.g. when developing a politically ambitious global health organisation. The definition is all-embracing; it does not exclude any state or condition by definition, nor does it limit the understanding of health to a disease-centred biomedical definition. The inclusion of physical, mental and social well-being reflects a holistic perspective on health, and the adjective 'complete' reflects ambitious goals.

On the other hand, this highly idealised, aspirational concept runs into trouble when applied in the real world. On the supply side of the healthcare system, the scarcity of resources, knowledge gaps, and political and value disagreements must be considered. On the demand side, a variety of social, political and practical factors influence people's everyday lives, which makes the idea of complete well-being, even in the absence of disease, unrealistic and unobtainable.

The definition is extensively criticised: i) it does not reflect the fact that people can adapt to their conditions and feel healthy despite chronic disease or disability (Callahan, 1973), ii) it cannot be operationalised (Huber et al., 2011), iii) it is insensitive to distinctions between the severity of health deficiencies (Larson, 1999) and iv) it is limitless and may contribute to unjustified medicalisation (Huber et al., 2011). Moreover, when compared to alternative models of health (for example (Hancock & Perkins, 1985), it can be criticised for v) not reflecting the embeddedness dimension of health, i.e., the fact that our perceptions of health are strongly influenced by cultural values and beliefs.

As an alternative, Huber and colleagues propose "the formulation of health as the ability to adapt and to self manage" (Huber et al, 2011: 3). While this represents both an intuitive and useful understanding of health, it is not targeted to ameliorate our concern regarding social inequality.We argue that this concept can vi) contribute to increasing or maintaining social inequalities in health. The need to acknowledge social inequality in this context is also acknowledged by Nobile (ref p 38), who argues that "(A)n aspect that is worth emphasizing is the influence of social factors in the determination of the state of health or disease". Yet, we are not aware of any concrete definition which attempts to encapsulate this concern.

Based on the objections i)-vi), we argue that a new concept of health is needed. In the following argument, we will we substantiate how the WHO definition, in combination with fundamental ethical principles, can be applied to increase social inequality in health. We conclude the paper with suggesting what a new definition need to capture in order to meet the objections.

Method

Our hypothesis is that the WHO definition of health can have an adverse impact on social health inequality. We support this claim with a theoretical argument that social inequalities can be reproduced by the healthcare system unless it is carefully designed to address and counterwork barriers that people who are socioeconomically disadvantaged experience. Further, we discuss how the combination of the WHO definition and central ethical principles in combination can support social health inequalities in the clinic. Unlike an empirical study, we discuss theoretically how of a concept combined with ethical principles and political strategies, can generate practical impact.

Determinants of health

A large number of empirical studies have documented that observable aspects of health correlate with socioeconomic status; the higher the education, income and occupational status, the better the individual prospects of health, other things equal (M. G. Marmot, 2003). Not only is this relationship between health, in terms of morbidity and mortality, and social inequality extensively documented, there is also broad consensus that the major causes of health inequality are found outside the healthcare system, namely in the unequal distribution of the social determinants of health (Commission on Social Determinants of Health, 2008; Dahlgren & Whitehead, 2006; Ottersen et al., 2014). Unfair health inequalities correspond with the notion 'health inequities' and we use the notions interchangeably in the text.

Health inequities are found everywhere, in high and low income countries, and in different health systems. To discuss how one might change the pattern, we begin with a conceptualisation of structural factors which can influence the patients' ability to have their healthcare needs fulfilled in the system.

Levesque and colleagues (Levesque et al., 2013) did a literature review of all interpretations of the notion 'access' to healthcare. They synthesised and revised the most cited frameworks into an overall conceptual framework. They defined 'access' as 'the opportunity to have health care needs fulfilled', and included all phases of desiring, seeking, reaching, using, and benefitting from healthcare. Support mechanisms and barriers were identified in each of these phases, according to how the healthcare system is organised on the one side and the abilities of the patients on the other (Levesque et al., 2013).

We find this framework useful in order to identify unequal opportunities between individuals. Unequal access between socioeconomic groups can occur if, for example, the health facility is difficult to reach without a car, opening hours makes it difficult to book an appointment for people who do not control their working hours, or when little education hinders an adequate understanding of the doctor's recommendations. When socioeconomic inequality creates unequal opportunities to have healthcare needs fulfilled, social health inequality arises.

Hence, unless a healthcare system is organised to accommodate the various ways socioeconomic factors influence patients' abilities to desire, seek, reach, use and benefit from care, the system itself will maintain social inequalities (Bærøe et al., 2018). Further, if socioeconomically advantaged groups more easily get healthcare needs fulfilled, the system itself will contribute to reinforcing the social inequalities in health.

How health definitions shape the understanding and organisation of healthcare

How we define health can have implications for how healthcare needs are interpreted and acted upon, hence also for the organisation of healthcare services. Policy shapes healthcare systems in different ways: decisions are made at the political, administrative and clinical levels according to political, bureaucratic and professional values.

In theory, both organisational policies and clinical practice can be influenced, directly or indirectly, by a health definition. This happens *directly* if, for example, a specific definition is used to define what count as healthcare needs, justify the divisions of departments in hospitals, or structure the distribution of resources and admission to services, or healthcare personnel interpret healthcare needs based on the definition. It happens *indirectly* when the definition shapes our understanding of health and health care, as reflected in e.g. legal regulations, ethical norms, governing instruments or monitoring bodies. This will, in turn, shape the professionals' interpretations of needs, with potentially significant impacts on their clinical work. Hence, the definition of health functions as a *cultural determinant of the shaping of healthcare services and systems*. Insofar as health concepts are applied to clinical interpretations of healthcare needs it makes sense to also regard health concepts as *cultural determinants of health.*

The practical significance of the WHO definition

Unless a definition of health is applied directly and openly in policy, its practical impacts are difficult to study empirically. Are there reasons to believe that the WHO definition of health indirectly influences policymaking and healthcare practices in directions that maintain or reinforce social health inequality? We believe there are such reasons, and in this section we discuss some potential indirect effects, with a particular focus on undesirable inequities.

In the Western world, the principles of respect for autonomy, non-maleficence, beneficence and justice have influenced theoretical and practical approaches for several decades (Beauchamp & Childress, 2001). To decide what ethical conduct requires in health care, all the principles should be considered together. Among them, beneficence and justice, and their interplay, can be seen as steering policy and clinical decisions in the same direction as the WHO definition.

The WHO definition and the principle of beneficence

The principle of beneficence is widely accepted and associated with the goal of medicine; healthcare providers should act in the best interest of the patient. If the patient trust that the physician's primary objective is to help her in the best possible way, this provides a strong motive to seeking care. To act in the best interests of the patient, involves that the health professional should contribute to health improvements, also when improvements are relatively small. The principle of beneficence, "doing good", involves few limitations to what should be offered, as long as the net benefit is positive, however little the benefit. Thus, the ethical principle of beneficence is generally compatible with the WHO's maximizing, ideal definition of health. This can, however, lead to social inequalities. Neither the WHO definition nor the principle of beneficence distinguishes between smaller or greater improvements; implying that the treatment of small ailments should have equal priority and regard as severe illnesses.

Vulnerability to disease is not evenly distributed in a society; some diseases, e.g. cardiovascular disease (Clark et al., 2009), and mental health issues (Silva et al., 2016), are more prevalent among the socioeconomically disadvantaged. Also, increased risk of multi-morbidity is associated with low education and deprivation (Pathirana & Jackson, 2018). Thus, differences in the distribution of health and well-being cannot be expected to be eradicated by healthcare unless this is specifically targeted. A healthcare system can be insensitive to such uneven distribution of diseases if it ignores the associations between low socioeconomic status and susceptibility to diseases on many levels: in preventive care, by not prioritising relevant research, or providing inadequate care. A socially skewed prevalence of health problems, lack of preventive care, research priorities, and insufficient care will contribute to maintaining social inequalities, despite healthcare personnel's aims of doing good.

The WHO concept of health and the principle of justice

A just distribution of healthcare relies on the principles of formal equality, requiring equal treatment of equal cases and unequal treatment of unequal cases, according to the relevant differences between them (Aristotle, 1984). A principle of justice that aims to distinguish between equal and unequal cases, thus guiding the distribution of healthcare, must be based on a theory of justice, of which there are several different (Beauchamp & Childress, 2001). Since people disagree about which substantive principles allocations should be based upon, some scholars emphasize the value of the decision making process itself (Daniels & Sabin, 2002). The idea is that a fair process will lead to fair results. Still, the result of a decision- making process must be justified according to one among many relevant principles. A principle of justice, in combination with the principle of beneficence, can, depending on its substantive content, either lead to social inequality or not.

We will first describe how a principle of justice can lead to the same social distribution of health inequality as the WHO health definition might involve.In the real world, resources are scarce. Priorities must be made, and limits set with regards to what can be offered. As argued by Larson (ref her), the WHO definition offers no guidance on how to distinguish essential healthcare from less essential care (Larson, 1999). This makes it useless in supporting fair real-world policymaking, unless one accepts that all requests are equally important to meet. If all requests are considered equally important, the distribution of just healthcare can be left with those who manage to get their claims through by claiming extraordinary beneficial effects (according to the beneficence principle), which qualifies them for special treatment (according to the formal equality principle). This is likely to be the socioeconomically better- offs, due to their social, cultural and economic resources which can be used to promote their interests, at the cost of increased social inequality in health. Consequently, distributive decisions based on the formal equality principle can lead to the same inequitable results as the WHO definition and the principle of beneficence.

Hence, social inequalities in health care must be mitigated otherwise. Conceptually, an additional principle to the formal equality principle is required. Most theories of distributive justice will hinder the unintended open-ended implication of the combined WHO definition and the principle of beneficence; they include specifications of what should be counted as equal viz unequal cases. Many theories of justice require to rank-order care according to medical need and the degree of improvement, some also cost of treatment and severity of disease. A utilitarian, for instance, will solely base a distributive decision on the cost- effectiveness of treatment, being insensitive to severity (unless the most severely ill can gain the most in terms of improvement), while a Rawlsian will be concerned with securing the worst off the greatest improvement (Ekmekci & Arda, 2015; Sen, 1980).

To hinder or reduce social inequality, the distributive principle should be accompanied by a specific identification of barriers to access (in the wide interpretation of 'access' as described by Levesque et al (ref). This also involves that decisions on treatment should be based on information about social and economic conditions which can represent hinders to the patient's ability to benefitting from treatment (Bærøe & Bringedal, 2011; Puschel et al., 2017).

Professional ethical guidelines emphasize that any kind of discrimination based on personal characteristics should be avoided (see, for example, the Geneva Declaration of the World Medical Association (WMA) (World Medical Association, 2018)). The reason is to avoid undue influence of socioeconomic advantages. There is, however, a need to be concerned with the opposite as well, namely undue discrimination based on socio-economic disadvantages. Unless it is made clear that socioeconomic factors can be relevant for appropriate care, guidelines run the risk of maintaining or reinforcing inequities (Bringedal et al., 2011; Bringedal & Rø, 2021). An explicit identification of the significance of socioeconomic factors can reduce such influence. This is not part of the WMA Declaration, which is unfortunate since transnational standards influence national professional ethical guidelines and thereby shape clinical judgments about needs.

Substantive principles of justice can be applied to promote health equity. In real world policy- making, such principles can justify decisions made on i) policies that indirectly influence the distribution of health problems, ii) research priorities, and iii) healthcare resource allocation. Furthermore, governing instruments such as legal regulations and economic incentives, can be construed with the aim of translating a political will to reduce inequities.

However, the relation between principles and policies is not 1:1, just as there is no such relation between a definition of health and policy. This gap between principles and decision- making in practice explains why we cannot expect decisions that coherently address health inequities across sectors and within the health area. At the same time, this gap also allows an idealized, no-limit-notion of health, to justify and drive expectations, demands and interests. And especially so, as we have argued, when this is compatible with ethical principles that otherwise influence the healthcare service. Thus, we cannot exclude the possibility that WHO health definition has an impact on the healthcare systems, via user's expectations. Moreover, we cannot exclude the possibility that this impact could be avoided by a health concept that reflects certain justified boundaries to perceptions of health and correlating expectations to healthcare.

A concept alone cannot mitigate health inequities influenced by the healthcare system, but it can be applied to shape regulations, expectations and judgments about healthcare needs. It can also be construed such that it does not drive towards inequities. A concept of health which ignores the difference between essential and less essential needs, will not protect from the maintenance or reinforcement of social inequalities in health care. Hence, if the political goal is less health inequities, we need a revised concept of health.

The WHO definition of health and the UN's Sustainable Development Goals (SDGs)

Should less health inequity be a political goal? There is transnational consensus on shaping local politics in that direction. The United Nation's Sustainable Developments Goals (SDGs) are endorsed by the member countries and provide goals for morally and politically justified societal developments (United Nations, 2015). These goals also provide endorsed normative frames for approaching health and the distribution of healthcare. Specifically, SDG 3.8, on universal health coverage, aims to provide "access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (United Nations, 2015: 16). Also, SDG 10.3 describes the following sub-goals: 'By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status' (United Nations, 2015: 21). Equal access to healthcare as broadly understood according to the framework proposed by Levesque and colleagues above, is a prerequisite for equitable health. Equitable health is necessary to promote equal opportunities in life (Daniels, 2007; Sen, 1980). Furthermore, equitable health is also required for equal opportunities to social, economic and political inclusion (Bærøe & Bringedal, 2014).

As we have argued, the WHO definition does not contribute to this notion of sustainable politics. Rather, the conceptualization functions as a cultural determinant of health with a capacity to increase exactly the unsustainable health inequity that the UN (the "mother organization" of the WHO) aims to reduce. Again, this inconsistency stresses the need for revising the healthcare concept so it drives together with the political goal of targeted reducing inequities instead.

Towards a concept of health for health equity

The interplay between the WHO definition of health and core ethical principles in health discussed above, illustrates how the concept, as a cultural determinant of health, can increase health inequity. The tension between potential inequity influenced by the WHO definition and the sustainable politics of UN, raises the question: How should a concept of health look like that would join forces with the SDGs to reduce health inequity? While it is beyond the scope of this article to go further into this, we will suggest several conditions this concept should meet

Elsewhere (WMJ, 2011), we have argued that the Hippocratic Oath (ref) needs a revision in order to sensitize health care personnel towards the fact that socioeconomic factors influence on an individual's ability to benefit from treatment, and that this need to be addressed explicitly to avoid social discrimination. In the same way as the doctor needs to adjust consultations and treatment options to age or disabilities, adjustments according to socioeconomic factors can be required in order to equalize the chances for benefitting from treatment.

A distinction can be made between input equality and outcome equality, where the latter requires unequal input in order to realize equal outcomes – or, in this case, equal opportunity to benefit from treatment despite socioeconomic or other factors. Based on this argument, we suggest that a new definition of health must include a phrase that addresses the variability between individuals, not only in terms of social background, but that too.

The next requirement to a definition recognizes that health is not a goal in itself, but a means to realize life goals; health should thus be understood relatively to an objective of ensuring everyone an equal range of opportunities to pursue one's life goals. The individual variations in health abilities to benefit from an equal range of opportunities are large. If the health professional focuses on raising the individual's health ability, treatment is required to vary according to all factors which influence health, socio-economic factors included. This argument is inspired by Amartya Sen and his Capability Approach (Sen, 1980) and Norman Daniels notion of 'just health' (Daniels, 2007). Together these approaches can constitute a useful perspective for the way forward in the development of a new concept.

Further, since good and bad health can be self-reinforcing, the definition should also acknowledge that health represents an ability to participate in activities which in the next turn foster good health. Thus, a new concept of health that promotes health equality should be based on evidence-based knowledge of activities which promotes health. To be able to work or go to school are examples of activities that promote health and, at the same time, can contribute to reducing unequal opportunities. These activities indicate the level of functionality healthcare system should strive to promote in their patients.

Thus, a new concept of health should:

I) specify explicitly targeted concerns for the socioeconomically disadvantaged, and

II) define healthcare needs in a way that is sensitive to the specific challenges of the socioeconomically disadvantaged

III) promote an understanding that health is not a goal in itself, but a means to realize life-goals

IV) indicate what kind of activities the healthcare system should strive to promote in their patients based on evidence of what kind of activities foster further good health

Conclusion

We have discussed different ways the WHO definition of health may work against health equity and the SDGs that call for reducing inequality and improving health equality. The concept can drive healthcare decisions in the wrong direction, i.e., toward maintaining or reinforcing health inequalities. Thus, there is a need for a conceptualization of health that can function as a cultural determinant of health in support of reducing inequality. We concluded the paper with sketching out elements of a new definition which we hope merits further discussion.

Notes

[1] Preamble to the Constitution of the World Health Organisation, as adopted by the International Health Conference, New York, 19–22 June, 1946, signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

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