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Governance, regulation and health equity

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1. Introduction

Whatever your beliefs about society, your political views, your outlook on life or your material circumstances, the enjoyment of adequate health is vital to the pursuit of whatever life you have reason to value. Health is intrinsic to living—no matter what one's walk of life. But health is not simply an instrument for the purposes of other social functions; it is an end in itself. Health is the product and reflection of society's attention to an adequate standard, available to all, in the conditions in which its population lives.

In spite of impressive initiatives by institutions worldwide, health issues are constantly in the news: famines, wars, early death and escalating healthcare costs from obesity, diabetes, cancers and mental illness, deaths and injuries from traffic accidents and extreme weather events, and the prevailing communicable disease killers such as malaria, tuberculosis and now Ebola keep the world busy (AP-HealthGAEN 2011; Frieden et al. 2014; Murray et al. 2012).

No country is immune from these concerns but such life and death experiences are not distributed evenly between or within nations. It seems remarkable that, today, a man living in the east end of Glasgow, where this author is from, is at risk of dying 15 years earlier than a man living

in the west end of Glasgow (GCPH 2014). Within a prosperous country such as Australia, is it fair that the poorest 20 per cent of the population can still expect to die younger (six years, on average) than the richest 20 per cent of the population (Leigh 2013), and that those who are more socially disadvantaged (by income, employment status, education) and Indigenous Australians also have a higher risk of depression, diabetes, heart disease and cancers (AIHW 2015)? People born in Papua New Guinea die, on average, 21 years earlier than people born in Australia (WHO 2014a).

It does not have to be like this. The causes of health inequities are complex, arising from the interaction of a variety of political, economic and social factors (CSDH 2008); health inequities are human-made.

To some extent, there is eagerness, globally, among many politicians, different levels of policymakers, researchers and non-governmental organisations (NGOs) to address these inequities. The World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) assessed the global evidence and made recommendations on what could be done to rectify the economic and social policies that have contributed to global and national-level health inequities (CSDH 2008). The political declaration of the United Nations (UN) high-level meeting on non-communicable diseases in September 2011 positioned these diseases as matters of concern for the highest level of global governance (UN General Assembly 2011). As the Millennium Development Goals approach the end of their current form, countries and institutions reflect on the successes, failures and opportunities to improve the lot of the world's poor (UN General Assembly 2000).

This chapter will assert, however, that, in spite of major advances in understanding the causes of health inequities, persistent poor governance at national and global levels, indifferent policy choices and suboptimal regulation underpin and perpetuate twenty-first-century health inequities. The specific aims of the chapter are twofold. The first is to define health equity such that the reader locates health and disease in the wider societal context and not simply as medical issues. Second, the chapter aims to draw attention to the political, economic and social drivers of health inequities and, in so doing, demonstrate what governance and regulation for health equity could look like. The argument will be that the use of multiple intersectoral policy instruments, involving a broad range of actors, is necessary to address

the ‘causes of the causes’—the fundamental structures of social hierarchy and the socially determined conditions these create in which people grow, live, work and age, and which ultimately affect health equity.

2. A theory of health equity

Universal as it is in principle, health manifests in practice very differently for different people around the world. There are many explanations for this, ranging from the personal to the political.

Poor people behaving badly

For many years, peoples’ behaviours received a lot of attention as a potential explanation for health differences. Various psychological theories dominated the health behaviour literature through the later part of the twentieth century. The focus was on personal beliefs, attitudes and expectations, thereby drawing attention to the idea of individual control and self-regulation (Becker 1974; Fishbein and Ajzen 1975; Leventhal et al. 1998; Bandura 2005).

Towards the end of the twentieth century, the underlying theory driving the behavioural explanation of social inequalities in health had shifted. Building on Weber’s work of rationality and lifestyles, Abel and Cockerham suggested that people’s health-related behaviours are based on choices from options available to them according to their life chances, and this varies depending on people’s social position (Abel 1991; Cockerham et al. 1993). This concurs with the empirical evidence worldwide that more of those with poor health also have poor lifestyle behaviours such as smoking and unhealthy diets, and are from lower socioeconomic groups (Wilkinson and Marmot 2003).

Beyond the proximate to society

While health *inequality* can be defined as the difference in health between different social groups and nations, health *inequity* is that part of the difference that could be avoided or remedied. If there is no necessary biological reason for the often staggering differences then they are not inevitable. And, if such differences in health are not inevitable, the failure to avoid or remedy them is to be found in political and social arrangements, and constitutes a failure of social justice.

But there are different ways of interpreting health (in)equity. On one hand, it can be seen as equality of people's opportunities to seek health; on the other, health equity can be seen as the societal obligation to work towards a reasonable equality among people in health outcomes. Two leading intellectuals, Rawls and Sen, invoke issues of regulation and governance through their theorising of the ways in which both structure and agency are fundamental to the pursuit of social justice, and embrace issues of opportunity and outcome.

The social production of health

Rawls's theory of justice operates on a contract basis, where people are asked, hypothetically, to choose the structure of society they want from behind a veil of ignorance, thereby ensuring impartiality and pursuit of arrangements that are fair for all:

[N]o one knows his place in society, his class position or social status, nor does anyone know his fortune in the distribution of natural assets and abilities ... This ensures that no one is advantaged or disadvantaged in the choice of principles by the outcome of natural chance or the contingency of social circumstances. Since all are similarly situated and no one is able to design principles to favor his particular condition, the principles of justice are the result of a fair agreement or bargain. (Rawls 1971: 11)

Operationalising this contract, Rawls's theory focuses heavily on the structures that provide opportunity and is organised around the importance of 'just institutions', including governments, markets and systems of property. Rawls also describes primary goods such as income, education and power as intrinsic to the pursuit of social justice (Rawls 1971). In essence, he is referring to the structures in society and the functioning of them in a fair and just way—many of the things described in the social production of disease/political economy of health argument, which is organised around notions of power, politics and economics (Navarro 2000).

Located within the political economy of health model is dependency or world systems theory, which is often used to understand differences between nations (Wallerstein 1974). Dependency theory suggests that the differences in health, and the differences in the conditions needed for health, between rich and poor countries reflect historical and current

international capitalist arrangements, often unequal, and the enormous differentials of national wealth and poverty that these generate (Stiglitz 2013).

Within countries, the health experienced by different groups corresponds very closely with their place in the social hierarchy or with their different living and working conditions. Empirical studies from around the world provide compelling evidence of a persistently graded relationship between social position and health. Generally, the further down the social ladder, the greater is the risk of poor health and premature death (Di Cesare et al. 2013; Marmot et al. 1991; Labonté et al. 2005).

At the core of a political economic explanation of health inequalities within countries is the Marxist belief that material disadvantage directly affects the variation in mortality and health outcomes, and that class relations underwrite the associations between social position and health outcomes (Scambler 2007). It is believed that material circumstance is structurally determined, evolving from political, economic and social contexts, and that individuals across the range of social positions are exposed to significantly differing daily environments as a result. In all societies, rich and poor, the materialist hypothesis suggests that social infrastructure—in the form of legislation and regulatory protections and controls, social protection systems and services such as education, health services, transportation and housing—is vital for health.

Freedoms and control

While opportunities for health are vital, they alone are not enough. The function of a just society is to do more than simply open the way for individuals to make use of their opportunities; it is to organise in such a way that, where people are deprived of opportunity to lead meaningful lives, such effects can be detected and changed. Sen (1999; 2009) does this by extending Rawls's argument through the introduction of people's capabilities or substantial freedoms: real opportunities based on natural and developed potentialities, as well as the presence of governmentally supported institutions, to engage in political deliberation and planning over one's life—that is, having the freedom to lead a healthy and flourishing life.

Freedom relates to agency and empowerment, which operate along three interconnected dimensions: material, psychosocial and political. As discussed earlier, people need the basic material requisites for a decent life, but they

also need to have control over their lives. Theorists such as Bourdieu and Weber argue that peoples' choices and their health are affected not only by the socioeconomic resources that they have available to them, but also by the very existence of a social structure and an individual's perception of where they lie within that and their experience of that grouping (Bourdieu 1989; Cockerham et al. 1993). This has been demonstrated empirically worldwide but the landmark study was that of UK civil servants, where Marmot and colleagues identified a strong social gradient in health outcomes across economically secure occupational positions. Based on these findings, it was postulated that the relationship observed between social position and noncommunicable diseases and mental health is mediated through psychosocial factors such as stress and social relations (Marmot 2004). Similarly, Wilkinson's work has demonstrated that, in developed countries, it is the relative distribution and not the absolute level of income that is related to life expectancy, and the social consequence of this relative income is a causal factor in health inequities (Wilkinson and Pickett 2010).

Governance and power

There is continuity between the previous two dimensions of empowerment through a third, which is to do with power and participation and the form of governance they combine to create: the degree to which individuals and communities are empowered to influence their nations' processes of governance and to influence the decisions that affect the conditions in which people live (Popay et al. 2008).

Farmer (1999), Navarro and various other political scientists argue that health inequities flow from the systematically unequal distribution of power and prestige among different social groups. Global, national and local politics and modes of governance, economic, physical and social policies and infrastructure and cultural norms generate and distribute power, income, goods and services. These are distributed unequally across the social hierarchy (Navarro 2000).

This manifests in inequities in both material and psychosocial conditions through the inequities in the daily conditions in which people are born, grow, live, work and age, meaning that who you are and where you live will affect access to quality and affordable education and health care, sufficient nutritious food, conditions of work and leisure, quality of housing and built environment and your social relations. Together, these factors affect health and health inequities (Marmot et al. 2008; Friel 2013).

Addressing the distribution of power involves fostering a process of ‘political empowerment’—broadly defined as the process whereby people, or groups, gain control over the decisions that affect them and increase and release their ‘capacity to act’ (agency) to effect change in the areas they define as important. Political empowerment, therefore, is a fundamental medium of social interaction, constituted both at the level of individuals (how much people can exercise control and decision-making over the course and content of their own lives) and at the level of communities (how people can effectively apply their collective values and interests to the way societal resources are distributed). Health equity depends on the political empowerment of individuals and groups to represent their needs and interests strongly and effectively and, in so doing, to challenge and change the unfair distribution of material and psychosocial resources to which all men and women, as citizens, have equal claims and rights (UN ECOSOC 2000).

3. The determinants of health equity in practice

So, what does all this mean for regulation and governance? The conventional biomedical model of health often directs health regulation towards medicines, health services or personal behaviours (Bandura 2005; Ratanawijitrasin and Wondemagegnehu 2002). These are important and are discussed by Healy (Chapter 34) in this volume.

But the exposé made in this chapter of the wideranging determinants of health inequity highlights that a conventional approach is insufficient to improve health equity globally and locally. Policy and regulation for health equity are complex, needing to address issues of, for example, trade, tax systems, food systems, the behaviour of multinational organisations or urban planning. The intersectoral nature of the determinants of health inequities demands a holistic response (see Burris, Chapter 32, this volume). It is no use, for example, getting the physical built environment right if the underlying social inequities prevail.

There also is an increasing array of actors, institutions and interests at stake (Kickbusch 2012). Returning for a moment to Rawls’s veil of ignorance, clearly, from a health perspective, the present arrangements are far from what we might choose under conditions of impartiality—suggesting deliberately unfair arrangements. But, as Sen reminds us,

creating ‘just institutions and structures’ is necessary but insufficient. Supporting people’s freedoms and opportunities and enabling people to realise their potential are essential. One might argue that responsive and smart regulation is in order (Ayres and Braithwaite 1992; Gunningham et al. 1998).

Regulatory approaches and health equity

Let me use the example of inequities in obesity to illustrate a range of possible equity-oriented regulatory mechanisms. Obesity is the result of an imbalance in energy consumed (via diet) and energy expended. In high- and middle-income countries, obesity is more common among socially disadvantaged groups (McLaren 2007; Ezzati et al. 2005).

Three major social changes over the past 50-plus years—globalisation, marketisation and the increasing power and impact of the business sector (Nye and Kamarck 2002)—are highly related to obesity and, in particular, diet.

One of the instruments of these social changes, trade liberalisation, sits often uncomfortably with health and diet-related inequities. Without doubt, trade agreements influence the distribution of power, money and resources between and within countries, which, in turn, affects people’s daily living conditions and the local availability, quality, affordability and desirability of products including food (Friel et al. 2015).

Health concerns relating to trade agreements have tended to focus on two areas: the protection of multinational intellectual property rights and the implications for access to essential medicines; and the privatisation of health care and health-related services (Labonté 2014; Blouin et al. 2009). However, as the scope and depth of trade agreements have expanded over recent decades, two further areas have been receiving greater attention: the reach of trade agreements into ‘behind-the-border’ issues affecting domestic policy and regulatory regimes (Labonté 2014; Thow et al. 2015); and trade and investment in health-damaging commodities (particularly tobacco, alcohol and highly processed foods) and the associated global diffusion of unhealthy lifestyles, which is particularly relevant for obesity (Hawkes et al. 2009, Stuckler et al. 2012).

Administrative regulatory capacity is essential to deal with these trade-diet risks. At the national level, countries must understand that free-trade agreements carry health and social risks and costs (Walls et al.

2015). Internationally, agencies such as WHO can play an important role to support countries to implement trade agreements, as well as provide technical guidance and support with respect to ensuring health concerns are represented at the international level.

Equitable food marketing requires binding international codes of practice related to healthful food marketing, supported at the national level by policy and regulation (Cairns et al. 2013). Restricting exposure to advertising of foods high in fat, salt and sugar is widely considered to be one of the most cost-effective child obesity prevention approaches available and may contribute to reducing dietary inequities due to the higher exposure and vulnerability of low-income children to marketing (Magnus et al. 2009; Loring and Robertson 2014). Reliance on voluntary guidelines may result in differential uptake either by better-off individuals or by institutions and provides little opportunity for private-sector accountability (Galbraith-Emami and Lobstein 2013).

Economic instruments can help regulate dietary intake, and involve domestic healthy food production subsidies and food taxes. According to modelling literature, regulatory approaches that combine taxes on unhealthy foods with subsidies on healthy foods such as fruits and vegetables are likely to have the greatest positive influence on inequities in healthy eating (Thow et al. 2010; Ni Mhurchu et al. 2013; Nicholls et al. 2011).

Urban planning levers hold promise in providing solutions to the problems of land use mix and equitable access to healthy food. The city of Sam Chuk in Thailand restored its major food and small goods market with the assistance of local intersectoral action inclusive of architects. In general, urban design and planning would be greatly aided by routine health-equity impact assessment of food retail placement, neighbourhood walkability, transport networks and street safety.

Without material and psychosocial resources, however, having nutritious food available and physically accessible means little. Prudent social policy initiatives such as social protection schemes and national wage agreements can provide material security if based on healthy standards of living, and if they reflect the real cost of healthy eating (Friel et al. 2006).

Unfortunately, the dominant focus is not on the above but on individual-level action to make people eat more healthily. The regulatory and governance arrangements are missing the heart of the problem (Friel et al. 2007).

Smart governance for health equity

Given the view that health is universal among basic human needs, maintenance of a population's health is a fundamental task of social organisation, and one in which the stewardship role of the state is central.

Government action can, broadly, take three forms: 1) provider or guarantor of human rights and essential services; 2) facilitator of policy and regulatory frameworks that provide the basis for equitable health improvement; and 3) gatherer and monitor of data about populations that generate information about health equity (Blas et al. 2008).

However, the context for governing health has changed, with much more interdependence between countries and problems. Globally, increasing acknowledgement of the need for collective action among states for shared benefits—including environmental protection and human security, among others—offers real opportunities to advance global health equity and also the arguments in favour of fair representation and equitable inclusion in existing and new global institutions.

Traditionally, society has looked to the health sector to deal with concerns about health and disease. However, action to address health equity necessarily moves outside the health system and cuts across many government departments, NGOs and service providers, business, a plethora of advocacy groups and international institutions. Policies and regulation must encompass key sectors of society, not just the health sector. That said, the health sector is critical to global change. It can champion action at the highest level of society, demonstrate effectiveness through good practice and support other ministries in creating policies that promote health equity.

Given the complex context in which health inequities arise today, there are obviously many other actors and institutions who must also play a role in the coproduction of health equity (WHO 2014b). With this come different power constellations, processes, interests and ideological positions nested within different political systems and cultures at different levels of governance (Kickbusch 2005). We must remember that good governance

involves many faces; as Rawls noted, we need fair and just institutions, but, returning to the notion of empowerment, we also have other mechanisms through which to enable actors and their agency.

Formal civil society organisations have enabled improvements to social determinants of health at all levels of society, through advocacy, monitoring, mobilisation of communities, provision of technical support and training and by giving a voice to the most disadvantaged sections of society. New social movements such as informal workers' alliances in low and middle-income countries, including fair-trade basic food producers and anti-child labour campaigns, are now also developing and affecting employment conditions in ways that are good for health.

Some argue, however, that the current global arrangements of norms and regulations render some actors structurally weak (Ottersen et al. 2014). To what extent can agency change the effects of structure? In part, the answer lies in agent-constructed webs of influence (see Drahos, Chapter 15, this volume) and exploiting networks of nodal governance to change flows of power and influence (see Holley and Shearing, Chapter 10, this volume). There are lessons from history on how to pursue health and health equity using soft forms of power and networked governance (see Box 33.1).

Box 33.1 Lessons from Doha

The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) was signed in 1994. It mandated 20-year patent terms for signatory countries. However, at the insistence of many low- and middle-income countries, the TRIPS agreement incorporated a number of flexibilities (health safeguards) for countries to bypass patents to protect public health (for example, in circumstances of emergency). The rights to use these safeguards were reaffirmed in the 2001 Doha Declaration on Public Health and the TRIPS agreement. How did this happen? Analysis by Drahos (2003) points to four elements of good governance: 1) good technical analysis of legal and economic issues; 2) clever framing of issues by advocacy groups; 3) circles of consensus, building unity among developing countries; and 4) networked governance, with a broad-based coalition of states integrated with NGO networks.

4. Conclusion

Health inequities are emergent structural properties of complex systems—changing only when systems change. If one were to take a Marxist approach then change would mean a replacement of the capitalist neoliberal order. However, as others in this book highlight, capitalism

has proven to be highly adaptive (see Levi-Faur, Chapter 17, this volume). A regulatory capitalism that embraces values of responsiveness and smartness may help to bring capitalism's basic arrangements for health equity closer to what citizens might choose for themselves under conditions of Rawlsian impartiality. The example of Doha and TRIPS demonstrates that it can be done; networked governance opens up capitalism to these kinds of possibilities.

Further reading

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This text is taken from *Regulatory Theory: Foundations and applications*,
edited by Peter Drahos, published 2017 by ANU Press, The Australian
National University, Canberra, Australia.