International Journal of Health Sciences
December 2022, Vol. 10, No. 2, pp. 37-46
ISSN: 2372-5060 (Print), 2372-5079 (Online)

Published by American Research Institute for Policy Development
DOI: 10.15640/ijhs.v10n2a5
URL: https://doi.org/10.15640/ijhs.v10n2a5

Applying the Political Economy of Health and Social Determinants of Health Frameworks together: can this approach improve our understanding of health inequalities?

Laura Kmentt[1]* and Jonathan Filippon[2]

Abstract

The Social Determinants of Health (SDH) framework is popular with academics and policy makers as a multifactorial explanation for unequal health attainment; Political Economy of Health is less debated and seldom a theoretical focus. We hypothesise that combining these theories unearths the roots of health inequalities and inequities. We propose a framework integrating both, which aims to not only identify 'health gaps' (SDH) but also aims to actively reduce these towards 'political economy'-informed health policies.

We conducted a literature search of four databases: PubMed, Embase, Web of Science and Scopus, to identify works which attempt to combine the social determinants of health and the political economy of health frameworks, explaining and interpreting health inequalities in different settings.

Out of 156 results, we included 13 papers for analysis. The main themes that emerged from this body of literature were: private-public sector health inequalities, adverse local health outcomes and governmental policies fostering the improvement of local health outcomes.

The concomitant application of political economy theories and the social determinants of health can be complementary to not only identify the so-called 'health gaps' between different social groups, but also to interpret these as outcomes of the economic system, affecting individuals and their social classes in different ways. Political Economy of Health can complement the SDH framework by inserting power relations into the interpretative mix as one of the keys to the creation, maintenance and reduction of health inequalities through health policy making.

Keywords: Political Economy of Health, Social Determinants of Health, Health Inequalities

1. Introduction

Health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1946). Access to such a state of well-being is, however, unevenly distributed within the global population. These inequalities have, for the last three decades, been interpreted through the "social determinants of health" framework. Social determinants of health (SDH) are defined by the WHO commission on the matter as "the conditions in which people are born, grow, live, work and age" and "the fundamental drivers of these conditions" (World Health Organization, 2021). These 'conditions' can be anything from GDP per capita in a given country, number of schools in the community, public transport availability to the number of fast-food chains in that part of town (World Health Organization, 2021). The availability and quality of medical care also plays a role in health outcomes, but less so in determining who becomes ill in the first place (Braveman and Gottlieb, 2014).

The SDH framework gained significant attention through the milestone Social Determinants of Health Report of 2008 by the WHO commission. However, despite the renewed attention in the 2000s, not much has been achieved to eventually close the health gap between social classes in most countries (Frank et al., 2020), they have, if anything, only widened or remained the same in some high-income countries. Eleven years after its publication, the framework was reviewed in terms of its suitability to explain and understand the challenges faced in the next decade ahead. While this review concluded that the SDH framework has positively altered the way public health is approached, especially since 2008, it is in need of revision to meet the evolving challenges faced by public health in the upcoming years (Frank et al., 2020).

[1] Barts and the London School of Medicine and Dentistry, Queen Mary University of London, United Kingdom. Email: kmenttlaura@gmail.com
[2] Wolfson Institute of Population Health, Barts and the London School of Medicine and Dentistry, Queen Mary University of London, United Kingdom

This is especially poignant in the wake of the ongoing, COVID 19 pandemic/endemic, which has altered the face of contemporary public health provision; some of the current changes and challenges were unthinkable during the conceptualisation of the SDH framework (Frank et al., 2020; Mesa Vieira et al., 2020). The participants of the review conference in 2019, for instance, suggested that the original SDH framework somewhat naïvely lacks recognition that powerful stakeholders and other interest groups influence the policy making process and may profoundly oppose policies which may improve health equity (Frank et al., 2020) without discriminating vulnerable groups.

In an effort to further understand why these differences in social determinants and health exist at all, the theoretical framework of the "political economy of health" (PEH) can offer alternative paths not yet explored (or valued, for that matter) by SDH scholars. Political Economy investigates how societies are shaped by economics, production and consumption, power relations, policies, institutions as well as culture and values; some of these also present in the SDH inequalities interpretations (McCartney et al., 2019); the add-on is mostly on how these interrelationships and power dynamics dictate health policies and their outcomes. In his article "Getting serious about the SDH", Dennis Raphael makes the point that whether a country is identifiably liberal, conservative or social democratic determines the presence and quality of certain SDH such as employment security or working conditions (Raphael, 2008), directly affects health outcomes. Liberal nations such as Australia or the United Kingdom have relatively little governmental involvement in the support of the SDH, whereas social democratic governments, such as those in the Scandinavian nations are far more involved in this and conservative governments are somewhere in between the two (Raphael, Rioux and Bryant, 2010). At the other end of the capitalist spectrum, where low- and middle-income countries are, the effects of centuries of colonialism and non-planned industrialisation play an essential role on the kind of health policies and systems put in place.

It seems plausible that these two theoretical frameworks, while intrinsically different, could complement each other to investigate populational access to health and healthcare, shedding more light on the roots of health inequalities at a global level. If this hypothesis is correct, why is this a less explored academic route?

Based in our personal and anecdotal experience, we consider that the two main reasons for this are (i) historical, based on the origins of each 'school of thinking' and (ii) the absent consideration of 'levels of power' in social determinants of health, which comfortably leaves out of the equation of health policy making difficult matters such as who sets up the global health governance agenda, where financing (and 'knowledge') comes from, and with which intention. Both, sciences and a great deal of the SDH evidence, remain historically aseptic and 'non-biased'.

This paper aims to act as a preliminary scoping review to identify the extent to which the political economy of health theories are included in publications on the SDH, the hypothesis being similar to that put forward by Frank *et al.* (2020) and the review conference on the SDH; that the current SDH framework lacks recognition of the important underlying political and economic influences on policy making and ultimately the SDH. A further aim is to suggest how the political economy of health framework could be integrated into the SDH framework, creating a more "materialist model" of health, to inform a more comprehensive and historically grounded analysis of health inequalities.

2. Methods

We conducted a systematic literature review using the PRISMA guidelines on four databases: Web of Science, PubMed, Scopus and Embase. A broad and single search term was used to identify initial records: "political economy AND social determinants". Our aim was to conduct a preliminary and broad scoping review, for this reason such broad search terms were used. This search retrieved a total of 156 records, which decreased to 65 records after all duplicates were removed. The titles of these 65 publications were screened, and 21 excluded for not relating to the topic and 3 excluded for not being available online. No publications were excluded due to the third exclusion criterion "outside date range (2000-2020)". After this screening, 41 publications were assessed for eligibility. Of these 41, 28 were excluded as not relating to the research question, and the remaining 13 were included for analysis.

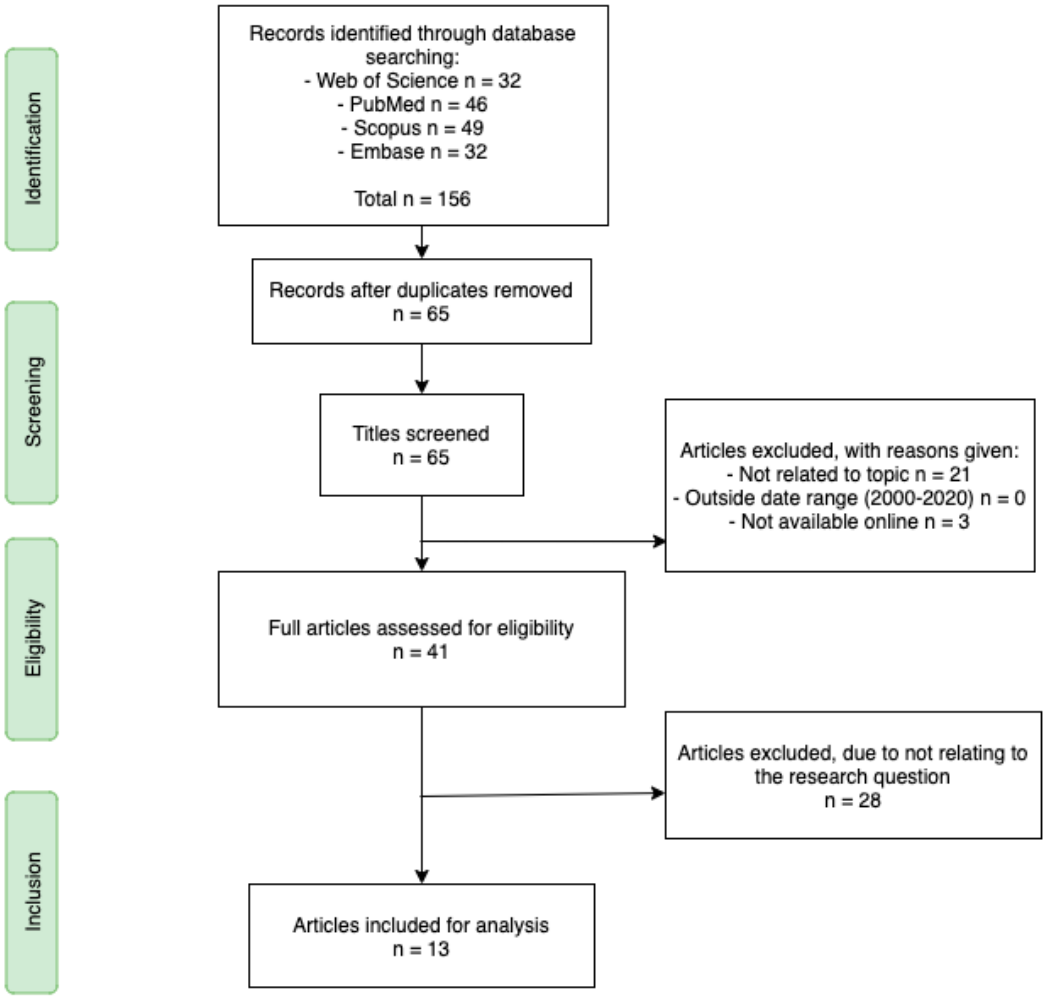

Figure 1: PRISMA chart of the systematic literature search strategy (correct as of November 2020)

3. Results

The results included for analysis have been broadly categorised into 3 categories: (i) discussions on private versus public sector health outcomes in different countries, (ii) the effects of corporations and capitalist expansion on local health and (iii) how governmental policies allow for neoliberalism to flourish.

(i) Private versus public sector

In their analysis of health inequalities in South Africa, John Ataguba and Olufunke Alaba examine these through the lens of political economy. The neoliberal policy approach taken by different South African governments since the end of Apartheid in 1996 has led to a widening income inequality gap as well as significantly impacting the access to social and health services and continued fostering of power for a white elite sustained by the mining and energy sectors due to strong links between governments and corporations (Williams and Taylor, 2000; Baker, 2010; Ataguba and Alaba, 2012). In South Africa, the private healthcare sector, which caters to approximately 20% of the population – mainly the wealthy and powerful elite – has seen rapid expansion, at the same time as government commitment and funding to public healthcare has weaned (Ataguba and Alaba, 2012). While user fees for public sector primary health care were abolished in 1996 in an attempt to minimise the large access to healthcare gap between rich and poor, the resulting increase in healthcare uptake was not accompanied by a corresponding governmental funding increase for public sector health care (Gilson and McIntyre, 2005; Ataguba and Alaba, 2012).

Alexander Kentikelenis examines how social determinants and health are affected by structural adjustment programmes (SAPs), such as those historically recommended by the World Bank (WB) or the International Monetary Fund (IMF). For instance, the austerity measures imposed by SAPs may change governments' public health expenditure, often being replaced by private sector health provision, and leading to changes in the volume and quality of services available (Karanikolos *et al.*, 2013; Reeves *et al.*, 2014; Kentikelenis, 2017). Austerity measures placed through SAPs also often include limits on wages of civil servants, which could lead to the healthcare workforce being affected by redundancies, wage cuts or hiring freezes as it was the case in Greece in the wake of the 2008 Great Recession.

This could ultimately lead to worker migration in search for better employment conditions and the communities reliant on this healthcare provision being left without adequate services and ultimately worse health outcomes (Kentikelenis, 2017). Another barrier to accessing healthcare are user fees or co-payments for medicines, which are also frequently implemented by SAPs and which have led to reduced access for the socially vulnerable (Yates, 2009; Kentikelenis, 2017). SAP austerity or stabilisation aspects can also lead to reduced availability or access to education, precarious working conditions, changes in the availability and cost of housing; trade and capital account liberalisation can foster job insecurity and wage reduction due to increased competition; and privatisation can lead to mass redundancies which may result in adverse health behaviours such as addiction (Kentikelenis, 2017). However, Kentikelenis also notes that SAP measures may foster social cohesion and integration into community initiatives, leading to stress resilience, in the face of austerity or privatisation strategies (Kentikelenis, 2017).

In their paper on establishing a basic income guarantee (BIG) in Canada, Dennis Raphael and colleagues analyse how liberal welfare states such as Canada, the USA and the UK, in which the state provides limited benefits and social security to its population, and is instead dominated by capitalist business interests, experience larger gaps in health equality than for instance conservative or social democratic welfare states (Raphael, Bryant and Mendly-Zambo, 2019). With a BIG, however, one of the most basic SDH could be improved upon – income – which could lead to reductions in homelessness, food insecurity and improve health for those living in the poorest conditions (Raphael, Bryant and Mendly-Zambo, 2019). However, there may be some overlooked problems with this seemingly easy and efficient solution: firstly, that true health improvement, as seen when moving beyond, not just towards, the relative poverty threshold, cannot be achieved solely through BIG. Secondly, that implementing BIG may actually justify the removal of other pre-existing social programmes; and thirdly, this may divert attention from the impact that businesses and corporations have on the welfare state (Navarro and Shi, 2001; Mays, Marston and Tomlinson, 2016; Raphael, Bryant and Mendly-Zambo, 2019). Raphael and colleagues argue that a true shift in the health outcomes for those living in more disadvantaged settings, would require investment above and beyond the average spending by liberal welfare states, and not just a BIG scheme. This would allow the provision of affordable housing, childcare, medical care, social assistance, disability benefits and employment benefits, and ultimately lead to better health outcomes for the entire population (Raphael, Bryant and Mendly-Zambo, 2019).

(ii) Local health

Birn et al. describe how certain SDH in mining communities in South America are influenced and worsened by actions of large Canadian mining companies (Birn, Shipton and Schrecker, 2018). They find that the actions of such transnational corporations result in significant health injustices: for instance, the Marlin Mine in Guatemala, which is Canadian-owned, has led to increased poverty and food insecurity, forced dispossession, heavy metal poisoning and significant environmental damages in the surrounding Mayan communities, without these communities benefiting from any substantial mining revenue (Caxaj *et al.*, 2014; Birn, Shipton and Schrecker, 2018). The adverse health and social effects on communities subjected to the rule of profit-seeking large corporations such as these mining companies are many: toxic environmental exposures, violence, poverty, community disruption, loss of traditional and ancestral lands, forced displacement and strains on community cohesion (Birn, Shipton and Schrecker, 2018; Schrecker, Birn and Aguilera, 2018).

MacLean and MacLean take the approach that major health inequalities between rich and poor have in part resulted from a gap in the research into diseases affecting primarily the poor. This is driven by international organisations investing 90% of funds into diseases that only affect 10% of the global population (MacLean and MacLean, 2009). They further stress that the majority of funds invested by such organisations in "infectious diseases" are directed towards high-end biotechnological treatments for a handful of infectious diseases and often omit the majority of other ailments that have a high share in the burden of mortality and morbidity in the global south (MacLean and MacLean, 2009). Additionally, MacLean and MacLean emphasise the negative impacts that the structural adjustment programmes of the 1980s and 1990s have had on "public health service provision" in Sub-Saharan Africa. This has resulted in monitoring of population health, surveillance and prevention of diseases and the maintenance of environmental and food security being swept away by the privatisation and commercialisation of healthcare (Sanders, Todd and Chopra, 2005; MacLean and MacLean, 2009). With organisations – governmental, non-governmental and philanthropic – continuing to provide pharmaceutical treatments targeting only a handful of diseases, mainly malaria and HIV, rather than providing human resources and funds to combat the SDH and strengthening health systems, little is likely to change (Nishtar, 2004; Garrett, 2007; MacLean and MacLean, 2009).

Sanders et al. discuss the social and economic roots of the 2014 Ebola epidemic, and argue that the exploitation and over-farming of land in Africa has led to unforeseen ecological changes and has resulted in new patterns of infection.

The populations most affected by the actions of large multinational corporations extracting raw materials from their land, have been driven further into the wilderness in search of sustenance and have thus invariably been brought into closer contact with wildlife than ever before. This new mixing of humans and animals can lead to new zoonoses and potentially to further epidemics such as the 2014 Ebola outbreak in Sierra Leone (Sanders, Sengupta and Scott, 2015). Like the arguments made by Birn et al. on the impact of mining companies on the populations of South America, years of fierce competition over natural resources in Africa have resulted in civil unrest and mass displacement of local populations who receive next to no benefit from the valuable raw materials their land yields. This displacement and civil strife, not only makes sustenance harder, but brings with it a myriad of other negative health consequences to the local populations (Sanders, Sengupta and Scott, 2015).

In a paper on poverty, inequality and a political economy of mental health, Jonathan Burns discusses how economic disparities, especially income and wealth inequality, significantly drive adverse mental health outcomes (Burns, 2015). Burns interestingly comments on a study by Crick Lund and colleagues which showed how there is a weaker association between the social determinant "poverty" and mental health disorders in equitable societies such as Ethiopia, than in inequitable societies such as Chile or Brazil (Lund *et al.*, 2010). Burns states that market-oriented policy making leads to larger income inequality and worsening mental health outcomes. Burns uses the example of post-Soviet Union Russia's Gini index rising sharply from 23.8 in 1988 to 48.4 in 1993 and the population mental health plummeting concomitantly (Burns, 2015).

(iii) Political economy of health theory and international political economy of health

The theory behind how the political economy of a country can influence the SDH of its population is outlined by Dennis Raphael in a paper of 2008. He argues that liberty and minimal governmental interference are the guiding principles of liberal welfare states such as Canada, the USA or the UK, also known as the *laissez faire* approach. While this may foster a widespread belief that market freedom leads businesses to prosper and profit (in fact capital tends to accumulate), those in need of social assistance face a bleak outlook of high levels of income inequality, next to no safety nets and resultant poor population health outcomes (Navarro and Shi, 2001; Raphael, 2008). The opposite is true of social democratic and conservative welfare states, such as those seen in Scandinavia or central and southern Europe. Here the state takes on a more proactive role with the goal being to achieve poverty eradication, and for the most part, it has worked, resulting in better levels of equity - which means some inequality is always residual, however basic human needs are better covered. This approach, which bases its policy on the identification of social problems and then intervening to counteract these, has led to social and wage stability as well as social integration, and ultimately better health outcomes for the overall population (Block and Esping-Andersen, 2001; Bambra, 2004; Raphael, 2008).

The lack of focus on the SDH in 'liberal' welfare countries can be due to increasing corporate control of media platforms; which might explain its apparent low rate on the political and societal agenda (Raphael, 2011). Considering the population's health as a collective responsibility would be contrary to the individualist concepts found in such societies (Raphael, 2011). Raphael and Bryant (2011) relate specific governmental policy actions taken by the Canadian government that have led to a decline in the national SDH standards, the main one being governmental spending on health as a proportion of Gross Domestic Product (GDP), resulting in Canadian health spending being amongst the lowest of developed countries.

Political economy also influences the social determinants of child health. With governments determining taxation levels, housing policies, the extent and cover of the social benefits system, early life is shaped through the availability of food, educational opportunities, and housing (Raphael, 2015b). The availability of these resources can be directly affected by the parents' wages, working conditions and employment security, all of which are largely determined by public policy (Block and Esping-Andersen, 2001; Raphael, 2015b). In liberal capitalist states, market principles are likely to drive policy agendas, especially in a liberal welfare state where there is little market regulation (Raphael, 2015b).

Corporations exert different types of power to influence public policy. Structural power, which exists simply by the corporations being present and paying taxes in a country, forces market-driven governments to safeguard the business' needs in fear of corporations relocating (Raphael and Bryant, 2015). Agency power is exerted when structural power is no longer sufficient to ensure the needs of corporations. Agency power is the direct and indirect lobbying and political activities that businesses might undertake to influence governmental policy making (Raphael and Bryant, 2015). Furthermore, the power exerted by corporate businesses can have two effects on the societal perception of the ideal governmental involvement: either fostering the idea that the government should have a minimal role in distributing economic and social resources, or that involvement of the state leads to economic deregulation and that resource allocation should be left to the corporate sector (Raphael and Bryant, 2015). Both of these scenarios lead to minimal public health policy and governmental spending on programmes targeting the improvement of the SDH.

Table 1: Summary of the main themes identified in the literature search, countries/geographical regions analysed and authors.

Main themes identified	Country/countries/geographic region	Authors (Year)
Private-public sector health inequalities	South Africa	Ataguba and Alaba (2012)
	-	Kentikelenis (2017)
	'liberal' countries	Raphael et al. (2019)
Adverse population health outcomes	Latin America	Birn et al. (2018)
	Sub-Saharan Africa	MacLean and MacLean (2009)
	West Africa	Sanders et al. (2015)
	-	Burns et al. (2015)
Governmental policies fostering neoliberal approaches	'liberal' countries	Navarro and Shi (2001)
	-	Raphael (2008)
	Canada	Raphael (2011)
	Canada	Raphael and Bryant (2011)
	-	Raphael (2015b)
	-	Raphael and Bryant (2015)

4. Discussion

Our scoping literature search highlights an apparent, yet expected, lack of scholars that attempt to combine the discussions/theoretical frameworks of the SDH and the political economy of health. Whereas a keyword search on PubMed for the "SDH" retrieves over 28,000 records, and a search on the same database for "political economy of health" retrieves over 23,000 records, the combined search, as conducted in this report, only generated 46 results.

While the SDH framework highlights the existing health inequalities between populations and the conditions they live in, or surround them, and the impact this has on their health, the political economy of health approach and theories examine how power and resources are contested and distributed, resulting in health policies and affecting population health outcomes according to their social class, inevitably influencing the population's SDH.

The articles analysed here discuss a wide range of situations by which the political economy impacts the SDH and as a result the health of individuals and communities. Examples of these are how the neoliberal approach taken by the South African government since the end of Apartheid has fostered health inequalities by enabling privatisation of the healthcare sector, in favour of the wealthy population and further decreasing access to healthcare for those already at a disadvantage, who already suffer from worse health outcomes based on their socioeconomic status (Ataguba and Alaba, 2012). This demonstrates how economic interests of stakeholders influence policy makers and result in certain health policy outcomes which then influence the SDH of, particularly those, in the lower socio-economic classes (Ataguba and Alaba, 2012). We also saw how local health is affected by the profit-driven expansion of companies into South America leading to adverse environmental and local health outcomes (Birn, Shipton and Schrecker, 2018). The absence or weaknesses of policies and laws protecting the lives and livelihoods of those local populations expose people to much worse SDH, as these are not a market concern unless it influences profits. Wealthy corporations have a large influence on policy making across the board, from traditional and more established industrial economies to emerging and late-industrialised ones, putting forward power relations that result in policy making influence, which might be translated into SDH at different extents and realities (environment, income distribution, nutritional availability and education, social mobility, etc) (Raphael, Rioux and Bryant, 2010; Birn, Shipton and Schrecker, 2018; Schrecker, Birn and Aguilera, 2018). Stakeholders do not only exert this form of indirect power, they can also directly and actively lobby for or against certain policies which affect nationwide health outcomes, mostly as a byproduct of the prioritisation of their profit making capacity (Raphael and Bryant, 2015).

The economic system also plays a role in the policy making arena. The stability and resources of a country's economic system determine the extent to which policies on certain issues are created and implemented; it also determines their feasibility, and also the involvement and level of power of corporate stakeholders. Since the policy-making bodies are so inextricably linked with and influenced by the political and economic environment, and the policies created and implemented invariably shape the SDH and result in varying health outcomes among the population, a combined approach, using both frameworks, would at minimum, shine a different light onto policy making. While both frameworks are extremely valuable in their own right, a combined approach may allow for a more grounded contextual analysis, better equipped to truly reduce health inequalities.

A suggestion of such a combined framework is depicted below. It aims to illustrate how stakeholders, the political system and policy makers, the economic system, public health policy, the SDH, health inequalities and the resulting ill health are interlinked and influence each other.

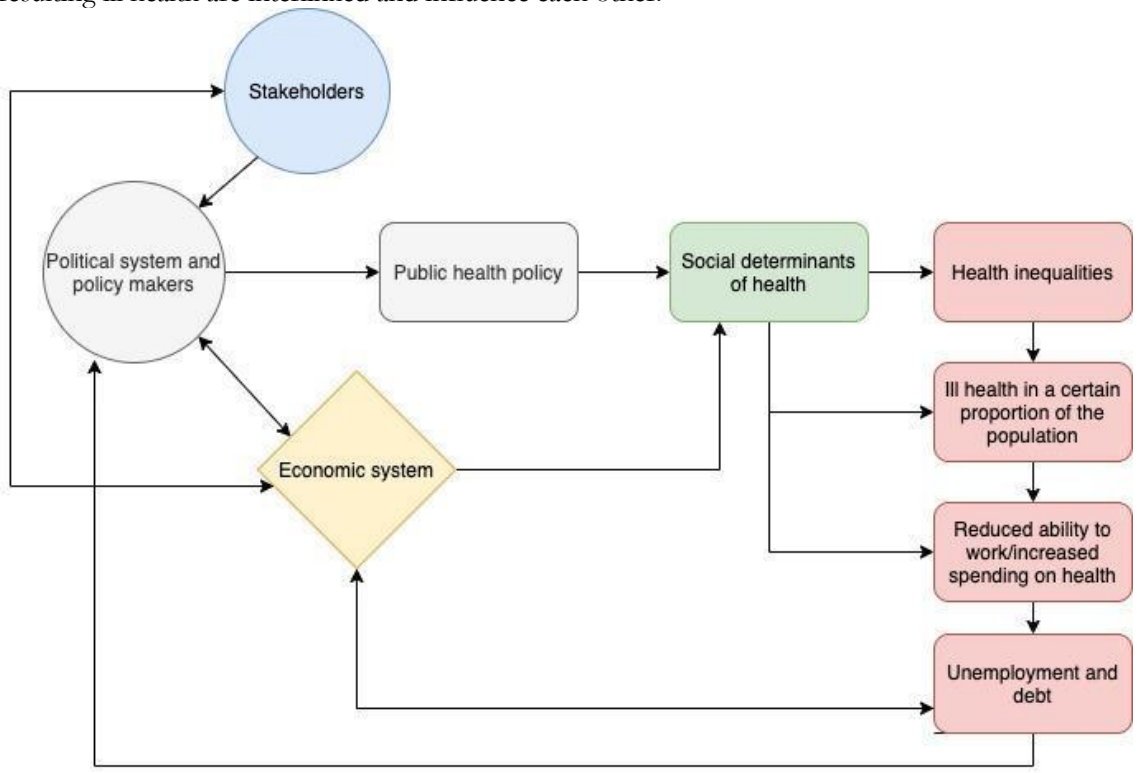

Figure 2: A diagram illustrating how the SDH and the political economy of health can be visualised together.

The above proposed combined framework schematically shows the different players and layers involved in creating public policy which then impact SDH and health inequalities. Stakeholders, such as large corporations, but also the public, can have varying degrees of influence on the policy makers, depending on the type of government and their vested interests in certain policy areas. These stakeholders are in turn influenced by the economic conditions in the country. A stable economic system may render these stakeholders without any particular desire to intervene or change any public health policy, or it may be exactly the opposite. The economic state of the country influences which policies can be created and enacted dependent on which financial and workforce resources are present. The economic system can also have a direct influence on the SDH through taxation, salaries, sick payment, and pensions available to individuals, which is however also influenced by their employers and companies. Ill health, the inability to work and unemployment and debt in the community, could also impact the stability of the economic system in the country, thus again influencing the resources available to policy makers to create/reform a welfare state that also acts towards the SDH through redistribution of resources via education, housing, health and social protection.

Describing this combined framework highlights the complexity and interconnectedness of all the respective components, of which there surely are many more not mentioned here. It demonstrates how a large part of the creation or development of health inequalities would be missing if one framework, such as the SDH alone, were used to analyse the problem. An example highlighting the connection between SDH and the political economy of health is that of the "developmentalist" public health approach of Latin America in the late 1960s. This theory of social medicine postulated that economic growth would result in the improvement of health conditions for the entire society. This however was not observed to be the case, and much of Latin America entered into a health crisis with substantial deterioration of collective health, in the form of rising infant mortality rates, malnutrition and degenerative diseases, despite much economic development during this time (Laurell, 1989).

Waitzkin et al. describe in detail the role of Salvador Allende in Chile, who was pivotal in the social medicine movement in the first half of the 20th century (Waitzkin *et al.*, 2001). During his role as health minister of Chile in the late 1930s, Allende analysed several public health concerns such as maternal and infant mortality and emphasised how they were affected by the state of the country as a whole, rather than the individuals' conditions (Waitzkin *et al.*, 2001). This analysis in turn also allows for evaluation of population health and its impact on a country economically – a healthy workforce allows for heightened economic productivity, which was an essential consideration in the period of rapid economic development of the socialist Latin American states in the 20th century (Laurell, 1989; Waitzkin *et al.*, 2001).

Deregulated and *laissez faire*-based economic development does not equate to better health, or have a positive impact on the SDH, for that matter. This is exemplified by the Latin American case and, more recently, by the 'extractive development' in Africa, especially in the Sub-Saharan region, which prioritises the collection of raw natural resources like oil, despite negative effects on local communities. Health, in its most comprehensive aspect as not only the absence of illness**, is not the concern of an economic model that prioritises growth above all**, and the examples are clear and come from different contexts across nations. The combination of the SDH accumulated knowledge and political economy can address the key factors driving the widening of health inequalities; the major issue, however, is the uneven power balance of the players who set out the priorities of the economic model, as three centuries of capitalism have demonstrated.

5. Conclusion

To what extent are the political economy of health and the SDH frameworks used together to investigate existing health inequalities? To a very limited extent.

This review has attempted to show the possibilities and limitations of a common analysis of health inequalities using both the political economy and the SDH frameworks, as well as highlighted the gap in studies attempting to combine both approaches. Depending on one's perspective, it can be said that from a historic and materialistic perspective, the SDH are limited and "*acritical*" in their way of appointing the so-called health gaps and failing (some would say in a purposely blind way) to also point the causation of such wide health differences in society. The issue, however, is that some scholars might point out that it is *theoretically impossible* to combine these frameworks as SDH are in fact a *result* of the political economic arrangements between state, society (and its different classes) and capital (and the respective capitalists). We believe that even if it is only to contextualise the SDH as a result and creation of the current political economic arrangements, there is an urgent need to *consider the bigger picture* when being radical about proposing policy solutions that reduce and eventually eliminate 'health gaps. In fact, by not considering power relations in the proposals to act on the SDH, these remain innocuous, inefficient and eventually hollow - such as the now long past 'millennium development goals' - which aimed to reduce/eliminate health gaps by the year 2000. What we have seen, now more than 20 years later, is that health gaps increased despite increased world wealth (and development?).

We touched upon the varying degrees by which the public can influence policy makers to bring certain aspects of public health policy onto the agenda. The power of the public to do this depends to a certain extent on the type of government present in a certain country, but also the level of education and advocacy provided to facilitate such an involvement. By large social involvement in the public policy making process, the neoliberal approaches of a government not much involved in public policy making and a profit-making focus, led to a large extent by large transnational corporations, could be countered. For this reason, it is important to see the public not as passive recipients of public health policy, dependent on whatever SDH are influenced by the political economy of health, but as active players in the policy arena.

In conclusion, there is a need for further research into how the political economy of health, the analysis of how power, politics and economics shape health problems and the approaches to these health problems, and the SDH framework can be used together to investigate and tackle the existing and evolving global health inequalities. Not only can such an integrated and informed approach help to unearth the complex underlying causes of global health inequality, it may also encourage policy makers and the state to take more responsibility in counterbalancing the power relations between different social classes through their policy decisions. With changing patterns of inequalities and evolving healthcare needs, an updated approach to analysing these is called for. In the wake of the COVID-19 pandemic, we could see an increase in money-related social determinants of ill health, such as debt, and this to varying degrees in the different types of welfare states seen around the world. A social-democratic welfare state with a comprehensive social security system in place will leave far less scope for individuals to be plunged into irreconcilable debt, than countries with more liberal welfare systems, where people might receive less continuous governmental assistance. These challenges call for alternative approaches to unearth the roots of these inequalities and an updated framework might be able to achieve just that.

6. References

Ataguba, J. E.-O. and Alaba, O. (2012) 'Explaining health inequalities in South Africa: A political economy perspective', *Development Southern Africa*, 29(5), pp. 756–764. doi: 10.1080/0376835X.2012.730962.

Baker, P. (2010) 'From apartheid to neoliberalism: Health equity in post-apartheid South Africa', *International Journal of Health Services*. doi: 10.2190/HS.40.1.e.

Bambra, C. (2004) 'The worlds of welfare: illusory and gender blind?', *Social Policy and Society*. doi: 10.1017/s147474640400171x.

Birn, A. E., Shipton, L. and Schrecker, T. (2018) 'Canadian mining and ill health in Latin America: a call to action', *Canadian Journal of Public Health-Revue Canadienne De Sante Publique*, 109(5–6), pp. 786–790. doi: 10.17269/s41997-018-0113-y.

Block, F. and Esping-Andersen, G. (2001) 'Social Foundations of Postindustrial Economies', *Contemporary Sociology*. doi: 10.2307/3088996.

Braveman, P. and Gottlieb, L. (2014) 'The social determinants of health: It's time to consider the causes of the causes', *Public Health Reports*. doi: 10.1177/00333549141291s206.

Burns, J. K. (2015) 'Poverty, inequality and a political economy of mental health', *Epidemiology and Psychiatric Sciences*, 24(2), pp. 107–113. doi: 10.1017/S2045796015000086.

Caxaj, C. S. *et al.* (2014) 'Gold mining on Mayan-Mam territory: Social unravelling, discord and distress in the Western highlands of Guatemala', *Social Science and Medicine*. doi: 10.1016/j.socscimed.2014.03.036.

Frank, J. *et al.* (2020) 'The Social Determinants of Health: Time to Re-Think?', *J. Environ. Res. Public Health*, 17, p. 5856. doi: 10.3390/ijerph17165856.

Garrett, L. (2007) 'The challenge of global health', *Foreign Affairs*. doi: 10.4324/9781315254227-39.

Gilson, L. and McIntyre, D. (2005) 'Removing user fees for primary care in Africa: The need for careful action', *British Medical Journal*. doi: 10.1136/bmj.331.7519.762.

Karanikolos, M. *et al.* (2013) 'Financial crisis, austerity, and health in Europe', *The Lancet*. doi: 10.1016/S0140-6736(13)60102-6.

Kentikelenis, A. E. (2017) 'Structural adjustment and health: A conceptual framework and evidence on pathways', *Social Science and Medicine*, 187, pp. 296–305. doi: 10.1016/j.socscimed.2017.02.021.

Laurell, A. C. (1989) 'Social analysis of collective health in Latin America', *Social Science and Medicine*. Pergamon, 28(11), pp. 1183–1191. doi: 10.1016/0277-9536(89)90011-7.

Lund, C. *et al.* (2010) 'Poverty and common mental disorders in low and middle income countries: A systematic review', *Social Science and Medicine*. doi: 10.1016/j.socscimed.2010.04.027.

MacLean, S. J. and MacLean, D. R. (2009) 'A "new scramble for Africa": The struggle in sub-Saharan Africa to set the terms of global health', *Round Table*, 98(402), pp. 361–371. doi: 10.1080/00358530902895535.

Mays, J., Marston, G. and Tomlinson, J. (2016) 'Basic Income in Australia and New Zealand', *Springer*. doi: 10.1057/9781137535320.

McCartney, G. *et al.* (2019) 'Impact of political economy on population health: A systematic review of reviews', *American Journal of Public Health*. doi: 10.2105/AJPH.2019.305001.

Mesa Vieira, C. *et al.* (2020) 'COVID-19: The forgotten priorities of the pandemic', *Maturitas*. Elsevier Ireland Ltd, 136, pp. 38–41. doi: 10.1016/j.maturitas.2020.04.004.

Navarro, V. and Shi, L. (2001) 'The political context of social inequalities and health', *Social Science and Medicine*. doi: 10.1016/S0277-9536(00)00197-0.

Nishtar, S. (2004) 'Public-private "partnerships" in health - A global call to action', *Health Research Policy and Systems*. doi: 10.1186/1478-4505-2-5.

Raphael, D. (2008) 'Getting serious about the social determinants of health: new directions for public health workers.', *Promotion & education*, 15(3), pp. 15–20. doi: 10.1177/1025382308095650.

Raphael, D. (2011) 'Mainstream media and the social determinants of health in Canada: Is it time to call it a day?', *Health Promotion International*, 26(2), pp. 220–229. doi: 10.1093/heapro/dar008.

Raphael, D. (2015a) 'Beyond policy analysis: The raw politics behind opposition to healthy public policy', *Health Promotion International*, 30(2), pp. 380–396. doi: 10.1093/heapro/dau044.

Raphael, D. (2015b) 'THE PARAMETERS OF CHILDREN'S HEALTH: KEY CONCEPTS FROM THE POLITICAL ECONOMY OF HEALTH LITERATURE', *International Journal of Child Youth & Family Studies*, 6(2), pp. 186–203. Available at: %3CGo.

Raphael, D. and Bryant, T. (2006) 'Maintaining population health in a period of welfare state decline: political economy as the missing dimension in health promotion theory and practice.', *Promotion & education*, 13(4), pp. 236–242. doi: 10.1177/175797590601300402.

Raphael, D. and Bryant, T. (2015) 'Power, intersectionality and the life-course: Identifying the political and economic structures of welfare states that support or threaten health', *Social Theory and Health*, 13(3–4), pp. 245–266. doi: 10.1057/sth.2015.18.

Raphael, D., Bryant, T. and Mendly-Zambo, Z. (2019) 'Canada considers a basic income guarantee: Can it achieve health for all?', *Health Promotion International*, 34(5), pp. 1025–1031. doi: 10.1093/heapro/day058.

Raphael, D., Rioux, M. H. and Bryant, T. (2010) *Staying alive : critical perspectives on health, illness, and health care*. 2nd edn. Toronto: Canadian Scholars' Press.

Reeves, A. *et al.* (2014) 'The political economy of austerity and healthcare: Cross-national analysis of expenditure changes in 27 European nations 1995-2011', *Health Policy*. doi: 10.1016/j.healthpol.2013.11.008.

Sanders, D. M., Todd, C. and Chopra, M. (2005) 'Confronting Africa's health crisis: More of the same will not be enough', *British Medical Journal*. doi: 10.1136/bmj.331.7519.755.

Sanders, D., Sengupta, A. and Scott, V. (2015) 'Ebola epidemic exposes the pathology of the global economic and political system', *International Journal of Health Services*, 45(4), pp. 643–656. doi: 10.1177/0020731415606554.

Schrecker, T., Birn, A. E. and Aguilera, M. (2018) 'How extractive industries affect health: Political economy underpinnings and pathways', *Health Place*, 52, pp. 135–147. doi: 10.1016/j.healthplace.2018.05.005.

Waitzkin, H. *et al.* (2001) 'Social Medicine Then and Now: Lessons From Latin America', *American Journal of Public Health*. American Public Health Association Inc., 91(10), pp. 1592–1601. doi: 10.2105/AJPH.91.10.1592.

Williams, P. and Taylor, I. (2000) 'Neoliberalism and the political economy of the "new" South Africa', *New Political Economy*. doi: 10.1080/13563460050001961.

World Health Organization (1946) *Preamble to the Constitution of WHO as adopted by the International Health Conference*. New York. Available at: https://www.who.int/about/who-we-are/frequently-asked-questions (Accessed: 3 March 2021).

World Health Organization (2003) *Belfast Declaration for Healthy Cities The power of local action*.

World Health Organization (2013) *The Helsinki statement on Health in All Policies*, *WHO*. Helsinki: World Health Organization. Available at: http://www.who.int/healthpromotion/conferences/8gchp/statement_2013/en/ (Accessed: 3 March 2021).

World Health Organization (2021) *Social determinants*. Available at: https://www.euro.who.int/en/health-topics/health-determinants/social-determinants (Accessed: 3 March 2021).

Yates, R. (2009) 'Universal health care and the removal of user fees', *The Lancet*. doi: 10.1016/S0140-6736(09)60258-0.