Social Determinants of Health in Palestine

By Ben Bouquet

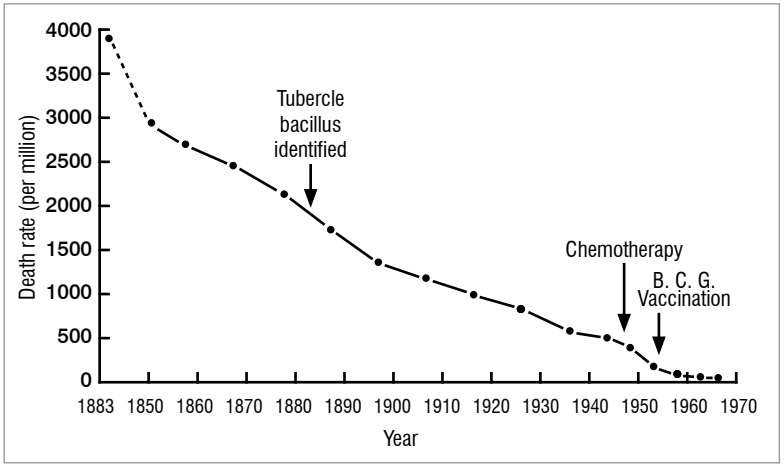
Caring for the health of a society and its members is an important aspect of the common good. The factors that determine health lie beyond heredity and individual disposition. According to the World Health Organization (WHO), the social determinants of health are "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." The social conditions in which we live not only influence our sense of well-being, they also determine our chances of experiencing illness or death throughout the course of our lives.

The notion of social determinants affecting health has come from comparisons of vastly different health outcomes across different populations and social groups. Equally, we can choose to see the causes of such large disparities in health through a political or economic lens, and indeed we cannot separate our understanding of such disparities from the political landscape in which they arise. On average, those who are poorer not only die at a younger age, they also experience more illness and disability throughout their lives. However, overall wealth cannot account for all health differences. For example, in 2013, adult mortality (a person's chance of dying between the ages of 15 and 60 years) was 49 per 1,000 persons in Iceland and 102 per 1,000 in the United States. In the same year, the GDP per capita of each country amounted to $47,493 and $52,660 respectively. Adults in the wealthier country (USA) were more than twice as likely to die in the same year as their counterparts in Iceland.

Similar disparities can be seen within any country for different social groups, for example when differentiating by class, gender, ethnicity, or even religion, and taking into account age. The concept of social determinants of health draws on social models of disease. These explicitly try to transform our understanding of what are chance occurrences and what are preventable causes of death and disease. In line with this, in 2001 *the BMJ* banned the inappropriate use of the term "accident" from its pages, especially in relation to motor vehicle crashes.[1] The authors explained: "An accident is often understood to be unpredictable – a chance occurrence or an 'act of God' – and therefore unavoidable. However, most injuries and their precipitating events are predictable and preventable." Indeed, vast disparities in death rates resulting from road traffic collisions can be found in different countries. For example, in 2013, people were more than 25 times more likely to die in a motor vehicle crash in Libya (at 73.4 road deaths per 100,000 of the population) than they were in Sweden (at 2.8 per 100,000), according to the WHO Global Health Observatory, 2016. Historical trends show as well that large numbers of deaths and diseases are preventable, even many diseases that we might have considered as "natural." Thomas McKeown's famous graph of death rates from tuberculosis in England and Wales demonstrates that the bulk of decline in deaths from tuberculosis occurred before the introduction of antibiotics (chemotherapy) and vaccination. He argued that improvements in living standards, including better housing, sanitation, hygiene and especially nutrition, account for this decline.

> Many of the factors that determine health exist outside of medical facilities and medical practice. They are the social, political, and economic circumstances in which we live and which impact upon our sense of well-being and influence our chances of experiencing illness or death throughout the course of our lives.

So what can be said about the social determinants of health in Palestine? Life expectancy in the occupied territory in 2015 was 73.5 years, according to the Palestinian Health Information



Thomas McKeown's graph of death rates from tuberculosis over time in England and Wales. Graph from The Modern Rise of Population by McKeown, 1976.

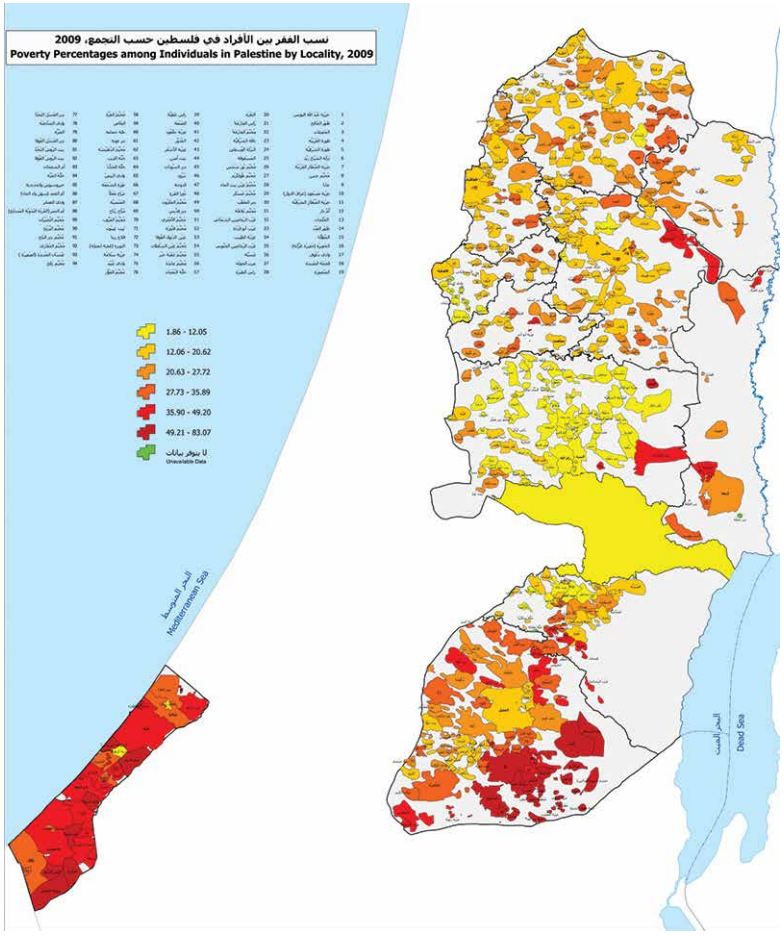
The Separation Wall.

Center (PHIC).[ii] Where cause of death was recorded, the major causes were noncommunicable diseases such as heart attack, stroke, and cancer. While in this respect the situation is similar to surrounding countries such as Jordan and Lebanon (where life expectancy is 74.1 and 74.9 years, respectively), it compares unfavorably to Israel, where life expectancy is 82.5 years, as reported on the WHO Global Health Observatory 2016. The WHO Constitution declares "the highest attainable state of health as a fundamental right of every human being." The most pertinent comparison must always be the higher achiever; all countries should ask what factors prevent their citizens from achieving the highest possible life expectancy. To further explore social factors that affect the health of Palestinians, we must consider that such factors are contingent on political and economic circumstances. In fact, analysis of social factors outside of a consideration of the political systems and power relations in which they arise can be misleading or patronizing at best.

The United Nations Common Country Analysis (UNCCA) for 2016 emphasizes that the primary driver of vulnerability in Palestine continues to be the military occupation. Access to healthcare is one important social determinant of health, and barriers to accessing healthcare can be financial, political, geographical, and social. The WHO report *Right to Health: Crossing barriers to access health in the occupied Palestinian territory, 2014–2015* points out that prevailing restrictions on movement through the system of checkpoints and permits impact upon Palestinians' access to healthcare and life-saving treatments. In addition, restrictions on the entry of medications and medical equipment to Gaza affect the availability of essential therapeutics.[iii] Beyond healthcare, restricted access to resources including land, water, gas and oil reserves, quarries, and Dead Sea minerals have impeded Palestinian economic development (where these resources in the occupied territory have directly profited Israel.[iv] Trade restrictions imposed by Israel since its occupying of the Palestinian territory in 1967, have cut off Palestinian producers from their traditional trading partners.[v] Such economic conditions impact upon access to secure employment, which has important implications for social and psychological well-being and long-term physical health. The unemployment rate for Palestine in 2015 was the highest in the world (at 25.9 percent of the working-age population), and the figure was most dire for the Gaza Strip (with 44 percent of the working-age population unemployed).

Poverty is a major factor affecting health in Palestine. Even where individuals are covered by Government Health Insurance, access to healthcare can be prevented by costs of travel, loss of revenue, and lack of information. Poverty influences access to decent housing, heating, food, clean water, and adequate sewerage, all of which have consequences for health. According to UNRWA in 2014, a third of households in Palestine experienced food insecurity. The situation is worst in Gaza, where 57 percent of households experienced food insecurity and, according to the Palestinian Micronutrient Survey in 2014, 29 percent of children were stunted due to chronic malnutrition.[vi] Living in a particular area of the West Bank or Gaza influences a person's chances of experiencing poverty or deprivation and of suffering from the associated detrimental effects on long-term health. A map showing the percentage of poverty in various localities, published by the Palestinian Central Bureau of Statistics (PCBS) in 2009, demonstrates wide disparities in the level of poverty in different areas in Palestine. The poorest areas correspond to those most affected by what the UNCCA highlights as locational drivers of vulnerability. These include residing, working, or accessing services in: Area C of the West Bank (around 65 percent of the area of the West Bank, under direct Israeli military control); Area H2 in Hebron (20 percent of the WB's largest city, under direct Israeli control); East Jerusalem; the Seam Zone (the area between the 1949 Armistice or Green Line and the Separation Barrier); and the Gaza Strip.

The proper and regular collection of data has been critical to improving our overall understanding of the social determinants of health. Statistics can present surprising results that challenge our assumptions and our culturally constituted attitudes towards aspects of our societies such as poverty, gender, sexuality, race, or religion, and improve our understanding of social causes. Statistical techniques can demonstrate the proportion of an overall death rate that is directly attributed to a social



The percentage of individuals in poverty in localities of the West Bank and Gaza. Map courtesy of the Palestinian Central Bureau of Statistics, 2009.

phenomenon such as smoking. In 2016, WHO estimated that tobacco accounts for 6 million deaths globally each year. In 2008, it predicted that, of the estimated 1 billion smokers in the world, around 500 million will die as the result of smoking and that roughly 80 percent of these deaths will be in lower income countries.[vii] Tobacco use, as reported in surveys, shows striking social variations and Palestine is no exception in this regard. Results of the *STEPS Survey for Palestine 2010–11*,[viii] published by WHO, showed the prevalence of daily smoking among men at 43.2 percent compared to 3.1 percent among women. While this vast difference may reflect some reporting bias, such reporting differences demonstrate cultural gender ideals that are attached to smoking, and which are utilized, reinforced, and even constituted through tobacco advertising campaigns. However, inducing people to begin smoking is not only dependent on advertising. The availability of tobacco products to children is an important factor in influencing whether children take up, and subsequently become addicted to, cigarettes. There can exist gaps between legal provisions to control tobacco and daily practice. An important aspect of whether tobacco control programs are successful is their acceptability to the population at large. In spite of a ban on selling single cigarettes, because the practice facilitates the sale of tobacco to children, the continued sale of single cigarettes can still be seen in some shops in the West Bank and Gaza.

In summary, the social determinants of health are not a set list of social causes but a way of reframing our understanding of health and illness beyond medicine to the social contexts in which we live and grow. This way of seeing health challenges our assumptions about what are "natural" or chance events to address the social factors that predispose us to illness and particular causes of death. For Palestinians, the ongoing military occupation is a critical determinant of population health. However, inequalities in health outcomes exist among different social groups within Palestinian society. Improving our understanding of such inequalities through continued data collection and monitoring and through analysis of the complexity of power relations that exist in society can help to inform our actions and efforts to ensure better health for all in Palestine.

The sale of single cigarettes on a counter in the West Bank in 2016: a practice that is banned in many countries, including Palestine, because it targets the sale of tobacco to minors. Photo courtesy of the author.

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[i] Ronald Davis and Barry Pless, *BMJ bans "accidents,"* British Medical Journal, 2001, available at http://www.bmj.com/content/322/7298/1320.

[ii] *Health Annual Report: Palestine 2015*, Palestine Health Information Center (PHIC), October 2016, available at http://moh.ps/Content/Books/FDVFRuU5ORaxrOaq4C5Q987a3GBwIIDpumLafURDQJcT7ggdf9Yk13_UEpLZXH64SsaOSyrQeQlET7OljGkpE1QXz48MqlmMZXlgFpARQZQdE.pdf.

[iii] *Right to Health, 2014–2015*, WHO, available at https://unispal.un.org/DPA/DPR/unispal.nsf/47d4e277b48d9d3685256ddc00612265/fb66fb6c596a494e8525807a00572134?OpenDocument.

[iv] *Facts on the Ground*, Al Haq, 2016, available at http://www.alhaq.org/publications/publications-index/item/facts-on-the-ground?category_id=10; *Area C and the Future of the Palestinian Economy*, The World Bank, 2013.

[v] UNCCA, 2016.

[vi] Ashrita Rau, "Malnutrition in Palestine," *Borgen Magazine*, May 20, 2015, available at http://www.borgenmagazine.com/malnutrition-palestine/. Elmadfa, A. et al., *Palestinian Micronutrient Survey*, March 2014; UNRWA *Food insecurity in Palestine remains high*, June 3, 2014, available at: https://www.unrwa.org/newsroom/press-releases/food-insecurity-palestine-remains-high.

[vii] *WHO Report on the Global Tobacco Epidemic, 2008*, World Health Organization, available at http://apps.who.int/iris/bitstream/10665/43818/1/9789241596282_eng.pdf.

[viii] *STEPS Survey 2010–11*, World Health Organization, available at http://www.who.int/chp/steps/Palestine_FactSheet_2010-11.pdf.