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Mental Health and Social Determinants: Their relationship with Public Policies. A brief analysis

Salud Mental y los Determinantes Sociales: Su relación con las Políticas Públicas. Un Análisis Breve

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Abstract:

This manuscript aimed to briefly analyze the historical background of the health-disease process and its implications for the role played by the individual in making healthy decisions. It is observed how the understanding of the process itself has initially placed the individual as an expectant being before specialized medical knowledge and the recommendations or interventions necessary to obtain health; however, as knowledge has advanced, this perspective has been surpassed because the material resources at the level of health systems have not worked to reduce mortality in populations. That is why nowadays, a vision of individual agency has been chosen; however, in a more current vision for both physical and mental health, it is observed that contextual conditions such as social and material conditions significantly influence individuals to choose their healthy behaviors.

Keywords:

mental health, public policies, lifestyle, social determinants, health-disease process

Resumen:

El presente manuscrito tuvo como objetivo analizar de forma breve el recorrido histórico sobre el proceso salud-enfermedad y las implicaciones en el rol que ejerce el individuo para tomar decisiones saludables. Se observa como el propio entendimiento del proceso ha puesto en un primer momento al individuo como un ser expectante ante el conocimiento médico especializado y las recomendaciones o intervenciones necesarias para obtener la salud, sin embargo, conforme ha avanzado el conocimiento esta perspectiva se ha visto superada pues los recursos materiales a nivel de sistemas de salud no han funcionado para disminuir la mortalidad en poblaciones. Es por eso por lo que ahora se ha optado por una visión de agencia individual, no obstante, en una visión más actual tanto para la salud física y mental se observa como las condiciones contextuales como las sociales y materiales tienen gran influencia para que los individuos puedan elegir sus comportamientos saludables.

Palabras Clave:

salud mental, políticas públicas, estilo de vida, determinantes sociales, proceso salud-enfermedad

INTRODUCTION

The World Health Organization[1] has established that mental health is a state that goes beyond the absence of a mental disorder as well as physical health. It establishes an integrative parameter in which the subject can make decisions favorable to his or her well-being, build positive interpersonal relationships, and implement strategies that enable him or her to cope with stressful or distressing events in his or her individual and social sphere and turn, nurture himself or herself through growth, personal and community.[2,3]

While this conceptualization of mental health is widely accepted, there may be many issues with it. While the focus of this essay is distinct from discussing the concept of mental health, it is worth looking at the journey that the conceptualization of health has taken and recognizing that the ingredients that now make up this vision have been integrated piecemeal.[4]

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This path, as well as that of physical health, has evolved from a uni-causal and biological vision towards material and social contextual integration, in which health results from the interaction between the individual and his environment and the resources and opportunities provided to him. These latter aspects are considered in the so-called social determinants, which condition how the individual develops in his environment and how these circumstances favor his health and disease.[5]

Discussing the social determinants of health, as outlined by Lalonde, is a way to recognize the constant evolution of society and the problems inherent to this progress. Seventy-five years ago, the World Health Organization[6] recognized that health was a complete state of physical, mental, and social well-being and not only the absence of disease or illness, and 26 years later, in 1976, the Canadian lawyer and minister published a series of policy proposals that would give light and follow-up to that international conference held in New York, denoting that there is more of the mind and much more of the social when talking about health.[7-9]

For this reason, we take up what was stated in 2008 by the Commission on Social Determinants of Health and in 2011 in the Rio Political Declaration on Social Determinants of Health, where both state that governance should shift towards a vision in which health and development conditions that impact on daily life are improved, so that the implementation of public strategies such as policies aimed at health, also integrate the unequal distribution of power, money, and resources, which are pillars for living conditions.[10,11]

CONCEPTUALIZATION OF HEALTH AND ITS IMPLICATIONS

Based on Table 1, mentioning the temporal aspects of the concept of health and its implications allows us to understand that the updates on this concept are young about the history of contemporary society. However, it is something that, from a simple analysis, we can recognize why. The first conception of the health-disease process came from a divine explanation, in which some evil had to be a punishment for carrying out an immoral act. However, in the 5th century, Hippocrates began to recognize the importance of the natural/biological causes of disease and the influence of the environment on health.[9]

However, during the Middle Ages, the West needed to see a proliferation of the knowledge that Hippocrates and some other contemporary authors were able to establish. However, the Middle East began to recognize material principles that influenced this process: pure air, moderation in eating and drinking, rest and work, wakefulness and sleep, and emotional reactions. Under these principles, it was proposed that there could be tiny organisms in the water or the atmosphere that produced diseases and that these are explained by the characteristics of the individual and the environment.[12]

Europe's economic and cultural resurgence in the Modern Age allowed it to move away from the church. Its explanations of the health-disease process and the knowledge of Hippocrates (Old Age) and those coming from the Middle East (Middle Ages) were retaken with greater strength, which also joined the technological advances such as the microscope, which gave rise to microbiology which formalized the materialistic, physical, and biological interpretation of the disease. However, this was still a uni-causal path of the disease; the disease is caused by an external agent that alters the organism.[13]

Table 1. *Brief historical overview of advances in health.*[9,12,13]

Historical Stage	Description
Old age	In ancient Greece, Hippocrates began the search for a rational explanation of diseases, considering their symptoms in order to formulate a diagnosis and offer the most appropriate treatment. In Egypt and Mesopotamia, the first descriptions of diseases were made. In India, Ayurvedic medicine was developed.
Middle age	The concept of a hospital was created, a place where patients could be treated by physicians with specialized equipment. The Salernitana Medical School played a crucial role in the transmission of medical knowledge.
Modern age	The true nature of the heartbeat and blood circulation was established. The invention of the microscope made it possible to investigate blood cells, spermatozoa and even microbes. Important medical schools were founded.
Contemporary age	Penicillin, the first antibiotic, was discovered. New techniques, technologies and approaches were developed that transformed the field of medicine, such as the use of cutting-edge technology. The three-dimensional structure of proteins was predicted using artificial intelligence

In this growing trend in Europe regarding the health-disease process, the medical police system was initiated to make the State responsible for the population's health. On the other hand, the impact of labor and socioeconomic conditions and their relationship with disease was recognized, which gave way to social medicine as a strategy for dealing with people's health problems. Between 1830 and 1851, a series of actions were taken to formalize the Public Health movement, which led to the need to improve the hygiene and housing conditions of the workers who migrated from the countryside to the city due to the industrialization that was taking place in France. The extreme poverty in which the workers found themselves meant

that the most common diseases were tuberculosis, pneumonia, measles, smallpox, and cholera, which can be recognized as diseases directly associated with the immediate material context.[14,15]

This stage of industrialization and the need to address working conditions were critical for the implementation of labor laws or policies that were already strategies directly focused on the safety and health of employees, so much so that we can already point to the emergence of social security, as a series of guidelines that take care of the worker during his working hours, disability, and family. Starting, of course, from the fact that the conditions in which they lived forced them not to stop working despite being injured or sick since their livelihoods depended on each day they worked. Moreover, this is a conditioning aspect of health and illness.[14,16]

However, the rise of the uni-causal biological process diminished proposals by physicians, economists, politicians, and even philosophers that pointed to a health-disease relationship and sociopolitical context. This also brought with it a vast knowledge of the biological substratum of disease as processes began to be understood at the level of organs, cells, tissues, and biochemical components of the human organism, both the healthy and the sick individual. Likewise, scientists acquired chemical and physical resources that favored diagnosis and treatment. On the other hand, genetic progress allowed the medical field to interpret, treat, and manipulate some diseases. Here, it can be noted that since there was such an established paradigm and a transparent object of study, the multiple actions saw surprising results, which already began moving the population away from infectious diseases.[17]

At this point, it can be thought that uni-causal and multicausal variables coexist in the field of health; however, the biomedical model has predominated due to the needs that have arisen. However, the critical analysis carried out throughout history by various authors has focused attention on a vision that encompasses micro and macro levels that could point to an ecological model of the health-disease process, in which it can be understood that although there are triggering variables, there are others that potentiate or mitigate the effect of stimuli or pathogenic behaviors.[18,19]

With time, infectious diseases influenced mainly by unhealthy environmental factors decreased considerably, and some have even been eradicated from some population contexts; however, mortality is a variant that is still present, attracting the attention of epidemiologists and health personnel.[20] In other words, the question remains: what type of populations continue to be primarily affected by infectious diseases? The answer may follow along the lines that the material resources or living conditions to which a person is exposed or to which he or she can aspire are the main reason.

A NEW UNDERSTANDING OF HEALTH

In 1974, Marc Lalonde published his report on New Perspectives on the Health of Canadians, in which he adopted a broader vision of the health-disease process, involving aspects of human biology, the environment, lifestyle, and the organization of health care at the institutional level.[21]

This postulate lays the foundations for health promotion and disease prevention. It first recognizes that at an economic level, large amounts of resources were allocated to the institutional organization in health, which implied detecting, curing, or alleviating health problems; however, the numbers were not lower in mortality. It is at this point where the analysis arises that states lifestyles had a more significant influence on mortality, but less attention and resources were given to it.[22]

The problem was mainly that the cost of health care and services increased, but this was not directly related to the improvement in the health of the population, i.e., there was no increase in the number of healthy people or decrease in disease. Therefore, a new space is given to lifestyles based on the relationship between investment and the influence on mortality, moving away from a purely biomedical model. This space focuses the intervention on informing people on how they can or should take care of their health so that they, in turn, make decisions that will lead them to healthy habits.[4]

Although Lalonde's report in 1976 is one of the most emblematic documents on the determinants of health, this vision was already being discussed in countries such as England, Germany, the United States, and even Latin America, where, since the eighteenth century, the importance of poverty and the policies surrounding it that could impact on the health of the population was mentioned. In addition, these visions not only play the role of understanding the health-disease process from the elements in which the person developed, but they are also a critique of the political system, which, through the established structures, maintains social problems such as inequality, which generate physical and mental discomfort.[23-26]

The rise of the healthy lifestyles model recognizes the agency of people to operate in terms of their health[27], based on knowledge; however, just as in the beginning, institutional medical care had the most significant weight in the health-disease process, it seems that over time now the individual responsibility began to be the central axis of getting sick, without considering that the person is still subject to a specific context that enables or hinders knowing and acting in favor of health.[28]

Based on the above, Dahlgren and Whitehead[29] 30 years ago built a model that exemplifies this subject-context relationship, in which individual variables of people influence their health, which in turn are conditioned by their lifestyles, which are also related to the social and community networks in which they find themselves, and which are also influenced by the living and working conditions that are ultimately under the order of socioeconomic, cultural and environmental conditions.

Figure 1 shows that this model is structured in layers, where a higher layer influences each condition while related to a previous layer. Under this conception, health strategies that only consider one of the levels have less capacity to impact compared to those that focus on several levels.

The model[29] allows us to visualize that although the most significant health burden is related to the actions and decisions taken for well-being, this lifestyle choice is conditioned by the options one may have, i.e., it is not the same to opt for a healthy life when one has education, adequate economic income and lives in a safe neighborhood, as when one has minimal income, no education and limited access to essential services. Therefore, the paradigm of the health-disease process is expanded, where the loss of health is related to social inequalities rather than agency and choices, which are not only notorious in terms of extremes, i.e., poor-rich, but even in people with average resources and options, inequality also exists.

Figure 1. Dahlgren and Whitehead's Model of Social Determinants.[29]

On this point, the social epidemiologists Wilkinson and Marmot[30] in their report "*Social Determinants of Health. The Proven Facts*" identifies ten social factors that have an impact comparable to variables such as obesity, tobacco, and alcohol consumption. These factors include social slope, stress, early life, social exclusion, work, unemployment, social support, addictions, and diet. This perspective is considered the determinants or conditions behind the fields mentioned by Lalonde in 1974 and is related to Dahlgren and Whitehead's model in 1991.

Thus, the situations in which one is born, grows and develops are subject to the way in which economic and material resources are distributed, which has an impact on the conditions of inequality that permeate the health of the population. For example, authors such as Hart[31] postulate that the availability of medical care moves inversely to the needs of the population, i.e., better, and better health services are accessible to people who can pay for them. However, this segment of the population does not necessarily need them most since the very conditions in which they develop make them less vulnerable to pathogens or risky behaviors. On the other hand, people with more significant deprivation and fewer needs require greater attention because they are more susceptible to illness due to the lifestyle to which they are disposed, which, in addition, limits them from seeking adequate health care.

It is also recognized that conditions such as social class, gender, age, ethnicity, and territory exert an influence of power within the population where some benefit more than others so that these inequalities are maintained.[32]

Therefore, Mexico and all Latin America are no strangers to being guided by a social-political vision on the attention to existing health problems since it is precisely in these places that inequalities exceed a biomedical care model and hinder a model of agency that makes the subject responsible for their own health.[17]

In recent years, political management has attempted to have an impact on those social determinants that influence health with the aim of reducing gaps or inequalities in this field through targeted interventions in vulnerable groups and marginalized communities, but these objectives have remained developmentalist policies, because although through programs it has been sought that people in extreme poverty have the possibility of having an extra income from the government to subsidize areas such as nutrition, this strategy was incomplete, because within the chain and dynamics of inequalities, only one link was covered and there was a lack of connection with other determinants, This strategy was incomplete, because within the chain and dynamics of inequalities, only one link was covered and there was a lack of connection with other determinants, i.e., although money is vital in this capitalist system in which the country and each of the individuals who inhabit it find themselves, it is necessary that this money can have an integral impact. That is to say; it must be helpful to improve the overall quality of life in the future, since it alone will not be enough, since there will be no opportunities if the people living in extreme poverty are in places with a lack of essential services, if the schools are hours away, if the neighborhood where they live is unsafe or if there is no employment, among others. Therefore, the greatest challenge is the need for articulation between strategies at the different levels of intervention, as stated in the social determinants.[33]

INTEGRATION OF SOCIAL DETERMINANTS IN HEALTH

By 2024, the year this manuscript was written, the National Development Plan 2019-2024[34] is being implemented, establishing a series of social and political objectives to build a country with well-being. Within the plan, a series of programs for development and social welfare that impact the population's health are contemplated.

Most of the plans coincide in providing economic support, under the concept that the lack of such support is the main reason for the malaise and social symptoms. However, under the model of social determinants and structures of inequality, economic deprivation results from social inequalities, which in turn maintain and aggravate the disparity, thus creating a vicious circle. On the other hand, as mentioned, few programs visualize an interrelation between social determinants.[35,36]

Table 2. Those plans that explicitly contemplate the integration of social determinants for public policies can be observed.

MENTAL HEALTH CONSIDERATIONS

Currently, thinking about mental health and illness does not mean considering the presence of clinically relevant disorders diagnosed using a manual, such as ICD-10[37] or DSM-V[38], but also those situations that incapacitate the person due to the intensity of psychosocial or emotional distress, which can translate into a perception of considerable anguish, functional disability, or risk of self-injurious behavior.[37,39] A clear example of this paradigm shift is the feminist vision regarding mental health in women, as it has brought to the table aspects that are exclusive to the condition of being a woman, such as menstruation and its related conditions, which incapacitate women from being productive and being able to solve themselves, which has psychosocial repercussions since a woman who has high stress due to an illness that limits her productive activity will be involved in a downward spiral where the previous condition generates more and more stress.

Table 2. *Specific Action Programs that consider Social Determinants*. [35,36]

Specific Action Program	Description
On healthy environment and communities 2013-2018	- Encourage communities and environments to be hygienic, safe and conducive to better health. - Encourage municipalities to comprehensively address the determinants that influence the health status of the population. - Strengthen the competencies of health personnel and the different social actors in the community and the municipality. - Strengthen monitoring and evaluation mechanisms to increase the Program's effectiveness.
Health Promotion and Social Determinants 2013-2018	- Deliver health promotion services with a focus on health determinants. - Strengthen health promotion in comprehensive lifeline care. - Develop knowledge, skills, and attitudes for the adequate management of health determinants. - To favor the incorporation of healthy public policies in public, social and private services. - Generate habits and behaviors favorable to health, based on the principles of social marketing in health. - Strengthen monitoring and evaluation mechanisms to increase the Program's effectiveness.

Therefore, it would not speak of a deficiency in her mental health but rather of the lack of attention by Public Health to provide tools and strategies to women with these conditions.[40]

The above is related to the general vision in this manuscript, which is based on a contextual vision in which mental health depends more on the social conditions in which one lives than on a psychological or even biological "marker" that affects mental health. Moreover, it is also necessary to recognize that from a purely psychological point of view, human suffering and pain are part of life. It is part of existence, however, noting, for example, the alarming figures of mental disorders speak of suffering that perhaps goes beyond the expected. However, there is a systematic neglect of the political system that justly continues without solving the daily life of people and facilitating their individual and social development.[41,42]

The most common conditions that have an impact on mental health are anxiety and depression, as shown in Table 3. In 2020, it is recorded that they increased between 26% and 28% due to the COVID-19 pandemic.[1,43] In addition, although there are scenarios for preventing and treating these ailments, people do not have access to timely and effective intervention where; in addition, it is children who are most vulnerable and continue to present sequelae for the year in which this manuscript is being written. In 2019, 301 million people around the world suffered from an anxiety disorder, of which 58 million were children and adolescents; on the other hand, depression affected 280 million people, among whom 23 million were children and adolescents.[44]

Table 3. *Mental disorder statistics in 2019 according to WHO.*[44]

Mental Disorder	Statistics
Anxiety	301 million people suffered from anxiety, including 58 million children and adolescents.
Depression	280 million people suffered from depression, including 23 million children and adolescents.
Bipolar	40 million people suffered.
Schizophrenia	It affects an estimated 24 million people, or one in 300 people.
Eating behavior	14 million people suffered from eating disorders, of whom almost 3 million were children and adolescents.
Disruptive and dissocial behavior	40 million people, including children and adolescents, suffered from dissocial behavior disorder.

Both anxiety and depressive disorders are characterized by an intense emotional reaction, the former by an excessive burden of worry, fear, and danger, the latter by a perception of emptiness, meaninglessness, and hopelessness. Although the etiology of these problems is multifactorial, a vital vulnerability

is recognized in adolescents due to their stage of development, which is characterized by a greater emotional reactivity to life events. This implies that the loss (or the possibility) of an important person, such as a friend, family member, or partner, can trigger a series of unhealthy behaviors that put the health of themselves or others at risk.[37,38]

In general, it has been recognized that some risk factors for mental health loss are lack of emotional skills, substance abuse, genetics, poverty, violence, inequality, adverse environmental circumstances, rigid and punishing parenting styles, and bullying, among others, and on the other hand, some protective factors to prevent mental health loss may be the development of individual emotional skills, positive social interactions, quality education, teachers' work, safe communities, social cohesion, among others.[45,46]

It is essential to stop at this point and, without pretending to sound too malicious, present the intention of this essay: to ask whether it is possible to talk about a Public Health problem because the statistics say that people are staying sick and dying or that the economic cost is exceeding the budget without apparent gains. At first glance, the two visions are not necessarily contrary; however, as has been said, all subjects live in a context, and the public service, in turn, is also immersed in a more extensive economic and political system. One is to ask whether the capitalist structure pulled the strings in seeking to improve the health system.

It is then recognized that although people have agency in their health care, healthy lifestyles are conditioned by inequalities in society, gender, age, ethnicity, and territory. Thus, a new perspective emerges to address the problems of Public Health, highlighting the systematic neglect of vulnerable populations, such as children, through power structures that prioritize segments of the population that are profitable to maintain. It also highlights those aspects associated with *education, public health policies, health, community infrastructure, and local economic development* must achieve an interconnection that favors a bridge for the entire population, reducing inequalities as much as possible.

Each aspect of public health is a crucial link that impacts the well-being of the population. It is acknowledged that various programs in the country attempt to address these aspects. However, the lack of integration and disconnection between these actions create a vicious cycle that perpetuates health problems. This highlights the urgent need for a more comprehensive and integrated approach. It is important to understand that physical and mental health cannot thrive without adequate social conditions. These conditions extend beyond economic resources and must address people's fundamental needs, providing resources that create opportunities.[47-49]

CONCLUSIONS

Therefore, reflection must maintain and reinforce a broader vision of health, considering the interaction of the determinants of life and health and moving away from normative and stigmatizing criteria. This implies rethinking the concept of health and going beyond the WHO definition, considering mental health as a combination of material and cultural aspects, which condition and limit the individual and access to health care. Finally, mental health should be considered a pillar of universal health coverage, bearing in mind the material, scientific, academic, and innovative aspects.

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