THEMES AND DEBATES

Social Determinants of Health: Perspective of the ALAMES Working Group on Social Determinants

Oliva López Arellano, José Carlos Escudero & Luz Dary Carmona

Introduction

The recent discussion of the social determinants of health, which has been promoted by the WHO[1] as a way to approach global health conditions is neither a new nor a foreign subject for Latin American social medicine or collective health. Indeed, this approach to health derives from the principles of 19th century European social medicine which accepted that the health of the population is a matter of social concern, that social and economic conditions have an important bearing on health and disease, and that these relationships should be subjected to scientific enquiry. (Rosen, 1985:81)

The specific socio-historical conditions of Latin America in the 1970's fostered the development of an innovative, critical, and socially-based health analysis, which was manifested in an evolving theoretical approach with deep social roots. (Cohn, 2003) This analysis calls for scientific work which is committed to changing living and working conditions and to improving the health of the popular classes. (Waitzkin et al. 2001; Iriart et al. 2002).

From its beginning, this school of socio-medical thought recognized that collective health has two main areas of research: 1) the distribution and determinants of health and disease and 2) the interpretation, technical knowledge, and specialized practices concerning health, disease, and death. The goal is to understand health and disease as differentiated moments in the human lifecycle, subject to permanent change, and expressing the biological nature of the human body under specific forms of social organization, all this in such a way as to allow discussion of causality and determination. (Breilh y Granda, 1982; Laurell, 1982). Latin American social medicine criticized biomedical and conventional epidemiological approaches for isolating health and disease from social context, misinterpreting social processes as biological, conceptualizing health phenomena in individualistic terms, and adopting the methodological procedures of the natural sciences

Latin American social medicine postulated that health and disease were expressed in the human body and psyche, that most disease was generated by social processes, and that these are historical phenomena. Together these postulates suggest a specific field of study which requires research into the relationships between humans, between humans and an external environment (fashioned by humans) and into the ways in which individuals become social beings. This allows the recognition of different levels of analysis and of the various processes which exist in multidimensional hierarchical systems. Social determinants do not act in the same way as biological, chemical, or physical

[1] The creation in 2004 of a Commission on the Social Determinants of Health (CSDH) by (then) WHO Director General, Dr. Lee Jong-wook, was key in fostering this perspective.

This text is the product of discussions held during the Latin American Workshop on the Social Determinants of Health, September 29 - October 2, 2008, Mexico City. The proceedings of this workshop will be published fully in future editions of Social Medicine. We hope they stimulate a discussion which leads eventually to an official position by ALAMES. Suggestions and commentaries can be sent to the General Coordinators of ALAMES: Drs. Catherine Eibenschutz Hartman (eibencaty@gmail.com) and Leticia Artiles Visbal Bisval (leticia.artiles@gmail.com).

agents in the generation of illness. They do not have etiological specificity, and they do not obey a mechanistic dosage-response curve. (Laurell,1994)

The Social Determinants of Health

The analysis of the health/disease process (as well as other vital processes such as nutrition, sexuality, and reproduction) has a both material dimension — with organic, biological, and social manifestations **—** as well as a subjective dimension which can be seen when these processes are subjectively experienced by a group of people. Thus the analysis of health and disease must be developed theoretically in its biological and social dimensions, as well as in the material and the subjective. (Doctorado en Ciencias en Salud Colectiva, 2002)

Thus, analytic approaches are needed which can delve deeply through different levels of interpretation and can also explain not only the specific character of each layer, but also how various layers interact and function as a whole. (Granda y col. 1995) On the other hand, to recognize that health and disease are socially determined implies adopting a specific viewpoint on the way in which society is shaped and a theoretical model to explain its dynamics. The choice of theoretical model is crucial; it determines how the totality of society is reconstructed and interpreted and how the essential social processes are clarified. The model also determines which methodology will be used to decipher reality and reconstruct those groups which show most clearly the social dimension of health/disease and the historicity of biology. (Blanco, López y Rivera, 2007)

The perspective of Latin American social medicine is based on historical materialism and the work of Gramsci. It recognizes that the means of production and consumption and the logic of distribution – where the State plays a key role[2] –are determinant in the shaping of the profiles of health, disease, and death within social groups. In capitalist social formations, the historical processes of social reproduction express the contradictions between private property, collective production, and the unequal appropriation of wealth. These are expressed in economic relations of exploitation and exclusion, in relationships of power which are deeply asymmetrical and oppressive. (López y Blanco, 2003) Social inequalities synthesize these relationships, as well as the antagonisms and contradictions in the economic, political, and ideological areas; they are expressed in axes of exploitation, domination, subordination, and multiple exclusions: of class, gender, ethnicity and age, among others.

These inequalities are found in all capitalist societies. They become more or less apparent depending upon the particular stage of capitalist development. However, the current phase of capitalist development has brought about a rapid deterioration in the quality of life for the majority of the world's population. This is the result of four separate but interrelated processes: increasing poverty, worsening economic and political inequalities, ecological deterioration (with its attendant health consequences), and an increase in the social-health gap. Together these have resulted in increasingly polarized societies.

Capital's current phase of reorganization, referred to as globalization, promotes programs to restructure the world according to principles of neoclassical economics and neoliberal ideology. Its characteristics include the supremacy and unrestricted mobility of financial capital and the integration of national economies into the world market. As a result, a small number of enterprises control worldwide production and trade. Accelerated and uneven scientific-technical progress transforms and delocalizes productive processes, imposes new modalities for the use and exclusion of the workforce and the hyperconcentration of the planet's resources (natural, economic, financial, politico-military, intellectual, and informatic), resulting in the massive exclusion of populations from the satisfaction of their basic needs. (López y Blanco, 2007).

This worldwide reorganization consolidates the dominion of a group of superpowers thereby eroding the position of nation-states and imposing upon most countries a subordinate role in the economic,

[2] The state is understood here as a place where relations of power are condensed, where social relations are regulated, and as a factor promoting the cohesion of a social formation. (Belmartino, 1992:123)

political, and social fields. The essence is global subordination to a world order based upon market forces. Supranational institutions increasingly make political and economic decisions. National sovereignties are redefined. Mega social projects are undertaken which limit the functioning of the welfare state; constrain the exercise of economic and social, cultural and environmental rights; reduce public spaces; appropriate for private purposes all that is public and profitable; and turn the essential factors for human wellbeing into commodities. (López y Blanco, 2007) As a result of this reorganization, the world has returned to forms of international behavior which had been considered a thing of the past: preventive wars, wars of occupation, and the use of massacres and torture as weapons of these wars.

In this process, any discussion of the social determinants of health and of the possibility of building projects for change leads to understanding, challenging, and modifying the worldwide capitalist relationships of globalization and subordination, which have invaded the entire planet with their capacity to exploit, pillage, exclude and exterminate.

Perspective of the ALAMES work group

The creation of the Commission on the Social Determinants of Health (CSDH), its exhaustive work gathering evidence on determinants and health inequalities, and its various thematic reports represent an advance in the task of making public the relationship between social inequalities and inequalities in health. (CSDH, 2008) This task of exposing and giving proper importance to the social in producing conditions of disease, death, and health care is essential at a time when there is a dominance of managerial and technocratic approaches to the study and solution of the world's problems of health and disease. (WHO, 2000; WHO, 2001).

Furthermore, the Commission's interest in formulating recommendations to reduce health inequalities, and its insistence on policies which guarantee access to essential services, irrespective of ability to pay, are a counterweight to proposals which support the privatization of goods, resources, services, and of life itself. (World Bank, 1993; World Bank, 1994; World Bank, 2004)

The Commission's final report presents a remarkable description of social and health inequalities and places social determinants at the center of the world debate on health. This is a subject which is marginalized by "the new public health" or trivialized in the biomedical model. (Jarillo, López y Mendoza, 2005) As the Commission states:

> *The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.* (CSDH, 2008:14)

The Commission puts forward a series of interventions designed to guarantee the implementation of its three main recommendations, made to eliminate health inequalities in the space of a generation. (CSDH, 2008)

The first recommendation, which deals with improving everyday living conditions, proposes a) a more equitable start on life, b) a healthy environment for a healthy population (including access to high quality housing, potable water, and sanitation services as a birthright of humans); c) fair employment and decent work, d) universal social protection throughout life cycle, and e) universal health care.

The second recommendation proposes a fight against the uneven distribution of power, money, and resources. The Commission's most relevant strategies for achieving this goal are that health equity should be a criteria for evaluating the performance of governments; the creation of a national progressive tax structure; honoring the commitment to increase international aid to 0.7 % of GNP, evaluation of the consequences on health equity of the most important international, regional, and bilateral agreements; the strengthening of public sector leadership in the provision of essential goods and services for health and in the control of health-damaging objects; that laws to promote gender equity be put in place and applied; that the representation of all social groups in decision making be guaranteed; that the UN make social equity a fundamental objective in world development programs; and that indicators of social determinants of health be developed in order to measure any improvements made.

The third recommendation relates to measuring and analyzing the problem of social determinants. The Commission proposes that data collection systems measuring social inequities and social determinants of health be established. Mechanisms need to be created to insure that these data are interpreted and used in the development of more effective policies, systems, and programs, and that there be sensitization and training in the area of social determinants of health.

Among the social actors that the Commission calls upon to carry out these strategies, the main ones are governments and the public sector. Other actors which are called upon to act in support of implementing these actions include international institutions and organizations, national and local authorities, civil society, the academic and research community, and the private sector. (CSDH, 2007)

Multinational organizations are asked to design policies and carry out interventions that are based on a coherent intersectorial approach to increasing heath equity. WHO is asked to increase its leadership role through an action program on the social determinants of health and global health equity. National and local authorities are asked for coherence in governmental policies, an intensification of equity-promoting measures and their financing, as well as measurement, evaluation and training. Civil society is asked for participation in the planning of policies and planning, their evaluation, and the follow up on program outcomes. The private sector is asked to increase its responsibility, investments, and research; and research institutions are asked to develop and disseminate knowledge about the social determinants of health.

This vision of both action and actors may have worthwhile aspects. But it has two drawbacks which became clear during the three year experience of civil society organizations working with the Commission. First, it is difficult to generate common objectives and joint actions among diverse actors. Government participation in questions of health equity is lacking. In Latin America only progressive governments were committed to reducing health inequities. (ALAMES, CLOC, RSST, 2006) A second limitation is that the Commission does not acknowledge a key player and one with a powerful ability to influence national and international decisions within the globalization process: the transnational corporations. Never before has Capital been able to exercise such far reaching power as these corporations have today. Never before has Capital been able to impose upon the rest of world its policies, its interests, and its dogmas in such an overwhelming fashion. (Benach and Muntaner, 2005) Therefore, to develop strategies that ignore such a powerful actor greatly limits any plans that might transform the social determinants of health inequities and which might impact on the concentration of economic, political, and knowledge power by these corporations.

On the basis of these reflections and our perspective we would like to highlight a series of problems in the Commission's Report which we feel should be further discussed:

- There is a lack of an explicit theoretical development of the concept of society. As a result, the definition of determinants is relatively ambiguous. It refers to structural determinants without developing the concept sufficiently, and to living conditions, which jointly constitute social determinants of health.
- It limits the problem of social inequalities to a question of distribution, in which the unfair

allocation of goods, income, services, and power affects peoples' lives. Its critique of the social order limits itself to pointing out that this unequal distribution is tolerated, and even favored, by social norms, policies and practices.

- The methodology of collecting evidence about the *social factors* which generate health inequalities reproduces the limitations of the dominant paradigm in epidemiology and in public health. (Almeida, 2000; Breilh, 2003) It does this by fragmenting reality into "factors", taking for granted that, held in isolation, factors maintain their explanatory power and are susceptible to modification.
- Social determinants, once they are converted into factors, lose their nature as socio-historical processes, as the expression of specific relationships between men, and between men and Nature. This facilitates their simplification and they come to be seen and understood as "risk factors," or poor lifestyle choices, etc.
- The report expresses a limited understanding of the configuration, dynamics, and current development capitalist societies. Thus, it generates abstract political recommendations for the reduction of social inequalities; it limits itself to "improving living conditions", and "sharing resources." These are recommendations without a context and are limited to resolving managerial issues.
- There is a lack of critical reflection and of analysis on the current phase of capitalist development, on neoliberal globalization, and on a geostrategic reordering of the world. This reordering imposes a rapacious and harmful global structure, which damages the life and health of world populations and promotes processes which put at risk the viability of the planet (global climatic change, wars for renewable and non renewable resources, and more recently the food and financial crises).
- The report is silent about problems which produce destruction, mass death, and enormous suffering in populations: imperial wars, genocide, and the manipulations of transnational pharmaceutical and food companies, among others.
- The report does not discuss the limitations on the reduction of social and health inequalities imposed by capitalism in general and by specific capitalist formations. In other words, there is no discussion about the contradiction posed by adopting a "politically correct" concern over poverty, which proposes to reduce social and health differences, while at the same time, ferociously defending the market economy.
- The reduction of health inequalities is presented as an ethical imperative. However, there is no explicit discussion of the principles and values of an ethics of life and health, which would transcend bioethics, and challenge the "thanatopolicies" which reign in our globalized world and which places the debate in the arena of biopolitics.
- The activities of the various actors are seen as a matter of will. The report does not acknowledge power relationships and their inequality. The role of transnational actors with great weight on health and nutrition has been made invisible.
- In summary, the Commission's report amply fulfils its purpose of gathering evidence on health and socioeconomic inequalities, and of stressing the importance of socioeconomic determinants. But it falls short of advancing an understanding of the origin of these problems, what Benach and Muntaner have called "the causes of the causes of the causes." (Benach and Muntaner, 2008)

Political Action

A central element characterizing Latin American Social Medicine/Collective Health (Granda, 2003) is the understanding that health is a political matter. This viewpoint that can be traced to the positions of Virchow in the 19th Century, who argued that medicine is a social science. (Rosen, 1985) Latin Americans adopted and deepened this analysis in the last half of the 20th century by arguing that "medicine is a social act, and there are no apolitical social acts." (Fergusson, 1983)

Given this orientation, Social Medicine/ Collective Health assumes that health matters are linked to political matters, that is to say with collective and individual decisions and consequently with relationships of power, which define the life course of social groups as well as their health, wellbeing, illness, and death. This has been called biopolitics (Berlinguer, 2007), a field which examines politics in its relationship to life. For Social Medicine/Collective Health biopolitics should promote social decisions and actions which favor dignity, wellbeing, health, and justice. Social Medicine/Collective Health recognizes that, in political terms, the concept of social determinants of health has a double meaning: on one hand there is recognition of a political dimension within health determinants. On the other hand it assumes that modification of health determinants requires political action.

Social Medicine/Collective Health argues that politics are a determinant since politics defines the distribution of political and economic power, it establishes the "macro" context for those economic, social, and health policies in international, national, and local arenas, which directly affect health, illness, and the health care of populations

Social Medicine/Collective Health sees political action as confronting and transforming the social determinants of health. It will be political decisions and acts which overcome the unequal distribution of social and economic power which determine the unequal health conditions of the people. (Benach and Muntaner, 2005)

For Social Medicine/Collective Health, the social determinants perspective is a useful tool to make visible those structural aspects which promote health in a society. This perspective also provides a greater political content to the health rights approach (understood as part of the group of economic, social, cultural, and environmental rights). It should be clear that the guarantee of a right to health implies structural changes in the way societies organize production and consumption. It means, furthermore, the just distribution of economic resources, knowledge, and power for and among peoples

Social Medicine/Collective Health see that the linkage between a structural understanding and a rights-based approach offers tools for the organization of campaigns to demand that the State fulfill its responsibilities to act on the social determinants of health and to guarantee the right to health. However, the reach of the Commission's report is further limited in the current international context where decision making is dominated by transnational corporations and international organizations (World Bank, IMF, BID, and the WTO). These actors wield enormous power over the direction of public health policies.

In this adverse context, the political usefulness of the WHO initiative lies in the opportunity given by the Commission's report to denounce the totality of persisting global health inequalities and to center the international debate on health inequalities on questions of the distribution of wealth, power, and knowledge as fundamental determinants of these inequalities. The report also allows us to propose and advocate political actions to modify these determinants, but no more than that. The strategies that the Commission suggests to improve the quality of life are limited, although one must acknowledge a number of proposals which can ameliorate the suffering of people and which can contribute to diminish health inequalities.

The Commission strives, in large measure, to make manifest global health inequities, an important concern and one shared by Social Medicine/ Collective Health. However, for Social Medicine/ Collective Health, and particularly for ALAMES (the Latin American Association of Social Medicine) – which is Social Medicine's organized political manifestation – the core of the matter lies in organizing political movements along with diverse actors. These would include: populations expressing themselves through organizations and political movements, progressive and anti-neoliberal governments, and academia. Our goal is to strengthen our resources/power and our political capacity to influence the distribution of resources within society.

From the Social Medicine/Collective Health perspective the central actors for change are the peoples of the world, through their organizations, movements, and networks, both social and political. The social determinants perspective can be considered as a tool to diffuse knowledge about the causes of unjust inequalities and to confront the current model of neoliberal globalization; shaping new forms of socioeconomic development, which are not founded on the accumulation of capital, on consumption, individualism, and the destruction of solidarity; and which effectively guarantee economic, social, cultural, and environmental rights, as the productive structures and inegalitarian distribution of wealth and power are modified.

The Challenges

The collapse of the capital's current phase of neoclassical and neoliberal globalization as a model of society is also a theoretical and political crisis. It demands new political practices and new capacities for theoretical elaboration, a daily theoretical and political endeavor which makes possible the development of proposals for the construction of a world without exploitation, domination, discrimination, and alienation. (Sader, 2003) The guiding principles of our daily work should be emancipatory and anti-capitalist.

Among the essential challenges for our political work, the following can be identified:

- To strengthen critical reflections in academia and to train professionals (strategic mediators) with theoretical capabilities and technical knowhow, who are committed to the transformation of the collective conditions of health, disease, and health care. They can join with and strengthen movements for change. (Granda, 2000)
- Professionals with solid theoretical ability to characterize and interpret not only the contradictions of this capitalist phase and its negative consequences for quality of life and the health of populations, (ALAMES, 2007) but also the keys to understanding the new forms of anti-imperialist struggle in Latin America, the emergence of political and social movements, the surge of anti-neoliberal and sometimes frankly anti-capitalist governments, and the contents of proposals which envisage another social order.
- To articulate the work of diverse political, institutional, academic, and social actors, with common agendas in the defense and enlargement of the scope of economic, social, cultural and environmental rights
- To assist in the development of proposals which respond to collective needs in the short run, while simultaneously contributing to social transformation and the creation of new relationships. (Bustelo and Minujin, 1998)

Given these challenges Social Medicine/ Collective Health proposes a set of action agendas whose success depends on the mobilization of multiple actors as well as a favorable correlation of forces. Social Medicine/Collective Health's theoretical and practical activity will provide the content for these agendas with a goal of advancing movements that both prefigure and strengthen new forms of social and institutional organization.

- Defense of the right to health
- Defense and broadening of economic, social, and cultural rights (Non-regressive, and such that citizens are empowered to demand them and seek legal recourse when infringed).
- Guarantee that basic needs will be satisfied, irrespective of ability to pay.
- Fair policies to protect employment and provide dignified work.
- Modification of trade agreements to assure equity.
- Progressive and redistributive tax policies.
- Social protection throughout life.
- Universal and public health systems.
- Sustainable ecological policies.

Social Medicine/Collective Health and ALAMES seek structural change given that the problem of social and health inequities is intrinsic to the very essence of capitalist society. The aim is to strengthen a continental and global movement for health equity, as part of the broad regional and global coalition for the right to health, for just development, for the equitable distribution of material wealth, political power, knowledge; and to do so without destroying nature. We seek societies which break with the hegemonic model of concentration of wealth, with its emphasis on the consumption of commodities as synonym of happiness and success.

A real modification of the determinants of social inequities requires the efforts of multiple actors, who can tip the scales in favor of political forces which favor life, wellbeing, and health and against the forces of accumulation, of exclusion, of illness, and of death. It requires invigorating the values of solidarity, cooperation, defense of life, and of environment. These are found in the agendas of social and cultural movements in struggle, in the women's movement, in indigenous organizations, among workers and professionals, in democratic and progressive political parties, and in the public action of local and national progressive governments.

The Agenda

Social medicine and collective health arise from the recognition that the processes of health and disease, their representations and societal responses to them, are socio-historical facts, occurring in human collectives, and that it is necessary to understand the determination and distribution of these processes by moving beyond their immediate causality and beyond the realm of biology. (Granda, 2003) In spite of considerable progress in the explanation of diverse forms of health and disease, nonetheless in the context of particular systems of social reproduction, a well-founded theoretical-methodological framework has yet to be fully developed. (López and Peña, 2007)

Among the challenges is to continue decoding the processes of union/incorporation[3] between the social, the ecological, and the psycho-biological while at the same time avoiding models which explain health and disease from a biological-natural or epidemiological-positivist perspective. It is necessary to resolve the debate between history and nature, biology and society, recognizing that these relationships are insufficiently understood from an epistemological viewpoint. (Doctorado en Ciencias en Salud Colectiva, 2002)

These theoretical and epistemological challenges not only imply understanding relationships between the biological, the psychic, and the social, but also suggest the limitations and deficiencies of social theory as a tool to comprehend the relationship of the individual and the collective, as well as a more precise delimitation of its area of study, and the means of approaching its objects of study. (Almeida, 2001)

A broadening of the field and a reformulation of its object of study are unfinished tasks. To accomplish them, it is necessary to transcend a medicalized view and to shift the trajectory of the field to the intermediate stages of the health and disease process, to incorporate the social determinants perspective, the perspectives which emphasize the importance of human action in the construction of the social, and to reassess the importance of the subjective element.

The training of health personnel and health research are arenas in which it is necessary to update and to renew the many aspects and criteria in the development of health care personnel, as well as to examine the bases upon which research is proposed, executed, and validated.

Action on the social determinants of health requires the confluence of different disciplines. This is due to the complexity of the objects of study. Not only are there questions of interpretation but also ones of instrumental nature: how to transform understanding into political and practical interventions. It is necessary to think of creating comprehensive fields rather than simply disciplines. What is required are proposals for training and research where one moves from the model of static and rigid discipline-based research to fields of knowledge which are, at least, multidisciplinary and, at best, interdisciplinary. (Jarillo, López and Chapela, 2007)

From our point of view, it is urgent to develop an ethical perspective to guide decision making in collective health, and to begin a rigorous analysis of potentially applicable principles to a field of health knowledge and practice. This perspective should not shirk from adopting a specifically political character. In this sense, it is desirable to start with an examination of those principles which are recognized as fundamental to the analysis of political ethics. In this case they are the principles of a) solidarity, b) responsibility, c) caution, d) protect-

[3] Translator's note: *articulación/subsunción*.

tion, and e) participation. (López and Tetelboin, 2006)

Social Medicine/Collective Health, as a field of knowledge and practice, attempts to understand and transform the processes of health, disease, care, and nurturing. However, it is not a matter of creating a finished, unalterable, and mechanical model that can be extrapolated to every moment, space or population. Rather, it is a matter of adopting a critical and inventive attitude, linked to a methodology of understanding the historicity of bio-psychical human expressions as a synthesis of more general socio-historical processes, to recover their multiple dimensions and modes of articulation, and to support processes of social transformation.

Social Medicine/Collective Health and ALAMES propose the following tasks:

- Prepare an evaluation of how Social Medicine/Collective Health has used the social determinants perspective in Latin America and how far these concepts have permeated the management of health services and local and national governments. The goal is to recognize failures and successes in the application of the social determinants perspective.
- To assist in presenting the discourse of social determinants in less technical terms and establish clearly the connection between social determinants and the right to health. This should broaden the agendas of both continental and global health movements, enriching them with new analytical tools, new tactics, and new strategies addressing structural determinants.
- To strengthen the capacity for academics to disseminate knowledge and develop action-oriented research which can continue to reveal the way in which health inequalities are developing in the Continent, their structural causes and possible ways of overcoming them
- To assist social movements and health organizations in their efforts by adopting, deepening, and strengthening their proposals for universal and multi-cultural health systems. These systems should protect the rights of health workers, defend occupational health as a right, consider pharmaceuticals as public goods, demand universal access to essential drugs, recognize water as a public good whose use is a human right, defend food sovereignty and security for all peoples, and oppose war and militarization. (Civil Society Representatives to the CSDH-WHO, 2007)
- To collaborate with health advocates/workers so that they understand, adopt, and advocate for a social determinants perspective, remembering that they are main actors for implementing any change in health policies.
- Influence the platforms of democratic and progressive political parties to incorporate a social determinants perspective and to influence governmental programs to develop integral trans-sectorial actions.
- To work with progressive governments, both at local and national levels to design public policies supportive of the transformation of social determinants.
- To demand that WHO and of PAHO recover global leadership in health-related matters, to confront those international financial organizations which support privatization in health, to demand that WHO and PAHO support health policies designed with a social determinants perspective and that they also energetically denounce the growing ethical violations occurring in clinical trials of drugs, diagnostic equipment, and other forms of medical technology.

In conclusion, the political path ahead of us is clarified by the Brasilia Letter, a consensus statement adopted by a wide array of Latin American social organizations (Movimientos y organizaciones sociales y populares de las Américas, 2007):

> *It is clear to the civil society movements and organizations present at this meeting that health is a universal human right, a duty of the State, whose achievement needs an array of determinants, such as safe and secure food, the right to a dignified job, a recognition of reproductive labor, an adequate income, access to, use of, and permanence of land rights, a*

sustainable use of renewable natural resources, suitable housing with sanitation, democratic popular participation, universal access to the appropriate health and educational services, which should be humane, high-quality and culturally-sensitive, universal and inclusive public policies, and social relationships which are neither sexist nor racist, with religious and cultural tolerance, and which also express that both the determinants of health and the right to heath are indivisible and independent.

In this context, it becomes evident that, in order to advance towards overcoming health inequities, a fundamental requirement is the development of social and economic models of development which are sustainable, which guarantee human, civil, political, economic, social, cultural, environmental, sexual, and reproductive rights; a model of the State that guarantees such rights; a movement towards food sovereignty and security which eradicates hunger from the continent, promoting agrarian reforms which ensure access, use and property of land; sustainable agricultural processes which preserve ancestral seeds in the framework of a proposal for family and peasant agriculture which is adequate to the climatic diversity of the region; urban reforms which propose a better distribution of urban land, a democratization of the cultural capital of humanity through universal access to education, the realization of participatory democracy, and the development of public policies which are intersectorial, universal, integral, equitable, and participative.

This, then, outlines the contours of our common goals. To reach them requires that democratic and progressive forces on the Continent acquire the political power necessary to fight those who perpetuate unjust conditions.

In short, it is power disparities which produce health disparities. If we accept this, then the main task of Social Medicine/Collective Health is to bring to light the inequitable systems of production and distribution of power, wealth, cultural resources, knowledge, and environmental resources. These, in their turn, generate multiple inequities in class, gender, ethnicity, age, and ultimately in health. Strategies are needed to face these inequities and change them. One of the challenges and political tasks of Social Medicine/Collective Health and ALAMES is to make a contribution towards this change.

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