Latin American Social Medicine and the Report of the WHO Commission on Social Determinants of Health

Rafael González Guzmán

In October 2008 the Latin American Social Medicine Association (ALAMES) organized an international workshop entitled "The Social Determinants of Health." Representatives of ALAMES' seven regions participated in discussions of the various consultative papers prepared by the working groups of the WHO Commission on the Social Determinants of Health as well as the Commission's final report. The workshop considered how ALAMES should respond to the work of the Commission. In this paper we summarize the main points outlined in the position paper prepared by the Organizing Committee[1] and offer a synopsis of the main contributions made by each of the workshop's study sections.

Contextual Considerations

In the years following the Alma Ata Declaration a "New Right" came to power in the world's leading countries. As a result the new right gained control over the major international organizations such as WHO and UNICEF. The goals of "Health For All in 2000" and the strategy of Primary Health Care (PHC) were already quite limited in their scope and not particularly demanding in terms of the State's duty to guarantee health rights (leading Mario Testa, for example, to wonder if it would not be better to speak of "Primitive Health Care" rather than "Primary Heath Care"[2]). Nonetheless, these goals were now set aside by an overtly neoliberal position that promoted Selective Primary Health Care and the Millennium Development Goals.[3] By 1985 the Rockefeller Foundation was talking about "Good Health at Low Cost," UNICEF had retreated from the ideals of PHC, and the US saw the birth of "selective PHC" designed to "improve health statistics, but abandoning Alma-Ata's focus on social equity and health systems development."[4]

Initially, selective PHC was offered as an interim measure until integral PHC could be fully implemented. Over time, however, it became an entirely new strategy which promoted private sector participation in health care; separation of health care financing from service provision; decentralization; a focus on efficiency rather than equity; and, more recently, the encouragement of vertical campaigns directly financed and branded by the world's leading entrepreneurs. Far from advancing towards Health for All during the 1980s, "the thirty-seven poorest countries in the world reduced their public spending on education by 25% and their public spending on health by 50%."[5] At the same time WHO's role in setting health policy was gradually displaced by the World Bank. The Bank, using its leverage as lender, imposed the strategies outlined in its 1982 and 1993 reports. In 1998, WHO's new Director General, Gro Harlem Bruntland, moved PHC supporters into a new commission on Social Determinants (formed in 1997), while encouraging a Commission on Macroeconomics and Health, led by Jeffrey Sachs, an open supporter of neoliberalism.

In 2003, Dr. Lee was elected Director General of WHO and revived some of the Alma Ata proposals.[4] In 2004 he proposed the formation of a Commission on Social Determinants of Health (CSDH) centered on the search for equity in health services. Sir Michael Marmot was appointed to head the Commission. Marmot, a representative of European social epidemiology, was closer to the positions of Halfdan Mahler (WHO Director General at the

Rafael González Guzmán, ALAMES México. Email: rgcs@servidor.unam.mx. This article is based on documents and discussion from the Latin American Workshop on the Social Determinants of Health organized by the Latin American Social Medicine Association (ALAMES) with support from the Pan American Health Organization (PAHO) in October of 2008 in Mexico City.

time of the Alma Ata meeting) than to the neoliberal canon. For three years, seven working groups undertook the task of polling governments, academic organizations, and civil society groups on a number of subjects: work, cities, child development, gender, globalization, exclusion, and health systems. The working groups produced seven theme-specific reports which were integrated into a summary report by the entire Commission. Together these documents represent an important challenge to neoliberal approaches to health. While they offer an alternative to the onslaught of the New Right, there are significant differences between the approach of the Commission and that of Latin American Social Medicine and Collective Health, both of which have long developed positions that are deeper, more radical, and more committed to the peoples' struggles.

The Social Determination of Health

The Commission called attention to the need for action on the social determinants of health so as to improve the overall global situation and tackle the underlying social inequities upon which health inequity are based.

The Commission drew heavily from the work of European social epidemiology. This school recognizes two different classes of social determinants which affect health. The first are structural determinants and include: a) the socioeconomic and political context (composed of governance, macroeconomic policies, social status, public policies, culture and social values) and b) socioeconomic status, social structure and social class which condition education, employment and income (as mediated by gender and ethnicity). The second class of determinants are considered *inter-mediary* because they link the afore-mentioned structural determinants with actual health outcomes. Intermediate determinants include material circumstances (such as living and working conditions), behavioral and biological elements, psychosocial factors, and the health system itself. These intermediate determinants affect wellbeing and health equity.

Latin American Social Medicine has critiqued this approach to health and society on both epistemological and theoretical grounds; this critique has both political and ethical corollaries. The epistemological critique was articulated at the Social Determinants workshop by Jaime Breilh,[5] Ecuadorian critical epidemiologist, who presented a paper arguing that the Commission had adopted a neo-causalist approach in which social determinants are seen as risk factors with external connections between them. This approach ignores the analysis of social determinants as historically conditioned processes and expressions. The Mexican epidemiologist Carolina Martinez,[6] referred to these individual risk factors as *risk portfolios*, inherent to each social way of life. The risk factor approach leads to policies which seek to change isolated factors rather than structural processes. Breilh pointed out that Latin American Social Medicine and Collective Health have gone beyond this approach in several ways: by contextualizing exposures within different modes of living, by exploring the dialectic between individual and collective health, and by studying health as something that is both complex and multi-dimensional. Carolina Martínez[6] argued that the Commission, instead of limiting itself to the epidemiology of risk factors, should have incorporated other perspectives (e.g. social, anthropological, economic). The Commission should have seen the "objects" of epidemiological research as *subjects* who make their own observations and their own interpretations concerning what happens within their spheres of action.

From a theoretical viewpoint, the Commission's report offers a comprehensive denunciation of the huge inequalities in global health. The wide dissemination of this denunciation is particularly important during the current crisis, product in part of more than two decades of neoliberalism. The responsibility for this situation should be placed with those who, from the World Bank and within the WHO itself, have promoted neoliberal policies. However, the theoretical framework of the Commission's critique is too limited to conceptualize health inequities as the outcome of a specific mode of social organization.

Building upon prior work, the position paper prepared for the workshop[1] offered this critique of the conceptual frameworks used by the social determinants of health school and European social epidemiology:

> *[These approaches] pay little attention to our current society as it is, focusing rather on the effects it produces within a model incorporating education, occupation, and income. The model itself is based on functionalist sociology, which*

sees the relationship between education, occupation, and income as deriving from socio-economic stratification. According to this approach, one of the central measures of social justice or injustice is how equitably a society provides individuals with access to a good education. A quality education is supposed to ensure better jobs and consequently better incomes. These, in turn, permit better living conditions and thus better health. The only possible social transformations from this analytic perspective are changes within an inherently unequal society. Such changes remove only the most aggressive and lethal aspects of the social system (such as forced labor, child labor, occupational hazards, etc.).

In continuity with his epistemological critique, Breilh noted that the Commission's theoretical framework did not analyze society as a whole nor did it examine the logic underpinning our current social organization: accumulation, property, and social relations. The Commission limited itself to what is called governance and to specific social policies. Secondly, the Commission's model of social class and its components (education, occupation, and income) was overly linear and skewed towards questions of consumption.

Our colleagues from the Master's Program in Social Medicine and the Doctoral Program in Public Health[7] (Mexico) highlighted further limitations to the Commission's approach. First, inequity is reduced to a problem of how social goods are distributed and thus, the critique of a given society is limited to whether it tolerates unequal distribution or not. Secondly, the Commission's approach fragments social reality by separating it into individual factors. These lose their explanatory power once they are isolated and this isolation obscures their role as elements of a socio-historic process. Thirdly, the Commission's approach does not take into account the arrangement, dynamics, and time course of capitalist development. This gives its recommendations a rather abstract quality. Finally the Commission does not point out the limitations imposed by capitalism in its current formation for the reduction of health inequalities.

In contrast to this approach, the Latin American Social Medicine and Collective Health have developed a theoretical framework that leads to a very different way of understanding – but more importantly *addressing* – social inequities in health. This framework starts out from the inherent tendencies of a capitalist society in terms of the distribution of labor, property, and power and the mode of social reproduction. These are then used to explain the vast differences in the quality of life for different social classes, genders, and ethnicities. At the same time, it explains how individuals and communities develop a set of particular meanings for their own health and life, meanings which are then reflected in their health practices. When these practices are expressed in specific, socially determined environments, they form a way of life. Health becomes a zone of conflict in which various movements struggle to eliminate – either partially or entirely – restrictions on living a healthy life. These struggles include the creation of spaces for the free choice of how to live, enjoy and – is it impossible to imagine? – live in a democratic and egalitarian way both as individuals and as communities. Finally, another key difference is that the theoretical approach of Latin American Social Medicine and Collective Health, in contrast to the Commission, understands both the distribution of health and disease, as well as the organized social response to this distribution, as byproducts of conflicts within a society. Such conflicts are part of the power struggle between the ruling classes, which use multiple strategies to maintain their hegemony and domination, and those who oppose this hegemony, such as trade unions, social movements, etc.

The theoretical constructions of Latin American Social Medicine and Collective Health integrate a critique of how a society is structured, how it encourages or hinders health, and how social structure gives birth to struggles for the defense of health and for a better society freed from the exploitation and pillage of capitalism.

The problem of inequality, inequity and injustice

The Commission's report, through its initial and very explicit goal of narrowing the gap of inequity over the course of generation, places ethical concerns front and center.[*] In doing so, the Commission adopted much of Margaret Whitehead's[8] conceptual framework. Briefly, the

[*] We note that this goal was lost in the Spanish translation of the Executive Report. "Closing the gap in one generation" was translated as "Subsanar las desigualdades en una generación." [Translator's note: the word *subsanar* can be translated as resolve, correct or excuse/pardon.]

Commission assumes that an important part of health inequalities have a social origin. These inequalities, which are systemic and avoidable, reflect the different places of individuals occupy within a given social order and are designated as *health inequities*. The Commission considers them as unjust in so far as they violate the human right to health.

The Commission saw health inequities as deriving from an unequal distribution of wealth and power between groups of individuals in society. Consequently, the Commission suggested that to achieve equity in health, social policies are needed which empower individuals, communities, and countries. Social wealth must be redistributed in such a way as to promote a healthy and prosperous life. The Commission's proposals are therefore aimed at reducing inequalities in health, as previously noted, by closing the gap in health over the course of a generation.

Whitehead and Dahlgren's position, adopted by the Commission as well as other international health organizations, could be the subject of extensive ethical discussion. But in this summary we will highlight only the important contribution of Colombian historian Mario Hernandez[9] at the ALAMES workshop. Hernandez points to three major ethical positions with respect to health: liberal, redistributive liberal (including social-democratic positions), and social egalitarian. He classifies Latin American Social Medicine within the social egalitarian tradition. Neoliberal positions seek only to assure equality of opportunity and tend to accept social differences as valid since they supposedly result from effort and merit. In contrast to this position Hernandez sees that of Whitehead and the Commission as closer to the liberal redistributive position which sees health (or food or housing) inequalities as unjust since health (or food or housing) are social rights. The liberal redistributive position accepts the restrictions imposed by the existing social division of labor and property which indentures the vast majority of humanity to the service of a property-owning minority. It proposes a redistribution of wealth so as to reduce inequity. This perspective, as valid and defensible as many of its demands may be (e.g. universal, free and state-provided education and health care), does not seek to abolish inequality, but rather to reduce its consequences.

Latin American Social Medicine and Collective Health have developed an approach that is closer to Hernandez's definition of social egalitarianism. Jaime Breilh in his well-known book *Epidemiología Crítica*[10] presents the issue in the following terms:

> *Unequal societies are characterized by social processes which distribute power unequally. This power controls not only the ownership and use of material wealth, but also the ability to define and develop a sense of identity as well as the dreams and plans for a better tomorrow [los proyectos y las aspiraciones de utopías].*

Inequity is not injustice in distribution and access; it is the unjust system that generates the unequal distribution and access. Inequity refers to the way the social formation determines access and distribution (social inequality), the latter being a consequence of the former. This distinction is most important in strategic terms. If our analysis remains focused on inequality, it becomes distracted by the symptoms of the problem, rather than its determinants. Inequity reflects the essence of the problem; inequality is an empirical measure of inequity made apparent through statistical analysis.

Inequality is injustice in access, denial of use, and disparity in the quality of life. Inequity, the lack of equity, is the inherent trait of a society that impedes the realization of the common good. Inequity is injustice producing inequalities.

The recognition of inequality requires us to unravel the inequity that produces it. Inequality is the observable and collective expression of inequity. It shows a contrast within a given trait or measure caused by inequity. Inequalities are measured; inequities are judged.

With the appearance of inequity in human societies – expressed as the appropriation and concentration of power by certain classes, genders, and ethnic groups – human diversity, rather than being a source of social progress, becomes a vehicle for exploitation and subordination. The ultimate source of all inequity is the appropriation of power: the private appropriation of wealth which gives rise to social classes, the appropriation of patriarchal power, and the use of ethnic differences to impose forms of ethnic domination. This triple inequality is what produces health inequalities. Current health inequalities are a product of this triple inequity. They are organically linked to those social structures, like capitalism, which are based on the accumulation of wealth at one social pole and the

accumulation of exploitation, dispossession, and exclusion at the other.

Latin American Social Medicine and Collective Health do not see the main problem as limited to health inequalities (which the Commission equates with inequities). Rather we must examine the source of social inequity, recognizing that it arises and takes its specific forms from a system of appropriation of power and wealth. Latin American Social Medicine and Collective Health, while supporting the Commission in its call for social policies that reduce inequality in health, does not limit itself to such policies. It will also seek to overcome the social inequities that produced said inequality in the first place.

This is not a minor difference. If health care is presented by the ruling classes as way of "equalizing" things within a society marked by exploitative and oppressive social relations, we must ask whether this proposal is part of a social program aimed at the causes, that is, the forms of capitalist oppression, or whether it is merely one more resource to maintain the hegemony of the powerful and wealthy.

Political action

The third area of discussion with respect to the Commission's approach concerns political action on the social determinants of health. Clearly, this question is closely linked to the previous two; any political action derives from a specific understanding of social structure and the place of inequity and injustice within that social structure. This understanding informs who will be the subjects of any political action and what forms that action will take.

Asa Cristina Laurell[11] began her presentation by noting that from its beginnings social medicine has focused its political activity on proposals aimed at profound changes in social relations, changes that were seen as part of a larger social revolution. Later, social medicine would also emphasize the activities of health systems (either after a revolution, as in Nicaragua, or as part of a reform process, as in Brazil). In either case, the objective has been to encourage those trends within social processes that lead to transformation of social relations. This transformation aims at overcoming – i.e. rendering obsolete – all forms of exploitation and oppression that create not only health care inequities, but also lives overwhelmed with preventable disease, inequity, and injustice.

During the workshop several colleagues pointed out how the conceptual differences with the Commission noted above will lead to differences in political action.

Carolina Martinez[6] remarked that all the Commission's proposals were designed to be carried within the current social structure, and consequently within the limits of a society that prohibits more far-reaching solutions. She added that this is probably how we should understand the work of this kind of international agencies: to make recommendations which seek to reduce the most onerous of the disease-promoting effects of our societies' lifestyles.

Similarly Francisco Rojas Ochoa noted that "we should not hope that the Commission, given its nature and its position within the World Health Organization, would encourage a political, economic or social revolution; it is prescribing warm compresses to treat an abscess. It denounces, but does not point out the culprit. The Spanish term "subsanar" itself, the first word in the title of the Analytical Report (*"Subsanar las desigualdades en una generación"* "Resolving inequalities in a generation"), would mean to leave everything as it is, if we apply the first meaning given to *subsanar* in the dictionary of the Spanish Royal Academy *"Subsanar. Disculpar o excusar un desacierto o delito"* ("to forgive or excuse a crime or mistake").[12]

Along similar lines, Mauricio Torres stated:

> *The approach encouraged by the Commission, while highlighting the political, social, and economic determinants of inequities does not explore the model of social production and reproduction which are the causes of these determinants. Consequently when suggesting alternatives, the Commission does not touch the nature of capitalist society at its core."*[13]

Afterwards, Rojas Ochoa would remark that the Commission had not considered a number of key social issues:

> *…such as labor deregulation, privatization of public services and social security; exploitation of migrants; discrimination according to skin color, ethnicity, gender, sexual orientation or religion; intellectual property rights, subsidies to agricultural production by rich countries; the limited and conditional aid to development; global warming and climate change; and many other components of contemporary capitalist*

society which include more specifically war, terrorism – in its most harmful form of state terrorism – and violence, which is incorporated into the culture of peoples as violence against children, women, and senior citizens. All the above are tied to social determinants. Why not denounce them and fight them?

Rojas Ochoa mentioned another issue not discussed by the Commission – pharmaceuticals – and wondered:

Inequity in access to medicines is proverbial. Why was this subject not discussed? Could it be that the reach of pharmaceutical industry is long enough to ensure that "its business" is not spoken of?

José Carlos Escudero also wondered:

Why did the Commission not make any mention of the more than one million preventable deaths caused by imperialist aggression in Iraq?[14]

Mario Hernandez[9] added that although the Commission calls for a broad and global movement for social change, its proposals and recommendations tend to focus on the role of the State and on the social responsibility of capital. This latter can easily be translated into traditional philanthropy. Thus, "the [Commission's] proposals may foster redistributive mechanisms that indeed reduce some inequalities while leaving intact the structures and processes that, in reality, determine the production and reproduction of inequality."

Finally, the workshop's position paper[1] offered yet another element to be considered:

Latin American Social Medicine and Collective Health are not centrally concerned with the particular policies adopted by the governments of the powerful nor does it see itself as an advisor to such governments. Demands such as an increase in the health budget, the creation of a universal health system, building more schools, or making jobs safer, must take place within the process of struggle between the hegemony of the ruling classes and the creation of a counter-hegemony by those below.

This leads us to a summary of the elements of ALAMES' alternative. Carolina Martinez presented the general outlines defining a critical analysis of health:

Critical thinkers should not be satisfied with measures that mitigate the effects of our current lifestyle on the less privileged members of society, but must instead work on building a better world for everyone.[6]

Picking up on this idea, several colleagues from the Master's Degree Program in Social Medicine, and the PhD in Public Health, emphasized that "our daily academic and political work should by guided by a perspective that is anti-capitalist and emancipatory."[7]

It is within the context of this "emancipatory" project that Latin American Social Medicine and Collective Health makes particular demands against the government. These demands are not designed to "forgive" or minimize the inequities in a deeply unequal world. Rather they are part of constructing a counter-hegemonic alternative from below. The colleagues from the Master's Degree Program in Social Medicine and the PhD in Public Health stated a set of immediate demands to be raised within this perspective.

Mauricio Torres noted that the struggle for health care rights within a context of social transformation can also respond to immediate problems. This occurs when the struggle for realization of health care rights involves political organization. He stated: "[t]he central change agents are the world's peoples, through their organizations, movements, and social and political networks"; therefore some of the issues denounced by the Commission can and should be disseminated among the world's peoples, in an appropriate language, so as to promote the struggle for health care rights and popular organization to support this struggle.

In contrast to neoliberal positions which have constantly sought to hide social inequalities or to minimize them as "sanitary inequalities", the Commission has made an important synthesis of the "social determinants" of health. Emerging from this synthesis the Commission offered a wide-ranging denunciation of the huge social health inequalities existing in the world and has drawn attention in turn to the inequities they represent and the importance of immediate action in this situation. It was felt that ALAMES should welcome the public discussion of these issues and the Commission's call to action on the social determinants of health. However, we

cannot limit ourselves to the Commission's approach which tends to reduce social determination to a focus on risk factors isolated from social processes. This approach leaves out an analysis of social processes and structures from the standpoint of justice. Consequently, the recommended political agenda does not question or address the oppressive capitalist system that leads to social health inequities and inequalities.

Our colleague Rojas Ochoa stressed the need for ALAMES to become more fully involved in current social struggles against the global regime:

> *ALAMES can not forget its history. It cannot abandon what I would consider scholarly work; this should continue. But this should not be our priority. It is necessary to return to the trenches of social and political movements. ALAMES should become a movement itself, and make alliances with those social movements currently fighting for the better world that IS possible. This is happening every day in our America as words are becoming deeds. We must live committed lives. It is time for citizens to say: "Enough!" It is time for ALAMES to say "Enough!* [12]

References

1. Comité Organizador del Taller Internacional de Determinantes Sociales de la Salud (2008), "Documento Base para la Discusión", Taller Latinoamericano de Determinantes Sociales de la Salud, 29 de septiembre al 2 de octubre, ALAMES, México, D.F. Available at: http://www.alames.org/-eventos/materiales-taller-determinantes-sociales/
2. Mario Testa (1997), *Pensar en salud*, Lugar Editorial, Buenos Aires.
3. Alec, Irwin y Elena Scali (2005), "Action on the social determinants of health: Learning from previous experiences. A background paper prepared for the Commission on Social Determinants of Health", World Health Organization, Secretariat of the Commission on Social Determinants of Health, Geneve, Available at: http://www.determinants.fiocruz.br/pdf/texto/IN_texto1.pdf
4. WHO Director Lee Jong-Wook stated: "A crucial part of justice in human relations is promotion of equitable access to health-enabling conditions….The Alma-Ata goal of Health for All was right. So were the basic principles of primary health care: equitable access, community participation, and intersectoral approaches to health improvement. These principles must be adapted to today's context" (cited in Alec Irwin y Elena Scali, *ibid. p. 31*).
5. Jaime Breilh (2008), "Una perspectiva emancipadora de la investigación y acción, basada en la determinación social de la salud", ponencia, Taller Latinoamericano de Determinantes Sociales de la Salud, 29 de septiembre al 2 de octubre, ALAMES, México, D.F. Available at: http://www.alames.org/eventos/materiales-taller-determinantes-sociales/
6. Carolina Martínez Salgado (2008), "Abrir la Epidemiología", ponencia, Taller Latinoamericano sobre Determinantes Sociales de la Salud, ALAMES, octubre 2008, México, D.F. Available at: http://www.alames.org/eventos/materiales-taller-determinantes-sociales/
7. López O., Blanco J., Garduño M.A., Granados J.A., Jarillo E., López S., Rivera J.A., Tetelboin C, Los determinantes sociales de la salud y la acción política. Una perspectiva desde la academia. Ponencia al Taller Latinoamericano de Determinantes Sociales de la Salud, octubre 2008. Available at: http://www.alames.org/eventos/materiales-taller-determinantes-sociales/
8. Whitehead, Margaret and Göran Dahlgren (2006), *Levelling up (part 1). A discussion paper on concepts and principles for tackling social inequities in health*, WHO Europe, Collaborating Centre for Policy Research on Social Determinants of Health, University of Liverpool, UK, Denmark, Available at: http://www.who.int/social_determinants/resources/leveling_up_part1.pdf
9. Hernández, Mario (2008), "Desigualdad, inequidad e injusticia en el debate actual en salud: posiciones e implicaciones", ponencia, Taller Latinoamericano de Determinantes Sociales de la Salud, 29 de septiembre al 2 de octubre, ALAMES, México, D.F. Available at: http://www.alames.org/eventos/materiales-taller-determinantes-sociales/
10. Jaime Breilh, *Epidemiología Crítica*, Editorial Lugar, Buenos Aires –Quito, 2003.
11. Laurell, Asa Cristina (2008), "Los determinantes sociales de la salud y la acción política", ponencia, Taller Latinoamericano de Determinantes Sociales de la Salud, 29 de septiembre al 2 de octubre, ALAMES, México, D.F. Available at: http://www.alames.org/eventos/materiales-taller-determinantes-sociales/
12. Rojas Ochoa, Francisco (2008), "Los determinantes sociales de la salud y la acción política", ponencia, Taller Latinoamericano de Determinantes Sociales de la Salud, 29 de septiembre al 2 de octubre, ALAMES, México, D.F. Available at: http://www.alames.org/eventos/materiales-taller-determinantes-sociales/
13. Torres, Mauricio (2008), "Los determinantes sociales de la salud y la acción política", ponencia, Taller

Latinoamericano de Determinantes Sociales de la Salud, 29 de septiembre al 2 de octubre, ALAMES, México, D.F. Available at: http://www.alames.org/eventos/materiales-taller-determinantes-sociales/

14. Escudero, José Carlos (2008), comentario, Taller Latinoamericano de Determinantes Sociales de la Salud, 29 de septiembre al 2 de octubre, ALAMES, México, D.F.

Visit our blog at www.socialmedicine.org