Introduction
New opportunities are emerging to improve health and tackle health inequities through action on the social determinants of health (SDH). The March 2005 launch of the World Health Organization’s (WHO) Commission on Social Determinants of Health (CSDH) signals a commitment among global health leaders to promote policy action on social determinants and to support developing countries, in particular, in implementing SDH policies.

Many of the ideas underlying a social determinants approach are hardly novel. For some observers, the messages emerging from the CSDH thus far may have a flavour of déjà vu, recalling the WHO discourse of the late 1970s ‘Health for All’ period in which a social vision of health was prominent. This resemblance is by no means necessarily negative – it may be the best news from WHO in some time. However, the perceived failures of Health for All raise questions about the capacity of the CSDH to deliver on its promises and about the overall viability of a social determinants agenda.

To evaluate opportunities for action on SDH and understand which strategies will raise chances of success requires a critical historical perspective. Plans for addressing SDH should be developed with an awareness of past similar efforts and factors that contributed to their success or failure. This article provides elements for such an analysis. We begin by examining key milestones in the history of action on SDH over the last half century, with special attention to the Health for All agenda and its political-economic context. We then move from the global level to highlight specific contributions of the Latin American tradition of social medicine. We argue that this tradition, too little known outside its region, provides tools for understanding and responding to the historical challenges confronting movements for health equity. Using these inputs, we frame recommendations for the CSDH and the contemporary agenda on social determinants, in particular around issues of civil society participation.

Abstract
Issues addressed: To evaluate opportunities for action on social determinants of health (SDH) requires a historical perspective. Plans for addressing SDH should be developed with an awareness of past similar efforts and factors that contributed to their success or failure.

Methods: Review of published historical literature on analysis and action on SDH, in particular from the Latin American social medicine movement.

Results: In the period since World War II, global public health has oscillated between a social vision of health and a more individualistic, technological and medicalised model. Action on SDH was central to comprehensive primary health care as promulgated at the 1978 Alma-Ata conference and championed by the movement for ‘Health for All by the Year 2000’. Subsequently, commitment to addressing SDH declined under the impact of restrictive interpretations of ‘selective primary health care’ and the pressure of neo-liberal economic and health policies.

Conclusions: Through its critique of politically naive medical and public health approaches and of neo-liberal ideology, the Latin American social medicine tradition offers important lessons for today’s efforts to advance action on SDH. Key lessons concern: (1) the model of praxis, consciously uniting reflection and action for political change; and (2) the importance of civil society and community participation in action on SDH.

So what?
Opportunities exist today for significant progress in addressing SDH through national action and global mechanisms such as the Commission on Social Determinants of Health. Historical analysis suggests that civil society participation will be crucial for the success of these efforts.
**Action on social determinants: a historical overview**

The awareness that people’s chances to enjoy good health depend heavily on their different positions within society may be as old as society itself. Giovanni Berlinguer, following Henry Sigerist, found evidence of a lucid recognition of the inequitable effects of occupation and social status on health in Egyptian papyri written thousands of years before the Common Era. In the 19th Century, understanding the impact of social factors on health enabled the achievements of public health pioneers such as German epidemiologist Rudolf Virchow, who asked: “Do we not always find the diseases of the populace traceable to defects in society?”

In the period since World War II, global public health has oscillated between the embrace of a social vision of health and the rejection of this vision in favour of a more individualistic, technological and medicalised model. A social approach to health was enshrined in the 1948 Constitution of the World Health Organization (WHO), which famously defined health as a “complete state of physical, mental and social well-being” and mandated intersectoral action to improve health by addressing social and environmental factors. However, this view was eclipsed during the 1950s and 1960s as WHO focused on attacking diseases through technology-driven vertical campaigns, rather than on the positive development of health.

**Social determinants in the Health for All era**

Action on SDH gained prominence again through the landmark 1978 Alma-Ata Conference on Primary Health Care and the global movement towards ‘Health for All by the Year 2000’, to which the conference gave impetus. Werner and Sanders have shown how the Alma-Ata model of primary health care (PHC) grew out of community-based health programs pioneered during the 1960s and 1970s, whose common points included a holistic model of health attentive to social and environmental determinants and a fundamental commitment to community participation and empowerment in health action. China’s rural health workers (figuratively referred to as ‘barefoot doctors’) famously exemplified one aspect of this approach, but community-based initiatives flourished in numerous African, Asian and Latin American countries. In the Philippines, for example, some groups practised community-based ‘structural analysis’ through which community members traced the social and political roots of their health problems.

Many of the principles and practices tested in community-based programs were taken up in the model of primary health care (PHC) promulgated at Alma-Ata and promoted by WHO under the leadership of Halfdan Mahler, head of the organisation from 1973 to 1988. For Mahler, PHC was the fundamental mechanism to achieve health for all people. PHC, properly understood, included the rapid expansion of basic health care services to disadvantaged communities but also action to address non-medical determinants. “Health for all,” Mahler argued, “implies the removal of the obstacles to health – that is to say, the elimination of malnutrition, ignorance, contaminated drinking water and unhygienic housing – quite as much as it does the solution of purely medical problems.” Accordingly, the pillars of WHO’s PHC strategy included intersectoral action to address health determinants.

The Alma-Ata declaration specified that PHC required action across multiple policy sectors, including agriculture, education, housing and industrial policy. Following Alma-Ata, WHO altered its own organisational structures to lend greater support to intersectoral action on social and environmental health determinants. From the mid-1980s, SDH were also given prominence in the emerging health promotion movement. The 1986 Ottawa Charter on Health Promotion famously identified eight key determinants (‘prerequisites’) of health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity.

**The retreat to ‘selective PHC’**

From early on, both the potential costs and the political implications of a full-blown version of PHC were alarming to some constituencies, particularly those with an economic and/or ideological stake in market-based, individualistic models of health care. ‘Selective PHC’ was rapidly proposed in the wake of the Alma-Ata conference as a more pragmatic, financially palatable and politically tolerable alternative.

Rather than pinning hopes for health progress on utopian visions of social transformation, advocates of selective PHC maintained that, at least in the short term, developing countries should concentrate their efforts on a small number of cost-effective health interventions aimed at major sources of morbidity and mortality. Selective PHC focused particularly on maternal health and child health, seen as areas where a few simple interventions could dramatically reduce illness and premature death. The most famous example of selective PHC was the strategy for reduction of child mortality known as ‘GOBI’ – short for growth monitoring, oral rehydration therapy, breastfeeding and immunisation.

By prioritising wide implementation of these interventions in developing countries, proponents argued, rapid progress could be made in reducing child mortality without waiting for the completion of long processes of health systems strengthening, much less for structural social and political change. Accordingly, the GOBI strategy became the centrepiece of the ‘child survival revolution’ promoted by UNICEF in the 1980s.

For proponents of selective PHC, progress in child survival during the 1980s confirmed the superiority of this less ambitious but more pragmatic approach. For its critics, then as now, selective PHC betrayed the Alma-Ata vision and sanctioned a destructive retreat from holistic, pro-equity approaches in health. The prolonged and often bitter debates between defenders of comprehensive and selective PHC take on fresh relevance in the context of current efforts to promote action on SDH through mechanisms such as the CSDH.
The failure of Health for All and the ascendance of neo-liberal models

The decades that followed the 1978 Alma-Ata Conference saw scant progress towards the more ambitious Health for All goals in many of the countries where needs were and are greatest.\textsuperscript{17} In some settings, significant advances were made towards the less ambitious objectives associated with selective PHC and child survival. However, in some of the most vulnerable countries and communities on the planet, particularly in sub-Saharan Africa, not only did Health for All remain a distant dream, but key health and social indicators actually went backwards during the decades between the Alma-Ata conference and the Health for All target year of 2000.\textsuperscript{18}

The reasons for the failure of Health for All have been widely debated. While numerous factors exerted influence, the increasing impact of neo-liberal economic doctrines on global and national policy contexts in the 1980s and 1990s contributed decisively to derailing the Alma-Ata ideal.\textsuperscript{19,20} The core of the neo-liberal vision was (and is) the conviction that markets, freed from government interference, “are the best and most efficient allocators of resources in production and distribution” and thus the most effective mechanisms for promoting the common good, including health.\textsuperscript{21} Neo-liberal doctrines have affected health through two main mechanisms: (1) the macro-economic structural adjustment programs (SAPs) imposed on numerous developing countries by donor governments and the international financial institutions as a condition for debt restructuring and other forms of international support; and (2) health sector reform packages that have applied market-oriented, neo-liberal approaches specifically to the health system. Research has demonstrated negative effects of SAPs and neo-liberal health sector reforms on vulnerable populations in many instances.\textsuperscript{18,22,23} Most significantly for the current discussion, drastic cuts to public sector social spending mandated by neo-liberal theory negatively affected key social determinants of health and weakened the capacity of many developing country governments to intervene on SDH.\textsuperscript{8,24}

The Latin American social medicine tradition

One global region that has been heavily affected by neo-liberal economic and health policies – but which has also developed critical tools for understanding and acting on the social and political dimensions of health – is Latin America. The Latin American tradition of social medicine offers a rich body of critical reflection on health and society that remains too little known by practitioners unable to read Spanish and Portuguese.\textsuperscript{25} In Brazil, the social medicine movement has adopted the name ‘collective health’. The term underscores the rejection of disease and medical intervention as the sole axis of reflection on health. Instead, health/illness is conceptualised as a collectively constructed process. The concept of collective construction describes both the forms in which health and illness express themselves in a society and the possibilities for shared action to bring change.

Historical trajectory

Originating in the middle decades of the 20th Century, the Latin American social medicine movement drew from progressive European social and political thought and challenged the established disciplines of hygiene, public health and preventive medicine.\textsuperscript{26} The movement was and remains rooted in political practice with explicit ideological objectives.\textsuperscript{26,27} Political commitments were clear, for example, in the work of Salvador Allende, pathologist and later president of Chile, who contributed centrally to the early flourishing of Latin American social medicine beginning in the 1930s. In 1939, Allende, then Minister of Health, published his groundbreaking book La Realidad Médico-Social Chilena (The Chilean Socio-Medical Reality), which focused primarily on health problems generated by the poor living conditions of the working class: maternal and infant mortality, tuberculosis, sexually transmitted and other communicable diseases, emotional disturbances, and occupational illness.\textsuperscript{28} Allende concluded his study with proposals for health improvement that emphasised social change rather than medical interventions: income distribution, a national housing program, and industrial reforms.\textsuperscript{29} Allende’s example shows that attention to social determinants and health equity – and the effort to translate these ideals into political action – has been central to the Latin American tradition since its beginnings.

Conceptual and methodological aspects

Debora Tajer\textsuperscript{30} has described the core elements of the Latin American social medicine tradition:

- A conceptual framework that highlights the economic, political, subjective, and social determinants of the health/disease/care process within human collectivities.
- A political dimension represented by political and social movements in Latin America that have valued the improvement of health status and equitable access to health services as pillars of the liberation of the people.
- A view of the concept of subjectivity theoretically and practically based on the Marxist tradition that considers the subject as historically conditioned and at the same time a maker of history.

Iriart, Waitzkin and colleagues, along with others, have clarified the theoretical-methodological approach used by Latin American social medicine. Social medicine considers the population and also social institutions as a whole that transcends the individuals that compose them.\textsuperscript{25,31,32} For this reason, social medicine’s main analytical categories include: social reproduction, social class, economic production, culture, ethnicity and gender.\textsuperscript{33} Only in light of these categories can individual specificities such as sex, age, or education have explanatory relevance.

Social medicine considers health-illness as a dialectical process and not as a dichotomy. It studies the health-illness process within its social context, considering the effects of social changes over time. Tracing the epidemiological profile of a given society requires a multi-level analysis to understand why and how social
conditions crystallise into different ways of life that characterise groups situated in different positions within power structures. Different social positions determine differential access to favourable-protective or unfavourable-destructive health conditions, defining the dynamic that shapes health–illness. In this light, as A.C. Laurell and others have stressed, a social medicine approach restores the importance of the concept of social class, defined in terms of relations of economic production. The concept of ideology is another theoretical axis for the social medicine tradition. Ideology includes the specific ideas and doctrines of a particular social group. A ‘hegemonic’ ideology tends to justify the interests of the classes that dominate a given society in a particular historical period. The demystification of dominant ideology in the contemporary context is part of the theoretical and political task Latin American social medicine sets itself.

Praxis and participation
To describe the link between theory and practice, social medicine uses the concept of praxis, which is understood as the interrelationship of thought and action. In this sense, the social medicine movement, influenced by Italian Marxist philosopher Antonio Gramsci, underscores the two-way process of theory. Theory contributes to efforts tending towards social change, but theory is at the same time nourished by these efforts. Accordingly, in many cases, the research activities of social medicine practitioners are developed together with trade unions, women’s groups, coalitions of Indigenous people and community organisations. Thus, inseparably linked to the model of praxis in social medicine is the concept of people’s right to participation in the decisions and actions that affect their health and well-being.

In summary, the Latin American social medicine tradition offers the example of an approach to understanding health that gives central importance to the social context and which also grasps the process of scientific reflection on health as necessarily linked to a project of political transformation. Health is understood as belonging to the arena of social policy, and in the end the task of social medicine necessarily lies in the political arena. For this reason, the movement recognises alliances with grassroots groups and social and political movements as vital.

Grasping new opportunities for action on SDH: the role of civil society
Knowledge of history prohibits facile optimism about the chances for rapid progress in addressing SDH. On the other hand, historical comparison also helps us appreciate the strategic opportunities emerging today. Scientific knowledge about SDH and health inequities has grown substantially in the past decade, although the bulk of research remains focused in wealthy countries. Increasingly, as well, concern with health inequities has moved beyond the scientific community into broader public and political forums, although again with a disproportionate share of the debates occurring in high-income countries. Today, a small but growing number of countries have begun to put in place interventions, and in some cases broad national public health policies, oriented to the social determinants of health. Meanwhile, WHO’s launch of a global Commission on Social Determinants of Health signals a fresh concern among some key global public health institutions – bolstered by an explicit commitment to engage middle- and low-income countries.

It is vital to take advantage of these opportunities to advance SDH agendas. History suggests a number of lessons for how today’s movement for action on SDH can increase chances of long-term success. One of the most vital of these lessons concerns the participation of civil society in designing and implementing SDH policies. The success of national efforts to reduce health inequities through action on social determinants, and the relevance and impact of global exercises such as the CSDH, will depend heavily on the extent to which these processes: (1) engage civil society and communities as committed yet autonomous partners; (2) empower civil society and community groups for knowledge and leadership on SDH; (3) empower and support civil society for ongoing social monitoring of SDH conditions and policy responses.

The CSDH has pledged to incorporate partnership with civil society as a core component of its program. In contrast to some other international bodies, the CSDH has tried to create space for autonomous, critical civil society participation. To this end, the CSDH has invited civil society groups themselves to define their terms of engagement and preferred strategies for collaboration with the commission. CSDH civil society strategies have been developed through consultative processes led by civil society groups in four global regions (Africa, Asia, the Eastern Mediterranean and Latin America/Caribbean). The civil society networks facilitating regional strategy development, and which will also have responsibility for co-ordinating implementation, are called CSDH regional civil society facilitators (CSFs).

Four themes appear especially relevant for understanding how civil society and communities can contribute to successful action on SDH:

1. The knowledge of SDH emerging from civil society and communities, ‘civil society knowledge’ being understood as rooted in collective daily experience and leading to people’s empowerment.
2. The role of civil society in advocacy and dissemination of findings on social determinants.
3. Civil society’s capacity for social monitoring of SDH policy processes at local, national and global levels.
4. The need for a nuanced view of civil society organisations themselves, avoiding romantic clichés and acknowledging civil society’s internal diversity and conflicts.

Recalling the history of SDH action, and in particular experiences emerging from Latin America, prompts us to underscore the following lessons for the CSDH. The commission should orient itself to the concept of praxis as reflection inseparably interwoven with action for political change – implying a break with
conventional postures of scientific ‘neutrality’. At the same time, the CSDH and other institutions driving action on SDH must strive to make civil society participation a reality. Often such participation has been altogether absent, or else civil society and community groups have been instrumentalised as contributors to processes they do not own or control. The challenge is to integrate civil society participation not as a means but as an end in itself – the democratic space in which social control of institutions (including the CSDH) becomes real.\textsuperscript{42} This will not be easy to achieve and maintain, because it implies a change in the concrete distribution of decision-making power. If the CSDH succeeds in sustaining such a model of genuine partnership with civil society, this in itself will constitute a meaningful legacy for future collective action on social determinants of health.

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Marilyn Wise, from the Australian Centre for Health Promotion, responds:

This paper addresses one of the most significant contemporary issues for health promotion across the world. It draws on a body of knowledge and experience that is not readily accessible to English-speaking Western readers and expands our understanding of the perspectives of other parts of the world. It is important in its own right and a reminder of the power of comparison among theories, traditions, and experience. It is also a reminder of the relationship between history and contemporary social and economic conditions and of the lessons we can learn from history. Furthermore, it is an example of one of the positive outcomes of this period of globalisation – of the expansion of knowledge to incorporate a wider range of philosophy, theory, experiences, and cultural perspectives.

However, in my view there are some aspects of the paper that merit deliberation.

Although intuitively the argument for praxis and the high level of engagement of civil society is completely synchronous with the evidence of effective health promotion, it is necessary in this age to examine the rhetoric in light of practice and evidence. For example, where has the model been translated into action in Latin America and what have been the results? What is the evidence of the effectiveness of the Latin American approach in improving the health of populations – proximal or not?

The only evidence of improved health outcomes included in the paper actually points to a World Health Organization success with its model of primary health care, at least in the short term. Of course, this model means that the pool of need (mothers and children) is unlikely to have been reduced because the model of intervention and care has not addressed the social determinants of poor maternal and child health. But nonetheless, the fact that there is evidence of progress and that many women’s and children’s lives have been saved and improved seems to contradict the authors’ point about primary health care, praxis and engagement of civil society. Rather, it points to the contribution that highly focused efforts can make – and the fact that this is an example of what’s possible when the right combination of commitment and resources is applied to a health issue. I am not arguing against the Latin American model – quite the reverse. It is the question of evidence that is at issue here.

The paper is based on a strong ideological stance and expresses values with which I happen to agree strongly. I also agree strongly with the authors’ analysis and criticisms of the dominance of neoliberal economic and health policies and the harm they are wreaking on people, communities and countries. However, I believe that there is real danger in substituting one ideological stance for another without evidence. I also believe that there is evidence to support the policy directions being proposed in this paper and that it should be used. Although their empirical work is based on national data, Navarro et al.’s paper on politics and health in the Lancet demonstrates, again, that even in Western democracies there is a significant positive difference in the health of populations in countries in which strong welfare and civic engagement approaches have guided democratic decision making.

A final point of discussion in the paper is the emphasis on the engagement of civil society and the building of a social movement. Clearly, the widespread, profound social changes implied by a focus on improving the distribution of the social determinants of health will require the active engagement and mandate of civil society. These are vital in their own right as a social determinant of health (as the authors point out). However, the argument presented in the paper leaves government, private industry (particularly large corporations), and global organisations untouched.

But governments, global organisations, and corporations are the instruments of we, the citizens. On our behalf, as citizens, they play central roles in creating and distributing the determinants of health. It is, of course, true that civil society can and should agitate and advocate for change and should hold decision-makers in all sectors accountable for their/our decisions and their consequences. But it is through the instruments of government and non-government agencies and through private sector organisations that the actions that actually redistribute power and resources must be taken ultimately. Our purpose is to ensure that every citizen of every country has, throughout their lives, access to the conditions they need to become and stay healthy (and to achieve a high level of well-being). We cannot wait for governments and industry to make bad decisions (or decisions that are bad for health) and then bring civil society (and health promotion for that matter) to bear on these. Our goal is to have them make the right decisions in the first place.

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